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REPORT TO THE LEGISLATURE:

PROGRESS REPORT
Rate Setting Task Force for Publicly Funded Health Care

Prepared by:

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Pursuant to 1995 Minn. Laws Chap. 207 Art. 6 Sec. 118

Progress Report
Rate Setting Task Force for Publicly Funded Health Care

TASK FORCE

Authority: Minnesota Laws Chapter 207, Article 6, Sec 118 required DHS to establish a rate setting task force, to prepare a progress report in January, 1996, and to provide a final report in December, 1996.

Composition: Representatives from health plans, public program providers, disproportionate share and teaching hospitals, independent actuaries, regional coordinating boards, and consumers make up the Task Force membership. The Task Force consists of 30 individuals, 15 of whom are from outside the Twin Cites metropolitan area. In addition, there are staff and observers. A complete list of members, observers and staff is attached.

Purpose: The authorizing legislation states, in part, that the purpose of the task force is "...to develop recommendations for a prospective rate setting methodology with a risk adjustment mechanism to be implemented January 1, 1998. The methodology .... must take into the account the following factors:

(1) costs of ensuring appropriate access to health care in all counties;

(2) cost of medical education, disproportionate share payments, provisions for federally qualified health care centers, rural health clinics, and other adjustors historically provided for in the fee-for-service payment to specific providers;

(3) health status;

(4) statistically valid regional utilization patterns as well as population characteristics;

(5) the benefit set to be provided through the prepaid medical assistance program; and

(6) utilization demands resulting from program changes and newly created access to care."

The task force began meeting in September, 1995, and has held four meetings. It is anticipated that monthly or bi-monthly meetings will be held through 1996. It should be noted that issues closely related to those of this task force have been studied or are in the process of being studied by other groups. Examples of these groups are: a risk adjustment task force, a

DOER/DHS integration task force, a medical education and research advisory group and others. Integration of these related activities will be needed as the methodology moves toward implementation.

GOALS OF RATE SETTING

The development of any rate setting methodology has several goals. The goals in some cases are conflicting, and it is recognized that different alternatives may achieve some goals better than others. The objective of the task force and DHS is to identify the alternatives and find the best balance. In brief, the goals are identified below.

Consistency with Federal Reform. Federal reform efforts are in process and may provide Minnesota with greater flexibility in purchasing strategy design, as well as a reduced level of federal monies. Both purchasing strategy design and rate methodology will need to be consistent with federal requirements with the goal of maximizing the federal component of the funding.

Affordability for the State. The State must be able to predict and control the cost of publicly funded health care. The rate setting methodology that is used to fund public enrollees, as well as the eligibility and benefit set, must consider State revenue forecasts and budgeting. This is especially important given the anticipated ceiling on federal financial participation.

Reward Efficiency. The rate setting methodology should reward efficiencies in service delivery and cost containment by health care service delivery networks and providers. Network and consumer incentives to deliver and use services appropriately would aid in controlling cost increases in health care for all parties.

Reward Quality and Innovation. Networks should be encouraged and rewarded for meeting and exceeding quality objectives. Examples of objectives might be achieving immunization rate or high consumer satisfaction criteria. The definition of quality measurements will be a necessary component of this effort.

Based on Actuarial Principles. The rate setting methodology must be actuarially sound and consider historical data on utilization of services by the publicly funded populations. Actuarial judgement will need to be applied to project utilization for current and future years. These judgements will reflect the trends of both public enrollees and commercial populations to determine rating differentials for the various sub-populations that are publicly funded.

Credibility, Consistency, and Predictability. Both the health care service delivery networks and the State benefit from greater rate consistency for budgeting purposes as well as provider relations. The methodology developed should have stability which

will provide credibility and predictability in the rates each year.

Administrative feasibility. The rate methodology must consider the existing administrative and systems structure, including the payment, adjudication, and auditing mechanisms currently in place. Any changes in administrative procedures will require appropriate lead time to implement.

PAYMENT RATES

Task force discussions to date have centered on the following models, components, and considerations. The discussions concerning these areas will continue to be refined in future meetings. The task force has not come to any conclusions or made any decisions concerning which of these models to use in the rate setting process.

ALTERNATIVE APPROACHES TO RATE DETERMINATION

Two general models can be used to prospectively set payment rates for networks that provide health care services on a prepaid basis. One model, described as a Department determined methodology, requires the payor to set the payment rates based upon the value of a benefit set for a specific population. The second model, described as a competitive bid methodology, requires health care service networks to submit bids for the opportunity to deliver health care to Minnesota's publicly funded health care enrollees. There are other models for prospectively setting payment rates that include additional components such as unique cost considerations, risk/bonus arrangements and negotiated rates. However, these other models are seen as forms of the two general models for determining rates. Regardless of which basic model is used to determine payment rates, there is much common ground between them.

DHS Determined Rates. Currently, DHS sets rates for enrollees in its prepaid contracts based on fee-for-service data and actuarial advice. The rates are determined on a detailed cost component basis for specific geographic areas and networks. For example, different rates are determined for different geographic areas and different health plans depending upon the hospitals with which they do business.

Competitively Bid Rates. The Task Force has explored competitive bidding by health care service delivery networks for contracts to deliver specific sets of services to a defined population. Competition among bidders for the opportunity to deliver health care to the enrollees is considered to be a method of obtaining the lowest cost and a method that is responsive to the marketplace.

COMPONENTS TO CONSIDER IN METHODOLOGY

Under either approach, payment rates can vary due to several factors. The following briefly discusses those factors which will need to be considered under either model.

Special Cost Considerations. In the past, capitation rates have reflected the unique costs of certain types of facilities. When calculating payment rates through either a DHS determined methodology or a competitive bidding methodology, it is necessary to address the issues surrounding payment for these unique costs. A primary concern would be how payment for services provided in these facilities is actually received by the facilities. These payments can be made either indirectly to a network, or directly to a facility.

The following three types of cost considerations are associated with some, but not all, facilities:

- Medical education costs. Certain facilities incur additional costs associated with the provision of medical education. Networks which provide additional payments to these facilities may be at a competitive disadvantage.

- Disproportionate Population Adjustments (DPA). Payments for inpatient hospital services increase in conjunction with an increase in the number of low-income patients provided with services. These payments vary greatly among hospitals.

- Cost-based payments. Federal laws require payments for rural health clinics and federally qualified health centers to be on a cost basis under fee-for-service. This may limit the ability of networks to negotiate rates with these providers.

The task force agreed that allocations for direct medical education and disproportionate population adjustments should be removed from the rates and distributed directly to the appropriate providers.

Rate Component Considerations. In developing a prospective rate setting methodology, adjustments to the rate can be made for many factors. For payment rates set using a DHS determined methodology, these factors will need to be explicitly addressed. However, payment rates set using a competitive bidding methodology are unlikely to explicitly address these factors, although they may be indirectly taken into account. The factors are as follows:

- Access adjustments: Payment rates can vary to encourage access to services such as child immunizations or dental care.

- Fee-for-service data and utilization data: Payment rates may vary based upon the data used in calculating the rate. Use of fee-for-service data in calculating rates may perpetuate certain undesirable past health care delivery practices. Likewise, utilization data may unfairly reflect certain institutional utilization patterns. Furthermore, only DHS has extensive experience with certain populations (e.g., the disabled).

- Trending: payment rates may be adjusted for inflation or other reasons on an annual basis according to a state created mechanism or an index (e.g., the consumer price index).

General Considerations. Payment rates set through either a DHS determined methodology or a competitive bid methodology will need to address the following matters:

- Fee-for-service experience: The fee-for-service utilization and payment experience that has been used to determine rates thus far has eroded and will not be available for future rate setting. An alternative source of utilization data (i.e., encounter data) will need to be accessed. Any rate setting methodology will depend on reliable and timely utilization data. It is imperative that the Department puts more resources into the collection of data and production of reports that are of high quality and responsive to the needs of all parties for fiscal planning.

- Data sharing: Additional data (e.g., information on enrollment, eligibility, population at-risk) will be needed by the State and the health care service delivery networks. In order for new networks to enter the market in a competitive model, they must have access to historical utilization data. For certain public populations (e.g., the disabled) only DHS has utilization data. The ability and willingness to share data by all players will be critical.

- Risk adjustment: Coordination between rate setting and risk adjustment is essential. Risk adjustment is a mechanism for distributing dollars among networks by which those networks which attract more high risk patients receive higher payments. A risk adjustment mechanism will compensate networks for the health status of individuals enrolled. It will be necessary to determine which risk factors will be reflected in the rate methodology and which risk factors will be reflected in the risk adjustment system. The Minnesota Departments of Health and Human Services have jointly convened a task force to develop a risk adjustment mechanism for implementation in 1998. A separate

report will be prepared for the Legislature on risk adjustment.

- Regional variations: Payment rates under fee-for-service have varied depending on where the service is provided (e.g., urban, metro or rural rates). Some of these differences are due to the special cost considerations mentioned above. After removal of the special costs, any regional variations should be actuarially justified. A discussion of the continued need for regional variations will be part of the ongoing business of the task force.

- Profit-Loss Sharing: Reduction of risk to the networks need to be considered, at least in the short term, until the networks gain the experience necessary to serve many specific populations. A good risk adjustment mechanism will reduce the need for risk sharing, however.

- Upper limits: Currently, Federal law does not allow the State to pay more for health services to enrollees under a prepaid arrangement than under a fee-for-service arrangement. In the future, federal health care reform may change or eliminate this limit, but budgetary or other constraints will continue to limit the payment rates.

- Populations served: The publicly funded enrollees differ in important ways from those served by traditional health coverage. For instance, some enrollees have little or no income to pay for premiums or co-pays, and they may not be incented to select the lowest cost alternatives.

- Incentives: Incentives for networks to offer the lowest cost service package at the highest quality need to be developed.

- Selection process: The process of selecting a network to provide services on a prepaid basis will require DHS to define the methods governing the operation of the contracting process.

DR. CRAIG AMUNDSON HEALTH PARTNERS P O BOX 1309 MINNEAPOLIS, MINNESOTA 55440-1309 MEMBER - DENTAL PHONE: 883-7577 FAX: 883-5380	MR. MORRIE ANDERSON CHILDREN'S HEALTH CARE 2525 CHICAGO AVENUE SOUTH MINNEAPOLIS, MINNESOTA 55404 MEMBER - HOSPITAL PHONE: 813-6633 FAX : 813-6674
MR. WALTER A. BALDUS M.S REM-MINNESOTA INC. P.O. BOX 1047 107 ELEVENTH AVENUE NE AUSTIN, MINNESOTA 55912 MEMBER PHONE: FAX	MR. STEVE BJORUM FIRST PLAN HMO 1010 4TH STREET TWO HARBORS, MINNESOTA 55616 MEMBER - HEALTH PLAN PHONE: 218-834-7207 FAX: 218-834-7250
MR. EDWARD BLACK R3-18 C/O BLUE CROSS/BLUE SHIELD OF MN 3535 BLUE CROSS ROAD ST. PAUL, MINNESOTA 55164 MEMBER - REGION FIVE RCB PHONE: 612-456-6443 FAX: 612-683-2313	MR. WILLIAM BLUHM, FSA, MAAA MILLIMAN AND ROBERTSON, INC. 8500 NORMANDALE LAKE BLVD. SUITE 1850 MINNEAPOLIS, MINNESOTA 55437 MEMBER - ACTUARY PHONE: 612-820-2450 FAX:: 612-897-5301

MR. MARK BRITTON MR. KEVIN WALLI FRYBERGER, BUCHANAN, SMITH & FREDERICK 1190 CAPITOL CENTRE BUILDING 385 NORTH WABASHA STREET ST. PAUL, MINNESOTA 55102 OBSERVER PHONE: FAX:	MS. KAREN CAMPBELL ITASCA MEDICAL CARE ITASCA COUNTY HUMAN SERVICES 123 NE 4TH STREET GRAND RAPIDS, MINNESOTA 55744 MEMBER - HEALTH PLAN PHONE: 218-326-7704 FAX : 218-326-7708
MR. JERRY CREST IMMANUEL ST. JOSEPH'S HOSPITAL P.O. BOX 8673 MANKATO, MINNESOTA 56002-8673 MEMBER - HOSPITAL PHONE: 507-345-2646 FAX: 507-345-2908	MR. ROBERT B. CUMMING CONSULTING ACTUARY MILLIMAN & ROBERTSON 8500 NORMANDALE LAKE BLVD. SUITE 1850 MINNEAPOLIS, MINNESOTA 55437 0BSERVER PHONE: 820-2453 FAX: 897-5301
MR. RICHARD DIERCKS MINNESOTA DENTAL ASSOCIATION 2236 MARSHALL AVENUE ST. PAUL, MINNESOTA 55104 OBSERVER PHONE: 612-646-7454	MR. DAVID EWALD 26 E. EXCHANGE STREET ST. PAUL, MINNESOTA OBSERVER PHONE: FAX:

MR. PHIL GRIFFIN PREFERRED ONE 200 SOUTH SIXTH STREET SUITE 300 MINNEAPOLIS, MINNESOTA 55402-1428 MEMBER - HEALTH PLAN PHONE: FAX:	DR. MARCUS GUSTAFSON MINNESOTA DENTAL ASSOCIATION ADDRESS: MEMBER - DENTAL ASSOCIATION PHONE: FAX:
MR. TODD ERIK HENRY QUALITY HEALTH ALLIANCE 501 HOLLY LANE PO BOX 8674 MANKATO, MINNESOTA 56002-8674 OBSERVER PHONE: FAX:	MS. JENNIFER HO BLUE CROSS/BLUE SHIELD 3535 BLUE CROSS ROAD P.O. BOX 64357 W1 52 ST. PAUL, MINNESOTA 55164-0357 MEMBER - HEALTH PLAN PHONE: 683-2701 FAX: 456-1050
MR. LEE HOLTER WATONWAN MEMORIAL HOSPITAL P.O. BOX 460 ST. JAMES, MINNESOTA 56081-0460 MEMBER - HOSPITAL PHONE: 507-375-3261 FAX: 507-375-5171	MR. MARK HUDSON UCARE MINNESOTA 2550 UNIVERSITY AVENUE W. SUITE 201 SOUTH ST. PAUL, MINNESOTA 55114 MEMBER PHONE: 612-647-2605 FAX: 612-627-4143

MR. ALLEN JOHNSON METROPOLITAN HEALTH PLAN 822 S. 3RD STREET SUITE 140 MINNEAPOLIS, MINNESOTA 55415 MEMBER - HEALTH PLAN PHONE: 347-3421 FAX: 337-7115	MR. JOHN KLEIN HEALTH STRATEGIES GROUP 23 EMPIRE DRIVE SUITE 192 ST. PAUL, MINNESOTA 55103-1857 OBSERVER PHONE: 223-8595 FAX: 293-9309
DR. JIM KNAPP 736 SHOREWOOD DRIVE DETROIT LAKES, MN 56501 MEMBER - REGION PHONE: FAX:	MR. JOEL M. KOEMPTGEN ST. MARY'S MEDICAL CENTER 407 EAST THIRD STREET DULUTH, MINNESOTA 55805 MEMBER - HOSPITAL PHONE: 218-726-4371 FAX: 218-726-4383
COMMISSIONER MARILYN KRUEGER ST. LOUIS COUNTY 100 N. 5TH AVENUE W #208 DULUTH, MINNESOTA 55802 MEMBER - COUNTY PHONE: 218-726-2450 FAX: 218-726-2469	MR. DAVID LEE FISCAL ANALYST MHHP, SUITE 425 2221 UNIVERSITY AVENUE SE MINNEAPOLIS, MINNESOTA 55414 OBSERVER PHONE: FAX:

MICHAEL MADDY, M.D. 3104 GREYSOLON ROAD DULUTH, MINNESOTA 55812-2315 MEMBER - MMA PHONE: 218-722-8364 FAX:	MS. LOIS MCCARRON FISCAL/POLICY ANALYST 125 CHARLES AVENUE ST. PAUL, MINNESOTA 55103-2108 OBSERVER PHONE: 612-224-3344 FAX: 612-224-6540
MS. KRISTINE MCKEON INDIAN HEALTH BOARD OF MINNEAPOLIS 1315 EAST 24TH STREET MINNEAPOLIS, MINNESOTA 55404-3959 MEMBER - CONSUMER/FQHC PHONE: 612-721-9819 FAX: 612-721-7870	MR. MARCUS MERZ PREFERRED ONE ONE MAIN STREET S.E. SUITE 400 MINNEAPOLIS, MINNESOTA 55414 MEMBER - HEALTH PLAN PHONE: FAX:
MR. MEL NEFSTEAD 930 N. 8TH STREET STAPLES, MINNESOTA 56479 MEMBER - REGION PHONE: FAX:	MR. BRIAN NERMOE 720 4TH STREET NORTH FARGO, NORTH DAKOTA 58122 OBSERVER PHONE: FAX:

MS. MAUREEN O'CONNELL 46 EAST 4TH STREET SUITE 734 ST. PAUL, MINNESOTA 55101 OBSERVER PHONE: 222-3749 EXT 104 FAX: 222-0745	MS. DORI PETERSEN HEALTHPARTNERS 8100 34TH AVENUE SOUTH PO BOX 1309 MINNEAPOLIS, MINNESOTA 55440-1309 MEMBER - HEALTH PLAN PHONE: 883-7102 FAX: 883-5076
MR. RON PRATT THE CHILDREN'S HOSPITALS 6901 W. 84TH STREET, #303 BLOOMINGTON, MINNESOTA 55438 OBSERVER PHONE: 622-7299 FAX: 829-9951	MS. JEANNE RIPLEY HEALTH PLAN CONTRACTS DIVISION FAIRVIEW CORPORATION 2450 RIVERSIDE AVENUE MINNEAPOLIS, MINNESOTA 55454 MEMBER - HEALTH PLAN PHONE: FAX:
MR. TIM SAYLER NORTHERN PLAINS HEALTH PLAN 1000 SOUTH COLUMBIA ROAD GRAND FORKS, NORTH DAKOTA 58201 MEMBER - HEALTH PLAN PHONE: FAX:	MS. JEAN SEDIN NORTHSTAR PHYSICIANS PLAN 600 EAST SUPERIOR STREET SUITE 502 DULUTH, MINNESOTA 55802 MEMBER - REGION 2 CB PHONE: 218-722-8802 FAX: 218-722-9418

MS. JANET SILVERSMITH MINNESOTA MEDICAL ASSOCIATION SUITE 300, BROADWAY PLACE EAST 3433 BROADWAY STREET N.E. MINNEAPOLIS, MINNESOTA 55413-1761 OBSERVER PHONE: 378-1875 FAX: 378-3875	MR. TOM SYVERSON HENNEPIN COUNTY MEDICAL CENTER 701 PARK AVENUE SOUTH MINNEAPOLIS, MINNESOTA 55415 MEMBER - HOSPITAL PHONE: FAX:
COMMISSIONER MARY TAMBORNINO HENNEPIN COUNTY 3851 SUSAN LANE MINNETONKA, MINNESOTA 55345 MEMBER - COUNTY PHONE: FAX:	MS. CAROLYN TASKER 1305 WEST FAIRVIEW OLIVIA, MINNESOTA 56277 MEMBER - CONSUMER PHONE: 612-523-2320 FAX:
MR. JOHN W. TOMLIN GILLETTE CHILDREN'S HOSPITAL 200 EAST UNIVERSITY AVENUE ST. PAUL, MINNESOTA 55101 OBSERVER PHONE: FAX:	MS. LISA F. TOURVILLE, ASA, MAAA ACTUARIAL & RESEARCH DELTA DENTAL PLAN OF MINNESOTA 7807 CREEKRIDGE CIRCLE P.O. BOX 330 MINNEAPOLIS, MINNESOTA 5540-0330 OBSERVER PHONE: FAX:

MS. PATTI WARDEN ALLINA HEALTH PLANS P.O. BOX 9310 ROUTE MN07 7661 MINNEAPOLIS, MINNESOTA 55440-9310 MEMBER - HEALTH PLAN PHONE: 992-3241 FAX:	MS. GHITA WORCHESTER U CARE MINNESOTA 2550 UNIVERSITY AVENUE WEST SUITE 201 SOUTH ST. PAUL, MINNESOTA 55114 MEMBER - REGION 4 PHONE: 647-2608 FAX: 627-4143
MR. RODNEY WOXLAND GAROT-CHRISTMAN AGENCY 1751 N HWY 52, PO BOX 6417 ROCHESTER, MINNESOTA 55903-6417 MEMBER - REGION #6 PHONE: (507) 282-3273 FAX: (507) 282-3858	AMERICAN PHYS. THER. ASSOCIATION JEAN C. GORELL, CAE 1711 W. COUNTY ROAD B, S-101 ROSEVILLE, MINNESOTA 551113 OBSERVER PHONE: 635-0902 FAX: 635-0903
DR. BERNIE MELLEMA 101 WILLMAR AVENUE WILLMAR, MINNESOTA 56201 OBSERVER PHONE: FAX:	

STAFF

PAUL OLSON
DEPARTMENT OF HUMAN SERVICES

LYNN BLEWETT
DEPARTMENT OF HEALTH
METRO SQUARE
121 EAST 7TH PLACE, SUITE 400
P.O. BOX 64975

JIM CHASE
DEPARTMENT OF HUMAN SERVICES

BARB CHLEBECK
SENATE FINANCE 122
G-21 CAPITOL

RANDY CHUN
HOUSE RESEARCH
600 STATE OFFICE BUILDING

JOHN DEGAN
DEPARTMENT OF HUMAN SERVICES

LEA DEVILLERS
HOUSE RESEARCH
600 STATE OFFICE BUILDING

DAVE GIEL
SENATE COUNSEL AND RESEARCH
G-17 CAPITOL

BARB HAHN
DEPARTMENT OF HUMAN SERVICES

BUDD JOHNSON
DEPARTMENT OF EMPLOYEE RELATIONS

MARY KENNEDY
DEPARTMENT OF HUMAN SERVICES

VICKI KUNERTH
HOUSE FINANCE
376 STATE OFFICE BUILDING

PATRICIA MACTAGGART
DEPARTMENT OF HUMAN SERVICES

TIM ROSS
DELOITTE AND TOUCHE
400 ONE FINANCIAL PLAZA
120 SOUTH SIXTH STREET
MINNEAPOLIS, MINNESOTA 55402-1844

GINI WESLOWSKI
DEPARTMENT OF HEALTH
121 E. 7TH PLACE
ST. PAUL, MINNESOTA
PHONE: 282-6339
FAX: 282-5628

JASON WILEY
DEPARTMENT OF HUMAN SERVICES

GREG GIFFORD
MINNESOTA DEPARTMENT OF HEALTH
121 E. 7TH PLACE SUITE 400
ST. PAUL, MINNESOTA
PHONE: 282-5643
FAX: 282-5628

MICHELE DANEN
MINNESOTA DEPARTMENT OF HEALTH
SUITE 400

PHYLLIS KRAUTBAUER
DEPARTMENT OF HUMAN SERVICES

RICHARD TESTER
DEPARTMENT OF HUMAN SERVICES

LIZ BACKE
DEPARTMENT OF HUMAN SERVICES

KIM MESUN
ATTORNEY GENERAL'S OFFICE
YY