

DEPARTMENT

Dr. Young
 of Public Welfare

STATE OF MINNESOTA

126 Office Memorandum

TO : Darcy Miner
 Governor's Office

DATE: November 9, 1981

FROM: Kevin P. Kenney
 Director Office of Policy
 Analysis

PHONE:

SUBJECT: DPW Response to Recommendations of the Governor's Health Care Task
 Force

The attached is an effort by various DPW staff to advise you as to our best judgment concerning the recommendations made to the Governor by the Health Care Task Force.

Each relevant program manager was asked to analyze the recommendations. The staff of the Office of Policy Analysis then attempted to condense and summarize those analyses. In general, the format is:

1. The recommendation
2. DPW position (a brief summary statement)
3. Policy and Administrative Implications
4. Observations about Implementing the proposal
5. Our best judgment as to impact on the state budget

A general comment about the fiscal impact item should be made. In general, the estimates of savings made by Task Force staff are "reasonably close" to estimates of DPW fiscal analysts. However, three observations should be made about those savings:

1. It is very unlikely that any of the recommendations can be implemented by January 1982 - especially given a December Special Session.
2. Some of the large dollar recommendations possibly could be implemented by 7/1/82 but only under ideal circumstances including:
 - A. Legislation enacted early enough to allow for timely notice and implementation;
 - B. Authority for emergency rule making;
 - C. No injunctions or other legal actions; and
 - D. Increased personnel.
3. The recommendations developed by the Task Force may produce general state savings of approximately \$22 million in fiscal year 1983 but two of the recommendations pertaining to services to the mentally retarded will increase MA costs by \$17.4 million. State savings to the MA program without implementation of these two recommendations could be approximately \$11.45 million according to rough DPW estimates.

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Please advise me if more Information is needed on any proposal under consideration. Of course, once the Governor decides which proposals he will recommend to the Legislature, we will do our best to draft legislation, provide more detailed background material and develop more detailed fiscal notes.

KPK:mhp

Attachment

LONG TERM CARE

RECOMMENDATION 1: The Department of Public Welfare should be authorized to freeze the number of MA funded beds in skilled nursing facilities (SNF's) at 17,946; to lower the minimum number of nursing hours in ICF-I's from 2.0 to 1.5; to reduce the per diems for ICF-I's by \$3; and to restrict the rate of increase in per diems to 8%. These provisions should be effective on January 1, 1982. (If they become effective on July 1, 1982, the SNF bed limit should be 19,037, and the ICF-I limit should be 11,518)."

DPW POSITION:

- A. Supportive of concept as a means of controlling Long Term Care costs.
- B. Because of administrative complexity, there is serious question whether it could be done even by July 1982. Also, it assumes staff resources in DPW and MDH which are not presently available.
- C. DPW analysis is in general agreement with savings attributed by Task Force (conditioned, however, by B above).

- A. Freeze the number of MA funded SNF beds at 17,946 (January 1, 1982) or 19,037 (July 1, 1982), and restrict the rate of increase in per diems to 8%.

POLICY AND ADMINISTRATIVE IMPLICATIONS:

The length of time in which the moratorium should be in effect and definition of the fiscal year are important for policy and should be specified. A moratorium on beds can be effective only if the breathing time is used to revise the regulations affecting nursing homes; both the quality standards and the reimbursement rules.

The "heavy care" persons may find it very difficult to gain admission into a nursing home, and hospital length-of-stay and/or increases in state hospital admissions may increase. A premium for serving those persons may become necessary;

Geographic distribution of skilled nursing home beds may become a problem, especially in areas where alternatives are not feasible or where demand grows faster.

It will be extremely difficult to maintain the proposal's bed limits for MA eligibles. If, as it is implied in the proposal, no more SNF beds are certified, that does not automatically mean that the average number of MA (as opposed to private pay) recipients in SNF's will not grow.

A concerted and intensive effort by the DPW and the MDH will be necessary in order to revise rules and to rechannel demand away from SNF.

The backup of "heavy care" patients in hospitals may become quite serious and expensive in some areas of the state. Close monitoring of this problem complemented with the ability to remedy the problem must be in place.

Since different areas of the state may be more or less affected by the moratorium, the DPW and the MDH must develop mechanisms to respond to extreme hardship situations and to help the local areas with technical assistance or other resources. This cannot be done if reductions in state agency staff continue.

IMPLEMENTATION:

Legislation and rulemaking are needed in order to allow the freezing of the number of MA funded beds and the appropriation of the 8% cap. For timely implementation, the DPW and the MDH will need temporary rulemaking authority.

- B. Lower the minimum number of nursing hours in ICF-I's from 2.0 to 1.5; reduce the per diems for ICF-I's by \$3; restrict the rate of increase in per diems to 8%; and achieve a monthly average in ICF-I's of 11,518 persons if implemented effective July 1, 1982. (In conversation with Mr. Franczyk, he explained that if the policy is implemented on January 1, 1982, the average monthly number of ICF-I persons will be 12,500.)

POLICY AND ADMINISTRATIVE IMPLICATIONS:

The reduction of the required minimum hours coupled with a \$3 reduction and 8% cap give the providers the incentive to achieve most of their savings in the direct care areas. The consequences for quality of care can be very serious.

Since the number of beds available in ICF-I's will not be frozen, one can expect great development in this area, as beds that had been previously certified skilled are changed to ICF-I. The policy projects a growth in ICF-I's to 11,518 if the policy is implemented on July 1, 1982 and 12,500 if the implementation takes place on January 1, 1982. The assumption is that all beds that couldn't be skilled because of the freeze under (A) would seek and get ICF-I certification.

Three questions arise: a) if a previously SNF certified bed is recertified to ICF-I, what will be the base that gets the \$3 reduction?; b) without control on the number of ICF-I beds, how is the average monthly number of persons in ICF-I's controlled?; c) how are new ICF-I beds going to be priced?

The cost of the expansion in ICF-I beds will partly offset any savings resulting from freezing the SNF beds and from imposing caps and per diem reductions.

A concerted and intensive effort by the DPW and MDH will be necessary in order to revise rules, monitor quality of care and devise methods of controlling unnecessary expansion of ICF-I's.

The determination of the per diem in new or recertified ICF-I's will be administratively complex.

IMPLEMENTATION:

Legislation and rulemaking are needed in order to implement all changes proposed under B. For timely implementation, the DPW and MDH will need temporary rule-making authority.

The costs for implementing A and B include a full-time equivalent analyst for at least three months in order to develop procedures at \$7,000 and rulemaking at \$5,000.

FISCAL IMPACT:

Biennial Savings (Millions)*

Implementation Date	1-1-82	7-1-82
Savings (millions)	\$15.2	\$6.6

* Computations involve long-term care facility fiscal year.

RECOMMENDATION 2: Minnesota should implement pre-admission screening for nursing homes statewide and mandate that all applicants to nursing homes who are eligible for MA or who may reasonably be expected to become eligible for HA within three months be screened. Screening should be required of applicants who are applying for nursing home residence from hospitals.

DPW POSITION:

- A. Continued support of expanded pre-admission screening,
- B. Cannot be implemented without additional state agency staff.
- C. Future savings assumes (1) alternative care is available and less costly and (2) the care provided actually reduces number of MA persons in nursing homes.

POLICY AND ADMINISTRATIVE IMPLICATIONS:

The current plan is to implement pre-admission screening in the metropolitan counties plus 10 to 15 rural counties by 1/1/82 and to expand the program statewide by 6/30/83. Presently counties implement the program on a voluntary basis. The recommended requirement would necessitate a policy change mandating that counties implement the program without regard for procedures currently in place and with

only limited program experience. The recommended expansion of the program would require additional staff.

IMPLEMENTATION:

Implementation by 7/1/82 may be possible with additional program staff authorized.

FISCAL IMPACT:

There will be no savings this biennium due to high initial screening costs; savings may occur in the future. If implemented 7/1/82, will cost \$0.5 million. Estimates of future costs and savings are based on the following assumptions: all screening will take place, all nursing home stays would be 12 months, a 75% cap is maintained (75% of cost of nursing home care), all persons screened would truly have required SNF or ICF-I level of care, addition of 3 staff.

Savings of \$5.3 million for one year could be realized if these assumptions are true to fact. It is questionable that savings will be realized unless payment for each unit of non-nursing home care represents payment for one less unit of nursing home care.

RECOMMENDATION 3: Alternative care grants should be available to persons in nursing homes and hospitals who choose to move to the community or to ICF-II's.

DPW POSITION:

A. Supportive of alternative care, but question whether a significant number of people would choose to move out of ICF-II care.

B. No savings this biennium. Future savings dependent upon some assumptions as in 2 C (above).

POLICY AND ADMINISTRATIVE IMPLICATIONS:

To the degree individuals are inappropriately placed in hospitals or nursing homes, this recommendation has merit. It seems unlikely that a large number would return to the community if well integrated into present environment. Providing alternative care grants to persons in ICF-II's when the MA program is already reimbursing for their care needs as indicated in individual plans of care needs more clarification.

IMPLEMENTATION:

Difficult to determine without clarification. Certainly not possible by 1/1/82.

FISCAL IMPACT:

There will be no savings this biennium. See previous recommendation.

RECOMMENDATION 4: The state should seek federal match under Title XIX for the state appropriation for alternative care grants*

DPW POSITION:

- A. Supportive and already being implemented.
- B. Obtaining federal match will increase total funds available but will not reduce state costs: no savings.

POLICY AND ADMINISTRATIVE IMPLICATIONS:

This is already in state law and the waiver is being developed for the federal match.

IMPLEMENTATION:

The response to the waiver may be received within 90 days after being submitted.

FISCAL IMPACT:

No cost savings due to federal match.

RECOMMENDATION 5: The Department of Public Welfare should apply to the Department of Health and Human Services for waivers to:

- A. Eliminate the requirement for a medical director in nursing homes;
- B. Require physician calendar visits only once every six months or as needed;
- C. Use a sample population of MA recipients and private residents in nursing homes in the Quality Assurance Review;
- D. Eliminate the requirement for the Utilization Review Committee; and
- E. Eliminate the requirement of consultants in the areas of records, diet, social work, activities and psychiatric services.

DPW POSITION:

- A. Question whether state can monitor quality of care if waivers are obtained.
- B. May not be possible to implement by July 1982 (dependent upon federal response and requirements).
- C. Serious question whether savings claimed by Task Force will be realized.

POLICY AND ADMINISTRATIVE IMPLICATIONS:

Waivers on these five items suggest appropriate quality care can be provided and monitored without these additional professionals or reviews involved. The question of who is responsible for determining medical necessity and appropriate placement remains unresolved. There is a question as to whether all of these items can be waived unless an 1115 demonstration grant is applied for and received

IMPLEMENTATION

If an 1115 demonstration grant application must be completed, implementation may not be possible even by 7/1/82.

FISCAL IMPACT:

Because the waiver is only to waive the requirement and not payment, it is not possible to estimate savings. If these items were waived and then eliminated by long term care facilities in relation to the potential 8% cap, there would be no savings as they would be already computed in the cap reduction.

RECOMMENDATION 6: Minnesota should consider the use of the state tax structure to encourage increased family responsibility for the care of elderly and disabled family members. Tax incentives should be considered to encourage:

- A. Direct care outside institutions,
- B. Health insurance funds (comparable to individualized pension funds) that would include long term care,
- C. Family contribution for institutional care,
- D. Private insurers to cover long term care, and
- E. Employers to provide their employees with long term care coverage.

DPW POSITION:

The Department of Public Welfare has asked the Revenue Department to respond.

SERVICES FOR THE MENTALLY RETARDED

RECOMMENDATION 1: The procedure for allocating state hospital costs should be modified to reflect actual costs in separate per diems for persons with mental retardation, mental illness and chemical dependency".

DPW POSITION:

- A. DPW has been analyzing this for some time and is supportive but should not be mandated to adopt it until it is certain to reduce total costs.
- B. Commissioner should be given authority in statute to make this modification.
- C. Proposal produces a net gain to state treasury but increases rather than reduces MA budget. Task Force's "reduction" must be understood in this way.

POLICY AND ADMINISTRATIVE IMPLICATIONS:

Currently the state hospital per diem is a single statewide figure representing the average cost of serving all state hospital residents without differentiation based on nature of disability or any other variable. The DPW has been analyzing the possibility of having three separate statewide per diems for each of the disability groups (MR, MI, CD). The separation will provide a higher average per diem for the mentally retarded, the group with the largest MA coverage.

The larger federal reimbursement for the MR group will be offset by lower federal and third party pay reimbursement and private pay for MI and CD residents and by the increased state share of MA expenditures.

By reducing private pay and private insurance collections in the MI and CD programs with a corresponding increase in the public sector, the proposal encourages a transfer which is inconsistent with current national policy.

It will add cost to the counties for MR persons, but decrease cost to the counties for MI and CD persons.

Reclassifications of residents within a state hospital will have to be reported immediately to the Reimbursement Division. Therefore, reporting systems will have to be reviewed and strengthened.

The reimbursement automated system at the state level can handle the change with" minor modifications.

Better cost-accounting procedures will be required in state hospitals.

IMPLEMENTATION:

The Commissioner's statutory authority to set three rates rather than one must be clarified by the Legislature.

There will be a one time cost of \$7,000 for data processing.

FISCAL IMPACT:

	<u>Biennium (Millions)</u>	
	Effective 1-1-82	Effective 7-1-82
Increase in Revenue to Gen. Fund (Federal Share of MA)	\$6.5 M	\$4.5 M
Increase in MA State Budget (State Share of MA) - Increase in Revenue to Gen. Fund	\$5.0 M	\$3.4 M
Increase In County MA Budget (County Share of MA) - Increase in Revenue to Gen. Fund	\$.553	\$.380
Net decrease in Revenues from other Third Party Payors or Private Pay	(\$1.254)	(\$.862)
Net Revenues	\$10.8 M	\$7.4 M
Minus State MA Budget Increase	<u>\$ 5.0 M</u>	<u>\$ 3.4 M</u>
Net Gain to State Treasury	<u>\$ 5.8 M</u>	<u>\$ 4.0 M</u>

This proposal produces a net gain to the State Treasury of \$5.8 million or \$4.0 million depending on the time of implementation during the 82-83 biennium. The proposal increases the state MA budget by \$5.0 million or \$3.4 million. However, the state share goes right back to the General Fund so it is not an actual expenditure. For some time, the DPW has been talking to the Department of Finance in order to figure out a different appropriation scheme for state hospitals that would eliminate the double funding of the state share of MA for the state institutions. If we could use our direct funding of state institutions as the state match for MA eligible residents, there would be no need to increase the state MA budget under this proposal.

Under this proposal, the counties' MA budgets increase due to the larger per diems for MR residents. That increase (\$.553 M or \$.380 X' is reflected on the table above. However, that increase will probably be completely offset by decreases in other parts of the county budgets used to pay for the 10% county share of state hospital costs for MI and CD persons who are not eligible for MA.

*(Decrease to Cos of
Medicaid etc*

RECOMMENDATION 2: The per diem increase for community ICF-MR facilities should be limited to 6%.

DPW POSITION:

- A. Supportive of a cap on ICF-MR per diems but question equity of lower cap on this class of provider while not on others (e.g. nursing homes).
- B. DPW is exploring ways to control ICF-MR costs. Revision of the reimbursement rule in a manner similar to proposed Rule 49 changes. However, failure to gain legislative support for that proposal suggests difficulty in getting support for ICF-MR cost control is likely.
- C. Savings from 6% cap, if actually imposed, are as determined by Task Force.

POLICY AND ADMINISTRATIVE IMPLICATIONS:

Less Than SNF care

The average costs for ICF-MR care are significantly more than the average costs of SNF care and this recommendation reacts to those higher per diems. The fiscal year must be defined and the question of whether facilities would be put out of business must be answered. It is difficult to justify a 6% cap to these providers if others are at 8% for reasons of equity.

IMPLEMENTATION:

May be possible to implement 1/1/82.

FISCAL IMPACT:

Savings of \$2.2 if implemented 1/1/82 and \$0.9 if implemented 7/1/82.

DPW POSITION:

- A. This is a form of "cap" on ICF-MR per diems. DPW is supportive.
- B. Comments on recommendation # 2 are pertinent here.
- C. Savings are dependent on timing and extent of maximum-unknown at this time.

POLICY AND ADMINISTRATIVE IMPLICATIONS:

The recommendation suggests ICF-MR's should not receive a greater per diem than that of the state hospitals for MR patients. This is an attempt to resolve the issue of the increasing per diems in ICF-MR's. The Department' of Public Welfare is currently working on a new formula that will combine a maximum with regional averages to become effective under Rule 52.

need to do on 3 levels years.

IMPLEMENTATION:

Could be implemented 7/1/82.

FISCAL IMPACT:

The savings are unknown at this time.

RECOMMENDATION 4: Minnesota should implement a similar maximum per diem for existing ICF-MR facilities, except that facilities with per diems above the maximum will have their per diems reduced by one-third of the difference each year for three years.

DPW POSITION:

Same as Recommendation #3.

POLICY AND ADMINISTRATIVE IMPLICATIONS:

See recommendation above regarding maximum per diem for new ICF-MR facilities.

RECOMMENDATION 5: Minnesota should seek federal match under Title XIX for the following state appropriations and expenditures:

- A. Semi-Independent Living Services,
- B. CSSA monies expended for adults in Developmental Achievement Centers, and
- C. Cost-of-care for the mentally retarded.

DPW POSITION:

A. DPW does not support this recommendation:

- 1. It will increase the MA budget and decrease CSSA budget;
- 2. It is based on an assumption that a future federal cap on MA will protect accounts added to MA by the state just before the cap is put on; and
- 3. There is no justification for adding services to mentally retarded to MA without also including mentally ill and chemically dependent.

B. DPW estimates that it will increase state MA budget by \$14 million. Thus, this does that it will with Task Force "savings" of \$3.3 or \$2.4 million. Increased federal revenues would either go to state treasury or be passed on to the counties.

County

POLICY AND ADMINISTRATIVE IMPLICATIONS;

The proposal would help to fulfill one requirement of the Welsch v Noot Consent Decree, i.e., remove fiscal incentives for counties to place retarded in state institutions. It would relieve counties from having to pay for these services with severely limited Title XX and CSSA funds. This is true, however, only if most of the increased federal revenue is passed on to counties - not - *note* used to increase revenues to state treasury.

None of the program shifts contemplated will reduce expenditures in the Medical Assistance Program, since all of the fund transfers involve recovering only the additional MA state share incurred because of the program shift.

It is questionable whether large cost increases can be controlled once Medical Assist coverage begins, per the example of ICF-MR's. Since rat *DPW want Administ* statewide basis, and since MA is perceived as being an open-ended source by many, it may not be possible to ensure that "reasonable cost" reimbursement does not become unreasonable.

It is possible that the numbers of clients will increase greatly because "open-ended"! MA funding will encourage case-finding and service expansion, the so-called "woodwork" effect.

Because of MA's perceived status as an "open-ended" funding source, there may be shifting of service delivery and classifying of clients to services and categories covered by MA, regardless of individual needs. The history of ICF-MR's is again pertinent.

If costs accelerate greatly and the MA deficit increases commensurately, how will inevitable program cut-backs be handled? We may be forced to eliminate or

reduce covered medical services, e.g., dental care for the medically needy, because we chose to expand MA coverage to DAC's, adult foster care, etc. This concern is intimately tied to one's concept of the basic purpose of the MA program and which services are most essential to meet basic health care needs when there is not enough money to pay for all services.

If a cap is placed on federal Medicaid expenditures, the concerns listed above become even more serious.

Transferring funds out of CSSA to Title 19 means that local control of those funds is lessened. Counties will lose the option of deciding how those funds should be spent and the state will have to decide, on a categorical basis, the amount of the transfers. *reduce OAC*

The issue of equal coverage within categorical groups must be resolved. If we cover semi-independent living services for the MR population, must we not also cover such services for the mentally ill? If so, the whole area of costs and coverages expands greatly. *No! not eligible*

Shifting individuals out of state hospitals saves the MA program money only if state hospitals are closed. If the hospitals all remain open with high fixed costs, a reduction in patients means only an increase in per diem for those remaining. *policy*

IMPLEMENTATION:

May be possible by 7/1/82.

FISCAL IMPACT:

This recommendation will increase MA costs \$14 million in fiscal year 1983.

RECOMMENDATION 6: Minnesota should investigate the use of tax incentives to encourage increased family responsibility for the care of mentally retarded members (see Recommendation #6, Long Term Care).

DPW POSITION:

Revenue Department has been asked to comment.

provider who over-services or over-prescribes for patients. To the degree these providers are identified and sanctioned, the recommendation has merit.

IMPLEMENTATION:

This recommendation would be extremely complex, costly and time consuming to accomplish. It probably could not be done this biennium.

FISCAL IMPACT:

High initial computer costs. Would also require additional county and state staff time and/or personnel. Savings would not occur this biennium but could be significant in the future.

RECOMMENDATION 2: The Task Force supports in principle the establishment of a rate-setting mechanism for MA-related hospital reimbursement and encourages continued developmental work by the state.

DPW POSITION:

- A. DPW is currently attempting a prospective rate review mechanism.
- B. DPW is proposing legislation to prevent legal challenges to its authority to impose this rate-setting mechanism.
- C. This will help to contain growth to the 8% cap imposed in 1981 legislation.

POLICY AND ADMINISTRATIVE IMPLICATIONS:

The Department of Public Welfare is currently attempting to implement a prospective rate review methodology for inpatient hospital costs which would have the features of cost containment, incentives for efficiency and economy and allow the State Agency the ability to assess budgetary needs with greater accuracy

Current experience on that effort would indicate that legislation is required to the Commissioner of Public Welfare the authority to establish rate methodologies and set rates without being encumbered by following the Administrative Procedures Act.

IMPLEMENTATION:

The implementation date for the current effort is 12/1/81. There are potential legal enjoinders over such issues as the legality of any percent containment and the authority of the State Agency to develop such a rate setting methodology.

ACUTE CARE

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

- A. Each recipient would choose a primary care physician as their case manager; each recipient could change their case manager at periodic intervals.
- B. The case manager would be the gate-keeper to all services provided or ordered by physicians, but would not have control over services not provided or ordered by physicians (e.g., dental services, nurse midwife services, chiropractic services).
- C. The costs of all services under the responsibility of the case manager would be attributed to the case manager for purposes of measuring utilization.
- D. Case managers with cost profiles beyond the established norms would be subject to a range of penalties (e.g., reductions in their reimbursement rates).
- E. Each recipient will also choose one pharmacy to which the recipient will be restricted, but changes will be allowed at periodic intervals.
- F. All non-emergent hospital admissions will be subject to a pre-admission screening process and non-delegated concurrent review, which will be contracted out to an appropriate body for a negotiated price. Mental health, chemical dependency, and behavior modification treatments will be subject to mandatory triage.
- G. Emergency room use and medical transportation will be limited to cases of genuine emergencies; other cases will not be reimbursed by the Medical Assistance program unless the case manager has given prior approval.

DPW POSITION:

- A. DPW is supportive of concept, especially the 'attempt to control providers who provide unnecessary services in order to obtain reimbursement.
- B. Would be costly and time-consuming to implement.
- C. Savings would not occur this biennium but could be significant in the future.

POLICY AND ADMINISTRATIVE IMPLICATIONS:

This recommendation is an expansion of the present "restriction" program that limits use of providers by documented overutilizers of health care services. The rest of the recipient population, not overutilizing health care services, would be restricted to certain providers. A much more costly problem to the state is the

FISCAL IMPACT:

Unknown, however the current effort would allow the State Agency to meet the 1981 state legislation of containing inpatient hospital growth to a maximum of 82 annually.

RECOMMENDATION 3: Minnesota should encourage the development of a uniform chart of accounts for all hospitals,

DPW POSITION:

- A. CPU does not see need for this if prospective rate setting mechanism is accomplished.

POLICY AND ADMINISTRATIVE IMPLICATIONS:

In concert with the recommendation of a rate-setting mechanism, a uniform hospital chart of accounts would appear to be unnecessary if the proposed prospective rate reimbursement methodology is accepted and adopted since the State Agency would be looking at specified expense categories to be potentially increased by uniformed economic change indicators.

RECOMMENDATION 4: Minnesota should implement stricter standards for physicians who over-provide; penalties should include reduction in reimbursement rates and expulsion from the MA program.

DPW POSITION:

- A. DPW is supportive of concept, but does not see possibility of implementing without:
1. A peer review mechanism;
 2. Additional professional and legal staff; and
 3. Changes to Administrative Procedures Act.
- B. Additional costs would not negate possible savings.

POLICY AND ADMINISTRATIVE IMPLICATIONS:

Authority is granted the Commissioner in Minnesota Statute I 256B.064 to seek monetary recovery and impose sanctions against vendors of medical care for abuse or for a pattern of presentment of claims for services not medically necessary. This statutory authority is further amplified in DPW Rule 12 MCAR § 2.064 regarding surveillance and utilization review. Additional statutory or rule authority would not be necessary.

However, a decision to implement stricter standards with commensurate penalties must address the following considerations:

Prior notice and an opportunity for a hearing must be available prior to implementing sanctions against providers. DPW cannot take timely, aggressive action and time and money must be obligated to lengthy contested case hearings as required under the Administrative Procedures Act.

Hew stricter standards must be defined through the rule making process.

Current provider data define services provided above the norm but do not address the validity of a high level of services. Staff and peer reviews would be required to determine medical necessity.

It is unreasonable to expect significant gains in utilization control through stricter standards unless the Administrative Procedures Act is modified, and professional and legal staff plus peer review consultants are available to handle an increased number of provider reviews and sanctions.

IMPLEMENTATION:

With temporary rule making authority and broader departmental authority, implementation may be possible by 7/1/82.

FISCAL IMPACT:

Not possible to estimate savings without clarification of the "stricter standards". A peer review mechanism and additional professional and legal staff would not negate the possible savings.

RECOMMENDATION 5: Minnesota should seek the implementation of stricter standards of "medical necessity" in the MA program, should not provide MA reimbursement for cosmetic surgery, and should limit surgical transplants to vital organs.

DPW POSITION:

- A. Recommendation appears to arise from perception that HA currently reimburses cosmetic surgery and unnecessary transplants: it does not.
- B. "Medical necessity" is determined by professional provider. The only way to make that "stricter" is to define it in law.
- C. Savings, if any, could be eliminated by court challenges.

POLICY AND ADMINISTRATIVE IMPLICATIONS:

It would appear that a stricter standard of medical necessity would require legislation of such a definition at the state level. Currently the Medical Assistance program does not make reimbursement for cosmetic surgery and surgical transplants are limited to vital organs. In fact it would seem that all surgical transplants do pertain to vital organs when one eliminates hair transplants which are not covered under Medical Assistance since baldness does not constitute a condition of medical necessity.

IMPLEMENTATION:

With the exception of a stricter definition of medical necessity which is currently left to the discretion of the reviewing professional in each individual case, this recommendation would appear to be currently in effect. If the definition of medical necessity is to be legislated, it would appear that July 1, 1982 would be feasible.

FISCAL IMPACT:

Unknown; depends on definition of "medical necessity", appeals, and the court systems involvement in this issue.

RECOMMENDATION 6: Minnesota should require laboratory tests and X-rays to be performed on a pre-admission basis when possible.

DPW POSITION:

- A. This is similar to #5. It is partially in effect already and it assumes state agency capability to critique medical judgment of provider.
- B. Savings are unidentifiable.

POLICY AND ADMINISTRATIVE IMPLICATIONS:

This recommendation would appear to be contiguous with the current Medical Assistance policy in that payment for services on an inpatient basis are correlated with an appropriate diagnosis reflecting the need for inpatient care.

To expand upon the current policies and to further this recommendation, it would appear that additional professional staff time as well as money for additional systems work would be required.

IMPLEMENTATION:

It would be difficult to place an implementation date on this recommendation since it is partially in effect and would appear to be an on-going effort.

FISCAL IMPACT:

Unknown.

RECOMMENDATION 7: Minnesota should implement an expanded program for enrolling MA recipients in HMO's and other prepaid health plans in accordance with the principles approved by the Task Force and contained in the final report.

DPW POSITION:

- A. DPW is supportive of concept, but has not been able to provide incentives to recipients or HMO's to increase utilization.
- B. There will be short-term costs, which will possibly result in future savings.

POLICY AND ADMINISTRATIVE IMPLICATIONS:

The Department has always supported expanding HMO enrollment as a potential cost-saving effort in the MA program. Basic roadblocks to realizing this goal have been restrictive federal regulations; lack of client incentive to join an HMO because of full availability of services in the fee-for-service sector; lack of staff to market HMO's to clients; data privacy restrictions on HMO marketing efforts. Changes in federal law have eased some of the regulatory problems, though others remain. Each of the other problems could be approached by changes in state law or additional staff appropriations.

The amount and difficulty of administrative effort involved would vary with the proposal selected. Short-term costs will be involved with any effort to expand HMO enrollment. The theory is that later savings will compensate for this cost. Major administrative concerns center on the willingness of HMO's to greatly expand MA enrollment along with their willingness to share with DPW information on service utilization.

IMPLEMENTATION:

No proposal to expand HMO enrollment can be implemented by 1-1-82. With much staff work, some proposals could be implemented by 7-1-82.

FISCAL IMPACT:

Completely dependent on type of proposal implemented and speed of implementation.

ELIGIBILITY

RECOMMENDATION 1: Minnesota should adopt the personal property resource standards of the Supplemental Security Income program for Medical Assistance: \$1,500 for a single person and \$2,250 for a married couple.

DPW POSITION:

- A. DPW supports and has proposed it previously.
- B. Given legislative reluctance to enact, implementation not likely before July.

POLICY AND ADMINISTRATIVE IMPLICATIONS:

This change would make Medical Assistance eligibility more restrictive by requiring clients to spend more of their own resources before becoming eligible for MA. The Department has supported lowering of the resource standard, especially the \$10,000 standard. SSI levels may be fairly restrictive, however, especially if we want to encourage individuals to remain in the community.

This would be relatively easy to implement by notification to local agencies and their subsequent efforts to require clients to dispose of the excess resources.

IMPLEMENTATION:

Not feasible by 1-1-82, given legislative reluctance previously to lower the limits.

FISCAL IMPACT:

\$1.4 to \$2.9 million for one year.

RECOMMENDATION 2: Minnesota should eliminate the present cost-of-living RSDI disregard in determining eligibility of Social Security recipients for Medical Assistance and replace it with the disregard mandated by the federal government.

DPW POSITION:

- A. DPW supports as in the past.
- B. Federal Government has recently granted waiver requested as a result of 1981 legislation. This will make it more difficult to obtain legislative support

POLICY AND ADMINISTRATIVE IMPLICATIONS:

Department has consistently supported the elimination of this disregard because of its cost and inequitable client effect.

Local agencies would have to redetermine all RSDI cases and terminate many from the program.

IMPLEMENTATION:

Could be accomplished by 1/1/82 if state law is changed.

FISCAL IMPACT:

Savings for one year could be \$1.4 million.

RECOMMENDATION 3: Minnesota should limit the Medical Assistance eligibility of AFDC-related medically needy to persons under age 19.

DPW POSITION:

- A. DPW supports, but questions likelihood of significant savings.

POLICY AND ADMINISTRATIVE IMPLICATIONS:

Twenty and 21 year olds would no longer be eligible for MA, regardless of income or medical need. This item incorrectly does not include needy children coverage

ending at age 19, along with AFDC-related. It is likely that many of these individuals would qualify for GAMC and, since we receive no federal share for GAMC, cost-savings would be small. Also, the sickest cases would be likely to remain eligible for MA since they would qualify on a disabled basis.

IMPLEMENTATION:

Could be possible to implement 1/1/82 with state law change.

FISCAL IMPACT:

Unknown, but likely to be small.

RECOMMENDATION 4: Minnesota should provide Medical Assistance services to AFDC-related medically needy above the age of 19 and caretaker relatives of AFDC-related medically needy children only upon enrollment in a prepaid health plan.

DPW POSITION:

A. DPW questions:

1. Can coverage be denied people who do not have geographical access to an HMO, and
2. Will HMO's accept?

B. Savings likely to be small.

POLICY AND ADMINISTRATIVE IMPLICATIONS:

Appears unfair and difficult to defend denying MA coverage to individuals who do not happen to live in an area with HMO coverage. Also, as above, many AFDC caretakers would qualify for GAMC with no federal share. Finally, it is not clear that HMO's would be interested in this forced enrollment.

IMPLEMENTATION:

This could not be implemented before 7-1-82 because of the necessity of negotiating with the HMO's.

FISCAL IMPACT:

Unknown but any savings are likely to be small.

RECOMMENDATION 5: Minnesota should extend MA eligibility to AFDC-related medically needy pregnant women for their entire pregnancy, not just the last trimester.

DPW POSITION:

- A. DPW supports because, it may encourage early prenatal care and reduce high risk situations.
- B. May have potential for savings on long term basis.

POLICY AND ADMINISTRATIVE IMPLICATIONS:

The Department of Public Welfare does not save money by not covering pregnant women until the last trimester since obstetricians usually charge a set fee for all prenatal, delivery and postnatal services. This change could help lower hospitalization costs by encouraging early prenatal care and thereby reduce the number of high risk situations.

IMPLEMENTATION:

Could be implemented 1/1/82.

FISCAL IMPACT:

None immediately but may have potential for savings on a long range basis.

DRUGS

RECOMMENDATION 1: The Department of Public Welfare should reimburse for prescription drugs on the basis of actual acquisition cost plus a fixed dispensing fee, with generic drugs dispensed unless the physician specifically indicates otherwise or the generic drug is not biocompatible.

DPW POSITION:

A. DPW supports this recommendation.

POLICY AND ADMINISTRATIVE IMPLICATIONS:

The current variable fee system, where the fee increases in proportion to the cost of the drug, serves as a disincentive to the use of generic or less expensive drugs. Administration of actual acquisition costs and a fixed fee will not require significant time or manpower. The auditing of invoices to assess compliance with actual acquisition cost will require additional time and manpower.

IMPLEMENTATION:

Actual acquisition cost and fixed fee can be implemented 1/1/82.
Implementation of mandatory use of generic drugs is possible by 1/1/83.

FISCAL IMPACT:

Implementation of fixed fee only:	\$ 0
Actual acquisition cost plus fixed fee:	Impossible to estimate
Dispensing of generic drugs:	\$.48 million per year

RECOMMENDATION 2: The Department of Public Welfare should limit MA recipients to three prescriptions per month in order to reduce expenditures associated with dispensing fees.

DPW POSITION:

- A. Although this recommendation was included in the 1981 "Governor's Bill", DPW has reservations about recommending it again - principally because it will be necessary to approve many exceptions to it.

POLICY AND ADMINISTRATIVE IMPLICATIONS:

The average number of prescriptions for all clients is three per month. Some client groups average more than three, e.g., clients in nursing homes. If implemented, the Department of Public Welfare will receive thousands of prior authorization requests to exceed the limit.

IMPLEMENTATION:

Not possible to implement until 1/1/83, due to computer programming and eligibility card changes.

FISCAL IMPACT:

The estimated savings of \$.73 million per year would be reduced by additional manpower required to review authorization requests.

NOTE: Although the Department included this in the 1981 bill, it would now have reservations about recommending it.

RECOMMENDATION 3: The Department of Public Welfare should restrict reimbursement to one dispensing fee for each maintenance drug per month to reduce expenditures associated with dispensing fees.

DPW POSITION:

- A. DPW supports this recommendation.
- B. Savings are questionable.

POLICY AND ADMINISTRATIVE IMPLICATIONS:

Because maintenance drugs are taken for extended periods of time, the payment of dispensing fees for having prescriptions for such drugs filled more than once a month is questionable. Guidelines would have to be developed regarding maintenance therapy and for allowing for trial periods to assess the patients' ability to tolerate the drug. Post-payment review will be required for assessment and compliance and recovery.

IMPLEMENTATION:

Could be implemented 1/1/82.

FISCAL IMPACT:

The greatest impact will be on those nursing home providers having unit dose systems.

The savings are impossible to estimate.

RECOMMENDATION 4: The Department of Public Welfare should not reimburse for over-the-counter drugs, except for insulins, antacids, aspirins, acetaminophen, prenatal vitamins, vitamins for children under age 7, and family planning agents.

DPW POSITION:

- A. DPW supports this restriction.
- B. DPW's estimate of savings is less optimistic than the Task Force (\$.5 million vs \$.8 million).

POLICY AND ADMINISTRATIVE IMPLICATIONS:

The majority of state Medicaid Programs disallow payments for over-the-counter drug products, probably because they are easily identified and not generally considered to be essential to medical care. The administration of such a restriction would be relatively simple and inexpensive and is therefore recommended.

Numerous legend drugs (those which require a prescription) should also be considered for non-payment.

Physicians may object to exclusion of over-the-counter drugs because these products may be essential to a plan of care and, if not covered by MA, the patient will not purchase with his/her own funds. Drug manufacturers object on the basis of claims that when over-the-counter drugs are not provided, the physician will substitute a more expensive legend drug.

IMPLEMENTATION:

The 1/1/82 date is possible although time is needed to notify providers.

FISCAL IMPACT:

An estimated \$.5 million per year could be saved if there is no more than a 50% conversion from over-the-counter to legend drug prescriptions.

RECOMMENDATION 5: The Department of Public Welfare should not reimburse for appetite suppressants or drugs listed by the FDA as "ineffective" or "possibly effective". ("DESI")

DPW POSITION:

- A. DPW supports - and some federal action in this direction is already in place.
- B. DPW estimates a maximum savings of \$170,000 per year.

POLICY AND ADMINISTRATIVE IMPLICATIONS:

The Minnesota MA program is one of only a few state programs which provides appetite suppressants. They are not generally considered essential for medical practice. The federal government has already removed FDA "DESI" drugs from reimbursement although injunctions may halt implementation of the payment cutback.

IMPLEMENTATION:

Can be implemented by 1/1/82.

FISCAL IMPACT:

Savings due to elimination of appetite suppressants: \$50,000 per year

Savings due to elimination of DESI drugs: \$120,000 per year

ADMINISTRATION

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

DPW POSITION:

- A. Although DPW has reservations about this decision-making being made by the Commissioner (instead of Legislature), it is recognized as a way to keep within appropriation.
- B. Legislation should establish priorities for reduction and clarify exactly when the Commissioner is authorized to make reductions. Approval of LAC should be required.

POLICY IMPLICATIONS:

This is the proposal from the "Governor's Bill" in 1981. Discussion centered around the following issues: (a) Gives Commissioner control over services, provider reimbursement and indirectly, property tax burden traditionally reserved to elected officials in the Legislature. (b) In Minnesota's county administered system, reductions in state reimbursement increase pressures on county boards to substitute state funds with property tax dollars. (c) Exemption from rule-making (needed due to short time frames) severely restricts opportunity for public participation in reduction decisions.

ADMINISTRATIVE IMPLICATIONS:

A well-defined system of indicators of "underfunding" would have to be in place to justify Commissioner's decision to stake reductions. Reductions would have to be made in a timely fashion to realize the amount of savings to be realized in a particular biennium. Priorities would have to be established, e.g., reduced provider payments, service elimination, reduction in state share of costs.

FISCAL IMPACT:

Proposal assumes spending will be limited to amount appropriated.

extremely slow. Some opportunity for public input would be sacrificed or reduced, but much greater flexibility is needed in making policy changes to react to fiscal emergency.

FISCAL IMPACT:

The recommended changes which would allow more rapid adjustments to prevent spending beyond appropriations in the entitlement programs would obviously reduce' costs. The savings would depend upon the size of the adjustment and the period of time saved by using these recommended changes. Additionally, Department money would be saved by less use of public hearings (hearing examiner costs) and shorter public hearings.

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

- A. The state can file a claim regardless of the age at which the deceased person's medical expenses were paid by the Department of Public Welfare, and
- B. The state's claim on the estate of a deceased persons' estate is invalid only when the entire estate is bequeathed to a living disabled child.

DPW POSITION:

- A. DPW supports proposal.
- B. Savings will be small, but proposal is good policy apart from amount of savings.

POLICY AND ADMINISTRATIVE IMPLICATIONS:

These changes are a way of making the claims process more equitable.

Local agencies would have to be informed of the changes for implementation in their recovery process.

IMPLEMENTATION:

Possible to implement 1/1/82 if state law is changed.

FISCAL IMPACT:

Savings are unknown but probably small.

RECOMMENDATION A: Minnesota should develop competitive bidding procedures for purchasing laboratory services and medical supplies.

DPW POSITION:

- A. DPW supports proposal.
- B. Fairly substantial savings (not quantifiable at this time) could result.

POLICY AND ADMINISTRATIVE IMPLICATIONS:

Competitive bidding is effective when dealing with items provided by a limited number vendors and where the choice of vendor is of little importance to the client. This is a method of reducing costs without reducing services. The major administrative function will be the letting and awarding of contracts; State Procurements currently performs these functions for the state hospitals.

IMPLEMENTATION:

If contracts are let through State Procurement bidding, could be implemented 1/1/82. If the Department of Public Welfare performs this function, start up time will delay implementation to 7/1/82.

FISCAL IMPACT (State Dollars):

Savings for medical supplies and equipment: \$.4 million per year

Savings for laboratory services are not available but are estimated to be substantial.

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

DPW POSITION:

- A. DPW questions the value of creating a new "appropriate mechanism".
- B. If existing mechanisms are seen as inadequate, they should be eliminated before creating a new one.
- C. To perform its task, the new "mechanism" will need additional public or private funds for staff, etc. The only hope of savings lies in the belief that this "mechanism" will do what others have been unable to do.

POLICY IMPLICATIONS:

The recommendation appears to arise from the perception that state government establishes health care policy in a reactive rather than proactive manner, i.e., to resolve an immediate budget problem rather than establish a long range plan and make specific policy decisions which lead the state toward the goals of that plan. Since there have been numerous task forces and advisory committees in recent years, in both the public and private sectors, with goals similar to those of this recommendation, it will be difficult to avoid the criticism that this proposal simply duplicates what is already happening and is a way of avoiding rather than straightforwardly dealing with the problems of the state's health care system.

ADMINISTRATIVE IMPLICATIONS:

Since state and county agencies - Health, Welfare, Health Planning, Community Health Boards, County Boards - already see this as their charge and have a variety of task forces and advisory committees to assist them, the need for additional staff expertise to keep a new "Task Force" informed will be brought up. Therefore, elimination of existing mechanisms should be part of any proposal to establish a new "appropriate mechanism". The role and authority of this mechanism vis-a-vis the statutorily defined responsibilities of state and county agencies will have to be clearly specified.

FISCAL IMPACT:

If successful, the "appropriate mechanism" will arrive at a method of controlling the growth in health care costs. To accomplish its goal, certain administrative funds - staff, supplies, travel, etc. - will have to be made available.

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

DPW POSITION:

A. DPW is generally supportive of these recommendations and is in communication with the Hearings Examiner concerning proposed changes in the Administrative Procedures Act.

- A. Clarification of statutory language to define anticipated appropriate overruns as appropriate grounds for temporary rule promulgation.

POLICY AND ADMINISTRATIVE IMPLICATIONS:

The proposed amendment would allow temporary rule-making to meet the above emergency situation. This would reduce, in these cases, the time period required to amend a rule by 85 - 135 days.

In summary, the proposed amendment would greatly reduce the time needed to amend a rule in response to an emergency situation.

- B. Lengthening of the period of time temporary rules are binding when promulgated for this purpose.

POLICY AND ADMINISTRATIVE IMPLICATIONS:

Temporary rules can now be effective for only 180 days. Department experience is that it takes from 162 - 212 days after a rule has been drafted by the Department to become effective if promulgated following a public hearing. This means that the Department must have drafted and approved a proposed permanent rule within 18 days of the effective date of the temporary rule to have a chance at adopting the permanent rule before the temporary rule expires.

Temporary rules promulgated to meet a budgetary crisis and all other temporary rules should be effective for longer than 180 days. Given the length of time it takes to promulgate a permanent rule with a public hearing, up to one year would not be an unreasonable effective period. This would allow some time to gain experience with the temporary rule and to examine other options.

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

POLICY AND ADMINISTRATIVE IMPLICATIONS:

- (1) Anything done to reduce redundant testimony would be helpful. The most important person in controlling this is the hearing examiner. An additional paragraph could be added to all Notices of Hearing pertaining to consolidating testimony by groups with similar viewpoints.
- (2) Allowing ample time for state departments to prepare responses and rebuttals to testimony is very important in influencing the hearing examiner to concur with the state department's viewpoint in his/her hearing report. Presently the hearing record remains open either five days or 20 days after the hearing depending upon the hearing examiner's ruling. State departments do two things during that period (1) they prepare testimony to rebut opposing testimony given at the hearing; (2) they check the hearing record almost daily to see if any additional opposing testimony has been received so that a rebuttal for it may be prepared and entered into the hearing record.

A time period for state agencies to prepare responses and rebuttals after the hearing record is closed would be very helpful. Presently, it is hard to prepare rebuttal for testimony received the last day the record is open.

- (3) If the state agency established the necessity and reasonableness of a proposed rule, then hearing examiner time and state agency staff time need not be spent considering, responding to or rebutting suggested changes.

The negative impact of reduced opportunity for public input needs to be weighed against more rapid adoption of "needed and reasonable" rules by state agencies.

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

POLICY AND ADMINISTRATIVE IMPLICATIONS:

This proposed amendment would allow a state agency to make a much more rapid policy change when the risk of spending beyond an appropriation is imminent. (Even temporary rules take approximately 49 days to become effective after they are drafted.)

This amendment suggests philosophical questions of safeguarding the right of public input versus budget realities and the need for rapid action to deal with budget realities. Unfortunately a state agency faced with an imminent appropriation overrun would probably not have many fiscal alternatives even if rule-making were utilized. Additionally, rule-making, even temporary rule-making, is a slow method of response to emergencies.

IMPLEMENTATION:

All of the recommended changes would help state agencies to move more rapidly in dealing with a fiscal crisis. The rule-making process, with a public hearing, is