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Minnesota Prepaid Medical Assistance Status Report

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**MINNESOTA PREPAID
MEDICAL ASSISTANCE PROGRAM
STATUS REPORT**

**THE MINNESOTA DEPARTMENT OF HUMAN SERVICES
Division of Health Care Administration
Managed Health Care Unit**

May 1, 1992

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OVERVIEW OF THE PREPAID MEDICAL ASSISTANCE PROGRAM

Waivers

The Minnesota Department of Human Services (DHS) was awarded the following waivers of Title XIX of the Social Security Act (SSA) under 1115 authority to conduct a three-year demonstration project. The purpose of the demonstration project was to test the viability and cost effectiveness of a prepaid, capitated program for the administration and delivery of health care services to Medical Assistance beneficiaries. Waivers authority has been extended through June 30, 1996.

1115(a)(1) Authority

Section 1902(a)(1) of the SSA and 42 CFR 431.50. This waiver exempts the State from the requirement to administer Medical Assistance (MA) uniformly on a statewide basis.

Section 1902(a)(23) of the SSA and 42 CFR 431.51. This waiver permits the State to restrict the recipients' freedom of choice.

Section 1902(a)(13)-42 CFR 447.250, 447.252-447.371
Section 1902(a)(30)- insofar as it is implemented by the regulations cited above.

Section 1902(a)(4)-insofar as it is implemented by
42 CFR 431.523(a)(2) and 431.565

These waivers enable the State to obtain maximum flexibility in arranging reimbursement agreements with health care providers.

Section 1902(a)(10) of the SSA and 42 CFR 440.240(b). This waiver allows differences in the amount, duration and scope of benefits to recipients.

Section 1902(a)(7) and 42 CFE 431.306. This waiver allows for the release of information to brokers.

1115(a)(2) Authority

Under the authority of Section 1115(a)(2) of the SSA, expenditures made by the State for the items identified below (which are not otherwise included as expenditures under section 1903) are, for the period of the project, regarded as expenditures under the State's Title XIX Plan.

Expenditures to permit the State to contract with organizations not meeting the 75% Medicare/Medical Assistance enrollment limitation as designated under section 1903(m)(2)(A)(ii) and 42 CFR 434.26(a).

Expenditures to permit the State to restrict enrollees from disenrolling on demand as designated under section 1903(m)(2)(A)(vi) and 42 CFR 434.27(b)(1).

Expenditures to permit the State to contract with non-Health Maintenance Organizations (HMOs) on a prepaid, capitated basis, as designated under section 1903(m)(2)(A)(i) and 42 CFR 434.20.

Design

This prepaid, capitated program is operating in three counties: Dakota, Hennepin and Itasca, which serve respectively as suburban, urban and rural sites. In Hennepin County, 35% of the Medical Assistance eligibles were initially enrolled in the project, with the remaining 65% on fee-for-service to provide a control group for study purposes. HCFA granted expansion authority and the remaining 65% of the eligible Medical Assistance populations were enrolled by the end of 1991. Most AFDC and aged recipients in the three counties participate. There are, however, several groups of Medical Assistance recipients excluded from participation in the project:

- Community based medically needy individuals who are Medical Assistance eligible on a spend-down basis.
- Recipients of the Refugee Assistance Program.
- Blind and disabled recipients under 65 years of age.
- Recipients residing in state institutions.
- A group of recipients in Itasca County who live near the county border and who use providers in a neighboring county.
- Children in designated out-of-home placements.
- Children eligible for Medical Assistance through subsidized adoptions.
- Recipients who have private health care coverage through a certified HMO.
- Recipients who have a Personal Care Assistant prior to enrollment in a health plan.

The following groups of Medical Assistance recipients were also added as exclusions in the most current revision of Minnesota rules governing the Prepaid Medical Assistance Program.

- Recipients who are Qualified Medicare Beneficiaries (QMB) and who are not otherwise eligible for Medical Assistance.

- Recipients who are terminally ill and who, prior to enrollment in a health plan, are being treated by a primary physician who is not part of a health plan network.
- Children who prior to enrollment in a health plan are determined to be severely emotionally disturbed and whose primary mental health therapist is not part of a health plan network.
- Children who prior to enrollment in a health plan are determined to be in need of protection, are identified to the State by the county social service agency, and are receiving Medical Assistance covered services through a provider who is not part of a health plan network.
- Recipients who have a communicable disease with a prognosis of terminal illness and who, prior to enrollment in a health plan, have a non-participating primary physician who certifies that disruption of the existing patient-physician relationship is likely to affect the patient's compliance with health services. In this instance, "terminal illness" may exceed six months.

Eligible Medical Assistance recipients in Hennepin and Dakota Counties are required to choose a participating health plan and then receive all health care services through the health plan. Once enrolled in the health plan, the recipient receives an identification card from the plan and no longer receives a Medical Assistance Identification (MA ID) card. Unless recipients request a change within the first year after enrollment, they remain in the health plan of choice for one year or as long as they remain eligible for Medical Assistance. A 30-day open enrollment period is offered each fall.

The State pays a capitation rate every month to the health plan on behalf of each enrolled recipient. For this rate the health plan provides all Medical Assistance covered services. Base rates do not vary by health plan and are based on an actuarial analysis of the State's historical cost experience with groups of recipients and other cost and utilization factors. Recipients are assigned rate cells based on several factors, including: age; sex; Medicare, institutional, and eligibility status; and county of residence.

Nursing facility costs are not included in the rate. Capitation payments for nursing facility residents cover all services except the residential per diem costs.

The State also provides for reimbursement of certain items outside of the capitation payment. Traditionally, the State has reimbursed health plans for Medical Education (ME) costs and Disproportionate Population Adjustment (DPA) costs. The State recognizes that in certain counties, these items may need to be reimbursed on a health plan specific basis, since health plans may vary significantly in their use of teaching facilities and DPA hospitals. If the State averaged ME and DPA costs into the rates in Hennepin County, some

health plans potentially could be undercompensated, while others could be overcompensated for these services. In the past, the State has accommodated these costs outside of the capitation payments in retrospective settlements.

Beginning July 1, 1992, ME and DPA costs will be built into the rates on a health plan specific basis in Hennepin County, based on each health plan's historical use of teaching and DPA hospitals.

Additional items reimbursed outside of the capitation have included incentive payments for providing preventive care. The contract beginning July 1, 1990, provided for reimbursement of designated costs of immunizations. The contract beginning July 1, 1992, will continue the immunization incentive, and will also add incentive payments for providing enhanced services to pregnant substance abusers. In Hennepin County, an additional incentive is allowed for providing outreach services to specified high risk recipients.

In addition to the capitation rates, inpatient hospital stop-loss protection is offered. Coverage is 80% of costs above a \$15,000 threshold. Beginning in contract year 1990, health plans were given the option of having the State supply this reinsurance, or assuming full financial responsibility for all inpatient hospital costs. For health plans who choose the second option, the value of the stop loss coverage is incorporated directly into the capitation rates.

The design of the prepayment program in Itasca County is different from that of Hennepin and Dakota. In Itasca, the County administers the health plan. The County contracts with providers for provision of services, and the State pays the capitation rate directly to the county. Each recipient accesses services through the health plan, designating a primary care physician and dentist. Recipients receive an identification card which identifies them as enrolled in "Itasca Medical Care" (IMC).

History

The Minnesota Prepaid Medical Assistance Program (PMAP), initially called the Minnesota Prepaid Medicaid Demonstration Project, is one of the five original 1115 competition demonstration projects authorized by HCFA. In the early 1980's, HCFA solicited states to examine cost effective alternatives for payment and delivery of Medical Assistance services. Minnesota submitted an initial application in April 1982 and the following June received a grant award to design the program.

An extensive and lengthy planning process followed. The PMAP design evolved from an advisory committee process. The State assembled a committee consisting of State, county, provider, HMO, advocate, and consumer representatives. The committee actively participated in decisions regarding PMAP implementation and assisted in writing the program protocol that was submitted to HCFA.

The length of the program planning phase was the result of the committee process and of roadblocks in obtaining county participation. Decision makers in both Itasca and Dakota counties were eager to participate in the experiment and volunteered to be the rural and suburban sites respectively. Securing an urban site was more difficult. Hennepin County had indicated an interest in participating as the urban site, but the county board expressed reservations about the program. The State subsequently mandated Hennepin County's participation, as state statute directed the Commissioner of Human Services to designate an urban site.

The PMAP had strong legislative support and the enabling state statute (Minnesota Statute 256B.69) was passed in 1983. The legislature allocated funds for county administrative expenses connected with research and development and administrative expenses resulting from participation in the PMAP. The State agreed to pay the 50% county share of administrative costs associated with the program; the remaining 50% of costs are covered through federal Medicaid administrative funds. In addition, the State offered participating counties a 50% reduction in their share of service costs, i.e., counties would pay 5% of the non-federal share of service costs instead of the usual 10%.

Itasca County implemented the PMAP on July 1, 1985. The program was delayed five months for the Dakota and Hennepin County sites, due to lack of Hennepin County approval for the PMAP. In December 1985, the prepaid program was implemented in the remaining two counties. The PMAP demonstration period was to run until December 31, 1988, giving a full three year experience for two counties and three and one-half years for Itasca County.

The program protocol was submitted to HCFA in March 1985. Preliminary HCFA approval was obtained on July 10, 1985. Final approval by HCFA of the operational phase of the PMAP was granted on December 6, 1985.

Difficulty in obtaining usable service encounter data from the health plans made it difficult to evaluate the PMAP. In addition, delays in enrollment of recipients resulted in considerably less than three years of actual program experience. The State thus requested in the summer of 1987 that a two-year program extension be granted. This was denied in September 1987. HCFA encouraged instead a transition to 1915b waivers.

The State then decided to pursue a dual course of action: pursuit of 1915b waivers and a two-year program extension under 1115 waiver authority through Congressional action. A 1915b waiver application was completed and submitted to HCFA in August 1988. State staff considered the 1115 waiver extension crucial to continuation of the PMAP as there was insufficient interest by the health plans in the 1915b waiver option. One of the features of the program design considered critical by the health plans is the 12-month recipient

lock-in to a given health plan. HCFA is currently unable to grant this under 1915b waiver authority. Without a 12-month lock-in, enrollees could change plans from month to month. Health plans were concerned with their financial risk in this scenario.

Several health plans had dropped voluntary AFDC contracts. Lack of enrollment stability in this program contributed greatly to health plan dissatisfaction. The 12-month consumer lock-in provides them with greater financial stability, since they can be assured of a few months' premium from a given enrollee. Without a lock-in, an enrollee could incur thousands of dollars in obstetrical costs, for example, then choose to leave the health plan. The health plan would never recover in premiums its expenditures.

In July, 1988, the State requested that health plans submit a letter of intent to participate under either the 1115 waiver or the 1915b waiver programs. Physicians Health Plan (PHP), a participating health plan, indicated they would not participate under the 1915b waiver option, and other health plans, especially PreferredOne, expressed strong reservations about participating without the flexibility of the 1115 authority. The State considered recipient access to be inadequate without PHP's participation. Thus, only the 1115 waiver option appeared viable.

During the same period, Minnesota succeeded in obtaining federal legislative authority to continue under current waivers through the Welfare Reform Bill. An amendment to this bill extended the PMAP under 1115 waiver authority for an additional 18 months. The bill, titled the Family Security Act (SF1511), was passed and signed by the President in October, 1988, thus giving HCFA the authority to extend the PMAP until June 30, 1990. Congressional authority to continue for an additional year, through June 30, 1991, was granted as part of the Reconciliation Bill.

State authority was granted during the 1989 State legislative session, giving Minnesota authority to expand prepayment to other Commissioner-designated counties.

Finally, in October of 1990, the U.S. Congress granted authority to continue the PMAP through June of 1996. Under this authority, Minnesota is permitted to expand the prepayment program to other viable counties.

Continued Expansion

With the demonstrated success of the PMAP in the two metropolitan counties of Hennepin and Dakota and the rural county of Itasca, the State is interested in expanding the counties served by the PMAP. In evaluating which county(ies) would be most amenable to such an expansion, the State examined a number of criteria related to accessibility, current utilization patterns, the size of the potential population, the number of potential health plan

contractors, the potential cost savings, and administrative ease. In reviewing these criteria, it became apparent that Ramsey County was the logical choice. Comprising the city of St. Paul, Ramsey County has the second largest Medical Assistance population base in the State. With regard to geographic size, however, Ramsey County ranks as one of the smallest in the State. The combination of large population size within a small geographic area bodes well for the viability of a prepaid system within Ramsey County.

Ramsey County has been a participant in the AFDC voluntary prepayment program since the early 1980's. Current enrollment in the voluntary program is 650 recipients, most of whom are enrolled in Group Health Inc. Although UCare Minnesota became an option for AFDC recipients in June 1991, enrollment in this health plan is still quite limited. In preparation for implementation of the PMAP in Ramsey County, the county will be more aggressively marketing the advantages of the health plan system.

In addition to the AFDC voluntary program, the county participates in the Prepaid General Assistance Medical Care Program, a mandatory program with an enrollment of approximately 4000 recipients. Through its participation in the Voluntary AFDC and the General Assistance Medical Care prepayment programs, Ramsey County has demonstrated experience in the prepayment area, which should prove useful as the State expands to a mandatory prepayment system for the AFDC and MA aged populations in the county.

MA Population Size

There are approximately 40,000 Medical Assistance recipients eligible to participate in the PMAP in Ramsey County. The AFDC population comprises about 33,000 of this number, with the aged, pregnant women and needy children groups making up the difference.

Potential Health Plan Contractors

At this time it is unknown which health plans will participate in Ramsey County. Several health plans have extensive Ramsey County networks and could provide recipients with improved access to care with minimal disruption of existing provider-patient relationships. The State anticipates that the Ramsey County recipient population would be offered a choice from among several health plans. Each health plan will be required to adhere to the same service delivery standards in Ramsey County as in the three counties currently participating in the PMAP.

Consumer Education and Enrollment Schedule

It is anticipated that PMAP enrollment in Ramsey County will begin no later than fall, 1992. Based on prior experience in enrolling recipients into the prepayment program, the county will be required to educate recipients about their health plan choices as part of the intake process. Consequently, enrollment will be phased in

over a one year period of time. This process should result in recipients receiving more personalized attention to their current health care concerns, which will allow them to choose the health plan that best meets their needs. Enrolling recipients at intake also cuts down on the number of initial and open enrollment changes.

Quality Assurance

In order to insure that the level of care provided by each health plan meets acceptable standards, the State will monitor the quality of care provided by each health plan. This will be accomplished through an ongoing review of each health plan's quality assurance system, complaint procedure, service delivery plan, and summary of health utilization information. Ramsey County recipients will also be included in the annual quality assurance audit conducted under state contract. A complete description of the quality assurance requirements is set forth in the contract between the health plan and the State.

Complaint and Appeal Procedures

As described in the "Complaint and Appeal" section of this document, the State has developed a number of mechanisms for protecting enrollee rights and fulfilling due process requirements. Each enrollee will have access to a complaint procedure within the health plan and a State appeal procedure, including an expedited appeal option. In addition, recipients will have access to a health care advocate at the County level and a State ombudsperson, who can assist recipients in resolving problems with health services.

Rate Setting Methodology

The rates paid to the health plans participating in the PMAP in Ramsey County were developed in accordance with the rate setting methodology described in the "Rates" section of this document. The Ramsey County rates are based on the fee-for-service metropolitan data base.

Cost Savings

In fiscal year 1990, Medical Assistance expenditures in Ramsey County totalled approximately \$55 million for the population to be included in the expansion. Using this figure, the anticipated cost savings at full enrollment (calendar year 1994) should be nearly \$2.5 million (approximately 5%). For calendar year 1993, however, the State anticipates a short term deficit due to the lag time in fee-for-service reimbursement.

PROGRAM ADMINISTRATION

State

The program is administered by the State Department of Human Services (DHS), Health Care Management Division, Managed Health Care Unit. State program administration includes:

- Contract negotiation and enforcement.
- Rate setting and financial management.
- Quality assurance monitoring.
- Evaluation.
- Management of the appeals process.
- Oversight of the consumer education process.
- Health plan payment.
- Reporting to health plans (e.g., enrollment reports) and to providers (e.g., nursing home enrollment report).
- Education of providers, health plans, advocates, and other interested groups.
- Coordination with county program officers.
- Policy setting and dissemination.
- Promulgation of rules.

Counties

Dakota, Itasca and Hennepin Counties are responsible for the following functions:

- Recipient education and enrollment.
- Coordination of the PMAP at the county level including training of county workers.
- Monitoring and evaluation of the PMAP from the county's perspective.
- Program reporting to the County Board and county advisory groups.
- Information and technical assistance on the PMAP to county staff, community and provider organizations, and the general public.

- Identifying and responding to problem areas and problem cases.
- Providing input to the State in the development of policy.
- Advocating for recipients who need assistance with accessing health care or with the appeal process.

Administrative Costs: Projected Budget - 1992 - 1993

County

Hennepin	\$ 856,800
Dakota	224,700
Itasca	126,000
Ramsey	<u>483,000</u>
Total County	\$1,690,500

State

Personnel	\$ 418,950
Overhead	35,858
Data Processing	36,750
Quality Assurance contract	128,015
Other	<u>29,719</u>
Total State	\$ 649,292
<u>Total</u>	\$2,339,792

Rule and Policy

Statute Amendment

During the 1991 legislative session, the State initiated language that would exempt Medical Assistance contracted vendors from paying Minnesota Comprehensive Health Association dues on Medical Assistance Enrollees. Effective August 1, 1991, Statute 62E.11, Subd. 5 was amended to include this language.

Minnesota Rule 62

The revised Minnesota Rule governing the PMAP (Rule 62) was promulgated on November 4, 1991. The following changes were adopted:

- The grievance panel process was eliminated and replaced with the State Medical Assistance fee-for-service appeal process. This transferred the grievance responsibilities to the State

Appeals Unit, pursuant to the procedure established under Minnesota Statutes, Section 256.045, subdivision 3.

- New categories of Medical Assistance recipients excluded from the Program were added.
- The ability to pursue prepaid programs in other counties where the viability of a prepaid program has been defined by the Commissioner was established. This is consistent with the federal authority received in October, 1990.
- The enrollment period in which a recipient may change health plans for any reason was changed from sixty days to one year after the initial effective date of enrollment in a health plan.

Other minimal changes not mentioned were made for clarification purposes and administrative ease.

Policies and Procedures Manual

The revised Prepaid Medical Assistance Program and General Assistance Medical Care Program Policies and Procedures Manual was published in March 1992 and distributed to the appropriate state, county and health plan staff. Copies are available at the Department of Human Services.

SERVICE PROVIDERS

Participating Health Plans

During the first two years of the PMAP, the State contracted with eight prepaid health plans. Health plans were given the option of enrolling only one Medical Assistance population. However, the State stipulated that any health plan contracting to enroll AFDC recipients would also be required to cover one of the higher risk populations, either aged or blind/disabled. Five health plans served both Hennepin and Dakota Counties, while two additional health plans were offered in Hennepin County only. A list of the health plans and the counties and populations served follows.

1986 and 1987 Health Plan Participation

	<u>Blind/</u> <u>AFDC Aged Disabled Hennepin Dakota Itasca</u>				
BCBS Sun Series Plan	X	X	X	X*	X*
Group Health, Inc.	X	X		X	X
Itasca Med. Care	X	X	X		X
MedCenters Health Plan	X	X		X	X
Metropolitan Health Plan	X	X	X	X	
Physicians Health Plan	X	X		X	X
PreferredOne	X	X	X	X	X
UCare Minnesota	X	X	X	X	

*BCBS terminated the contract in December, 1987.

In January of 1988, the program underwent two major changes. Blue Cross and Blue Shield withdrew from the program; and the blind and disabled populations were disenrolled. The remaining seven plans served all covered populations: AFDC, aged, and needy children. With the removal of Blue Cross/Blue Shield, there remained four health plans serving Dakota County and six serving Hennepin County for the third year of the program.

1988 Health Plan Participation

	<u>All Covered Populations</u>	<u>Hennepin</u>	<u>Dakota</u>	<u>Itasca</u>
Group Health	x	x*	x	
Itasca Medical Care	x			x
MedCenters Health Plan	x	x**	x**	
Metropolitan Health Plan	x	x		
Physicians Health Plan	x	x	x	
PreferredOne	x	x	x	
UCare Minnesota	x	x		

* Group Health terminated their Hennepin County contract for the AFDC population in December, 1988.

**MedCenters terminated the contract in December, 1988.

The fourth year of the PMAP brought further changes in health plan participation. MedCenters Health Plan terminated their participation at the end of 1988. They cited financial losses and State regulatory burden as their reasons for dropping out of the program.

Additionally, Group Health, Inc. (GHI) indicated that they would no longer serve the AFDC population in Hennepin County after December 31, 1988. Group Health, Inc.'s experience had been less favorable in Hennepin County than in Dakota County. Because GHI is a group-staff model plan, they received a lower proportion of enrollees who selected their health plan. Thus, the proportion of their assigned enrollees was higher. GHI staff cited adverse financial experience in Hennepin County due to out-of-plan bills.

1989 Health Plan Participation

	<u>Hennepin AFDC & AGED</u>		<u>Dakota AFDC & AGED</u>		<u>Itasca AFDC & AGED</u>	
Group Health, Inc.	X		X	X	X	X
Itasca Medical Care					X	X
Metropolitan Health Plan	X	X				
Physicians Health Plan	X	X	X	X		
PreferredOne	X*	X*	X*	X*		
UCare Minnesota	X	X				

*PreferredOne terminated the contract on September 30, 1989.

Program Year Five was affected by PreferredOne's decision to terminate the contract. Citing financial losses, PreferredOne was unable to continue to the end of the year, terminating the contract on September 30, 1989.

PreferredOne's termination posed a potential serious threat to the provider access and continuity of care for PMAP recipients. Three health plans remained in Hennepin County and access to services was carefully monitored. In Dakota County, based on the recommendation of the Dakota County Board of Commissioners to insure adequate access, PreferredOne enrollees were offered a choice of one of the two remaining health plans or fee-for-service. UCare contracted as a health plan in Dakota County on July 1, 1990. With an additional health plan option, these fee-for-service recipients were enrolled in a health plan in the fall.

Health plan participation has remained stable since that time and access to services continues to be monitored.

1990 Through April, 1992 Health Plan Participation

	<u>Hennepin</u> <u>AFDC & AGED</u>		<u>Dakota</u> <u>AFDC & AGED</u>		<u>Itasca</u> <u>AFDC & AGED</u>	
→ Group Health, Inc./ Seniors Plus		X	X	X		
Itasca Medical Care					X	X
Metropolitan Health Plan	X	X				
Medica (Formerly Physicians Health Plan)	X	X	X	X		
UCare Minnesota	X	X	X*	X*		

*UCare's contract in Dakota County was effective July 1, 1990.

Health Plan Descriptions

Group Health, Inc. and Seniors Plus

Group Health, Inc. (GHI) has contracted with DHS to serve AFDC enrollees since 1977 and continues to serve them under a voluntary AFDC contract as well as under the PMAP at their 27 participating clinics and 11 hospitals. This health plan began as a staff model HMO, but in recent years moved to a group model. GHI has an enrollee base of 330,591, less than 1% of which is Medical Assistance enrollment. GHI is a clinic model, i.e., most clinics are full service, offering physician, dental, eye care, pharmacy, and other services in one setting. Mental health and chemical

dependency services are provided through in-house practitioners and through referral to outside providers.

GHI has contracted to deliver services to aged Medical Assistance enrollees through Seniors Plus, part of a national Social HMO project that has separate federal waivers as a Medicare demonstration project. It is a joint venture of GHI and Ebenezer Society, a long established social service agency serving the Hennepin County elderly population. The goal of the Social HMO project is to test the feasibility of providing long-term care and alternatives to long-term care for the elderly through an HMO. Seniors Plus has a separate contract with DHS for up to 800 dual Medicare/Medical Assistance eligibles. Enrollees must be eligible for Medicare, Parts A and B, and must enroll in a Medicare risk plan if they choose Seniors Plus. Seniors Plus members receive services at 20 GHI staff model clinics and 6 hospitals.

Metropolitan Health Plan (MHP)

Metropolitan Health Plan (MHP) has been contracting with the State to serve Medical Assistance recipients since 1984. This health plan is also offered to Hennepin County employees. Enrollment as of March 1992 is 27,000, including 15,775 Medical Assistance and 6,450 General Assistance Medical Care beneficiaries. MHP is a Hennepin County operated network model HMO using Hennepin County Medical Center (hospital), 740 primary and specialty physicians, the HCMC outpatient clinics and a network of 15 other clinics.

MHP is a primary care clinic model offering many outpatient services at one location and requiring referral to specialty services by the member's primary care physician. Mental health and chemical dependency services are provided through a network of over 30 county operated or contracted agencies. Dental services are provided by designated members of the Delta Dental network. Since MHP is not eligible for a Medicare Risk contract at this time, benefits for aged enrollees are coordinated with Medicare.

Medica

Medica Choice, formerly Physicians Health Plan, is an independent practice association (IPA) model HMO which has participated in the PMAP since the beginning of the program. This health plan has 416,059 enrollees as of March 1992, 44,055 of whom are enrolled in the Medical Assistance program (Medica Choice Care) in Hennepin and Dakota counties.

Medica provides services through a network of 4,220 physicians and clinics, 10 hospitals and 684 pharmacies. Mental health and chemical dependency services are provided through United Behavioral Systems (UBS) clinics. Dental services have been provided by Delta Dental, but effective July 1, 1992, dental services will be provided by Medica Dental.

UCare Minnesota

UCare Minnesota is a clinic model plan offering services at 22 clinics, 8 hospitals, and 150 pharmacies in Hennepin and Dakota Counties. This health plan has served Hennepin County since 1985 and Dakota County since July 1, 1990. Ramsey County AFDC recipients are also served by UCare through the Voluntary Program.

UCare was developed by University Affiliated Family Physicians, University of Minnesota, to serve Medical Assistance recipients, and has since begun serving General Assistance Medical Care recipients. Total enrollment as of March 1992 is 10,451 with 6,833 of those eligible for Medical Assistance. UCare utilizes a family practice model, with the primary care physician as the care manager and specialty service referral source. UCare uses a broad network of community based pharmacy, dental, mental health and chemical dependency providers. Mental health and chemical dependency services are provided at the clinics, and dental services are provided by Delta Dental providers. UCare coordinates benefits under Medicare and other third party payers.

Itasca Medical Care (IMC)

Itasca Medical Care has served Itasca County as a primary care provider health plan model since 1985. IMC has a network of 36 physicians, 22 dentists, 11 pharmacies, 3 hospitals, 8 mental health providers including the Community Mental Health Center, 7 chiropractors, 4 vision and other ancillary providers throughout Itasca County. Administrative services and medical management (quality assurance/utilization review) are provided by a Managed Care Unit within Itasca County Human Services. Claims processing and other automated functions are provided by an outside contractor, utilizing the same managed care system which is used in Arizona. Benefits are coordinated with Medicare and other third party payers.

Service Delivery Issues

Computer Systems

Over the last year, the three PMAP counties have undergone a massive conversion of all cases to a new eligibility computer system (MAXIS). As with all new programs, there have been instances where intervention has been needed to assure that the health plans are paid and recipients are enrolled. For the most part, the new computer system has worked quite well in terms of easing the administrative workload for county financial workers. Some difficulty has occurred, however, in counties where prepayment exists. The relationship between the new system and the HMO payment report has been affected, causing a problem in matching cases with health plan and state files. State and county staff have been working closely with the MAXIS staff to work out areas of

discrepancies as well as planning for improvements with the implementation of a new MMIS for January 1993.

Evaluation of Service Access

The State has an obligation to participants in its prepaid programs to monitor the availability and accessibility of health care. The State is currently monitoring closely to ascertain when these areas become a problem.

Managed Care staff have done an analysis of current health plans' capacities, looking closely at geographic areas that have been identified as having some problems, notably northern Hennepin County. The State has discussed this with each of the participating health plans, which have responded to the issue by adding hospitals, clinics or individual providers to their networks. The State will continue to monitor access in potential problem areas.

Access for Itasca County recipients is considered to be adequate since most providers participate in IMC. Recipients who live near the county border and use out-of-county providers are excluded from participation in the PMAP to insure health care accessibility. This exclusion was implemented because the Hibbing (out-of-county) providers chose not to participate in IMC, so recipients would have to travel a considerable distance to receive care. Services were not considered to be accessible under those circumstances.

Out-of-Network Bills

Some out-of-network bills continue to occur. In the past, enrollees who were referred to a non-participating provider by a participating provider were liable for the bill for those services. The new PMAP rules hold the prepaid health plans responsible for services that were authorized by a participating physician to a non-participating provider. These rules were promulgated in November 1991; contract language will be added to the next contract to ensure compliance with this provision.

Delivery of Mental Health and Chemical Dependency Services

The State, health plans, county representatives, and service providers have been meeting as a group throughout the last year to clearly distinguish between those services that are eligible for payment under the Medical Assistance program and those that are covered through various grants. During March of 1992, the group satisfactorily delineated the payment source of the chemical dependency services. They will continue to meet and pursue the same strategy for mental health services.

1992 Contracts and Rates

Request for Proposals

In October 1991, the State issued a Request for Proposals (RFP) for

existing and new health plan contractors covering the contract period July 1, 1992 through June 30, 1994. Although the State received no proposals from new health plans, all of the current health plan contractors submitted a response to the RFP for Hennepin, Dakota and Itasca Counties. The proposals were reviewed and accepted. The State is currently in the process of negotiating a new contract with each of the current contractors, and has met with each health plan individually to discuss its proposal.

The State received only one proposal to serve Ramsey County. As this was considered inadequate, the State reopened the RFP process for Ramsey County, inviting interested health plans to submit a letter of intent by April 24, 1992. Four health plans submitted letters of intent to participate. These responses are considered sufficient to serve the Ramsey County recipient populations. An RFP was issued on May 18, 1992, requiring full proposals from interested health plans to be submitted by June 29, 1992. It is expected that enrollment of Ramsey County recipients will begin by fall, 1992.

1992 Contracts

Contracts are currently being negotiated for the period of July 1, 1992, through June 30, 1994. Below are the substantive changes being proposed in the new contract:

- Incentive for pregnant substance abuse clients: Health plans will be paid \$1000 for each member identified by the health plan and provided with enhanced services. The State will preapprove the service delivery plan for each health plan.
- Enrollee satisfaction survey: Health plans will be required to do an annual consumer satisfaction survey. The contract will require the survey to be Medical Assistance specific if the health plan's Medical Assistance enrollment is 5000 or more members.
- Outreach incentive: The State will be authorizing payments to each health plan in Hennepin County that submits a plan with a budget for providing outreach to Medical Assistance recipients. The State will preapprove the plans for each health plan and designate an amount of payment. The health plans will be required to submit outcome information for those recipients who received the enhanced services.
- Medical education and DPA: Both the medical education and DPA payments will now be included in the rates. The health plans will be paid the calculated base rate, with a health plan specific add-on for medical education and DPA for Hennepin County.
- Encounter Data: The specifications for the encounter data has changed in the proposed contract.

EDUCATION AND ENROLLMENT

Education and Enrollment History

Dakota and Hennepin Counties

For the first year of the project, the PMAP education and enrollment process was administered by an independent recipient education and enrollment broker under contract to the State. The Minnesota Institute of Public Health served as broker and was known to recipients as the Medical Plan Information Center (MPIC).

An independent broker was used for two reasons. Since the Hennepin County plan was one of the health plan options, a potential for conflict of interest on the part of the county workers would be eliminated. It was also administratively simpler than training many county workers.

The process involved the following steps:

- The State notified recipients by letter of the change in the Medical Assistance Program.
- MPIC contacted recipients by letter, inviting them to an education presentation.
- MPIC offered on-site presentations for recipients in nursing homes, elderly high rises, board and care facilities, group homes, and other residential settings.

Recipients either completed their enrollment forms at the presentation site or took them home and mailed them to MPIC. Recipients failing to make a choice by the deadline were randomly assigned to a health plan by MPIC, notified of the assignment, and given the option to make their own choice of health plan during the 60-day change window.

MPIC notified the county of choices or assignment of the recipients, and the county enrolled the recipients in the health plans.

In Dakota County, MPIC was responsible for the education and enrollment functions for the first year of the project. Dakota County chose to assume all education and enrollment responsibilities for new Medical Assistance eligibles beginning August 1, 1986, leaving the responsibility for education and enrollment of existing Medical Assistance recipients with the broker.

Client education proved to be a time-consuming process, involving approximately 4,500 telephone hours assisting recipients in the first year and, proportionally, about the same amount of time in

the second year. County, State and health plan staff also received and responded to numerous client inquiries.

In September 1987, the Minnesota Institute of Public Health informed the State that they would terminate their contract. The State and the Institute then engaged in extensive negotiations, but were unsuccessful in negotiating a mutually satisfactory contract. A request for proposal (RFP) for a new broker contractor was issued in the fall of 1987. Since the only bid received by the State was over the estimated State budget, the State decided to assume the recipient education and enrollment functions until alternate plans could be made.

The State conducted the PMAP education and enrollment process from October 1, 1987 through January 31, 1989. The State process was similar to MPIC's, except only one recipient mailing was necessary. By February 1, 1989, all recipient education and enrollment functions had been delegated to the counties.

Hennepin County began implementing a change in the PMAP recipient education process in January, 1989. Like Dakota and Itasca, Hennepin County staff began educating and enrolling recipients at the time of Medical Assistance application. In an educational process similar to Dakota County's, recipient presentations explaining the PMAP and health care options were given at the locations where Medical Applications were completed.

In the fall of 1989, the Hennepin County Board of Commissioners held several meetings to discuss the merits of the PMAP. Ultimately their charge was to recommend either to continue the PMAP in Hennepin County with the current 35% of the eligible Medical Assistance population or to expand the PMAP to a full 100% of the Medical Assistance eligibles. The Board recommended that the State pursue the expansion. The expansion effort began in July of 1990, and was completed in December, 1991.

Currently, the process used to educate and enroll recipients into the PMAP combines the most effective and the most administratively efficient methods. Enrollment staff at both Dakota and Hennepin Counties are enrolling newly eligible Medical Assistance recipients at the time of Medical Assistance application. Dakota County staff educate and enroll approximately 200 recipients per month, while Hennepin County staff educate and enroll roughly 1000 per month.

Itasca County

In Itasca County, education and enrollment of recipients into the PMAP took place over a two month period in 1985. The aged, blind and disabled were enrolled in July 1985, while the AFDC group was enrolled in August 1985.

The PMAP education and enrollment process in Itasca County was less complex than that of the other two counties because recipients had only one health plan option. Prior to enrollment, recipients were invited to educational presentations conducted by county staff at sites throughout the county. The presentations described the changes in the program and explained how to obtain services from the health plan. About 70% of the recipients attended the presentations.

Although only one health plan option was available, recipients designated a primary care physician and dentist. In the vast majority of cases, recipients selected their current physician and dentist.

Itasca County staff continue to educate and enroll new recipients at the time of Medical Assistance application. Enrollees may change their primary care physician or dentist once during the initial year of enrollment in Itasca Medical Care (IMC), the health plan available in Itasca County. An opportunity to change primary care physicians or dentists is also offered each year at the recipient's annual Medical Assistance eligibility determination.

Description of the Education Process

New Eligibles Process

New eligibles are recipients being educated about their health care options at the time they are applying for Medical Assistance; this is an ongoing process. New eligibles are offered choices from the PMAP health plans available in their respective counties.

The new eligibles PMAP education and enrollment process is conducted by specially trained county staff. As recipients apply for Medical Assistance, they are asked to attend a presentation at the county intake site and are directed to choose a health plan. County intake staff direct all recipients to the presentation site after the intake interview. Enrollment materials are mailed to recipients who do not attend the presentation. Assignment to a health plan occurs only if the recipient does not return the enrollment forms within a designated time period.

The concept behind the new eligibles enrollment and education process is that recipients are more likely to select a health plan option that fits their medical needs and to better understand the PMAP program parameters.

Dakota County's new eligibles education has been highly successful. Only 4.3% of recipients were assigned to health plans from August 1 through December 31, 1986, compared with 30% of the conversion recipients in 1986. For the second year in Dakota County, the assignment rate was 2.4%, and for the third year, 2.6%. The assignment rate has remained relatively stable since that time. By

tying health plan choice to Medical Assistance eligibility, there has been a better recipient response.

The results of on-site education in Hennepin County had much the same result as in Dakota County where the rate of individuals who selected a health plan dramatically increased. Before the change to on-site education, recipient attendance at community site presentations was low (20% attendance) which resulted in a low rate of health plan selection. The change in the education process encouraged more recipients to attend the presentation. The rate of recipients who do not select a health care plan has decreased from 50% to approximately 3%. With this change in recipients' attendance and selection of health plans, Medical Assistance recipients are more knowledgeable about their health care options and the services available from each.

Conversion Process

After Hennepin County began the new eligibles process, there remained a group of recipients who were found to be Medical Assistance eligible but had not had the opportunity to select a health plan option. Hennepin County began enrolling these conversion recipients by mailing PMAP enrollment notices. Those who did not select a health plan were contacted and asked to choose one.

Since sending information through the mail provided the least amount of education, Hennepin County began to take a different approach to PMAP recipient education for conversion recipients. The new method, designed to take up to a year to complete, used the recipient's annual eligibility review date as the point of entry into the PMAP education and enrollment process. This method included sending a notice to recipients on their monthly check stubs, as well as on their notices for redetermination which were mailed one month prior to their appointment dates. The notice informed recipients to plan on spending an extra 30 minutes after their eligibility interview to discuss their health care needs and the selection of a health plan.

After meeting with their financial workers for their eligibility review, recipients were referred to the county enrollment staff to attend the health plan presentation. By combining the medical information with their Medical Assistance eligibility review, recipients received a face-to-face information session and increased their likelihood of selecting a health plan. After follow-up was completed, only those who did not select a health plan were randomly assigned.

Upon HCFA approval, Hennepin County implemented plans to educate and enroll the remaining 65% of the eligible Hennepin County populations who were not part of the original 35%, utilizing the above described education and enrollment process. Enrollment began

on July 1, 1990. The County prepared for the increased enrollment by completing all the enrollment material (including forms and notices), working with the county information systems to monitor recipients' choices, and meeting with appropriate county staff and county contracted staff to inform them of the changes that would occur in enrollment for many of the recipients they served. In December, 1991, the conversion process was completed, thus expanding the Hennepin County population to 100% of the eligible groups. The State continues to monitor for any eligibles who may have been missed during the conversion process.

Institutionalized Elderly Process

The enrollment and education of the institutionalized elderly was handled somewhat differently from the conversion method or the new eligibles process. Planning and informational sessions were held for personnel of nursing homes and provider groups who serve the elderly residing in nursing homes. Nursing homes were notified of the residents who were to be enrolled in health plans. Letters informing elderly recipients of the necessity to make a health plan selection were sent to the recipient and/or the recipient's authorized representative. The mailings included a statement of consumer rights and a notification of appeal rights.

The county scheduled a presentation at each nursing home site, arranged according to geographic area. A presenter and a county advocate conducted each presentation, and were available to answer any questions that arose pertaining to the enrollment process, or the change in the program. Enrollment of the remaining 65% of the elderly population was completed in December, 1991.

Open Enrollment Experience

Until the promulgation of the revised Rule 62 on November 4, 1991, PMAP enrollees were locked into a health plan after 60 days from the initial effective date of enrollment for up to one year. The new Rule allows enrollees an opportunity to change health plans for any reason once during the first year of initial enrollment. In addition to the first year health plan change option, an open enrollment period is offered for Dakota and Hennepin County recipients. Each November, enrollees have a 30-day period during which they may change health plans.

Hennepin County and Dakota Counties

The independent broker completed the first annual open enrollment in November, 1986. Of all recipients eligible for open enrollment in Hennepin County, 5.1% changed health plans. There were not enough recipients enrolled in the PMAP in Dakota County to determine the change rate. The first open enrollment was probably not a true test of the process because clients were changing health plans during their initial 60 day change option period and they had little experience with health plan use.

The second annual open enrollment, also administered by the broker, was completed in November, 1987. Results in Hennepin County were similar to the first year, with 4.5% changing health plans. In Dakota County, 6% changed health plans. The 5,229 enrollees who were required to change health plans because of the Blue Cross/Blue Shield contract termination are not included in the rate change percentage figures. The number of these enrollees who would have otherwise changed health plans cannot be estimated. Thus, the State again did not have the opportunity to test the open enrollment process during the second year.

For 1988, the open enrollment conducted by the State reflected a similar proportion of enrollees changing health plans. Of the Hennepin County enrollees eligible for an open enrollment change, 5.4% changed health plans. This rate did not include MedCenters and Group Health, Inc. enrollees who were required to change because of health plan contract terminations. Dakota County had an open enrollment change rate of 4%, which did not include MedCenter enrollees.

For the 1989 open enrollment, the rate of change in Hennepin County was 4.8%, and in Dakota County, 1%. These figures did not include the PreferredOne enrollees who changed health plans due to contract termination.

There was an underlying assumption that the rate of change in Hennepin County would decline as a result of persons being enrolled for a longer period and growing accustomed to using the prepaid system, as was the case in Dakota County. Instead, the rate of change remained relatively stable. This may be due to the large number of conversion recipients enrolled each year who were not familiar with the prepaid system. Also, recipients were not exercising their option to select a health plan during their initial enrollment, creating a significant assignment rate and making it more likely that they would select a new health plan during open enrollment.

The 1990 open enrollment reflected a 2.8% change in Hennepin County, and 1% in Dakota County. The State speculates that the majority of those electing to switch were new to a health plan.

The open enrollment rate increased slightly in 1991, reflecting the substantial increase of recipients new to a health plan due to the completion of the conversion process in Hennepin County. 4.3% elected to change health plans in Hennepin County, while 3% changed health plans in Dakota County. The overall percentages of the PMAP population requesting health plan changes remains quite low with no substantial increases. The State will continue to monitor the health plan change rates.

Open Enrollment Results

Hennepin County

<u>Year</u>	<u>Rate of Change</u>
1986	5.1
1987	4.5
1988	5.4
1989	4.8
1990	2.8
1991	4.3

Dakota County

<u>Year</u>	<u>Rate of Change</u>
1986	not enough enrolled
1987	6.0
1988	4.0
1989	1.0
1990	1.0
1991	3.0

Consumer Satisfaction Survey

Each year during the open enrollment period, the Department of Human Services conducts a consumer satisfaction survey of participants. Although few PMAP recipients elected to change health plans, many responded to a variety of issues presented in the survey.

Results show that responders are generally happy with their physicians and pharmacies. Some are, however, dissatisfied with the length of time it takes to get an appointment and the difficulty in receiving specialty care. The issue of satisfaction clearly overlaps with the issue of access.

Enrollment Tables

Health Plan Enrollment by County Population by Plan - April, 1992

	AFDC & Needy Children	Aged	Total	% of Metro*
HENNEPIN COUNTY				
Group Health Seniors Plus	0	124	124	.18
Metropolitan Health Plan	15,225	1,049	16,274	23.96
Medica	33,357	4,258	37,615	55.37
UCare Minnesota	<u>5,934</u>	<u>549</u>	<u>6,483</u>	<u>9.54</u>
Totals	54,516	5,980	60,496	89.05
DAKOTA COUNTY				
Group Health	1,975	1	1,916	2.91
Group Health Seniors Plus	0	50	50	.07
Medica	4,588	402	4,990	7.35
Metropolitan Health Plan	0	5	5	.01
UCare Minnesota	<u>305</u>	<u>109</u>	<u>414</u>	<u>.61</u>
Totals	6,868	567	7,435	10.95
Total Metro	61,384	6,547	67,931	100.00
ITASCA COUNTY				
Itasca Medical Care	<u>3,073</u>	<u>567</u>	<u>3,428</u>	
Totals	3,073	567	3,428	
TOTAL ALL COUNTIES	64,457	7,114	71,359	

*Metro counties are Hennepin and Dakota Counties

COMPLAINTS AND APPEALS

Health Plan Complaint Procedure

Each health plan has internal procedures in place for resolving enrollee problems, both informally and formally. The informal process takes less than ten days and involves enrollees calling the health plan's member services department or the clinic to indicate concern about service or administration issues. The health plan attempts to address the enrollee's complaint without necessitating a written grievance. If the enrollees are not satisfied with the outcome of the informal process, they may submit a complaint in writing. The plan must provide for a hearing on the complaint and a resolution in writing within 30 days.

Enrollees may file a grievance with the State whenever they are not satisfied with the outcome of the health plan's complaint process. Although enrollees are encouraged to exhaust the health plan's complaint procedure before filing a grievance with the State, enrollees have the right to deal directly with the State or to pursue both complaint procedures simultaneously.

State Grievance Process - (1985 - December 31, 1989)

For the first three years of the program, the State utilized a State Grievance Panel System. A list of health care and social service practitioners, advocates, Medical Assistance consumers, and state staff willing to serve on the grievance panel was compiled. Participation was solicited primarily through professional provider associations. Each time a grievance was filed, a panel of three to nine persons from the list was assembled for a hearing. The hearing and dissemination of the written resolution took place within 30 days from the receipt of the written grievance by the State.

Hennepin County administered the State grievance process for Hennepin County recipients. Dakota and Itasca County recipients dealt directly with the State when filing a grievance, while Hennepin County consumers contacted the Hennepin County program office. Otherwise the process was exactly the same. In January, 1989, the State assumed responsibility of administering the grievance process for all three counties.

State Appeals Process

The above two procedures were designed to resolve service delivery problems. During the first two years, many recipients wished to appeal their participation in the program. They objected to mandatory participation and sought exemptions from the program. It was inappropriate for the PMAP grievance panel to hear such appeals, since they involved reinforcement of the PMAP rules rather

than rulings on service issues or disputes of fact. As a result, the State Appeals Unit chose to hear those appeals. Although no recipients have been exempted from the program because there is no provision in state laws or rules for individual exemptions, the State does not deny the recipient the right to appeal.

Change in the Grievance Procedure

In July of 1989, State law was changed to incorporate the two avenues for a state appeal. The grievance panel was disbanded, and authority was transferred to the State appeal process. This is the process used today by all Medical Assistance recipients to resolve service, eligibility and administration issues. The change in the process freed up the grievance coordinator, which enabled her to work with the recipients and the health plans to resolve service issues without necessitating a hearing. Many issues were able to be resolved prior to going to a hearing. The same year, Minnesota statute mandated the commissioner to designate a state ombudsperson to work with recipients, providers and health plans to actively resolve recipient complaints. Thus, the grievance coordinator was designated as the State ombudsperson.

Appeal Notification of Enrollees

All PMAP enrollees receive a certificate of coverage (COC) from their health plan. The COC gives an explanation of the health plan's internal grievance procedure, right to a second medical option within the health plan, and the state appeal procedure. Appropriate phone numbers are included. The health plan's written internal grievance resolution must also notify the enrollee of the availability of the state appeal procedure. For written complaints, health plans must notify the state ombudsperson within three working days. Additionally, a notice of grievance and appeal rights is sent to each enrollee with the initial enrollment materials and each year at open enrollment. Beginning in March 1989, county advocates and state grievance coordinators also began sending a formal notification of grievance rights each time an enrollee requested assistance in complaint resolution.

Health Plan Notification Requirements and Continuation of Services Pending Outcome of a Grievance

As an additional safeguard for enrollees, the State added the following health plan requirements for 1989, 1990 and 1991 contracts:

In all cases when services are denied, reduced, or terminated, the health plan must notify the enrollee of: the denial or action by the health plan; the reasons for the action taken; the specific federal or state regulations or health plan policies which require the action; and an explanation of

grievance rights (both health plan and state); and the circumstances under which services must be continued.

Beginning July 1, 1990, all health plans began notifying recipients when services are reduced, terminated or denied, by a written form letter that is reviewed by the state prior to implementation. If the health plan proposes to reduce or terminate the enrollee's ongoing medical services and a health plan provider has ordered the service, the above written notice must be provided at least 10 days in advance of the proposed health plan action.

If the enrollee has filed an internal grievance with the health plan, the health plan may not take the proposed action to reduce or terminate services until 10 days after a written decision is issued by the health plan.

If the enrollee has filed an appeal with the State, the health plan may not take the proposed action to reduce or terminate services until a written decision is issued by the State.

Results

The following is a summary of the number of appeals submitted to the State during the period of January 1, 1990 through April 1, 1992:

Number of Appeals Filed 1990 through April 1, 1992

	Year 5 (1990)	Year 6 (1991)	Year 7 (1992) To 4/1/92
Hennepin	39	62	36
Dakota	13	10	5
Itasca	5	1	0
Total	57	73	41

Several appeals were resolved or withdrawn prior to hearing. A summary of the number of grievances and appeals, including mandatory participation appeals, that were heard through the State grievance or appeals process from 1986 through April 1, 1992, is listed next.

**Number of Hearings and Grievances Conducted to Date
(Includes Mandatory Participation Appeals)**

	Year 1 (1986)	Year 2 (1987)	Year 3 (1988)	Year 4 (1989) Jan-June	Year 4 (1989) July-Dec	Year 5 (1990)	Year 6 (1991)	Year 7 (1992) To 4/1/92
Hennepin	7	15	45	14	18	18	26	11
Dakota	1	6	11	10	10	7	7	3
Itasca	0	0	0	0	2	2	1	0
Total	8	21	56	24	30	27	34	14

The following summary depicts the number of appeals pertaining to mandatory participation that were heard through the State appeals process 1986 through April 1, 1992.

Mandatory Participation Appeals Conducted

	Year 1 (1986)	Year 2 (1987)	Year 3 (1988)	Year 4 (1989) Jan-June	Year 4 (1989) July-Dec	Year 5 (1990)	Year 6 (1991)	Year 7 (1992) To 4/1/92
Hennepin	6	11	0	0	3	5	4	0
Dakota	0	0	0	0	1	1	1	0
Itasca	0	0	0	0	0	0	0	0

In the first year, two service grievances were heard by the grievance panel, one in Hennepin County and one for a Dakota County recipient. The Hennepin County grievance related to an out-of-plan referral for mental health services. The recipient was not satisfied with the health plan's offer of four out-of-plan visits. In addition to the service related grievances, the State referees conducted six administrative hearings relating to mandatory participation in Hennepin County.

The one 1986 grievance and six 1987 Dakota County grievances were heard by the grievance panel in January 1987. All related to termination or reduction of physical and/or occupational therapy (PT/OT) for nursing home residents. All recipients were from the same nursing home. In addition to these seven, three grievances relating to the same services were withdrawn. The grievance panel generally upheld the decisions of the health plan to terminate or reduce PT or OT services. In some cases, therapy was restored for a short period of time with a recommendation that the nursing home's rehabilitative nursing program then take over. Additional recommendations included improvements in the health plan's case management system and Health Department review of the adequacy of the nursing home's rehabilitative nursing program. (The Health Department is the agency responsible for reviewing compliance with nursing home regulations). One of these cases was settled at the hearing and a panel decision was not necessary.

In 1987, four service related grievances were heard in Hennepin County. All related to the reduction or denial of mental health services. In three cases, the panel ordered reinstatement of services or gradual transition from services. In one case, the decision of the health plan to deny services was affirmed. Some of these cases involved day treatment services and were appealed by enrollees considered disabled because of chronic mental illness.

In addition to the service related grievances, eleven appeals relating to mandatory participation were conducted in Hennepin County.

Of the 56 grievances filed in 1988, 45 were administrative rather than service grievances. These involved recipients who requested health plan changes and were not permitted to change because of the rules governing the program. They were former Blue Cross enrollees who were assigned to new health plans but did not have a sixty-day change option available to them. In 61% of the cases, the panel determined that the recipient should be permitted to change health plans.

Of the 11 service grievances heard in 1988, the panel upheld the decision of the health plan in eight of the hearings. Six cases related to a denial of service or out-of-plan referral, while five cases involved denial of out-of-plan bills. In addition to the 11 grievances which went to a grievance hearing, 23 additional grievances were filed by consumers. These grievances were either withdrawn or resolved before the hearing.

For the first half of 1989, 24 grievances were heard by the State. This was a decrease from the past year. This decrease was due to the additional work done by the advocate staff at the county and State. They were able to spend more time investigating and resolving recipients' complaints. Many of the complaints filed since July of 1989 have been administrative in nature as opposed to service-related issues. Many service-related grievances have been resolved without necessitating a hearing.

As noted, beginning July 1, 1989, State legislation transferred the grievance responsibilities to the State Appeals Unit. This eliminated the grievance panel process and replaced it with a fair hearing conducted by a State appeals referee. The grievance coordinators assumed new responsibilities, assisting recipients in the resolution of complaints on service delivery. For the July, 1989 through December, 1989 period, 13 of the appeals filed dealt with administrative issues, 13 with service issues, and 4 with mandatory participation.

In 1990, 57 appeals were filed. 30 of the filed appeals were resolved before they went to a hearing. Of the 27 hearings that were conducted, 17 were service related, 4 concerned change of health plan, and 6 were mandatory participation appeals.

Health plan denial of payment for out-of-plan services was the issue in eight of the cases. The Commissioner upheld the health plans' decisions in four cases, and overturned their decisions in the remaining four cases. Six appeals dealt specifically with reduction or termination of day treatment or other mental health services. The Commissioner overturned the health plans' denial of services in all six cases. In the remaining three service appeals, the decisions of the health plans were also overturned.

Of the 73 appeals filed in 1991, 39 were resolved before the hearing. Of the 34 appeals conducted, 19 were service related, 10 concerned requests for change of health plans, and 5 pertained to mandatory participation.

Five of the service-related hearings involved billing issues. In all five cases, the decisions of the health plans to deny payment were upheld. The other 14 hearings dealt primarily with out-of-plan mental health treatment, coordination of mental health and chemical dependency services, and dental issues. The Commissioner upheld the decisions of the health plans in nine cases and overturned the health plans' decisions in the remaining five cases.

From January 1 through April 1, 1992, 41 appeals have been filed. Of the 41 appeals, 16 are service related, 24 involve requests to change health plans, and 1 is a mandatory participation appeal. With the exception of 8 service related and 6 change of health plan appeals, all filed appeals have been resolved prior to hearing.

Aside from the appeals and grievances heard by the State, the health plans responded to written complaints and grievances. Health plans are required to report to the State all written complaints or requests to file a grievance. In year one of the program, the average number of internal grievances reported by health plans was 4.3 per plan with a range of 0 to 15 grievances. For year two, the average was 8.5 with a range of 0-26. Internal grievances and complaints for year three averaged 17 per health plan with a range of 0-61. In year four, the average was 10.1 per health plan with a range of 0-41.

Consumer Advocacy - Advocate Network

A network of 22 volunteer advocates for Dakota and Hennepin Counties was organized early in the program. Advocates assisted recipients in the education, as well as the complaint and grievance processes. A list of the advocates was disseminated in the enrollment ("Choose") packet and sent to recipients upon request.

An initial advocate training session was provided before the program began. Advocates were sent packets of information on the program and periodic updates throughout the year. Two follow-up training sessions were held in year two.

Advocates were surveyed in 1987 to evaluate the extent to which the network was used by enrollees. Their services were underutilized by consumers. Half of the advocates had received requests for assistance. The average number of requests was 13, but the range was from 2-80 over an 18-month period.

By 1989, this network of volunteers was disbanded, as their services were not often utilized and orienting them was difficult. This network was replaced with the county advocate system.

County Advocates

In 1987, Dakota County contracted with a health care advocate to assist consumers in resolving problems and complaints. The advocate also assisted in filing grievances and often represented consumers at grievance hearings. In 1992, Dakota County hired a full-time county staff person to assume the advocacy responsibilities.

Hennepin County has three consumer advocates on staff. They have been active in resolving recipient grievances and assisting in the appeal process. The State ombudsperson and county advocate staff meet monthly to identify trends and cooperate in resolving problematic cases. In July 1990, advocates began documenting all telephone inquiries and reviewing trends.

State Ombudsperson

Minnesota Statute requires the State to provide for the services of an ombudsperson to assist consumers in accessing services and resolving problems associated with prepaid health plans. The State ombudsperson serves a critical role in resolving recipient complaints. The ombudsperson is familiar with the contracts and can often act as a mediator or negotiator in resolving recipient complaints without going to an appeal hearing.

REIMBURSEMENT TO HEALTH PLANS

Capitation Rates

Rates: 1985-1988

Rates for the program were based on Minnesota's historical fee-for-service costs for the year 1982 for Itasca and Hennepin Counties, and 1983 for Dakota County. Rate development involved the following steps:

- Historical cost data were generated.
- Data were broken out into rate cells, reflecting similar cost experience for a given group of recipients.
- Per capita cost for rate cell (costs divided by eligibility months) was calculated. This step included adding to the base costs the health plan's 20% share of hospital and long-term care costs that exceeded the stop-loss limit.
- Capitation was trended forward to the current fiscal year using an inflation factor. The factor used was based on the projected cost increases in the Medical Assistance program: 13.9% for noninstitutionalized populations and 15.2% for institutionalized populations for FY 1985 for Hennepin and Itasca Counties. For Dakota County, prorated figures were used: 9.27% and 10.13% respectively.

For subsequent fiscal years, a 5% per year inflation factor was used for both institutional and noninstitutional populations.

- Rates were discounted by 5% for aged, blind and disabled populations and 10% for the AFDC population.
- A rate adjustment for medical education expenses was allowed for Hennepin County. A percentage of rates (1.71%) was held back to redistribute to the health plans for medical education expenses incurred.

Rate cells were determined using the following factors: age, sex, Medicare status, institutional status, category of eligibility, and county of residence. Rate cells were fixed for a "rate-cell year" which was the time period between initial enrollment and a recipient's Medical Assistance eligibility review date, or the date of disenrollment, whichever occurred sooner, regardless of changes in the rate cell factors.

Capitation rates included all hospital costs up to the stop-loss limitation and 20% of costs over the limit. Rates also included the first 90 days of nursing home care and 20% of costs after 90

days. A rate for "needy children" was added in year one. Otherwise, the rate methodology did not change during the first three program years. Separate reimbursement for obstetrical costs was proposed for year three, but the State never implemented this due to health plan dissatisfaction with the proposed reduction in the base rates.

Rates: 1989

For contract year 1989, rates were calculated on a historical cost basis using the FY 1987 experience. It was determined that encounter data could not be used due to lack of uniformity and under-reporting. For Hennepin County, the experience of the 65% control group was used. For Itasca and Dakota Counties, the aggregate experience of two demographically similar counties was used: for Itasca, Beltrami and Crow Wing Counties were used; for Dakota, Anoka and Washington Counties were used.

The rate setting methodology used for 1989 rates was the same as for previous contract years with the following exceptions:

- A rate cell for the 0-1 year age group was added, as the costs for this group were significantly higher than for the 2-14 year age group.
- Inflation factors of 3.4%, 3.8%, and 2.25% were used to trend the rates forward to calendar year 1989.
- A medical education adjustment was not applied. Medical education costs remained in the rates.
- An adjustment for prenatal care services was added to account for both an estimated increase in the number of pregnancies and for coverage of additional prenatal services. Certain prenatal services were reimbursed on a fee-for-service basis.

Rates: January 1, 1990 - June 30, 1990

Rate changes for this period included the deletion of the nursing home 90-day liability, change in stop-loss threshold for the aged from \$30,000 to \$15,000 and elimination of separate prenatal care adjustments.

The following guidelines were used in establishing the rates in effect for this contract period:

- Fiscal year 1987 and 1988 fee-for-service data was combined and used as the basis for the rate cell determination.
- Hennepin county data were used to develop the Hennepin County rates. Data from the seven county metro area of Dakota, Ramsey, Anoka, Hennepin, Washington, Scott, and Carver counties were

used to develop the Dakota County rates. All of the remaining (non-metro) county data was combined to develop the rates for Itasca County.

- As in previous years, 80% of inpatient hospital reimbursement in excess of \$15,000 was removed from the capitation rate base. These funds were used to provide stop loss protection. Stop-loss settlement occurs at the end of the contract year.
- The fee-for-service base was inflated to project the health care costs of the current contract year. The factors used to increase the 1987 and 1988 base data were the following:

	AFDC	AGED
1987-1988	6.1 %	8.6 %
1988-1989	6.0 %	8.3 %
1989-1990	3.8 %	5.2 %

- After inflation was accounted for, the calculated rate cell amounts were discounted by 5% for the aged population and by 10% for the AFDC population.
- These rates were then increased to reflect: 1) the expansion of income eligibility limits for pregnant women to 185% of the poverty level and 2) additional reimbursements available to provide prenatal screening and services for high-risk pregnancies.

Rates and rate setting methodology were reviewed by an independent actuary, Tillinghast, Inc.

Rates: State Fiscal Year 1991

As of July 1, 1990, nearly all prepayment contract years were converted to be consistent with the State's fiscal year. Following is the methodology used to establish the capitation rates for this period:

- Fiscal year 1989 fee-for-service data was used as the basis for this contract period's rate cell determination.
- The geographical areas used for the determination of the Hennepin, Dakota, and Itasca rate cells were the same as those used for the calculation of the 1990 rates.
- The inpatient stop loss value was again removed from the capitation rates as it was for the 1990 rates.
- In Hennepin County, the capitation rates were reduced by the estimated value of that county's disproportionate population adjustment. Separate compensation for this cost was made

available through an additional settlement mechanism (see Disproportionate Population Adjustment under "Additional Reimbursement").

- The fee-for-service base was inflated to project the health care costs of the current contract year. The factors used to increase the 1989 base data were the following:

	AFDC	AGED
1989-1990	4.4 %	5.5 %
1990-1991	5.1 %	5.3 %

- After inflation was accounted for, the calculated rate cell amounts were discounted by 5% for the aged population and by 10% for the AFDC population.
- There was a concern from the health plans that the capitation amounts might be insufficient for chemically-dependent newborns. In response to this concern, an adjustment was made to the 0 - 1 year old AFDC rate cell to accommodate the anticipated, continued increase in the frequency and cost of chemically-dependent babies. A subsequent (February 1991) review of this situation has shown, however, that the hospital health care costs for these cases has in fact been declining since 1989 through the use of corticosteroids and surfactant. This treatment has significantly decreased the neonatal intensive care length of stay and the need to send these children home on ventilators. This adjustment was removed from the fiscal year 1993 capitation rates.

Rates and rate setting methodology were reviewed as in the previous year by an independent actuary, Tillinghast, Inc.

Rates: State Fiscal Year 1992

Capitation rates for SFY 1992 were developed at the same time as were those for SFY 1991. The methodology used to develop these rates was identical to that used for the contract year 1992 rates with two modifications:

- The inflation factors used to trend forward the data to fiscal year 1992 were:

	AFDC	AGED
1991-1992	3.9 %	5.6 %

- Health plans were given the option to assume full risk for their hospital inpatient costs or to include the value of the stop loss expense (originally subtracted from the capitation rate base) into their prepaid capitation rates.

Rates and ratesetting methodology were reviewed by an independent actuary, Tillinghast, Inc.

Rates: State Fiscal Years 1993 and 1994

Several changes occurred with State fiscal years 1993 and 1994 rates. Hennepin County was excluded from the metropolitan region because Hennepin-specific rates are already being calculated using county data. Because Hennepin is a high-cost county as compared to the other six metro counties, metro rates may have been unjustifiably high in the past.

Trending factors were developed for each service category according to price and utilization increase. Price trends reflected legislatively mandated increases which have been or are projected to occur within the same time period. The utilization trends were developed as the result of a review of information from the Department's Research and Statistics Division. The trending factors were then added to the estimated prepayment amounts developed from the fee-for-service data and discounted to 95% for the Aged and 90% for AFDC and related.

Add-ons to the discounted and trended fee-for-service base were adjusted to account for chemical dependency (CD) treatment services. Since CD services were paid for out of the Consolidated Chemical Dependency Treatment Fund (CCDTF), they were not in the fee-for-service base. These data were extracted separately, trended, and added to the estimated prepayment amount.

Rates and rate-setting methodology were reviewed by an independent actuary, William M. Mercer, Inc.

Rates: Beyond State Fiscal Year 1994

Beyond SFY 1994, the rate methodology will probably change from a discount from fee-for-service because of possible erosion of the fee-for-service data base due to high prepaid enrollment of eligibles. The State will contract with an independent actuarial firm to assist in the development of the new methodology along with input from the current contracted health plans. The degree of erosion of the State's fee-for-service database will not be known until the 1989, 1990 and 1991 fee-for-service data is analyzed in the late summer of 1992.

Risk Sharing and Reinsurance

Risk Sharing and Reinsurance: 1985-1987

Three risk-sharing mechanisms were available to health plans for the first two years of the program. Stop-loss protection for

inpatient hospital and long-term care costs were provided as follows:

<u>Stop Loss</u>	<u>Threshold</u>
Inpatient Hospital	\$30,000 aged, blind and disabled \$15,000 AFDC
Long-term Care	90 days

Costs over the threshold were shared on an 80-20 basis: 80% state, 20% health plan.

In addition, aggregate risk sharing, designed to alleviate health plan liability in serving high risk populations, was available for the first two years of the program. Risk sharing was on a 50-50 basis up to the following limits:

	Year 1	Year 2
AFDC	110%	100%
Aged, Blind, Disabled	115%	105%

Limits refer to percentages of fee-for-service costs. These figures were derived from the capitation payments made to the health plans.

Risk sharing was based on actual costs identified by the health plans on encounter data submitted to the State. For claims without identified costs, the Medical Assistance allowable cost was used.

Risk Sharing and Reinsurance: 1988-1989

For contract years 1988 and 1989, only the inpatient hospital and long-term care stop-loss reinsurance mechanisms were available. The terms of the reinsurance were the same as for previous years.

Risk Sharing and Reinsurance: January 1, 1990 - June 30, 1990

For the contract period January 1, 1990 through June 30, 1990, the long-term care stop-loss was dropped from the PMAP, leaving only hospital stop-loss reinsurance. The hospital stop-loss threshold for the aged population was lowered from \$30,000 to \$15,000.

Risk Sharing and Reinsurance: State Fiscal Years 1991 and 1992

For the two year contract period of July 1, 1990 through June 30, 1992, only the inpatient hospital stop-loss was available. Health plans had the option of including the dollar value of the stop-loss protection in the rates, or of continuing to be reinsured by the State.

Risk sharing and Reinsurance: State Fiscal Years 1993 and 1994

For the two year contract period of July 1, 1992 through June 30, 1994, only the inpatient hospital stop-loss is available. Health plans have the option of including the dollar value of the stop-loss protection in the rates, or of continuing to be reinsured by the State.

Risk Sharing and Reinsurance: Beyond State Fiscal Year 1994

Provisions for risk-sharing will be included in the new methodology. Determinations concerning the accommodation of individual risk-sharing provisions will be made when the new methodology is known in approximately November, 1992.

Status of Risk Settlements

All aggregate risk settlements have been completed, as well as all long-term care stop-loss settlements. Hospital stop-loss settlement is complete through 1989 and medical education is complete through June 30, 1990.

Disproportionate Population Adjustment

Disproportionate Population Adjustment (DPA): State Fiscal Years 1991 and 1992

For Hennepin county contracts covering the period of July 1, 1990 through June 30, 1992, the value of the DPA was subtracted from the capitation rate amounts. Compensation for this adjustment was made available to the affected hospitals on a 'per discharge' basis.

Medical Education

Medical Education Costs: 1985 - June 30, 1990

In addition to the rates and risk sharing dollars available to the health plans, the State agreed to reimburse health plans for medical education costs incurred by teaching hospitals. As noted for 1986 through 1988, the Hennepin County rates were reduced by 1.71 percent to provide a pool of funds to be used to reimburse teaching facilities for medical education costs incurred for hospital days utilized by PMAP enrollees. The State agreed to reimburse the health plans for 100 percent of direct and 50 percent of indirect medical education costs using current Medicare methodology. The health plan then could "pass through" these funds to the appropriate hospitals.

The State developed a report format to generate statistics on hospital costs incurred at designated teaching facilities by PMAP enrollees. It used these statistics and the hospitals' current

Medicare cost reports to manually calculate medical education dollars to be reimbursed.

For 1989 contracts, medical education costs were left in the rates. The State intended to eliminate the separate medical education reimbursement mechanism. However, MHP and the State later negotiated additional reimbursement. The provision in the MHP contract for additional medical education reimbursement was also available for the contract period January, 1990 through June 30, 1990.

The State estimated that medical education equated to five percent of the rates. MHP's contract provided for maximum reimbursement to the health plan of the difference between the five percent already in the rates and the health plan's expected medical education costs.

The only other plan which was likely to incur substantial medical education costs was UCare which used University of Minnesota Hospital, a large teaching facility. When a similar calculation was done for UCare, the five percent medical education costs already in the rates was shown to be adequate.

Medical Education Costs: State Fiscal Years 1991 and 1992

For the contract covering July 1, 1990 through June 30, 1992, medical education was included in the capitation rate. An additional \$705,550 per year was made available to the health plans who use teaching hospitals. The reimbursement amount for each health plan will be allocated based on a weighing of all admissions to teaching hospitals by Hennepin county enrollees. The total amount available was based on one percent of the total fee-for-service experience.

Medical Education Costs: State Fiscal Years 1993 and 1994

With the two year contract beginning July 1, 1992, both medical education and DPA are included in health plan specific rates for Hennepin County. The State calculated an "add-on" to the base rates based on the estimated use of teaching facilities and DPA hospitals. Thus, separate medical education and DPA settlements will be eliminated.

Immunizations

Immunizations: State Fiscal Years 1991 and 1992

To accommodate the increasing cost of immunizations against measles, mumps, rubella, diphtheria, pertussis, tetanus, polio, and meningitis, the State allocated a one-time reserve equivalent to 1%

of the proposed capitation. This one-time reserve covered the contract periods of July 1, 1990 through June 30, 1992. The health plans will be reimbursed on a 'per immunization' basis following the completion of the contract periods.

Additional Reimbursement To Health Plans - State Fiscal Years
1993 and 1994

As an incentive toward providing better prenatal services to pregnant women, an additional amount was calculated to pay the health plans for prenatal assessment forms and education. An amount was also added for the estimated per member cost of interpreter services, which is a new contractual requirement. In addition, a per member rate add-on for health plans that contract with at least one Federally Qualified Health Center was established, pursuant to new federal guidelines.

For health plans contracting to service Hennepin County, the rate methodology was changed from the past lengthy settlement process for disproportionate population adjustment (DPA) and medical education (ME). Rates were increased based on the estimated number of Hennepin admissions based on projected population size and admission rate. The distribution of admissions by hospital and health plan was estimated and DPA and ME amounts per admission were calculated. Then the hospital and health plan-specific number of admissions were multiplied by the per admission DPA and ME amounts and divided by the member months to generate per member per month add-on amounts.

Stop-loss values were offered as add-ons to the new rates as an alternative to using the existing settlement process. The stop-loss values were calculated based on the existing stop-loss coverage by the Department of 80% of the DRG value over \$15,000 for inpatient hospital stays only.

In recognition of higher treatment costs incurred for pregnant substance-abusers, the State is offering the health plans an extra \$1,000 payment for each enrollee treated under this contract provision.

Another change for this year was the calculation of an immunization reimbursement incentive pool for AFDC and Needy Children. The target rate for DPT, DT, MMR, Polio, and HIB shots was calculated for a child during the years 0-15 and then divided by the number of member months for those years. Health plans can receive up to the maximum incentive amount by submitting a claim for all the immunizations given in the year.

Finally, the State is offering to the health plans in Hennepin County a one-time payment to provide outreach services to enrollees. Each health plan must submit for State approval a proposed outreach plan and budget before a payment is authorized.

QUALITY ASSURANCE (QA)

1988 Quality Assurance Review

Health Plan Internal QA System

Health plans are required to have an internal Quality Assurance (QA) System which meets State standards as set forth in the contract between the health plan and DHS. These standards are consistent with those required for State HMO licensure.

External Review of Quality of Care

As outlined in the demonstration protocol, the State had planned to conduct an external audit of quality of care provided in health plans through the Department's Surveillance and Utilization Review Section (SURS). However, a 1986 amendment to section 1902(a)(30) of the Social Security Act (42 U.S.C. 1396(a)(30)) requires an annual quality care review by an independent organization. The State, therefore, proceeded with plans in late 1987 to secure a contract for these services.

Subsequent to the usual bidding process, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) was selected to conduct the independent review. JCAHO began work immediately after contract signing. JCAHO staff met with the health plans to discuss issues of sample selection, records retrieval, and other procedures for carrying out the review.

Components of the Study

The JCAHO review consisted of the following components: a structural review of quality, a review of process, and to a limited extent, an outcome evaluation of quality.

Administrative Review of the Health Plan: This portion of the study consisted of a review of the existence and operation of a quality assurance program which monitors and evaluates care; existence and operation of a governing body which sets policy and has overall responsibility for the health plan's quality assurance program; administration of the health plan in a manner which promotes high quality services; definition of and adherence to patient's rights and responsibilities; effective educational and training activities conducted by the health plan; and pathology, laboratory, pharmaceutical, and radiology services that meet professional and legal standards.

JCAHO staff met with administrative staff of each health plan and reviewed health plan documentation on the above.

Clinic Site Review: Each health plan was asked to select two provider sites to be reviewed by the Joint Commission survey team.

Some sites were selected because of heavy use by Medical Assistance recipients, and others because they reflected a mix of Medical Assistance and other patients. The survey team evaluated the sites in terms of treatment accorded to patients; concern by providers about the acceptability, accessibility, availability, continuity, and cost of services; medical records which were easily accessible and which were legible, well documented and documented in a timely manner, which contained appropriate patient-specific information and in which examination reports were authenticated in a timely manner; functional, safe, and sanitary environment; and provision of pharmaceutical, pathology, laboratory, and radiology services in a manner that met professional practices and legal requirements.

This portion of the review took place simultaneously with the administrative review.

Medical Records Audit: The Department of Human Services specified 15 conditions of interest whose manner of treatment by each of the health plans DHS wanted the Joint Commission to evaluate. The 15 conditions covered all eligibility groups enrolled in prepaid programs and were generally those cited in the medical review literature as areas to be included in a quality assurance review.

The Joint Commission developed standards for evaluating the specified conditions of interest. The standards were based on the published views of professional groups representative of each of the sub areas of specialization to be surveyed. These standards were then modified to reflect the standards of medical practice in Minnesota. The Department of Human Services submitted the standards to each of the health plans for review. Their suggestions were included in the standards against which quality is being evaluated.

The Joint Commission subcontracted with a data retrieval firm to have data extracted from health plan charts for the review of conditions of interest. A team, using "lap-top" computers for immediate data entry, went to each of the health plans to review charts which had been selected randomly within each of the eligibility groups.

The following conditions of interest were examined:

- Well baby care (birth through 11 months);
- Early childhood care (12 months through 4 years);
- Late childhood care (5 years through 12 years);
- Prenatal care (females 15 years through 44 years);
- Diabetes Mellitus (5 years through 50 years);
- Hypertension (adults 15 years through 44 years);

- Major affective disorders (chronic mental illness);
- Dental services (over age 36 months);
- Chemical dependency;
- Schizophrenia (appropriateness of admission);
- Respiratory infections (appropriateness of admissions);
- Asthma (appropriateness of admission);
- Post surgical readmissions (within 30 days of discharge);
- Alzheimer disease (appropriateness of long-term care); and
- Home care (consideration as part of discharge planning).

Problems Encountered

During the course of the clinic site reviews, a number of problems emerged. Because the clinic sites were designated by the health plans for review by JCAHO without much explanation from the health plans, some clinics refused to participate while others reluctantly cooperated. For the latter, availability of staff to answer questions, availability of charts to be reviewed and the willingness to provide requested documentation varied and was sometimes difficult to obtain. In addition, some clinics were not given adequate advance notice of the visits by the health plans. They therefore could not provide information requested by the surveyors.

There was concern expressed by some clinics that adverse publicity could result from any deficiencies found. They felt that they were being singled out for special oversight and argued that fee-for-service providers were not subjected to the same kind of scrutiny by the State. The clinics, of course, serve all types of patients: Medical Assistance recipients, commercial health plan patients and self-pay patients. The reviewing agency, therefore, considers the review of the clinics as a proxy for review of the provision of health care for all Minnesota residents who receive their health care through clinics.

Some difficulties were also encountered in the chart review portion of the study. Several problems related to retrieval of information. Some health plans did not have cases involving some of the conditions of interest requested. Others did not have enrollment sufficiently large to provide statistically useful information for each condition. Some problems stemmed from the inability of certain health plans to identify cases by diagnostic code. In addition, some health plans were unable to gain provider

cooperation in obtaining charts. The final report indicated, however, that data retrieval difficulties did not, in and of themselves, have an effect upon the quality of health care provided to Medical Assistance recipients. They reflected instead, some organization difficulties which could lead to quality of care issues.

An additional concern raised by the health plans related to release of the JCAHO reports. The health plans were concerned about negative publicity if deficiencies were found and either health plans or individuals were named in newspaper accounts of the review. Since the final reports were public information, the State was not able to prevent their release to anyone who requested them. However, all information was aggregated to the health plan level. In this and all subsequent reports conducted by an outside review organization, it was impossible to obtain information on specific individuals. Furthermore, health plan clinics were numbered, not named, so that identification of specific cites was difficult to determine. The State, in addition, did agree to allow plans to review the first draft of the individual health plan report and the report on aggregate results. Health plan comments were then included as an addendum to the report. The report itself was not altered either by the State or by the health plans unless it was determined that an error had been made in a specific area by a member of the survey team.

Findings - 1988

On the corporate level, the review team from the Joint Commission found that health plans generally understood the importance of a well documented and implemented quality assurance program. However, there was found to be insufficient documentation of corporate involvement in quality assurance programs, few fully developed quality assurance studies and, in general, inadequate documentation that the results of peer review of charts and provider profiles translated into improved medical care.

Most of the clinics that were reviewed generally appeared to be clean and well run. Recipients were treated with dignity and respect and there were no overt indications that Medical Assistance recipients were treated differently in any way from commercial patients.

In almost all clinics visited, medical charts did not contain medication lists and health condition lists. In addition, most charts were deficient in the areas of authentication of procedures by appropriate staff: radiology, pharmacy and laboratory units with preventive maintenance programs for equipment; a complete array of policy and procedures manuals available for all appropriate staff; public health policies written and known by all staff, policies in place for the maintenance of current sample medications and for the disposal of outdated ones; and systematic

approaches for checking on and maintaining current files on licenses and credentials of all staff. Nor was this available at the corporate level which tended to rely on clinics to maintain such information.

The quality assurance review also included an evaluation of specific Conditions of Interest. The Joint Commission found that health plans, in general, had difficulty in locating charts by standard means of identification. This made it difficult to conduct a review of all the Conditions of Interest specified in the contract entered into by the Department of Human Services and the Joint Commission. The areas in which the Joint Commission was able to conduct an in-depth review showed some unexpected deficiencies. In general, the care of diabetics and of hypertensives, according to the screens employed, was average. In the areas of infant and of well child care there were lapses. Either as a result of failure to chart or failure to provide, immunization levels and testing for sickle cell anemia fell below acceptable levels set forth in the Joint Commission/State of Minnesota standards.

Hospitalization for severe mental health disorders appeared to be appropriate.

The various findings alerted the health plans, the Department of Human Services and Minnesota Department of Health to issues of some significance. The period between the first and second quality assurance reviews was devoted to determining the extent and severity of the difficulties identified during the 1988 quality assurance audit.

Corrective Action Plans

Aggregate reports and individual health plan reports were distributed to each of the health plans. The State requested that each health plan develop and submit a plan to the Department which addressed any deficiencies identified in the quality assurance reports. The Department of Human Services (DHS) then reviewed the corrective action plans submitted by the health plans. This was done to verify that they addressed all the issues raised during the quality assurance review.

It was intended that a portion of the 1989 review would focus on a number of specific areas of deficiency found during the 1988 audit. The State could then ascertain health plan progress toward fulfillment of its corrective action health plan.

1989 Quality Assurance Review

In preparation for the 1989 Quality Assurance Review of prepaid health plans, DHS proceeded in the manner described above for the 1988 audit in order to obtain the service of a contractor who could fulfill federal requirements and complete the type of review the

Department found so valuable in 1988. The JCAHO submitted a bid which fulfilled these requirements.

Components of Study

The 1989 Quality Assurance audit was composed of four distinct parts. Once again DHS evaluated the corporate entity and two clinics for each of the health plans. In the case of the corporate review, the standards established in 1988 were applied once again. So too, were the standards for the clinics except that in the 1989 audit, a clinic seen in the previous year as well as a new clinic were visited by the JCAHO survey team.

The Conditions of Interest list changed somewhat and was reduced in number. These alterations were made in response to a decision by the State to target specific information of the greatest value to the State agencies and to husband resources to the maximum possible. The Conditions of Interest reviewed in the 1989 Quality Assurance audit were the following:

- Prenatal care
- Well baby care - birth through 11 months
- Well baby care - 12 months through four years
- Late childhood care
- Otitis media
- Chemical dependency
- Home care
- Preventive health care
- Women's health care
- Surgical readmission within 30 days of discharge
- Use of emergency room services

The fourth component of the review was designed to evaluate the manner and extent to which the health plans complied with their own corrective action plans. In dealing with this section of the quality assurance audit, the reviewers were instructed to emphasize the evaluation of health plan responses to five key problem areas. These were common to all health plans reviewed in 1988 and which, therefore, were selected for particular attention. The key areas were:

- Involvement of the governing body of the health plan in assuring high quality patient care and in supporting the implementation and maintenance of a health-plan-wide quality assurance program.
- The quality assurance program provided for peer review by appropriate health care professionals, including physicians and support service clinical staff.
- In addition to monitoring important aspects of patient care, that the quality assurance program included a review of patient satisfaction to evaluate the responsiveness of the grievance system and to analyze disenrollments.
- The health plan had a governing body that set policy and had overall responsibility for the health plan.
- The health plan had in place public health issue reporting mechanisms which are easily available and whose mechanisms are known to all staff with patient care responsibilities.

Conducting the Quality Assurance Review

DHS found that conducting the Quality Assurance Review for 1989 proved to be far less troublesome for the health plans than it had been in the previous year. Health plans found it far less difficult to make available required documentation for review by surveyors.

Copies of the 1988 quality assurance audit had been made available to the State legislature, legislative library and to many groups in the community and no adverse publicity resulted from the findings. The absence of adverse criticism helped to assure health plans that the 1989 quality assurance audit would also be less than contentious. Furthermore, health plans had, in general, taken seriously the recommendations made in the quality assurance report and were eager to demonstrate improvements which had been made in both governing body involvement and at clinic sites.

Findings

Clinics

The final results of the Quality Assurance Review for 1989 became available at the end of June 1989. One of the major findings dealt with the clinic aspect of the review. The first observation was that clinics reviewed in 1988 and then revisited in 1989 had made remarkable progress toward compliance with the Minnesota standards as applied during the site visits. In many areas, including the availability of educational materials and policies and procedures manuals, sample drug procedures, safety, and sanitary procedures,

the training of medical students and medical records charting, clinic managers had implemented corrective action plans. Thus, clinics reviewed for the second time had benefitted greatly from the appropriate use of information obtained during the 1988 quality assurance audit.

Conditions of Interest

The Joint Commission Review team reviewed conditions of interest to gain insight into the quality of care being provided by health plans to Medical Assistance recipients. The results were mixed. It had been hoped that the low immunization levels discovered during the 1988 review would encourage health plans to step up their efforts in this regard. Unfortunately, many health plans demonstrated lower immunization levels during the second review year than in the first. The quality of women's health care, including care provided for pregnant women, was also less satisfactory the second year.

These findings led the Minnesota Department of Health, working in conjunction with the Minnesota Department of Human Services, to request health plans specifically to address these matters in their annual reports submitted to that agency. It also compelled the Department of Human Services to look further into the issue of compliance on the part of recipients.

The Department must also review what steps have been taken in order to insure that Medical Assistance recipients receive adequate preventive health care. Department staff began meeting on a regular basis with health plan executives to review these issues, to suggest areas for improvements, and to devise methods for improvement oversight.

Corrective Action Plans

The Joint Commission Review team reviewed the extent to which the health plans implemented the Corrective Action Plans that had been designed subsequent to the 1988 audit. In general, the findings were favorable. All the health plans appeared to have taken specific steps to integrate quality assurance programs with the oversight of the governing bodies of the health plans. Much progress was made in the area of attention to recipient grievances. It also was apparent that the peer review function became far more active during the 1988-1989 period. However, not all health plans had in place a fully developed public health issues reporting mechanism.

1990 - 1991 Quality Assurance Review

The 1988 and 1989 Quality Assurance Reviews suggested that the health plans associated with the Minnesota Prepaid Medical Assistance Program made significant strides toward associating

their governing bodies with quality assurance programs which were actively involved in improving the quality of health care provided to participants in the health plans. They expressed great interest in addressing issues relative to immunizations of children and in exploring ways of providing more complete preventive health services to pregnant women and to women in general.

This concern was most appropriate because as of mid-1990 the PMAP expanded to encompass a much larger portion of the Medical Assistance population of Hennepin County as well as continuing in Itasca and Dakota for about the same number of people. This dramatic increase put strains on the health plans and on their quality assurance programs. Under difficult circumstances such as rapid increases in enrollment, it is important to monitor how the most vulnerable in the population are affected.

In planning for the 1990 Quality Assurance Review, staff from the Minnesota Department of Health and the Minnesota Department of Human Services hoped to work together with the outside quality assurance review organization in order to increase efficiency, avoid duplication of efforts and to concentrate on those issues which the regulatory agencies believe deserve particular attention as the program increases in size.

Unfortunately, the Joint Commission on Accreditation of Healthcare Organizations decided to discontinue the provision of third party reviews for ambulatory care. Consequently, the Department of Human Services devoted considerable time and effort to locate a review organization that would continue in the methods of review the State found to be so effective in the past and which would also be acceptable to HCFA.

The long search to find such an organization not only enabled DHS to locate a review entity but, more importantly, opened the broader question of national standards with regard to quality assurance audits of prepaid, capitated health plans.

Findings

The Minnesota Department of Human Services contracted with HealthPro of Worcester, Massachusetts, to conduct its outside, independent, quality assurance audit for 1990 - 1991. This audit was conducted in 1991 for care provided in 1990 and 1991. The organization followed closely the process followed during the two previous reviews except that in-depth interviews were conducted to determine in what ways health plans were addressing the needs of minority and special needs populations among their enrollees.

With a few exceptions, the audit revealed a rather consistent effort on the part of the health plans to address issues raised in the Corrective Actions Plans for 1989. Almost all the health plans have made concerted efforts to get the results of those studies to the attention of their providers. In addition, the Department was

pleased to see the great lengths to which most of the health plans have gone to improve upon their internal quality assurance programs.

Medical records have improved, although there still remain issues associated with lack of uniformity, particularly in the area of the listing of medications and of ongoing medical issues. The Department is appreciative of the efforts being made by health plans in this area.

Immunizations continue to be a problem. Several of the health plans have addressed this issue in their internal quality assurance studies. It appears that patient compliance as much as any other problem stands in the way of reaching one hundred percent health plan compliance in this area. However, health plans are aware of the problem and are directing resources to achieving improvements.

EVALUATION

Minnesota's Prepaid Medical Assistance Program has taken a multifaceted approach to evaluation. Evaluation efforts were designed to investigate from a variety of perspectives, the effectiveness of a prepaid, capitated medical delivery system for a diverse group of Medical Assistance recipients.

What follows is an overall description of the many approaches taken to evaluate the various participants in the program. Where available, details of findings to date have been included.

State Evaluation Advisory Committee

An Evaluation Advisory Committee, representing a diverse body of government, health and human service interest groups, met early in 1986. The charge of this body was to develop a comprehensive evaluation plan which integrated federal, state and county efforts.

The Advisory Committee developed an elaborate set of questions dealing with prepayment issues. These were fashioned into a comprehensive evaluation plan reflective of existing time, resource and human constraints. This evaluation plan represents a thorough, wide-ranging and detailed inquiry into the impact of the PMAP on the Medical Assistance populations in Minnesota's three demonstration counties. It was understood, however, that previously unidentified constraints might hinder the exploration of all questions detailed in the evaluation plan. The State assumed responsibility for carrying out the evaluation plan to the extent possible.

Federal Evaluation

The Health Care Financing Administration (HCFA) was particularly concerned with prepayment results regarding Aid to Families with Dependent Children (AFDC), and aged populations. HCFA therefore contracted with Research Triangle Institute (RTI) to conduct individualized and cross-project studies of the Medical Assistance competition demonstration projects. RTI was charged with evaluating cost containment effects, utilization of services, quality of care, access to care, client satisfaction, and physician and institutional participation, using information gathered from encounter and client survey data, medical records, and case studies.

Although RTI's study was more extensive for other State sites, Minnesota's evaluation included a client satisfaction survey and case studies. Using a pre-test, post-test study design, RTI completed a survey of 300 AFDC and 300 aged Medical Assistance enrollees in Hennepin County and an equal number of recipients in the control group. The survey included questions dealing with consumer satisfaction, utilization of services, health status and functional ability.

It was anticipated that RTI would analyze the encounter data received from the health plans. However, delays in receiving acceptable data prevented this analysis.

Lewin and Associates was under subcontract with RTI to complete case studies describing the program in Minnesota. The case study reports were based on key informant interviews and dealt with such issues as the marketing of health plans, consumer choice concerns, and implementation problems. Lewin and Associates interviewed State, county, legislative and provider personnel associated with the program. Lewin and Associates completed a total of four case study reports between 1984 and 1988.

The findings across all sites highlighted greater-than-anticipated start-up difficulties with the program, problems with enrollment and eligibility data, and unattractive reimbursement levels for providers as well as some difficulties relating to ensuring access and quality of care.

RTI reported that case management by health plans reduced utilization; and limitations on freedom of choice by recipients did not adversely affected the quality of health care received. The integrative report was cautiously optimistic regarding ability of prepaid programs to realize a modest savings in Medical Assistance costs without adversely affecting the quality of care, access to care or the satisfaction of participants in managed health care programs.

County Studies

Hennepin County Studies

Impact of the Medical Assistance Demonstration Program on County Contracted and Operated Mental Health Agencies

In 1986, Hennepin County Prepaid Program staff administered a study to evaluate the cost of out-of-plan use of county-contracted and operated mental health and chemical dependency agencies. This was an important consideration to Hennepin County, as agencies that previously billed Medical Assistance were frequently being denied payment by prepaid health plans because the services were provided "out-of-plan" or without prior authorization by health plans.

The 25 agencies that participated in the study were asked to document when PMAP recipients requested services, the types of services provided, and whether the agency requested prior approval from the health plan. The study concluded that the amount of financial loss to these agencies as a result of absorbing out-of-plan costs represented a small percent of their budgets, so they were willing to continue to provide uncompensated care to Prepaid Program recipients.

Hennepin County Crisis Intervention Center Study

Conducted in 1987 and 1988, this study was administered by Hennepin County's Office of Planning and Development, the State Prepaid Medical Assistance Program Office and the Community Services Management and Planning Department to determine whether enrollment in a prepaid health plan affected the use of the free Hennepin County Crisis Intervention Center (CIC) by chronically mentally ill individuals. The study concluded that chronically mentally ill persons enrolled in health plans through the PMAP used the agency significantly less often than a comparison fee-for-service chronically mentally ill group.

The Effects of Prepaid Health Care on Institutionalized Elderly Medical Assistance Recipients in Hennepin County

Using county program administrative funds, Hennepin County sponsored a 1988 study of the impact of a prepaid health care delivery system on the institutionalized aged. Data from 800 patient charts were examined to determine if the study group manifested adverse health outcomes after a year of receiving health care through prepaid health plans. Functional health status, number of physician visits, therapy visits, length and number of hospitalizations and changes in nursing home case mix classifications were measured.

Chart reviews of the two study groups revealed no significant differences in the health status of the two groups. While the study group showed a decrease in the amount of occupational and physical therapy received, all other ancillary services such as visits to a primary care physician and specialists remained the same.

University of Minnesota Studies in Hennepin County

Impact of Capitation on the Non-institutionalized Aged Population

Using DHS data and Hennepin County administrative funds, a research team from the University of Minnesota School of Public Health studied the ability of health plans to provide care to a group of non-institutionalized aged Medical Assistance recipients. The team examined health and functional status and cost and use of medical services by the aged, comparing aged recipients on the fee-for-service system with aged recipients using health plan services. The study results demonstrated that there were no statistical differences between the two groups in any of the areas of health care measured by the study.

Impact of Capitation on the Chronically Mentally Ill

A research team from the University of Minnesota School of Public Health used DHS data and Hennepin County administrative funds to

study the effect of using a capitated system of health care for the chronically mentally ill. The results of this 1987 - 1988 study indicated that there were no notable differences relating to mental health status, or physical and social functioning between the group receiving health care through the fee-for-service system and the group receiving care through a managed care program provided by health plans.

Dakota County Studies

Client Satisfaction Survey

Dakota County contracted with Program Evaluation Resource Center (PERC) to conduct an evaluation on access to and satisfaction with mental health and chemical dependency services. The PERC study indicated a decline in mental health service use between 1986 and 1988, a decline in chemical dependency services, somewhat longer waiting times and fewer appointments per month. Overall, there was satisfaction with outpatient mental health care.

Interviews with Dakota County Nursing Homes

The Dakota County Nursing Home Study was conducted to examine the reasons for a series of grievances filed during 1987 in Dakota County on behalf of aged participants in the PMAP. The study revealed that nursing home staff were dissatisfied with additional administrative work involved, and were confused about some health plan policies and transportation issues.

Itasca County Satisfaction Survey

The State and Itasca County conducted a survey in 1989 that measured the reaction of Itasca County Medical Assistance recipients to receiving their health care through a managed health care system. The 41% who responded indicated satisfaction with the level and quality of health care being provided. Recipients indicated that the waiting times involved to receive that care had not changed because of its delivery through Itasca Medical Care. Recipients were least satisfied with the health plan's vision services and the requirement to obtain a referral to a specialist through a primary care physician.

Minnesota Department of Human Services Studies

Grievance Panel Survey

Department staff conducted a survey of those involved in the Grievance Panel Process including panel members, staff, recipients, health plan participants, recipient advocates and volunteer advocates. Much valuable information regarding the actual workings of the PMAP was learned through the panel discussions and evaluations of the grievances presented. The survey conclusion,

however, was that the grievance process would be extremely difficult to continue for the entire duration of the PMAP and would be too costly in staff and health plan time.

What Private Managed Health Care Systems Can Learn From a Medical Assistance Quality Assurance Program

This report indicated that Department oversight as part of the external quality assurance review brought about significant improvements in clinics visited in successive years. Clinic management became aware of areas requiring changes both in patient care and in site safety and sanitation. Most clinics improved their ability to deliver health care to all people who use their clinics and to demonstrate that high quality health care was provided to PMAP recipients.

Satisfaction Surveys - Recipients

The Department of Human Services sent satisfaction surveys to recipients both during yearly open enrollment periods and when health plans withdrew from the PMAP. The recipient satisfaction surveys reflected an extreme reluctance on the part of individuals to change providers or to enroll in health plans, but they expressed considerable satisfaction once they had established relationships with health plan providers.

For AFDC recipients, convenience of access to clinics and hospitals were the major determinants in selecting a health plan. For Aged recipients, attachment to their own physicians determined health plan choice.

Name recognition, desire to retain mental health, chemical dependency and dental providers played little or no role in health plan selection. Recipient advance knowledge of managed health plans increased satisfaction with health plan selection. It significantly reduced the rate of change in health plans during Open Enrollment periods.

Satisfaction Surveys - Providers

State staff designed an instrument to survey providers involved in the Program. Provider input for the survey instrument was received as a result of a focus group which was convened by an outside consultant on behalf of the Department of Human Services in October 1988. DHS administered the provider satisfaction survey in December 1988.

Providers believed that quality health care was being delivered and, where the county was the health plan, the transition to a managed health care system caused few difficulties. Providers expressed dissatisfaction with levels of reimbursement, amount of paper work required of them and level of recipient knowledge of the

managed health care system.

Analysis of Cost Savings - Calendar Years 1987, 1988 and 1989

DHS developed a study to determine cost savings associated with the PMAP. The results of the study show an estimated savings in 1987 of \$5.7 million, for 1988, \$6.5 million and for 1989, \$1.5 million.

Seen from the perspective of cost savings per Medical Assistance eligibility month, DHS experienced the following savings: 1987 - \$20.75, 1988 -\$19.30, and 1989 - \$5.03.

As predicted, the 1989 analysis yielded more moderate savings than 1987 and 1988 due to rebasing of rates to a more current year's experience. Prepaid health plan capitation rate payments for AFDC and Needy Child populations were 83% of the estimated fee-for-service experience. For the Aged population, payments were 124% of the fee-for-service estimates. It is believed that the inflated payment for the Aged population resulted from the effects of Medicare Catastrophic Coverage in 1989. This coverage reduced costs for fee-for-service Medical Assistance recipients while capitation payments for that year reflected the historical fee-for-service experience of SFY 1987.

There are serious limitations to the precision of these results. The fee-for-service comparison data included retroactive months of eligibility. In addition, PMAP rates for 1987- 1988 were based on fixed inflation factors that tended to increase the appearance of cost savings. In spite of these limitations, results of this study suggest an ability to control health care cost trends through a managed, capitated system of health care provision.

Inpatient Utilization Reporting (Utilization Data Definitions Committee)

One of the major outcomes of the PMAP has been a redefinition of inpatient reporting requirements for state licensed HMO's to the Minnesota Department of Health. The reporting tool was completely redesigned, to isolate obstetrical and newborn data elements from the previous gross Med-Surg category of reporting. All the new categories (Med-Surg, Mental Health, Chemical Dependency, Obstetrics and Newborn) defined by specific ICD-9 codes and DRG codes, are totally distinct from non-acute hospital days and are reported in an identical manner by all health plans in the State. (The group which redesigned the reporting tool, The Utilization Data Definitions Committee, is made up of representatives of a number of health plans, county staff, and staff from the State regulatory agencies. It has undertaken the task of defining a new outpatient reporting tool based on uniformity of data elements.)

Phase I, dealing with the reporting of information regarding inpatient care is complete. The Committee is in the final stages

of completing Phase II of its work. Phase II deals with the reporting of information relating to ambulatory care. The Committee decided that at the present time it would be impossible to design a reporting mechanism that would encompass all of ambulatory care that was comparable across health plans. Instead, the Committee elected to use proxies that would be reflective of important aspects of health care as provided by health plans. The Committee decided to combine Phase I and Phase II of work under one cover. The work has recently been published.

Public Health Nursing Study

To address concerns raised by public health nursing agencies in both Hennepin and Dakota Counties, the State implemented a study to document the effects of prepayment on these agencies. Claims of underservice to enrollees by health plans and provision of uncompensated out-of-plan services by agencies were examined. An instrument to document cases involving health plan enrollees seeking public health nursing services was designed and staff in each county began using the tool in June 1988. They were asked to keep data for the remainder of 1988.

The results of the study were sketchy. The organizations involved in the study found it difficult and time consuming to collect the information requested. In general, they did not dedicate to the program the human resources necessary to obtain sufficient information regarding the financial considerations which initially had brought them to the Department of Human Services.

The results, however, were sufficient to suggest two tentative conclusions. Public health nurses tend to provide not only medically necessary services covered under Medical Assistance but also a certain amount of what may be considered social services and which may or may not be specifically identified in the Medical Assistance Manual.

The Department of Human Services is charged with paying for the costs of the medically necessary services of eligible individuals. While it recognizes the extreme value and importance of social services, it has no authority to pay for such services.

The second observation was that greater attention to billing all possible reimbursable services will reduce the excessive costs currently being incurred by the public health nursing services. While the participating agencies had difficulty reporting what percentage of their nurses were entering required data or what percentage of their case loads were represented in the information reported to DHS, the agencies knew how much money had been spent and how much had been billed. Armed with this information, one of the counties discovered that by hiring an individual to manage the office accounts of the agency, the agency's unreimbursed services were reduced by seventy-five percent.

While this attempt to monitor health plan vs. public agency provision of some public health services did not yield statistically useful information, it did suggest the importance to DHS of monitoring care provision in this area.

Although this study is somewhat limited, DHS recognizes the need for further review of claims data to determine whether or not health plans are providing necessary public health services to their capitated enrollees.

Encounter Data

Over the past several years, considerable effort has been expended by the Department of Human Services in an attempt to obtain from participating health plans encounter data which would allow the Department to monitor the utilization of health care services. A vast array of technical difficulties have thus far thwarted efforts to do so effectively.

From 1986 through June 30, 1990, the health plans were required to submit encounter data in the fee-for-service claims format. Extensive resources on the part of the health plans and the state were devoted to submitting and processing these data. In spite of these efforts, lack of uniform data definitions and under-reporting proved to be roadblocks to the state in reporting accurate utilization statistics using these data.

Because of difficulties encountered in using the fee-for-service claims format, the State moved to a new reporting format for the contract period beginning July 1, 1990, which promised to be less cumbersome for both the health plans and the State. Health plans were required to report several data elements on every service encounter. These data elements include: name of health plan, diagnosis codes, procedure codes, gender, rate cell number, units of service, length of stay, place of service, and provider type or specialty.

The State found that the accuracy of utilization reporting using these data was diminished due to the failure to require two additional data elements: recipient identifier and date of service. These data elements will be added to health plan contracts as required reporting items for the contract period beginning July 1, 1992.

Because of the above-described difficulties in obtaining and processing encounter data, the State is left with limited utilization data which is accurate enough to warrant the generation of utilization reports. However, there are two areas in which the state believes that accurate encounter data has been reported: dental care and the experience of the General Assistance Medical Care (GAMC) population in RamseyCare. Therefore, state staff are working on utilization reports in these areas.

The extensive efforts described above in obtaining useable encounter data has caused considerable frustration on the part of the State and the health plans and has still left the State with an inability to report accurate utilization figures for health plan enrollees. The advent of a new MMIS for the Medical Assistance Program provides an opportunity for the state to "fix" these reporting problems. The State proposes to require all health plans to report encounters utilizing uniform billing formats, including the following Electronic Media Claims formats:

- EPSDT: DHS form
- inpatient hospital: UB-92
- dental: American Dental Association Form
- pharmacy: NCPDP Claim Form
- all other services: HCFA 1500

So as not to impose an undue burden on the health plans and to avoid the problems encountered initially when the fee-for-service claims format was required, the State will require that initially the health plans submit at a minimum the data elements outlined above, including the two additional items added to the current contract.

The new MMIS will be on-line effective in 1993. Therefore, the health plans will be required to begin reporting in the above formats for all reporting periods subsequent to MMIS implementation. The MMIS will initially edit only the fields containing the designated data elements. No claims will be rejected or suspended. Health plans may be expected in future contract years to complete more of the data elements for the required claims formats. These data will be processed and reported as encounter data. Capabilities of reporting utilization on the new system will be considerable. Quarterly utilization reports will be available to assist the state in managing the prepaid programs.

Dental Utilization Study

The Department is in the process of preparing a report dealing with the provision of dental services to participants in the managed care programs. The report is nearing completion and will be available before the summer of 1992. With access to dental services decreasing in the State, the information in this report suggests that one of the advantages of a managed care program is the ability of the State to provide access to dental care for its recipients.