OLA
OFFICE OF THE LEGISLATIVE AUDITOR
STATE OF MINNESOTA

EVALUATION REPORT

Financial Management of Health Care Programs

FEBRUARY 2008

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OFFICE OF THE LEGISLATIVE AUDITOR
STATE OF MINNESOTA • James Nobles, Legislative Auditor

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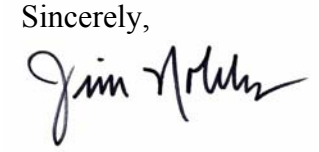
Members of the Legislative Audit Commission:

In fiscal year 2007, Minnesota spent $6.5 billion on health care programs serving lower-income people. Payments were made on a fee-for-service basis to health care providers, as well as on a per enrollee basis to a variety of private and county-owned managed care organizations that have contracts with the state.

We found that Minnesota's use of managed care provides several advantages over fee-for-service, but that approach does not automatically control costs. Therefore, we recommend greater scrutiny of costs—as well as health outcomes—in both managed care and fee-for-service. We also discuss alternative service delivery models that the Legislature could consider.

This report was written by Joel Alter (project manager), Valerie Bombach, and Timothy Dykstal. We received the full cooperation of the departments of Human Services, Health, and Commerce, and we also received helpful advice from health plans, counties, and many others.

Sincerely,



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1 Background

SUMMARY

Minnesota has several publicly funded health care programs that serve lower-income Minnesotans. Most enrollees are in "managed care" programs, but most of the expenditures occur through "fee-for-service" arrangements. Minnesota's Medicaid program (called "Medical Assistance") costs significantly more per enrollee than the U.S. average for Medicaid programs, probably due to Minnesota's more comprehensive benefit package and its relatively large shares of spending for long-term care and enrollees with disabilities. Three state agencies—the departments of Health, Human Services, and Commerce—play key roles in the financial management of Minnesota's health care programs.

Recently, the director of the U.S. Congressional Budget Office testified to Congress that "[t]he nation's long-term fiscal balance will be determined primarily by the future rate of health care cost growth."[1] He noted that, over the past four decades, the costs per beneficiary of Medicare and Medicaid have increased about 2.5 percentage points faster annually than the nation's per capita gross domestic product.[2] Health care programs for people with low incomes are also a major factor affecting state governments' spending levels, and this chapter addresses the following questions:

- **What are Minnesota's main publicly funded health care programs, and what role do they play in Minnesota's health care system?**
- **How much do these programs cost, and how do Minnesota's costs per enrollee compare with those in other states?**
- **What is "managed care" and "fee-for-service" health care? To what extent are the state's health care programs delivered through each?**
- **What are the key responsibilities of Minnesota state agencies in the financial management of health care programs?**

[1] Peter R. Orszag, *Health Care and the Budget: Issues and Challenges for Reform: Testimony Before the Committee on the Budget, U.S. Senate* (Washington, D.C.: Congressional Budget Office, June 21, 2007), 1.

[2] *Ibid.*

2 Progress on DHS Cost Containment Strategies

SUMMARY

State agencies and the Legislature have made mixed progress in implementing strategies identified in a 2005 Department of Human Services (DHS) report on ways to contain publicly funded health care costs and improve services. The state has taken important first steps to implement evidence-based medicine, electronic medical records, and care management in fee-for-service health care, for example. But a number of key DHS suggestions have not been implemented, and the report's net impact on health care costs is unclear. DHS should provide a status report on its 2005 recommendations to the 2009 Legislature.

State law requires the Commissioner of Human Services to administer a "comprehensive health services system."[1] In addition to promoting health care access and quality, the law requires the commissioner to implement a system that "manages care, . . . contains cost in all health and human services[,]" and supports effective services throughout the state.[2] This chapter addresses the following questions:

- **To what extent has the state made progress toward implementation of strategies suggested by the Department of Human Services in 2005 to control the cost of state health care programs?**
- **Have these strategies resulted in documented cost savings so far?**

2005 DHS COST SAVINGS REPORT

The 2003 Legislature directed DHS to "determine the appropriateness of eliminating reimbursement for certain payment codes under medical assistance, general assistance medical care, or MinnesotaCare" and suggest possible modifications of services covered under these programs.[3] After consulting with legislative leadership, DHS expanded the scope of this study "to identify strategies that could produce long-term positive impacts on both the budget and program enrollees' health status."[4] Over the course of 14 months, DHS received advice from a consultant (Bailit Health Purchasing), an "expert panel," a

[1] *Minnesota Statutes* 2007, 256B.04, subd. 1a.

[2] *Ibid.*

[3] *Laws of Minnesota* First Special Session 2003, chapter 14, art. 13C, sec. 2, subd. 7.

[4] DHS, *Health Care Services Study: Findings and Strategies for Savings* (St. Paul, January 2005), 4.

3 State Payment Rates for Health Care Programs

SUMMARY

The Department of Human Services (DHS) annually sets rates that determine the amounts it will pay to managed care organizations to serve enrollees in public programs. In recent years, payment rates have usually exceeded the managed care organizations' medical and administrative costs, contributing to program stability and growth in the organizations' reserves. But the use of a managed care approach does not guarantee cost containment, and Minnesota's managed care spending per enrollee rose faster than the national increase between 2000 and 2005. The Legislature and DHS should continue to pursue strategies to contain costs. In fee-for-service care, there have been few changes in the state's physician reimbursement rates over the past 15 years. This has helped contain costs, but questions about the adequacy and equity of fee-for-service payment rates deserve the attention of policy makers.

Minnesota's aggregate spending levels for publicly funded health care programs are determined partly by the rates the state sets to pay for health care services. In the case of managed care, the Department of Human Services (DHS) annually sets rates for monthly "capitation" payments—that is, a prepaid amount per enrollee to compensate health plans for the services they are required to provide. In the case of fee-for-service care, DHS reimburses health care providers for services they have already delivered, based on a state-determined schedule of rates for various medical procedures. This chapter addresses the following questions:

- **How do Minnesota's rates for paying health plans and fee-for-service providers compare with rates in other states?**
- **Has DHS set managed care capitation rates that contain costs while allowing for reasonable returns to the health plans?**
- **Have Minnesota's fee-for-service payment rates contained costs while providing reasonable reimbursement levels for health care providers?**

Federal law requires that states establish methods of paying for Medicaid services that (1) "are consistent with efficiency, economy, and quality of care" and (2) "are sufficient to enlist enough providers so that care and services are available [under the state's Medicaid program] at least to the extent that such care and services are available to the general population in the geographic area."[1]

[1] *42 U.S. Code*, 1396a.

4 Administrative Spending

SUMMARY

Minnesota spent $318 million in 2006 to administer publicly funded health care programs, including nearly $200 million in health plan administrative costs and $119 million in Department of Human Services (DHS) costs. Between 2000 and 2006, health plans' administrative spending levels increased faster than program enrollment but more slowly than medical costs. Three state agencies oversee various aspects of health plans' spending, but the depth of their reviews has been limited. DHS should more closely scrutinize and limit administrative spending for public programs, especially through its rate-setting and contracting processes.

One part of controlling publicly funded health care spending is controlling the costs to administer these programs. Similar to medical care costs, the state has experienced consistent growth in administrative expenditures. Three state agencies—the departments of Human Services, Health, and Commerce—each play a role in overseeing health plan spending. This chapter addresses the following questions:

- **How much does the Minnesota Department of Human Services (DHS) spend to administer its managed care and fee-for-service health care programs? How much do health plans spend to administer public programs on behalf of the state?**

- **Have state agencies taken sufficient steps to ensure that health plans' administrative spending is reasonable and accurately reported?**

- **Has DHS done enough to control the administrative spending of health plans with which it contracts?**

Some people have expressed concern about the accuracy of health plans' reporting of their administrative costs. For example, the Minnesota Office of the Attorney General has questioned the adequacy of federal, state, and insurance industry reporting standards, and it has questioned how some plans have defined their administrative expenses.[1] The Attorney General also concluded that one health plan's 2000 administrative costs were almost twice the level publicly reported by the health plan.[2] Health plans and Department of Commerce staff have disputed the Attorney General's conclusions, contending that the plans report administrative costs in a manner consistent with accepted standards. Our evaluation did not review in detail whether individual health plans properly categorized expenditures as "administrative" costs, nor did we conduct a

[1] Minnesota Office of the Attorney General, Chapter 6: [Allina] Administrative Expenses (St. Paul, 2001), 1-5.

[2] *Ibid.*, 8-9.