E X E C U T I V E S U M M A R Y

Final Report and Recommendations

of the

Governor's Task Force on Health Care

Submitted to:

Governor Albert H. Quie

October 15, 1981

INTRODUCTION

This report contains the recommendations of the Task Force on Health Care appointed by Governor Albert H. Quie and provided for by the Minnesota Legislature in May, 1981 (Laws of 1981, Chapter 360, Section 1). The official charge of the Task Force and the guiding principles selected to provide a philosophical foundation for those recommendations are also included.

While several major themes underscored the four and one-half months of deliberation (e.g., cost control, family responsibility, market competition, alternatives to institutional care, utilization control), containing health care costs within current fiscal parameters was the dominant concern. For this reason, the Task Force encourages immediate implementation of these recommendations. In addition, continued work toward the development of a health care system that is both adequate in scope and fiscally manageable is seen as critical.

Whenever possible, the estimated reduction in state expenditures that would result from the implementation of any recommendation were computed. Two computations were made for each recommendation: one assuming an implementation date of January 1, 1982 and another assuming an implementation date of July 1, 1982.

IF ALL OF THE RECOMMENDATIONS WERE IMPLEMENTED ON THE EARLIER DATE (JANUARY 1, 1982), BIENNIAL STATE EXPENDITURES WOULD BE REDUCED BY $37.5 million.

IF ALL OF THE RECOMMENDATIONS WERE IMPLEMENTED SIX MONTHS LATER (JULY 1, 1982), BIENNIAL STATE EXPENDITURES WOULD BE REDUCED BY $22.2 million.

Any additional savings that might result from recommendations for which it was not possible to compute a savings estimate would increase the amounts shown above.

CHARGE TO HEALTH CARE STUDY TASK FORCE

To make recommendations for the provision and improvement of publicly funded health care programs related to Medicaid. The purpose of this study is to review the existing design, operation and implementation of publicly funded health care programs and to make recommendations to improve the adequacy and contain the cost of those programs. The recommendations shall address:

-- The number and level of services provided

-- The priority assigned to services

-- The relationship between and among federal, state and local government in the design, financing and administration of programs

-- The necessary changes in federal and state regulations, rules and procedures which govern the operation of programs

-- The necessary changes in state and federal statutes

-- The use of alternative services

-- The design of a mechanism to assure expenditures within appropriations.

The study should project the financial impact of its recommendations for fiscal year 1983 and the 1984-85 biennium. The recommendations as they relate to Medicaid shall not exceed (the amount appropriated) for fiscal year 1983.

The recommendations shall be developed by a Health Care Study Task Force and reviewed and evaluated by a more broadly based Health Care Committee representative of the legislature, the general public, providers, local government, recipients and state agencies. The report of the Task Force is due October 15 and the final report by the Committee and the Task Force shall be submitted to the Governor by November 15.

GUIDING PRINCIPLES AND DECISION CRITERIA

1. Market competition in the health care industry is a potentially more effective method of cost control than regulation.

2. When providers and consumers are "at risk" that is, share some of the financial responsibility for the medical services they provide or receive, they are more likely to make cost conscious decisions than under the traditional system.

3. Health care financed by the public should (a) be available to persons with the greatest financial need, (b) give priority to medical services that emphasize protection of the general public, and (c) strive toward maximizing personal health for every public dollar spent.

4. Health care financed by the public should encourage a balance between self-help, family responsibility and public responsibility, and none of these should be neglected.

5. Government reimbursement for medical services should provide incentives for efficiency and selection of the least expensive levels of appropriate care, and for the development of a less costly delivery system.

6. State government should be a prudent purchaser of economical health care.

7. The various parts of public health care policy should be related to each other in a coherent strategy to the extent possible.

8. Recipients of health care financed by the public should be authorized to choose among selected providers of service whenever practical and provided incentives to be prudent purchasers of those services.

9. The eligibility for and the kind of medical services received should be related to the functional level and choice of the individual.

<u>The following suggestions for guiding principles were reviewed and rejected</u>:

1. A two class health care system should be avoided.

2. If cuts in medical benefits or reimbursement must be made, they should be distributed more or less proportionately across all provider and recipient groups.

3. Resources for health care financed by the public should be distributed equitably across the various recipient groups.

4. The more government costs are shifted to a lower level of government, the more carefully tax funds will be spent and the more satisfactorily becomes the allocation of funds between competing public services.

LONG TERM CARE

The unrestrained growth in institutional long term care has been the major factor in the escalation of Medical Assistance expenditures. The recommendations below move toward a balance between institutional and non-institutional approaches by (1) restraining the growth of institutional expenditures, (2) building upon recent state initiatives to expand the community-based approaches, (3) reducing the regulation-driven costs within nursing homes, (4) promoting increased family responsibility for the elderly and disabled, and (5) increasing choices available to recipients.

Recommendations	Estimated reductions in millions, if implemented on: 1/1/82	7/1/82
1. The Department of Public Welfare should be authorized to freeze the number of MA-funded beds in skilled nursing facilities (SNFs) at 17,946; to lower the minimum number of nursing hours in ICF-Is from 2.0 to 1.5; to reduce the per diems for ICF-Is by $3; and to restrict the rate of increase in per diems to 8%. These provisions should be effective on January 1, 1982. (If they become effective on July 1, 1982, the SNF bed limit should be 19,037, and the ICF-I bed limit should be 11,518.)	$15.2	$ 6.6
2. Minnesota should implement pre-admission screening for nursing homes statewide and mandate that all applicants to nursing homes who are eligible for MA or who may reasonably be expected to become eligible for MA within three months be screened. Screening should be required of applicants who are applying for nursing home residence from hospitals.	($ 0.5)	($ 0.5)
3. Alternative care grants should be available to persons in nursing homes and hospitals who choose to move to the community or to ICF-IIs.		
4. The state should seek federal match under Title XIX for the state appropriation for alternative care grants.	$ 0.4	$ 0.4

	Estimated reductions in millions, if implemented on: 1/1/82	7/1/82
5. The Department of Public Welfare should apply to the Department of Health and Human Services for waivers to:		
a. Eliminate the requirement for a Medical Director in nursing homes,	$1.0	$ 1.0
b. Require physician calendar visits only once every six months or as needed,	$ 0.3	$ 0.3
c. Use a sample population of MA recipients and private residents in nursing homes in the Quality Assurance Review,		
d. Eliminate the requirement for the Utilization Review Committee, and	$ 0.2	$ 0.2
e. Eliminate the requirement of consultants in the areas of medical records, diet, social work, activities, and physiatric services.	$ 1.1	$ 1.1
(It is unlikely that these changes can be made effective before July 1, 1982.)		
6. Minnesota should consider the use of the state tax structure to encourage increased family responsibility for the care of elderly and disabled family members. Tax incentives should be considered to encourage:		
a. Direct care outside institutions,		
b. Health insurance funds (comparable to individualized pension funds) that would include long term care,		
c. Family contribution for institutional care,		
d. Private insurers to cover long term care, and		
e. Employers to provide their employees with long term care coverage.		

SERVICES FOR THE MENTALLY RETARDED

The following recommendations reflect a thrust toward the use of less intensive, community-based residential options and services intended to promote the development of independent, daily living skills. In addition, they acknowledge the excessively high per diems of proposed and recently developed ICF-MR facilities and seek to promote a more cost conscious approach in the development of future bed capacity. Increased family responsibility for care of mentally retarded persons is also encouraged.

Recommendations	Estimated reductions in millions, if implemented on: 1/1/82	7/1/82
1. The procedure for allocating state hospital costs should be modified to reflect actual costs in separate per diems for persons with mental retardation, mental illness and chemical dependency.	$5.4	$3.7
2. The per diem increase for community ICF-MR facilities should be limited to 6%.	$2.2	$0.9
3. Minnesota should establish a maximum per diem for new ICF-MR facilities based upon the actual cost for the mentally retarded in state hospitals less the costs of programs provided by the state hospitals but not by ICF-MR facilities.		
4. Minnesota should implement a similar maximum per diem for existing ICF-MR facilities, except that facilities with per diems above the maximum will have their per diems reduced by one-third of the difference each year for three years.		
5. Minnesota should seek federal match under Title XIX for the following state appropriations and expenditures:	$3.3	$2.4
a. Semi-Independent Living services,		
b. CSSA monies expended for adults in Development Achievement Centers, and		
c. Cost-of-Care for the mentally retarded.		
6. Minnesota should investigate the use of tax incentives to encourage increased family responsibility for the care of mentally retarded members (see Recommendation #6, Long Term Care).		

ACUTE CARE

The recommendations on acute health care accomplish several objectives--(1) cost containment through utilization controls placed on providers and recipients, (2) improvements in reimbursement mechanisms, and (3) an enlarged reliance upon market competition in the Medical Assistance program.

Recommendations	Estimated reductions in millions, if implemented on: 1/1/82	7/1/82

1. Minnesota should implement a case management system for all Medical Assistance recipients in accordance with the following principles:

   a. Each recipient would choose a primary care physician as their case manager; each recipient could change their case manager at periodic intervals.

   b. The case manager would be the gate-keeper to all services provided or ordered by physicians, but would not have control over services not provided or ordered by physicians (e.g., dental services, nurse midwife services, chiropractic services).

   c. The costs of all services under the responsibility of the case manager would be attributed to the case manager for purposes of measuring utilization.

   d. Case managers with cost profiles beyond the established norms would be subject to a range of penalties (e.g., reductions in their reimbursement rates).

   e. Each recipient will also choose one pharmacy to which the recipient will be restricted, but changes will be allowed at periodic intervals.

   f. All non-emergent hospital admissions will be subject to a pre-admission screening process and non-delegated concurrent review, which will be contracted out to an appropriate body for a negotiated price. Mental health, chemical dependency, and behavior modification treatments will be subject to mandatory traige.

   g. Emergency room use and medical transportation will be limited to cases of genuine emergencies; other cases will not be reimbursed by the Medical Assistance program unless the case manager has given prior approval.

	Estimated reductions in millions, if implemented on: 1/1/82	7/1/82
2. The Task Force supports in principle the establishment of a rate-setting mechanism for MA-related hospital reimbursement and encourages continued developmental work by the state.		
3. Minnesota should encourage the development of a uniform chart of accounts for all hospitals.		
4. Minnesota should implement stricter standards for physicians who over-provide; penalties should include reduction in reimbursement rates and expulsion from the MA program.		
5. Minnesota should seek the implementation of stricter standards of "medical necessity" in the MA program, should not provide MA reimbursement for cosmetic surgery, and should limit surgical transplants to vital organs.		
6. Minnesota should require laboratory tests and X-rays to be performed on a pre-admission basis when possible.		
7. Minnesota should implement an expanded program for enrolling MA recipients in HMOs and other prepaid health plans in accordance with the principles approved by the Task Force and contained in the Final Report. Although the short-range reductions in expenditures may be small, a sustained effort in this direction should produce significant reductions in future years.	$ 0.2	$ 0.1

ELIGIBILITY

The financial crisis of state and local government warrants a review of the criteria used to identify persons most in need of medical care funded by the general public. The Task Force encourages Minnesota to adopt eligibility standards commensurate with other states and extend the period of eligibility for those recipients whose need for health education and prevention services is greatest.

Recommendations	Estimated reductions in millions, if implemented on: 1/1/82	7/1/82
1. Minnesota should adopt the personal property resource standards of the Supplemental Security Income program for Medical Assistance: $1,500 for a single person and $2,250 for a married couple.	$ 2.1-4.3	$ 1.4-2.9
2. Minnesota should eliminate the present cost-of-living RSDI disregard in determining eligibility of Social Security recipients for Medical Assistance and replace it with the disregard mandated by the federal government.	$ 1.9	$ 1.4
3. Minnesota should limit the Medical Assistance eligibility of AFDC-related medically needy to persons under age 19.		
4. Minnesota should provide Medical Assistance services to AFDC-related medically needy above the age of 19 and caretaker relatives of AFDC-related medically needy children only upon enrollment in a prepaid health plan.		
5. Minnesota should extend MA eligibility to AFDC-related medically needy pregnant women for their entire pregnancy, not just the last trimester.		

DRUGS

The recommendations below emphasize the role of state government as a prudent purchaser of drugs that are genuinely necessary for the medical health of recipients.

Recommendations	Estimated reductions in millions, if implemented on: 1/1/82	7/1/82
1. The Department of Public Welfare should reimburse for prescription drugs on the basis of actual acquisition cost plus a fixed dispensing fee, with generic drugs dispensed unless the physician specifically indicates otherwise or the generic drug is not biocompatible.	$ 1.7+ *	$ 1.1+ *
2. The Department of Public Welfare should limit MA recipients to three prescriptions per month in order to reduce expenditures associated with dispensing fees.	$ 1.4	$ 1.0
3. The Department of Public Welfare should restrict reimbursement to one dispensing fee for each maintenance drug per month to reduce expenditures associated with dispensing fees.	$ 0.3	$ 0.2
4. The Department of Public Welfare should not reimburse for over-the-counter drugs, except for insulins, antacids, aspirins, acetaminophens, prenatal vitamins, vitamins for children under age 7, and family planning agents.	$ 1.2	$ 0.8
5. The Department of Public Welfare should not reimburse for appetite suppressants or drugs listed by the FDA as "ineffective or "possibly effective."	$ 0.1	$ 0.1
	$ 4.7+	$ 3.2+

* These estimates include only one aspect of the reductions--a fixed dispensing fee set at $.35 below the "average" dispensing fee (the average dispensing fee, however, is artificially high because currently dispensing fees are adjusted with the cost of the drugs--i.e., a higher-cost drug warrants a higher dispensing fee, although the work involved in dispensing is the same).

ADMINISTRATION

During periods of limited public resources, government must have the capacity to expeditiously modify existing programs and procedures to deal with impending fiscal crisis. This need is greatest in matters pertaining to health and welfare entitlement programs. The Task Force recommends two complementary methods of enlarging this capacity.

The recommendations below also reflect the Task Force's recognition that major work toward developing alternatives to the existing health care system still needs to be done. A continuing effort is suggested.

Recommendations	Estimated reductions in millions, if implemented on: 1/1/82	7/1/82

1. The Commissioner of Public Welfare should be provided with legislative authority to adjust reimbursement to providers and services to recipients when health care expenditures are expected to exceed the designated appropriation.

2. Modifications to the Administrative Procedures Act should be made to facilitate emergency decision making to prevent spending beyond appropriations in welfare entitlement programs, including:

   a. clarification of statutory language to define anticipated appropriation overruns as appropriate grounds for temporary rule promulation;

   b. lengthening of the period of time temporary rules are binding when promulgated for this purpose;

   c. simplification of the procedural steps involved in both permanent and temporary rule promulgation such that (1) public testimony is not redundant, (2) ample time is given to state departments to prepare responses and rebuttals, (3) suggested changes in the proposed rule that are made during the promulgation process do not add to the length of that process; and

   d. inclusion of a provision which temporarily exempts state departments from the rule making process when the risk of spending beyond the appropriation is imminent.

	Estimated reductions in millions, if implemented on: 1/1/82	7/1/82

3. Statutory language pertaining to the state's claim on the estates of deceased Medical Assistance recipients should be modified so that:

   a. The state can file a claim regardless of the age at which the deceased person's medical expenses were paid by the Department of Public Welfare, and

   b. The state's claim on the estate of a deceased persons' estate is invalid only when the entire estate is bequeathed to a living disabled child.

4. Minnesota should develop competitive bidding procedures for purchasing laboratory services and medical supplies.

5. The Task Force recognizes the critical need to continue the exploration of alternatives to the existing health care system. The Governor is encouraged to establish an appropriate mechanism for identifying long-range health policy goals, investigating options for restructuring health-related institutions, formulating methods for re-ordering incentives in the health care system, and evaluating issues of cost, quality, equity, and access in recent recommendations to the state.