

State and Local Policy Program

**No Easy Cure:
Possible Options
for Controlling Minnesota's
Medical Assistance Spending**

HUBERT H. HUMPREY INSTITUTE OF PUBLIC AFFAIRS

UNIVERSITY OF MINNESOTA

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A handwritten signature in black ink that reads "Estelle Brouwer". The signature is written in a cursive, flowing style.

**Estelle Brouwer
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Executive Summary

Chapter One: Trends in Minnesota's Medical Assistance Spending

Medicaid spending has grown rapidly over the past several years. Between 1985 and 1992, Minnesota's total spending on Medicaid, or Medical Assistance, increased from approximately \$993 million to \$1.9 billion. This is an increase of 92 percent, or 13 percent per year. Total Medical Assistance spending per recipient during this period increased 28 percent (4 percent per year), from \$2324 to \$3,606.

Minnesota's single largest category of Medical Assistance spending In 1992 was nursing homes at approximately \$675 million, followed by Inpatient hospital services (\$250 million), Intermediate Care Facilities for the Mentally Retarded (ICFs-MR - \$147 million), HMOs (\$133 million). Regional Treatment Centers (RTCs - \$121 million), physician services (\$95 million) and prescribed drugs (\$88 million).

In terms of spending per recipient, the RTCs ranked first in 1992, at \$68/440, followed by ICFs-MR (\$31,769), nursing homes (\$16,223), inpatient hospital services (\$4,548), HMO services (\$1,155), prescribed drugs (\$290) and physician services (\$288).

In some categories (inpatient hospital services, physician services, prescribed drugs), Minnesota's experience in terms of growth in per recipient spending compares quite favorably to relevant national inflation factors. For a variety of reasons, the state's experience in other areas (especially nursing homes, ICFs-MR and RTCs) compares less favorably.

For nursing homes, ICFs-MR and RTCs, all of the growth in total Medical Assistance spending between 1985 and 1992 can be attributed to increases in per recipient spending. For inpatient hospital services, physician services, prescribed drugs and HMOs, growth is due to a combination of changes in per recipient spending and changes in the numbers of recipients served.

Chapter Two: Support for Individuals, Not Institutions

Minnesota's system of care for the elderly is heavily biased toward institutional care and away from non-institutional, community-based forms of care. For people with disabilities that are less severe, institutional care is generally more expensive than non-institutional care. One possible way to address this imbalance would be to limit Medical Assistance spending on nursing homes while placing greater emphasis on alternative forms of care.

Advantages of this approach are that it could control long term growth in Medical Assistance spending on long term care, it would move Minnesota toward a "new paradigm" for long term care, and older people and their families tend to be at least as satisfied with care they receive in alternative settings as they are with nursing home care.

Obstacles to implementing this option include the state's difficult financial situation, the threat of a Boren Amendment challenge on the part of nursing home providers, and the fact that adequate community options do not yet exist throughout the state for nursing home residents who could be displaced if the state's nursing home spending were reduced.

Despite the deinstitutionalization/community integration movement of the last decade, Minnesota's system of services for persons with developmental disabilities still relies more heavily than other states' on institutional care. Minnesota's system of services for people with serious mental illness is also biased toward institutional care and is even more lacking in community alternatives. For both populations, institutional care tends to be more expensive than community care. A possible way to address these imbalances is to limit Medical Assistance spending on institutions for people with developmental disabilities and mental illness while increasing the emphasis on development and utilization of alternative forms of care.

The advantages of this option include the fact that it would contribute to a service environment that is less institutionally biased, more cost-effective and more focused on meeting the needs of individual clients.

The disadvantages are that it could create economic disruption in communities whose institutions are closed, and could result in some RTC residents being moved to locations far away from their families.

The most important obstacle to implementing this option is the political difficulty of doing so.

Fund consolidation is often carried out as a means of ensuring that service dollars "follow" clients, rather than clients following dollars to funded entities. It may be that some of the lessons learned through Minnesota's implementation of the Consolidated Chemical Dependency Treatment Fund can be applied in other areas.

Minnesota's system of services for older people is funded through many sources, is administered by many entities and is not well coordinated. A possible option for dealing with this problem is to consolidate the funding and administration of services for Minnesota's elderly citizens.

The advantages of this option are that it would lead to greater efficiencies and would help set the stage for a system that is more flexible and more focused on meeting the needs of individual senior citizens.

A perceived disadvantage of this option is that, by consolidating funds, some elderly persons who are currently receiving services will somehow be cut off from those services. Because this fear does exist, it is crucial that consumers be represented all through the process of designing and implementing a fund consolidation strategy.

Obstacles to implementing this option include the political difficulty of doing so, and the federal government's Medicaid financial reporting requirements.

Like its system of services for the elderly, Minnesota's system of services for persons with developmental disabilities is funded through multiple sources and administered through multiple entities. One way to address this problem is to attempt to consolidate the funding and administration of services for persons with developmental disabilities.

The advantages of this possible option are that it would lead to great efficiencies and would help set the stage for a system that is more flexible and more focused on meeting the needs of individual consumers.

The disadvantages and obstacles to implementing this option are similar to those related to the previous option, consolidating funding and administration of services for elderly citizens.

Chapter Three: Limit Medical Assistance Benefits to the Middle Class

Anecdotal evidence suggests that increasing numbers of elderly people are transferring their wealth to family members to avoid "spending down" to Medicaid eligibility levels when they enter a nursing home. To the extent that these individuals actually do enter nursing homes, this practice places an increasing burden on the Medicaid program to pay nursing home costs for individuals who could actually afford to pay for their care. A possible approach to addressing this problem is to attempt to limit asset transfers and/or recover transferred assets from elderly citizens. Because the state's range of possible action in this area is limited, it may be most productive to aggressively lobby federal policy makers for changes in the relevant federal laws and rules.

The primary advantages of this option are that it would save money for both the state and federal government and that it could help to encourage the use of less expensive alternatives to nursing homes.

Two obstacles to implementation of this option are our society's deeply held belief in the right of older people to pass on an inheritance to their children, and the fact that enforcement of asset transfer rules can be difficult

Connecticut's system of offering private long term care insurance pegged to the amount of assets an elderly person wants to protect has two key disadvantages: 1) it subsidizes private insurers, and 2) it explicitly uses the Medicaid system to protect the assets of middle class people.

Chapter Four Basic Benefit Level for All Minnesotans

Minnesota policy makers have devoted a great deal of attention over the past few years to various efforts to improve access to health care for those who lack adequate health insurance. These efforts culminated in 1992 with enactment of the HealthRight (MinnesotaCare) Act. An issue that has generated much discussion in each of Minnesota's efforts to plan for expanded access to health care is which health insurance benefits should be included in a "basic" benefit package. The approach discussed in this chapter would attempt to provide the basic benefit level defined by MinnesotaCare to all Minnesotans. This approach would extend the MinnesotaCare benefit package to enrollees in Minnesota's Medical Assistance and General Assistance Medical Care programs, and, through a tax mechanism, to those whose health insurance is provided by their employers.

The chief advantages of this approach are that it would generate savings for the state, and would help to streamline and simplify the health care system.

The disadvantages of extending the MinnesotaCare benefit package to Medical Assistance and General Assistance Medical Care are that benefits would be reduced for individual recipients, and the MinnesotaCare benefit package may not be adequate to meet the needs of some individuals.

The federal government's Medicaid laws and regulations could present an obstacle to implementation of the Medical Assistance component of this approach.

Disadvantages of the tax component of this approach are that it would complicate the state income tax filing process, would disproportionately affect middle-income taxpayers, and could result in some families reducing their health insurance coverage to avoid a tax increase.

Chapter Five: Assure that Consumers Receive Lowest Cost Appropriate Care

Managed care is widely seen as an effective means both of saving health care dollars and ensuring that health care consumers receive appropriate care. Minnesota is a national leader in the use of managed care to provide services for its AFDC Medical Assistance population, but may be able to further expand the use of managed care to other populations and to other geographic areas within the state.

The advantages of this option are that it could save state Medical Assistance dollars and improve the quality of care for many individuals.

A disadvantage of managed care programs is that managed care arrangements that are not monitored carefully enough can sometimes restrict, rather than improve, access to health care.

An obstacle to implementing this option is that because of the financial risk involved, it can be difficult to recruit and retain entities to serve as the "managers" of care. In sparsely populated areas with limited numbers of providers, managed care can be difficult to implement

Chapter & Other Possible Reforms

Minnesota's total Medical Assistance spending is growing rapidly. Because of the entitlement nature of the program, total Medical Assistance is not limited - as most government programs are -- to a specific appropriation determined by the legislature. The possible option discussed in this section would cap the state's total Medical Assistance spending.

The advantages of this possible option are that it would save money for the state and, if it were carefully implemented, could contribute to more innovation in the way the Medical Assistance program is administered.

The disadvantages are that it would very likely lead to reductions in health care benefits for Medical Assistance recipients, and to increased uncompensated care burdens on public hospitals.

There are two primary obstacles to implementation of this option:

- 1) Developing a mechanism for holding total MA spending within the designated appropriation would be a politically charged, contentious process, and**
- 2) The federal government's current Medicaid laws and regulations would likely not allow such a dramatic change in Minnesota's program. This option would very likely require a change in federal law.**

Introduction

Context

This study was conducted as part of a larger effort - involving the Humphrey Institute's State and Local Policy Program, the Minnesota Business Partnership, the Citizens League, the Minnesota Taxpayers Association and the Minnesota Chamber of Commerce - to analyze and better understand why particular pieces of the state's budget are growing so rapidly, and to consider alternative ways of controlling that growth. Health care was selected as a focus both because health care programs comprise a major portion of the state's general fund budget and because the state's health care expenditures are growing very rapidly. The focus was further narrowed to Medical Assistance (Minnesota's Medicaid program), because it is the largest single source of state funding for Minnesota's health care programs. All but two possible options discussed in this report focus directly on Medical Assistance spending.

A Capsule History of Medicaid

In order to understand the context of this study, it is helpful to also understand the history of the Medicaid program.

Medicaid (Title XDC of the Social Security Amendments of 1965) was enacted as a counterpart to Medicare, the national program that provides medical insurance for the elderly. Unlike Medicare, however, Medicaid was to be financed jointly with the states and to serve only certain groups enrolled in public assistance programs (Old Age Assistance, Aid to Families with Dependent Children, Aid to the Blind, and Aid to the Partly and Totally Disabled) and the "medically needy." Medicaid was intended to improve the access of these low income people to mainstream medicine.

Under Medicaid, states retain considerable discretion to set their own standards, within federal guidelines, for eligibility, services and other elements of the program. The federal government pays a portion of states' Medicaid costs - the federal cost-sharing rate varies by state depending on a number of economic and demographic factors. Currently, the federal government pays approximately 53 percent of Minnesota's total Medicaid costs.

Intent

It will be immediately obvious to readers that this report does not offer a simple formula for controlling Medical Assistance spending. Rather, it attempts to describe and analyze a number of possible options for doing so. These possible options were chosen through a research and consultative process involving the author and an advisory committee composed of representatives of the University of Minnesota's Schools of Public Health and Social Work, the Humphrey Institute, the Minnesota Extension Service, and the Minnesota Business Partnership.

The analysis in this report is not intended to imply or conclude that the possible options considered are the only options that would help to control Medical Assistance spending, or even that they are the best ones. The report does, however, reflect the author's and the committee's best efforts to design possible options that are within the state's control, that could reduce state spending, in the short and/or long term, and that might also contribute to a more effective, fair and efficient system. Most of these possible options would require some degree of further study and/or development prior to their implementation. In particular, the options considered

in Chapters 4 and 6 - "Basic Benefit Level for All Minnesotans," and "Other Possible Reforms" -and Sub-option 3 under Option C2 - "Turn over the RTCs to boards, etc" - require more thorough analysis of advantages, disadvantages and savings potential than could be accomplished within the scope of this study.

Finally, progress is already being made in some of the areas discussed in this report; in those cases, an effort is made to credit those responsible.

Health Care Reform Themes

As this report was researched and written, several themes emerged. Where possible, discussions of possible options are organized around these themes.

The first theme is the idea of support for individual consumers rather than institutions. According to this theme, the state should stop subsidizing institutions that house people who need certain kinds of care and focus instead on providing appropriate services that will meet the specific needs of individual consumers. While it is not clear that this approach will save money in the short run, many believe that it would contribute to a system that is more flexible and better able to meet the needs of clients.

Possible options related to this theme include limiting Medical Assistance spending on nursing homes and institutions for people with developmental disabilities while placing greater emphasis on alternative forms of care, both for elderly people and for people with developmental disabilities or mental illness; and consolidating funding and administration of services, both for the elderly and for those with developmental disabilities.

A second theme is the idea that the "middle class" should not receive Medical Assistance benefits. According to this theme, the Medicaid program was created to provide health care for people without the means to pay for it themselves, and should therefore not subsidize care for those who can afford to pay. Actually applying this theme to the Medical Assistance program is a complicated task, largely because there is little agreement in society about how much an individual should be required to give up in order to pay for their own health care.

Only one of the possible options discussed in this report - increasing efforts to limit asset transfer and/or recover transferred assets from Minnesota's elderly residents - is clearly related to this theme.

A third theme is that the state should create a means by which all Minnesotans have access to a *basic* level of health benefits. The possible options related to this theme include extending the MinnesotaCare benefit package to both the Medical Assistance and General Assistance Medical Care programs, and requiring workers who receive health insurance through their employers to pay state income tax on the value of their health insurance exceeding the value of the MinnesotaCare package. Although these steps taken alone would not ensure achievement of the goal of basic universal health coverage, they do represent one means by which the state could begin to move in that direction.

The fourth theme is assuring that consumers receive the lowest cost care that is appropriate to their needs. Several possible options are related to this theme, including expanding the use of managed care in Medical Assistance, and limiting Medical Assistance spending on nursing homes and other institutions while placing greater emphasis on alternative forms of care.

A fifth and final theme that is compelling but not discussed in this report because of time limitations is that many of the problems addressed through our Medical Assistance system could be prevented through better coordination of our health care, public health and social services systems. This is a theme that would seem to hold a great deal of promise for long term improvements in the way services are delivered and the outcomes that are achieved.

Chapter One

Trends in Minnesota's Medical Assistance Spending: 1985 to 1992

Medicaid spending, at both the state and national levels, has grown rapidly over the past several years. According to a recent Urban Institute report, national Medicaid spending grew from \$35.5 billion in 1984 to \$68.9 billion in 1990. During the same period, the number of Medicaid enrollees in the nation increased from 24.1 million to 28.4 million, and national Medicaid spending per enrollee increased from \$1,473 to \$2,428.¹

The Urban Institute report cites several drivers behind this growth, including the following: new federal mandates (including those covering pregnant women and children), the recession, rising health care costs, the aging of the population, and state efforts to shift previously state-funded services into Medicaid.²

Between fiscal years 1985 and 1992, Minnesota's total spending³ on Medicaid, or Medical Assistance (MA), increased from approximately \$993 million to \$1.9 billion, a total increase of about 92 percent, or 13 percent per year. Unduplicated recipient numbers during the same period increased by about 50 percent, from 351,342 to 528,910. Total MA spending per recipient increased from \$2,824 in 1985 to \$3,606 in 1992, an increase of approximately 28 percent, or 4 percent per year. (See Table 1 for data related to this paragraph.)

Table 2 lists Minnesota's total spending in several categories within the Medical Assistance program - nursing homes, ICFs-MR (Intermediate Care Facilities for the Mentally Retarded), inpatient hospital services, physician services, prescribed drugs, RTCs (Regional Treatment Centers, formerly known as state hospitals) and HMO (health maintenance organization) services. While there are many other categories of MA spending, these seven were chosen because they are the largest in terms of total spending and, taken together, they account for nearly 80 percent of Minnesota's total MA spending.⁴ As Table 2 illustrates, Minnesota's single largest category of MA spending in 1992 was nursing homes, at nearly \$675 million, Inpatient

¹Holahan, John, Teresa Coughlin, Leighton Ku, David Heslam, Colin Winterbottom, *Understanding the Recent Growth in Medicaid Spending*, The Urban Institute, Washington D.C., July 1992, Table 1.

²*Ibid*, p. 7.

³Total spending includes federal, state and county shares. From fiscal year 1985 through fiscal year 1992, the federal share was approximately 53 percent, state share was 42 percent and county share was 5 percent. On 1/1/91, the state took over responsibility for county share - effective state share since then is the sum of state and county shares, or about 47 percent.

⁴Department of Human Services MA expenditures reports (Forms OD-00239) list 43 separate service categories.

hospital services ranked second in terms of total spending, at \$250 million. Spending on ICFs-MR and HMO services ranked third and fourth respectively.

Table 3 shows total MA recipients and Table 4 shows total MA spending per recipient for each of the seven categories, for the years between 1985 and 1992. According to Table 4, per recipient spending for RTCs was consistently the highest of the seven categories, at \$68,440 in 1992. Second highest was per recipient spending on ICFs-MR - this figure was \$31,769 in 1992. Nursing homes ranked third in terms of per recipient spending, at \$16,223 in 1992.

Table 1
Minnesota's Total Medical Assistance Spending, Number of Recipients,
and Spending Per Recipient
1985 to 1992

(Federal dollars included, total spending — dollars in thousands)

Category	FY 1985	FY 1986	FY 1987	FY 1988	FY 1989	FY 1990	FY 1991	FY 1992
Total spending	\$992,713	\$1,019,173	\$1,064,253	\$1,170,322	\$1,245,103	\$1,403,246	\$1,623,187	\$1,907,504
Number of recipients	351,542	366,728	380,219	387,138	404,762	423,005	469,405	528,910
Spending per recipient	\$2,824	\$2,779	\$2,852	\$3,023	\$3,076	\$3,317	\$3,459	\$3,606

Note 1: Recipient numbers are unduplicated.

Note 2: From FY 85 to FY 92, federal Medicaid share was approximately 53%, state share was 42% and county share was 5%. In 1/91, the state took over county share - effective state share since then is about 47%.

Data source: Minnesota Department of Human Services Forms OD-00239, fiscal years 1985 through 1992.

Table 2
Minnesota's Total Medical Assistance Spending In Selected Categories
1985 to 1992
(Dollars in thousands, federal dollars included)

Service category	FY 1985	FY 1986	FY 1987	FY 1988	FY 1989	FY 1990	FY 1991	FY 1992
	\$440,717	\$442,240	\$456,448	\$450,433	\$454,556	\$506,531	\$589,169	\$674,607
Nursing homes								
ICFs-MR	\$104,431	\$107,332	\$108,107	\$110,854	\$112,092	\$119,676	\$131,843	\$146,835
Inpatient hospital	\$135,637	\$123,442	\$124,500	\$184,270	\$189,401	\$213,098	\$212,070	\$250,094
Physician services	\$50,836	\$55,380	\$65,378	\$61,416	\$74,912	\$77,850	\$91,139	\$95,149
Prescribed drugs	\$39,437	\$45,003	\$47,413	\$50,823	\$56,135	\$64,836	\$76,876	\$88,208
RTC's	\$109,282	\$108,808	\$107,915	\$118,883	\$109,798	\$118,182	\$123,035	\$121,482
HMO services	\$4,645	\$10,789	\$27,196	\$30,653	\$35,047	\$34,733	\$63,472	\$132,961

Note 1: Nursing homes category includes nursing homes (general), ICF-1 and ICF-2.

Note 2: RTCs category includes expenditures for MR, MI and CD residents.

Note 3: From FY 85 to FY 92, federal Medicaid share was approximately 53%, state share was 42% and county share was 5%. In 1/91, the state took over county share – effective state share since then is about 47%.

Note 4: The number of months of HMO service per enrollee per year varied substantially during this period, ranging from a low of 5.2 in 1986 to a high of 8.1 in 1989. This results in HMO spending numbers that are skewed. See text for more discussion.

Data source: Minnesota Department of Human Services forms 0D-00239, FY 1985 through FY 1992.

Table 3
Minnesota's Unduplicated Medical Assistance Recipients in Selected Categories
1985 to 1992

Service category	FY 1985	FY 1986	FY 1987	FY 1988	FY 1989	FY 1990	FY 1991	FY 1992
Nursing homes	42,392	48,124	50,579	48,701	44,025	39,231	48,139	41,584
ICFs-MR	5,758	5,838	5,833	5,718	5,137	4,607	4,642	4,622
Inpatient hospital	48,443	48,458	45,988	52,701	55,494	51,277	53,296	54,990
Physician services	265,282	273,170	266,912	265,514	280,049	294,112	317,147	330,612
Prescribed drugs	227,055	236,405	238,614	241,084	249,356	273,037	291,979	304,589
RTC's	3,806	3,082	2,908	2,474	2,146	2,040	1,893	1,775
HMO services	11,687	27,015	43,097	45,773	42,568	43,119	83,166	115,073

Note 1: Nursing homes category includes nursing homes (general), ICF-1 and ICF-2.

Note 2: RTCs category includes MR, MI and CD residents.

Note 3: The number of months of HMO service per enrollee per year varied substantially during this period, ranging from a low of 5.2 in 1986 to a high of 8.1 in 1989. See text for more discussion.

Data source: Minnesota Department of Human Services forms OD-00239, FY 1985 through FY 1992.

Table 4
Minnesota's Medical Assistance Spending Per Unduplicated Recipient in Selected Categories
1985 to 1992
(Federal dollars included)

Service category	FY 1985	FY 1986	FY 1987	FY 1988	FY 1989	FY 1990	FY 1991	FY 1992
Nursing homes	\$10,396	\$9,190	\$9,024	\$9,249	\$10,325	\$12,895	\$12,239	\$16,223
ICFs-MR	\$18,137	\$18,385	\$18,534	\$19,387	\$21,821	\$25,977	\$28,402	\$31,769
Inpatient hospital	\$2,800	\$2,548	\$2,707	\$3,497	\$3,413	\$4,156	\$3,979	\$4,548
Physician services	\$192	\$203	\$245	\$231	\$267	\$265	\$287	\$288
Prescribed drugs	\$174	\$190	\$199	\$211	\$225	\$237	\$263	\$290
RTCs	\$28,713	\$35,304	\$37,110	\$48,053	\$51,164	\$57,932	\$64,995	\$68,440
HMO services	\$397	\$399	\$631	\$670	\$823	\$806	\$763	\$1,155

Note 1: Nursing homes category includes nursing homes (general), ICF-1 and ICF-2

Note 2: RTCs category includes expenditures for MR, MI and CD residents.

Note 3: From FY 85 to FY 92, federal Medicaid share was approximately 53%, state share was 42% and county share was 5%. In 1/91, the state took over county (share – effective state share since then to about 47%.

Note 4: The number of months of HMO service per enrollee per year varied substantially during this period, ranging from a low of 5.2. In 1986 to a high of 8.1 in 1989. This results in spending per recipient number* that are skewed. See text for discussion.

Data source: Minnesota Department of Human Services Forms OD-00239, FY 1985 through FY 1992.

Table 5
Minnesota's Total Medical Assistance Spending in Selected Categories
FY 1985 and FY 1992
Total Percentage Increase and Average Annual Percentage Increase
(Dollars in thousands, federal dollars included)

Category of service	FY 1988	FY 1992	Percent Increase	Ave annual increase
Nursing homes	\$440,717	\$674,607	53%	7.6%
ICFs-MR	\$104,431	\$146,835	41%	5.8%
Inpatient hospital	\$135,637	\$250,094	84%	12%
Physician services	\$50,836	\$ 95,149	87%	12%
Prescribed drugs	\$39,437	\$88,208	124%	18%
RTCs	\$109,282	\$121,482	11%	1.6%
HMO services	\$ 4,645	\$132,961	2,762%	395%

Note 1: Nursing homes category Includes nursing homes (general), ICF-1 and ICF-2.

Note 2: RTCs category includes expenditures for MR, MI and CD residents.

Note 3: From FY 85 to FY 92, federal Medicaid share was approximately 53%, state share was 42% and county share was 5%. In 1/91, the state took over county share - effective state share since then is about 47%.

Note 4: The number of months of HMO service per enrollee per year varied substantially during this period, skewing HMO spending numbers. See text for more discussion of high growth rate in spending on HMO services.

Data source: Minnesota Department of Human Services Forms OD-00239, FY 1985 and FY 1992.

Tables 5 and 6 help to illustrate where the highest percentage increases have occurred in the seven categories, both in terms of total spending and per recipient spending. Table 5 shows that the average annual increase in total spending on HMO services between 1985 and 1992, at 395 percent, overshadowed all others. There were policy reasons for this very large increase in spending - throughout the late 1980's and early 1990's, the legislature was deliberately encouraging expanded use of managed care and HMOs in the MA program. (For background information, see "Option D1: Expand the Use of Managed Care in Minnesota's Medical Assistance System.")

In terms of the increase in per recipient spending (Table 6), HMO services still rank high, with a 27 percent average annual increase between 1985 and 1992. According to Department of Human Services officials, this relatively large average increase is due to several factors:

- 1) A great deal of the recent expansion in the use of HMOs in the MA program took place in Hennepin County, where health care costs (particularly those that are MA-reimbursed) are higher than in other parts of the state;
- 2) Because utilization of HMOs in the MA program was being phased in between 1985 and 1992, the number of months of HMO service per enrollee per year varied

substantially during this period, ranging from a low of 52 in 1986 to a high of 8.1 in 1989. The trend in number of months of service per enrollee per year moved gradually upward over the period from 1985 to 1992;

3) Some one-time administrative costs are incurred in the shift from a fee-for-service to a capitated payment system, artificially inflating spending figures when capitation is initiated.

At 19.8 percent, the RTCs ranked second in terms of average annual growth in spending per recipient. The major factor underlying this high growth rate is the fact that RTC populations have been shrinking in recent years, but the overall capacity of the system has not been reduced proportionately. (See "Option A4: limit Spending on Institutions for Persons with Developmental Disabilities, Mental Illness; Increase Emphasis on Alternative Forms of Care" for discussion of RTC capacity issue.)

Table 6
Minnesota's Medical Assistance Spending Per Recipient in Selected Categories
FY 1985 and FY 1992
Percent Increase and Average Annual Increase
(Federal dollars included)

Category of service	FY 1985	FY 1992	Percent increase	Ave annual increase
Nursing homes	\$ 10,396	\$16,223	56%	8%
ICFs-MR	\$ 18,137	\$ 31,769	75%	11%
Inpatient hospital	\$ 2,800	\$ 4,548	62%	8.9%
Physician services	\$ 192	\$ 288	50%	7.1%
Prescribed drugs	\$ 174	\$ 290	67%	9.5%
RTCs	\$28,713	\$66,440	138%	19.8%
HMO services	\$ 397	\$ 1,155	191%	27%

Note 1: Nursing homes category includes nursing homes (general), ICF-1 and ICF-2.

Note 2: RTCs category includes expenditures for MR, MI and CO residents.

Note 3: From FY 85 to FY 92, federal Medicaid share was approximately 53%, state share was 42% and county share was 5%. In 1/91, the state took over county share - effective state share since then is about 47%.

Note 4: The number of months of HMO service per enrollee per year varied substantially during this period, skewing HMO spending numbers. See text for more discussion of high growth rates in spending on HMO services.

Note 5: See text for discussion of high growth rates in spending on RTCs.

Data source: Minnesota Department of Human Services Forms OD-00239, FY 1985 and FY 1992.

Table 7 compares the annual increase in per recipient spending in each of the seven categories to the annual increase that could have been expected, based on national inflation factors for comparable services. It is important to note that the numbers in the column called "average annual increase in spending per recipient" do not take into account changes in the quantity or intensity of services consumed by each recipient in a given category. This factor has the potential to overstate growth rates in spending per recipient as compared to national inflation indexes. Per recipient spending on nursing homes, for example, would increase by some amount if the average length of stay of MA recipients in nursing homes was longer in 1992 than in 1985. A change in average length of stay, however, would have no effect on the relevant national inflation index.

Minnesota's actual MA experience in the categories of inpatient hospital services, physician services and prescribed drugs compared quite favorably to the expected increases based on national inflation factors. This almost certainly reflects the fact that general health care costs are growing as rapidly throughout the nation as they are in Minnesota.

In the other four categories, however, Minnesota's growth rates compared less favorably. For nursing homes and ICFs-MR, increases in spending per recipient are related to reimbursement increases approved by the legislature and to the fact that the resident populations of nursing homes and ICFs-MR are gradually becoming older and more disabled as more elderly people and individuals with developmental disabilities have either stayed at home longer or moved out of institutions into community settings.

A similar point can be made regarding the RFC resident population - as individuals requiring less intensive services have gradually moved into less restrictive settings in the community, the remaining resident population has become more and more disabled. It also appears, however, that rapid growth in per recipient spending on RTCs is largely attributable to the fact that the fixed costs of operating these institutions has gradually been spread over a smaller and smaller resident population.

As was pointed out earlier, rapid growth in the per recipient cost of HMO services is related to the fact that recent expansion in HMO utilization in the MA program has been concentrated in Hennepin County, where general health care costs are relatively high, and that the phase-in to HMO utilization in MA resulted in wide variations in number of months of HMO service per enrollee per year.

Table 7
Average Annual Increases
in Minnesota's Total Medical Assistance Spending Per Recipient
Compared to Expected Average Annual Increases, Based on Inflation
FY 1985 to FY 1992

Category of Service	Ave annual increase in spending per recipient	Expected ave annual increase, based on national inflation index
Nursing homes	8%	4.6%
ICFs-MR	11%	4.3%
Inpatient hospital	8.9%	8.8%
Physician services	7.1%	6.9%
Prescribed drugs	9.5%	8.5%
RTCs	19.8%	4.3%
HMO services	27%	7.7%

Note 1: See text for discussion of high growth rates in spending on RTCs and HMO services.

Note 2: Inflation factors are from "DRI-McGraw Hill Health Care Costs: National Forecast Tables."

Note 3: This table does not take into account changes in the quantity or intensity of services consumed by each recipient.

Note 4: The number of months of HMO service per enrollee per year varied substantially during this period, skewing HMO spending numbers. See text for more discussion of increases in HMO spending.

Table 8
Change in Minnesota's Total Medical Assistance Spending, 1985 to 1992,
Portions Due to Change in Quantity, Price
(Dollars in thousands, federal dollars included)

Service category	Total spending change 1985-1992	Spending change due to price change	% of spending growth due to price change	Spending change due to quantity change	% of spending growth due to quantity change
Nursing homes	\$233,890	\$242,290	100%	(\$8,400)	0%
ICFs-MR	\$42,404	\$63,007	100%	(\$20,603)	0%
Inpatient hospital	\$114,457	\$96,126	84%	\$18,331	16%
Physician services	\$44,312	\$31,793	71.7%	\$12,519	283%
Prescribed drugs	\$48,771	\$35,304	72.4%	\$13,467	27.6%
RTCs	\$12,200	\$70,516	100%	(\$58,316)	0%
HMO services	\$128,316	\$87,224	68%	\$41,092	32%

Note 1: "Price" refers to per recipient payments. "Quantity" refers to number of unduplicated recipients.

Note 2: Nursing homes category includes nursing homes (general), ICF-1 and ICF-2.

Note 3: RTCs category includes expenditures for MR, MI and CD residents.

Note 4: From FY 85 to FY 92, federal Medicaid share was approximately 53%, state share was 42% and county share was 5%. In 1/91, the state took over county share - effective state share since then is about 47%.

Note 5: In three categories - nursing homes, ICFs-MR and RTCs - total recipient numbers actually dropped between 1985 and 1992. If prices in these categories had remained constant, total spending would also have declined.

Table 8 is helpful in understanding the respective effects on total spending of changes in per recipient spending and in the number of individuals receiving particular services. ("Price" in this table refers to per recipient spending; "quantity" refers to unduplicated number of recipients.) Table 8 shows the total change in spending between 1985 and 1992 for each of the seven categories, and then breaks that total change down into the portion that is attributable to a change in spending per recipient and the portion that is attributable to a change in the number of recipients.

For example, the total increase in spending on inpatient hospital services between 1985 and 1992 was \$114,457,000. Of that amount, \$96,126,000 was the amount of spending change that was due to an increase in per recipient spending. The amount of spending change due to a change in the number of recipients was \$18,331,000. According to this analysis, 84 percent of the total growth in spending for inpatient hospital services was due to a change in price, and 16 percent of the growth was due to a change in quantity. (See footnote to Table 8 for explanation of negative numbers in column 5.)

For more discussion of trends in Minnesota's Medical Assistance spending between 1985 and 1990, refer to Randall Chun and Jayne Sprinthall Rankin's, "Medical Assistance Trends 1985-1990: A Background Paper," House Research Department, St. Paul, January 1992. Following is a sampling of data from this report:

The majority of MA dollars (78 percent in 1990) are spent on people who are old or have disabilities, even though the majority of MA recipients are AFDC families. In state fiscal year 1990:

- AFDC recipients were 63 percent of MA recipients and accounted for 16 percent of MA spending;
- Elderly people comprised 12 percent of recipients and accounted for 37 percent of spending;
- People who were blind or disabled were 11 percent of recipients and accounted for 41 percent of spending;
- Non-AFDC families and children were 13 percent of recipients, accounting for 6 percent of spending.

For information on national trends in Medicaid spending, refer to the following documents: 1) Holahan, John, Teresa Coughlin, Leighton Ku, David Heslam, Colin Winterbottom, *Understanding the Recent Growth in Medicaid Spending*, The Urban Institute, Washington, D.C., July 1992, and 2) *Medicaid: Intergovernmental Trends and Options*, Document A-119, Advisory Commission on Intergovernmental Relations, Washington, D.C, June 1992.

Chapter Two

Support for Individuals, Not Institutions

Possible Option: Limit Medical Assistance Spending on Nursing Homes, Increase Emphasis on Alternative Forms of Care

Issue

Minnesota's system of care for the elderly is heavily biased toward institutional (nursing home) care and away from non-institutional, community-based forms of care. For people with disabilities that are less severe, institutional care is generally more expensive than non-institutional care.

Background

Compared to the nation as a whole, Minnesota has a high rate of institutionalization of its elderly residents. In 1989, 7.8 percent of Minnesotans over age 65 were in institutional care, compared to five percent nationally and three percent in Oregon.⁵

On a per capita basis, Minnesota spends more on Medicaid for nursing home care than almost any other state, ranking third in the nation after Alaska and New York.⁶ On a per recipient basis, Minnesota's spending is not a great deal higher than the national average (Minnesota - \$12,900 per Medicaid recipient in 1990; national average - \$12,110 per Medicaid recipient in 1990),⁷ but the fact that our rate of institutionalization is relatively high keeps our total costs of nursing home care high.

Minnesota has taken steps over the past several years (such as implementation of the Alternative Care program and a moratorium on construction of nursing home beds) to slow the growth in Medical Assistance spending on nursing home care. In fact, the number of Medical Assistance recipients on behalf of whom payments were made to nursing homes dropped from roughly 50,600 in FY 87 to 39,300 in FY 90. However, because per recipient spending increased during this period, total spending also increased, from \$456 million to \$506 million.⁸

⁵Minnesota Departments of Human Services, Health, Finance, Minnesota Board on Aging, *A Strategy for Long Term Care in the State of Minnesota, Developed in Response to the SAIL 1990 Report, 1992-1993*, ("SAIL Strategy"), p. 6.

⁶*Ibid.*

⁷See data discussion earlier in report, and Advisory Commission on Intergovernmental Relations, *Medicaid: Intergovernmental Trends and Options*, Washington, D.C., June 1992, p. 39.

⁸See section entitled "Trends in Minnesota's Medical Assistance Spending: 1985 to 1992."

The Department of Human Services and the Interagency Long Term Care Planning Committee estimate that if current demographic trends continue, Minnesota will need an additional 8,500 nursing home beds by 2010. Assuming the additional beds are added and allowing for a five percent inflation rate each year, the state share of Medicaid expenditures on nursing homes will increase from \$225 million in 1990 to \$713 million in 2010, a 217 percent total increase.⁹

It is not true that alternative forms of care are always cheaper than nursing home care; in fact, for nursing home residents who need a great deal of care, nursing home care is indeed usually cheaper than the alternative - round-the-clock home nursing care. However, for those residents who need less care, other care arrangements may indeed be less expensive. For example, privately paying adult foster care residents in Oregon paid an average rate of \$900 per month for their care in 1989. (The average Medicaid rate was somewhat lower, as Oregon does not require that private and Medicaid rates for residential facilities be identical) In FY 1990, the average monthly rate Minnesota paid to a nursing home for a resident classified "A" on the case mix scale was \$1,508, for a "B," \$1,636.¹⁰ In 1990, 30 percent of Minnesota's nursing home residents were A's and B's.

Possible Option

Control growth in Medical Assistance spending on nursing homes while aggressively increasing efforts to develop alternative forms of care and delivery systems.

What has been/is being done in Minnesota

SAIL (Seniors Agenda for Independent Living) began in 1989 as an effort on the part of the Minnesota Board on Aging and the Interagency Board for Quality Assurance (now called the Interagency Long Term Care Planning Committee, or INTERCOM) to develop a plan to move Minnesota away from its dependency on institutional care for older people, and toward a system that allows older people to maintain their independence in the community for as long as possible.

In a recent report, *A Strategy for Long Term Care in the State of Minnesota*, the state Departments of Human Services, Health, and Finance and the Minnesota Board on Aging have presented a plan for continuing to develop alternative forms of care for Minnesota's elderly citizens. This report lays out the following 20-year mission:

To create a new community-based care paradigm for long term care in Minnesota, in order to: 1) maximize independence of the frail older adult population, and 2) maximize cost-effective use of financial and human resources.

The report goes on to identify outcomes that are expected to result from implementing the long term care strategy. By the year 2010, the report states, the state will have:

⁹*SAIL Strategy*, pp. 8-9,

¹⁰Case mix designation "A" is assigned to a resident who is determined to be in the category of nursing home residents with the least severe disabilities. The case mix scale includes designations from "A" to "K," representing residents with disabilities that are less to more severe.

- a-Achieved a broad awareness and utilization of low cost alternatives to nursing homes;
- b-Developed a statewide system of access points to assure easily accessible, accurate information;
- c-Developed enough alternative placements to serve the increased number of people needing long term care rather than build new nursing home beds;
- d-Maintained the moratorium on new construction of nursing home beds;
- e-Lowered the projected Medicaid caseload in nursing homes from 29,000 to 24,000;
- f-Lowered the projected number of nursing home residents with case mix level A to 8 percent of the total residents [In 1990,722 percent of Minnesota's nursing home residents were at case mix level A];
- g-Lowered the institutionalization rate from 7.8 percent in 1990 to 6.1 percent.

The 1991 Legislature appropriated \$1,150,000 to implement six SAIL demonstration projects involving a total of 36 counties. Major objectives of these demonstration projects are to improve the screening and assessment process, so that older people are referred to the most appropriate and least costly care alternative that meets their needs, and to recruit and license additional community-based providers and place individuals in these settings.

Although final evaluations of the SAIL projects have not been completed, some policy makers are convinced that the SAIL approach will need to be funded much more aggressively if it is to succeed.

As lead agency in the SAIL effort, the Department of Human Services is also developing a concept it calls "Minnesota Chore Corps," a marketing strategy focused on building demand among senior citizens for services they can purchase that will help them stay in their homes longer.

What other states are doing

A good deal of the SAIL strategy is based on the experience of other states, especially Oregon, which has over the past decade significantly reduced its reliance on nursing homes and built up a system of community alternatives - adult foster care, and more recently, assisted living -- that is cheaper and more attractive to most senior citizens and their families.¹¹

¹¹For information on Oregon's approach, see the following works: Kane, Rosalie A., Laurel Hixon Distort, Robert L. Kane, John A. Nyman, (with assistance from Elizabeth A. Kutza, and Keren Brown Wilson), *Meshing Services with Housing: Lessons from Adult Foster Care and Assisted Living in Oregon*, Long-Term Care DECISIONS Resource Center, University of Minnesota, Minneapolis, May 1990; Wilson, Keren Brown, "Assisted Living: A Model of Supportive Housing," *Journal of the American Geriatrics Society*, Fall 1992.

Advantages of this option

A clear advantage of this option is that it holds some potential for controlling long term growth in the state's Medical Assistance spending on long term care for our older citizens. In addition, it will move Minnesota toward the "new paradigm" for long term care that is needed in order to meet the financial and capacity challenges of the 21st century. Finally, experience in Oregon and elsewhere has shown that older people and their families tend to be at least as satisfied with the care provided in alternative settings, such as foster care and assisted living, as they are with nursing home care. In the long run, then, this option could also help build a system in Minnesota that does a better job than the one we currently have at meeting the actual needs and desires of our senior citizens.

Disadvantages/obstacles related to this option

One of the most significant obstacles to implementation of the SAIL long term care strategy appears to be the state's difficult financial situation.

It is logical in this context to examine the possibility of limiting growth in Medical Assistance spending on nursing homes, in order to free up resources to devote to implementation of the long term care strategy. The Department of Human Services has projected that Minnesota's Medical Assistance spending on nursing homes will grow from approximately \$1.4 billion in the FY 92-93 biennium, to \$1.5 billion in FY 94-95 (state share: \$645 million in FY 92-93, \$706 million in FY 94-95).

A major obstacle to limiting spending on nursing homes, however, is the threat of a Boren Amendment challenge on the part of nursing home providers. (The Boren Amendment is a federal law that restricts states' ability to limit rates paid to institutional providers.) So far, the courts have never ruled on the side of a state when the state's rationale for limiting nursing home payments has been to save money. One leading attorney in the field, however, believes that a state might have a chance of prevailing in a Boren challenge if the state has limited spending on nursing homes because it is spending more on community options.

A second obstacle to imposing a short-term limit on payments to nursing homes is that adequate community options do not yet exist throughout the state for nursing home residents who would be displaced if providers were given the option of reducing their resident numbers rather than absorbing cost increases. Even in Oregon, where in the early 1980's political, economic and regulatory forces were all pushing in the direction of system reform, actual numbers of nursing home residents began to drop significantly only after 1986. In Minnesota, the SAIL effort is beginning to address the shortage of community options, but the supply is probably not yet adequate to meet the demand that would be realized under this option.

Savings potential

The long term savings potential of this option, in terms of controlling future growth in Medical Assistance spending on long term care, appears to be quite high. In Oregon, the nursing home utilization rate dropped from 4.6 percent in 1980 to 3.5 percent in 1989. According to a 1986 analysis by Oregon's Division of Senior and Disabled Services, the state was spending at approximately 89 percent of anticipated levels without intervention - a \$13 million annual savings.

The following factors will affect the degree to which long term savings are realized by a similar approach in Minnesota:

-The level of regulation to which new alternative care providers are subjected. Part of Oregon's success in reforming its long term care system is attributed to the fact that foster care and assisted living regulations are much less prescriptive than traditional nursing home regulations.

-The amount of time allowed for system reform and the resources devoted to it in the short run. If Minnesota expects to significantly control growth in the near future, a commitment must be made to devote significant resources in the short term to development of alternatives, and to relocation of current nursing home residents. A policy decision regarding the future of Minnesota's nursing home bed supply - should it remain constant or should some nursing homes be closed? — must also be made.

Implementation notes

A key element of Oregon's success in achieving long term care reforms is the "1915(d) waiver" that the state negotiated with the federal government. This waiver has given Oregon a great deal of flexibility in using Medicaid dollars to pay for community-based services for older people. In exchange for that flexibility, the state accepts a cap on federal cost-sharing in its Medicaid expenditures for persons 65 and older.

A second key to Oregon's success has been that state's endorsement of the practice of nurse delegation, e.g. giving registered nurses the authority to delegate routine nursing tasks to trained non-nurses. Kane, *et al*, made the following observation regarding nurse delegation in Oregon;

The Oregon Nurses Association initially objected to the delegation provisions and continues to be concerned about their effect on resident safety and the quality and level of nursing care provided in the adult foster home. But the State argued that...professional nurses could best use their time in patient assessment, supervision and teaching of non-professionals rather than in the actual performance of routine nursing tasks.¹²

Because nurse delegation has contributed to the simplicity and cost-effectiveness of Oregon's long term care system, other states may want to consider it as a part of their reform efforts.

¹²Kane, *et al*, p. 105.

**Possible Option:
Limit Spending on Institutions
for Persons with Developmental Disabilities, Mental Illness;
Increase Emphasis on Alternative Forms of Care**

Issue

Despite the deinstitutionalization/community integration movement of the last decade, Minnesota's system of services for persons with developmental disabilities still relies more heavily than other states' on institutional¹³ care. Minnesota's system of services for people with serious mental illness is also biased toward institutional care and is even more lacking in community alternatives. For both populations, institutional care tends to be more expensive than community care.

Background

Compared to the nation as a whole, Minnesota has a high rate of institutionalization of both its developmentally disabled and mentally ill populations. In 1990, Minnesota ranked second nationally - after Louisiana - in the number of ICF-MR¹⁴ residents per 100,000 of the state's population; Minnesota had 129 compared to a national average of 58.¹⁵ Minnesota also ranked third nationally in 1990 on ICF-MR expenditures per state resident - \$53.12 compared to a national average of \$29.92.¹⁶

A recent national assessment of states' systems of services for people with mental illness said this about Minnesota:

Unlike some states, Minnesota has no shortage of supervised housing facilities. It has nearly 1,400 beds in such facilities... It also has a sizable mentally ill population in another kind of Institution: nursing homes. Furthermore, the state has several hundred hospital patients who could be discharged immediately if appropriate living situations were available in the community. Mentally ill Minnesotans not living in the hospitals, nursing homes, or supervised facilities mostly end up in

¹³For purposes of this report, "institutions" are facilities that are Medicaid-certified and require 24-hour care plans for their residents. The institutions referred to in this section are Intermediate Care Facilities for the Mentally Retarded (ICFs-MR). It is important to note that while some ICFs-MR are very large and "institutional" (e.g., Regional Treatment Centers), others are small and home-like.

¹⁴Intermediate Care Facility (group home) for the Mentally Retarded. In Minnesota, the state Regional Treatment Centers (formerly called State Hospitals) are technically public ICFs-MR. In this paragraph only, references to ICFs-MR include RTCs.

¹⁵Center on Residential Services and Community Living, University of Minnesota, Minneapolis, and Systemetrics, Lexington, Mass., *An Independent Assessment of Minnesota's Medicaid Home and Community Based Services Waiver Program*, March 1992, ("Waiver Assessment"), p. 59.

¹⁶*Ibid.*, pp. 59-60.

licensed board and care homes of varying quality. All of this adds up to a heavily institutional system, a basic orientation that must change if the state is to move forward.¹⁷

It is important to note that most clients of Minnesota's service systems and their family members and advocates support the concept of deinstitutionalization so long as it is coupled with increased emphasis on development of community alternatives.

While it is obvious that people with developmental disabilities and people with mental illness have unique care and treatment needs, it is important to note what they have in common in Minnesota - that their needs are more often addressed in institutional settings here than in many other states. The largest, most expensive institutions that these two populations share are the state's eight Regional Treatment Centers (RTCs, formerly known as state hospitals).¹⁸

In 1990, the average daily population of people with mental illness or developmental disabilities at Minnesota's Regional Treatment Centers was 2,691 (1,312 with mental illness and 1,379 with developmental disabilities).¹⁹ The daily rate in that year for a mentally ill resident of a RTC who was Medicaid eligible ranged from \$273 at Willmar to \$401 at Fergus Falls; this translates into annual costs per Medicaid eligible mentally ill resident ranging from \$99,645 to \$143,365.²⁰ The average daily cost of residential, medical care and day services for a RTC resident with a developmental disability was \$227, or approximately \$83,000 per year.²¹

In 1991, the average cost of services for a person with mental illness living in a community residential treatment facility with 16 or fewer beds was \$106, or about \$38,700 per year. For a person in a larger community facility, the average cost per day was \$82 - about \$30,000 per year. For a person in supported housing, average cost per day was \$85, or \$31,000 per year.²²

In 1990, the average cost of services for a person with a developmental disability living in an existing private ICF-MR was \$112 per day, or about \$41,000 per year. In a new facility, the daily cost was \$205, or approximately \$75,000 per year. In a state-run ICF-MR (state-operated

¹⁷Torrey, E. Fuller, Karen Eidman, Sidney M. Wolfe and Laurie M. Flynn, *Care of the Seriously Mentally Ill: A Rating of State Programs* (Third Edition), Public Citizen Health Research Group, National Alliance for the Mentally Ill, 1990, p. 110.

¹⁸Minnesota's eight RTCs are in Anoka, Brainerd, Cambridge, Faribault, Fergus Falls, Moose Lake, St. Peter and Willmar.

¹⁹Total average daily population at the RTCs in 1990 was 2,909. This includes 250 residents receiving chemical dependency treatment and 19 residents of a skilled nursing unit at Brainerd RTC

²⁰Daily and annual rates are based on data obtained from the Minnesota Department of Human Services Residential Program Management Division.

²¹Minnesota Department of Administration, Management Analysis Division, *Public Expenditures for Services to Persons with Developmental Disabilities in Minnesota*, April 1991, p. 109.

²²Minnesota Department of Human Services Mental Health Division, *1991 Mental Health Report to the Legislature*, p. 53.

community services, or SOCS), the estimated cost in 1990 for providing services to a person with a developmental disability was \$236 per day - \$86,000 annually.²³

The average cost for a person with developmental disabilities receiving home or community based services ranged from \$53 per day - about \$19,000 per year - for semi-independent living services (SILS),²⁴ to \$80 per day - about \$29,000 per year - for the Home and Community Based Services waiver program.²⁵

The data above clearly demonstrate that, for both developmentally disabled and mentally ill clients currently receiving services in the community, the average cost of those services is less than for those clients receiving services through RTCs or ICFs-MR. While it is not accurate to deduce from this data that all clients could be served less expensively in the community, it is interesting to note that even "enhanced waiver" services, a special funding category created for former RTC residents with developmental disabilities who require more intensive care in the community, on average cost \$195 per client per day — \$71,000 per year — in 1990. That is significantly less than the \$83,000 per resident per year cost of RFC services or the \$86,000 per resident per year cost of SOCS, and even somewhat less than the \$75,000 annual per resident cost of a new private ICF-MR.

Possible Option

Limit spending on institutions for persons with developmental disabilities and mental illness while increasing emphasis on development and utilization of alternative forms of care.

What has been/is being done in Minnesota

Minnesota has made some progress over the past decade in moving RTC residents with developmental disabilities or mental illness out into the community. From 1980 to 1991, the RTCs' developmentally disabled population dropped from 2,688 to 1,268 and is expected to drop to 901 by FY 1993. This represents a 66 percent reduction over 13 years. On the other hand, the RTCs' mentally ill population is expected over the same time period to drop only 15 percent - from 1,524 in 1980 to 1,289 in 1993. The RTCs housed 1,301 residents with mental illness in 1991.

The state's relative success at moving RTC residents with developmental disabilities into the community and its relative failure at achieving the same goal for residents with mental illness is in part a reflection of the unique care needs of the two populations, but is also a reflection of the legislative successes and failures of advocacy groups representing the two groups and, probably, of biases and fears related to mental illness that are still widely held in our society.

It should be obvious from the earlier discussion that community alternatives for people with developmental disabilities do exist in Minnesota - in fact, they range from small private ICFs-MR to waiver services to family foster care to board and lodging facilities to semi-independent living services. The key issue for this population appears to be whether there are enough "slots"

²³*Ibid.*, pp. 107-108.

²⁴*Ibid.*, pp. 109, 111.

²⁵*Waiver Assessment*, p. 51.

in these various alternatives to absorb the remaining RTC residents (there aren't), and whether adequate incentives exist for counties to place developmental disabled clients in some of the less expensive community alternatives (they don't).

For people with mental illness, however, it does not appear that community alternatives exist to the extent that they do for people with developmental disabilities. In 1989, the Legislative Auditor made the following observation:

Although there have been recent improvements in community mental health services, we found that the Legislature's goal of a comprehensive mental health system by 1990 has not been met...People with mental illness still have too few choices about where to live and receive mental health services.²⁶

Torrey, *et al*, were less diplomatic in their 1990 assessment of states' mental health programs:

In the 1988 survey, Minnesota was said to be "improving most impressively"; the Governor's Mental Health Commission had indicted the non-system of public care and the state legislature had passed sweeping reforms mandating comprehensive community programs...in each county by 1990. It is now 1990, and the Promised Land seems as far off as ever. In 1988, the legislature was mandating community services and housing; in 1990, the legislature is considering spending \$35 million to add 630 new beds to the state hospitals because the 1988 legislation has not been put into effect. This is progress?²⁷

Between 1987 and 1991, the state's spending on community nonresidential mental health services did increase 76 percent - from \$41 million to \$72 million. Meanwhile, however, spending for mentally ill residents of RTCs also increased 57 percent - from \$56 million to \$88 million - resulting in a state mental health system that is still heavily institutional.²⁸ The 1992 Legislature may have helped to perpetuate this institutional bias when it earmarked \$13.4 million in bonding authority to reconstruct or remodel RTC mental health units.

All of Minnesota's RTCs have been downsized in recent years, but none have been closed in a decade. (Rochester State Hospital was closed in 1982.) As RTC resident populations have dropped, per resident costs have increased because fixed costs have remained constant and staffing ratios have increased. In 1980, the staff-to-resident ratio ranged from 1.01 FTE per resident at Anoka to 1.41 at Cambridge. In 1991, those ratios ranged from 1.53 FTE per resident at Moose Lake to 2.05 at Fergus Falls. In total, the RTCs in 1991 employed 4,952 FTE to care for 2,773 residents (1.79 FTE per resident). In 1980, they employed 5,153 FTE to care for 4,392 residents. (1.17 FTE per resident.)²⁹

²⁶Office of the Legislative Auditor, Program Evaluation Division, *Community Residences for Adults with Mental Illness*, State of Minnesota, 1989, p. x.

²⁷Torrey, *et al*, p. 109.

²⁸Minnesota Department of Human Services Mental Health Division, 1991, *Mental Health Report to the Legislature*, p. 15.

²⁹Ratios are based on data obtained from the Department of Human Services, Residential Program Management Division.

This increase in staffing is at least in part the result of a court order; In 1980, the Welsh Consent Decree required Minnesota to reduce the number of persons with mental retardation in RTCs to improve conditions and increase staff-to-resident ratios.

As RTC resident numbers continue to decline, it becomes increasingly important for the state to decide where is the line beyond which it is no longer an efficient use of state resources to continue to operate all eight RTCs. An objective analysis of the data would appear to indicate that we have already crossed that line. Certainly, the data discussed above points to steadily decreasing returns for the state's investment in RTCs. The argument could easily be made that it is time for the state to take one of the following policy directions:

Sub-option 1 - Close some of the RTCs and relocate their residents in the community and in the remaining RTCs;

Sub-option 2 - Phase in closure of all of the RTCs while gradually relocating their residents in the community, or

Sub-option 3 - Turn over the RTCs to boards that are representative of the regions (catchment areas) they serve, and give those boards responsibility for the future of the RTCs, including their funding. Regional boards could be given the authority to close their institutions, levy taxes to support them, or approach the legislature for continued funding. Incentives could be built into this option that would encourage a region opting to dose its institution to develop more community alternatives.

What other states are doing

In 1988, the governor of Oregon formed a commission charged with developing a blueprint for moving inpatient mental health services closer to where people live and work. The outcome of the work of the commission and ensuing discussions at the Oregon legislature is a system that allows people with serious mental illness to receive inpatient services through hospitals in their local communities rather than through state hospitals, and a system that fully integrates Oregon's state hospitals into its community system of care.

In the four years since the blueprint was developed, the state of Oregon's Division of Mental Health and Developmental Disabilities has negotiated contracts with six community hospitals around the state to provide inpatient mental health services to people who are eligible for public assistance and would otherwise receive their services in a state hospital. The state has concurrently developed additional services in the communities surrounding these hospitals and has worked to strengthen Oregon's 32 county mental health programs.

Over this same four-year time period, the average daily census of adults living in Oregon's state hospitals has dropped from 540 to about 400 and several state hospital units have been dosed. By the end of October, 1992, for example, all adult units at Oregon State Hospital in Salem will have been closed.

According to Richard Lippincott, administrator of the Division of Mental Health and Developmental Disabilities, the following principles underly Oregon's blueprint for inpatient mental health services:

1-Appropriate treatment settings in the community tend over time to be less expensive than institutions;

2-Current principles of psychiatric practice indicate that people always do better in appropriate community settings than in institutions;

3-Mental health services need to be individualized and institutions require regimentation.

Oregon's reform of its mental health system has been successful in tipping the balance between the state's financial support for the state hospital system and its support for community services. In the 1987-88 budget, 60 percent of the state's mental health expenditures went to support state hospitals; 40 percent went for community services. In 1992-93, 45 percent went to state hospitals; 55 percent went to the community.³⁰

According to Richard Lippincott, the budget shortfalls that Oregon and so many other states have faced in recent years have been an ally in the reform process - "Our best friend in getting some of this done is the financial distress of this state."

Advantages of this option

Any policy option that shrinks Minnesota's RTC system and builds on its community options for people with developmental disabilities and mental illness has the obvious advantage of moving the state toward a service environment that is less institutionally biased, more cost-effective and more focused on meeting the needs of individual clients. Both sub-options 1 and 2 would achieve this end.

Sub-option 3 would very likely have the same result, and has the additional advantage of allowing the regions to determine for themselves what is the best solution for them. This sub-option could be designed so as to give regions the option of continuing to operate their RTCs, while encouraging them to consider closing them and developing more community options.

Disadvantages/obstacles related to this option

The clear disadvantage associated with any of these sub-options is that they would all cause varying amounts of economic disruption in various parts of the state. Some state employees would inevitably lose their jobs under any of these scenarios; others might be re-employed at lower pay. Unless economic development efforts are simultaneously undertaken, the RTCs' home communities would no doubt suffer some economic distress.

A second disadvantage of any of these sub-options is that a shortage of community placements in the immediate vicinity of a RTC that is closed could result in some residents being moved to locations that are far away from their families. Such situations are probably avoidable, but if they do occur, would be very difficult for the affected residents and their families.

The key obstacle to all of these sub-options is the political difficulty of implementing them. A number of powerful political groups - including the state's employee unions - have a great deal at stake in discussions of the future of the RTCs, and will certainly continue to make their presence known as various options are considered.

³⁰Richard Lippincott, telephone conversation 9/29/92.

Savings potential

According to data provided by the Department of Human Services Residential Program Management Division, the average daily population in Minnesota's eight RTCs in July 1992 was 2,440. Licensed bed capacity in the system, however, was 4,022; in other words, there were 1,582 beds in the system that were licensed but empty.

A preliminary analysis of the data indicates that, when space alone is considered, the four largest RTCs - Willmar, Moose Lake, St. Peter and Faribault³¹ - could easily accommodate the existing residents of all of the state's RTCs. This suggests that the state could achieve significant efficiencies by closing as many as four of the existing RTCs in the immediate future.³² Short term savings would likely be small or nonexistent, as significant costs accompany the closing of a major state institution, but the potential for longer term savings is substantial. To the extent alternative uses can be found for any of the institutions that are closed, it is possible that short term savings could be realized.³³

It is more difficult to assess the savings potential associated with gradually closing all of the RTCs. This option, which closely resembles Oregon's approach, essentially requires overlapping funding as additional community services are phased in and the RTCs are phased out. The discussion earlier in this paper of comparative costs of institutional and community services, however, does point to significant long term savings if this option is adopted. For example, Oregon has found that hospitalizing a person with mental illness in a community hospital costs about one-half of what it would cost to hospitalize that person in an acute unit of a state hospital.

The third sub-option, which would turn the operation, governance and funding of the RTCs over to regional boards, would result in near term savings in the state's MA budget and would fundamentally alter the character of the political debate surrounding the RTCs.³⁴ Under this scenario, each regional board would be given the authority to levy regional taxes to support its RTC, or to close the RTC and support the development of additional community alternatives. (It must be recognized that this option would not actually reduce costs - it would merely shift to the regions costs that are currently borne by the state.)

³¹The four have a combined licensed bed total of 2,531.

³²This analysis is based solely on the licensed bed capacity of the four RTCs and is not intended to advocate that these are in fact the institutions that should continue to operate. It is beyond the scope of this report to recommend which RTCs should remain in operation and which should not.

³³In 1985, the Minnesota State Planning Agency reported that, of the 31 state hospitals that had closed throughout the nation prior to that date, 24 of them were being used in the following capacities: federal or state prison, college, religious organization, VA home or hospital, state administrative offices, county detox center, county mental health center, elderly apartments. (State Planning Agency, *Policy Analysis Series Paper No. 1: Minnesota State Hospital Facilities and Alternative Use*, 1985, pp. 28-29)

³⁴The presence of a RTC is an economic boon to any community because it is a major source of state dollars and state jobs. This fact has vastly complicated the political discussion surrounding the future of the RTCs.

Implementation notes

In January 1987, the governor of New York announced the decision to close six of its developmental centers (like our RTCs, but housing only people with developmental disabilities). For insight and information on the implementation challenges encountered in New York's process, see: Castellani, Paul J., "Closing Institutions in New York State: Implementation and Management Lessons," *Journal of Policy Analysis and Management*, Vol. 11, No. 4, Fall 1992.

Consolidated Funds: A Concept

The idea of pooling a diverse set of funding streams that pay for diverse services for a single population is not new, either to Minnesota or to other states. Fund consolidation is often carried out as a means of ensuring that service dollars "follow" clients, rather than clients following dollars to funded entities. When fund consolidation is done this way, it appears generally to be attractive to clients and advocates but can be threatening to providers and administrative agencies.

As a later section will demonstrate, Oregon is one of several states that have consolidated their funding streams for services for the elderly. In the areas of services for people with developmental disabilities and people with mental illness, ongoing discussions regarding the need for system - and funding - coordination are taking place among state agencies, providers and advocates in Minnesota.

Minnesota's Consolidated Chemical Dependency Treatment Fund (CD Fund), developed and implemented in the late 1980's, is a nationally recognized model of how to "do" fund consolidation in the specific area of chemical dependency (cd.) treatment. Because it seems clear that some of the lessons learned through implementation of the CD Fund can be applied in other areas, the next section is devoted to a summary of its history and experience.

Minnesota's Consolidated Chemical Dependency Treatment Fund: History and Experience

Minnesota's Consolidated Chemical Dependency Treatment Fund was created as a result of a unique confluence of events. At the request of the legislature, the Department of Human Services' CD Division had been examining both the cost of chemical dependency treatment and the delivery system, and had come to the conclusion that the system needed to be better coordinated.

In the mid-'80's, then-Governor Perpich expressed to the Department a strong desire to close down the chemical dependency units that were located at the state's Regional Treatment Centers (RTCs).³⁵ At the time, the Department believed that actually dosing the units was too extreme an action. As an alternative, they developed the concept of the CD Fund, which was intended to place the RTCs on an equal, competitive footing with other chemical dependency providers and assure that chemical dependency treatment dollars followed clients to the most appropriate treatment setting. The authorizing legislation for the CD Fund was adopted by the legislature in 1986³⁶

Funding for the CD Fund came from the following sources:

³⁵See Option A2 for more information on the RTCs.

³⁶*Minnesota Statutes 1991*, Section 254B.

- RTCs chemical dependency budget
- Medical Assistance
- General Assistance Medical Care
- Federal Alcohol, Drug Abuse and Mental Health Block Grant
- General Assistance
- State treatment grants

Following is an excerpt from the Department's 1991 CO Fund report to the legislature that is helpful both in understanding the need for the CD Fund and the reason its implementation is generally considered to have been successful:

Prior to the CD Fund, chemical dependency treatment services for low income persons were tied to the idiosyncrasies of various funding sources. Medical Assistance would pay for hospital-based inpatient programs but not halfway houses and extended care. Minority clients and women had no systematic access to treatment programs that met their needs. Halfway houses and extended care settings received few publicly funded clients. Poor persons who were not enrolled in public assistance programs faced lengthy waits for eligibility determinations, assessment and placement. Treatment options were limited, and many potential clients were unserved...

No longer does treatment availability depend on the particular kind of public assistance program a client happens to be enrolled in...The funding follows the client, rather than the other way around.³⁷

Department staff say the CD Fund has been both clinically and fiscally successful. According to the Department's 1991 report, "Recovery rates are excellent Approximately 66 percent of persons completing treatment through the CD Fund who are contacted following treatment are abstinent six months later."³⁸ The same report states that more poor people are receiving chemical dependency treatment since implementation of the CD Fund, at costs that are approximately 20 percent less than private-pay or third-party-pay clients. Overall, fewer clients are receiving the most expensive, inpatient services (RTCs) and more clients are receiving less expensive, outpatient and intermediate level services.

Certainly, the CD Fund is not without its critics. One criticism focuses on the fact that the Regional Treatment Center system has not materially shrunk since the CD Fund was implemented. Department of Human Services data do show that average daily populations in the Regional Treatment Centers' chemical dependency treatment units dropped from 589 in 1986 to 199 in 1991, a decline of 66 percent over five years. However, according to the Department of Human Services:

Under the provisions of [Minnesota law], the CD Fund is required to advance funds to the Regional Treatment Center CD units to assist their cash flow... The RTCs were unable to repay the \$2,847,000 advance made in FY 90... In FY 91, the CD

³⁷Minnesota Department of Human Services, Chemical Dependency Program Division, *Report on the Status of the Consolidated Chemical Dependency Treatment Fund and Plans to Implement the Eligibility Provisions of Laws 1990, Chapter 568, Article 2, Section 59*, February 1991, p. 6.

³⁸*Ibid.*, p. 4.

Fund advanced the RTCs \$2,615,000. There is little likelihood that this advance will be repaid since the RTCs continue to face substantial fixed costs because of legislation which does not allow them to reduce staffing to manage personnel costs in light of a declining census.³⁹

It appears that fund consolidation alone is not a powerful enough tool to achieve an objective as politically contentious as physically reducing the size of the RTC system.

A second criticism of the CD Fund is related to the fact that the legislature in 1990 gave the Department a means of rationing funds to serve the "neediest" clients in the event that available funding is not sufficient to treat all eligible clients. The law now designates three client "tiers":

- 1-Those eligible for Medical Assistance, General Assistance Medical Care, or meeting the MA income test ("entitled");
- 2-Those earning up to 60 percent of the state median income ("low income");
- 3-Those earning between 60 and 115 percent of the state median income ("sliding fee").

For various reasons, including the recession and increasing poverty rates, CD Fund dollars are no longer able to reach into the third tier to serve "sliding fee" clients. This raises the question of how access to chemical dependency services should be made available to those who lack adequate insurance coverage to cover their chemical dependency treatment but are not poor enough to qualify for MA. It also raises the question whether fund consolidation itself might somehow contribute to an increased demand for services.

The CD Fund does appear to have successfully addressed two major issues that are often raised as obstacles to fund consolidation - 1) how to create a management information system to implement the fund consolidation strategy, and 2) how to deal with federal reporting requirements for Medicaid.

The Department has created a new billing and invoicing system that appears to have greatly simplified those processes. According to Cynthia Turnure, executive director of the Chemical Dependency Program Division, "counties and providers actually stand up at meetings and talk about how wonderful our systems are." The system, says Turnure, is a simple, user friendly system that "works on two pieces of paper."

Although compliance with Medicaid reporting requirements is an ongoing issue, the philosophy behind the CD Fund has made the Medicaid issue manageable. That philosophy, again according to Turnure, is that "we're willing to forego some federal (Medicaid) dollars by treating people in more appropriate settings where they'll do better." In other words, sometimes a client who is Medicaid-eligible might be treated in a program that is not Medicaid certified. In such a case, the state cannot collect federal Medicaid match for that client, which means that the state is responsible for the entire cost of treatment. Turnure believes, however, that savings elsewhere in the system have made up for any Medicaid dollars lost through these kinds of cases.

³⁹*Ibid.*, p. 9.

⁴⁰The MinnesotaCare benefit package does include chemical dependency treatment, but it is limited to 10 hours per enrollee per year.

The next two sections of this report discuss fund consolidation in the context of two service systems - those providing services to elderly people and to people with developmental disabilities. The scope of this report does not allow for exploration of fund consolidation in other areas; other groups and Individuals, however, are exploring the possibility of consolidating funding of services for children and for people with mental illness.

**Possible Option:
Integrate/Consolidate Funding and Administration
of Services for
Minnesota's Elderly Citizens**

Issue

Minnesota's system of services for older people is funded through many sources, is administered by many entities and is not well coordinated.

Background

In 1990, the Minnesota Board on Aging and the Interagency Board for Quality Assurance (now called the Interagency Long Term Care Planning Committee, or INTERCOM) recommended as a part of the Seniors Agenda for Independent Living (SAIL) that long term care services and programs be coordinated at the client, regional and state level. The SAIL report characterized the current system this way:

- The current system consists of multiple state, local and federal programs which have their own administrative structures, procedures, goals and eligibility criteria.
- These programs often are not coordinated with each other at the planning, administrative or delivery phases.
- Programs have been added upon programs without a basic framework.
- In (public) hearings, the confusion of the long term care system was a frequently mentioned barrier to independence.

At the state and regional levels, this means that limited resources could be used more efficiently and effectively. Current programs may be contradictory, or too complex for all but an expert to understand.⁴¹

While the SAIL report does not specifically address the issue of uncoordinated *funding* of elderly services, it is apparent from the experience of other states that coordinated funding is a key piece of the system coordination puzzle. Rosalie Kane, *et al*, have noted:

*If funds can be pooled and if access to, monitoring of, and payment to nursing homes, home care programs, and creative living situations can all be consolidated, it is easier to design innovative combinations and to make system changes. [Emphasis added]*⁴²

⁴¹Minnesota Board on Aging, Interagency Board for Quality Assurance, *Seniors Agenda for Independent Living (SAIL) for the State of Minnesota*, ("SAIL Report"), October 1990, p. 22.

⁴²Kane, Rosalie A., Laurel Hixon Illston, Robert L. Kane, John A. Nyman, (with assistance from Elizabeth A. Kutza and Keren Brown Wilson), *Meshing Services with Housing: Lessons from Adult Foster Care and Assisted living in Oregon*, Long-Term Care DECISIONS Resource Center,

Following is a list of sources of funding for elderly services in Minnesota, along with a sampling of some of the services they cover

Medical Assistance - Nursing home care, home health aide, personal care, private duty nurse, various therapies, transportation, supplies and equipment

Alternative Care (AC) Program - Adult day care, homemaker services, home health aide, personal care, respite care, foster care, case management supplies and equipment, assisted living

Medicare - Skilled nursing care (facility and home), home health aide, therapies, supplies and equipment

Community Social Services Act (CSSA)/Social Services Block Grant (Title XX) -Assessment, case management, adult day care, adult foster care, chore services, home health aide, homemaker services, housing, money management services, personal care, congregate/home meals, respite care, screening, social/recreational services, transportation, supplies and equipment

Veterans Administration (VA) - Nursing home and hospital care

Title III (Older Americans Act) and Minnesota Board on Aging - Meals, advocacy, case management, chore services, counseling, adult day care, escort services, friendly visiting, health assessment, home health aide, homemaker services, hospice, housing assistance, information and referral, legal services, ombudsman, outreach, recreation, respite care, senior centers, transportation, senior companion, Foster Grandparents, Retired Senior Volunteer Program (RSVP)

Community Health Services (CHS) - Skilled nursing, home health aide, homemaker services, education, assessment, nutrition services, care coordination

Minnesota Housing Finance Agency — Housing subsidies

Minnesota Supplemental Aid (MSA) - Board and lodging facilities, board and care facilities, foster care, individual housing

Various demonstration projects, including Block Nurse, Living at Home, and Medicare Demo - Home care

Agencies involved in administering the services mentioned above include the counties (Medical Assistance, AC, CSSA, MSA, CHS), the federal government (Medicare, VA), the Minnesota Board on Aging and Area Agencies on Aging (Title III), and various private providers. It should be clear from reading the list of services covered that there is overlap among these funding sources - some sources pay for the same kinds of services that some other sources pay for. At this point, however, it is impossible to determine how much overlap exists, or even how many seniors are receiving each of these services, because the agencies administering the funding sources collect data in different ways.

Possible Option

Integrate/consolidate funding and administration of services for Minnesota's elderly citizens.

What has been/is being done in Minnesota

The SAIL report made the following recommendations related to coordination of long term care services and programs:

1-That an existing agency be designated the coordinating body for state long-term care planning and administration. This body will facilitate the development of regional and local bodies to plan and coordinate regional and local services, and

2-That the state assure a single regional or local point of access for persons seeking information on long term care services.⁴³

In 1991, the legislature approved legislation that begins to address the first recommendation. The 1991 law directs the Interagency Long Term Care Planning Committee (INTERCOM) to "identify long term care issues requiring coordinated interagency policies...and make recommendations to the commissioners for effective implementation."⁴⁴

The second SAIL report recommendation is in the process of being implemented in some areas through the SAIL demonstration projects (see Option A1, "What has been/is being done in Minnesota").

The third key piece of the puzzle - coordinated funding - has yet to be addressed. The SAIL authorizing legislation⁴⁵ does require that local SAIL projects make an effort to coordinate *planning* for funds to provide services to elderly people, but does not directly address the issue of coordinating *funding*.

What other states are doing

Several states - including Arkansas, Illinois, Maine, and Oregon - have taken steps toward coordinating funding of elderly services. Oregon tops the list as a state that has successfully consolidated *both* the funding and administration of elderly services, at both the state and local levels. The following excerpts from the work of Kane, *et al*, provide valuable insight into Oregon's success. First, their observations on state-level consolidation:

In 1981 ...a bill (SB 955) was introduced to establish a new Senior Services Division (SSD) within the Department of Human Resources. The legislation mandated that all primary services and funds for the elderly be managed within SSD...

The Senior Services Division became both the State Unit on Aging under the Older Americans Act, and the State Medicaid Long-Term Care Administrative Unit. Thus,

⁴³*SAIL Report*, pp. 22-23.

⁴⁴*Minnesota Statutes*, Section 144A.31, Subdivision 2a.

⁴⁵*Minnesota Statutes*, Section 256B.0917.

the scope of programs falling under SSD's management ranged from Meals on Wheels to skilled nursing homes. SSD was also empowered with the responsibility for adult protective services, and certification and licensing of care programs.

The impact of this administrative consolidation on the development and management of a long-term care system in Oregon cannot be overestimated. [Emphasis added] Responsibilities traditionally found in the Health Department such as conducting inspection of care, licensing and certification were now handled through SSD. With responsibility for rate setting and regulation of all providers from nursing homes to home care in one agency, SSD could reallocate resources among these various alternatives. Oregon officials well recognized that reallocation of resources must occur if genuine system change was to take place.⁴⁶

And, at the local level in Oregon:

The consolidation of functions at the state level are largely mirrored at local levels. In most areas, the entire range of SSD programs are administered by one of the 18 Area Agencies on Aging (AAAs) serving one or more of Oregon's 36 counties. In those instances, the case managers who do the client assessments for community-based services and the nursing home preadmission screenings are employed directly by the AAAs... The AAAs also continue their more traditional functions of developing contracts for Title III social services, such as congregate and home-delivered meals and senior centers. In seven rural areas (representing 13 counties but only 10 percent of Oregon's population), the AAA opted against administering the long-term care services. In these counties, the case management is done by employees of district SSD offices located in the regions.⁴⁷

So that the reader is not left with the impression that it was easy for Oregon to make this major adjustment in its elderly services system, it is useful to refer to the following excerpt from a National Governors' Association report:

Oregon did not develop this state-local financial management system for long term care services without difficulty. In particular, local AAAs had been used to grant funding and considerable autonomy vis-a-vis the state government. The AAAs undertaking of Medicaid program-related tasks required sharply different operating procedures, standardization and reporting, cultural changes and much less autonomy than previously. As a result of the difficulties involved in working out these relations, Oregon adopted for a time a highly structured, formal negotiation process between SSD and the local AAAs to implement its program management system.⁴⁸

⁴⁶Kane, *et al*, pp. 26-28.

⁴⁷*Ibid.*, pp. 28-29.

⁴⁸Justice, Diane, (with Lynn Etheredge, John Luehrs and Brian Burwell), *State Long Term Care Reform: Development of Community Care Systems in Six States*, Center for Policy Research, National Governors' Association, Washington, D.C., April 1988, p. 128.

Advantages of this option

The advantages of this option appear to be many. Following are two of the most compelling:

- 1) By identifying and eliminating overlaps, this option would lead to greater efficiencies in the way services are delivered to the elderly in Minnesota, and
- 2) By coordinating the actual delivery system, this option would help set the stage for a system that is both more flexible and more focused on meeting the needs of individual senior citizens than on funding particular institutions or agencies.

Disadvantages/obstacles related to this option

A perceived disadvantage of this option is that, by consolidating funds, some elderly persons who are currently receiving services will somehow be cut off from those services. Because that fear does exist, it is crucial that consumers be represented all through the process of designing and implementing a fund consolidation strategy. It is also important to continually emphasize that the primary objective of fund consolidation is to ensure that people who truly need services will receive the services they need, and that they will be able to access those services quickly and easily.

A chief obstacle related to this option is the political difficulty of implementing it.⁴⁹ As did Oregon (only perhaps more so), Minnesota has a number of strong constituencies whose concerns would need to be addressed in the implementation process. The SAIL pilot projects do provide some reason for optimism, however, that these difficulties can be overcome. Each pilot project is overseen by a long term care coordinating team consisting of county social service agencies, local public health nursing agencies, local boards of health, and the area agencies on aging. To the extent that these local coordinating teams are successful in setting aside differences and working together toward the common end of improving the long term care system, there is reason to believe that the same could be accomplished at the state level.

A second obstacle has to do with federal financial reporting requirements in the Medicaid program. According to Diane Justice:

The Oregon and Maryland experiences demonstrate that Medicaid funds cannot be "pooled" as an undifferentiated source of funds to be used at the full discretion of local governments. The Medicaid program, even with a 2176 waiver, has precise eligibility rules. Medicaid-covered services must be defined with standardized measures recognizable for payment by the state's Medicaid computer...⁵⁰

Minnesota could very likely benefit from the work of other states — and from its own experience in implementing the Consolidated Chemical Dependency Treatment Fund ~ in seeking to design a system that would both allow for the pooling of funds and also account clearly for the expenditure of Medicaid dollars.

⁴⁹In fact, a fund consolidation proposal developed in 1985 as part of the state's "Aging Strategy" failed for this reason.

⁵⁰Justice, p. 129.

Savings potential

Because the state does not have a reliable estimate of the amount of money currently being spent in Minnesota on elderly services, it is difficult to estimate the savings potential of this option with any precision. The most that can be said without further study is that this option would have short-term costs (largely for development of an integrated information system), but could generate long-term savings outweighing the short-term costs.

**Possible Option:
Integrate/Consolidate Funding and Administration
of Services for Persons with Developmental Disabilities**

Issue

Like its system of services for the elderly, Minnesota's system of services for persons with developmental disabilities is funded through multiple sources and administered through multiple entities.

Background

Minnesota's system of services for people with developmental disabilities is made up of at least 20 programs funded through four levels of government (federal, state, counties and school districts), and involving at least 32 separate funding sources.⁵¹ The system is administered by at least three federal departments, four state departments (including 12 different divisions alone within the Department of Human Services), one state agency, one state office, one state council, 87 county social service agencies, and 436 school districts.

Following is a list of some of the agencies and funding sources involved in providing services to the state's developmentally disabled clients:

Minnesota Department of Human Services - Medical Assistance, Supplemental Security Income, Social Security Disability Income, Minnesota Supplemental Assistance, Title IV-E (Foster Care), General Assistance, General Assistance Medical Care, Aid to Families with Dependent Children

Minnesota Department of Education - Special education funds, special educational grants, general revenue aid, federal special education funds, federal 94-142 education funds

Minnesota Department of Health - Services for Children with Handicaps, early childhood services, nursing homes and acute care hospitals

Minnesota Department of Jobs and Training - Project Head Start, Independent living Program, Job Training Partnership Act (Title II-A), basic vocational rehabilitation funds. Title I vocational rehabilitation, Title 6-E federal supported employment

County agencies - Other county funded social services (Community Social Services Act, Title XX and local levy), local educational levy⁵²

⁵¹Department of Human Services Budget Analysis Division, *Primer on Minnesota Programs and Services for Persons with Developmental Disabilities and Related Conditions ("DD Primer")*, June 1991, Executive Summary, and Johnson, Bruce H., "Delivering Services to Minnesotans with Developmental Disabilities: Some of the Issues and Problems," Ombudsman for Mental Health and Mental Retardation, St. Paul, p. 7.

⁵²*DD Primer*, p. 4.

In state fiscal year 1990, approximately \$583 million was spent in Minnesota on various services for the state's residents with developmental disabilities. Of that amount the Department of Human Services and the counties together spent \$425 million. Among the largest programs were:

- Special education (\$142 million)
- Intermediate Care Facilities for the Mentally Retarded (\$120 million)
- Regional Treatment Centers (\$108 million)
- Medical Assistance waivers (\$56 million)
- Day training and habilitation (\$46 million)
- Acute medical care services (\$20.5 million)
- Non-waiver case management (\$16 million)⁵³

Uncoordinated funding and service delivery tend to result in systems that are less responsive to clients' needs than they might be. Draft recommendations of a developmental disabilities management study group formed by Minnesota's Commissioner of Human Services make the following observation: "Every state agency involved with people with developmental disabilities tends to focus only on the programs and services which fall within its jurisdiction and may be oblivious of or reluctant to address problems and issues that involve other state agencies."⁵⁴

As is the case with Minnesota's elderly services system, uncoordinated data systems among the many programs for persons with developmental disabilities have made it extremely difficult to make sense of the current configuration of services, much less plan for the future. According to one recent report:

It is not feasible to determine future escalation in d.d. program costs. Logically, one would look at the d.d. population not yet being served and compare that number to service costs to arrive at some indication of future cost growth. Unfortunately, data collection methods prevent computation of the necessary numbers.

Neither the statistics on total population nor unserved population are reliable. Estimates of Minnesota's d.d. population span from 43,000 to 103,000 persons. Approximately 16,000 of them were served in FY 1990 by Department of Human Services programs. Another 13,000 were served, that same year, by state special education programs. However, there is substantial duplication of the two client numbers because many, though not all, special education students receive other d.d. services. The extent of duplication is not reasonably determinable because DHS and the Department of Education collect data in non-compatible ways.⁵⁵

⁵³*Ibid.*, Executive Summary

⁵⁴"DD Management Report Recommendations," third draft, August 1992, p. 7.

⁵⁵*DD Primer*, Executive Summary.

Possible Option

Integrate/consolidate funding and administration of services for persons with developmental disabilities.

What has been/is being done in Minnesota

The fact that Minnesota's system of services for persons with developmental disabilities is not well coordinated will come as no surprise to people who have experience with the system. Currently, there are at least two efforts underway in and around state government to explore ways to better coordinate services to people with developmental disabilities. One of those efforts, the developmental disabilities management study group referred to above, includes representation from the Department of Human Services, the counties, providers, and advocates, and has resulted in a set of draft recommendations that are expected to be finalized before the legislature convenes in January 1993. That draft makes the following observation about the service system for persons with developmental disabilities:

One of the primary reasons why the system for delivering services to people with developmental disabilities is fragmented and difficult for both providers and consumers to comprehend and deal with is that there is currently no effective mechanism for the state of Minnesota to formulate unifying and comprehensive policies and to identify, track, and address issues that extend across agency lines at the state level.

The following points are included in the draft recommendations:

The Executive Branch should be restructured so that:

- Interagency cooperation and coordination on policies and issues that cross agency lines can be monitored, facilitated and, if necessary, enforced...
- Within DHS there is internal, centralized coordination of functions related to developmental disabilities in order to be user friendly.⁵⁶

In the specific area of coordinated funding, the Department of Human Services is in the process of developing a plan to both integrate funding of services for persons with developmental disabilities and implement a new service delivery system that is more focused on the needs of individual clients. According to Department officials, representatives of all stakeholders in the system - including advocates, counties, providers and the federal government - have responded positively to the design concept. If the necessary legislative authority and federal waivers can be obtained, the Department may be able to implement a pilot project in three or four counties starting in July, 1994. Phase-in of the statewide system would occur over a four-period ending in 1998.

What other states have done

Although it does not appear that a great deal of information is available regarding other states' experience in the area of consolidating funding for services for people with developmental

⁵⁶"DD Management Report Recommendations," third draft, August 20, 1992, pp. 7-8.

disabilities, it may be helpful to refer again to Oregon's experience in consolidating funding for elderly services. (See Option A3: "What other states have done.") The populations, services and funding streams in Oregon's case are certainly different, but the basic issues - fragmented funding and fragmented service delivery - are similar.

Advantages of this option

See Option A3: "Advantages of this option." The advantages of coordinating funding of services for people with developmental disabilities appear to be identical to the advantages of coordinating funding of elderly services.

Disadvantages/obstacles related to this option

Again, see option A3: "Disadvantages/obstacles related to this option." The disadvantages and obstacles of coordinating funding of services for persons with developmental disabilities are very similar to the disadvantages of coordinating funding of elderly services. They also appear to be similarly surmountable.

Savings potential

The state does seem to have a better handle on how much money is currently being spent in Minnesota on services for people with developmental disabilities than on elderly services. However, because of the systems issue mentioned above ("Background"), it is equally difficult to estimate the savings potential of this option. Similarly to Option A3, the most that can be said without further study is that this option would have short-term costs for development of an integrated information system, but could generate long-term savings outweighing the short-term costs.

Chapter Three

Limit Benefits to the "Middle Class"

**Possible Option:
Increase Efforts to Limit Asset Transfer
and/or Recover Transferred Assets
From Minnesota's Elderly Residents**

Issue

Anecdotal evidence suggests that increasing numbers of elderly people are transferring their wealth to family members in order to avoid "spending down" to Medicaid eligibility levels when they enter a nursing home. To the extent that these individuals actually do enter nursing homes, this practice places an increasing burden on the Medicaid program to pay nursing home costs for individuals who could actually afford to pay for their care.

Background

Documenting the extent to which asset transfer is taking place among our elderly citizens and the extent to which the practice is actually causing growth in the nursing home portion of the MA budget is extremely difficult. Because no comprehensive studies have been conducted to determine the scope and magnitude of this problem, it is necessary to rely largely on anecdotal evidence. A report produced in 1991 by SysteMetrics/McGraw Hill and the Health Insurance Association of America cited the following "circumstantial evidence" of the existence of the asset transfer problem:

[Medicaid officials in] every state visited in this study [Connecticut Maine, Minnesota, Florida, New York, Maryland] believed that Medicaid estate planning is a serious and growing problem. State Medicaid officials felt that the number of persons becoming aware of Medicaid estate planning options is growing rapidly...There are a growing number of attorneys specializing in elder law practice and Medicaid estate planning. Elderly persons now have more assets to protect than previous generations. The cost of an extended nursing home stay is one of the most serious risks to the financial well-being of the elderly and to the preservation of their estates for their heirs. The availability of alternative mechanisms for asset protection, such as private long term care insurance, are [sic] not well understood⁵⁷

The following excerpt from a recent issue of the *National Journal* is typical of stories told by those familiar with the asset transfer phenomenon:

Harriet Fridkin tries not to let her personal opinions cloud her professional advice. But Fridkin, an information and referral specialist at the Alzheimer's Association of

⁵⁷Burwell, Brian, *Middle-Class Welfare: Medicaid Estate Planning for Long-Term Care Coverage*, SysteMetrics/McGraw-Hill, Lexington, MA, September 1991, p. 33.

Greater Washington, which is located in an affluent suburb of the nation's capital, sounded slightly galled as she recounted the telephone call from a brother and sister, both young professionals. They wanted to know how they could get Medicaid, the federal-state welfare program that's intended for poor people, to pick up the tab for their widowed mother's nursing home costs while preserving her assets for their inheritance. "Dad didn't mean all that money to go for long term care," Fridkin recalled them saying.

"It's not my job to prejudge them," Fridkin said. "It's my job to refer them" to books and professionals that can help. But Fridkin is also sympathetic to the plight of many of the growing number of callers who want to know how they can qualify for government help without bankrupting themselves. "Most of them think the system's unfair, and I go along with them on that," she said. "Many of them saved for a rainy day, and they get a rainstorm that never ends. When you place someone in a nursing home, that's the rainstorm that never ends."⁵⁸

Federal law provides for penalties to individuals who transfer assets within 30 months of applying for Medicaid to cover the costs of nursing home care. In Minnesota, the penalty is a period of ineligibility for MA that is determined by dividing the total value of the transferred asset by the average monthly MA nursing home rate (currently \$2377). The resulting number is the number of months of ineligibility for MA-paid long term care. For example, if the individual had transferred assets worth \$50,000, the resulting penalty would be 21 months (\$50,000 divided by \$2,377) of ineligibility for MA-paid nursing home care.

If an individual transfers an amount one month, and a second amount the next month, the associated penalties run concurrently. If, for example, this individual transferred \$50,000 in January and another \$50,000 in February of the same year, he or she would receive a penalty of 21 months of MA ineligibility for each transfer, but the total period of ineligibility would only equal 22 months because the two ineligibility periods overlap.

Because the maximum penalty for asset transfers within the 30-month period is 30 months of ineligibility, an individual who transferred a very large amount (\$500,000, for example) within the 30-month period would be ineligible for the same period - 30 months — as a person who transferred \$72,000.

There is no mechanism in current law to prevent or penalize asset transfers that take place more than 30 months prior to applying for Medicaid. Following is an explanation of the rationale for the "30-month rule":

Part of the rationale for the 30-month rule is that most people cannot anticipate when they will need nursing home care. Usually, people don't initiate Medicaid estate planning strategies until nursing home placement is imminent or even until placement has already occurred. Another reason is that it would be difficult for states to track asset transfers farther back than 30 months, including establishing the "intent" of the transfer.⁵⁹

⁵⁸Kosterlitz, Julie, "Middle-Class Medicaid," *National Journal*, November 9, 1991, No. 45, p. 2728.

⁵⁹Burwell, p. 17.

Both categories of asset transfer — those that fall within the scope of the 30-month rule and those that do not — appear to be increasing at least in part because of an explosion of activity in the legal and financial planning professions in recent years.

According to the *National Journal*, large numbers of elderly Americans began seeking legal help to understand the spousal impoverishment benefit that was enacted in 1988 as a part of the Medicare catastrophic coverage act

The new wave of clients helped to fuel the growth of a hitherto small and peripheral legal specialty: elder law. The National Academy of Elder Law, founded just three years ago, now boasts 1,300 members. "Spousal impoverishment helped create the elderly law bar," said Nancy Coleman, director of the American Bar Association (ABA) Commission on Legal Problems of the Elderly.⁶⁰

In Minnesota, various legal organizations contribute to this trend by sponsoring continuing legal education seminars designed to educate lawyers in the fine points of MA eligibility and asset transfer rules. In 1991, the Minnesota State Bar Association sponsored a full-day continuing legal education session entitled "A Lawyer's Guide to Medical Assistance, or How to Guide Individuals and Families Through the Asset Management Maze," featuring discussions of asset transfer, real property transfer, and planning for MA qualification. In 1992, the Association sponsored a session called "Medical Assistance 1992," again featuring discussions of asset transfer and the MA application and appeal process.⁶¹

The Minnesota Institute of Legal Education also offers legal education on MA eligibility and asset transfer rules. In 1991, the Institute held a seminar entitled "Law of the Elderly: Health Care and Long Term Care Issues/¹ featuring discussions of MA eligibility for nursing home care, MA asset transfers, and alternatives to nursing home placement.

For everyone affected, the stakes of these activities increase as our nation's elderly citizens become wealthier. According to one study, the median net worth of Americans age 65 and older increased from \$68,600 in 1984 to \$73,471 in 1988, and is expected to continue to increase.⁶² Over the same period, the median net worth of American households dropped three percent, to \$35,752.⁶³

Possible Option

Increase efforts to limit asset transfer among Minnesota's elderly residents.

⁶⁰Kosterlitz, p. 2730. According to *Governing* (June 1992, p. 44), the National Academy for Elder Law now has 1,600 members.

⁶¹To the Association's credit, an addition to the 1992 seminar was a discussion of long term care alternatives, e.g. the elderly waiver program, the alternative care program, etc.

⁶²Burwell, p. 5.

⁶³Kosterlitz, p. 2730.

What has been/is being done in Minnesota

As mentioned in the above discussion, Minnesota does impose penalties, in the form of a period of ineligibility for MA, on elderly individuals who have transferred assets within 30 months of making application for MA for nursing home care.

Minnesota legislators have made attempts over the past few years to tighten up MA rules regarding asset transfer. Some progress has been made - in 1992, for example, the legislature passed a law that limits the use of certain financial instruments to shelter assets. State legislators who recognize the seriousness of the problem, however, are also frustrated by the fact that their efforts will have minimal effect unless the federal government also acts.

Minnesota's counties do have the authority to place claims against the estates of individuals whose long term care has been paid by MA. According to officials at the Department of Human Services, the counties recovered a total of \$8.8 million in these claims in FY 1992, \$5.1 million in 1991, and approximately \$6 million in 1990, placing Minnesota in the top five or six states in terms of assets recovered for the Medicaid program. However, because approximately half of the recovered amount is federal share, and half of the state share is given to the counties as an incentive payment, the state general fund nets less than a quarter of the total amount recovered through this program (e.g. less than \$5 million over the three years from 1990 through 1992).

What other states are doing

According to one recent article, there is agreement that the asset transfer problem is worse in some states than others.

New York leads the list, followed by California, Connecticut, Florida and Massachusetts. In New York City alone, reports Barry T. Berberich, director of the state's long term care program, 40 to 50 people a month are now qualifying for Medicaid coverage of long term care after transferring assets. The average amount of assets transferred is \$200,000.⁶⁴

In the absence of significant federal policy changes, several states have begun to move ahead on their own solutions to the problem of asset transfer. Connecticut, for example, has begun to offer private long term care insurance pegged to the amount of assets an elderly person wants to protect. An elderly person could, for example, buy \$50,000 worth of insurance if he or she wants to protect \$50,000 worth of assets. In turn, the state agrees to protect from Medicaid spend-down every dollar of assets that the insurance policy paid out.⁶⁵

A number of states (including Minnesota) recover assets after the fact, but only a few enforce their programs aggressively enough to recover substantial sums. Oregon places a claim against the estate of anyone over 65 who has received any kind of Medicaid benefit. For many who receive long term care benefits, the biggest asset is a home. When that home is sold, the state can recover from the sale of the home at least part of the money it spent on Medicaid benefits.

⁶⁴Lemov, Penelope, "The Dilemma of Long Term Care," *Governing*, June 1992, pp. 44-45.

⁶⁵*Ibid.*, p. 45

Maryland's legislature is one of the few that have authorized the use of liens on homes to recover Medicaid benefits.

In effect, the lien allows an elderly person who owns a home to become eligible for Medicaid coverage of nursing home costs while continuing to own the home. If the person is able to return home after a stay in the nursing home, the lien is removed. Other than that, the lien remains in force until the property is sold, at which time a portion of the proceeds from the sale are used to satisfy Medicaid claims - unless there are extenuating circumstances.⁶⁶

Advantages of this option

The obvious advantage of any option limiting the ability of elderly individuals to transfer assets in order to avoid MA spend-down is that it would save money for both the state and federal government. These options could have another, less obvious advantage: By encouraging seniors to pay more of their nursing home costs out of their own pockets, these options could also help to encourage the use of less expensive alternatives to nursing homes. (See Option A1 for discussion of alternatives to nursing homes.) Unfortunately, it appears that the state's range of possible action in this area is limited. It may be most productive to aggressively lobby federal policy makers for changes in the relevant federal laws and rules.

Lien-based recovery systems like Maryland's carry with them the advantage that they allow older people to retain their homes when they go into a nursing home. Under current law in Minnesota, an individual living in a nursing home is required to sell his or her home after six months on Medicaid, unless he or she has a spouse living in the home. Sometimes, the knowledge that an old person's home has been sold is enough to keep that person in the nursing home, when he or she might in fact have gone home if home was still there.

Disadvantages/obstacles related to this option

Options designed to limit the ability of elderly persons to transfer assets is that they run head-long into the value held by many in our society that older people have a right to pass on an inheritance to their offspring, and that offspring have a right to an inheritance. According to *Governing*, even our state and federal laws reflect our society's belief in inheritance rights:

Underlying this behavior is a deep-seated conflict over social policy... A person should be able to pass down to children a home and other assets that are the worldly manifestations of a lifetime of hard work. They shouldn't have to see these assets dribbled away on nursing home care.⁶⁷

Two disadvantages associated with Connecticut's long term care insurance approach are: 1) it subsidizes private insurers, and 2) it explicitly uses the Medicaid system to protect the assets of middle-class people. Representative Henry Waxman (D-Calif.), chair of the Energy and Commerce Subcommittee on Health and the Environment makes the following observation:

I'm troubled by the idea of the Medicaid program, designed to assist the poorest of

⁶⁶*Ibid.*, p. 46.

⁶⁷*Ibid.*, p. 44.

the poor elderly, being used to subsidize private insurers by backing up a private insurance policy ...I don't think it should be a program to protect the assets of middle-class people; it should be a safety net program for the poor.⁶⁸

Enforcement appears to create an obstacle to the success of asset recovery programs based on claims - like Minnesota's and Oregon's. It may be that a state-administered system like Oregon's is more easily enforced than a county-administered system like Minnesota's.

Savings potential

According to Department of Human Services officials, the state's automated data system (MAXIS) does have the capability of reporting the value of assets transferred within 30 months of an individual's applying for MA to cover their nursing home care. The statewide aggregate of these numbers would be a measure of the cost to the MA program of asset transfers that fall within the scope of the 30-month rule, and would provide a basis for calculating the savings' that could accrue from efforts to limit these transfers. This data, however, is not currently being recorded by the counties.

Because asset transfers that occur more than 30 months before applying for Medicaid coverage of nursing home care are not tracked, it is currently not possible to estimate with any precision the savings potential of measures limiting these transfers.

A long term goal of Connecticut's insurance program is to save three to four percent of the long term care portion of the state's Medicaid budget - approximately \$30 million a year.⁶⁹

Oregon's asset recovery program yields nearly \$10 million per year - about five percent of the state's long term care costs. For every dollar spent in the recovery effort, the program brings in about \$15.⁷⁰ According to a 1988 report by the inspector general of the federal Health and Human Services Department, if every state recovered assets as effectively as Oregon, nationwide collections in 1988 could have been \$589 million instead of the \$74 million that was recovered that year.⁷¹

Maryland claims that it takes in more than \$10 for every dollar it spends on collection in its lien program. Wisconsin recently passed legislation to place liens on the homes of elderly Medicaid recipients, estimating it could recover \$13.4 million a year.⁷²

⁶⁸Kosterlitz, p. 2729.

⁶⁹Lemov, p. 45.

⁷⁰*Ibid.*, p. 46.

⁷¹Kosterlitz, p. 2730.

⁷²Lemov, p. 46.

Chapter Four

Basic Benefit Level for All Minnesotans

Discussion of a Theme: Establish a Basic Health Benefit Level for All Minnesotans

As rapidly increasing health care costs have become a more and more pressing issue for many Americans, Congress has responded by introducing and considering a number of health care reform proposals over the past few years. Two categories of universal health insurance systems that have received a great deal of attention from policy makers, the health care industry and the media, are the "single payer" system and the "play-or-pay" system.

Generally, single payer systems are government-run, tax-based health insurance systems that guarantee access to health coverage for the entire population. The Canadian system is often cited as an example of a single payer system.

Under a play-or-pay system, employers are required to provide health insurance to their employees or pay a tax that goes to a government-sponsored health insurance fund to insure those not covered by employer plans.

Although many health care reform proposals have surfaced in Washington, none of them have been enacted to date. States have been particularly frustrated by the fact that Congress has not reformed the Employee Retirement Income Security Act of 1974 (ERISA), the federal law that preempts state authority to regulate self-insured employer health plans. Over half of US workers are employed in firms that self-insure; states cannot require these employers to provide a specific health plan or pay state-imposed premium taxes⁷³.

In the absence of federal action, many states have taken the initiative and begun to implement their own reforms. In fact, during the 1991 legislative sessions, state legislators in every state introduced some form of health reform plan.⁷⁴

In Minnesota, policy makers have devoted a great deal of attention over the past few years to various efforts to improve access to health care for those who lack adequate health insurance. These efforts culminated in 1992 with enactment of the HealthRight (MinnesotaCare) Act. This legislation establishes a new health insurance program for those without adequate health insurance, enacts a funding mechanism for that program, and puts into place a process for controlling growth in the state's general health care costs over the next several years.

An issue that has generated much discussion in each of Minnesota's efforts to plan for

⁷³U.S. General Accounting Office, *Access to Health Care: States Respond to Growing Crisis*, Washington, D.C, June 1992, p. 2.

⁷⁴*Ibid.*, p. 15.

expanded access to health care is which health insurance benefits should be included in a "basic" benefit package. The MinnesotaCare program defines a basic benefit package that is available to those who enroll in the new state health insurance program, and also allows insurance companies to offer small employers a new, scaled-back health care benefit set.

Some critics of the MinnesotaCare health insurance program believe that it is flawed because it does not make health insurance coverage mandatory, and that it wrongly establishes a maximum benefit level for various groups of people, rather than a minimum level for all⁷⁵ Others point out that the basic benefit package offered through the program is probably not adequate to meet the needs of many individuals.

Most proponents of the program recognize that MinnesotaCare is probably neither a final nor a complete answer to Minnesota's health care access problems. They believe, however, that it does represent an important step toward the goal of universal access to health care for all Minnesotans.

What follows is a discussion of a possible approach to attempting to provide the basic benefit level defined by MinnesotaCare to all Minnesotans. This approach would extend the MinnesotaCare benefit package (or some other basic benefit package that is determined to be more appropriate) to enrollees in Minnesota's Medical Assistance and General Assistance Medical Care programs and, through a tax mechanism, to those whose health insurance is provided by their employers.

While this report will not endorse the approach discussed in the following sections, it will attempt to fairly assess the advantages and disadvantages of each of its three component parts.

⁷⁵"See Priester, Reinhard, "HealthRight can't reach goal of fair, universal health care," *Saint Paul Pioneer Press*, July 5,1992.

**Possible Option:
Substitute MinnesotaCare Benefit Package
for Medical Assistance Acute Care Benefit Package**

Issue

Minnesota's Medical Assistance (MA) program offers a different, more generous benefit level than does the new MinnesotaCare program.

Background

In Minnesota, MA benefits are available to both the "categorically needy" and the "medically needy." The categorically needy include certain children, pregnant women, and others who are deemed eligible based on their eligibility for other government assistance programs such as Aid to Families with Dependent Children (AFDQ) or Supplemental Security Income (SSI).

The medically needy are those who have too much in the way of income and/or assets to qualify as categorically needy, but who meet the nonfinancial standards for categorical eligibility and whose income and resources, after deducting medical expenses, fall below specified standards. Persons with income above the medically needy level may reduce income to the requisite level through spending on medical care, as many do on long term care. The medically needy program is in fact primarily a benefit for institutionalized elderly and disabled persons.⁷⁶

Increasingly in recent years, however, the medically needy program is providing health care coverage for families with a one-time catastrophic medical need.

See appendices for tables, excerpted from a Minnesota House Research Department information brief, describing MA eligibility categories, income and asset standards, and benefits.⁷⁷

MA benefits are defined in *Minnesota Statutes*, chapter 2568. MinnesotaCare benefits are defined in *Minnesota Session Laws 1992*, chapter 549, article 4, section 4. MinnesotaCare covered services include all those covered by MA, with the following exceptions: education, private duty nursing, orthodontic, personal care assistant and case management, hospice care, nursing homes and intermediate care facilities, and inpatient mental health. In addition, MinnesotaCare imposes the following limits on payments for certain services: outpatient mental health - \$1,000 per adult and \$2,500 per child per year; chemical dependency treatment — 10 or fewer hours per year; medical transportation — emergency transportation only; inpatient hospital — \$10,000 per year for adults, no limit for children.

MinnesotaCare also requires the following copayments:

-10 percent for inpatient hospital services for adults not eligible for MA (annual out-of-pocket maximum - \$2,000/individual, \$3,000/family)

⁷⁶Advisory Commission on Intergovernmental Relations (AQR), *Medicaid: Intergovernmental Trends and Options*, Report A-119, June 1992, Washington, D.C, p. 11.

⁷⁷Chun, Randall, "House Research Information Brief: Medical Assistance," Research Department, Minnesota House of Representatives, February 1992, pp. 5, 13-14.

-50 percent for adult dental services (except preventive services)

-\$3 per prescription for adults -\$25 for eyeglasses for adults

Possible Option

Substitute MinnesotaCare benefit package for MA acute care benefit package.

What has been/is being done in Minnesota

The idea of reducing benefits available to MA enrollees is not new - most recent legislative sessions have seen proposals to reduce or eliminate MA "optional" services. Services considered optional by the federal government but offered through Minnesota's MA program include the following: inpatient mental hospital services, HMO services, Intermediate Care Facilities for the Mentally Retarded (ICFs-MR), home health services, prescribed drugs, medical supplies and transportation, and the services of dentists, optometrists, psychologists, physical therapists, speech therapists, chiropractors and audiologists.

It is important to note that some of the most expensive optional services (such as ICFs-MR, HMO services, and waiver services for people with mental retardation and related conditions) could not be eliminated without causing serious disruption in Minnesota's service infrastructure.

In some cases, eliminating optional services would force MA recipients to substitute higher cost mandatory services for lower cost optional services. Mandatory services include inpatient and outpatient hospital, nursing home, lab and x-ray, nurse-midwife, nurse-practitioner and physician services. An example of this substitution effect: MA recipients with back problems would see physicians rather than chiropractors.

What other states are doing

According to a report produced by the National Association of State Budget Officers, six states in 1991 and seven states in 1992 sought to control growth in their Medicaid budgets by eliminating some optional services. Those states included Arkansas, Kansas, Michigan, Massachusetts, New Jersey, Oregon, and Utah. Ten states in 1991 and 15 in 1992 limited the amount, duration and scope of optional services - some of those states were Arizona, Colorado, Kansas, Massachusetts, Missouri, New Hampshire, North and South Dakota, and Washington.

In addition, six states in 1991 and eight states in 1992 limited the amount, duration and scope of mandatory services - included were Kansas, Maine, New Hampshire and South Dakota. Finally, eight states in 1991 and 11 in 1992 limited payments for prescription drugs. Those states included Arkansas, Florida, Georgia, Kansas, New Hampshire and South Dakota.^{78 79}

⁷⁸National Association of State Budget Officers, *Balancing the State Medicaid Budget FY 1991 and FY 1992*, Washington, D.C., March 1992, Appendix, Tables 4 and 5.

According to a report produced by the Advisory Commission on Intergovernmental Relations:

Currently, many states are finding it necessary to cut services. For example, Arkansas cut back on a number of options including its adult medically needy program, which was a major service, Missouri made cuts in podiatry and dental services. Michigan made across-the-board reductions in the program and is considering deleting certain optional services entirely.⁸⁰

Advantages of this option

The two primary advantages of this option are: 1) it would generate short-term savings for the state, and 2) it would simplify the health care system by making two major state programs — MA and MinnesotaCare - more consistent with each other.

Disadvantages/obstacles related to this option

An obvious disadvantage of this option from the perspective of the MA recipient is that it represents a reduction in health care benefits. For those MA recipients who require intensive chemical dependency or mental health services, the MinnesotaCare benefit level would probably be inadequate.

In the area of inpatient hospital services, the \$10,000 upper limit that is a part of MinnesotaCare would also in many cases be inadequate. As MA currently operates, it is the "payer of last resort" for people who have run out of money and assets with which to pay their medical bills. It certainly appears that MinnesotaCare was intended to have under it the safety net of MA, so that if a MinnesotaCare enrollee exhausted his or her \$10,000 inpatient hospital benefit and could not afford to pay for additional required hospital services, at least there would be the chance of qualifying for MA. A \$10,000 inpatient hospital maximum imposed on MA would either force people out of the hospital while they are still sick, or force hospitals to absorb or pass on to other payers a great deal more in the way of uncompensated care than they currently do.

The federal government's Medicaid laws and regulations would present an obstacle to implementation of this option. While federal officials from the President on down have expressed a willingness to allow states more flexibility in managing their Medicaid programs, the first real test of that willingness resulted in the federal government's rejection of Oregon's request to make major reforms in their Medicaid program.

On the other hand, Minnesota's Medicaid program is generous compared to those of other states, so it is possible that the federal government would allow reforms in Minnesota's Medicaid program that would bring it closer in line with other states. For example, a number of the services that would be eliminated or limited for MA recipients under this option are categorized by the federal government as optional services - it is possible that those changes could be made without a waiver. Extending Minnesota Care's \$10,000 inpatient hospital

⁷⁹Although it is not specifically related to this option, another cost containment strategy that has been adopted by a number of states is reductions in provider reimbursements. Ten states reduced provider reimbursements in 1991; 15 states did so in 1992.

⁸⁰ACIR report, p. 21.

maximum to the MA program, however, would require a waiver, if not a change in federal law.

Savings potential

Although it is very difficult to project exactly how much this option would save, it appears that annual savings in total MA dollars might be on the order of about \$200 million, or about \$92 million per year in state general fund dollars in the upcoming biennium. This assumes that a number *of* MA services - private duty nursing and personal care assistant, hospice care, case management and inpatient mental hospital services - would be eliminated completely, and two others - medical transportation and general inpatient hospital services - would be substantially reduced. (See appendix for calculation.)⁸¹ This calculation does not account for the substitution effect discussed earlier, or for long term costs that could accrue due to a lower standard of health care for some individuals.

⁸¹This number is a rough estimate, based on DHS forecasts, spending reports, and conversations with DHS officials. Because the data were not available, some factors necessary for a precise estimate are not included. See appendix for calculation.

**Possible Option:
Consolidate General Assistance Medical Care
with MinnesotaCare**

Issue

Minnesota's General Assistance Medical Care (GAMC) program offers a different set of benefits from those offered through either the MinnesotaCare program or Medical Assistance

Background

GAMC is a state-funded program⁸² that pays for health care services for individuals who are poor but not eligible for other health care programs such as MA. Many GAMC recipients are young men who are unemployable because of their mental illness, chemical dependency or other debilitating condition. Uninsured single women between the ages of 55 and 65 comprise another large group of GAMC recipients. In 1993, the state expects to spend approximately \$177 million on services for 39,000 GAMC recipients.⁸³

Of the \$161 million the state spent on GAMC in 1992, approximately \$50 million, or 31 percent, went to pay for inpatient hospital care. Another \$62 million (38.5 percent) paid for HMO services. Of the remaining amount, \$18.3 million (11 percent) paid for physician services; \$9.6 million (6 percent) for prescribed drugs; \$93 million (6 percent) for outpatient hospital services; \$3.3 million (2 percent) for dental services.⁸⁴ (See appendix for a list of services covered through GAMC.)

The GAMC program has grown from total expenditures of \$57.5 million in FY 1985 to a projected \$203.5 million for FY 1995. This represents growth of 254 percent over 10 years, or average annual growth of approximately 25 percent⁸⁵ During the same period, monthly average recipients will have increased from approximately 20,000 in 1985 to a projected 41,000 in 1995.⁸⁶ This represents growth in recipient numbers of 105 percent, or average annual growth of approximately 10.5 percent

While it is beyond the scope of this study to thoroughly analyze the reasons behind this rapid

⁸²Before 1991, counties paid a portion of GAMC costs. As of 1/91, the state took over the counties' share of GAMC.

⁸³Department of Human Services, "Minnesota Family Self-Sufficiency and Medical Entitlement Programs and Related Programs: Revised Projections for the FY 1992-1993 Biennium (February 1992 forecasts adjusted for changes made by the 1992 Legislature)," St Paul June 30, 1992, p. 13.

⁸⁴Department of Human Services, "State of Minnesota: Fiscal Year 1992 Monthly Payments to Recipients by Type of Care (Form OD-00239)," July 13, 1992.

⁸⁵Department of Human Services Forms OD-00239 for FY 1985 and FY 199Z

⁸⁶Department of Human Services forecast data.

growth in GAMC costs, rising overall health care costs and the economic recession have certainly played a role, as they have in rising Medicaid costs nationwide. As a recent Urban Institute study pointed out:

We believe there are several reasons for Medicaid spending growth in recent years. These include the federal mandates covering pregnant women and children, some of the other new mandates, *the recession, rising health care costs*, the aging of the population, and state efforts to shift previously state-funded services into Medicaid. [Emphasis added.]⁸⁷

Some of these factors would not affect GAMC; those that are highlighted clearly would. Other factors contributing to the recent growth in spending on GAMC include enactment of a federal law in the late 1980s that made some mentally ill individuals living in large institutions ineligible for Medicaid, and the fact that more and more Minnesotans are without health insurance.

Possible Option

Consolidate GAMC program with MinnesotaCare.

What has been/is being done in Minnesota

Consolidation of GAMC with MinnesotaCare was discussed during the 1992 deliberations on the HealthRight legislation. The HealthRight (MinnesotaCare) Act directs the commissioner of administration to, by January 1, 1994, make recommendations to 1) improve the effectiveness of public health care purchasing, and 2) streamline and consolidate health care delivery, through merger, transfer or reconfiguration of existing health care and health coverage programs. Presumably, the GAMC program will be examined in the context of this effort.

What other states are doing

California's Medically Indigent Adult (MIA) program is similar to our GAMC program - both programs are state- and/or county-funded and provide health care services to poor people who do not qualify for Medicaid. According to Robin Baker, a budget analyst with the California Department of Finance, funding for the MIA program has undergone a major "realignment" over the past two years. As a result, the MIA program now receives a percentage of the state's revenue from vehicle license fees and the sales tax. To the extent that demand for health care services through the MIA program exceeds the ability of these revenue sources to cover that demand, counties must pick up the tab.

In previous years, California's MIA program for "small" counties (34 of the state's 58 counties are considered small) was administered like an entitlement — the state served as the "deep pocket" when small counties were unable to pay their total MIA costs. In 1992, however, the legislature capped total state spending on the small counties MIA program. It remains to be seen how those counties will deal with this new restriction.

⁸⁷Holahan, John, Teresa Coughlin, Leighton Ku, David Heslam, Colin Winterbottom, *Understanding the Recent Growth in Medicaid Spending*, The Urban Institute, July 1992, p. 7.

According to Robin Baker, California's MIA program has taken numerous cuts in recent years. The decision to shift funding sources and cap MIA costs was a direct result of California's severe fiscal crisis.

Advantages of this option

The two primary advantages of this option are identical to those related to Option C1: 1) it would generate short-term savings for the state, and 2) it would simplify the health care system by making two major state programs - GAMC and MinnesotaCare - more consistent with each other.

Disadvantages/obstacles related to this option

The primary disadvantage of this option is related to the fact that GAMC is tailored to help meet the needs of a distinct population. For example, GAMC is specifically designed to help meet recipients' mental health needs, which are relatively great; MinnesotaCare's mental health benefit is quite limited. Extending the MinnesotaCare benefit package to GAMC would probably mean that some of the unique needs of the population served by GAMC would no longer be met.

Other disadvantages of this option are actually very similar to the disadvantages of extending the MinnesotaCare benefit package to MA. MinnesotaCare's \$10,000 per adult per year inpatient hospital maximum would present a problem if it were extended to the GAMC program, just as it would if it were extended to MA. MA serves as the "payer of last resort" for certain groups of people; GAMC serves the same purpose for other groups. A \$10,000 inpatient hospital maximum in the GAMC program would either force some people out of the hospital while they are still sick, or force hospitals to absorb or pass on to other payers more in the way of uncompensated care than they currently do. This effect would be felt disproportionately by public hospitals in the Twin Cities because GAMC serves a population that is disproportionately urban.

Another disadvantage is related to MinnesotaCare's limitations on chemical dependency and mental health services. For GAMC recipients who require intensive services in those areas, the MinnesotaCare benefit level would very likely be inadequate.

Because no federal funds are involved in the GAMC program, federal laws and regulations are not an obstacle to implementing this option.

Savings potential

It is difficult to develop a precise estimate of the savings related to this option, but it appears that they might be on the order of \$16 million a year in the upcoming biennium. (See appendix for calculation.)⁸⁸ It is important to note that, for reasons discussed above, this option could have significant long term costs.

⁸⁸This very rough estimate is based almost entirely on projected spending on inpatient hospital services in GAMC. See appendices for calculation.

**Possible Option:
Tax Value of Employer-Purchased Health Insurance
That Exceeds Value of MinnesotaCare Benefit Package**

Issue

Under current federal law, all contributions to health plans made by employers on behalf of employees are excluded from employees' gross income, regardless of the cost or extent of the coverage. This exclusion has resulted in a system in which health insurance is relatively cheap and accessible for people with good jobs, and relatively expensive and inaccessible for people who work part-time, are self-employed, or work for small or marginal organizations that do not cover employee health insurance.

Background

Accompanying the discussion in recent years of how to improve the US. health care/health insurance system has been a discussion of how best to finance a more equitable and accessible system. One potential funding mechanism that has been discussed in many sectors is the idea of taxing the value of health insurance that employees receive through their employers.

Currently, federal law provides that all payments for health insurance made by employers on behalf of employees are excluded from employees' gross income, regardless of the cost or extent of the coverage. As early as 1984, the U.S. Department of the Treasury, in its annual report to the president, advocated the idea of taxing a portion of the health insurance benefits provided to employees by their employers. That report made the following points in favor of limiting the income tax exclusion of health insurance benefits:

As with other tax-free fringe benefits, the exclusion of employer-provided health insurance from income subsidizes the cost of such insurance for eligible taxpayers. Within limits, this tax-based incentive for employee health insurance is an appropriate part of the national policy to encourage essential health care services. In its present unlimited form, however, the exclusion provides disproportionate benefits to certain taxpayers, encourages the overconsumption of health care services, and contributes to higher than necessary marginal tax rates.

The exclusion from income of employer-provided health insurance is unfair to individuals who are not covered by employer plans and who must therefore pay for their health care with after-tax dollars...Because many employer-provided plans are so generous that the employees pay very little, if anything, out-of-pocket for health services, the employees are more likely to overuse doctor and hospital services and medical tests...The rapid increase in the cost of health care services in recent years can be attributed at least in part to overconsumption of such services by employees for whom they are tax free and, in many cases, available without limit⁸⁹

⁸⁹Office of the Secretary, Department of the Treasury, *Tax Reform for Fairness, Simplicity, and Economic Growth: The Treasury Department Report to the President (Volume 2: General Explanation of the Treasury Department Proposals)*, November 1984, pp. 23-24.

Since the Treasury Department report was written in 1984, of course, health care and health insurance costs have escalated dramatically - even most of those whose health insurance is covered by their employers now have some out-of-pocket costs in the form of co-payments or deductibles. The policy discussions presented in the report, however, have if anything become more compelling since 1984: 1) the income exclusion for employer-paid health insurance is unfair to those who are not in a position to benefit from it, and 2) the income exclusion contributes to over-utilization of health care services.

These inequities could be addressed to some degree by limiting the value of employer-paid health insurance that is excluded from income to the value of the MinnesotaCare benefit package (or some other basic benefit package). In other words, for an individual worker, if his or her employer purchases health insurance above the level of the MinnesotaCare benefit package, that individual would pay income tax on the value of the health insurance that he or she receives that exceeds the MinnesotaCare benefit level. If the employer purchases an amount of insurance whose value is equal to or less than the MinnesotaCare package, the employee would still pay no income tax on his or her insurance coverage.

Possible Option

Require workers who receive health insurance through their employers to pay state income tax on the value of health coverage they receive that exceeds the value of MinnesotaCare coverage (or some other basic benefit package).

What has been/is being done in Minnesota

The idea of taxing health insurance benefits that workers receive through their employers was discussed both by the Health Care Access Commission (the commission established by the legislature and then-Governor Perpich in 1989 to develop a plan for improving access to health coverage for the uninsured) and by the team of legislators and Carlson administration representatives who negotiated the package of health care reforms eventually passed in 1992 in the form of the HealthRight Act (now MinnesotaCare). In both cases, the concept was raised as a potential funding mechanism for a health insurance program for the uninsured. In 1992, the legislature rejected the idea in favor of a two percent tax on health care providers.

What other states are doing

It appears that no other states have eliminated or reduced the exclusion from income of employer-paid health insurance benefits.

Advantages of this option

There are two primary advantages associated with this option:

1-It could reduce health care costs in the long run. According to a 1991 Revenue Department memo: "Currently many employees can consume health care services without incurring any costs, those costs being paid by the employer or insurer. This system provides incentive to consume the highest cost health care alternative. If employees bore some of the cost of consuming health care services, they might choose lower cost alternatives."

2-It would result in greater tax revenues for the state, thereby contributing to resolution of the state's budget shortfall.

Disadvantages/obstacles related to this option Following

are a few of the disadvantages of this option:

1-It would complicate the state income tax filing process and create a paperwork burden for employers, who would be required to report each employee's taxable benefit amount.

2-It would disproportionately affect middle-income taxpayers, and would be perceived as an increase in taxes on working people. (This effect could be offset to some extent with a tax credit)

3-It would increase the state income tax liability of taxpayers whose employer-paid health benefits are more generous than the MinnesotaCare standard. Those who anticipate this effect might reduce the level of their health insurance so as to avoid the extra tax penalty, thereby potentially leaving themselves or their families vulnerable to an expensive health condition not covered by their insurance.

The primary obstacle related to this option is the fact that the legislature just last session adopted a health care provider tax as part of the HealthRight legislation. Reducing or eliminating the income tax excludability of employer-paid health benefits was considered during the 1992 HealthRight negotiations, but it and the provider tax were seen as *alternative* financing mechanisms for the new health insurance program, not as policy ends in themselves.

Savings potential

According to Revenue Department estimates, taxing the total value of employer contributions to employee health insurance would raise approximately \$270 million in FY 1992 and \$306 million in FY 1993.⁹⁰

It is very difficult to estimate with precision the amount of revenue that would be generated by taxing only the amount of employee health insurance that is above the MinnesotaCare level. However, Department of Human Services officials have indicated that the insurance value of the MinnesotaCare benefit package is "worth" approximately 80 percent of the insurance value of the MA benefit package for non-institutional services. If we assume that the value of the "average" employee benefit package is approximately equivalent in value to the MA benefit package (this may be a generous assumption), then the amount of revenue that would be raised by taxing benefits above the MinnesotaCare level is equal to 20 percent of the revenue that would be generated by taxing the total benefit. Those amounts are \$54 million in 1992 and \$61.2 million in 1993. If the average employee benefit package is in fact less generous than MA, the revenue potential would be reduced accordingly.

⁹⁰These estimates are based on federal estimates prepared for the Joint Committee on Taxation, and do not include health insurance purchased by self-employed individuals.

Chapter 5

Assure that Consumers Receive Lowest Cost Appropriate Care

Possible Option: Expand the Use of Managed Care in Minnesota's Medical Assistance System

Issue

Managed care is widely seen as an effective means both of saving health care dollars and ensuring that health care consumers receive appropriate care. Minnesota is a national leader in the use of managed care to provide services for its AFDC Medical Assistance population, but may be able to further expand the use of managed care to other populations and to other geographic areas within the state.

Background

Even though it is widely used, "managed care" is a term that is difficult to define because it means different things to different people. The US. General Accounting Office describes managed care this way:

Under managed care arrangements, enrollees are somewhat restricted in their choice of providers, and they must choose a primary care physician who participates in the managed care plan in which they are enrolled. Usually, enrollees are required to contact their chosen primary care or "gatekeeper" physician to obtain referrals for specialists or inpatient care.⁹¹

The Health Insurance Association of America defines network-based managed care plans as those that integrate the financing and delivery of appropriate health care services to covered individuals by means of the following four basic elements:

- 1-Arrangements with selected providers to furnish a comprehensive set of health care services to members;
- 2-Explicit standards for the selection of health care providers;
- 3-Formal programs for ongoing quality assurance and utilization review;
- 4-Significant financial incentives for members to use providers and procedures associated

⁹¹US. General Accounting Office, *Medicaid: Oregon's Managed Care Program and Implications for Expansion (Report to the Chairman, Subcommittee on Health and the Environment, Committee on Energy and Commerce, House of Representatives)*, Washington, D.C., June 1992, pp. 14-15.

with the plan.⁹²

By design, managed care costs less than the traditional fee-for-service approach to delivering health care. Under a typical government-sponsored managed care arrangement, an HMO (the managing entity) is paid a given amount per month to provide all the health care services needed that month by a particular consumer. (The Minnesota Department of Human Services typically pays 90 to 95 percent of fee-for-service experience.) The HMO is then responsible for "managing" both its finances and the health care of its subscribers - it either realizes a surplus, which it is allowed to keep; comes out even, or incurs a deficit, which it must absorb.

In the 1980's, the federal government approved Medicaid managed care programs as a way to contain costs, while recognizing that managed care could also help ensure access and quality of care for Medicaid enrollees. The federal Department of Human Services, through the Health Care Financing Administration (HCFA), began to grant states waivers of federal Medicaid rules to permit them to develop managed care systems.

By June 1991, 32 states and the District of Columbia had one or more prepaid managed care plans for Medicaid clients. Medicaid managed care enrollment increased from approximately 187,000 in 1981 to 2.8 million in 1991, and this growth is expected to continue. Approximately 11 percent of all Medicaid clients nationwide are currently enrolled in managed care programs.⁹³

Possible Option

Expand the use of managed care in Minnesota's Medical Assistance system.

What has been/is being done in Minnesota

Since the early 1980's, Minnesota has been exploring and implementing managed care strategies in its MA program. In 1983, Minnesota received a grant from HCFA to design its Minnesota Prepaid Medicaid Demonstration Project (now called the Minnesota Prepaid Medical Assistance Program [PMAP]).

The PMAP was implemented in 1985 in three counties - Itasca, Hennepin and Dakota. With a few exceptions, MA enrollees in these three counties are required to participate in the prepaid system. In Hennepin and Dakota counties, enrollees are required to choose a participating health plan and then receive all health care services through the health plan. In Itasca County, the county administers the health plan and contracts with providers for services. In Hennepin County, 35 percent of MA eligibles were initially enrolled; the remaining 65 percent were enrolled by the end of 1991.⁹⁴

In Minnesota, approximately 20 percent of the state's total MA-eligible population are enrolled

⁹²Hoy, Elizabeth, Richard Curtis and Thomas Rice, "Change and Growth in Managed Care," *Health Affairs*, Winter 1991, p. 19.

⁹³The material in this and the preceding paragraph is drawn from VS. General Accounting Office, *Medicaid: Oregon's Managed Care Program and Implications for Expansion*, p. 15.

⁹⁴Minnesota Department of Human Services, Division of Health Care Administration, *Minnesota Prepaid Medical Assistance Status Report*, May 1, 1992, pp. 2-5.

in the PMAP. (Thirty-one percent of Minnesota's GAMC eligibles are enrolled in managed care arrangements.)⁹⁵

The state is currently working on expanding the PMAP to Ramsey County, which because of its population density and relatively small geographic size, is particularly suitable to a managed care approach. In May 1992, the Department of Human Services projected that PMAP enrollment in Ramsey County would begin by fall of 1992. There are approximately 40,000 MA recipients eligible to participate in the PMAP in Ramsey County.⁹⁶

The HealthRight (MinnesotaCare) law includes a provision requiring the Department of Human Services to present to the legislature by January, 1993, a plan for providing all MA and MinnesotaCare services throughout the state through managed care arrangements.⁹⁷ The Department has formed a committee composed of representatives of health care providers, health plans, consumers, advocacy organizations and legislators to assist in developing this plan.

The Department of Human Services is also working to develop plans to expand the use of managed care to the portions of the MA-eligible population that are elderly or that have developmental disabilities or mental illness.⁹⁸ For example, the Department has received a Robert Wood Johnson Foundation grant to develop a managed care approach to providing long term care, inpatient and outpatient hospital, physician and social services to elderly MA recipients.

Ramsey, Itasca and Lake Counties also operate mandatory prepaid General Assistance Medical Care (GAMC) programs.

What other states are doing

Arizona, which did not participate in the Medicaid program prior to 1982, has implemented a statewide mandatory Medicaid managed care program called the Arizona Health Care Cost Containment System. With this system, Arizona has been able to limit its Medicaid cost increases to an annual average of 5.6 percent "'We've learned a lot of lessons, made a lot of mistakes, and have been able to come out with a system that has some major health care providers in the state at the table,' says Joseph Anderson, president of Arizona Physicians IPA, the biggest contractor in the state."⁹⁹

A relatively new component of Arizona's program is the Arizona Long Term Care System (ALTCS). "Designed to offer institutional care and home and community based services to the

⁹⁵Based on Department of Human Services data.

⁹⁶DHS, *Minnesota Prepaid Medical Assistance Status Report*, p. 7.

⁹⁷*Minnesota Session Laws 1992*, chapter 549, article 4, section 1, subdivision 4.

⁹⁸It is important to note that it will only be possible to implement managed care arrangements for these populations after some degree of fund consolidation takes place. See fund consolidation sections of this report for discussion.

⁹⁹"Medicine & Health Perspectives," Christina Kent, ed, April 13, 1992.

elderly, physically disabled and developmentally disabled, ALTCS is a hybrid of both traditional and innovative long term care thinking."¹⁰⁰ ALTCS provides services through program contractors. These long term care "health plans" are capitated per member per month and required to provide all covered services, including medical care, through a network of providers operating in their contracted area. By state law, Maricopa and Pima counties must participate as program contractors for ALTCS and the remaining counties (Arizona has only 15 counties) have the option to do the same

A number of other states have made attempts to develop managed care systems for their Medicaid recipients with mental illness or severe disabilities. For example, New York, Massachusetts, South Carolina, Utah and Florida are at various stages of implementation of Medicaid managed care programs serving persons with mental illness. Also, with financial support from the Robert Wood Johnson Foundation and the Pew Charitable Trusts, the "Medicaid Working Group" of the Boston University School of Public Health is developing a managed care approach to providing care to individuals with severe disabilities and chronic illness.

Advantages of this option

The idea of expanding managed care to more populations and geographic areas in Minnesota has clear advantages. If it is carefully implemented, expanded managed care has the potential to both save state MA dollars and improve the quality of care for many individuals.

Disadvantages/obstacles related to this option

A disadvantage of managed care programs frequently cited by critics is that managed care arrangements that are not monitored carefully enough can sometimes restrict, rather than improve, access to health care.

One of the chief obstacles to implementing risk-based managed care arrangements in the Medical Assistance program is the difficulty of recruiting and retaining entities to serve as the "managers" of care.

For example, when Minnesota's PMAP program began in 1986, the state had contracts with eight prepaid health plans - Blue Cross/Blue Shield, Group Health, Itasca Medical Care, MedCenters Health Plan, Metropolitan Health Plan, Physicians Health Plan, PreferredOne and UCare Minnesota. Gradually, however, plans began to withdraw or limit their participation: Blue Cross/Blue Shield withdrew in 1987; MedCentere withdrew in 1988; Group Health terminated their Hennepin County AFDC contract in 1989, and PreferredOne withdrew in 1989. According to the Department of Human Services, PreferredOne's termination posed a potentially serious threat to provider access and continuity of care for PMAP recipients.¹⁰¹ The situation was eventually resolved, and health plan participation has remained stable since that time.

The financial risks to health plans of participating in PMAP, however, do not appear to have

¹⁰⁰*Arizona Health Care Cost Containment System: Annual Report - July 1990 through June 1991*, December 1991, p. 133.

¹⁰¹DHS, *Minnesota Prepaid Medical Assistance Status Report*, p. 14.

dissipated. According to a Citizens League publication, the two largest HMOs in the state lost money on their MA plans in 1991. "Group Health lost \$435,000 on its two Medical Assistance programs... Medica Choice, which has more public assistance enrollees than any other HMO, lost \$1.6 million in 1991."¹⁰²

(Interestingly, Minnesota's two HMOs that were created specifically to serve MA and GAMC recipients both reported surpluses in 1991. Metropolitan Health Plan, which is operated by Hennepin County's Bureau of Health, reported a surplus of \$7.1 million for its public program. John Bluford, Metropolitan's director, said the surplus was the result of a well-integrated system that emphasizes delivering an appropriate level of care. UCare, which is affiliated with the Department of Family Practice at the University of Minnesota, had a surplus in 1991 of \$2.1 million.¹⁰³

For populations that need intensive services - those with severe disabilities, for example - the challenge of recruiting and retaining managed care entities is even more difficult

Another disadvantage of managed care is that it is difficult to implement in sparsely populated areas that have a limited number of providers.

Savings potential¹⁰⁴

The savings potential of this option is difficult to estimate. However, the data on savings realized to date in Minnesota's Prepaid Medical Assistance Program (PMAP), AFDC voluntary prepayment program and GAMC prepayment program are helpful in understanding the magnitude of potential savings.

For 1987-1989, gross savings attributed to the PMAP were \$21.5 million; net savings to the state general fund were \$6.3 million, an average of \$2.1 million per year. For 1990-1991, gross savings from PMAP were \$12.2 million; net savings to the state general fund were approximately \$3.1 million, or \$155 million per year.

For the AFDC voluntary program, net savings to the state for 1989 were approximately \$181,000. For 1990 and 1991 combined, net state savings were approximately \$64,000 - \$32,000 per year.

For the GAMC prepayment program, net state savings for 1989 were \$3.5 million. For 1990 and 1991 combined, net state savings were approximately \$4.3 million, or \$2.15 million per year.

Rates paid by the Department of Human Services in its current capitated programs range from 90 to 95 percent of fee-for-service experience.

¹⁰²Baumgarten, Allan, "Two Medicaid HMOs post large '91 surpluses," *Minnesota Journal*, Vol. 9, No. 5, May 12, 1992, p. 6.

¹⁰³*Ibid.*

¹⁰⁴The data in this section were drawn from the following: Minnesota Department of Human Services, *Minnesota Prepaid Medicaid Programs: Analysis of Cost Savings Calendar Years 1987-1989*, April 1991, and an unpublished draft version of the same report for calendar years 1990 and 1991.

Other possible options that would contribute to assuring that consumers receive the lowest cost appropriate care include the following:

Option A1 - Limit Medical Assistance spending on nursing homes while placing greater emphasis on alternative forms of care;

Option A2 - Limit Medical Assistance spending on institutions for people with developmental disabilities and mental illness while increasing the emphasis on development and utilization of alternative forms of care;

Option A3 - Consolidate the funding and administration of services for Minnesota's elderly citizens, and

Option A4 - Consolidate the funding and administration of services for persons with developmental disabilities.

Chapter 6

Other Possible Reforms

Possible Option: Cap Minnesota's Total Medical Assistance Spending

Issue

Minnesota's total Medical Assistance spending is growing rapidly. Because of the entitlement nature of the program, total MA spending is not limited - as most government programs are - to a specific appropriation determined by the legislature.

Background

Minnesota's total spending (federal, state and county spending combined) on Medical Assistance has grown from approximately \$993 million in FY 1985 to \$1.9 billion in FY 1992.¹⁰⁵ In FY 1995, the Department of Human Services projects that Minnesota will spend approximately \$2.4 billion on MA.¹⁰⁶ These total amounts translate into state and county spending on MA of approximately \$467 million in 1985, \$874 million in 1992, and a projected \$1.1 billion in 1995.¹⁰⁷ If Department projections prove correct, state and county spending on MA will increase a total of \$633 million, or 135 percent, between 1985 and 1995. The average annual increase during that ten-year period will have been approximately 13.5 percent

(For more background information on growth in the MA program, see earlier section entitled "Trends in Minnesota's Medicaid Spending: 1985 to 1992")

As has been discussed in other sections, Minnesota policy makers have been aware for some time of the need to control costs in the MA program. As a result, a great deal has already been accomplished in the way of implementing cost control mechanisms in MA-supported programs. However, these measures can only do so much in terms of controlling growth in health care costs.

Beyond attempts to build more administrative cost controls and efficiencies into the MA program, and enacting reforms such as those discussed in the earlier sections of this report, there really are only three additional means by which major savings can be achieved in MA. They are:

- 1-Reductions in provider payments,

¹⁰⁵Department of Human Services Forms OD-00239 for FY 1985 and FY 1992.

¹⁰⁶Based on Department of Human Services FY 1994-95 forecast.

¹⁰⁷Based on data table from Department of Human Services Reports and Statistics Division, "Shares of Funding for Medical Assistance and AFDC," September 16, 1991.

2-Eligibility restrictions, and

3-Limitations on services provided.

If the state's total MA costs were capped, some combination of the above cost-saving strategies would need to be implemented in order to manage the MA program within the capped appropriation.

Possible Option

Cap the state's total MA spending.

What has been/is being done in Minnesota

It does not appear that the idea of capping total MA spending has been seriously considered by Minnesota policy makers.

What other states are doing

Various states have implemented various combinations of the three primary Medicaid cost-saving strategies (reductions in provider payments, eligibility restrictions and limitations on services provided) over the past several years. According to a report published by the National Association of State Budget Officers, ten states in 1991 and 15 states in 1992 reduced provider payments in their Medicaid programs; seven states in 1991 and ten in 1992 restricted Medicaid eligibility, and 19 states in 1991 and 23 in 1992 eliminated and/or limited Medicaid services.¹⁰⁸

According to Joshua Wiener of the Brookings Institution:

...States have responded to increasing Medicaid budget pressures by cutting payments to providers so radically that many, especially physicians, no longer treat Medicaid patients. States have also lowered financial eligibility standards for groups not explicitly mandated by federal law (in Alabama a family of two is not eligible for Medicaid if it earns more than \$87 a month) and set arbitrary limits on the number of covered hospital days, physician visits, and prescriptions.¹⁰⁹

It appears that Oregon may be the only state that has made a serious attempt to limit its total Medicaid spending. Even under that state's "Medicaid rationing" plan, however, the Oregon legislature could have chosen to appropriate more money if Medicaid spending were projected to exceed the original appropriation and the legislature did not wish to reduce the number of conditions covered under Oregon's Medicaid program.¹¹⁰ It appears for the time being that Oregon's plan will not be implemented, as the Bush administration recently refused Oregon's

¹⁰⁸National Association of State Budget Officers, *Balancing the State Medicaid Budget FY 1991 and FY 1992*, Washington, D.C, March 1992, Appendix, Tables 4 and 5.

¹⁰⁹Wiener, Joshua, "Oregon's Plan for Health Care Rationing," *Brookings Review*, Winter 1992, p. 28.

¹¹⁰For a summary and analysis of Oregon's plan, see Joshua M Wiener's article, "Oregon's Plan for Health Care Rationing," in the Winter 1992 *Brookings Review*.

request for the authority to waive certain Medicaid rules in order to implement the plan.

Advantages of this option

The obvious advantage of this option is that it would save money for the state and contribute to resolution of the state's projected budget shortfall. If it were carefully implemented, this option could also contribute to greater innovation in the way the MA program is administered.

Disadvantages/obstacles related to this option

From the perspective of the MA enrollee, the primary disadvantage of this option is that it would lead to reductions in health care benefits. To the extent that provider payments would be reduced, eligibility would be limited, and limitations would be imposed on covered services in order to implement this option, the health status of MA enrollees could be adversely affected.

Also, if implementation of this option resulted in eligibility restrictions and limitations on covered services, the uncompensated care burdens of public hospitals would increase. If it resulted in reductions in provider payments, some providers would become reluctant and some could eventually refuse to provide services to MA enrollees.

There are two primary obstacles to implementation of this option:

- 1) Developing a mechanism for holding total MA spending within the designated appropriation would be a politically charged, contentious process, and
- 2) The federal government's current Medicaid laws and regulations would likely not allow such a dramatic change in Minnesota's program. This option would definitely require a waiver and, very likely, a change in federal law.

Savings potential

If Minnesota's MA spending for FY 1994-1995 were held to the estimated spending level for FY 1992-1993, the state would save approximately \$319 million. If FY 1994-1995 MA spending were limited to the FY 1993 level times two, the state would save approximately \$250 million. If growth in MA for FY 1994-1995 were limited to five percent per year, the state would save approximately \$103 million.¹¹¹

¹¹¹Calculations in this section are based on Department of Human Services forecast data.

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Appendices

Benefits

Benefits in General

The following services are available under the GAMC program

- inpatient hospital services
- outpatient hospital services
- services provided by Medicare-certified rehabilitation agencies
- prescription drugs

- medical supplies and equipment for diabetics
- eyeglasses and eye examinations by a physician or optometrist
- hearing aids and prosthetic devices
- laboratory and x-ray services

- physician services
- medical transportation
- chiropractic services if covered under the MA program
- podiatric services
- dental care

Benefits Related to Mental

In addition, to address the special needs of the mentally ill, GAMC covers the following services for eligible persons

- outpatient services provided by an authorized mental health center or clinic under contract with a county board
- day treatment services provided under contract with a county board
- medication prescribed for a person diagnosed as mentally ill who is at risk for institutional care
- case management services, psychological services, medical supplies and equipment, and Medicare premiums, coinsurance, and deductibles for persons who would be eligible for MA if they did not reside in an institution for mental diseases

Provider Reimbursement

Recipients do not receive direct cash assistance from GAMC. The state and counties reimburse the individuals and institutions (called "providers" or "vendors") that provide services to GAMC recipients. GAMC reimburses providers at the same rate as MA. A rate reduction had been in effect for services provided between July 1, 1981 and June 30, 1989.

Appendix 4
GAMC Savings: Option C2
(Dollars in thousands)

Category	FY 1994	FY 1995	Total
Inpatient hospital	\$14,895	\$15,266	\$30,161
Transportation	\$347	\$335	\$682
Case management	\$1,245	\$1,228	\$2,473
	\$16,487	\$16,829	\$33,316

Note 1: Inpatient hospital total savings is estimated, based on 7.5% of total projected CAMC spending for FY 1994 and 1995, and on discussions with Department of Human Services officials.

Note 2: Transportation total is a rough estimate - 25% of total transportation spending projected for FY 1994 and FY 1995.

Income Limits

Income limits for MA have been established for several categories of individuals. Tables showing allowable income by household size for various groups can be found in the appendix. These income limits are based on either the AFDC income standard or the federal poverty guidelines. The AFDC income standard varies with family size and is not automatically adjusted for inflation. The federal poverty guidelines vary with family size and are adjusted annually for inflation.

The chart below lists the income standard, asset standard, and covered services for major eligibility groups. Eligibility criteria for disabled adult children, disabled widows and widowers, and other eligibility groups can be found in M.S. sections 256B.055 and 256B.057.

MA Eligibility - Income and Asset Limits - Benefits

Eligibility Category	Income Limit¹	Asset Standard	Benefits
Family and children	Up to 133-1/3% of the AFDC income standard	Basic asset standard in M.S. § 256B.056 applies	All necessary services
Aged, blind, disabled	Up to 120% of the AFDC income standard	Basic asset standard in M.S. § 256B.056 applies	All necessary services
Pregnant women and infants up to age one	Up to 185% of the federal poverty guidelines for family size	No asset standard	All necessary services
Children one through five years of age	Less than 133% of the federal poverty guidelines for family size	No asset standard	All necessary services
Children six through 18 years or age, born after September 30, 1983	Less than 100% of the federal poverty guidelines for family size	No asset standard	All necessary services
Persons entitled to Medicare Part A benefits	Up to 100% of the federal poverty guidelines for family size	Assets must not exceed twice the SSI asset limit	Medicare Part A and Part B premiums, coinsurance, deductions, and cost effective HMO or competitive medical plan premiums
Persons entitled to Medicare Part A benefits as "working disabled adults"	Up to 200% of the federal poverty guidelines for family size	Assets must not exceed twice the SSI asset limit	Medicare Part A premium
Disabled children eligible for services under the Children's Home Care Option ²	Up to 120% of the AFDC income standard ³	Basic asset standards in M.S. section 256B.056 applies ³	All services necessary to assist the child to remain at home

House Research Department

¹See tables on pages 13 and 14.

²Authorized by section 134 of the federal Tax Equity Fiscal Responsibility Act (TEFRA) of 1982.

³Only the income and assets of the child are counted in determining eligibility.

Appendix 2
Medical Assistance Savings: Option C1
Total \$\$ - federal and state
(Dollars in thousands)

Category	FY 1994	FY 1995	Total
Nursing services	\$82,803	\$88,783	\$171,586
Hospice care	\$271	\$284	\$555
Case management	\$4,256	\$5,102	\$9,358
Transportation	\$5,144	\$5,459	\$10,603
Inpatient mental health	\$25,000	\$25,000	\$50,000
Inpatient hospital, general	\$90,000	\$90,000	\$180,000
	\$207,474	\$214,628	\$422,102

Note 1: Nursing services includes private duty nursing and personal care assistant.

Note 2: Hospice care total is estimated - assumes 1992 total plus 5% per year inflation.

Note 3: Transportation total is a rough estimate - 25% of total transportation spending projected for FY 1994 and 1995,

Note 4: Inpatient mental health total is estimated, based on discussions with Department of Human Services officials.

Note 5: Inpatient general total is estimated - based on 7.5% of total projected MA non-institutional spending for FY 1994 and 1995 (based on discussions with Department of Human Services officials.