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Evaluation Report Summary / February 2008

Financial Management of Health Care Programs

Minnesota should continue to rely significantly on managed care to serve enrollees in the state's publicly funded health care programs, but with enhanced efforts to contain medical and administrative spending.

Major Findings:

- National research has shown mixed results regarding managed care's impact on health care costs, outcomes, and access. However, providing health care services to low-income Minnesotans through "managed care" has offered several advantages over "fee-for-service."
- The Department of Human Services (DHS) has paid managed care health plans at rates that have enabled them to remain financially healthy, but more rigorous cost containment efforts will be required by DHS and the Legislature to address rising spending per enrollee.
- State agencies have conducted limited review of health plans' administrative spending for public programs, which totaled $200 million in 2006.
- Minnesota's Medical Assistance program costs more per enrollee than the U.S. average for Medicaid programs, reflecting its more comprehensive benefit set and higher proportions of spending for long-term care and people with disabilities.
- County-based health plans have made significant efforts to improve services in rural parts of Minnesota, but it is still unclear whether their services are better or less expensive than those of other health plans.
- The Legislature and DHS have not adequately updated fee-for-service reimbursement rates in publicly funded health care programs.

Recommendations:

- DHS should report to the 2009 Legislature on (1) progress to implement its cost containment strategies in publicly funded health care programs and (2) reasons for differences between DHS's targets for health plans' net income and the plans' actual net income.
- DHS should increase its scrutiny of administrative spending by health plans serving Minnesota's public programs. The Legislature should require the departments of Health and Commerce to develop procedures for more detailed reviews of the "reasonableness" of health plan expenditures.
- The Legislature should retain the option of using both private and county-based health plans to administer managed care for public programs, but it should restrict expenditures to health-related purposes. It should also authorize DHS to periodically reconsider which plans will serve counties that have single-plan purchasing arrangements.
- The Legislature should consider a modest increase in certain fee-for-service rates.

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Report Summary

Minnesota has three main health care programs for lower income people: Medical Assistance (which is Minnesota's version of the federal Medicaid program), MinnesotaCare, and General Assistance Medical Care. Together, these programs cost $6.5 billion in fiscal year 2007.

The Department of Human Services administered $6.5 billion in health care services in 2007, using a combination of managed care and fee-for-service care.

Managed care offers several advantages over fee-for-service, although definitive evidence on cost-effectiveness is lacking.

Minnesota pays for publicly funded health care programs in two ways. Under a "fee-for-service" approach, the state reimburses health care providers for services already delivered to program enrollees. Under a "managed care" approach, the state contracts with health plans and pays them a predetermined rate for services to enrollees, and the health plans bear the risk for any costs above this rate. A majority of the enrollees in Minnesota's public programs are served by managed care, but most spending occurs through fee-for-service care.

In Minnesota, managed care has been implemented in a way that offers several advantages over fee-for-service. For example, state contracts with health plans provide a mechanism for leveraging improvements in access, accountability, and quality that has been lacking in fee-for service. Also, managed care (in contrast to fee-for-service) limits the state's financial risk to predetermined payment levels. In addition, managed care enrollees generally have more recourse when problems arise than do enrollees in fee-for-service care. This is one reason that our report recommends that the Legislature consider expanding the duties of the state's managed care ombudsman to encompass fee-for-service enrollees. Finally, health plans' efforts to engage enrollees in health improvement activities contrast with the more passive and uncoordinated approaches that have characterized fee-for-service care.

Nationally, studies have reached mixed conclusions about whether managed care leads to better outcomes, lower costs, and greater access to services than fee-for-service care. Minnesota set out to determine in the 1980s whether managed care programs were more cost-effective than fee-for-service programs, but it never produced definitive, statewide evidence. In general, Minnesota health plans have performed fairly well on measures of service quality compared with national averages,[1] while there has been little measurement of quality in fee-for-service care.

Minnesota needs stronger efforts to contain health care costs, especially in managed care.

Research has indicated that Minnesota's Medicaid costs per enrollee are well above the national average—probably reflecting Minnesota's more comprehensive benefit package and its higher proportion of costs for long-term care and people with disabilities. Also, Minnesota's payments per enrollee to health plans for public managed care programs are higher than those in most states.

There has been significant growth in Minnesota's managed care spending in recent years. Medical spending per managed care enrollee grew 12 percent annually between 2000 and 2006. Also, among non-disabled enrollees under age 65, Minnesota's growth in managed care spending per enrollee exceeded the nation's growth rate.

[1] We recommend that the departments of Human Services and Health agree on a single way to compute and publicly report on health plan performance; currently, these two departments use different methods.

DHS proposed a variety of health care cost savings strategies in 2005, but containing health care costs remains unfinished business.

Minnesota's health plans have typically made money from their participation in public programs. In recent years, the plans' overall net income from these programs ranged from 0.7 percent of total revenues (2006) to 4.9 percent (2004). States must set managed care rates that are "actuarially sound," but this does not ensure cost containment (and might even contribute to cost inflation). Health plans' net returns have often exceeded the levels targeted by DHS during its rate-setting process, although plans have consistently experienced losses in the General Assistance Medical Care program. Health plans' reserves grew significantly in recent years, but there is no authoritative benchmark regarding the maximum level of reserves plans should have.

In fee-for-service care, the Legislature and DHS have not adequately updated Minnesota's fee-for-service reimbursement rates for physician services. For example, the Legislature has authorized only one general increase in physician reimbursement since 1992, and DHS has not implemented a legislatively-mandated change intended to make reimbursement rates fairer.

In 2005, DHS proposed a wide range of strategies to contain costs in Minnesota's health care programs. In some cases, there has been important progress—for example, DHS has started to implement "evidence-based" practices to determine when to cover certain medical services, and the Legislature and Department of Health have initiated an ambitious project to foster the use of electronic medical records. In other cases, there has been little progress—for example, in fostering multi-county service consolidation and improving case management services for people in home and community-based services. DHS should present the 2009 Legislature with a status report on its strategies to contain health care costs.

There has been limited state oversight of health plans' administrative spending.

The costs to administer Minnesota's health care programs are significant. At the state level, DHS spent an estimated $119 million to administer managed care and fee-for-service health care in 2006, with increases in these expenses averaging 10 percent annually since 2000.

Health plans' administrative spending totaled $200 million in 2006, and their administrative spending per enrollee grew by about 8 percent annually between 2000 and 2006. In aggregate, health plans' administrative spending for public programs was about 7 percent of their total spending in 2006 (excluding premium taxes and surcharges), and these expenditures ranged from 6 percent to 20 percent among individual health plans.

State rules require the departments of Health or Commerce to periodically review the "reasonableness" of health plans' spending, but these reviews have not been program-specific, nor have they focused on administrative costs in detail. Officials in these departments say they lack the directives, resources, and clear standards to conduct in-depth reviews.

For the state's public programs, DHS rarely reviews health plans' subcontracts for services, does not review detailed information on subcategories of administrative expenditures, and does not set caps or incentives to ensure that health plans' spending for administrative services aligns with the department's assumptions during the managed care rate-setting process. DHS's rate-setting methods and contract requirements should address administrative spending more closely, and the Department of Health should develop guidelines to help plans consistently allocate costs among their lines of business.

With some modification, county-based purchasing deserves more time to demonstrate its value.

The Legislature should retain county-based purchasing but change some laws that govern it.

The 1997 Legislature authorized groups of counties to purchase or provide health care on behalf of enrollees in Minnesota's public programs. Three "county-based purchasing" organizations now administer services in all or parts of 27 counties.

These organizations have made significant efforts to respond to local priorities and work with county agencies. But their administrative costs, in aggregate, have been higher than those of private health plans, and it is unclear whether county-based plans' efforts to integrate health care and social services have contained costs. Also, county-based plans have had mixed performance on measures of program quality and compliance with regulations.

County-based purchasing deserves more time to demonstrate its value, but the Legislature should make several changes in the laws governing it. For example, county-based purchasing organizations can now choose whether to allocate surplus revenues to their member counties, and state law should require that public program revenues (whether for county-based or other health plans) be used to serve health-related purposes. Also, state law has designated some county-based organizations to be the sole health plan in certain counties. To help ensure that services are cost-effective, the Legislature should authorize DHS to periodically reconsider which plans will serve these counties. In addition, the Legislature should require county-based plans to meet statutory reserve requirements *without* relying primarily on county taxing authority as a guaranty of these revenues.

Summary of Responses

We received written responses to the report from the departments of Human Services, Health, and Commerce, as well as the Association of Minnesota Counties. Human Services Commissioner Cal Ludeman said the report "provides a fair and accurate accounting of [his department's] management activities." He acknowledged that DHS has not implemented some cost savings strategies it raised in a 2005 report but said "the department should not be judged against a set of strategies that we were not authorized to implement." He agreed with the report's call for greater state oversight of health plans' administrative expenses.

Health Commissioner Sanne Magnan also said closer scrutiny of administrative spending would be useful, but she noted that her department's reviews of health plans' aggregate administrative costs have not "triggered concerns that might lead to a more in-depth review." She agreed with the report's recommendations for streamlining provider credentialing and unifying the state's measures of health plan performance.

Deputy Commerce Commissioner Kevin Murphy said his department's role is to assess and monitor the overall financial solvency of health plans, not to examine the "reasonableness" of expenses at the program level. He also said local taxes could be an important revenue source for ensuring the solvency of county-based plans.

Paul Wilson, president of the Association of Minnesota Counties, said that county-based purchasing organizations serve a broader purpose than health maintenance organizations. He said county-based plans should be allowed to continue their existing arrangements, "assuming that they continue to meet state requirements and effectively coordinate services."

The full evaluation report, *Financial Management of Health Care Programs*, is available at 651-296-4708 or:
www.auditor.leg.state.mn.us/ped/2008/healthcare.htm