A Rural Government Role In Medicaid Managed Care: The Development of County-based Purchasing in Minnesota

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Astrid Knott, Ph.D.
Jon B. Christianson, Ph.D.

Rural Health Research Center
Division of Health Services Research and Policy
School of Public Health
University of Minnesota

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EXECUTIVE SUMMARY

There has been a widespread shift of state Medicaid programs to managed care during the 1990s. While early Medicaid managed care initiatives focused primarily on urban areas, more recently there has been substantial expansion into rural areas. Given the county role in the administration of the Medicaid program and the counties' responsibilities for indigent care, efforts by the Medicaid program to contract with managed care plans have drawn responses from rural county governments. Managed care programs for Medicaid beneficiaries are a potential threat to rural county governments in two ways: revenues can be diverted away from county providers when these providers are not included in managed care networks, and the availability of services that Medicaid recipients have historically received can be curtailed.

The purpose of this report is to describe the development and implementation (to date) in Minnesota of a model for rural county government participation in Medicaid managed care initiatives. This model is of interest to health policymakers because it provides an opportunity for rural communities to shape and control Medicaid managed care initiatives at the local level. The Minnesota model – called County-Based Purchasing (CBP) – allows county governments the option of functioning as direct purchasers of health care for the Medicaid beneficiaries in their area, accepting financial risk for service delivery. The main reasons that county governments have chosen to pursue CBP are a belief that care coordination is best done locally, a desire to protect the local health care infrastructure, and the fear of cost-shifting from managed care plans to counties.

The report discusses the national and state context in which CBP was developed, describes the legislative and administrative evolution of CBP, and summarizes the implementation experiences to date of three rural CBP initiatives, which also are presented in detailed case studies in appendices.

These initiatives were relatively far along in their development and had followed a similar development pattern. In all three of these initiatives, counties formed partnerships along geographical lines, some in congruence with prior collaborations at the county level. All three initiatives created Joint Powers Boards (JBP) as the administrative mechanisms for implementing CBP.

The main funding sources for the development efforts have been in-kind and financial contributions by the counties and, more recently, Medicaid matching funds. Some financing was provided by federal and state grants and state appropriations. Relations with providers were an important issue in the development process. Initial support for CBP came mainly from ancillary providers who felt threatened by their potential exclusion from managed care provider networks. Physicians were skeptical at the beginning that counties would be able to develop CBP. Further along in the development process, physicians were mainly interested in the operational details of CBP, especially reimbursement. The proposed level of provider reimbursement has been an issue that has strained relationships between at least one initiative and providers. In all three initiatives, physicians were guaranteed reimbursement above current Medicaid rates, after negotiations. The initiatives plan to rely on utilization management to control their costs.

Another issue that arose during the development of CBP is the relationship between the counties and the state. There were disagreements about the basis of the relationship; counties saw themselves as government units engaged in purchasing, while state officials saw them as similar to health plans engaged in contracting. Therefore, from the state's viewpoint, the initiatives were subject to the same types of regulatory oversight as licensed HMOs in Minnesota.

The three initiatives chose very similar delivery system models. They will require beneficiaries to choose a primary clinic or providers, they contract with any willing provider in their areas, and they will hire third-party administrators to perform a variety of management functions, including utilization management. The initiatives will contract with pharmacy benefit managers to implement formularies and other methods to contain pharmacy costs.

Based on the success of a prototype demonstration project in northern Minnesota (Itasca County) the counties are optimistic about the future of CBP. The initiatives have avoided some of the issues that have been implicated in the failure of a county organized health system in California, but some issues remain. Reimbursement, utilization management, and the functioning of the joint powers boards will be critical factors in determining the success of CBP in Minnesota, assuming that HCFA approvals are granted.

If the CBP concept is to be incorporated into Medicaid programs nationally, a number of issues need to be addressed. First, the HCFA approval process for CBP initiatives. Specific requirements are needed for CBP initiatives to fulfill in order to receive approval, and with a specified time frame that allows CBP initiatives to plan for implementation. Second, the relationship between state and county agencies was a major issue in the development process and remains unresolved. Counties have defaulted into a model where the state regulates CBP initiatives essentially as health plans in order to move the development of CBP along. And, third, counties have expended a large amount of resources – both time and money – to develop CBP. Funds were obtained from a variety of sources (counties, legislature, grants) but for at least one initiative, start-up financing was a crucial issue in the development process. Identifying sustainable sources of developmental funding will be critical for adoption of CBP on a wide scale.

INTRODUCTION

The purpose of this report is to describe the development and implementation (to date) in Minnesota of a model for rural county government participation in Medicaid managed care initiatives. This model is of interest to rural health policymakers because it provides an opportunity for rural communities to shape and control Medicaid managed care initiatives at the local level. Briefly, the Minnesota model – called County-Based Purchasing (CBP) – allows county governments the option of functioning as direct purchasers of health care for the Medicaid beneficiaries in their areas, contracting with providers, disbursing payments, assuring quality, and bearing the risk of financial shortfalls. In theory, it addresses many of the concerns that rural leaders have expressed with respect to the efforts of state Medicaid programs to expand the reach of managed care contracting to their communities. In practice, however, it raises a variety of difficult implementation questions concerning the allocation of power and responsibility between state and local governments, the readiness of rural governments to accept and manage the financial risk associated with providing medical services to the Medicaid population, and the ability of various groups in rural areas to forge and sustain the alliances necessary for CBP to function effectively.

This report is based on information gathered from several different sources, including: published state and county documents; internal reports prepared by state and county government staff; background material provided by the Association of Minnesota Counties (AMC) and its consultants; meeting notes and memoranda provided by rural entities participating in CBP; and newspaper accounts. However, interviews (conducted during the period of January, 1999 through August, 1999) are the primary source of data for the report. At the state level, we interviewed representatives from the Minnesota Departments of Human Services (DHS) and Health (DOH) and the Association of Minnesota Counties. At the local level, we focused on

three rural CBP efforts located in different parts of Minnesota. We visited the communities in which these efforts were based, attended meetings, and interviewed county commissioners, program staff, consultants, providers, and employees in county health and social services departments. All interviews were conducted using a standardized interview protocol that varied by position of the respondent (e.g. county commissioners received a different protocol than providers).

In the main body of the report, we discuss the national and state context in which CBP was developed, describe the legislative and administrative evolution of CBP, and summarize the implementation experiences to date of the three rural CBP initiatives. In three appendices to the report, we describe, in detail, each of the three rural CBP initiatives. These appendices are essentially "stand-alone" case studies, although they use a common organizing framework to facilitate comparisons across initiatives.

BACKGROUND

The shift of state Medicaid programs to managed care during the 1990s has been widespread. By 1995, managed care was part of Medicaid programs in 49 states, with 11.6 million people (one-third of all Medicaid recipients) enrolled in HMOs, Primary Care Case Management (PCCM) programs, prepaid plans, and other arrangements (Moscovice, Casey, and Krein, 1997). In a few cases, the conversion to managed care contracts was dramatic, occurring on a statewide basis at a single point in time (e.g. in Arizona and Tennessee), with all Medicaid recipients required to enroll in a managed care plan. There were severe implementation problems associated with these efforts (Gold, Sparer, and Chu, 1996), and most states chose to move more cautiously. Typically, Medicaid programs introduced managed care through negotiated contracts with plans serving specific urban areas. Where enrollment was voluntary, relatively few

recipients selected managed care options. As a result, it is now typical for states to require enrollment in managed care plans, where these plans are available, but to offer beneficiaries a choice of plans.

While early Medicaid managed care initiatives focused primarily on urban areas, more recently there has been substantial expansion into rural areas as well. About 10 percent of rural Medicaid beneficiaries were enrolled in managed care plans in 1995, with the bulk of this enrollment (86 percent) concentrated in five states (Tennessee, Arizona, Hawaii, Oregon, and Washington; Moscovice et al., 1997). Based on 1997 data, Slifkin et al. (1998) concluded that just over half of rural counties had some sort of managed care option for Medicaid beneficiaries, with PCCM programs being the most common option by far. Fully capitated options were available in only ten percent of rural counties.

Slifkin et al. (1998) discussed several reasons why these options have proven difficult to implement in rural areas. Provider fear of managed care and a desire to preserve autonomy in clinical decision making have been obstacles, because these issues make it more difficult for managed care plans to construct rural provider networks that meet Medicaid requirements with respect to beneficiary access to services. The limited potential for commercial managed care enrollment in some rural areas has also been a problem, as managed care plans have been hesitant to incur the costs of establishing and administering rural provider networks to serve only a limited number of Medicaid enrollees. Managing rural Medicaid enrollees also can be more costly than managing urban enrollees, because rural residents sometimes are unfamiliar with managed care, and therefore are more resistant to managed care policies. Finally, some Medicaid state staff may not be enthusiastic about expanding Medicaid managed care to rural areas because they view the administrative costs as outweighing potential cost savings to the program.

In their own assessment, Slifkin et al. (1998) characterize as "puzzling" the emphasis that some state programs place on cost control as the motivation for extending managed care to rural areas, because costs of medical care already appear low in most rural areas. Also, opposition on the part of rural communities and their elected state representatives is quite common, typically based on concerns about the possible impact of managed care on the finances of local "safety net" providers. Despite the opposition of some rural communities and, frequently, a lack of enthusiasm on the part of managed care plans, most state Medicaid programs have adhered to their intent to increase the number of rural Medicaid beneficiaries served under managed care, apparently in search of cost savings, administrative simplicity, consistency in policies statewide, and/or enhanced access to some services (Slifkin et al., 1998). Recently, states have found it easier to secure waivers of selected Medicaid program requirements, which has facilitated efforts to expand managed care initiatives into rural areas (Slifkin et al., 1998).

Whether in rural or urban areas, the strategies adopted by Medicaid programs to contract with managed care plans have captured the attention of county governments. Prior to Medicaid, counties bore the responsibility for providing health care for their low-income residents. Many counties had well-established networks of clinics and public hospitals to discharge these responsibilities, but the costs of providing care severely strained county tax bases and budgets. The Medicaid program reduced the financial burden on counties by providing federal and state funding to reimburse providers for services delivered to individuals meeting Medicaid eligibility requirements. Counties responded by reducing the number and capacity of the medical facilities they owned and operated, but typically retained some delivery capability to serve low income populations not eligible for Medicaid, as well as Medicaid beneficiaries who chose to use those facilities. In rural areas, county-owned hospitals were usually retained as the only local sources

of inpatient care for residents. In addition, counties retained, and in some cases expanded, public health programs for the poor. In fact, these county-owned facilities and programs often received, and continue to receive, a substantial portion of their revenues from serving Medicaid patients. Therefore, any shift in Medicaid payment policies is a matter of concern for county governments and the providers they employ, or who use their facilities.

Managed care programs for Medicaid beneficiaries are a potential threat to rural county governments in two ways: they can divert revenues away from locally-based providers by not including these providers in their networks, and they can limit the availability of, and access to, services that Medicaid recipients historically have used. If the latter occurs, local providers may be pressured to deliver these services and they may then call on county governments for reimbursement. Rural counties characterize this situation as cost-shifting. In their view, managed care plans are responsible for providing the services, and the cost of the services is included in the capitation rate paid by the Medicaid program to the managed care plan, since this rate typically is based on past service use by Medicaid recipients. From a county's perspective, when managed care plans fail to deliver these services they are "cost-shifting" onto the county; in essence the services are paid for twice, once by Medicaid in the plan's capitation rate and a second time by the county when it provides the service.

Managed care plans dispute this characterization of the issue, arguing that they are allowed to determine what is "medically necessary" and are not required to provide a service on demand simply because it is a covered benefit under Medicaid. These issues are particularly salient in rural counties, where the county hospital may be the only hospital available for all county residents, where there are few opportunities for providers to find alternative revenues to replace Medicaid dollars diverted due to policies of managed care plans, and where the health

care sector is an important source of local employment. For rural county governments, efforts by Medicaid programs to extend managed care to their communities raise potential economic development, as well as health care delivery, issues. PCCM models are the least threatening in this respect. To go beyond these models, and still address the concerns of rural county governments, some states – particularly California and Minnesota – have experimented with approaches that offer counties a much larger role in implementing managed care in their communities. The first of these approaches was developed as part of the Medicaid Competition Demonstration of the early 1980s, with mixed success.

In 1982, the federal Health Care Financing Administration approved demonstration projects in six states to experiment with different financing and delivery system approaches for Medicaid recipients. California proposed two approaches that featured counties in central roles: the Monterey County Initiative and the Santa Barbara County Initiative. In each case the counties established new authorities to accept capitation payments from Medicaid. These entities then contracted with local providers to deliver services. The Santa Barbara initiative was extended beyond the demonstration period (Heinen, Fox, and Anderson, 1990), but the Monterey Initiative was terminated in 1985. Aved (1987) notes that the entity created by Monterey County to contract with the state had no ability on its own to raise capital; there were no financial incentives for physicians to control service use, nor were there any utilization management mechanisms in place; in order to secure provider participation, reimbursement rates were generous; the MIS was not adequate for the management of service use or the payment of providers in a timely manner; and the entity's Board was not sufficiently knowledgeable in operating an "at risk" health care system. The board was hesitant to make hard business

decisions for fear of jeopardizing provider support. It expected the state to "bail it out" if it experienced financial difficulties (Aved, 1987).

In the early 1990s, California dramatically restructured its Medicaid program in an attempt to develop an expanded role for managed care (Sparer, 1996). While the California plan was revised several times in response to political pressures, sometimes from counties, and federal government rulings, it provided options through which counties could play an expanded role in managing care for Medicaid beneficiaries. For instance, in 1993 the California Department of Health proposed a "two model" approach under which each county had the option of creating a local private/public partnership (a County-Organized Health System, or COHS) to accept and manage state Medicaid funds. The state indicated its intent to contract with a COHS, where it was present, along with an HMO in each county, providing beneficiaries with a choice. By 1996, six different California counties had assumed responsibility for the health care of about 400,000 Medicaid beneficiaries in California, with five COHSs contracting directly with providers to establish service delivery networks (Health Strategies Group, 1998). As with the earlier Santa Barbara and Monterey Initiatives, the COHSs cannot raise tax revenues and counties are not responsible for COHS debts or contracts. In 1996, HCFA approved a waiver that would allow extension of this model to twelve counties (Yokoi, 1996).

Minnesota was the only other demonstration state in 1982 to define a significant role for county government. Three demonstration counties were chosen – one urban (Hennepin), one suburban (Dakota), and one rural (Itasca). In the urban and suburban counties, beneficiaries were required to enroll in prepaid plans, but in the rural county the county itself functioned as a manager of care delivery. Itasca County, located in north central Minnesota, covers two million acres and has 40,000 residents. It accepted capitation payments from the Minnesota Medicaid

program, organized and managed a provider network (IMCare), and paid providers for the services they delivered (Heinen, Fox, and Anderson, 1990). The director of IMCare is an employee of the Itasca County Department of Human Services. The Itasca initiative became operational in 1982 and expanded its scope in 1985. In 1988, Minnesota obtained federal authority to continue its demonstration projects until June, 1990. Legislation later was passed that permitted Minnesota to extend its prepayment program to other counties (Minnesota Department of Human Services, 1992).

The Itasca program still functions largely as it was originally implemented, with some modifications over the years in financial arrangements with its contracting providers. In their evaluation of IMCare, completed in 1996, Moscovice et al. (1996) observed that the success of the initiative "depends critically on the willingness of local providers to participate" and that "The 'glue' that holds this partnership together is the realization by participating providers that they benefit financially from the arrangement" (p. 46).

In summary, it is important to understand the development of Minnesota's County-Based Purchasing initiative in the context of efforts nationwide to expand the presence of managed care in Medicaid programs, as well as in relation to past efforts within the state of Minnesota to reorganize Medicaid around managed care models. At the national level, counties have always played important roles in Medicaid; county employees determine program eligibility and provide medical and public health services to Medicaid beneficiaries, and county governments fund services for low income residents who move on and off Medicaid. Therefore, changes in Medicaid contracting procedures, eligibility rules, and payment levels have important implications for county programs and finances.

Counties can be expected to pursue policies and alternatives that protect and further their interests in political decision-making around major changes in Medicaid, such as the introduction of managed care. One way in which this has occurred is through the support of alternatives to contracts between state Medicaid offices and managed care plans as the preferred mechanisms for introducing managed care to Medicaid. IMCare, in which a rural county receives capitated payments from the state Medicaid program and contracts with local providers for care, is a functioning model for other rural counties to emulate. Its success over a period of time provided support for, and lent credence to, the efforts of counties in Minnesota to gain state legislation establishing County-Based Purchasing as an alternative to Minnesota's Prepaid Medical Assistance Program.

DEVELOPMENT OF CBP LEGISLATION

In 1992 the Minnesota Legislature passed health system reform legislation. Based on the experiences with the demonstration projects in the Prepaid Medical Assistance Program (PMAP) in Dakota, Itasca, and Hennepin counties, the State Legislature passed a law (1993) making participation in PMAP mandatory by January 1, 1999. One major concern for rural counties in the expansion of PMAP was the potential for cost-shifting from health plans to public health authorities; Ramsey County (St. Paul) officials believed this happened in that county's early PMAP experience. During its first year of PMAP (1993), Ramsey County allegedly incurred $600,000 of non-reimbursable expenses for case management, service brokering, health promotion visits, and home care. According to Ramsey County officials, the health plans that signed contracts under PMAP did not reimburse the county for those services. The county absorbed the losses, which increased demands on property tax revenues (Association of Minnesota Counties, 1998).

With the experience of Ramsey County in mind, rural counties became aggressive supporters of an alternative to PMAP called County-Based Purchasing (CBP). They were concerned about the effect of selective contracting on local providers, possible lack of sensitivity of large health plans based in Minneapolis/St. Paul to local, rural health care issues, and the potential for cost-shifting to the county as the provider of last resort for services not provided by health plans. The problems associated with the statewide introduction of Medicaid managed care in Tennessee (TennCare) further heightened county concerns over PMAP.

Most of the urban counties in Minnesota already had some kind of managed care for Medicaid beneficiaries and were, therefore, not as concerned about the move to statewide PMAP. However, the CBP idea, which was proposed by the Association of Minnesota Counties (AMC), was supported by some urban counties because CBP could provide leverage they could use in negotiations with health plans. They believed it would make it easier for the counties to ensure the fulfillment of public health goals by the plans.

The statewide PMAP expansion began in 1995 and resulted in increasing tension between the state and the counties. One of the first rural counties the state picked for conversion from fee-for-service medical assistance (MA) to PMAP was rural Stevens County. The county filed an injunction against the state, citing a perceived lack of involvement of the county in the process, which constituted noncompliance with legislation passed in 1995 requiring such involvement. As a result, the DHS, which was charged with implementing PMAP, retreated from its initial demands.

At the urging of the AMC, a CBP bill was introduced in the 1995/6 legislative session and quickly garnered support from key legislators. However, when the bill was in committee, a stipulation was included that required counties to abide by the same consumer protection

standards as health plans, where these standards were based on state HMO statutes. In the view of the counties, represented by the AMC, the state HMO statute was not a good model for the legislation.

Before the bill passed the House, there was a negotiating meeting between the health plans and the counties. Some of the suggestions made by the health plans as a result of that meeting were included in the proposed legislation, but disagreement between AMC and the health plans persisted regarding the issue of competition. The health plans argued that counties acting as health plans should compete, while the counties saw themselves as purchasers of care and argued that a competitive model was not appropriate. The bill passed the Senate and the House, but, following lobbying efforts by the health plans, it was vetoed by the governor, and the House failed to override the veto.

DHS raised concerns about the proposed CBP legislation, suggesting that counties be given a choice instead between an "enhanced PMAP" option and CBP, both of which would mean the delegation of some responsibility to the local level. Under enhanced PMAP, counties can make recommendations to DHS regarding participating plans and providers, provide input in the process for issuing requests for proposals, and specify local health goals to be included in contracts.

According to county officials, DHS was opposed to CBP for four reasons. First, it argued that competition in the health care market already existed and CBP would, therefore, only add complexity. Second, the program would create more work for DHS because it would increase the number of plans or initiatives under DHS supervision. Third, planning for CBP would limit DHS's ability to move forward on other health care reform issues that would benefit the state. Fourth, to reach the goal of expanding Medicaid managed care across the whole of Minnesota,

DHS needed the cooperation of the health plans. The health plans indicated that they would not participate in managed care in rural Minnesota without being able to have contracts in Hennepin County (Minneapolis).[1] If Hennepin County chose CBP, this would jeopardize the statewide expansion of managed care under Medicaid. To alleviate the last DHS concern, a clause was added to the CBP bill to the effect that the participation of no single county in CBP may damage the infrastructure of health care in the state.

While the health plans opposed the 1996 legislation, their representatives did not testify against it publicly. The plans did not like the idea of dealing with a large number of counties on an individual basis. They continued their opposition to CBP after DHS, DOH, and the counties came to a tripartite agreement, in negotiations after the 1996 legislative session (see below). In the point of view of the plans, networks and operating procedures were already in place to implement Medicaid managed care and recreating them under CBP would be neither efficient nor effective.

Following the veto of the 1996 CBP bill, "AMC, DHS, and DOH established a working group to resolve concerns about the counties' role. As the result of these negotiations, revised legislation was introduced and passed in 1997. The language in this legislation expands the options of counties to participate in the management of health care including the option to submit an application to the State to act as the manager of health care for persons on Medical Assistance (MA) and General Assistance Medical Care (GAMC) and who are enrolled in PMAP. This authority is referred to as 'County Based Purchasing' " (Ramsey County, 1996-97).

According to the AMC, the willingness of the counties to take on risk in the 1997 bill was a major factor leading to its passage. Furthermore, there was strong support for the bill in the

[1] Hennepin County alone accounted for 26.6 percent of total Medical Assistance enrollment in Minnesota between July, 1998 and June, 1999 (DHS data).

legislature – as evidenced by its passage in the previous session – reducing the likelihood of another veto in 1997.

Under the 1997 law the "Minnesota Department of Health retains it full regulatory authority and, along with the Minnesota Department of Human Services (DHS), has oversight authority and monitoring responsibilities as defined in applicable statutes and rules. The Minnesota Department of Human Services, as the State Medicaid Agency, is accountable to the federal Health Care Financing Administration (HCFA) for the Minnesota Medicaid program. County government, as a subdivision of state government, is accountable to the State Medicaid Agency and would implement CBP within this policy framework" (Minnesota Department of Human Services, 1998).

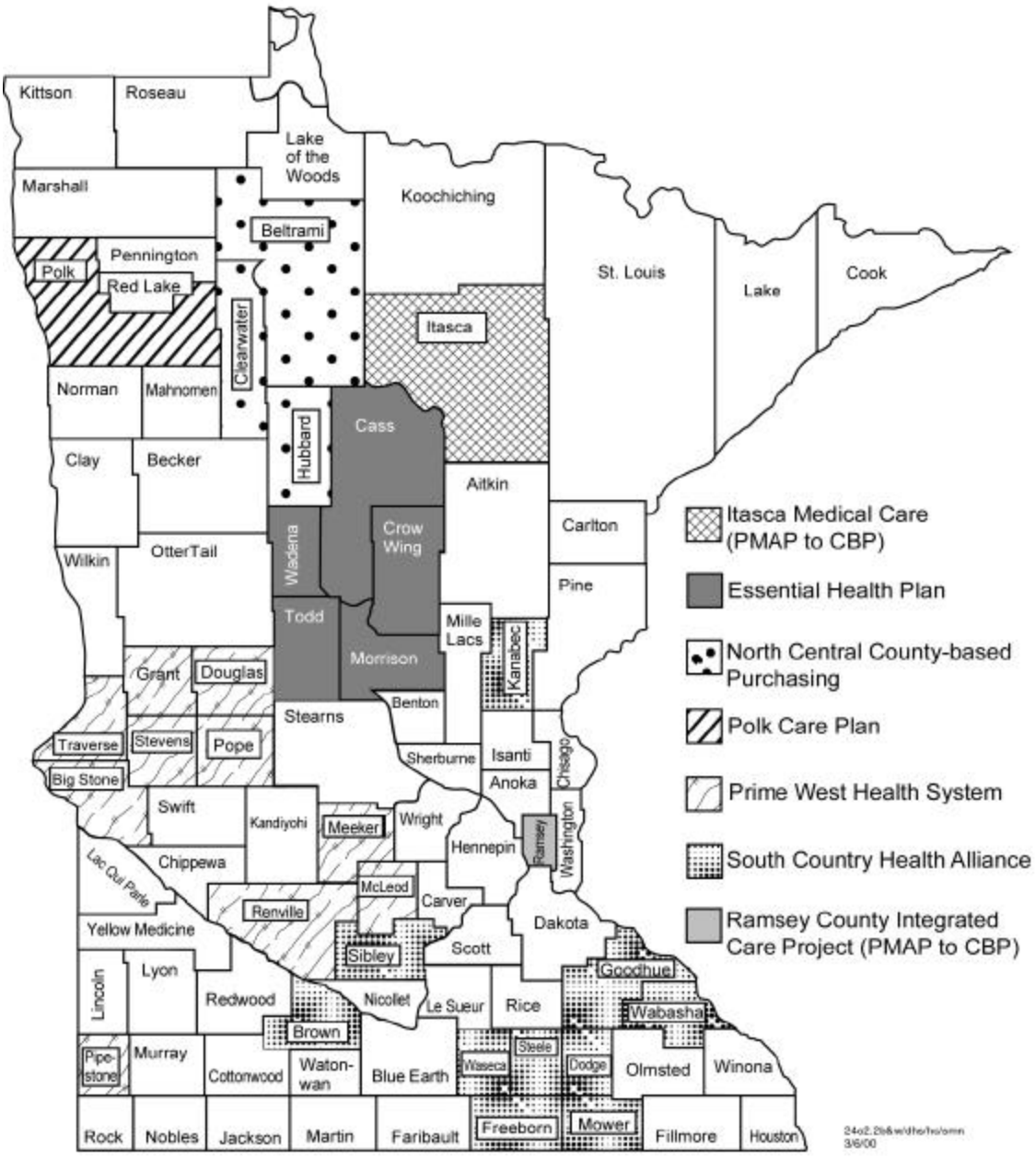
DEVELOPMENT OF COUNTY BASED PURCHASING IN THREE RURAL AREAS

Forty-seven rural counties in Minnesota expressed interest in CBP, and six different initiatives undertook developmental activities. Four of these initiatives met the April 1, 1999 deadline for the submission of final plans to the Department of Human Services (State Health Watch, 1999). (See Figure 1.) We selected three initiatives for study: PrimeWest Health System, Essential Health Plan, and South Country Health Alliance (Table 1). These three initiatives were relatively far along in their development when we began our study and are located in different parts of the state. (Each of the initiatives is described in detail in Appendices A-C of this report.)

The 25 counties in these three CBP initiatives vary in population size from 4,248 to 51,741 (mean 22,104), with an average population density of 33.8 inhabitants per square mile. Unemployment averaged 3.6 percent in 1998 with a range from 2.0 percent to 5.9 percent. The average per capita income was $21,994 in 1998 ($16,584-27,371). On average, 14.9 percent of

Figure 1

County-based Purchasing Initiatives



Source: Minnesota Department of Human Services, 3/6/00

Table 1

Organization of Rural County-Based Purchasing Initiatives

Initiative	Location	Governance	Developmental Funding
Essential Health Plan	Five counties in north-central Minnesota	Joint Powers Board formed in January 1999; executive director hired in July 1999	$115,000 from each of the participating counties; $12,500 from Central Minnesota Initiative Fund; Medicaid administrative matching funds
Prime West Health System	Ten counties in west-central and south-western Minnesota	Joint Power Board formed in December 1998; executive for four-county subgroup hired in June 1997	Approximately $370,000 in provider and county contributions; Rural Network Development Grant of $300,000 from Federal Office of Rural Health Policy; $500,000 start-up loan to be used as needed; Medicaid administrative matching funds
South Country Health Alliance	Ten counties in southeastern and south-central Minnesota	Joint Powers Board formed in summer 1998; executive hired in January 1999, replaced consultant who had worked with the Alliance since 1997	$500,000 in county contributions; $50,000 start-up grant from legislature to two counties; Medicaid administrative matching funds.

children in these 25 counties lived in poverty (7.2-29.4 percent) and 9.0 percent received Medical Assistance (Minnesota's Medicaid program). One county is a Health Professional Shortage Area (HPSA) and five others are partial HPSAs. In this section we summarize and contrast their experiences along the following dimensions: motivation; development; financing; relationships with providers; relationships with the Department of Human Services and the Department of Health; and delivery system model.

Motivation

The three CBP initiatives described a common set of motivations for pursuing CBP in preference to participating in PMAP. One reason was the potential for better coordination of medical and county-based social and public health services under CBP. This coordination was seen as particularly desirable for the most vulnerable of Medicaid recipients who typically need a wide array of services. Second, the counties saw CBP as a mechanism for protecting local providers from being excluded from managed care networks, which they feared would be the case under PMAP. It was felt that some protection was especially needed for mental health providers, pharmacists, and chiropractors. In some cases, providers of these types had been excluded from the networks of managed care firms serving private sector enrollees in the CBP counties. If they were to be excluded from Medicaid, there was concern that the providers might move their practices, and that this would weaken the economies of small towns. Third, there was concern that managed care plans would engage in cost-shifting behavior under PMAP by unduly limiting access to some types of services. Counties then would be pressured to provide those services, without any Medicaid reimbursement. The different initiatives placed different emphases on the relative importance of these three considerations. Indeed, there was variation in

the importance that participating counties within any given CBP initiative placed on them. However, in some form, all three were cited by participants in all initiatives.

Development

Early in the developmental process, the AMC played an important catalyst role. It kept rural counties in Minnesota apprised of legislative developments concerning PMAP and CBP, and also commissioned an actuarial study the counties found helpful in assessing their financial risk from participation. AMC made presentations to groups of counties explaining the concept of CBP. Representatives from IMCare in Itasca County also met with some counties to discuss their experience as a demonstration site. These meetings were important in providing evidence that the CBP approach in rural areas was possible in practice. The IMCare representatives were able to provide practical advice about how to organize and administer CBP initiatives. Local "champions" for CBP, often staff persons in county health or human services departments, sometimes emerged as a result of these meetings.

The DHS also was an important early catalyst in convincing rural counties to seriously consider CBP. DHS representatives met with counties late in 1995 to discuss their implementation plan for PMAP. This plan required that the counties respond in a time frame that was, in the opinion of the counties, unreasonably short. Many county representatives protested that the schedule revealed a lack of interest and effort on the part of DHS in seriously seeking out local input. The counties complained, and AMC lobbied DHS and key legislators on their behalf. As a result, the timeline for PMAP implementation was revised. However, this sequence of events convinced some counties that there would be little local input or control under PMAP, and that they should explore alternatives to PMAP.

Once CBP came under serious discussion in rural areas, counties began to explore partnerships, usually along geographic lines. Quite often, these partnerships were built on previous collaborations. In several cases, two or more counties already participated in Joint Powers Boards (JPB) to carry out various activities. Consequently, the JPB was seen as the logical administrative mechanism for implementing CBP, with all three initiatives eventually establishing JPBs to carry out CBP development. Signing the document establishing a JPB was often the "moment of truth" for counties regarding their commitment to the CBP initiative, as it required a vote of county commissioners in each county. Knowing the vote would not be positive, some counties dropped out of the process at that time. This occurred for a variety of reasons. For instance, one county was already participating in a health care demonstration program and county representatives did not believe that administrative resources were sufficient to take on CBP as well. In another case, physicians in the county were affiliated with a large urban-based system and supported PMAP rather than CBP. Where counties did vote to participate in a joint powers agreement, the vote was not always unanimous.

Counties perceived a variety of advantages to collaborating to carry out CBP. It allowed them to share administrative costs, spread risks through a larger enrollment pool, lower reinsurance costs and financial solvency fund contributions on a per county basis, and increase contracting leverage. The main disadvantage perceived in these collaborations was the loss of local input and control. As the number of counties in the collaboration increased, decisions were less likely to reflect the concerns of individual counties. As a result, one possible advantage of CBP over PMAP was reduced.

Financing

All three initiatives were funded in part through the ongoing in-kind contributions of staff time and financial contributions of participating counties. These contributions varied in size across the initiatives, with each county's share typically reflecting the relative size of its population. In the South Country Health Alliance, the contributions are considered to be loans, but there is no formal repayment schedule. In Essential Health Plan, the expectation was that the contributions would be repaid once the Plan became profitable. In addition to county contributions, PrimeWest received a $500,000 loan from the counties to be repaid in 3 years at 5 percent interest. This money could be used if other sources of funds are exhausted. All three of the initiatives relied on federal Medicaid matching funds to cover some of their CBP start-up costs. Costs associated with administering Medicaid (e.g. eligibility determination and enrollment activities) are eligible for federal financial participation. Because Minnesota has a county-administered Medicaid program, these funds flow back to the counties, in response to county-submitted cost reports.

Each initiative also sought funding from other sources. At the beginning of its existence, PrimeWest collected $250 from providers who wanted to be part of the planning process and received substantially larger contributions from a hospital and a clinic. It also received a federal Office of Rural Health Policy Rural Network Development Grant of $300,000, which it spent primarily on actuarial reports, legal services, and other consulting services. (Essential Health Plan applied for, but did not receive, a Rural Network Development Grant.) Essential Health Plan received an early grant of $12,500 from the Central Minnesota Initiative Fund, while two counties that are part of the South Country Health Alliance received a special legislative appropriation of $50,000 to fund their early developmental efforts.

A major funding issue for all three CBP initiatives related to the uncertainty surrounding when, or if, HCFA would grant the federal waivers or other administrative relief necessary to implement CBP. All of the initiatives hired staff or administrative firms to develop their infrastructures in preparation for implementation. A substantial delay of the federal approval the initiatives feared, would cause some counties to withdraw support for initiative activities slowing momentum for CBP implementation. This issue appeared to be of greatest concern with respect to the future of Essential Health Plan.

Relationships With Providers

As the initiatives evolved, a common pattern of provider relationships and issues emerged. The strongest provider support for the initiatives came from ancillary health care providers, including mental health providers, pharmacists, and chiropractors. They were the most concerned about being excluded from networks under PMAP, and therefore their incomes were the most threatened. They also viewed the experience of ancillary providers under IMCare as generally positive, offering some assurance that they would fare well under CBP.

Early in the development of CBP, physicians typically were skeptical that counties could develop a viable alternative to PMAP. They questioned the experience and expertise of the counties in organizing and managing a complicated enterprise such as CBP. Consequently, they were uninterested in CBP until it became closer to reality in their practice areas. Some of the physicians in these counties were participants in managed care networks and were comfortable with their contracts. For this reason, they expressed a preference for PMAP. Others were employed by large regional health care systems and left the strategizing over CBP to the administrators of those systems.

As it became clear that the three CBP initiatives could become reality, the attention of local physicians shifted to operational issues, focusing, in particular, on reimbursement. In all three cases, physicians sought reimbursement in excess of Medicaid rates – typically at 110 percent of these rates, which is what they expected under PMAP contracts. Ultimately, they were successful in attaining their reimbursement targets, although the process of reaching agreement created an adversarial relationship between physicians and CBP administrators. Another issue for some physicians, particularly those in Essential Health Plan, was a desire that CBP not disturb traditional referral patterns for Medicaid patients. The plan agreed to a service area that addressed this physician concern.

The South Country Health Alliance faced probably the most difficult provider relationship issues. Three large systems based in Minneapolis and Rochester, Minnesota, have a very strong presence in its counties, owning or managing a significant number of physician practices. Without the cooperation of the Mayo Clinic, in particular, the viability of the initiative was questionable. In the county in which it is located, the Mayo Clinic contracted with UCare, a Minneapolis-based health plan, to deliver services to Medicaid recipients. It was assumed that the Mayo Clinic would prefer this relationship in the nearby CBP counties as well, rather than contracting with the CBP initiative. The South Country Health Alliance attempted to address this issue by switching its administrative contract to UCare, but insisted that UCare's provider network be open, so as not to exclude ancillary providers. Some of these providers believe that, when patients are referred to the Mayo Clinic for physician services, they are not referred back to the community for other types of care.

Relationships with the Minnesota Department of Human Services

The rural counties believed that DHS strongly opposed the legislation that created CBP, and that this opposition carried over to early efforts to form CBP initiatives. In the opinion of the counties, DHS staff did not believe that the counties were capable of successfully carrying out CBP. Also, there was a basic disagreement about the relationship between the counties and DHS, as well as DOH. The counties saw themselves as governmental units engaged in purchasing. This left little in the way of an oversight role for either state unit. The state departments saw the counties as operating as health plans, and therefore subject to many of the same rules and regulations governing private health plans under PMAP. DHS also was faulted by some counties for a perceived failure to provide timely data that would allow the counties to assess the risk associated with CBP, or accurate information about the waiver process.

Beginning in the summer of 1999, relationships between DHS and the rural CBP initiatives improved, as the parties worked together in dealing with HCFA over the waiver process. By this time, two of the initiatives began to view the strained relationship between AMC and DHS as an impediment to this collaboration. One initiative – Essential Health Plan – sent a letter to AMC stating that AMC could no longer represent it in negotiations with DHS. South Country Health Alliance also adopted this policy.

Delivery System Model

In the early stages of their development, the three CBP initiatives proposed very similar delivery system models. All three models required that Medicaid beneficiaries choose a primary care provider or practice, in order to encourage coordination of services. Any willing providers in the CBP counties would be allowed to be part of the CBP networks if they met established criteria. Contracts also would be signed with providers outside of CBP counties as needed to

provide geographic access to services. Physicians would be paid at Medicaid rates or at ten percent above these rates with no risk sharing, at least initially. (It was planned that Essential Health Plan's acute care providers would share in surpluses, if any occur.) Costs would be contained through utilization management.

The initiatives each contracted with different third party administrators (TPAs) to manage utilization and conduct other network management activities. The initiatives also planned to contract with pharmacy benefits managers to implement formularies and other mechanisms to contain pharmacy costs. Referral policies within provider networks varied somewhat across the initiatives. For instance, Essential Health Plan would not require authorization to access services from within the network of county providers but would require authorization from its TPA for access to services from a referral provider network maintained by the TPA. South Country Health Alliance would require no referral for routine care but would require authorization from its TPA for access to other types of care.

CONCLUSIONS

In early 2000, all three CBP initiatives were poised to begin operations when and if they received approval from HCFA. In many ways, they had similar developmental experiences and planned similar approaches to the organization and delivery of services to Medicaid beneficiaries. These approaches were patterned after the ongoing success of IMCare, which has been operating for 15 years essentially as a rural, county-based entity in Minnesota that accepts capitated payment from DHS to provide medical care to Medicaid beneficiaries. Because of IMCare's favorable experience with DHS in this relationship, sponsors of the three initiatives were optimistic that they could be successful, avoiding the pitfalls of the Monterey County Health Initiative (see discussion above). The planned CBP initiatives clearly had a much

stronger focus on utilization management than the Monterey Initiative and appeared to have access to proven information systems. However, they also agreed to reimbursement rates in excess of standard Medicaid payments to secure provider participation. And, while they contracted with professional management, joint powers boards planned to exercise final decision-making authority, and these boards are newly formed with no experience in the business of prepaid health care. The relative importance of these different issues will be a critical factor in determining the ultimate success of CBP in Minnesota, if federal authority to proceed is granted. HCFA has indicated that a sole source provider would be acceptable in rural counties after a competitive bidding process. Under this ruling DHS could move forward under its existing authority to issue requests for proposals to select a single contracting entity, which could be a CBP initiative.

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APPENDIX A

PRIME WEST HEALTH SYSTEM

Reasons for Pursuing CBP

The three reasons for pursuing CBP, as stated in PrimeWest's business plan, were: (1) preservation of the local health care infrastructure, (2) better integration of public health and social service functions with acute medical services, and (3) enhanced local control (protection from cost shifting, and creating a health care system that meets unique, local needs) (PRMM Health System & West Central CBP Alliance, 1998).

The first point is essentially an economic development issue. The counties feared that the exclusion of local providers from provider networks developed by health plans participating in MA could cause some providers to leave the area. This was a major concern for PrimeWest counties with a small number of providers or with mainly independent providers. County officials cited as evidence the experience in PMAP counties where health plans generally sign contracts with a limited number of providers (the number of "needed" providers determined by the health plans is generally much lower than the number of providers practicing in the counties). This concern pertains mainly to physicians and allied health providers. Exclusion from networks was a real experience in a number of locales across the ten-county area. Providers in Renville County did lose contracts – for instance, for state employees – because health plans contracted with the larger providers in Willmar, Kandiyohi County. An independent clinic in Olivia (Renville County) – one of two physician providers in town – was excluded from a Blue Cross network. In Big Stone County, health plans were selectively contracting with pharmacies causing concern among county officials. For hospitals, this was not a concern because of the limited number of hospitals in the PrimeWest area.

Secondly, counties saw the opportunity to better integrate the variety of services provided for Medicaid clients. This view is supported by providers, who believe that better care could be offered to those patients if there was more local control.

Finally, there was a potential for cost shifting from health plans to the counties, especially in behavioral health. The counties were concerned that the standards for medical necessity used by health plans would leave the counties responsible for some services. The counties cited anecdotal evidence from Ramsey County that supported this concern.

The county commissioners felt that local control would lead to better responsiveness to the needs of the community and better budget control for the county. The counties did not see themselves as traditional HMOs, since their responsibility would not be as limited as an HMO's would be. In their view, they have a broader responsibility towards their residents.

Although county human services officials were opposed to PMAP from the start, and sought alternatives to PMAP, in the beginning county commissioners were not convinced that an alternative to PMAP was needed. However, once they investigated the issue their thinking changed. One county commissioner found, for instance, that only one health plan was available in the county and that it was not interested in contracting with any of the county's providers, thereby potentially forcing all county Medicaid beneficiaries to leave the area to seek care. This commissioner estimated that about forty percent of visits to local providers were Medicaid visits.

Development of PrimeWest Health System

PrimeWest Health System resulted from the merger of two distinct CBP-initiatives in southwestern and west central Minnesota. The impetus for the southwestern group came from Renville County with a population of 17,000. A presentation to the County Board on the PMAP by an AMC representative in July, 1996, and a subsequent DHS letter to the Human Services

Director of Renville County announcing the statewide expansion of managed care for MA (PMAP) triggered interest in CBP.

A Health Services Committee charged with improving hospital services for the county population, and reporting to the hospital board, already existed in Renville County. Its monthly meetings were attended by a county commissioner, the county Human Services Director, the county Public Health Director, and several providers. When DHS advised the counties about the statewide PMAP expansion, that topic was brought to the Health Services Committee by the Human Services Director. Committee members discussed the possible impact of the expansion on the local health care system and advised the county to explore other options. The PMAP issue was raised with providers, and the providers supported the county's decision to explore other options, as they were concerned about the impact of managed care in general and especially the possibility that urban-based plans would win the contract for Renville County.

In March, 1996, the Renville County Human Services Director recommended to the county board that it explore other options besides PMAP for the MA population. The county board decided to hire a coordinator to head the County-Based Purchasing effort. The coordinator began work in June, 1997; this was a milestone for CBP development in the State, since the new coordinator was the first staff person explicitly hired to develop CBP.

Renville County invited nine contiguous counties (Brown, Chippewa, McLeod, Meeker, Nicollet, Redwood, Sibley, Yellow Medicine) to a meeting on July 15, 1997. Pipestone County – which is not adjacent – was interested in CBP and attended the meeting. The purpose of this meeting was to inform others about CBP and to invite participation in the initiative. Three counties shared Renville County's concerns, and agreed to join in a CBP-initiative: Pipestone, Meeker, and McLeod. Chippewa and Kandiyohi Counties were also interested in CBP but

eventually chose the PMAP option. Sibley County joined the South Country Health Alliance (see Appendix B.)

Meeker County did not seriously consider CBP as an option initially because two HMOs participating in MinnesotaCare (a state-administered health insurance program for low-income residents) were present in the county. Meeker County officials assumed that these plans would be available under PMAP, too. Furthermore, Meeker County has a lower percentage of people in Medicaid than Renville County and, therefore, felt less threatened by PMAP. This position changed when a Meeker County commissioner became concerned about the efforts of one health plan to close a clinic. After further inquiry, the commissioner found that the MinnesotaCare HMOs were not going to contract with local mental health providers, and that Medicaid clients would have to go to Willmar (Kandiyohi County) for those services. In addition, the Meeker County Social Services Department anticipated that its employees would have to be advocates for Medicaid beneficiaries under PMAP, creating a burden on the staff without reimbursement. Furthermore, interest in CBP was developing in parts of the health care provider community, driven by ancillary service providers who were concerned about being excluded from networks.

In contrast to this support, physicians in Meeker County openly opposed CBP. Both clinics in the county's major community (Litchfield) are owned by health plans (Allina and Affiliated), whose corporate offices allegedly were opposed to the clinics participating in CBP. Consequently, the clinic physicians pressured county commissioners to move forward with PMAP instead of CBP. The county commissioners found themselves in a difficult position: if they supported CBP, responding to concerns of the County's Human Services Department and of some area providers, they risked upsetting local physicians, who had the power to shift admissions away from the local, county-owned hospital.

In the summer of 1997 Meeker County eventually joined the CBP initiative but support for CBP on the county board was not unanimous. When the initiative requested a second round of funding from participating counties (see below) in the spring of 1998, Meeker County was allowed to contribute only partial funding until a final decision on CBP could be made in December, 1998. At that time, the county board voted unanimously in favor of CBP.

During the second half of 1997 and through early 1998 each of the four counties (Pipestone, Meeker, McCloud, Renville) held its own monthly meetings, attended by the CBP coordinator. In December, 1997, the CBP initiative held an informational meeting on the existing Itasca County model, IMCare, which was attended by 100 representatives from the four counties. In March, 1998 the four counties signed a basic joint powers agreement, creating a single decision-making entity to address CBP issues.

The second group of counties interested in CBP developed to the northwest of Renville County. Stevens County was one of the first rural counties in which DHS attempted to implement PMAP. The county commissioners felt that they did not have adequate input in the implementation of PMAP as specified in state legislation, and filed an injunction in January, 1996. In the words of one county commissioner, DHS came to a district meeting at Fergus Falls on a Friday and wanted to know by the first part of the next week whether PMAP could go forward in the county. This was interpreted as DHS "railroading" the county into PMAP. The injunction stopped the implementation of PMAP in Stevens County. Letters of support from other counties were sent to the county attorney and the state. The county dropped the case in November, 1996, when DHS indicated that it was reexamining the PMAP implementation plan and would adhere to the law regarding county participation in the implementation process.

Stevens County evaluated enhanced PMAP when it became an option. Although it felt that this was a positive development, it believed that more could be done to involve counties. When CBP became a possibility, county officials in Stevens County decided to examine that option. They initiated a meeting with representatives from five other counties (Big Stone, Douglas, Grant, Pope, Traverse) in October, 1996. Subsequently, these six counties met on a monthly basis, with the meetings facilitated by the Public Health Director for Stevens and Traverse Counties, who effectively became the staff person for this effort. The initiative named itself the West Central CBP Alliance. All six counties committed to proceed with CBP in the fall of 1997 as the West Central CBP Alliance and signed a joint powers agreement in January, 1998. Precedents for a joint powers board between these counties existed, as Stevens and Traverse Counties already had such a board for public health. Each county contributed $22,500 in tax dollars for development of the CBP-initiative. Under the joint powers agreement, costs were to be shared equally.

The defacto staff person for the Alliance and the executive for the four-county CBP initiative met at meetings organized by the AMC and found that the projects were almost identical in their plans. A partnership between the two initiatives was first proposed in April, 1998 and quickly approved. By August, 1998 the initiatives were discussing the creation of one central administrative entity and the formalization of the relationship by creating a ten-county joint powers board. The following month the boards of both initiatives began to meet jointly, and a joint business plan for the two initiatives was presented in October, 1998. Continued support for CBP in three or four of the ten counties was questionable until a ten-county joint powers agreement was signed in December, 1998. Because the counties vary considerably in size

and MA population, they decided that contributions and losses should be shared based on each county's proportion of the 1997 MA population.

The merged entity was named PrimeWest Health System. In the assessment of its executive, the merger had a number of advantages: sharing of administrative costs, doubling the risk pool (now approximately 8,000-10,000 lives), lower reinsurance costs and financial solvency requirements per county, and more leverage in contract negotiations because of size. The only drawback was that the growing size of the initiative reduced the sense of local control in each county (PRMM Health System, 1998a).

The headquarters of PrimeWest Health System moved from Olivia (Renville County) to Alexandria (Douglas County) in the fall of 1999. This location was chosen by secret ballot after the two initiatives merged. Alexandria is located centrally in the northern 6-county area, and its location and opportunities were anticipated to make recruitment of a new CEO easier. The contract of the Executive Director was to expire September 30, 1999, but he agreed to stay until the end of October, 1999 to ease the transition and to speed up submission of documents to DHS/HCFA.

Financing

In 1997, the four-county initiative collected $250 per provider from those who wanted to be involved in CBP ("for a seat at the table"). Although this commitment also was used to gauge provider interest in CBP, non-participation did not preclude providers from contracting with the initiative. The provider contributions of $250 – one hospital and one physician clinic made significantly higher contributions – and $10,000 from each of the counties resulted in a total of $49,250. In March, 1998, the initiative requested an additional $31,979 from each county. The initiative received a Rural Network Development Grant in the amount of $300,000 in 1998 from

the Federal Office for Rural Health Policy. The grant funds were requested for network development activities and were spent on actuarial reports, legal services, and other consulting services. Each of the six counties in the Alliance contributed $22,500 in tax dollars for the development of CBP when they signed their joint powers agreement in the fall of 1997.

After the two initiatives merged in 1998, PrimeWest Health System obtained a $500,000 start-up loan (3 years, 5 percent) from the ten counties. Each county contributed to this loan proportionally to the size of its MA population; potential losses in the future will be shared in the same manner. These funds had not been touched as of July 1, 1999.

PrimeWest Health System expects an enrollment of between 6,000 and 10,000 MA beneficiaries. The original budget projects revenues of $29 million for 11,000 enrollees. Actuarial analyses suggest that the initiative would remain solvent with as few as 6,000 enrollees, although the margin would be very small.

Relationship with Providers

Relationships between PrimeWest and providers vary from county to county, as does support by providers for CBP. Historically there have been tensions between providers and county commissioners on a personal level in some locales. Furthermore, providers question the ability of county government to run a health system, citing its lack of experience and expertise. Input from providers was invited early in the process, however participation was spotty. The two formerly separate initiatives employed different strategies in developing relations with providers.

The four-county initiative started with provider involvement. Renville County had a Health Services Committee, consisting of providers, county staff, and others, which was charged with improving the local hospital. When CBP/PMAP became an issue, it was brought up in this committee. The counties invited all local health care providers to a series of meetings, and the

county commissioners explained the options for the Medicaid program (PMAP vs. CBP). The providers agreed that they did not like managed care and that CBP was the most desirable option (PRMM Health System, 1998b). Approximately 50 providers attended a December, 1997 meeting on CBP, and a smaller number attended the monthly CBP meetings in each of the four counties (PRMM Health System, 1998b). In January and February, 1998, a number of providers made appearances before the state legislature in support of their initiative and CBP (PRMM Health System, 1998b). The county commissioners and providers testified and requested an additional year for implementation of CBP, because data had not been furnished in a timely manner by DHS.

In contrast, the Alliance employed a mainly informational approach. It found that providers were opposed to PMAP, but their stance towards CBP was described as "more skepticism than opposition". Some described the providers in the "added" (west central) counties as being against CBP, possibly because there are a smaller number of independent providers in those counties. Others attribute the stance of these providers to being less informed, rather than being opposed to CBP, because those counties did not have the benefit of a full-time staff person working on CBP who could spend a significant amount of time on outreach and education efforts. Providers and other representatives from the four-county initiative talked to the providers in those counties.

The CBP initiative was generally supported by allied health providers (pharmacists, optometrists, chiropractors, mental health providers, etc.), who seemed to be more interested in CBP than physicians. Mental health providers supported CBP based on the negative experiences of mental health providers in counties that joined PMAP (exclusion from networks, limits on visits).

Dentists opposed, or were uninterested in, CBP. The reasons for this appear to be that: dentists are a unified group of independent providers who do not face competition from corporations as some other health professionals (e.g., optometrists) do; and, dentists do not like the Medicaid program because of its low reimbursement and large "hassle factor". Most dentists would probably not participate in Medicaid were it not a necessity to secure other state contracts.

The reaction of physicians depended on the health care environment in their counties, their practice situation, and their practice size. Providers in counties with more managed care (Hutchinson, McLeod, Meeker) seemed to be less opposed to PMAP than providers less familiar with managed care. Providers who are employees deferred to the wishes of their – mostly non-local – employers. Also, counties with a greater number of providers, e. g. Douglas County, seemed to be less concerned about the potential impact of PMAP on their health care infrastructure.

In one of the counties, physicians employed by a clinic that is part of a managed care organization voiced strong opposition to CBP because the managed care organizations favored PMAP over CBP. However, after the director of the CBP-initiative talked to the HMO administrators, the clinic administrator was willing to discuss CBP, since he wanted to retain Medicaid patients. Physicians generally seemed to become more interested in CBP when it moved past the planning stage and became closer to reality.

Three advisory committees – a Provider Advisory Committee, a Consumer Advisory Committee and a Public Health and Social Services Advisory Committee – are part of the structure of PrimeWest Health System. Nine different provider groups (physicians, hospitals, pharmacy, dentistry, vision care, chiropractic care, mental health/CD, long-term care, home health/DME) will be part of the provider advisory committee. Seven of the nine provider groups

will send one representative to the 11-member provider advisory committee. Hospitals and physicians will send two representatives each.

All four hospitals in the four-county initiative area had signed a letter expressing interest in network participation in support of the Rural Network Development Grant. The initiative mailed contracts to providers in September/October, 1999.

Relationship with DHS/DOH

In general, the relationship between the PrimeWest counties and DHS has been a strained one, probably dating back to the failed attempt at PMAP implementation in Stevens County. Also, DHS voiced opposition to the first CBP bill in 1996 and the negotiations that led to the second CBP bill are described as adversarial.

The general perception from county commissioners and county staff is that DHS has provided little, if any, support, and that DHS did not believe that the counties would be capable of carrying out this project. Accomplishments in the process have been characterized as occurring "despite DHS". County representatives attribute DHS's stance to the fact that CBP diminishes DHS's power and control.

A number of instances of lack of support by DHS were mentioned. Chief among them was the lack of usable and timely data supplied by DHS to the counties to evaluate CBP. Also cited were communications by DHS with HCFA in which no county representatives participated, and the results of which were not directly communicated to the counties. Other reasons for the strained relationship may include miscommunications/misperceptions about the waiver application process, its possible outcomes, and the timing of the application with other waiver applications from DHS to HCFA. Until late 1998, the counties seemed to have operated under the assumption that waiver approval by HCFA was not likely to be a problem.

DHS has a designated project development staff for the implementation of PMAP and CBP. The PrimeWest Health System executive describes the assigned development manager as a liaison and a first point of reference if questions arise. The initiative has used the DHS staff person mainly as a technical resource. Recently, however, the relationship has evolved into a functioning, working collaboration, and the counties concede that they cannot be perceived to be at odds with DHS if they hope to attain a HCFA waiver. A point of contention still is the county role in CBP; the counties see themselves as government, which does not leave a typical regulatory role for DHS.

In July, 1999, DOH informed PrimeWest Health System that it would not review any further submissions at this point. Some interpreted this as a suspension of the initiative. The PrimeWest executive sought clarification, and DOH said that it wanted to end an unproductive back and forth of submissions and indicated that it would look at a final complete submission. Final documents were submitted to DOH on September 29, 2000.

Waiver

The approval of the waiver is seen by PrimeWest Health System as another roadblock that is delaying CBP-implementation, but which will be overcome. There is some concern that the delay will diminish the commitment by the counties, but a financial commitment for CBP exists from all participating counties through late 2001. The Rural Network Development Grant has helped with that. In its own estimation, the initiative has spent less money than other initiatives, leaving it with more reserves than other initiatives, and the opportunity to wait for waiver approval. A concern is that the initiatives that are under financial pressure to start implementation soon, because they need revenues, will make concessions in their negotiations with HCFA/DHS that may raise obstacles for the other initiatives.

A conference call with HCFA early in 1999 in which DHS, AMC, county commissioners and the executives of the different CBP-initiatives participated, was described as unproductive by county representatives. County representatives felt they did not have time to present their projects in a meaningful way, and HCFA officials seemed uninformed about most details (the counties fault DHS for not passing on information).

In December, 1999, representatives of PrimeWest Health System – the executive director, a county commissioner/board member, a physician, and a nurse – met with HCFA staff in Washington, DC, because they feel that HCFA had not yet heard their case clearly presented. A Renville County Commissioner visited HCFA in January, 1999, at which time he also talked to staff of Senator Wellstone. The main purpose of the visit was to clear up confusion that existed around the waiver issue.

County officials visited with their state legislative delegations in March, 1999 regarding the implementation date for CBP set by the state legislature. The goal was to pass legislation that would establish an implementation date as the date of waiver approval plus six months. To the surprise of the county officials, legislators were largely unfamiliar with CBP. Those that were familiar seemed unaware of any problems in CBP implementation. The legislators supported the counties' efforts, and legislation extending the date of CBP implementation passed during the 1999 legislative session.

PrimeWest Health System retained the services of a consulting firm in August, 1999 to facilitate the submission of documents to DHS and HCFA by November, 1999. PrimeWest Health System wanted to underscore to HCFA that it was serious about this project and capable of seeing it through. The initiative was forcing the submission because it was looking for an

indication that HCFA would let it proceed before investing considerable sums into signing contracts, setting up systems, and hiring personnel.

The Model

PrimeWest Health System describes itself as a cooperative governmental effort (PrimeWest Health System, 1999). It is governed by a ten-member joint powers board consisting of one county commissioner from each participating county. PrimeWest Health System plans on contracting for the services of a TPA, a utilization management vendor, a pharmacy and a mental health benefits manager. In late 1999, the initiative had contracted with Nichols TXEN of Birmingham, Alabama, for claims administration and utilization management functions and was planning to select a pharmacy benefits manager and a mental health manager.

Although some providers signed letters in support of the Rural Network Development Grant application that indicated their interest in participating in a provider network, including development of risk-sharing arrangements (PRMM Health System, 1998b), most providers are reluctant to sign risk-based contracts. Therefore, PrimeWest Health System plans no risk sharing in year 1 of operations. PrimeWest Health System plans to contract with any willing provider within the ten county area, and reimbursement will be based on state-set Medicaid fee schedules (PRMM Health System, 1998b). Medicaid beneficiaries will be required to choose a primary care clinic and also may be required to designate other providers (PRMM Health System, 1998b).

Future

As of October, 2000, the anticipated start date of CBP for PrimeWest Health System is June, 2001. County officials are generally optimistic about the future of CBP and remain determined to implement it. An expansion of PrimeWest Health System to a larger number of

counties is possible after the initial implementation. However, there is a concern about keeping things local. Some respondents envisioned an expansion to Medicare and individual policies.

APPENDIX B

SOUTH COUNTRY HEALTH ALLIANCE

Reasons for Pursuing CBP

County officials cited three main reasons for pursuing CBP: (1) the ability to better serve clients with a locally controlled Medicaid program, (2) local economic development, and (3) a desire to avoid cost shifting from the health plans to the counties under PMAP.

First, the counties believed that they would be better able to coordinate care, provide early intervention, and generally improve services to their clients than could a health plan located elsewhere. They also believed that better services could be provided by integrating other county functions, such as Human Services, with medical care. The counties were especially concerned about vulnerable people who were likely to fall through the cracks of the system, and for whom they would continue to be responsible because of their mandates. Furthermore, the counties saw connections between MA and other programs. Analysis for the disability demonstration project of clients that move from the AFDC/GAMC category to the disabled category within the MA program, for instance, showed that there is a potential for improved services, fewer problems, and better outcomes if care delivery issues can be addressed earlier. Surpluses from the program could be invested in the local health care system (more or better services, higher reimbursement to providers).

The second reason for pursuing CBP can be described as an economic development issue. The counties were concerned about the possible effect of PMAP on their health care infrastructure. There was a fear that local providers would be excluded from health plan provider networks and the viability of their practices would be threatened as a result. Providers were, furthermore, concerned that clients referred out of the county would not return for care that

could be provided locally. Some county officials mentioned that this happened with MinnesotaCare beneficiaries who entered the Mayo system. In addition, counties provide a substantial amount of Medicaid services and would, therefore, be dependent on contracting with health plans under PMAP to continue to provide those services and retain their program employees.

The third concern related to the potential for cost shifting from health plans to the counties. There was a fear that, under PMAP, health plans would receive all Medicaid funds but would provide fewer services than currently received by Medicaid beneficiaries. The counties then would be called on to provide these services. Ramsey County's (St. Paul) experience under PMAP was cited as evidence of the potential for cost shifting under PMAP. Essentially, counties believed they would be at risk for certain services anyway, so they might as well manage them all.

Development of South Country Health Alliance

Goodhue and Wabasha Counties, located in southeastern Minnesota, have a joint Public Health Department. In the summer of 1995, amidst preparations by DHS to expand PMAP for Medicaid beneficiaries statewide, a new director was hired for this Public Health Department. The topic of PMAP implementation was discussed during a joint powers board meeting, and he became concerned about the lack of local involvement and local control under PMAP.

PMAP was to be implemented by January, 1996. A meeting between county and DHS representatives regarding PMAP was held on December 10, 1995, with DHS requiring a response from counties within three weeks. The counties voiced their complaints about the lack of local input and local control under PMAP, and about the very short time frame to respond to DHS's demands. DHS acknowledged that the time frame was too tight and dropped the January,

1996 implementation deadline. At the same time, the AMC lobbied very effectively at the state legislature, with the result that the legislature supported the counties on many CBP-related issues. In late 1995, AMC formed a CBP workgroup to provide a forum for discussion of PMAP and CBP and raise awareness of the issues. AMC also gave presentations to counties that were interested in CBP and wanted to learn more.

In 1997, Goodhue and Wabasha received funds from the legislature for a planning process around CBP. In addition to the Public Health and Social Services departments, the planning process involved a number of county commissioners. The support of the Social Services Director was crucial because Social Services controls funds and has power at the local level.

The two counties hired a consultant for actuarial work and found that they would be better able to manage the risk if they had a larger population. The Public Health Director for Goodhue and Wabasha Counties and the Goodhue County Social Services Director did presentations on CBP for educational purposes in cooperation with AMC. They also looked for partners for Goodhue and Wabasha Counties, which they found in a group of six counties located to the west (Dodge, Freeborn, Mower, Rice, Steele, and Waseca Counties). The two groups complemented each other; while Goodhue and Wabasha were ahead of the other six counties in terms of organizational development, those counties were more advanced in technical and compliance issues.

The six counties had started to explore CBP as an alternative to PMAP in early 1996, hiring a consultant to facilitate the process. In early 1997, the six county group held a retreat for purposes of team building, and to derive mission and vision statements. The counties established

a number of principles to define their role in the CBP process. This retreat was mentioned by a number of county officials as having been very helpful in the development of the project.

The Public Health and Social Services directors of the six counties formed a work group which reviewed risk and how to manage it. They surveyed providers in the counties regarding their interest in CBP, their experiences in serving people enrolled in public programs, and payment issues. Preparing documents for the preliminary plan, which had to be filed with DHS in September, 1997, helped underscore the complexity of the problem. While all counties committed time and energy to the effort, in at least one county the commitment was slightly problematic, because the Social Services Director was about to retire. However, the county managed the transition and remained involved with the initiative.

The third group of counties to become part of SCHA consisted of Brown, Sibley, and Blue Earth Counties. Sibley and Blue Earth were working together on a demonstration project for managed care for people with disabilities and were trying to determine whether CBP would complement that project by creating a larger risk pool and providing greater buying power. Brown and Sibley were committed to implementing CBP, but Blue Earth County – which has the largest population and is a regional medical center (Mankato) – decided not to go forward with CBP because of the large amount of resources already committed to the disability project. The remaining two counties needed a partner to reduce their risk. They looked at two adjacent CBP planning groups as potential partners, deciding that the six-county group was the better philosophical fit. They joined that group in early spring 1998, with Goodhue and Wabasha joining the initiative shortly thereafter.

At this time – in the spring of 1998 – a shift occurred from exploring CBP as a possible alternative to PMAP to the actual planning for CBP implementation. A decision by the counties

for or against CBP implementation had to be made by July, 1998. All counties decided to go ahead – two of them with close votes.

The ten counties met jointly in January, 1998 and started working together in March. In the summer of 1998, they formed a joint powers board. At that point, the Rice County Board voted 3-2 to withdraw from the Southern Minnesota CBP Initiative, and the initiative lost 3,000 potential enrollees. The move has been attributed to internal county politics and was not unexpected, according to a number of county officials, given Rice County's prior withdrawal from the disability demonstration project.

Shortly after Rice County's withdrawal, Kanabec County joined the initiative and brought the potential number of Medicaid recipients up to previous levels. Kanabec County is located in East Central Minnesota and is not adjacent to any of the other counties in the initiative. The county had been working on a CBP initiative with neighboring Pine County. County commissioners, the Public Health Department, and providers in Kanabec were committed to pursuing CBP. When Pine County decided to withdraw because of problems related to staff turnover, Kanabec was left to find a new partner. The commissioners of the counties in the Southern Minnesota CBP Initiative felt an obligation to let Kanabec join, even though staff objected to the move on the grounds that Kanabec was too distant and its inclusion did not make sense from a delivery system standpoint. Originally, there may have been the anticipation that Kanabec would soon find other (closer) partners.

Olmsted County, which borders on Dodge, Mower, and Wabasha Counties and is home to the Mayo Clinic, also explored CBP as an alternative to PMAP. However, in March, 1999, the Olmsted County Board voted to abandon the CBP process and begin PMAP enrollment. This move is generally attributed to the opposition of the Mayo Clinic to CBP and to the financial risk

associated with CBP in Olmsted County, which has high utilization and costs. According to an actuarial report commissioned by AMC, Olmsted County had the most unfavorable expense-to-revenue ratio of all counties interested in CBP (Health Strategies Group, and Reden & Anders, 1998).

The formation of the JPB was a milestone for the initiative. Support for the CBP initiative on the County Boards varied: four of the ten counties had unanimous votes of the commissioners, while the rest had split votes (3-2, 4-1). Forming a JPB for an initiative of this size raised some concerns among the participants. The concerns were related to possible problems in communication and cooperation between this many counties. However, the cooperation on the JPB has worked out well. Some of the participating counties had previously worked together on JPBs for other projects, but never in this configuration. And, while some counties were not as fully committed to CBP as others, mainly because of the risk associated with it, this has not affected the work of the JPB. The establishment of guiding principles for the CBP initiative early in the development process has been credited with the smooth operation of the board.

The JPB meets once a month and progress is sometimes slow; each time an issue arises, commissioners report back to their respective county boards, resulting in delays and no clear direction at times. Furthermore, due notice has to be given to call a meeting, which delays progress. To improve on the decision making process, the initiative formed an executive committee consisting of the chair, the vice chair, and the past-chair of the JPB. The executive committee meets one and a half weeks before the JPB meeting to deal with details and make recommendations to the board for discussion. The executive committee can obligate up to $5,000 without full board approval.

The initiative created a number of work groups (Social Services, Public Health, and others as needed) to work on the development of CBP. A large amount of time was spent on preparing materials for submission to the Minnesota Department of Health and the DHS. The work groups were also involved in design issues, and held consumer and provider meetings.

Shortly after the JPB was formed, the initiative started the search for an Executive Director. The Executive Director took over her duties in January, 1999. She had prior experience in managed care organizations and in health care contracting. The consultant that had worked for the initiative since 1997 ended her work shortly after the Executive Director position was filled. The executive director left in November, 1999 and was replaced by the Social Services Director from one of the participating counties. The Southern Minnesota CBP Initiative was officially named the South Country Health Alliance (SCHA) at the May, 1999 JPB meeting (Southern Minnesota Joint Powers Board, 1999b).

Financing

The ten counties together have approximately 15-18,000 MA enrollees. In 1998, South Country Health Alliance had a budget of $368,000. Part of the development effort was financed through federal matching funds (Medicaid administrative funds). These funds will not be available once the Alliance begins to receive capitation payments for Medicaid beneficiaries.

The majority of the funds for the project have come from the ten counties involved. They donated a total of $500,000. Contributions by individual counties were based on county population. The contributions are treated as loans, however no loan repayment schedule exists. At least one county has taken part of the funds contributed to South Country Health Alliance out of its Social Services budget. Goodhue and Wabasha received $50,000 as a onetime appropriation “for the development and start-up operational costs for a joint purchaser

demonstration project" from the State Legislature for fiscal year 1998 (S.F.1908, 80th Legislative Session, Minnesota Senate, 1997-1998). In addition to contributing financially, all ten counties have devoted staff time – mainly of Public Health and Human Services staff – to the project. County Public Health and Social Services directors estimate that they contribute 15-20 percent of their time to CBP.

In the spring of 1999, Steele County became the fiscal agent of the Alliance. It bills the counties on a quarterly basis for expenses incurred. The Alliance estimated that it would need approximately $300,000 to continue operations through the second half of 1999. The budget for 1999 was significantly higher than the budget for the previous year because of the increased activity needed to bring the initiative to operational status (services of actuarial firms for filings to DOH and DHS, actuarial analysis to determine payments to dentists, reinsurance, etc.). The initiative continues to be funded by the counties. South Country Health Alliance expects CBP revenues of $30 million annually. This compares to an annual budget of $18 million for all of Goodhue County.

Relationship with Providers

Provider relations were judged to be the weakest component of the Alliance by a number of officials. A survey of providers conducted by county officials showed that there was interest in CBP. One county official mentioned that providers were interested in contracting directly with the county, but that interest waned when it became clear that providers would have to contract with a third party administrator. According to some county officials, providers were watching the progress of CBP with "some amusement", because they did not believe that the counties would be able to see it through. However, counties objected to the notion that they had

no experience and expertise in health care. A number of them owned hospitals and/or nursing homes.

The counties held provider meetings early in the CBP process. Attendance was low and the most interest was shown by ancillary providers (pharmacy, dental, transportation, DME, etc.). Providers were mainly concerned about reimbursement, regulation, administrative details (forms, contacts, people responsible for coverage decisions, etc.), and the increased administrative burden of adding another "plan". None of the provider groups was willing to take on risk under CBP contracts.

The general strategy for informing providers about CBP, the Alliance, and the progress being made was to have local county staff talk with providers. In some counties, county commissioners or county staff sent out regular memoranda to keep providers updated on the development of the CBP initiative. Most of the ten-county area is dominated by three systems: Mayo, Fairview, and Allina. Consequently, most individual physicians and hospitals did not take a stand on the CBP issue. However, in some counties providers were opposed to CBP. In Goodhue and Wabasha, the hospitals indicated that their relationships with managed care organizations were fine and no change was needed. The Wabasha hospital administrator refused to discuss CBP with county officials. The Alliance decided to try to recruit physicians, in the hope that the hospitals would follow.

The Mayo Clinic is the major player in the southeastern Minnesota health care market. A substantial number of physicians and clinics in the area belong to the Mayo system, with contracting decisions being made by the Mayo Clinic centrally, and not by the local providers. The relationship with the Mayo Clinic therefore was of major concern to the Alliance. The Mayo Clinic, at least implicitly, indicated that it preferred PMAP to CBP and had contracted

with UCare to administer PMAP using the Mayo system in Olmsted County. The Alliance started informal discussions with the Mayo Clinic about CBP in October, 1998. Regarding reimbursement, the Mayo Clinic requested 110 percent of the Medicaid fee schedule. This stance on reimbursement rates was mirrored by the Fairview system (South Country Health Alliance, 1999a).

The general feeling among county staff and officials was that contracting with UCare improved the chances for a beneficial relationship with the Mayo Clinic. Relationships with the local Mayo affiliates were generally said to be good, however the local entities could not make decisions on contracting issues.

The main concern for mental health providers regarding CBP was inclusion of all willing providers in the provider network. Mental health providers in general responded well to the letters sent out by the Alliance. Ancillary providers (labs, chiropractors, pharmacies, transportation providers, etc.) demonstrated considerably more interest in CBP than physicians. A number of ancillary providers were in direct competition with the Mayo Clinic and wanted an open network. The county boards supported this position. The desire for open networks is mainly due to experiences with MinnesotaCare, where patients, once they entered the Mayo system, typically stayed within the system, because the Mayo Clinic could provide all services. Providers thought that patients were not informed about their other options.

One of the issues when CBP started was dental access. The assumption among county officials and commissioners was that higher payment to providers would increase access. In discussions with dental networks, the Alliance found that this was not true, and that payment was not always the most important issue. Some providers simply did not want to serve Medicaid recipients, in part because of a higher rate of broken appointments.

Relationship with DHS/DOH

County officials saw DHS as having a "one size fits all" approach to Medicaid managed care in Minnesota and no real understanding of the health care and development issues in rural Minnesota. Furthermore, there was a strong feeling that at least some of the DHS staff were opposed to CBP and did not think that CBP was actually going to be developed. Therefore, DHS had not developed very basic positions on how it would relate to counties under CBP. Recently DHS was described as more willing to work with the counties, providing necessary information and being supportive on the HCFA waiver issue. County officials observed a strained relationship between AMC and DHS. However, they acknowledge that AMC was successful with its lobbying efforts. In June, 1999, the Alliance decided to work directly with DHS on the waiver, using AMC as a resource and not having AMC speak for them (South Country Health Alliance, 1999a).

Waiver

Representatives from DHS attended a June, 1999 Alliance meeting, where they provided an update on the waiver process after a conference call between DHS, HCFA, and representatives from all CBP initiatives in early June, 1999. The main point was that HCFA had decided to review each CBP project separately, which would take more time than a blanket waiver for the concept would have required. Furthermore, HCFA did not have to abide by a time line, nor did it have to make a decision by a certain deadline. HCFA's concerns regarding CBP focused on four issues: administrative costs, consumer choice, competitive procurement, and cost effectiveness. The counties felt that competitive procurement would not be an issue, because there were not a lot of competitors in most counties.

The Alliance decided in its next meeting that it would be premature to terminate the CBP process due to difficulties in obtaining a waiver. The Alliance agreed to continue development with a start date of April, 2000 in mind. The uncertainty surrounding the waiver application process hindered progress of the CBP initiative.

Some individuals involved in Alliance development were less optimistic about the waiver approval than some county officials. In their opinion, HCFA thinks PMAP is working well and, therefore, sees no need to change anything in the Minnesota Medicaid program. The counties, however, argued that the private sector has moved beyond the paradigm of contracting with HMOs, and HCFA should not hold the public sector to the old paradigm.

In late October, 1999, the initiative provided additional documents to DHS in order to satisfy requirements of Minnesota Statutes 62D and 62N (relating to solvency requirements for health plans).

The initiative continues to monitor the progress of Essential Health Plan (EHP), the forerunner in the waiver process. When EHP met with HCFA in late October, 1999, HCFA officials reiterated their concerns about the lack of competitive procurement and choice under CBP. SCHA believes it has a slight advantage on this issue because its contract with UCare offers choice. Beneficiaries will have the whole UCare provider network to choose from, which reaches beyond the ten-county area. In addition, both UCare and the Mayo Clinic provide medical management for enrollees seeking care from their providers, offering an additional choice.

The Model

The Alliance has decided to employ a gatekeeper model. Each beneficiary will have to choose a primary care clinic or a primary care physician. These gatekeepers will be responsible

for referrals (Southern Minnesota Joint Powers Board, 1999b). A TPA is responsible for the management of acute care. In addition, a Social Services team for each county will work with the TPA to coordinate care for certain groups of patients. The expectation is that this kind of risk management will be looked upon favorably by HCFA in its decision on the waiver. In the future, the Alliance will go a step further and have risk assessment at enrollment, in order to start preventive care early.

In late 1998, the CBP initiative distributed an RFP for a TPA. The two leading contenders for the contract were Information Networks Corporation (INC) of Phoenix, Arizona and UCare of Minneapolis, Minnesota. The initiative selected INC as its third party administrator although some JPB members and county officials favored UCare because of its existing network in the area, its connections to the Mayo Clinic, and its involvement in the disability demonstration project. INC was chosen on the strength of its proposal and its expertise in claims processing. It does claims processing for IMCare in Itasca County, a project that is similar to CBP. INC offered favorable financial terms and expressed its willingness to help the counties get started and eventually turn its functions over to the counties. The proposal submitted by UCare featured its relationship with the Mayo Clinic prominently. At that point in time, UCare seemed unwilling to vary its processes to respond to the requests by the counties. In the view of the initiative, it was treating CBP like just another PMAP contract.

INC signed a letter of intent and began working on the project while its contract was still under review by an attorney for the counties. By March, 1999, the initiative was concerned about the slow progress made by INC. The director of the initiative was concerned about INC's lack of experience with contracting, its lack of experienced staff to work with medical providers, and the limited access to resources of the parent company, AmeriChoice (Southern Minnesota

Joint Powers Board, 1999a). INC was acquired by AmeriChoice – a health services management company that owns and operates health plans in New York City, New Jersey, and Pennsylvania (AmeriChoice Corporation Acquires, 1998) – at approximately the time of the RFP. Originally, INC had hoped that expertise in contracting that it did not have would be provided to the project by AmeriChoice.

The JPB resolved that the initiative would continue to work with INC but, in a June, 1999 JPB meeting concerns were raised again about INC's performance. An INC representative gave a presentation and assured the JPB that the project had the full support of AmeriChoice. A motion to sever ties with INC was tabled until the next JPB meeting and presentations from INC and two other vendors interested in the contract were invited for that meeting (South Country Health Alliance, 1999a).

At the July, 1999 JPB meeting, INC chose not to make a presentation and the JPB passed a motion to sever ties between South Country Health Alliance and INC. Two vendors – the Araz Group of Bloomington, Minnesota and UCare – made presentations to the JPB in support of their bids for the administrative contract. The JPB decided to award the contract to UCare (South Country Health Alliance, 1999b). Points in favor of UCare were its network, its existing compliance with state requirements, and an established relationship with the Mayo Clinic.

Since the Alliance has an any-willing-provider rule, UCare has to open its network to providers not currently included. UCare will receive a per member per month (PMPM) fee for its administrative services (contracts, quality assurance, utilization management, member materials, etc.). Providers will be paid on a fee-for-service (FFS) basis. SCHA will not hire a medical director. This role will stay with UCare, because SCHA found that directors' and officers' insurance was very difficult to obtain. The Alliance plans to create a quality committee, led by a

medical advisor, that will deal with some of the quality issues that are usually the responsibility of the medical director. The committee will do its own analysis of the data.

In late 1999, the Alliance finalized its contract with UCare. It also worked with an actuarial consultant on the issue of risk adjustment to Medicaid rates, and was developing an integrated care model, in order to bolster its argument to HCFA that CBP was preferable to PMAP.

One of the advantages of contracting with UCare is that processes for utilization review and management, pre-authorization, etc. are in place; providers will not face additional and different administrative procedures when contracting with SCHA. The Alliance – through UCare – contracts with any willing provider (physicians, chiropractors, pharmacists, mental health providers) in the ten-county area to realize its goal of preserving the local health care infrastructure. Generally, the any-willing-provider policy pertains only to providers in the ten county area, except for areas where outside providers are necessary to maintain access to primary care within a 30 mile radius for the beneficiary or where there is no continuous linkage to the other counties (Southern Minnesota Joint Powers Board, 1999b).

The model of care, as proposed, also includes a contract with PCS, a pharmacy benefits manager, that currently has relationships with all pharmacies in the area, and contracts with dentists, optometrists, ophthalmologists, and eye wear providers. No referral will be necessary for routine care, but all other care will require authorization from the utilization management department of the TPA (Southern Minnesota Joint Powers Board, 1999b). There will be direct access to mental health evaluation services. Care beyond initial evaluations will require authorization (Southern Minnesota Joint Powers Board, 1999b).

Future

The Alliance hopes to have a proven system of care established in about three years; at this time, the Alliance should be able to make an informed decision about whether to continue with CBP. A number of possible developments may influence that decision: introduction of risk adjustment, change in reimbursement rates, change in the MA population, and the general economic situation. County officials acknowledge that it could take time to create smooth operations between agencies in the ten counties and between agencies and providers. However, they also see great potential in this cooperation, especially by bringing people and agencies together that would not normally collaborate.

APPENDIX C

ESSENTIAL HEALTH PLAN

Reasons for Pursuing CBP

County officials cited local control and the ability to coordinate services as the attractions of CBP in comparison to PMAP. Medicaid managed care is seen as top-down control, whereas CBP is an opportunity to design a system in conformance with local priorities. Under CBP, the system would be driven by public health needs as opposed to cost containment and would stress access and not gatekeeping. County Public Health and Social Services officials believe that they can address the needs of Medicaid beneficiaries better locally, than can health plans headquartered in the Twin Cities. CBP is seen as an opportunity to improve care in their communities.

Another argument for implementing CBP was the concern about losing providers due to network restrictions by managed care plans. In Crow Wing County, some chiropractors and pharmacists were excluded from health plan panels. County officials also saw bypassing of local providers under MinnesotaCare, a means-tested health insurance program for low income Minnesotans.

Evidence of cost-shifting from health plans to counties under PMAP, especially in Ramsey County, was cited as a motivation to pursue CBP. The counties were concerned that health plans would provide fewer services under PMAP than were available before, resulting in an increase in county obligations because of county mandates. Also, Public Health and Social Services are heavily dependent on Medicaid revenue and consequently the counties were concerned that PMAP would limit services provided by these departments.

Development of Essential Health Plan

The five counties of Cass, Crow Wing, Morrison, Todd, and Wadena have a history of working together. They operate a number of joint projects in Social Services and Public Health. Among those projects are Northern Pine Mental Health – a five-county mental health project, the Community Action Program (CAP) Agency of Todd, Crow Wing, and Morrison Counties, and Community Correction (Todd and Wadena). Furthermore, the four smaller counties (Cass, Morrison, Todd, and Wadena) comprise one health district, while Crow Wing County forms its own health district.

In 1994, the Social Services Director for Wadena County was President of the Minnesota Association of County Social Service Administrators (MACSSA). In that capacity he attended a state Medicaid directors conference (1995) where Medicaid plans for using HMOs to deliver care – the Prepaid Medical Assistance Program (PMAP) – were discussed. This started a discussion of PMAP in Wadena County. Even when discussions of purchasing services for beneficiaries through counties was still in its infancy, the issue was monitored by the local Social Services Board. In an April, 1995 meeting of the Wadena County Social Services Board, the Board expressed its preference for joining with one or more counties in the region in an effort to buy Medicaid managed care services (Wadena County Social Services Board, 1995). In May, 1996, a district health meeting was held "to discuss [the] possibility of localizing managed care" (Wadena County Social Services Board, 1996, p. 3). It was attended by county commissioners and Health and Social Services directors.

While Wadena County started out planning a one county CBP project, the surrounding counties were aware of its efforts and supported them. In May, 1996, Cass, Morrison, Todd, and Wadena counties held a district health meeting at which a representative of IMCare – the demonstration project for prepaid Medicaid in Itasca County – made a presentation. This

meeting was attended by staff from the Human Services Departments and county commissioners. Representatives from Crow Wing County also attended, although the county is not part of the health district, because they were interested in CBP. In December, 1996, representatives from the Wadena County Board and representatives from the Wadena County Human Services and Public Health Departments met with the DHS Assistant Commissioner in charge of Medicaid in an attempt to gain support for a Wadena County CBP project. The other counties supported Wadena in its effort to develop a single county project.

Wadena County had originally set out to develop a one-county CBP initiative, but it became clear that a larger risk pool was needed. Wadena County found partners in Cass, Crow Wing, Morrison, and Todd Counties. The Public Health (PH) entities of these counties formed a workgroup in early 1997 to discuss and explore CBP.

Cass County did not commit to the CBP initiative at the beginning because of some unique issues relating to geography and population. The Public Health and Social Services Director for Cass County became aware of CBP through regional Public Health and Social Services meetings. The director and one of the county commissioners saw merit in CBP. They attended the early meetings for two different CBP initiatives, because they considered joining both. Eventually, Cass County decided to join the four-county group, because this group was further ahead in its development and the county felt more comfortable with the group.

Not all the county board members in the five counties fully supported the CBP idea, and participation by some counties was conditional on the participation of others. Wadena County took the lead from the start because it had started as a one county CBP project. Crow Wing County needed to be part of the initiative because of its size and number of Medicaid enrollees, but was reluctant because of the potential financial risk. Actuarial studies based on data

provided by DHS, and commissioned by the initiative, convinced the county commissioners that the risk was manageable. Morrison County was also key, because of its large population. The risk the county would be taking under CBP was a major issue for the Cass County Board. Support for CBP was not guaranteed, and the outcome of the vote on CBP was unpredictable until the date of the vote. The Cass County Board did vote in favor of CBP (3-2).

A joint powers board was formed in December, 1998. The former workgroup chair continued on as the interim executive director. The Board consists of one county commissioner from each of the five counties and one alternate from each county. Decisions are made by a five member board. Public Health and Social Services staff from the five counties play a support role. The search for a permanent executive director, the first employee of EHP, began in January, 1999. The executive director started his duties on July 6, 1999 (Essential Health Plan, 1999e).

EHP distributed an RFP for a third party administrator to 32 organizations in April, 1998. Interviews were held during the month of May. EHP decided to hire the Araz Group because of its philosophy and its ability to customize its program for the counties. Although the vote for the Araz Group was unanimous, actual support was more divided. The contract with the Araz Group was signed in early 1999. Under the contract, the Araz Group would be responsible for medical management, provider network credentialing and management, claims processing, member services, quality assurance, managing subcontracts for pharmacy and dental, and data reporting to the DHS and DOH. Responsibility for eligibility determination and enrollment remained with the counties. EHP and the Araz Group signed a 5-year contract, with the understanding that the counties would likely take over all of the responsibilities – except claims processing and some reports – by the end of the contract.

Contract negotiations with providers began in the spring of 1999, with a deadline set for July, 1999. Some of the contract negotiations with hospitals, clinics, and physicians were contentious, but contracting was completed in October, 1999.

The EHP was approved by the Minnesota Department of Health for meeting the requirements of Minnesota Statutes Chapters 62D and 62N in October, 1999. The approval was contingent on the finalization of the provider network.

Financing

In a first round of contributions (July, 1997), the initiative collected $10,000 from each of the five counties for research into the design and feasibility of CBP. In December, 1998, EHP received an additional $105,000 from each county. Under the joint powers agreement, the five counties contribute funds to EHP and share in the risk associated with CBP equally. In addition, the initiative received $12,500 from the Central Minnesota Initiative Fund (Lundquist, 1999).

Originally, repayment of the $105,000 to each of the counties was going to be the top priority for use of a surplus. However, hospitals and clinics were very adamant about receiving reimbursement higher than 100 percent of Medicaid fee-for-service rates. An agreement was reached to delay the repayment in order to ensure that hospitals and clinics would earn the ten percent withhold which is part of their reimbursement.

EHP expected revenues of $40 million per year to care for 16,000 Medicaid recipients in the five counties (Howatt, 1999). Any surplus would be used to build the required reserves, to improve reimbursement to providers, and to improve the local health care infrastructure.

The initiative applied for a Rural Health Network Grant in 1999. In late summer of 1999, EHP learned that it had not been funded. However, the initiative was told that it had a good

chance of being funded in the next cycle if it would resubmit its application with some changes. The new funding period started May 1, 2000.

In January, 1999, the initiative started paying a monthly fee of approximately $33,000 for the services of the Araz Group. Per member per month (PMPM) payments to the Araz Group were to begin in October, 1999 – then the anticipated start date for CBP. Due to the delay in implementation because of the pending waiver application, the initiative continued to pay approximately $36,000 per month instead of a PMPM payment to the Araz Group. The Araz Group has worked on network development and putting in place processes for claims processing and medical management.

By mid 1999, EHP was pushing aggressively to move the waiver process ahead, since its reserves would be expended by December, 1999 unless CBP revenues became available, the EHP received a grant, or additional funds were solicited from the counties. Although the counties are committed to CBP, continuing financial support from the counties with no firm implementation date would be problematic. However, since not moving forward would mean abandoning the effort and losing the investment, the counties may be persuaded to provide additional funds.

The financial situation was alleviated somewhat when it became clear that some costs incurred in CBP development could be covered by federal Medicaid matching funds (DHS, 1999a). In general, costs associated with the administering of Medicaid – such as enrollment, eligibility determination, etc. – are eligible for federal financial participation. Since Minnesota has a county-administered Medicaid program, these funds flow to the counties. Counties submit cost reports to receive these funds. Medicaid matching funds covered about fifty percent of

funds already expended on CBP. These funds (approximately $220,000-240,000) gave EHP the opportunity to continue CBP development through March, 2000.

EHP commissioned three actuarial studies, each of which produced slightly different results. The first two actuarial studies indicated expense-to-revenue ratios of between 82 percent and 85 percent. EHP developed a budget based on the assumption of an 87 percent expense to revenue ratio. A third – less detailed – actuarial study done more recently incorporated risk adjustment of Medicaid rates, as proposed by DHS. The results of this study indicated that total expenditures could be as high as 115 percent of revenues in a worst case scenario.

Relationships with Providers

The involvement of providers in the CBP planning effort varied from county to county. Some counties invited provider participation through meetings early in the process, while others relied on newsletters and written communications. Only a few physicians were involved at the start of the initiative. The reasons given for the low participation by physicians include a belief among physicians that the initiative would never come to fruition, very limited time available for physicians to spend on activities outside of their practices, very limited specific knowledge about CBP and no anticipated effect on their practice in the immediate future, and little involvement in the business side of medicine.

Some physicians and administrators voiced very vocal opposition to CBP. The expertise of county government regarding the operation of a health care system was questioned, as most physicians did not perceive local government as a component of the health care system. Some physicians were concerned that county government would not be able to implement CBP, while others viewed CBP as government intrusion into a strong private sector delivery system. Some providers would have preferred PMAP, because they had experience with reimbursement levels

under health plans such as UCare or Blue Cross, whereas EHP was an unknown. Other providers questioned the source of anticipated savings under CBP, indicating that these savings likely represented a "loss to providers."

In the course of the development of CBP, three contentious issues arose between EHP and physicians in the area. The first issue was reimbursement. In their negotiations, EHP and physicians started from different assumptions. EHP wanted to pay providers using the established Medicaid fee-for-service (FFS) rates. Physicians, however, thought negotiations should start at the reimbursement rates that were expected under PMAP: 110 percent of Medicaid FFS rates. Anything less was considered a loss. After hard negotiations between EHP and clinic administrators, EHP and physicians entered into a partial risk sharing model. The fee schedule now guaranteed 110 percent Medicaid FFS rates to primary care physicians for primary care diagnostic codes. All other physicians would be paid 110 percent with a 10 percent withhold that would only be dispersed if managed care savings targets were realized. Physicians perceived themselves to be taking risk under this model. According to the EHP medical director, primary care accounted for about half of the budget, making this 10 percent rate increase a substantial budget item. A related issue was the creation of a reserve fund to cover any future losses. Providers questioned whether they would ever receive the 10 percent withhold because the reserve had to be funded first.

The second point of contention was the EHP network area. In order to not disrupt existing care patterns, and to include providers in St. Cloud (Stearns County), Alexandria (Douglas County), Bemidji (Beltrami County), and other towns, the JPB added a 30-mile radius around the five counties to the network area. Physicians and clinic administrators saw the inclusion of providers outside of the 5-county area as limiting the ability of EHP to keep health

care dollars local, and potentially increasing administrative costs. Providers outside the five-county area, but inside the 30-mile fringe, were to be paid the same rates as local providers. Contracting with these providers was straightforward, according to EHP. They accepted EHP as just another plan. Local providers, however, were opposed to those rates, because they felt that these providers would have no incentive to control costs. The "30 mile fringe" was not an issue for providers in Cass County and Morrison County. Some areas of Cass County are only served by physicians in neighboring counties. Therefore, providers in Park Rapids, Deer River, Grant Rapids, and Bemidji (all outside the five-county area) had to be included in the network. A substantial number of residents of Morrison County receive their medical care in St. Cloud (Stearns County), which has a large hospital.

The third issue was related to open access vs. gatekeeping. The model allows self-referral within the five county area. Local clinics opposed open access, because of the opportunities for abuse of the system and the limited control it gives them over utilization, even though they are at risk for part of their fees. With the open access model, the Araz Group has the responsibility for preventing abuse through beneficiary education.

While the CBP work group was exploring CBP, a provider advisory group – consisting of interested providers – was formed in the fall of 1997. Its purpose was to give feedback on provider issues to the working group. This relationship was formalized after the JPB was formed by creating a provider advisory committee that provides input to the JPB. All health providers are represented on the committee, and representatives are elected by their peers. Meetings are held monthly, with the first meeting in March, 1999.

A report from the provider advisory committee to the JBP in May, 1999 showed that issues between providers and EHP remained. The provider community felt that communications

with EHP needed to be improved. The provider community also asked for assurances regarding improved reimbursement and again voiced its opposition to the inclusion of providers outside of the five counties in the provider network. As contract negotiations drew to a close, and energies became focused on operational issues, such as the formulary, an improved level of cooperation and trust between providers and EHP was noted.

One provider described the planning process as "a complete failure" when it comes to the inclusion of providers. In his opinion, providers were not brought in early enough; the model of asking a small number of providers to communicate to all the other providers in the region did not work; the communication between government employees and providers was not smooth; and, both the Araz Group and EHP focused on a vision and presented CBP from a policy perspective, while providers were interested in operational details that were not discussed. The process of negotiating prices clearly strained relationships between the representatives of EHP and the providers.

Ancillary providers were opposed to PMAP from the beginning and very interested in opportunities presented by local management of health care under CBP. These providers – mainly chiropractors and optometrists – had two main concerns regarding PMAP: losing Medicaid business by being excluded from managed care provider networks and being subject to gatekeeping by physicians.

Mental health providers also were active in the development phase. They formed a work group that met monthly. Initially this group was well attended, but interest dropped off and only representatives from the three or four largest provider groups continued to attend work group meetings regularly. The mental health community supported CBP because of the experience in Itasca County, where reimbursement rates were above Medicaid fee schedules. However, some

of the proposed methods/mechanisms represented marked changes from the Medicaid program; for instance, pre-authorization would be required at a lower number of visits.

Dental access for Medicaid beneficiaries is a problem in the area. Very few dentists accept new Medicaid clients on a regular basis but most have established Medicaid clients that they continue to serve. Children's access to dental services is a major concern. EHP hopes to improve the situation by raising reimbursement rates to dentists. The dentists have formed a cooperative based in Crow Wing County and have been very supportive of CBP.

The original deadline for providers to sign contracts with EHP was July 16, 1999. A week before the deadline, none of the physicians or clinics had signed contracts, although some had given assurances that they would sign. Some clinics/physicians were waiting for approval from their parent systems. EHP then changed the deadline, requiring letters of intent from the providers by October, 1999. Physicians were thought to have extended the contracting process in the belief that EHP might raise rates under pressure of an impending deadline.

By mid-October, 1999, the majority of clinics had signed contracts, and area hospitals were working out the last details of their contracts with EHP and the Araz Group. EHP had to make some concessions regarding inpatient referrals from small clinics owned by hospitals, allowing them to refer patients to their hospitals without written referrals (Essential Health Plan, 1999f). In addition, the hospitals wanted a guarantee that their withhold would be decreased from 10 percent to 5 percent in the second contracting year. EHP expressed its intent to do so.

Relationship with DHS/DOH

The relationship between the Association of Minnesota Counties (AMC) and DHS has been strained since negotiations on the CBP legislation in 1996/1997. AMC pushed for county authority and county involvement under PMAP and for the passage of the CBP legislation, while

DHS was opposed to CBP. This strained relationship hampered county negotiations and communications with DHS, according to EHP and county officials. EHP decided to approach HCFA together with DHS, and without representation by AMC, to further its cause. EHP sent a letter to AMC in April, 1999 declaring an end to their representation by AMC in relationships with DHS on matters regarding CBP (Essential Health Plan, 1999d).

Waiver

In order to implement CBP, an amendment to the existing 1115 waiver for the Minnesota Medicaid program would be desirable. The state requested a waiver of the following provisions among others: competitive bidding, conflict of interest provisions, freedom of choice, and state-wideness of the Medicaid program. In early 1999, EHP became aware of problems with the waiver application to HCFA, and that a waiver might not be granted as soon as expected. At the same time, county officials, AMC, and DHS seemed optimistic that a fall implementation date was still feasible (Essential Health Plan, 1999b). The state legislation indicated a start date of October 1, 1999. The JPB discussed the issue of a possible waiver delay and decided that it needed "to influence HCFA and the congressional contingency about the need for quicker time lines for waiver approval" (Essential Health Plan, 1999a, p. 3). In March, 1999, the JPB passed a motion "to support the concept of the Essential Health Plan being a possible Minnesota County Based Purchasing demonstration project for HCFA as a means of moving Essential Health Plan implementation forward" (Essential Health Plan, 1999c, p. 3). To raise awareness, EHP representatives met with Representatives Oberstar and Ramstad, staff of Senators Grams and Wellstone, and staff of Representative Peterson. Representative Ramstad was the only legislator with an appointment to a health committee and contacts with HCFA.

On October 27, 1999, EHP, represented by its staff, three county commissioners, and DHS officials (including Assistant Human Services Commissioner Mary Kennedy) visited HCFA to present and explain EHP. HCFA committed to reaching a decision in the shortest time possible. During a meeting between staff of Representative Peterson, Representative Ramstad, and HCFA in early September, 1999, HCFA officials mentioned January, 2000 as a date for the decision. EHP officials anticipated a start date two months after waiver approval by HCFA.

The Model

The third party administrator, the Araz Group, would provide a variety of services, ranging from medical management to claims processing. The counties may assume some or all of these functions in the future. In the development phase, the Araz Group supported the counties in developing policies and procedures, in negotiating contracts with providers, public relations, answering queries, selecting an actuarial firm, and securing reinsurance. EHP would pay a PMPM fee to the Araz Group for its TPA services. EHP assumed all the risk under this model. An RFP for reinsurance was sent out. EHP received quotes and would buy reinsurance from a vendor when the date for the start of operations was set.

Any willing provider in the five-county area plus a 30-mile fringe that meets the Araz Group's credentialing standards may become a network provider. "EHP will share with EHP Network physicians and hospitals the potential for financial benefit when there is a positive performance in EHP medical care costs as compared to budget. Pharmacy, dental, vision, chiropractor, mental health/chemical dependency and ancillary service providers are not included in this risk relationship" (Araz Group, 1999, p. 1). Optometrists would be reimbursed at the same rates as primary care providers for primary care codes – 110 percent of current Medicaid FFS rates. Reimbursement for dentists was set at 20 percent higher than current reimbursement.

Medicaid beneficiaries have to designate a primary care provider or clinic upon enrollment to ensure continuity of care. No referrals are required within the EHP network. EHP established a contracted referral network that can only be accessed with a referral request from a network physician and preauthorization by the Araz Group (Araz Group, 1999). The Araz Group is instituting medical management programs (practice guidelines, concurrent in-patient review, preauthorization for specific procedures, case management, preauthorization for referrals, concurrent and retrospective review) (Araz Group, 1999). EHP contracted with a pharmacy benefits manager and a dental TPA (Premier of Plymouth, Minnesota), and has a formulary that physicians will be required to follow.

Future

County and EHP officials hope to develop the skills and expertise necessary to take over a number, if not all, of the Araz Group's responsibilities by year three of CBP, if the budget permits. Furthermore, EHP expects to see improved cooperation and integration between the Public Health and Social Services agencies in its counties as they become experienced with CBP. Providers hope to see improved reimbursement rates, while public health officials want better access to care for Medicaid beneficiaries, along with more prevention-oriented care, if the fiscal situation permits.

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School of Public Health, University of Minnesota
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