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REPORT TO THE LEGISLATURE
MANAGED CARE RATE SETTING FOR PUBLIC PROGRAMS
DEPARTMENT OF HUMAN SERVICES
DECEMBER, 1996

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The cost of preparing this report was primarily absorbed by the existing Department of Human Services budget. However, additional costs for actuarial services and outside meeting facilities are estimated at $5100.

EXECUTIVE SUMMARY

Minnesota Laws Chapter 207, Article 6, Sec 118 require the Commissioner of Human Services to report to the Minnesota Legislature on the development of a managed care prospective rate setting methodology for implementation on January 1, 1998. The law requires the Commissioner to establish a task force to develop recommendations for a prospective rate setting methodology which is to include a risk adjustment mechanism. A task force was established consisting of representatives from health care networks, public program providers, disproportionate share and teaching hospitals, independent actuaries, regional coordinating boards, and consumers. The task force consisted of 30 individuals, 15 of whom were from outside the Twin Cities metropolitan area.

The objective of the task force and the Department of Human Services (DHS) was to develop a rate setting methodology which would strike a balance in achieving the goals of efficiency, quality, and innovation, while maintaining consistency with federal requirements and affordability for the state. In addition, the methodology should be credible, based on actuarial principles, and be administratively feasible.

One of the responsibilities of the task force was to review options and make a decision concerning the fundamental rate setting concept to be endorsed. Basically, there are two broad categories of rate setting methodology. In a regulated environment, rates would be determined by DHS and the networks would accept or reject the proposal. In a competitive environment, rates would be bid by the networks and DHS would accept or reject the proposals. Currently, DHS maintains the first type of rate setting methodology for most public program rates.

Due to the diverse composition of the task force, the members were unable to come to a unanimous recommendation of one of the above methodologies. The task force decided that the report should include a discussion of the principles, advantages and disadvantages of each methodology.

A vote was taken and a majority of the task force endorsed, in principle, a competitive bid process for the prepaid Medical Assistance program consistent with the issues and methodology as recommended by the task force and discussed in this report. DHS concurs with this endorsement. The network competitive bid methodology does not precisely mirror the competitive methodology used in the private sector because, for example, the state budget may limit rates. However, it does have the potential to increase efficiency, quality, and innovation while decreasing or maintaining total program costs. Because of the market forces inherent in the bid methodology, both DHS and networks would be freed from artificial rate adjustments.

A significant minority of task force members advocate the regulatory rate setting

methodology. They believe that achieving health care improvements through managed care is a long-term and complex undertaking that requires the active partnership of all primary stakeholders. This group of members believes that it is critical that any rate setting methodology provides for the continuity of care and the continuity of partnerships necessary to achieve long-term improvements. Because the network competitive bid methodology uses the exclusion of networks from participation in public programs as a key incentive for bidding aggressively, they believe that the regulatory bid methodology which allows all interested networks to participate at a set price will better serve those managed care goals they feel are the most important.

The following were other decisions by the task force members:

- Data used to determine rates, regardless of the methodology employed, should be a combination of fee-for-service data and utilization data supplied by the networks for public program enrollees. A verification process should be put in place to ensure that the data provided by a network accurately reflects the actual services provided.

- Medical education and disproportionate population adjustment (DPA) payments should be removed from the managed care rates and paid separately. DHS disagrees with the removal of the DPA payment from the capitation rate.

- The more sophisticated risk adjustment system which is being developed jointly by the Minnesota Department of Health and DHS should be implemented when it becomes available.

- A DHS in-house or purchased fee-for-service payment system should be continued for retroactively eligible individuals. Also, if a competitive bidding methodology is implemented, the fee-for-service payment system should be used for any geographic regions in which competitive bidding is not feasible. DHS, however, disagrees with retaining a fee-for-service system.

- If a competitive bidding process is implemented, it should not initially apply to the disabled population.

- If a competitive bid methodology is utilized, bid ranges should vary by geographic region with, initially, the small employer market indicator as a base differential factor. The top of each bid range should be set to 115% of the bottom of the bid range and all bids within 3% of the bottom of the range are automatically accepted and paid at the bid price.

- An independent rate setting commission of key stakeholder organizations should be created to deal with continuing rate issues. A minority of the task force members and DHS disagree with this recommendation.

I. BACKGROUND

A. Authority

Minnesota Laws Chapter 207, Article 6, Sec 118 require the Commissioner of Human Services to report to the Minnesota Legislature on the development of a managed care prospective rate setting methodology for implementation on January 1, 1998. The law requires the Commissioner to establish a task force to develop recommendations for a prospective rate setting methodology which is to include a risk adjustment mechanism. The law requires the Commissioner to provide a final report in December, 1996.

B. Task Force Composition and Purpose

The Commissioner established a task force consisting of representatives from health care networks, public program providers, disproportionate share and teaching hospitals, independent actuaries, regional coordinating boards, and consumers. The task force consisted of 30 individuals, 15 of whom were from outside the Twin Cities metropolitan area. Observers and Department of Human Services (DHS) staff attended task force meetings also.

The authorizing legislation states that the task force "...shall develop a prospective rate setting methodology for implementation on January 1, 1998. The methodology must incorporate the public program risk adjustment mechanism and, at a minimum, take into account the following factors:

(1) costs of ensuring appropriate access to health care services in all counties;
(2) costs 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 payments 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 held 14 meetings. A complete list of task force members, observers, and DHS staff that participated is attached in Appendix A.

It should be noted that any financing mechanism will interact with many aspects of health care delivery. The task force has maintained communication with other groups when the financing methodology is of mutual interest. These groups include a risk adjustment task force coordinated by the Minnesota Department of Health (MDH) and a Medical Education and Research Advisory Committee (MERC) also coordinated by MDH. Integration of these related

activities is imperative as a rate methodology moves toward implementation.

C. Goals of the Task Force in Defining a Rate Setting System

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

(1) Consistency with Federal Requirements: Both purchasing strategy design and rate methodology must be consistent with federal requirements and the goal of maximizing the federal component of the funding. Currently, federal law stipulates that a state cannot pay more for health services to enrollees under a prepaid arrangement than under a fee-for-service arrangement. Any rate methodology must take this federal requirement into account.

(2) 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 health care services for public enrollees in conjunction with eligibility and the benefit set, must be considered in the context of the state revenue forecasts and budgeting. This is especially important given the ceiling on federal financial participation which has been proposed.

(3) Rewarding Efficiency, Quality and Innovation: A 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 and efficiently would aid in controlling cost increases in health care for all parties. Networks should be encouraged and rewarded for meeting and exceeding quality objectives. Examples of objectives might be achieving immunization rates or high consumer satisfaction criteria. Although not the focus of this task force, quality measurements are an important component of this effort.

(4) Based on Actuarial Principles: A 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/risk adjustment differentials for the various sub-populations that are publicly funded.

(5) Be Credible, Consistent, and Predictable: Both the health care service delivery networks and the state benefit from greater consistency in rates for budgeting purposes as well as provider relations. The data used should have stability and reliability.

(6) Administratively Feasible: A 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.

D. History of Managed Care in Minnesota

Minnesota is committed to improving access to health care while containing the increase in health care costs and assuring high quality outcomes. To achieve these goals, DHS established demonstration projects for prepaid, capitated managed care programs to administer and deliver health care services to Medicaid beneficiaries.

Managed care is an organized and coordinated health care system that includes pre-established provider network and payment arrangements; administrative and clinical systems for utilization review, quality improvement, patient and provider services; and comprehensive or targeted management of health services. The goals of a managed care system are to:

- Improve access to quality care.
- Assure appropriate utilization of services.
- Enhance patient and provider satisfaction.
- Achieve cost efficiencies in the delivery of health care.

(1) General History

In 1985, DHS was awarded a waiver of Title XIX of the Social Security Act under 1115 authority to conduct a demonstration project. The purpose of the demonstration project was to test the viability and cost effectiveness of a prepaid, capitated program. Congressional action extended Minnesota authority to operate the Prepaid Medical Assistance Program (PMAP) through June 30, 1998.

Under this program certain eligible Medical Assistance (MA) recipients in designated PMAP counties within the state are required to choose a participating health care network and then receive all health care services through the network. Within the first year of their initial network enrollment, recipients may switch networks one time. After the first year of enrollment, recipients have the opportunity to switch networks during a 30-day open enrollment period each fall.

The state pays a monthly capitation rate to the health care network on behalf of each enrolled recipient. For this rate the network provides all public program covered health care services. Rates are based on an actuarial analysis of the state's historical cost experience with groups of recipients and other cost and utilization factors. The rates vary by network and geographical location. Recipients are classified by rate cells based on several factors: age,

gender, Medicare coverage, institutional residence, eligibility status, and county of residence. Nursing facility costs are not included in the rate. Capitation payments for nursing facility residents cover all services except the residential per diem costs.

The state has provided payment for Medical Education (ME) costs and Disproportionate Population Adjustment (DPA) costs as a separate component of the capitation payment. In certain counties, DHS paid these items on a network specific basis since networks varied significantly in their use of teaching facilities and DPA hospitals. There was a concern that if the state averaged ME and DPA costs into the rates in Hennepin County, some networks potentially could be undercompensated, while others could be overcompensated for these services. During early contract years, the state accommodated these costs outside of the capitation payments in retrospective settlements. Beginning July 1, 1992, ME and DPA costs were built into the rates on a network specific basis in Hennepin county, based on each network's historical use of teaching and DPA hospitals. The rates for networks in Ramsey and all other PMAP counties included the county average ME and DPA costs rather than network specific rates.

Inpatient hospital stop-loss protection is also offered to the networks. Coverage is 80% of costs above a $15,000 threshold. Health care networks are given the option of having the state supply this reinsurance or purchasing reinsurance privately. For networks who choose the second option, the value of the stop-loss coverage is incorporated directly into the capitation rates.

In addition to managed care being available to certain segments of the MA population, MinnesotaCare recipients and General Assistance Medical Care (GAMC) recipients in selected counties are also being enrolled into managed care.

(2) **PMAP Rates for 1996 and 1997**

Prior to the formation of this task force, a rates work group composed of network representatives, providers and DHS staff was established by DHS to receive input on alternative methodologies for setting capitation rates and on alternative purchasing arrangements for managed care services. As a result, a revised methodology was developed with the assistance of an independent actuarial consulting firm, Deloitte and Touche, for calendar year 1996. The 1996 rates used the fee-for-service experience over a four-year period (1990-1993) to establish a stable base and several adjustments were subsequently made. Rate cell relationships for age, gender, program eligibility, and geographic area were reviewed based on these data, and modified for future consistency. These rates were trended forward year by year to 1996 based on fee-for-service price (inflation) and utilization factors in each area. The following adjustments were applied to the trended data:

- stop-loss coverage by rate cell.

- Consolidated Chemical Dependency Treatment funding which was not in the 1993 base data.

- a hospital rebasing factor established for fee-for-service inpatient services.

- a legislatively mandated access adjustment that required non-metro area rates to be no less than 85% of the metro rates, excluding Hennepin county.

- a managed care savings factor legislatively mandated to be 10% for families and children and 5% for the aged.

- changes in coverage determined by DHS which will affect the rates in certain age/gender/eligibility cells.

- cost of interpreter services and non-emergency medical transportation costs which were not in the 1993 rates.

- network-specific adjustments in Hennepin county based on utilization of medical education facilities, and DPA hospitals. Since the utilization of these hospitals was different for each network, the rate adjustments varied by network.

Managed care rates for 1997 are a continuation of 1996 rates with a trending factor applied.

II. TASK FORCE OPTIONS AND FINDINGS

A. Rate Setting Methodology Selection

One of the main objectives of the task force was to review options and make a decision concerning the fundamental rate setting concept to be used. Basically, there are two broad categories of rate setting methodology. In a regulated environment, rates are determined by the purchaser and the network reacts. In a competitive environment, rates are bid by the network and the purchaser reacts. Currently, DHS maintains the first type of rate setting methodology for most public program rates. DHS determines the managed care rates, then seeks to find networks who are willing to provide the benefit set at the DHS determined rate. For the MinnesotaCare rates, a combination of the two concepts was used.

(1) Regulated Environment -- DHS Determined Rate Methodology

The basic concepts behind this type of rate setting methodology are:

- DHS distributes requirements for participating networks.
- DHS uses its own data to determine what it considers to be appropriate rates based on recent experience, program changes, trends, and adjustments.
- DHS proposes rates to the networks and the networks react.
- DHS contracts with networks to provide services at the established rate.

(2) Competitive Environment -- Network Bid Methodology

The basic concepts behind this type of rate setting methodology are:

- DHS distributes requirements for participating networks.
- DHS distributes historical utilization experience and other data including the applicable benefit set to the networks for their use in determining a rate.
- The network proposes rates to DHS and DHS reacts.
- DHS chooses networks that meet the bid criteria and also meet network qualification requirements.

Theoretically, in either of the rate setting methodologies, rates could be negotiated between DHS and the networks in order to reach agreement on a payment rate that satisfies both parties. Additional features could also be added to each type of methodology. An example would be profit/loss sharing. Also, a risk adjustment mechanism can be applied to the resulting rate in either methodology.

Due to the diverse composition of the task force, the members were unable to come to a unanimous recommendation of one of the above methodologies. The task force decided that the report should include a discussion of the principles, advantages and disadvantages of each methodology.

The task force voted and a majority of the task force endorses, in principle, a competitive bid process for PMAP consistent with the issues and methodology as recommended by the task force and discussed in this report. DHS concurs with this endorsement. The network competitive bid methodology does not precisely mirror the competitive methodology used in the private sector because, for example, the state budget may limit rates. However, it does have the potential to increase efficiency, quality, and innovation while decreasing or maintaining total program costs. In order to attain these advantages, the methodology must include proper incentives. Proposed incentives are described in this report in Section III.B.(4).

By necessity, the network bid methodology would increase the information flow between participating networks and DHS. This is an advantage to all concerned as it helps in the evaluation of the quality, efficiency, and appropriateness of health care delivery. The additional information available would aid in the analysis of care management and the associated financial requirements for the public program block of business.

The network bid methodology would relieve DHS of some of the adjustments and negotiations that are part of a regulated system. By using the market forces inherent in the bid methodology, both DHS and the participating networks would be freed from artificial rate adjustments.

The entire task force believes that, if a network bidding process is implemented, it should not initially apply to the disabled population. The members believe that DHS needs to evaluate the feasibility of rating the disabled population on a competitive basis. They believe that an evaluation is necessary because of the varying levels of risk within the population and to protect enrollees during the disabled population demonstration projects which are scheduled to begin January 1, 1998.

A significant minority of task force members disagree with the network bidding approach to rate setting for managed care public program enrollees. Instead, they recommend that the current method of regulated rate setting be continued for the MA and GAMC populations.

Since the task force feels that, over time, adjustments to any rate methodology process may become necessary, the task force recommends that an independent managed care rate commission be established. This commission would address rate setting and related issues. The commission would be modeled after advisory groups such as the federal PROPAC and PPRC groups. It would be made up of representatives of networks and provider entities from throughout the state as well as consumers, state finance department personnel, and DHS representatives.

DHS does not believe that a broad-based group to deal with capitation rates on a long term basis is necessary. DHS is responsible for the administration and budgeting for the public programs and has historically convened stakeholder work groups when necessary. In addition, the current process of utilizing an independent actuary for rate setting functions is an efficient

one.

B. Related Issues

The charge of the Managed Care Rate Setting task force was to make recommendations concerning a methodology for paying networks for delivering health care to enrollees of publicly funded health care programs. A number of tangent issues were discussed during the task force meetings. Where appropriate, some members of the task force have worked with other groups who are addressing these issues.

(1) Benefit Set

The benefit set refers to a specified array of health care services that must be provided for persons covered by a given public health care program. The benefit set is normally established by federal requirements and the legislature. Any rate setting methodology must take into account the defined benefit set and be capable of accommodating any changes that are made to it. The assortment of health care services included in the benefit set must be reflected in the universe of historical utilization data that is used in predicting future utilization, and thus, rates.

(2) Retroactive Eligibility

Retroactive eligibility occurs when an individual's eligibility for a public health care program begins prior to the date of application for assistance. Currently, retroactive eligibility may extend up to three calendar months prior to the date of application. Consequently, medical services provided during the retroactive eligibility period are eligible for public assistance payment. Under the current managed care system, DHS pays affected providers directly under a fee-for-service arrangement and enrolls individuals into managed care programs on a prospective basis the first month after discharge from a hospital. Under a total managed care system, this would translate into networks being responsible for payment of services provided to individuals who were not members at the time the services were provided.

Although coverage issues such as this are outside the scope of this task force, DHS is of the opinion that, if current eligibility policies remain in effect, a risk adjustment system based on health status could handle the retroactive eligibility situation equitably if capitation payments were made for all retroactive months of eligibility. (See Section II.B.(3).) Or, as an interim measure, specific rate cells for retroactively eligible individuals could be developed to accomplish these payment needs.

The task force does not believe that a risk adjustment system could adequately address the situation of retroactive eligibility. The task force recommends that a fee-for-service payment

method for retroactive eligibility should be continued in order to not place undue financial responsibility on networks for care unauthorized by the network. The task force recommends that, if DHS is not continuing a fee-for-service system for other eligibility groups, an alternative payment system be developed based on Medicare cost finding principles, or based on Medicare reimbursement rates for those services not subject to Medicare cost findings. DHS could then purchase administrative services for the retroactively eligible individuals.

DHS does not believe that a fee-for-service payment system of any type should be continued as this would require a duplication of administrative functions or costs that DHS would like to transfer to the networks.

(3) **Risk Adjustment Enhancements**

MDH and DHS have been directed by the legislature in Minnesota statutes Chapter 62Q.03 to develop a public programs risk adjustment system. Coordination between rate setting and risk adjustment is essential since both impact payment to networks for health care services to recipients.

The focus of the two concepts, rate setting and risk adjustment, can be differentiated by their impact on the total cost of the public program. The rate setting methodology will influence the level of the costs; the risk adjustment concept will influence the distribution of the payments. The form of risk adjustment application to rates should not affect the overall budget and operational effects, such as cash flow swings to the state and networks, should be minimized.

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 characteristics and health status, or predicted health care expenditures, of individuals enrolled. Risk adjustment allows networks to compete fairly, on the basis of cost and quality, rather than on the ability of the network to enroll only healthier members.

Capitation rates currently compensate networks for some of the differences in the patient population by adjusting for age, gender, Medicare coverage, institutional status, eligibility basis, and county of residence. However, these adjustments may not fully compensate for differences that exist between networks' enrollees. No adjustment is made for the health status of the enrollees or for any health conditions or social factors which could affect future health care expenditures for these individuals. As public program populations currently excluded from managed care, such as the disabled, become enrolled in managed care networks, such adjustments become much more important. For this reason, a sophisticated risk adjustment system will be critical to assure that networks compete fairly and to provide positive incentives to care for and manage disabled populations. The task force members believe that a risk adjustment system that takes into account health status must be in place before the disabled

populations are enrolled in managed care.

The task force therefore recommends that the final risk adjustment scenario developed by this separate risk adjustment work group be integrated as soon as feasible into the design of the managed care rate setting methodology as recommended by this task force.

(4) **Distribution of Medical Education and Research Funds**

As part of the 1993 and 1994 MinnesotaCare Acts, the legislature asked the Commissioner of Health to study the costs and financing of medical education and research. The Commissioner established the Medical Education and Research Cost (MERC) Advisory Task Force, representing key stakeholders, to assist in the study.

Teaching institutions have typically financed a portion of the cost of medical education and research through patient care revenues. Patient care charges at accredited teaching institutions are generally higher than those at non-teaching and non-research institutions because they are intended to cover a portion of the institution's teaching and research costs. Public and private health care group purchasers have traditionally paid this difference, thereby covering a portion of the cost of medical education and research. These costs were typically passed on to consumers in their premium rates at a time when there was less emphasis on cost containment.

The group purchasers' willingness to voluntarily pay the education and research increment is eroding. In a price competitive market, group purchasers of medical services are increasingly unwilling to pay the higher fees at teaching institutions when they can obtain care of the same quality for less cost at another institution. In Minnesota, as in many other areas of the country, group purchasers can obtain most patient care services at non-teaching institutions. In such a competitive environment, therefore, teaching institutions may no longer be able to include the education and research increment in their fees and expect purchasers to pay for the medical costs.

In its February 1996 report to the Legislature of preliminary findings, the MERC task force recommended the establishment of a Medical Education and Research Trust Fund and a financing mechanism which would be used to collect and distribute the funds for medical education.

The rate setting task force concurred with the MERC task force's recommendation and endorses removing ME funding from the managed care rates. With the removal of ME funding from the rates, payments for ME will be funded instead through a separate mechanism at a level determined by the legislature. The coordination of the two task forces ensures proper use of the funds to medical education and research as was intended when the funds were part of the fee-for-services payments. The MERC advisory task force will make a recommendation to the legislature as to the distribution of the ME funds. In the absence of a legislatively established

and funded distribution mechanism, the ME funding will remain in the managed care rates.

(5) **Network Qualifications**

For purposes of this report, the term 'network' uses a definition that is broader than 'Health Maintenance Organization'. It is defined in Minnesota's State Plan for Medical Assistance which describes the state's basic eligibility, coverage, reimbursement, and administrative policies. The state plan was approved by the Health Care Financing Administration (HCFA). (See Appendix B). This definition would define a network to include entities such as: an integrated service network (ISN), a community integrated service network (CISN), a non-profit corporation or any statutory or home rule charter city or county that has been issued a certificate of authority by the Department of Health.

The task force believes that it is important that consumer protection standards, such as solvency and quality of health care requirements, be applied to all networks. The task force believes that all entities allowed to participate in the bidding process should accept a certain amount of risk, be held to requirements for consumer protection and be accountable for defined criteria regarding risk-sharing arrangements.

The task force will not address network qualification criteria including such standards as access guarantees, provider/enrollee ratios, transportation strategy, and network administrative ability. This criteria is not a part of the rate setting process and, therefore, is out of the scope of this task force.

III. OVERVIEW OF PROSPECTIVE RATE SETTING METHODOLOGIES

The charge to the task force was to develop recommendations for a managed care prospective rate setting methodology. This section describes the methodologies considered by the task force and makes recommendations on those topics where consensus could be reached. The task force decided that, where unresolved disagreement among the task force members existed, the varied opinions would be detailed in this report.

A. Features of Any Rate Setting System

Regardless of whether a regulated or competitive bid methodology is used, there are a number of issues which need to be addressed under any prospective rate setting environment. Of critical importance to participating networks and DHS are:

- Access to the demographic and historical utilization data of public program participants
- A definition of the prospective capitation rate
- An understanding of risk adjustments to payment rates.

This section describes those issues as they apply to rate setting in general. The task force recommends that the following features be adopted as part of any rate setting system. A minority of the task force believes that all these features must be operationally in place before any new rate setting system is introduced.

(1) Data

An integral part of any managed care rate setting system is the historical health care utilization data of the populations to be enrolled. In the past, the DHS has used its own historical fee-for-service utilization and payment experience to determine the managed care rates. One problem with relying on fee-for-service data is that, as managed care becomes more pervasive, the fee-for-service base of data becomes eroded. In some counties within the state, this situation has already occurred for recipients of public health care programs. Because the public program enrollees can have characteristics and utilization patterns unlike those of the general population, data reflecting their actual usage is a necessity and substitution of data of other populations is not feasible. A second problem with using fee-for-service data in developing managed care rates is that it may tend to memorialize certain past health care fee-for-service financing levels. Likewise, the data may unfairly reflect certain institutional utilization patterns. Adding further to the problem is the fact that, for some public program populations, the disabled for example, fee-for-service data is all that is available to indicate past utilization and cost tendencies.

Since the fee-for-service data is eroding and is outdated in some cases, it will no longer be satisfactory to use it as the only source of utilization information. A system is currently being developed whereby networks submit to the state data reflecting utilization of health care services by enrollees in public programs. This data, generally referred to as encounter data and collected by DHS, will be an important part of the rate setting process. It will be imperative that the health delivery service networks provide reliable and timely encounter data for their public program enrollees to DHS. Likewise, it is also imperative that DHS allocate the necessary resources for the collection and processing of the data. This collected data will be an important component of the information provided to prospective networks as part of the process to solicit participants to provide health care to the public program populations. This data should be provided to prospective networks and other stakeholders regardless of the type of rate setting methodology employed.

Initially, the data provided will, of necessity, be a mix of DHS fee-for-service data and network encounter data. At the point that the state public program population is fully capitated, all utilization data disseminated will be data the networks have provided. The ability and willingness to share data by all players will be critical. In order for new networks to enter the public program health care market, utilization data of existing players must be available. This is also true for existing networks that wish to expand to new areas of the state.

As stated above, encounter data is currently being collected by DHS for federal requirements and state performance measurement purposes. The data fields currently being submitted to DHS by the networks on a detail claim basis are shown in Appendix C. A minority of the task force believes that the shared data should be in a summary rather than a detail format. Considerable work remains to be done to ensure adequate access to data for rate setting purposes, particularly in the area of defining and compiling data received from networks.

The quality and reliability of the data is an important issue to all parties. Therefore, it is recommended by this task force that a verification process be put in place to ensure that the data provided by a network accurately reflects the actual services provided.

The task force is split on the issue of delaying any overhaul or change to the existing rate methodology until a good encounter data system is in place.

(2) <u>Components of the Capitation Payment</u>

DHS makes a payment to the appropriate network each month on behalf of each public program enrollee. This payment is often referred to as the per member per month amount or PMPM. This PMPM payment to the network is made up of various components. Currently these components include the base rate associated with the rate cell of the enrollee and the ME and DPA adjustments to that rate.

(a) **Base Component**

At the current time, the basic component of the PMPM amount is the base rate associated with the 'rate cell' of the enrollee. This rate is based on an actuarial analysis of the state's historical cost experience with groups of public program recipients and other cost and utilization data. The rate cell groupings are those related to age, gender, Medicare, institutional, and eligibility status and county of residence of the enrollee.

(b) **Risk Adjustment**

In actuality, a rate cell is another name for the rudimentary risk adjustment grouping that is performed and which causes a different rate to be paid for each rate cell. Most of the variables used for rate cell assignment, such as age, gender, and institutional status, are direct enrollee characteristics that have a clear connection to average health care costs. However, the county location variable, as a risk adjustor, is a less direct measure, and stands as a proxy for client characteristics that are not otherwise measured, as well as for regional variations in the costs of operations. Because the county variable is less directly associated with health care costs, its role in rate setting has been more controversial.

The task force believes that these concerns can be remedied by adoption of a more sophisticated risk adjustment system, which incorporates as many as possible of the 'hidden variables' that underly county-based differences. These variables may include:

- Health status and incidence of chronic conditions.
- Duration of enrollment -- services may be more heavily concentrated in the early months of enrollment.
- Enrollee requirements for supporting services through the social services or public health systems.

Inclusion of these types of variables in the risk adjustment system may offset a large portion of the cost variations currently embedded in county-based rate cell differences.

The joint MDH / DHS risk adjustment work group will not have recommendations ready until sometime during 1997. Given the importance of risk adjustment to an overall rate setting methodology, the task force can only reserve judgement on the adequacy of the proposed risk adjustment enhancement to the network bid or the regulatory rate setting methodology.

(c) **Medical Education Component**

Currently, DHS capitation payments to networks include payment for medical education costs.

The task force recommends that medical education costs be excluded from the capitation

rate setting methodology. (See Section II.B.(4).) DHS anticipates turning funds attributable to the medical education costs of providing care to public program patients over to MDH. MDH will then distribute the funds consistent with the methodology developed by the Medical Education and Research Costs Advisory Task Force. The amount attributable to ME has been estimated by DHS. This is shown as Appendix D. However, a mandate from the legislature will be required to establish the amount to be reallocated.

(d) **Disproportionate Population Adjustment Component**

In the current fee-for-service arrangement, hospitals receive a DPA amount as part of the payment from DHS for inpatient services provided to public program patients. For purposes of this report, the term DPA will include the inpatient hospital small rural percentage increase as it was part of the same 1992 legislation that significantly increased the DPA percentages.

In the current capitation arrangement, networks receive an adjustment to their capitation rate to reflect the DPA levels of the hospitals which contracted with the networks to provide services to enrollees. In all counties of the state except Hennepin county, this adjustment to the capitation rate is an average DPA amount. Once this average DPA adjustment is included in the rate, it is no longer considered a DPA payment for federal and state capitation purposes and it is no longer considered a hospital payment. In Hennepin county an average is not used, instead, networks relying on hospitals that receive higher DPA amounts under fee-for-service receive greater funds through the capitation rate than networks relying on hospitals that were eligible for smaller DPA amounts or no DPA amounts.

The current capitation payment amounts attributable to DPA have been estimated by DHS. This is shown as Appendix D in conjunction with the medical education figures.

The task force recommends that the DPA funds be excluded from the capitation rates and placed in a separate fund that would be distributed directly to the DPA-eligible hospitals serving the public population. They believe that the integrity of the rate setting methodology would be better served by making these payments directly to the facilities rather than 'filtering' them through network capitation payments. They also believe that any new procedures to distribute DPA monies should recognize the increasing importance of outpatient services and facilities in serving public program patients. If DPA funds are paid separately from the capitation rates, a mechanism for the distribution of the DPA funds to the individual facilities would need to be developed.

DHS disagrees with separating the DPA funds from the capitation rate. There is a question as to whether it is appropriate to calculate DPA percentages for managed care solely with reference to inpatient days as is now required by federal law. Also, a DPA payment based on inpatient revenues, which are unknown when paid by a managed care organization, may be inappropriate. In addition, since networks are competing for a "market share", it may be inappropriate to pay a DPA payment to those that seek and gain a larger market share. Also,

DHS believes that separating the DPA funding from the capitation rates causes the monies to be a much easier target for elimination from federal funding.

The task force members believe that, since Minnesota is a relatively low DPA state compared to national norms, separately identifying and paying DPA amounts is a risk worth taking. However, if the DPA funding remains in the rates, the task force recommends that network bids should be net of DPA funding so the bids can be compared on a consistent basis. The rates paid to the selected networks should be their bid rates adjusted to include DPA funding based on each network's expected use of DPA providers in that geographic area.

DHS disagrees with the idea of making DPA adjustments on a facility-specific basis. DHS believes that the method of dealing with DPA monies as is currently being used in all counties other than Hennepin should be implemented on a state-wide basis instead. This method integrates the DPA amounts into the basic rate structure. DHS believes that this method increases network provider contracting options regarding quality, price, and value.

B. Network Bidding Approach

As discussed in Section II.A. above, a majority of this task force recommends a network bidding process for the managed care prospective rate setting methodology. Unlike a pure competitive bidding process, this type of bidding process would require bidders to restrict their bids to a range developed and published by DHS. This range is necessary because of budget and eligibility mandates from the legislature. The process features of the network bidding methodology are detailed in this section.

Networks interested in providing health care services to the public program population would respond to a DHS Request for Proposals (RFP) which would solicit bidders to participate in the process. The RFP package would include a set of background information, bidding rules, and demographic and historical utilization data. Using this set of information, the network would develop and submit a bid to DHS which will contain, among other items, the base amount, before risk adjustment payments, that the network proposes to be paid to provide health care to the covered population in the given geographic area.

Basically, the process of coming to an agreement with a network to provide health care services to the public program population in a defined region can be divided into the following three stages:

(1) Publication of the RFP

The first step in the process of selecting networks to provide health care services is the publication of an RFP. The RFP will provide essential background information that the

networks will need to prepare a response to the RFP. In addition, the RFP will provide health data describing demographics and the historical utilization of services for a certain region.

The content of the RFP will be similar to previous RFPs issued by DHS for the provision of health care services on a prepaid basis. The following items will be addressed in the RFP:

- Geographic areas. The geographic areas for which bids are being requested must be defined within the RFP.

  The task force members recommend that counties be grouped together based on historical referral patterns in order to create an actuarially-sufficient number of enrollees per area. For counties with a significant number of public program enrollees, such grouping may not be necessary.

- Services. The RFP will include a description of the benefit set.

- Qualification criteria. A network will need to establish that it can comply with a standard list of requirements before DHS can contract with the network (see Section II.B.(5)).

- Risk adjustment factors. In order to assist potential bidders in calculating their base rate bid, the RFP will contain the various risk adjustment factors. The initial rate adjustment system will multiply the base rate by a risk adjustment factor designed to reflect the current rate cell designations. This will be replaced with, or supplemented by, the risk adjustment methodology currently under development by MDH and DHS (see Section II.B.(3)).

- Data. Networks will be provided with demographic and utilization data to assist in calculating their base rate bid (see Section III.A.(1)). Appendix E contains an actuarial data format.

- Acceptable Bid Range. DHS will publish minimum and maximum base rate amounts below which and above which bids will not be considered acceptable. The basis of the range concept is two-fold. A bid should not fall below the minimum boundary since quality care for enrollees below this level of payment becomes unlikely. Conversely, DHS is required by the state legislature and federal regulations to achieve a minimum level of savings by moving from fee-for-service to managed care. When the state becomes fully capitated, DHS will still be limited by a budget determined by the legislature. This assumes that the DHS budget is adjusted for medical cost and utilization trends, benefit changes, program eligibility changes, population changes, and other relevant factors. The calculation of the DHS budget will be published in the RFP.

The task force recommends that:

- The top of each bid range for each geographic area is set to 115% of the bottom of the bid range.

- Midpoints of the bid ranges are set to meet the DHS budget.

- Bid ranges vary by geographic area.

- The geographic rate factors used in the initial RFP are set based on geographic rate variations observed in the small employer market. Consistent with statute, the ranges shall be set so that the midpoints statewide vary by no more than 15%.

- The geographic rate factors for subsequent bidding periods are adjusted based on the relationship between the prior bids by region. For example, if bids for non-metro regions were near the top of their bid ranges, and bids for the metro regions were near the bottom of their bid ranges, the geographic factors used for the next bidding period would be adjusted, with increases to the factors for non-metro regions, and corresponding decreases to the factors for metro regions. This adjustment would be in addition to regular updating of data years, assuming the adjustment was still warranted based on the relative differences in the ranges.

• Incentives. The RFP will contain the incentive package that DHS has developed to encourage networks to submit proposals that accomplish the dual need of quality health care and cost containment for the state (see Incentives Section III.B.(4)).

• Rules governing bidding system. The RFP will contain the criteria and method of network selection and all other rules governing the bidding system.

The task force believes that the importance of maintaining the integrity of the competitive bidding process makes it critical that all elements of the bidding and negotiation process be clearly defined in the RFP. All situations under which bids could be adjusted after the initial submission and the policies covering the adjustment procedures should be included in the RFP.

DHS would like to retain some flexibility in the area of bid negotiation and adjustment in order to effectively deal with unforeseen situations that may occur within the bidding process. An example would be: no bidders for a geographic area. In this case, DHS would like the flexibility to negotiate with a bidder in another region to provide coverage to the unpopular region as well.

The task force recommends that a fallback position be used which would allow geographic regions to remain fee-for-service if the new bidding methodology is not

workable for those geographic regions. For example, this fallback to fee-for-service, either DHS administered or purchased, would be employed if acceptable bidders could not meet the needs of the population in the geographic region.

DHS again does not agree that retaining fee-for-service capabilities is an efficient, cost effective way to handle the challenges that arise when converting to managed care.

(2) **Submission and Evaluation of Bids**

Within each geographic area, each bid submitted by a network will be evaluated to determine if the network meets a series of qualification criteria as discussed in Section II.B.(5). The following items may also impact the process of selecting qualifying networks:

- The types and numbers of providers participating in each network.
- The location of providers participating in each network.
- Past experience of the network in providing services for publicly funded health care programs.
- Demonstrated network competence in the areas of health care quality, access, and service.
- Continuity of care advantages that would be achieved because of the specific providers participating in the network.

The bid will be further evaluated to determine whether the bid price is within the applicable range of acceptable bids.

(3) **Selection of Bidders**

The task force recommends that all bids within 3% of the bottom of the applicable range be automatically accepted if the network meets other non-rate related criteria. If two bids do not fall within 3% of the bottom of the range, then the lowest two bids will be automatically accepted if other requirements are met. The accepted networks will be paid at the bid price.

When an additional number of bids meet the threshold criteria but have not been selected with the bid price selection criteria, DHS may determine that additional networks are needed to accomplish service or choice goals in the geographic area. The RFP will define the situations under which DHS will determine that additional networks are needed and the rules under which the additional networks will be selected.

In most contexts, the selection of winning bidders following a competitive bidding process will be done without any negotiation. However, due to the fact that neither DHS nor the networks can anticipate all of the issues arising from providing care for publicly funded health care programs, it is uncertain whether it will always be possible to reach a final agreement with an accepted network relying solely on a competitive bidding process.

(4) **Incentives**

(a) **Network Incentives**

Because the public programs business carries a different set of budgetary pressures, market forces, and incentive strategies for the networks, the bidding strategy and DHS's selection process will, of necessity, operate differently than it would in private industry. In a private sector competitive bidding environment, networks have the incentive to bid low and increase their market share of a profitable product. Since the enrollee does not use personal funds to make the premium payment, that incentive is not operating for the public plans. The tie between the network's bid price and the enrollee choice of network is missing. However, the competitive bid methodology is considered a major advantage to the state because of the potential to purchase health care at rates lower than in a regulated environment. Therefore, in order for a competitive bid methodology to work for the public plans, incentives must be in place that will encourage low bids from the networks.

Preferential selection by DHS of low bidders and the possible exclusion of high bidders is one incentive that could be utilized. Contract advantages for the lowest bidder(s) are another method of encouraging the networks to bid a low rate. These contract advantages could include the option of a longer contract period as well as attractive inflation increases in subsequent years of the contract. Certain limited marketing advantages could also be given to the lowest bidder. Another incentive might be the automatic enrollment of all unassigned enrollees into the low bid network. These unassigned enrollees are those that did not choose to designate a network themselves when given the opportunity. The optional incentives such as the increased contract length, marketing advantages, and automatic assignment of enrollees would be included as part of the contract only in agreement with the pertinent bidder.

The task force has advocated all of the above incentives for the network bid methodology. In addition, the task force has recommended the automatic acceptance of all bidders within the bottom 3% of the bid range or the lowest two bidders if there are not two within the bottom 3%. They believe that potentially excluding all other bidders from participation will create an effective incentive for networks to submit low bids.

(b) Consumer Incentives

Both DHS and the networks have an interest in the types of incentives that can be offered to new enrollees at the time of selecting a network. DHS would like to offer incentives to new enrollees to encourage enrollment in the lowest cost network. Networks would like to offer incentives to consumers to encourage enrollment in their network.

Federal regulations limit the incentives DHS can use to encourage MA recipients to choose cost-efficient health care to "additional services." Although the scope of "additional services" is undefined, it may include such incentives as bicycle helmets or car seats for children. These federal regulations also apply to the MinnesotaCare Program because federal funds are being earned for certain parts of the MinnesotaCare program.

DHS offered incentives other than "additional services" are more difficult to implement. The use of monetary rebates as an incentive appears inconsistent with federal regulations and raises eligibility concerns. The use of non-health care related incentives also appears to be inconsistent with federal regulations. Finally, it does not appear practical for DHS to encourage enrollees to choose the low cost network by requiring co-payments for certain services for all networks other than the low cost network due to the large number of population groups which cannot be charged a copay. Pregnant women, children, and institutionalized individuals are examples.

At the current time, the use of reduced premiums as an incentive to choose a low cost network does not appear feasible because only MinnesotaCare enrollees pay premiums. However, this may become a more practical option in the future if MA enrollees begin to make premium payments.

Currently, DHS monitors the marketing efforts of networks providing coverage for the enrollees of the publicly funded health care programs. Due to the problems other states have had with the marketing efforts of networks, DHS policy has not allowed the networks to market themselves through the use of incentives. However, once an enrollee has selected a network, the network is then free to use incentives to encourage desirable behaviors such as preventive care.

C. Regulated Rate Setting Approach

A regulated rate setting model was the methodology advocated by a significant minority of the task force members. This type of methodology is the approach used currently for PMAP and GAMC managed care rate setting. (See Section I.D. History of Managed Care in Minnesota.) The approach could be updated in the future to use DHS-collected encounter data rather than the fee-for-service data currently used in setting the rates.

The basic components of the current regulated rate setting methodology are:

- DHS issues an RFP requesting a response from networks interested in providing health care to public program populations.

- The RFP includes the rates that DHS has determined will be paid to participating networks. The rates are based upon three geographic groupings: the Minneapolis/St. Paul metropolitan area except Hennepin county (metro), Greater Minnesota (non-metro), and Hennepin county. Most base capitation rates do not vary by individual network. Hennepin county rates, however, are network specific due to hospital adjustments which are added to the base rates (see Section III.A.(2).(c). and (d).) For Hennepin county the estimated value of ME and DPA payments are taken out of the base rates and put back in on a network specific basis based on each network's projected used of ME and DPA hospitals.

- Interested networks submit proposals to DHS and, for accepted proposals, a contract negotiation process takes place.

This minority of task force members believes that achieving health care improvements through managed care is a long-term and complex undertaking that requires the active partnership of all primary stakeholders. This group of members believes that it is critical that any rate setting methodology provides for the continuity of care and the continuity of partnerships necessary to achieve long-term improvements. Because the network competitive bid methodology uses the exclusion of networks from participation in public programs as a key incentive for bidding aggressively, they believe that the regulatory bid methodology which allows all interested networks to participate at a set price will better serve those managed care goals they feel are the most important.

IV. CONCLUSIONS

The following were decisions by the task force members:

- A majority of the task force members endorse, in principle, a competitive bid process for PMAP consistent with the issues and methodology as recommended by the task force and discussed in this report. A significant minority disagrees with this recommendation and prefers to retain the current regulated rate setting methodology.

- Data used to determine rates should be a combination of fee-for-service data and utilization data supplied by the networks for public program enrollees. A verification process should be put in place to ensure that the data provided by a network accurately reflects the actual services provided.

- Members of the task force felt that medical education and DPA payments should be removed from the managed care rates and paid separately. DHS disagrees with the removal of the DPA payment from the capitation rate.

- The more sophisticated risk adjustment system which is being developed jointly by MDH and DHS should be implemented when it becomes available.

- Members of the task force felt that a DHS in-house or purchased fee-for-service payment system should be continued for retroactive eligibility and for geographic regions in which competitive bidding is not feasible. DHS disagrees with retaining a fee-for-service system.

- If a network bidding process is implemented, it should not initially apply to the disabled population.

- If a network bid methodology is implemented, bid ranges should vary by geographic region with, initially, the small employer market indicator as a base differential factor. The top of each bid range should be set to 115% of the bottom of the bid range and all bids within 3% of the bottom of the range are automatically accepted and paid at the bid price.

- An independent rate setting commission of key stakeholder organizations should be created to deal with continuing rate issues. A minority of the task force members and DHS disagree with this recommendation.

Since the development of this report, a general agreement has been reached by a joint health negotiating team from the Association of Minnesota Counties and senior management of MDH and DHS. The agreement provides that counties or groups of counties should have the

opportunity to develop, propose, and operate a purchasing system for the health care of the families, children and the elderly in MA and GAMC. Through this process, counties which choose to participate in PMAP will share power in the purchasing of health care for these enrollees. Issues which will need further discussion and resolution include the rate setting mechanism. The task force feels that, regardless of whether the contracting agency for the managed care public program business is DHS or a county agency, all principles outlined in this report should apply.

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Appendix B
Minnesota State Plan Language
(Network)

STATE: MINNESOTA ATTACHMENT 2.1-A
Effective: October 1, 1994
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"Health Maintenance Organization" (HMO) means an entity which:

1. provides, either directly or through arrangements with providers or other persons or entities, comprehensive health services for a fixed sum without regard to the frequency or extent of services furnished to a particular enrollee;

2. is organized primarily for the purpose of providing health care services;

3. makes the services it provides to its Medicaid enrollees as accessible to them as those services are to non-Medicaid enrollees within the HMO's service area, in terms of timeliness, amount, duration and scope; and

4. makes provision against the risk of insolvency to the satisfaction of the State and assures that Medicaid enrollees will not be liable for the HMO's debts in the event of insolvency.

This definition includes, but is not limited to:

1. a non-profit corporation or any statutory or home rule charter city or county that has been issued a certificate of authority by the Department of Health pursuant to Minnesota Statues, chapter 62D;

2. an integrated service network (ISN) licensed by the Department of Health pursuant to Minnesota Statutes, chapter 62N; and

3. a community integrated service network (CISN) licensed by the Department of Health pursuant to Minnesota Statutes, chapter 62N.

Appendix C

Encounter Claim Required Fields

I. HCFA-1500

Submitting Provider ID
HMO Provider ID
Group / Clinic ID
Recipient ID
Recipient DOB
Other Coverage Ind
Third Party Payment Amount
ICD-9 Diag Code
Procedure Code
Procedure Modifier
Units
Dates of Service
Place of Service
Treating Provider ID

II. Dental

Submitting Provider ID
HMO Provider ID
Group / Clinic ID
Recipient ID
Recipient DOB
Other Coverage Ind
Third Party Payment Amount
Procedure Code
Procedure Code Modifier
Tooth Number and/or Surface
Date of Service
Place of Service
Treating Provider ID

III. Pharmacy

Submitting Provider ID
HMO Provider ID
Pharmacy ID
Recipient ID
Recipient DOB
Third Party Payment Amount
NDC Number
Quantity/Units
Days Supply
Date of Service
Prescribing Physician ID

IV. Inpatient Hospital

Bill Type
Submitting Provider ID
HMO Provider ID
Hospital Provider ID
Recipient ID
Recipient DOB
Third Party Payment Amount
From-Through Statement Covers Dates
Covered Billing Days
Admission Date
Type of Admission
Source of Admission
Patient Status
Condition Codes
Revenue Codes
Days / Rates
Diagnosis Codes
Surgery / Procedure Code
Service Date
Units of Service
Attending Physician ID

V. Outpatient Hospital / Other Facility

Bill Type
Submitting Provider ID
HMO Provider ID
Facility Provider ID
Recipient ID
Recipient DOB
Third Party Payment Amount
From-Through Statement Covers Dates
Diagnosis Code (ICD-9)
Procedure Code
Proc Modifiers
Service Date
Units of Service
Attending Provider ID

ESTIMATED CAPITATION PAYMENTS FOR MEDICAL EDUCATION DISPROPORTIONATE POPULATION ADJUSTMENT

The purpose of the spread sheets on medical education and disproportionate population adjustment (DPA) was to:

1. estimate the payments associated with medical education and DPA that are included in the inpatient part of the capitation rates.

2. calculate the medical education and DPA portion of the rates so that the effect on future increases in capitation volume can be estimated.

3. show how much of the Hennepin, metro and non-metro capitation rate differentials are explained by the inclusion of medical education and DPA.

Medical education and DPA are difficult to extract directly from the capitation rates (PMPM). Therefore, since capitation rates are derived from the fee for service (FFS) rates, FFS numbers were used as a basis for the calculations. Both medical education and DPA vary by hospital as a percentage of the inpatient payment under FFS. It was our intent to find the average capitation percentage of payments from FFS data that are medical education and DPA.

Medical education is generally categorized into two categories: direct and indirect. The direct medical education costs (resident and supervising faculty salaries/fringe benefits)of each hospital that has medical education were calculated from the Medicare cost report which includes all costs from all payers. A percentage was derived for each hospital. Indirect medical education (greater use of ancillary services due to inexperience, decreased productivity of assisting staff)is a subjective estimate. The Medicare indirect percentage was used for each hospital because that is the only method known to be used at this time although it is controversial. The DPA was simply calculated as a fixed percentage of each hospital's payment based on the current DPA percentage add-on of each hospital that qualifies for a DPA. The total calculated percentage of inpatient hospital payment that was associated with medical education and DPA was further adjusted by the percentage of capitation rates that are inpatient so that the amount could be expressed as a percentage of the entire capitation rate (PMPM).

Although dollar figures were provided, both gross and as a PMPM, the percentages of the PMPM are the important numbers. This is because, as capitation expands, the percentage would automatically expand the dollar amount. Multiplying the enrollee volume by a constant percentage of rates results in a better

estimate than attempting to reestimate gross figures in the future as enrollment increases. Inpatient medical education and DPA are 7.0% of total rates, 9.4% of the Hennepin rate, 4.6% of the metro rate and 2.3% of the non-metro rate.

The results of the analysis are noteworthy because the PMPM rate differential due to medical education and DPA in the three geographic areas was thought to explain a large amount of the PMPM variance. After elimination of these costs, the rate differentials are still high. Hennepin is 6.7% ($184.75)above metro ($173.18) and non-metro is 12% ($152.33)below metro. Hennepin is 21.3% above non-metro versus the current differential of 30.8% before medical education and DPA are removed. Thus, the PMPM differentials have to be due to the hospital specific FFS rates and differences in FFS utilization and acuity by geographic area.

The two primary weaknesses of this estimation approach are the use of the Medicare indirect medical education number and the use of the current inpatient percentage of the PMPM. This could change when different eligibility groups are added. The disabled, for example, may use a smaller percentage of their total cost on inpatient services.

It should be noted that provider entities other than inpatient also have medical education costs. For example, although MA does not pay directly for medical education in outpatient rates, these costs are inherently included because provider charges are increased due to medical education costs and rates are based on a percentile of charges. In any event, the legislature will ultimately decide how much of the PMPM that is associated with medical education and DPA is diverted to a separate fund.

Summary of DPA and ME Cost Components of PMAP and PGAMC in CY 1996

	Hennepin	Metro	Regional	Total
(1) Total ME $ in PMAP Rates	$11,682,528	$3,277,301	$196,852	$15,156,681
(2) DPA $ in PMAP Rates	$5,896,793	$4,237,335	$80,236	$10,214,364
(3) DPA and ME $ in PMAP Rates	$17,579,321	$7,514,635	$277,088	$25,371,045
(4) 1996 PMAP Member-Months(1)	821,757	841,659	65,517	1,728,933
(5) 1996 PGAMC Member-Months(1)	91,323	62,094	10,977	164,394
(6) Total 1996 PPHP Member-Months(1)	913,080	903,753	76,494	1,893,327
(7) 1996 PMAP ME PMPM(2)	$12.79	$3.63	$2.57	$8 01
(8) 1996 PMAP DPA PMPM(3)	$6.46	$4.69	$1.05	$5.39
(9) PMAP DPA and ME PMPM	$19.25	$8.31	$3.62	$13.40
(10) CY 1996 Standardized PMAP Rates(4)	**$204.00**	**$181.49**	**$155.95**	**$191.54**
(11) Rate as a Percent of Metro Rate	112.40%	100.00%	85.93%	105.54%
(12) 1996 PMAP ME PMPM(2)	$12.79	$3.63	$2.57	$8.01
(13) ME as % of Rate	6.27%	2.00%	1.65%	4.18%
(14) CY 1996 Rates w/o Med. Ed.	**$191.21**	**$177.86**	**$153.38**	**$183.53**
(15) Rate as a Percent of Metro Rate	107.50%	100.00%	86.23%	103.19%
(16) 1996 PMAP DPA PMPM(3)	$6.46	$4.69	$1.05	$5.39
(17) DPA as % of Rate	3.17%	2.58%	0.67%	2.82%
(18) CY 1996 Rates w/o DPA	**$197.54**	**$176.80**	**$154.90**	**$186.15**
(19) Rate as a Percent of Metro Rate	111.73%	100.00%	87.61%	105.28%
(20) PMAP DPA and ME PMPM	$19.25	$8.31	$3.62	$13.40
(21) DPA and ME as % of Rate	9.44%	4.58%	2.32%	7.00%
(22) CY 1996 Rates w/o DPA and ME $(5)	**$184.75**	**$173.18**	**$152.33**	**$178.14**
(23) Rate as a Percent of Metro Rate	106.68%	100.00%	87.96%	102.87%

Notes:

(1) Annualized from actual enrollment for January thru April, 1996.

(2) Calculated by dividing line (1) by line (6).

(3) Calculated by dividing line (2) by line (6).

(4) Applies rates in each region to a standard MA and GAMC case mix (statewide enrollment in January, 1996)

(5) Calculated by subtracting line (16) from line (10).

Insurance Department Actuarial Form 1
1993 Period Data

Type of Service	Unit per 1000 Members	Cost per Service	PMPM
Inpatient Hospital			
Medical/Surgical			
Mental/Nervous			
Skilled Nursing			
Maternity			
Out-of-area			
Total			
Outpatient Hospital			
Emergency Room			
Outpatient Surgery			
Laboratory, X-Ray			
Home Health			
Extended Care			
All Other			
Total			
Physician Services			
Office Visit			
Capitated			
Non-capitated			
Inpatient Hospital Visits			
Inpatient Hospital Visits (Psych)			
Maternity			
Well Baby Visits			
Emergency Room Visits			
Inpatient Surgery			
Outpatient Surgery			
Injections/Immunizations			
X-Ray			
Laboratory			
Outpatient Mental Nervous			
Anesthesia			
Miscellaneous Office Vist			
Capitated			
Non-capitated			
Miscellaneous			
Total			
Other Services			
Ambulance			
DME/Prosthetics			
Speech & Hearing			
Chiropractor			
Podiatrist			
Prescription Drugs (10/92-9/93)			
Total			
Grand Total			

REC 9/27

HealthPartners

8100 34th Avenue South
P.O. Box 1309
Minneapolis, MN 55440

September 25, 1996

Mr. Paul Olson
Minnesota Department of Human Services
444 Lafayette
St. Paul, MN 55155

Dear Mr. Olson:

Thank you for the opportunity to participate in the managed care rate setting task force and to comment on the Department of Human Services' (DHS) Draft Rate Setting Report of September 9, 1996 ("draft report").

HealthPartners put together an internal workgroup to discuss the PMAP rate setting process and to review the draft report. This letter presents the results of our internal workgroup. We request that our letter be included as an appendix to the DHS/managed care task force report.

Our impression generally is that the draft report presented a confusing competitive bid process which is compounded by the lack of clearly defined rules. Further, we're concerned about the contradictions between incentives and required participation. If no change is made to the report, we will support a continuation of the current rate setting methodology as believe it's preferable to the process proposed in the draft report.

There are three major sections to our letter. The first section discusses the importance of the integrity of the competitive bid process and the elements needed to maintain that integrity. The second section outlines the competitive bid structure we've designed and are proposing as an alternative to that proposed in the draft report. The third section includes our comments or concerns on several other areas of the rating process. Appendix A, lists the specific changes to the draft report, resulting from the issues discussed in our letter.

Integrity of the Competitive Bid Process

We feel that maintaining the integrity of the competitive bid process is crucial to its long-term success. If the process is vulnerable to game-playing by the networks or DHS, or is perceived as advantaging certain players, it will be viewed with skepticism and is unlikely to be successful.

The importance of maintaining the integrity of the competitive bidding process make it critical that all elements of the bidding and negotiation process are clearly defined in the Request for Proposals (RFP) and that the competitive bid process is outside of the provisions of Rule 101.

Defined Bidding Process: Based on the draft report, we are concerned that DHS would establish or adjust the rules *after* receiving the bids. For example, the report refers to "adjust[ment of] their bid after the initial submission" and indicates that DHS would not determine how many networks would be selected until the bids have been reviewed.

Lack of definition of the bid requirements or the selection process would make it difficult for networks to develop their bids and is unlikely to result in an equitable process. Adjustment of the rules after the bids are submitted may encourage game-playing. Rules must be pre-established and must be followed by all parties in order to create fair opportunities.

The importance of maintaining the integrity of the competitive bidding process make it critical that all elements of the bidding and negotiation process are clearly defined in the RFP, including:

- the number of networks which will be selected in each geographic area;
- the criteria and method of network selection; and
- the situations and rules under which bids may be adjusted after the initial submission.

Rule 101: The draft report appeared to conclude that the "incentive for a low bid needs to be exclusion from the opportunity to do business". However, the report also discussed reliance on Rule 101 "as a tool to encourage changes to the submitted bids" and later indicated that the ability to eliminate networks will be "subject to Rule 101". Thus DHS seems to plan to use Rule 101 as a threat in the bidding process and at the same time be concerned that Rule 101 limits their ability to implement a bidding process which requires that networks be excluded.

Rule 101 is incompatible with competitive bidding. A competitive bidding process cannot occur if DHS may selectively invoke Rule 101 to force changes to submitted bids. (How is it determined when the "tool" of Rule 101 will be used?) It also cannot occur if Rule 101 limits the ability of DHS to follow a defined network selection process.

If DHS does not believe that a competitive bid approach is workable without requiring networks to accept rates defined by DHS, it is not clear why a change from the current regulatory rate setting method is being advocated. (In fact, isn't this the current method?)

Health Partners' Proposed Competitive Bid Structure

We propose what we consider a workable competitive bid structure as an alternative to the process described in the draft report. The following is an outline of our proposed competitive bid structure.

Geographic Areas: Geographic areas would be defined by county. Counties with 5,000 or more eligible public program members would be separate geographic areas. Counties with less than 5,000 public program members would be combined into areas by DHS, in consultation with the counties.

Bid evaluation and network selection would occur separately for each geographic area. Networks would submit separate bids for each geographic area in which they choose to participate and must be able to provide services throughout the area.

Bid Ranges: The acceptable bid ranges would be published in the RFP. The top of each bid range would be 115% of the bottom of the bid range. Midpoints of the bid ranges would be set to meet the DHS budget.

Bid ranges should vary by geographic area. Due to concerns regarding the source of the geographic variation built into the existing rate system, it may not be appropriate to continue the current geographic rate factors. Rather, the geographic rate factors used in the initial RFP could be based on geographic rate variations observed in commercial populations (for example, the small employer market). Geographic rate factors for subsequent bidding periods could be adjusted based on the relationship between the prior bids by region. (For example, if bids for non-metro regions were near the top of their bid ranges, and bids for the metro regions were near the bottom of their bid ranges, the geographic factors used for the next bidding period would be adjusted, with increases to the factors for non-metro regions, and corresponding decreases to the factors for metro regions.)

Setting the top of the bid ranges equivalent to the DHS budget has been discussed, given a concern that otherwise the bidding process would result in higher costs to the state than under the current rate setting methodology. If it is not believed that a competitive bid approach will result in savings for the state, it is not clear why a change from the current regulatory rate setting method is being advocated. Further, setting the top of the bid ranges to meet the DHS budget prohibits increases in rates for geographic areas underpaid by the current rate system.

Awarded Bids: All bidders within 3% of the bottom of the bid range in each geographic area would be automatically accepted. If this results in less than two selected networks, the two networks with the lowest bids would be accepted. Thus, the number of networks available in each geographic area would range from a minimum of two to an unlimited maximum.

Selected networks would be paid based on their bid rate.

Rate Components: The bid rate in each geographic area would be the base rate. Rate cell relationships for age, gender, and program eligibility would be defined in the RFP, as well as any further risk adjustment methodology that may be used. The base rate would be net of Disproportionate Population Adjustment (DPA) and Medical Education (ME) funding. If either (or both) are funded through the PMAP rates, the rates paid to selected networks would be their bid rates adjusted to include DPA/ME funding based on each network's historical use of ME and DPA providers in that geographic area.

Contract Length: There would be a two-year contract period. The bids would include rates for the first year of the contract period. An index factor, defined in the RFP, would be applied to the first year rates to produce the rates for the second year.

RFP: As discussed in the prior section, the importance of maintaining the integrity of the competitive bidding process makes it critical that all elements of the bidding and negotiation process be clearly defined in the RFP.

Other Areas

In addition to our concern with the overall bidding process, we have the following comments or concerns on other areas of the rating process:

Retroactive Eligibility: The current fee-for-service reimbursement for retroactive eligibility must continue. A "complex risk adjustment system" will not be able to equitably handle retroactive eligibility without being so complex as to approach FFS payment.

Medical Education: We agree with the recommendation that ME funding be removed from the managed care rates and funded through a separate mechanism. However, legislative approval of a new funding mechanism has not yet occurred and is not guaranteed. Protection needs to be added to ensure that the worst case scenario - where medical education funding is removed from the PMAP rates without the establishment of a separate funding mechanism - won't occur.

Disproportionate Population Adjustment: DHS has disagreed with the task force's recommendation to remove the DPA funding from the PMAP rates due to a concern that this would cause the DPA monies to be vulnerable to budget cuts. If the DPA funding remains in the rates, network bids should be net of DPA funding so the bids can be compared on a consistent basis. The rates paid to the selected networks would be their bid rates adjusted to include DPA/ME funding based on each network's historical use of ME and DPA providers in that geographic area.

Network Qualifications: It is important that the consumer protection standards such as solvency and quality of health care requirements are equally applied to all networks.

New Populations: The draft report briefly mentioned an expansion of PMAP to public program populations, such as the disabled, not currently included in capitated managed care (page 8). Enrollment of new populations in PMAP would bring additional complexities and issues into the rating process, such as:

- Due to the multiple sources of funding for certain populations, such as the disabled, additional funding sources would need to be considered in setting the capitation rates and overall budget.
- The new populations would require the addition of further variables and complexity to a risk adjustment system. Also, as discussed in the draft report, risk adjustment becomes much more important with enrollment of the new populations (under either a DHS Determined Methodology or a Bid Methodology).
- The new populations require more and different types of services than the current PMAP populations. It would be necessary to evaluate which services are appropriate to include under a prepaid, capitation rate and program.

We encourage the formation of a special task force or workgroup to research the additional rating complexities and issues involved with the possible expansion of the PMAP program to new public program populations, such as the disabled.

Thank you for considering these comments. I look forward to our next meeting and an opportunity to discuss them with the managed care task force. If you have any questions, please call me at 883-7102.

Sincerely,

Dorothy G. Petersen, FSA, MAAA
Corporate Actuary

cc: Managed Care Task Force Members
Michael Scandrett, HMO Council
Andrea Walsh, HealthPartners
Anne Darnay, HealthPartners

Appendix A
Proposed Revisions to Draft Rate Setting Report

This appendix lists our proposed revisions to the draft rate setting report, dated September 9, 1996.

Retroactive Eligibility
Pages 9 and 10, Section III. B. (2): Strike the 2nd and 3rd paragraphs. Replace the last sentence of the 1st paragraph with "If current eligibility policies remain in effect, a fee-for-service payment will be continued, in order to not place undue financial responsibility on networks for care unauthorized by the network."

Medical Education
Page 9, at the end of section III. B. (4) and page 12, at the end of section IV. B. (3), add: "In the absence of a legislatively established and funded distribution mechanism, the ME funding will remain in the managed care rates."

New Populations
Addition of new section, III. B. (6) Possible Expansion of PMAP:

DHS anticipates an expansion of PMAP to those public program populations, such as the disabled, not currently included in capitated managed care. Enrollment of new, high risk, populations in PMAP will bring additional complexities and issues into the rating process, such as:

- Due to the current multiple sources of funding for certain populations, such as the disabled, additional funding sources will need to be considered in setting the capitation rates and overall budget.
- The new populations will require the addition of further variables and complexity to a risk adjustment system. Also, as discussed in section (3), risk adjustment becomes much more important with enrollment of the new populations (under either a DHS Determined Methodology or a Bid Methodology).
- The new populations require more and different types of services than the current PMAP populations. It will be necessary to evaluate which services are appropriate to include under a prepaid, capitation rate and program.

The managed care rate setting task force therefore recommends the formation of a special task force or workgroup to research the additional rating complexities and issues involved with the possible expansion of the PMAP program to new public program populations, such as the disabled.

Network Qualifications
Page 9, replace section III. B. (5), with: "The managed care rate setting task force assumes that the consumer protection standards such as solvency and quality of health care requirements are equally applied to all networks by the appropriate state agency."

DPA
Page 13, at the end of section IV. B. (4), add: "If the DPA funding remains in the managed care rates, network bids must be adjusted based on each network's historical use of DPA providers."

Bidding Process
Page 13, section IV. C., add after the 3rd paragraph: "All elements of the bidding and negotiation process will be clearly defined in the RFP, including:

- the number of networks which will be selected in each geographic area;
- the criteria and method of network selection; and
- the situations and rules under which bids may be adjusted after the initial submission."

Publication of the RFP
Pages 13-14 section IV. C. (1),

Replace the 1st bullet point with: "Geographic Areas: Geographic areas will be defined by county. Counties with 5,000 or more eligible public program members will be separate geographic areas. Counties with less than 5,000 public program members will be combined into areas by DHS, in consultation with the counties."

Replace the 4th bullet point with: "Rate Components: The bid rate in each geographic area will be the base rate. Rate cell relationships for age, gender, and program eligibility will be defined in the RFP, as well as any further risk adjustment methodology that may be used. The base rate would be net of DPA and ME funding. If either (or both) are funded through the PMAP rates, the rates paid to selected networks will be their bid rates adjusted to include DPA/ME funding based on each network's historical use of ME and DPA providers in that geographic area."

Replace the 6th bullet point with: "Acceptable Bid Ranges: The acceptable bid ranges will be published in the RFP. The top of each bid range will be 115% of the bottom of the bid range. Midpoints of the bid ranges will be set to meet the DHS budget. Bid ranges will vary by geographic area. Due to concerns regarding the source of the geographic variation built into the existing rate system, the current geographic rate factors will not be continued. Rather, the geographic rate factors used in the initial RFP will be based on geographic rate variations observed in the small employer market. Geographic rate factors for subsequent bidding periods will be adjusted based on the relationship between the prior bids by region. (For example, if bids for non-metro regions were near the top of their bid ranges, and bids for the metro regions were near the bottom of their bid ranges, the geographic factors used for the next bidding period would be adjusted, with increases to the factors for non-metro regions, and corresponding decreases to the factors for metro regions.)

Delete the 7th bullet point.

Replace the 8th bullet point with: "All elements of the bidding and negotiation process will be clearly defined in the RFP, including:

- the number of networks which will be selected in each geographic area;
- the criteria and method of network selection; and
- the situations and rules under which bids may be adjusted after the initial submission."

Submission and Evaluation of Bids

Pages 14-15, section IV. C. (2), delete all but the 1st paragraph. Add:
"Bid evaluation and network selection will occur separately for each geographic area. Networks will submit separate bids for each geographic area in which they choose to participate and must be able to provide services throughout the area."

Also add: "Contract Length: There would be a two-year contract period. The bids will include rates for the first year of the contract period. An index factor, defined in the RFP, will be applied to the first year rates to produce the rates for the second year."

Selection of Bidders and calculation of base level rates

Page 15, replace section IV. C. (3), with "All bidders within 3% of the bottom of the bid range in each geographic area are automatically accepted. If this results in less than two selected networks, the two networks with the lowest bids will be accepted. Thus, the number of networks available in each geographic area will range from a minimum of two to an unlimited maximum. Selected networks will be paid based on their bid rate."

Network Incentives

Pages 15-16, section IV. D. (1), delete the last 2 sentences of paragraph (a) and all of paragraph (b).

Children's
HEALTH CARE

Gillette Children's
Specialty Healthcare

December 4, 1996

Mr. Paul Olson
Director
Primary Care Payment Policy Division
Minnesota Department of Human Services
444 Lafayette Road
St. Paul, MN 55155

Dear Paul:

At the final meeting of the Managed Care Rate Setting Task Force, you invited those who wished to do so to submit letters of comment on the Task Force's draft report, which would then become part of the final report as an addendum. This letter is our response to that invitation, and it supersedes the letters we submitted in the earlier stages of that process.

Before offering specific comments on the final draft, we first want to express our appreciation for the opportunity to participate in that Task Force process, and to thank you and your colleagues at the Department of Human Services for the time and effort you committed to it.

Following are our comments on specific components of the final draft:

Disproportionate Population Adjustment (DPA)

We very strongly reiterate our support for the recommendation of the Task Force that Disproportionate Population Adjustment (DPA) payments continue to be treated separately, rather than the Department's recommendation that they be incorporated into the new managed care rates. Segregating DPA will best assure that such payments will continue to be directed to those providers, such as the children's hospitals, who serve high percentages of the Medicaid population.

For the children's hospitals collectively, DPA payments in 1995 totaled $7.4 million; Children's Health Care's portion was $5.8 million, Gillette Children's Specialty Healthcare's $1.6 million; the significance of these

payments to the financial viability of the children's hospitals is evidenced by the fact that in both instances, DPA payments exceeded each hospital's total operating income in 1995.

We further advocate initiation of DPA-type payments for outpatient services, which are an increasing segment of overall services to the Medicaid population.

Benefit Set

While the draft report does not define the benefit set on which the new rate setting methodology would be based, we advocate continuation of the current Medicaid benefit set as the base.

Risk Adjustment

As we have expressed at meetings of the Task Force and in comments on previous drafts, we believe that a risk adjustment mechanism, such as that currently under development in the separate Risk Adjustment Work Group, should be adopted before implementation of a managed care rate setting methodology; and, we feel very strongly that such a mechanism must specifically address the uniqueness of the pediatric segment.

Appeals Process

We advocate retention of the appeals process currently available to Medical Assistance clients and providers. This would help to assure continuation of the present system of checks and balances between healthcare networks, providers and recipients.

Catastrophic Coverage

Because of the type of catastrophic cases we see within the children's hospitals and the extraordinary resources they absorb, we are concerned that the proposed payment methodology could lead to situations of extreme financial inequity, causing providers to absorb a greater share of the costs of such cases than is reasonably prudent. We believe that the state must reinsure for such cases so that providers are not placed at an undue risk.

Retroactive Eligibility

In contrast to the Department's position that a risk adjustment mechanism could handle retroactive eligibility situations, we continue to advocate retention of the fee-for-service payment system for such situations. We recommend that retroactive eligibility payments be based on Medicare cost-finding principles and that the Department purchase TPA services for these low-volume situations.

Again, we thank you for the opportunity to participate in this process. Should you have any questions, please feel free to contact John Tremble at 220-6057 or John Tomlin at 229-3841.

John S. Tremble
Director of Revenue Management
Children's Health Care

John W. Tomlin
Vice President of Finance
Gillette Children's
Specialty Healthcare

JST:JWT:pa

cc: J. Ron Pratt
The Children's Hospitals Group

DHS RATE SETTING COMMITTEE

Three major areas of concern include:

I. TIMELINE FOR IMPLEMENTATION

If the concept of moving toward more of a competitive bid model is adopted to replace the current regulated rate model, there are numerous implementation issues which must be addressed. These issues not only involve fair treatment of networks and providers but also issues associated with ensuring the continuity of care for enrollees. These components are critical to the success of any changes in the rate setting model. For example:

- Risk adjustment
- Detailed criteria to be utilized in evaluating submitted bids
- Establishment of budgeted trend factors
- Development methodology to be used by DHS for establishing ranges which will take into account changes in utilization brought about by eligibility changes recently enacted or enacted in the future.

Given the significant magnitude of what remains to be resolved, the time table for adopting the new rate methodology needs to have a more realistic implementation date. In addition, the recent agreement between the MDH, DHS, and AMC in which the role of counties is changed and may affect rate development is further reason for changing the implementation date. As such, implementation should be delayed until at least January, 1999.

II. RISK ADJUSTMENT

The report heavily incorporates the use of risk adjustment even though the key factors of any risk adjustment proposals are still under study. It is important to keep in mind that the rates currently used by DHS include factors such as geographic area and eligibility category as a basis for the rates. These factors have a strong track record and provide more predictability than age and sex alone. Any risk adjustment mechanism must be carefully evaluated prior to implementation to determine the cost/benefits of implementation across all programs. In other words, we want to be sure that the system we develop to replace the current one should bring us more benefits than the current one given the investment costs. Risk adjustment methods are still in the development stage and the report currently places heavy emphasis on their use. It would seem premature to premise our work on untested models. One approach would be to have selective testing of risk adjustment only for the pilot projects for persons with disabilities. However, it should be noted for these pilot projects that if an area or county does not have choice of care networks, then risk adjustment is not necessary.

III. ESTABLISHMENT OF BID RANGE

Establishment of the bid range for networks will be critical to the bidding process. With the loss of fee-for-service data, established methodologies for trend factors will be gone. Since DHS will have encounter information available, details need to be developed which will establish well supported ranges that factor in not only utilization changes but also the impact of eligibility and benefit changes implemented in the future. The state budget level, a key element of the proposed method, needs to be developed through the use of appropriate data.

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