Human Services

CHAPTER 6

As we discussed in Chapter 2, health and welfare has been the fastest growing major spending category in Minnesota, accounting for 34 percent of overall spending growth between 1957 and 1992. In this chapter we focus on large health and welfare programs, including means-tested health programs, income maintenance programs, and social service programs. Unlike the Census health and welfare category, we exclude energy assistance, air and water pollution control spending, veterans programs, and spending by public hospitals and health departments unless it is financed by one of the three major means-tested health programs (Medical Assistance, General Assistance Medical Care, and MinnesotaCare). In this chapter, we refer to the collection of programs that we examine as human service programs. Specifically, we address the following questions:

- **What have been the spending trends for human service programs?**
- **What factors explain the growth in these programs?**
- **How does spending in Minnesota compare with human service spending in other states?**
- **What factors explain the differences in per capita spending between Minnesota and other states?**

To analyze spending trends for Minnesota's programs, we used data from the Minnesota Department of Human Services. To make comparisons with other states, we used various national data sources. For example, we obtained comparative Medical Assistance spending data from the U.S. Health Care Financing Administration. We do not rely on Census data in this chapter because it does not break down human service spending by program.

This chapter begins by examining trends for human service programs. Then, it focuses on trends for Medical Assistance, the largest human service program. Finally, it compares Minnesota's human service spending with the national average.

HUMAN SERVICES SPENDING, 1995

In fiscal year 1995, Minnesota state and local governments spent $4.4 billion on the human service programs listed in Figure 6.1. The largest portion of human service spending was for medical services for the needy. As Table 6.1 and Figure 6.2 show, Medical Assistance was the largest program, accounting for 59 percent of human services spending in 1995. Social service programs were the second largest spending category (20 percent). Social service programs include child care, children's services (such as child protection), mental health services, adult services, and developmentally disabled services. Aid to Families with Dependent Children (AFDC) was the third largest category (7 percent), followed by Administration (6 percent), General Assistance Medical Care (4 percent), General

Figure 6.1: Human Service Programs

Income Maintenance Programs

Aid to Families with Dependent Children (AFDC): A federal/state program that provides cash assistance to low-income families with dependent children and a single parent, an unemployed parent, or an incapacitated parent.

General Assistance/Work Readiness: General assistance is a state program that provides cash assistance to needy people who are unable to work. It also funds certain group residential facilities, including battered women shelters. Work Readiness is a state program that provides cash assistance and employment services to needy people who are employable.

Minnesota Supplemental Aid (MSA): A state program that provides cash assistance to needy aged, blind, and disabled people. It also funds group residential housing for eligible MSA recipients.

Health Programs

Medical Assistance: A federal/state program that provides medical services to needy elderly, blind, and disabled people, pregnant women and children, and adults from AFDC-type families.

General Assistance Medical Care (GAMC): A state program that provides medical services to needy people who are not eligible for Medical Assistance.

Minnesota Care: A state program that subsidizes medical care for low-income people who do not qualify for Medical Assistance or GAMC.

Social Service Programs

Social service programs include (1) children's services such as adoption and child protection activities, (2) child care, (3) chemical dependency services, (4) mental health services, (5) services for the developmentally disabled, and (6) other adult services. These programs are funded by federal, state, and county governments. Social services funded by Medical Assistance are included with Medical Assistance expenditures rather than social service expenditures.

Table 6.1: Minnesota Human Service Expenditures by Program, 1995

	Expenditures (in Millions)	Per Capita	Percent
Medical Assistance	$2,588	$561	59%
Social Services	859	186	20
AFDC[1]	312	68	7
General Assistance/Work Readiness	65	14	1
General Assistance Medical Care	158	34	4
Minnesota Supplemental Aid	55	12	1
Minnesota Care	43	9	1
Child Support Enforcement	49	11	1
Administration			
Medical Assistance	151	33	3
AFDC	73	16	2
General Assistance/GAMC	15	3	< 1
Minnesota Supplemental Aid	5	1	< 1
Subtotal	244	53	6
Total	$4,373	$948	100%

Notes:

(1) All expenditures are for state fiscal year 1995 except social service expenditures, which are preliminary estimates for calendar year 1994.

(2) Figures for AFDC and General Assistance include expenditures for cases transferred to the Minnesota Family Investment Program.

(3) Figures for General Assistance and Minnesota Supplemental Aid include expenditures for cases transferred to the Group Residential Housing Program.

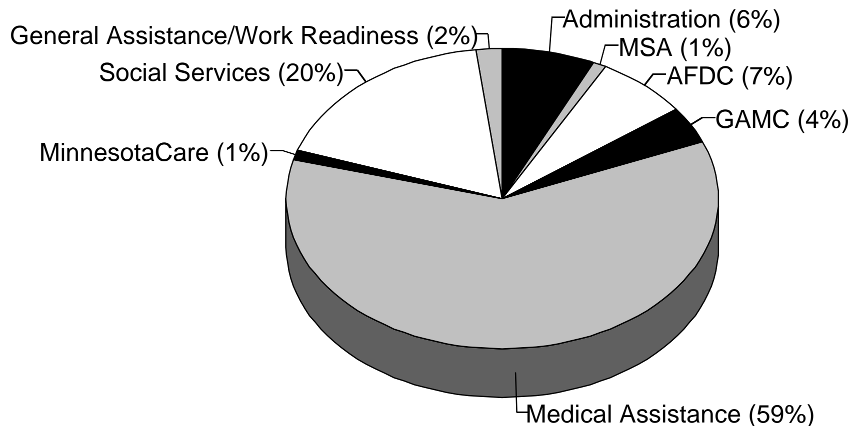
(4) Social services funded by Medical Assistance are included with Medical Assistance and not with Social Services.

Source: Minnesota Department of Human Services.

[1]AFDC expenditures include Emergency Assistance expenditures. They are net of AFDC child support collections.

A significant share of human service spending is for programs which are regulated and partially funded by the federal government.

Figure 6.2: Human Service Spending, Minnesota, 1995



Source: Minnesota Department of Human Services.

Assistance/ Work Readiness (2 percent), Minnesota Supplemental Aid (1 percent), Child Support Enforcement (1 percent), and MinnesotaCare (1 percent).

The federal government funds a significant share of human service spending. In fiscal year 1995, it funded about 54 percent of spending under the Medical Assistance and AFDC programs. The federal government did not help fund General Assistance, General Assistance Medical Care, Minnesota Supplemental Aid, or MinnesotaCare.

HUMAN SERVICE SPENDING TRENDS

Between 1980 and 1995, Minnesota's human service spending nearly doubled.

Comparable expenditure data were not available for social services prior to 1979 nor for program administration prior to 1981. As a result of these data limitations, our analysis of human service programs focuses on the 1980-95 time period. Later in this chapter, we discuss some of the earlier trends for Medical Assistance.

Overall, human service spending increased from $1.0 billion in fiscal year 1980 to $4.4 billion in 1995, more than a four-fold increase. Per capita, it grew from $270 to $948. After adjusting for inflation, human service spending grew by 95 percent, or 4.6 percent per year. Tables 6.2 and 6.3 show that spending for all of the

Table 6.2: Minnesota Human Service Expenditures per Capita (in Constant 1995 Dollars), 1967-95

Year	1967	1970	1975	1980	1985	1990	1995
Medical Assistance	$ 95	$121	$186	$262	$333	$371	$561
Social Services	N/A	N/A	N/A	80	102	139	186
AFDC[1]	43	67	92	82	90	80	68
General Assistance Medical Care	0	0	0	19	19	28	34
General Assistance/Work Readiness	8	9	11	9	26	19	14
Minnesota Supplemental Aid	0	0	4	5	6	11	12
Minnesota Care	0	0	0	0	0	1	9
Child Support Enforcement[2]	N/A	N/A	N/A	5	6	8	11
Administration[3]	N/A	N/A	N/A	24	26	36	53
Total[4]	$146	$196	$293	$485	$607	$693	$948

Notes:

(1) All expenditures are for state fiscal years except that social service expenditures are for calendar years ending in the same state fiscal year.

(2) Figures for AFDC and General Assistance include expenditures for cases transferred to the Minnesota Family Investment Program.

(3) Figures for General Assistance and Minnesota Supplemental Aid include expenditures for cases transferred to the Group Residential Housing Program.

Source: Minnesota Department of Human Services.

[1]AFDC expenditures include Emergency Assistance expenditures, they are net of AFDC child support collections.

[2]1980 child support enforcement expenditures are estimates based on 1983 expenditures. We assumed that they increased at the rate of inflation between 1980 and 1983.

[3]Includes administrative expenditures for Medical Assistance, AFDC, GAMC, General Assistance, Work Readiness, and Minnesota Supplemental Aid. 1980 administrative expenditures are estimates based on 1981 expenditures (except AFDC administrative expenditures, which are based on 1982 expenditures).

[4]Total expenditures are low for earlier years because expenditure data were not available for all programs.

About two-thirds of the spending growth was in Medical Assistance.

Table 6.3: Percent Change in Human Service Expenditures per Capita (in Constant Dollars) by Program, Minnesota, 1980-95

	1980	1995	Percent Change	Percent of Growth
Medical Assistance	$262	$561	114%	65%
Social Services	80	186	133	23
AFDC[1]	82	68	-17	-3
General Assistance/Work Readiness	9	14	65	1
General Assistance Medical Care	19	34	82	3
Minnesota Supplemental Aid	5	12	163	2
Minnesota Care	0	9		2
Child Support Enforcement[2]	5	11	101	1
Administration[3]				
Medical Assistance	10	33	217	5
AFDC	9	16	74	1
General Assistance/GAMC	4	3	-19	-0
Minnesota Supplemental Aid	1	1	21	0
Subtotal	24	53	118	6
Total	$485	$948	95%	100%

Notes:
(1) Expenditures are adjusted for inflation based on the PGSL.

(2) Figures for AFDC and General Assistance include expenditures for cases transferred to the Minnesota Family Investment Program.

(3) Figures for General Assistance and Minnesota Supplemental Aid include expenditures for cases transferred to the Group Residential Housing Program.

Source: Minnesota Department of Human Services.

[1]AFDC expenditures include Emergency Assistance expenditures. They are net of AFDC child support collections.

[2]1980 child support enforcement expenditures are estimates based on 1983 expenditures. We assumed that they increased at the rate of inflation between 1980 and 1983.

[3]1980 administration expenditures are estimates based on 1981 expenditures (except AFDC administrative expenditures, which are based on 1982 expenditures).

human service program categories, except AFDC, grew much faster than inflation. Between 1980 and 1995, eight of the nine program categories grew by at least 65 percent, after adjusting for inflation. Medical Assistance, the largest human service program, grew by 114 percent, or an annual increase of 5.2 percent. The fastest growing program was Minnesota Supplemental Aid, which grew by 6.7 percent per year. AFDC declined by 17 percent, or an annual decrease of 1.2 percent. Table 6.3 also shows that:

- **Medical Assistance explained 70 percent of the growth in human service spending between 1980 and 1995.**

This includes 65 percent from payments to health providers and 5 percent from administrative expenditures. Medical assistance explained most of the growth in human service spending because of its size and its faster than average growth.

Social services explained 23 percent. No other program explained more than 3 percent of the growth.

Increased caseloads explain much of the increase in human service spending.

We analyzed whether the growth in spending was due to increases in enrollment or payments per beneficiary for five major human service programs: Medical Assistance, AFDC, General Assistance, General Assistance Medical Care (GAMC), and Minnesota Supplemental Aid (MSA). Since a program's new enrollees may be different than those already enrolled, estimated impacts of enrollment growth on spending may not be precise. Nevertheless, it is useful to examine changes in enrollment and average expenditures per recipient. Overall, we found that enrollment growth appears to explain most of the growth in human service spending between 1980 and 1995, though increases in average cost was also a significant factor for some programs, particularly Medical Assistance. Table 6.4 shows that each of the five programs had strong enrollment growth between 1980 and 1995. The proportion of the population receiving General Assistance or Minnesota Supplemental Aid more than doubled between 1980 and 1995. Medical Assistance enrollment grew from 50 enrollees per 1,000 population to 92, an increase of 82 percent. Enrollment in GAMC and AFDC increased by 41 and 22 percent, respectively.

Table 6.4: Trends in Recipients and Cost per Recipient by Program, Minnesota, 1980-95

	Recipients Per 1,000 Population			Cost Per Recipient		
	1980	1995	Percent Change	1980	1995	Percent Change
Medical Assistance	50.3	91.8	82%	$5,205	$6,107	17%
AFDC	32.3	39.4	22	2,477	1,718	-31
General Assistance/Work Readiness	4.7	11.1	136	3,971	3,070	-23
General Assistance Medical Care	3.2	4.5	41	2,694	3,300	22
Minnesota Supplemental Aid	2.6	5.8	123	1,728	1,915	11

Source: Minnesota Department of Human Services.

Increases in average costs per enrollee explain some of the growth in Medical Assistance spending.

For Medical Assistance, most of the enrollment growth was by families and children, who cost much less on average than aged and disabled recipients. As a result, average cost per recipient grew much faster within each eligibility category than it did overall. We estimate that about 41 percent of the growth in Medical Assistance spending can be attributed to increases in average cost per enrollee. We examine trends for Medical Assistance in more detail below.

The average cost per recipient for MSA and GAMC grew by 11 and 22 percent, respectively. For two programs (AFDC and General Assistance), average benefits have not increased as fast as inflation. The average AFDC benefit per recipient declined by 31 percent, while the number of AFDC recipients grew by 22 percent. As a result, inflation-adjusted AFDC expenditures per capita declined by 17 percent. The average benefit per recipient under the General Assistance/Work Readi-

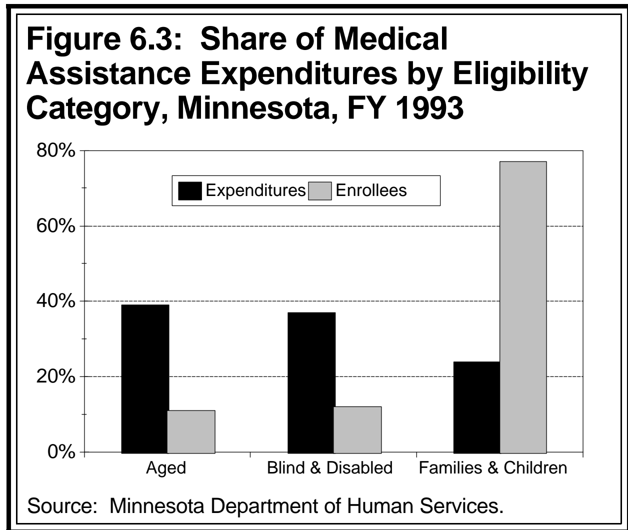
ness program declined by 23 percent, but this was more than offset by its enrollment growth of 136 percent.

MEDICAL ASSISTANCE

Most Medical Assistance enrollees are families or children, but most of the spending is for the aged and disabled.

In 1993, about 388,000 Minnesotans were enrolled in Medical Assistance, of whom 77 percent were low-income families or children, 12 percent were blind or disabled, and 11 percent were aged. The average cost varies greatly among these groups. On average, Minnesota spent $19,500 per aged enrollee, $17,800 per blind or disabled enrollee, and $1,800 per family or child enrollee. Because the average cost per recipient varies, spending is not proportional to the number of recipients. While low-income families and children make up 77 percent of enrollees, they account for only 24 percent of the cost. As Figure 6.3 shows, Minnesota spends most of its Medical Assistance dollars on the aged, blind, and disabled.

Figure 6.3: Share of Medical Assistance Expenditures by Eligibility Category, Minnesota, FY 1993



Source: Minnesota Department of Human Services.

Table 6.5 shows how Minnesota's Medical Assistance spending is distributed by type of service. In 1995, long-term care accounted for 57 percent of Medical Assistance spending and acute care made up 43 percent. Minnesota spent $1.46 billion on long-term care, including $1.13 billion for institutional facilities (including nursing homes, intermediate care facilities for the mentally retarded, and state residential facilities), and $0.34 billion for alternatives to institutional care (including home care and waivered services). Minnesota spent $1.12 billion on acute care services, including $0.27 billion on health maintenance organizations.

Medical Assistance Spending Trends

A variety of factors affect spending trends for Medical Assistance. First, federal and state governments have made numerous changes in eligibility criteria that have increased enrollment in Medical Assistance. For example, the program expanded eligibility for pregnant women and children who are not AFDC recipients during the late 1980s and early 1990s. Generally, Minnesota chose to expand coverage whenever the federal government gave states the option to do so. Subsequently, the federal government made some of these optional changes mandatory. As a result, under current law, states can not go back to the eligibility criteria that existed in the 1970s. In addition, the federal government has changed eligibility criteria for the disabled under the federal Supplemental Security Income

Table 6.5: Medical Assistance Expenditures by Type of Service, Minnesota, FY1995

	Expenditures (in Millions)	Percent Share
Long-Term Care		
Nursing Homes	$819	32%
ICF-MR Facilities	285	11
State Facility MI/CD	22	1
Nursing Home Waivers	23	1
ICF-MR Waivers	171	7
Home Care (Nursing and Home Health)	143	6
Subtotal	1,463	57
Acute Care		
Health Maintenance Organizations	268	10
Fee For Service Providers	857	33
Subtotal	1,125	43
Total	$2,588	100%

Source: Minnesota Department of Human Services.

Growth in Medical Assistance spending has resulted from state and federal eligibility expansions, increased health care costs, and growth in elderly and AFDC populations.

(SSI) program. These changes affect Medical Assistance because many people qualify for Medical Assistance based on SSI eligibility.

Second, demographic changes affect the need for Medical Assistance services. For example, the number of Minnesota residents aged 65 and over grew by 14.1 percent between 1980 and 1990, nearly twice as fast as the growth for the general population (7.3 percent). Furthermore, the population aged 85 or older grew by 33 percent, much more than other age categories. The number of AFDC recipients, who are automatically eligible for Medical Assistance, increased by 40 percent between 1980 and 1995.

Third, according to some health care analysts, rapid change in medical technology and United States policies that encourage its diffusion explains much of the increase in health care costs.[1] Fourth, medical inflation exceeded the rate of inflation for state and local governments, placing pressure on medical assistance rates. For example, between 1980 and 1995, medical costs (as measured by the medical component of the consumer price index) increased by 204 percent, considerably more than the rate of inflation for state and local governments (89 percent). While Medical Assistance reimbursement rates are regulated by the state, some analysts contend that lowering the reimbursement rates leads to greater utilization of medical services or shifts to more expensive forms of care.[2] Finally, the state has attempted to control long-term care expenditures by imposing moratoria on nursing

1 U.S. Congressional Budget Office, *Rising Health Care Costs: Causes, Implications, and Strategies*, (Washington: 1991). p 24-26.

2 U.S. Congressional Budget Office, *Rising Health Care Costs: Causes, Implications, and Strategies*, (Washington: 1991), p.21, 41-42. Analysts cite evidence that reductions in Medicare's prices led to increased utilization, offsetting some of the savings. They argue that since consumers typically do not pay for Medicare services, much of the increased utilization is due to actions by physicians.

homes and intermediate care facilities for the mentally retarded (ICF-MR), downsizing state hospitals, and by promoting home and community based alternatives to institutionalized care.

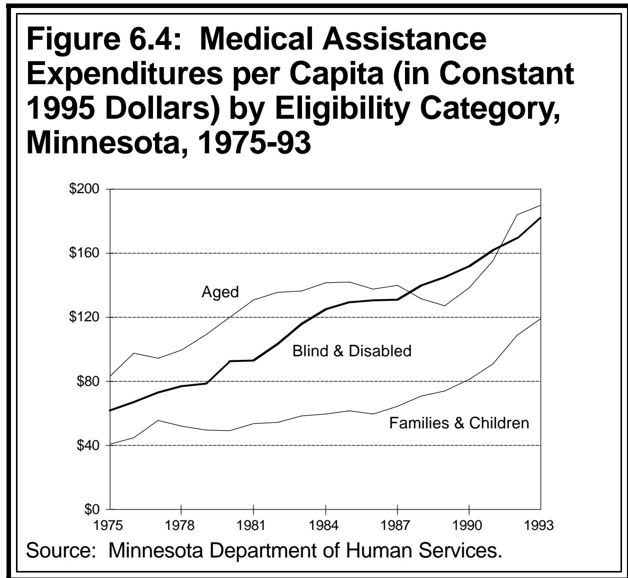
In this section, we examine trends in expenditures and enrollment by eligibility category (aged, blind and disabled, and low-income families and children) and type of service (long-term care and acute care). The factors driving growth in Medical Assistance spending vary among these categories.

Growth by Eligibility Category

Medical Assistance spending grew fastest for the disabled and families and children.

Table 6.6 and Figure 6.4 show that Medical Assistance spending per capita has grown considerably in each of the three eligibility categories since 1975. The fastest growing spending category was the blind and disabled category, which grew by 195 percent between 1975 and 1993. Spending on low-income families and children grew by almost the same rate (192 percent). These categories explained 39 and 26 percent of the per capita spending growth, respectively. The aged is the largest spending category, but grew at a slower rate (128 percent). It accounted for 35 percent of Medical Assistance's spending growth between 1975 and 1993.

Figure 6.4: Medical Assistance Expenditures per Capita (in Constant 1995 Dollars) by Eligibility Category, Minnesota, 1975-93



Source: Minnesota Department of Human Services.

Within each eligibility category, we analyzed how much of the growth was due to enrollment changes and how much was due to changes in average cost per

Table 6.6: Growth in Medical Assistance Expenditures per Capita by Eligibility Category, 1975-93

	Expenditures Per Capita (in Constant FY1995 Dollars)			
Eligibility Category	1975	1993	Percent Change	Percent of Growth
Aged	$83	$190	128%	35%
Blind and Disabled	62	182	195	39
Families and Children	41	119	192	26
Total	$186	$491	164%	100%

Source: Department of Human Services.

recipient. Since each program's new enrollees may have different medical needs than those already enrolled, we cannot precisely calculate how many additional dollars were spent because of the enrollment growth. Nevertheless, enrollment growth rates indicate the general magnitude of the effect on spending. As Table 6.7 shows,

- **Enrollment growth was a significant factor driving the increases in Medical Assistance spending for the blind and disabled and families and children, but not for the aged.**

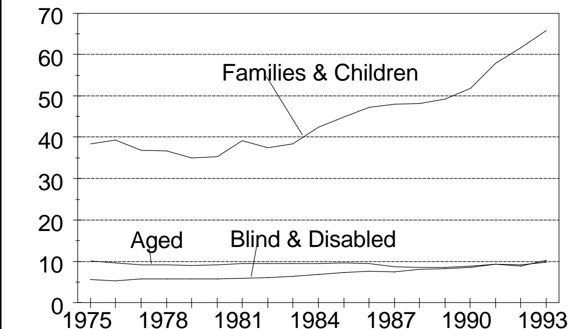
Table 6.7: Growth in Medical Assistance Enrollment and Inflation-Adjusted Expenditures by Eligibility Category, 1975-93

	Average Annual Growth Rates			
	1975-85	1985-89	1989-93	1975-93
Aged				
Expenditures per Enrollee	6.0%	0.3%	7.0%	4.9%
Enrollment per Capita	-0.5	-3.1	3.3	-0.2
Expenditures per Capita	5.5	-2.7	10.5	4.7
Blind and Disabled				
Expenditures per Enrollee	4.8	-0.2	0.2	2.6
Enrollment per Capita	2.8	3.1	5.7	3.5
Expenditures per Capita	7.7	2.9	5.9	6.2
Families and Children				
Expenditures per Enrollee	2.6	2.3	4.8	3.0
Enrollment per Capita	1.6	2.3	7.5	3.0
Expenditures per Capita	4.2	4.7	12.7	6.1

Source: Minnesota Department of Human Services.

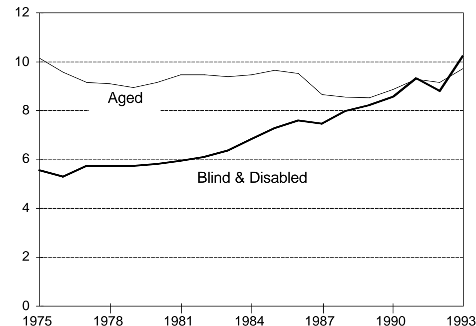
Between 1975 and 1993, as a fraction of the state's population, enrollment in the disabled category grew by an average of 3.5 percent per year and enrollment of families and children increased by 3.0 percent per year. However, enrollment in the aged category declined by 0.2 percent per year. Figures 6.5 and 6.6 illustrate the growth in enrollment between 1975 and 1993.

Figure 6.5: Medical Assistance Enrollees per 1,000 Population by Eligibility Category, Minnesota, 1975-93



Source: Minnesota Department of Human Services.

Figure 6.6: Medical Assistance Aged and Disabled Enrollees per 1,000 Population, Minnesota, 1975-93



Source: Minnesota Department of Human Services.

As a fraction of the general population, Medical Assistance enrollment of families and children did not grow between 1975 and 1983, but grew by 71 percent between 1983 and 1993. The enrollment of families and children grew rapidly after 1983 because the number of AFDC recipients increased and because the federal and state governments broadened eligibility for low-income families and children. Approximately 35 percent of this enrollment growth was due to the growth in AFDC caseload. The remainder is due primarily to changes in eligibility. The number of non-AFDC families and children enrolled in Medical Assistance grew by 626 percent between 1983 and 1993. The percentage of children in Minnesota who are in families below the poverty level went from 10.2 percent in 1979 to 12.4 percent in 1989, an increase of 22 percent. This suggests that demographic factors explain some of the enrollment growth of non-AFDC families and children, but their effect is small relative to the effect of changes in eligibility criteria. Previously, eligibility was restricted to AFDC-type families (families with a dependent child and a parent who is single, unemployed, or incapacitated). During the late 1980s and early 1990s, the federal and state governments extended coverage by loosening restrictions on the type of family eligible for Medical Assistance and by raising income limits. For example, pregnant women and children may now qualify based on income and assets regardless of their families' structure. On July 1, 1988, Minnesota raised the income limits for pregnant women and children age one or under from 133 percent to 185 percent of the federal poverty level.

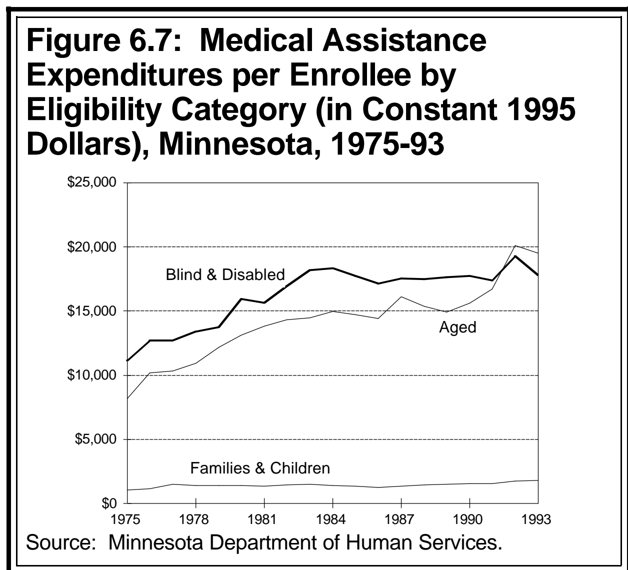
Eligibility changes explain most of the growth in enrollment of families and children.

Officials from the Department of Human Services cited several reasons for the large enrollment increase for the blind and disabled category. First, many disabled people qualified for Medical Assistance because the federal government changed the eligibility criteria for disabled under the federal SSI program. Second, disabled people may be more willing to participate in Medical Assistance. In addition, medical improvements allow disabled people to live longer. Finally, there has been an increase in certain diseases such as AIDS.

- **The average cost per enrollee increased faster than inflation for each eligibility group, particularly for the aged.**

After adjusting for inflation, the average cost per enrollee increased between 1975 and 1993 at average annual rates of 4.9 percent for the aged, 3.0 percent for families and children, and 2.6 percent for the disabled. Note that average costs reflect both changes in rates charged for care and changes in utilization. Figure 6.7 shows how the average cost changed between 1975 and 1993.

Figure 6.7: Medical Assistance Expenditures per Enrollee by Eligibility Category (in Constant 1995 Dollars), Minnesota, 1975-93

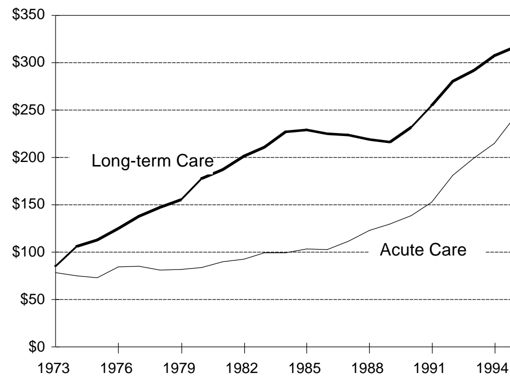


Source: Minnesota Department of Human Services.

Growth by Type of Service

Figure 6.8 shows the trends in Medical Assistance spending for long-term care and acute care. In 1973, Minnesota spent about the same amount on long-term and acute care under the Medical Assistance program. But thereafter, long-term care and acute-care expenditures followed different spending trends. Long-term care expenditures increased by 8.6 percent per year from 1973 to 1985, declined by 1.4 percent per year between 1985 and 1989, and increased by 6.6 percent per year between 1989 and 1995. In contrast, acute care expenditures grew slowly at first, but grew rapidly after 1985, particularly during the 1990s. Acute care expenditures grew by 2.3 percent per year between 1973 and 1985, much slower than long-term care's growth rate (8.6 percent). But between 1985 and 1995, acute care grew by 9.0 percent per year, much faster than long-term care (3.3 percent per year).

Figure 6.8: Medical Assistance Expenditures per Capita by Type of Service (in Constant 1995 Dollars), Minnesota, 1973-95



Source: Minnesota Department of Human Services.

After moratoria were established for long-term care facilities in 1985, long-term care expenditures declined until 1989, after which they grew rapidly.

Prior to 1985, long-term care expenditures rose rapidly because the average cost increased considerably faster than inflation and the number of Medical Assistance recipients living in institutional facilities increased faster than the general population. As Table 6.8 shows, constant-dollar institutional expenditures per recipient increased by 6.2 percent per year between 1975 and 1985 and institutionalized recipients per capita increased by 1.0 percent per year.

Long-term care expenditures under Medical Assistance declined between 1985 and 1989 for several reasons. First, moratoria on the construction of additional nursing homes and ICF-MR facilities restricted the supply of institutional facilities, the most expensive form of care. The 1983 Legislature enacted a moratorium on the certification of additional nursing home beds for Medical Assistance reimbursement. The 1985 Legislature extended the moratorium to all nursing home beds regardless of whether they were certified for Medical Assistance reimbursement. The 1983 Legislature also established a moratorium for the licensure of additional ICF-MR beds and established a cap on the number of ICF-MR beds that could be reimbursed by Medical Assistance.

Second, increases in the number of nursing home residents reimbursed through Medicare reduced the number of nursing home residents financed by Medical Assistance. This reduced the direct cost of nursing homes to Minnesota because the federal government finances all of Medicare, but only 54 percent of Medical Assistance. As Figure 6.9 shows, the percent of nursing home residents financed by

Table 6.8: Growth in Institutional Medical Assistance Inflation-Adjusted Expenditures by Eligibility Category, 1975-93

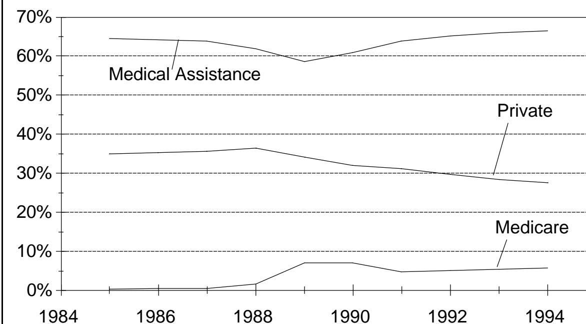
	Average Annual Growth Rates			
	1975-85	1985-89	1989-93	1975-93
Aged				
Expenditures per Recipient	5.1%	1.2%	4.8%	4.2%
Recipients per Capita	1.6	-4.2	4.5	0.9
Expenditures per Capita	6.9	-3.1	9.5	5.1
Blind and Disabled				
Expenditures per Recipient	7.3	2.4	5.3	5.8
Recipients per Capita	1.5	-6.2	-5.4	-1.8
Expenditures per Capita	8.9	-3.9	-0.3	3.9
Total Institutional				
Expenditures per Recipient	6.2	1.4	3.6	4.5
Recipients per Capita	1.0	-4.8	1.8	-0.2
Expenditures per Capita	7.3	-3.5	5.5	4.4

Source: Minnesota Department of Human Services.

Medicare increased from 0.4 percent to 7.1 percent between 1985 and 1989. During the same time period, the share of nursing home days of care reimbursed by Medical Assistance declined from 64.6 to 58.7 percent. The share financed by private-pay residents declined from 35.0 to 34.3 percent.

Finally, the average rates charged by institutional facilities increased much slower during the late 1980s than they did previously. Table 6.8 shows that the average cost per Medical Assistance recipient increased by only 1.4 percent per year between 1985 and 1989, considerably lower than the 6.2 percent annual growth rate between 1975 and 1985.

Figure 6.9: Source of Payment for Minnesota Nursing Home Residents, 1985-94



Source: Minnesota Department of Human Services.

After 1989, long-term care expenditures again grew much faster than inflation. One reason that long-term care expenditures grew rapidly after 1989 is that the average cost per institutional recipient (in constant dollars) grew by 3.6 percent per year between 1989 and 1993. The average cost increased faster than inflation in part because residents living in long-term care facilities were using more services. For example, according to Department of Human Services data, the average number of nursing hours has increased from 2.58

hours per resident day in 1989 to 2.92 hours in 1993. The reason for this may be that as the state restricts nursing home care to those who need it most, the level of care required by those who remain is greater than before. Trends in nursing home resident assessments made under the state's rate-setting system suggest that residents' needs are increasing. This may be due to the rapid growth in the number of individuals who are age 85 or older.

Nursing home expenditures increased because more nursing home residents are over 85 years old and fewer paid for their own care.

Another reason that Medical Assistance long-term care expenditures increased is that fewer nursing home residents are paying for their own care. The percentage of private-paying residents declined from 34.3 percent in 1989 to 27.7 percent in 1994. During the same time period, the percentage of residents covered by Medicare declined from 7.1 to 5.8 percent. As a result, the percentage reimbursed by Medical Assistance increased from 58.7 to 66.6 percent. Thus, even though the moratoria continued to restrict the supply of long-term care beds, the number of Medical Assistance recipients living in nursing homes increased.

Finally, long-term care expenditures increased because of the rapid rise in the expenditures for alternatives to institutional care under federally approved waiver programs. Table 6.9 shows that expenditures for long-term care alternatives increased more than three-fold between 1989 and 1995 (from $22 to $73 per capita). While long-term care alternatives are less expensive than institutional care, overall long-term care expenditures increased because the overall number of people receiving long-term care services increased during the 1990s. While the number of nursing home residents remained stable (though the percent covered by Medical Assistance has changed), the number receiving alternative care (through Medical Assistance's elderly waiver or the state alternative care program) increased by about 5,200, about 20 percent of the number of elderly nursing home residents covered by Medical Assistance.

Table 6.9: Medical Assistance Long-Term-Care Expenditures per Capita (in Constant FY1995 Dollars), 1973-95

	1973	1980	1985	1989	1995
Long-Term-Care Facilities					
Nursing Homes	$83	$121	$148	$126	$177
ICF-MR	N/A	50	73	65	62
State Facility MI/CD	2	5	4	4	5
Subtotal	85	176	224	195	244
Long-Term-Care Alternatives					
Nursing Home Waivers	N/A	N/A	1	2	5
ICF-MR Waivers	N/A	N/A	0	13	37
Home Care (Nursing and Home Health)	1	2	4	7	31
Subtotal	1	2	5	22	73
Total Long-Term Care	$85	$178	$229	$217	$317

Source: Minnesota Department of Human Services.

The number of developmentally disabled individuals served by institutional facilities under Medical Assistance declined by about 1,200 between 1990 and 1995, but the number served by less intensive care (under waivers for developmentally disabled people) increased by about 2,300 during the same time period. Thus, the overall number of developmentally disabled persons receiving long-term care services increased by about 1,100, an increase of 14 percent. Since the average cost of community-based care for people with developmental disabilities was $41,600 per person, compared with $68,600 for institutionalized care, the growth in total recipients appears to more than offset the savings due to placing people in less restrictive settings.[3] The growth in waivered services for persons with developmental disabilities is managed by the Minnesota Department of Human Services. Department officials expect growth to continue since there are waiting lists for these waivered services.

NATIONAL COMPARISONS

As we showed in Chapter 2, the Census data indicate that, in 1992, Minnesota's state and local governments spent nearly 30 percent more per capita on health and welfare than the national average of state and local governments. In fact, Minnesota's health and welfare spending has been consistently higher than the national average by at least 20 percent since 1975. In this section, we examine how Minnesota's spending compares with the national average for Medical Assistance and AFDC. Comparative spending data are not available for other human service programs.

Minnesota's above average human service spending is largely due to programs other than Medical Assistance and AFDC.

Federal government data indicate that in federal fiscal year 1993, Minnesota spent about 3 percent less per capita than the national average on Medical Assistance and about 4 percent less on AFDC. Since Minnesota's overall spending per capita for Medical Assistance and AFDC were close to the national average, the difference between Minnesota and other states must be due to other programs such as social services, general assistance, energy assistance, health programs, and supplemental benefits for the aged, blind, and disabled. However, because of the lack of comparative expenditure data for these programs, we cannot determine how much of the difference between Minnesota and the national average is explained by each program.

Medical Assistance

We compared Minnesota's Medical Assistance spending with the national average based on data from the Health Care Financing Administration for the federal fiscal year ending September 30, 1993. While Minnesota's overall Medical Assistance spending per capita is close to the national average, there are a number of important differences between Minnesota's and the nation's Medical Assistance spending. One difference is that Minnesota makes much less disproportionate share

3 The average cost per recipient of waivered services for the developmentally disabled includes about $2,000 in additional costs under Minnesota Supplemental Aid and $39,600 in Medical Assistance costs. These figures do not include additional costs under the federal SSI program.

hospital (DSH) payments per capita than the rest of the nation. Since most of these payments are not compensation for serving Medical Assistance recipients, it is useful to make national comparisons disregarding most of these payments. DSH payments were originally designed to compensate hospitals for losses due to treating a disproportionately large percentage of Medical Assistance patients. However, DSH payments became controversial after states greatly increased DSH payments from less than $1 billion in 1989 to about $17 billion in 1992, or one in every seven Medical Assistance dollars. A study of DSH payments found that they were not used primarily to help hospitals care for the poor, but rather "as a strategy to increase federal payments to States."[4] The study found that only one sixth of DSH payments was used to increase compensation for hospitals that treated Medical Assistance recipients, suggesting that most DSH payments should be disregarded when making spending comparisons. While Minnesota's Medical Assistance spending per capita is close to the national average, it would be 10 percent higher than average if all disproportionate share payments were disregarded. If one sixth of DSH payments were included (based on the study's results), Minnesota's spending would have been about 8 percent higher than the national average. The comparisons by eligibility category presented in this section do not include DSH payments because national data does not break down DSH payments by eligibility category. The study's results suggest that disregarding DSH payments underestimates overall national spending on Medical Assistance enrollees by about 2 percent.

Minnesota has fewer Medical Assistance enrollees and higher average costs than the national average.

Another difference between Minnesota and the nation is that for each eligibility category, Minnesota had fewer enrollees per capita than the national average. Table 6.10 shows that Minnesota had 18 percent fewer enrollees per capita than the national average for both the aged and families and children. It had 38 percent fewer blind and disabled enrollees per capita than average. Poverty statistics suggest that Minnesota would be expected to have fewer enrollees in a means tested program such as Medical Assistance. The 1990 Census found that 10.2 percent of persons and 7.3 percent of families in Minnesota were below the poverty level, compared with 13.1 percent of persons and 10.0 percent of families in the nation.

Minnesota's Medical Assistance spending per capita (disregarding DSH payments) exceeded the national average even though it had fewer enrollees. The reason is that:

- **Minnesota spent more per Medical Assistance recipient than the national average for all three major eligibility categories, particularly for the aged and disabled categories.**

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4 Ku, Leighton and Teresa A. Coughlin, "Medicaid Disproportionate Share and Other Special Financing Programs", Health Care Financing Review, Spring 1995 (Vol. 16, No. 3). Several states made large DSH payments to hospitals at the same time they taxed hospitals or obtained transfer payments from state hospitals. The federal government paid their normal Medical Assistance matching rate for the DSH payments, but did not receive any of the revenue obtained from the hospitals. As a result, states and hospitals gained at the expense of the federal government. The study found that only about one sixth of DSH payments actually were used to increase compensation for hospitals. About half was used to compensate providers who were taxed or made contributions, and one third was used to help states balance their budgets.

Table 6.10: Medical Assistance Enrollees and Expenditures by Eligibility Category, Minnesota vs. the United States, 1993

	Minnesota	United States	Percent Difference
Enrollees per 1,000 Population			
Aged	13	15	-18%
Blind and Disabled	13	21	-38
Families and Children	93	114	-18
Cost per Enrollee			
Aged	$14,223	$8,656	64
Blind and Disabled	12,481	7,273	72
Families and Children	1,384	1,211	14
Cost per Capita			
Aged	$178	$132	35
Blind and Disabled	165	154	7
Families and Children	129	138	-6

Note: HCFA data does not break down Medical Assistance HMO and Health Insurance payments by eligibility category. We allocated HMO payments and health insurance payments for Minnesota and the United States based on the distribution of payments in Minnesota. The data excludes Disproportionate Share Payments.

Source: U. S. Health Care Financing Administration (HCFA), *Medicaid Statistics, Program and Financial Statistics, Fiscal Year 1993*.

Minnesota has higher than average spending for long-term care and lower than average spending for acute care.

Minnesota's average payment was 64 percent higher for aged enrollees, 72 percent higher for blind and disabled enrollees, and 14 percent higher for families and children than the national average. Compared with national Medical Assistance spending per capita in 1993, Minnesota spent 35 percent more on the aged, 7 percent more on the blind and disabled, and 6 percent less on families and children.

Table 6.11 summarizes how Minnesota compares with the nation for long-term care and acute care spending under the Medical Assistance program.

Table 6.11: Medical Assistance Expenditures per Capita by Type of Service, Minnesota vs. the United States, 1993

	Minnesota	United States	Percent Difference
Acute Care	$185	$260	-29%
Long-Term Care			
Institutional	227	137	66
Home and Community	53	26	103
Subtotal	281	164	71
Total	$466	$423	10%

Note: Figures do not include Disproportionate Share Payments. These payments are made (in addition to normal fee for service payments) to hospitals that serve a disproportionate share of Medical Assistance recipients.

Source: U. S. Health Care Financing Administration, *Medicaid Statistics.*

- **In 1993, Minnesota spent 29 percent less per capita than the national average on acute care, but 71 percent more than average on long-term care.**

Minnesota spent substantially more on institutional care (66 percent more per capita) and home and community alternatives to institutional care (103 percent). Minnesota spent more on institutional care because a higher percentage of its population live in institutional facilities and because it paid higher facility rates. As Table 6.12 shows,

- **The primary reason that Minnesota's long-term care expenditures are higher than the national average is that the proportion of Minnesota's population receiving Medical Assistance in nursing homes and ICF-MR facilities is 48 percent higher than the national average.**

Minnesota has greater than average rates of institutionalization.

Table 6.12: Medical Assistance Institutional Long-Term-Care Costs, Minnesota vs. the United States, 1993

	Minnesota	United States	Percent Difference
Days of Care per Capita			
Nursing Homes	2.35	1.64	43%
ICF/MR Facilities	0.32	0.17	85
Total	2.67	1.81	48
Cost per Day			
Nursing Homes	$ 70	$ 62	13
ICF/MR Facilities	198	207	-4
Total	$85	$ 76	13
Payments per Capita			
Nursing Homes	$164	$101	62
ICF/MR Facilities	64	36	77
Total	$228	$137	66%

Source: U. S. Health Care Financing Administration, *Medicaid Statistics*.

Minnesota's Medical Assistance program pays for 43 percent more days of care in nursing homes per capita and 85 percent more days of care in ICF-MR facilities than other states. Minnesota's average facility rates per day of care were 13 percent higher in nursing homes and 4 percent lower in ICF-MR facilities.

It is not clear why Minnesota serves proportionately so many more than average. There is evidence that Minnesota has a much greater supply of nursing home beds than the rest of the nation, but it is not clear that we have a much greater need for institutional services. In 1992, Minnesota had about 51 percent more licensed nursing home beds per 1000 persons 65 and over than the nation. Neighboring states (including Wisconsin, Iowa, South Dakota, and North Dakota) also have between 40 and 54 percent more beds than the national average.[5]

5 Richard DuNah, Jr., et. al.,*Variations and Trends in Licensed Nursing Home Capacity in the States, 1978 through 1992* (University of California, San Francisco: 1993).

One reason that a higher percentage of Minnesota's residents live in nursing homes under Medical Assistance is that Minnesota's senior citizens are older, on average, than in other states. In 1990, the percentage of Minnesota's population that was 65 or older was about the same as the national average, but the percentage 85 or older was about 28 percent higher in Minnesota. We estimate that the percentage of Minnesota's residents who live in nursing homes in 1990 would have been about 14 percent higher than the national average if within each age category, the nation had the same percentage living in nursing homes as was the case in Minnesota. Thus, we estimate that differences in age distribution explain about a third of the difference in nursing home utilization between Minnesota and the nation.

AFDC

Aid to Families with Dependent Children is Minnesota's largest income-maintenance program. In 1993, Minnesota spent $85 per capita on AFDC, four percent less than the national average. As Table 6.13 shows, Minnesota paid benefits that were 34 percent higher per case than the national average, but had 27 percent fewer cases per capita. Higher child support collections helped reduce Minnesota's relative cost, while higher administrative expenses increased its relative cost.

Minnesota pays higher than average AFDC benefits, but has fewer recipients.

Table 6.13: AFDC Recipients and Expenditures, Minnesota vs. the United States, 1993

	Minnesota	United States	Percent Difference from United States
AFDC Expenditures per Capita			
AFDC Payments	$85	$86	-2%
AFDC Child Support Collections	12	9	32
Net AFDC Payments	73	77	-6
AFDC Administrative Cost[1]	13	11	11
Net Total Expenditures	85	89	-4
AFDC Recipients per 1,000 population			
Average Monthly Recipients	42	55	-23
Average Monthly Cases	14	19	-27
AFDC Expenditures per Case			
Gross Payments per Case	$6,000	$4,474	34
Child Support Collections per Case	875	485	80
Net Payments per Case	5,125	3,989	28
Administrative Cost per Case	898	593	51
Total Cost per Case	$6,023	$4,582	31

Source: Committee on Ways and Means, U.S. House of Representatives, *1993 Greenbook, Overview of Entitlement Programs* (Washington, 1994).

[1]Excludes administrative costs for child support collection.

SUMMARY

Human services spending is the fastest growing major spending category in Minnesota. Per capita spending for all of the large human service programs except AFDC grew by at least 65 percent (in constant dollars) between 1980 and 1995. Medical Assistance, the largest human service program, grew by 114 percent and accounted for 70 percent of the growth in human service spending. Social service programs accounted for 23 percent. AFDC expenditures declined by 17 percent because average benefits declined by 31 percent (in constant dollars).

Large enrollment increases explain much of the growth in human service spending. As a percentage of population, the number of General Assistance/Work Readiness and Minnesota Supplemental Aid recipients more than doubled between 1980 and 1995. Enrollment (as a percent of population) in Medical Assistance increased by 83 percent and accounted for nearly 60 percent of the spending growth.

Medical Assistance spending more than doubled (in constant dollars per capita) between 1975 and 1993 for each of the major eligibility categories: the aged, the blind and disabled, and families and children. The blind and disabled category was the fastest growing category and accounted for 39 percent of the overall growth. The aged constitute the largest, but slowest growing spending category, explaining 35 percent of the growth. Families and children accounted for 26 percent of the growth.

Growing enrollment explained much of the Medical Assistance spending growth for families and children and the blind and disabled, but not for the aged. Increases in AFDC caseloads were responsible for 35 percent of the growth in Medical Assistance enrollment of families and children. Most of the remaining growth was due to expanded eligibility for low-income families and children. The average cost per enrollee increased considerably faster than inflation for each category, particularly for the aged.

After 1989, long-term care expenditures increased even though state moratoria restricted the supply of beds in nursing homes and ICF-MR facilities and the state promoted alternatives to institutional care. Long-term care expenditures rose because nursing home rates increased faster than inflation, fewer nursing home residents are paying for their own care, and the overall number of Medical Assistance recipients receiving long-term care services (either institutional facilities or their alternatives) increased.

In 1992, Minnesota's state and local governments spent almost 30 percent more per capita on health and welfare than the national average. Minnesota's per capita spending for Medical Assistance and AFDC were close to the national average. However, Minnesota spent considerably more per recipient than the national average for both Medical Assistance and AFDC. The main reason that Minnesota spent more per recipient under Medical Assistance was that a higher percentage of Minnesota's population receives Medical Assistance in nursing homes, state hospitals, or intermediate care facilities for the mentally retarded.