

**INTEGRATED NETWORKS AND  
HEALTH CARE PROVIDER COOPERATIVES:  
NEW MODELS FOR RURAL HEALTH CARE  
DELIVERY AND FINANCING**

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## EXECUTIVE SUMMARY

Minnesota's 1994 health care reform legislation authorized the establishment of community integrated service networks (CISNs) and health care provider cooperatives, which were envisioned as new health care delivery models that could be successfully implemented in rural areas of the state. CISNs are HMO-like health care delivery and financing organizations that are responsible for arranging or delivering a full array of health care services to a defined population of fewer than 50,000 enrollees for a pre-determined, capitated premium. They are licensed and regulated by the Minnesota Department of Health (MDH) under state laws and regulations governing HMOs, with certain exceptions regarding governing board composition, net worth and solvency requirements, and administrative requirements. Health care provider cooperatives are corporations operated on a cooperative plan to market the services of health care providers such as physicians and hospitals to health plans through capitated or similar risk-sharing contracts. MDH's regulation of provider cooperatives is limited to the authority to review contracts between health care cooperatives and purchasers.

Initial CISN development in Minnesota has occurred either as expansions or conversions of urban-based HMO or PPO plans or as joint ventures between a large health insurer and a large, multi-specialty clinic in a relatively well-populated area. As of November 1995, four entities were licensed as CISNs. One rural CISN model with the potential for replicability is a joint venture between Blue Cross/Blue Shield and a large, multispecialty clinic in a relatively well-populated rural area. Another model for CISN development has been the conversion of a staff model urban-based HMO to a CISN, while the third model uses a provider network developed by a Twin Cities corporation for its preferred provider organization.

The 1995 Minnesota Legislature's repeal of both the Regulated All Payer Option and the requirement that all health plans become CISNs or ISNs clearly reduced the urgency many rural providers initially felt to develop CISNs. Several additional factors also appear to have limited the development of rural CISNs, including rural providers' negative perceptions of HMOs, the lack of a sufficient population base in many rural areas to spread risk and to cover the administrative costs of operating a CISN, and difficulty in obtaining the capital necessary to meet CISN requirements without financial guarantees from a large insurer or HMO.

Three organizations have been legally incorporated as health care provider cooperatives. All three were developed as joint hospital and physician ventures, but have taken somewhat different organizational forms depending on the commitment to local control and previous affiliations of the entities involved. The three cooperatives have chosen not to align themselves with a single large partner, but plan to negotiate contracts with multiple health plans. As of August 1995, only one of the cooperatives

had negotiated any contracts with health plans, although the other two cooperatives were planning to begin negotiations in the near future.

The flexibility of the cooperative model is a major source of its appeal to rural providers. However, the lack of specificity in the statutory definition of a cooperative has caused uncertainty for cooperatives, and resulted in disagreements between providers and state regulators regarding a cooperative's legal authority to engage in certain types of activities. Although the health care cooperative statute requires that contracts between cooperatives and plans be on a "capitated or similar risk-sharing" basis, the statute does not define these terms, and MDH has not issued any guidelines regarding the amount of risk a cooperative should bear under these contracts.

Direct contracting between provider cooperatives and self-insured employers has been another problematic issue for health care provider cooperatives. Currently, only one cooperative has statutory authority to contract directly with self-insured employers. The cooperatives believe that the Legislature should extend the authority to all provider cooperatives, while MDH is concerned that direct contracting between provider cooperatives and self-insured employers could result in insufficient consumer protection if the cooperative or the employer became financially insolvent.

The first CISN began operating on January 1, 1995. The first health care provider cooperatives were incorporated in November 1994 and February 1995, and are just now negotiating contracts with health plans. It will be some time before the CISN and cooperative models can be evaluated to determine whether or not they have improved the delivery of health care in rural areas and the health outcomes of the populations they serve. However, it is possible to reach some initial conclusions about likely trends in rural CISN and health care cooperative development in the future, based on the legislative and regulatory framework established by the state, and implementation efforts to date.

- **CISN regulatory requirements and the pattern of CISN development to date suggest that local development of CISNs in rural areas of the state is unlikely to occur without the financial assistance of a large health plan or tertiary care provider.**

Local providers trying to develop CISNs face many of the same problems that historically have limited HMO development in rural areas, such as acquisition of initial financing and achieving financially viable enrollment levels. Consequently, local ownership of a CISN or ISN does not appear to be a realistic prospect for many rural providers.

- **Health care provider cooperatives appear to have more potential than CISNs for developing as locally owned and controlled organizations in rural areas.**

**However, cooperatives still need to prove that they can successfully negotiate contracts with health plans, implement satisfactory provider payment mechanisms, and manage risk.**

Rural provider interest in the cooperative model has been fairly strong, especially among rural hospitals and small physician group practices. However, the health provider cooperatives need to prove that they can successfully perform three functions. First, the cooperatives need to negotiate capitated contracts with multiple health plans on terms that are beneficial for the cooperative members as well as the health plans. Second, they need to develop and implement provider payment mechanisms that will make providers, including both small and large providers in their service area, want to join the cooperative and remain members over time. Third, the cooperatives must successfully manage the risk that they assume under the "capitated or similar risk-bearing" contracts required by the cooperative statute.

- **Additional public sector involvement may be necessary if locally-based CISNs, health care provider cooperatives, or alternative health care delivery and financing models are to be successfully implemented, especially in less densely populated rural areas of the state.**

The current statutory incentives do not appear to be sufficient to encourage local CISN development in many rural areas of Minnesota. If the Legislature remains committed to implementation of locally-based CISN models, especially in less densely populated rural areas of the state, it may need to provide more significant incentives such as broader regulatory flexibility, grants, loans, or expanded technical assistance, and to specifically target the incentives to locally-based CISNs. Alternatively, the Legislature may need to support the development of additional rural health care delivery and financing models beyond CISNs and health care provider cooperatives.

- **Minnesota's experience with CISNs and health care provider cooperatives in rural areas will be of interest to policymakers considering current Medicare reform proposals.**

Congress is currently considering Medicare reform proposals to expand the number of Medicare enrollees in managed care plans, and to allow provider service networks to contract directly with the Medicare program to provide health care services to Medicare enrollees. Many of the policy issues raised by the Medicare legislation are similar to those Minnesota has faced regarding the development of CISNs and health care provider cooperatives in rural areas. State policy in Minnesota is clearly still evolving on these issues. However, policymakers can learn valuable lessons from Minnesota's attempts to define appropriate roles for government, health care providers, health insurers and HMOs in a restructured rural health care delivery system, as well as its efforts

to address regulatory issues involving the assumption of financial risk by CISNs and provider cooperatives and the protection of health care consumers.

## INTRODUCTION

Minnesota became one of the first states in the nation to enact health care reform legislation in 1992. Subsequent state legislation in 1993 and 1994 introduced new health care delivery and financing models that were expected to play a key role in restructuring Minnesota's health care system. However, Minnesota, like several other states, has recently repealed or delayed implementation of significant components of its health care reform legislation. The failure of comprehensive national health care reform efforts and the slowing pace of state health care reform raise two important questions regarding the implementation of new health care delivery models in rural Minnesota. First, will community integrated service networks and health care provider cooperatives play a meaningful role in health care delivery and financing in rural Minnesota? Second, are these models replicable in other rural environments?

To answer these questions, this paper describes the legislative and regulatory framework for rural health networks in Minnesota, and discusses the overall status of community integrated service network (CISN) and health care cooperative development in the state. Case studies are presented of two CISNs and three health care provider cooperatives that are currently serving rural areas of the state. The paper then discusses several policy issues related to the future development and implementation of rural CISNs and health care provider cooperatives in Minnesota.



## **THE LEGISLATIVE AND REGULATORY FRAMEWORK FOR NETWORK DEVELOPMENT IN MINNESOTA**

### **State Health Care Reform Legislation**

Minnesota's 1992 health care reform legislation set statewide cost containment goals, enacted small employer and individual insurance reform, and established MinnesotaCare, a subsidized insurance program for non-Medicaid eligible, low-income families and individuals. In 1993, the Minnesota Legislature concluded that Integrated Service Networks (ISNs) should be the principal means of providing care in a restructured health care delivery system, and that care delivered outside of ISNs should be governed by a Regulated All Payer Option (RAPO), a uniform payment system to control the price and volume of services. ISNs were defined as organizations responsible for arranging or delivering a full array of health care services to a defined population for a pre-determined, capitated premium. The 1993 Legislature required the Commissioner of Health, in consultation with the Health Care Commission, to develop an implementation plan that facilitated the formation of "locally controlled" ISNs in addition to ones sponsored by statewide health carriers. The plan was to allow ISNs to begin forming July 1, 1994.

The implementation plan and subsequent legislation enacted in 1994 attempted to respond to the concerns of many providers, especially rural providers, regarding the short time frame for ISN implementation and the barriers faced by potential community-based ISNs (e.g., difficulty in obtaining sufficient capital to meet net worth requirements). In an attempt to address these concerns, the 1994 legislation

authorized the establishment of community ISNs (CISNs) that could apply for licensure starting in July 1994 and begin providing health services to enrollees as of January 1, 1995. Like ISNs, CISNs were defined as organizations responsible for arranging or delivering a full array of health care services to a defined population for a pre-determined, capitated premium. However, CISNs were limited in size to fewer than 50,000 enrollees, and given flexibility in meeting certain regulatory requirements. The 1994 Legislature delayed the date that larger ISNs could begin forming until July 1996. It also established July 1997 as the date by which the restructured delivery system was to become fully operational, and all health plan companies were required to be licensed as CISNs, ISNs or RAPO insurers.

A separate provision of the 1994 legislation authorized the formation of health care cooperatives. The "Health Care Cooperative Act" stated the legislature's belief that "locally based and controlled efforts among health care providers, local businesses, units of local government, and health care consumers" could promote the attainment of health care reform goals (Laws of Minnesota 1994, Chapter 625, Article 11, Section 1).

During the 1995 session, the Minnesota Legislature continued the process of establishing requirements for ISNs in statute, but repealed the requirement that all health plan companies be licensed as CISNs, ISNs or be subject to the Regulated All Payer Option (RAPO) by 1997. The Legislature also repealed the RAPO system, modified the definition of universal coverage, removed the individual coverage mandate, and removed the July 1, 1997 target date for achieving universal coverage

in the state. A universal benefits set for health plans was debated extensively, but not adopted. Although the state is continuing to implement health insurance reform measures and to provide subsidized health care coverage through the MinnesotaCare program, Minnesota has clearly retreated from its initial goal of restructuring the health care delivery and financing system in the state.

## **Regulatory Requirements**

### Integrated Service Networks

The Minnesota Department of Health (MDH) is the licensing and regulatory agency for ISNs. MDH has adopted a two-part process for developing and implementing a regulatory framework for ISNs. Phase I involved the development of standards relating to access to care and credentialing, financial solvency, and quality. Phase II will address several issues, including enrollee rights; comprehensiveness of services; incentives to accept high-risk and special needs enrollees; methods to encourage competition; information reporting on costs, prices, revenues, volume of services, outcomes and quality; limitations on annual growth rates; and consolidated licensing and consumer protection audits (MDH, February 1995).

Rather than using time-consuming administrative rule-making procedures, MDH has pursued a strategy of making recommendations regarding ISN regulation to the Legislature, which has then incorporated ISN requirements into statute. Following MDH's Phase I recommendations, the 1995 Legislature established in statute ISN financial requirements, and requirements related to health care providers, enrollee

complaints, and quality of care. MDH is currently developing the second phase of ISN regulations, and expects to have draft legislation by January 1, 1996. MDH regulatory staff are trying to define the elements that will differentiate ISNs from other types of health plans such as HMOs or PPOs, and to develop incentives to further encourage ISN formation. In light of the lack of political support in the state for having all health plans become ISNs, MDH now envisions that the state will have a range of managed care plans that will include HMOs, ISNs, CISNs, and PPOs, and that some standards will be the same for all plans, but other requirements will vary.

Although ISNs can not legally apply for licensure until July 1, 1996, the development of large, urban-based integrated delivery systems preceded the passage of state health care reform legislation, and has continued to occur at a rapid pace (Minnesota Medical Association, 1994; Christianson, et al., 1995.) The Minnesota health care market is now dominated by three large players that together control 78 percent of the health plan market in the state: Blue Cross and Blue Shield of Minnesota (36 percent); Allina (24 percent); and HealthPartners (18 percent). BCBS has PPO, indemnity and HMO products, and a total enrollment of 1.3 million, which is almost evenly divided between self-insured plans and insured firms and individuals. Allina is composed of an integrated delivery system that includes hospitals, home health agencies, and other services; physicians; and a managed care component that includes an IPA model HMO (Medica) and a PPO with a total of about 850,000 enrollees. HealthPartners consists of a group-model HMO (MedCenters), a staff-model HMO

(Group Health), and Ramsey HealthCare, a small hospital-based system. Its 1993 enrollment totaled 571,014 (Nichols, et al., 1995).

### Community Integrated Service Networks

CISNs are licensed and regulated by MDH. They are subject to state laws and regulations governing HMOs, with certain exceptions regarding governing board composition, net worth and solvency requirements, and administrative requirements.<sup>1</sup> A CISN, like an HMO, must be either a non-profit corporation or a local unit of government. In addition to meeting the HMO requirement that 40 percent of governing board members be consumers elected by enrollees, a CISN must also have at least 51 percent of its governing body members residing in the CISN service area.

CISNs are exempt from HMO financial requirements but must meet alternative financial requirements. A CISN must have a net worth equal to the greater of: 1) \$1 million; 2) 2 percent of the first \$150 million of annual premium revenue plus 1 percent of annual premium revenue in excess of \$150 million; 3) 8 percent of the annual health services costs, except those paid on a capitated or managed hospital payment basis, plus 4 percent of the annual capitation and managed hospital payment costs; or 4) four months of uncovered health services costs. A CISN's net worth requirement may include reinsurance credit; may be phased in over 3 years; and may be reduced by use of guaranteeing organizations or contracts with "accredited capitated providers," who agree to provide services without payment to enrollees for

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<sup>1</sup> Minnesota Statutes, Chapter 62N contains provisions specific to CISNs. A summary of all HMO statutes and regulations that apply to CISNs can be found in Minnesota Department of Health, Establishing and Operating Community Integrated Service Networks, January 1995.

up to 120 days following a CISN insolvency. CISNs may reinsure high-risk individuals that they cover through small employer plans by enrolling them in a private reinsurance risk pool maintained by the Health Coverage Reinsurance Association.<sup>2</sup>

CISNs are required to offer the same benefit set as HMOs. CISNs may have individual deductibles up to \$1,000, provided that annual out-of-pocket expenses do not exceed \$3,000 per person or \$5,000 per family. (Prior to the 1995 legislative session, HMOs were limited to an annual deductible of \$150 per person. They now have the same deductible limits as CISNs.) CISN deductibles, like HMO deductibles, cannot apply to preventive health services. CISNs are exempt from certain HMO administrative requirements, such as preparing and filing written Quality Assurance plans, and conducting focused Quality Assurance studies. However, they are subject to other requirements that apply to all health plan companies, including collecting and disseminating information on performance and outcome measures.

Although CISNs were primarily envisioned as delivery and financing organizations that could be successfully implemented in rural areas of the state, the CISN statute and regulations do not restrict the development of urban CISNs, as long as their enrollment does not exceed 50,000 persons.

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<sup>2</sup> The Association was established following Minnesota's passage of small employer insurance reforms, including guaranteed issuance. It maintains a reinsurance risk pool to provide for a "fair and equitable transfer of risk" associated with health carrier participation in the small employer market. The pool is funded by assessments on the carriers based on their premium volume. The 1995 Legislature added CISNs and ISNs to the categories of carriers that must participate in the Association unless exempted by the Minnesota Department of Commerce.

## Health Care Provider Cooperatives

The 1994 MinnesotaCare Act authorized the establishment of health care provider cooperatives, which are corporations operated on a cooperative plan to market the services of health care providers such as physicians and hospitals to health plans.<sup>3</sup> Provider cooperatives are subject to the provisions of state statute governing cooperatives in general, except as limited or enlarged by the health care cooperative statute.<sup>4</sup> The general cooperative statute defines the process for incorporation as a cooperative and the powers given to cooperatives, including the power to enter into contracts or agreements for the cooperative or its individual members, or between the cooperative and its members. The statute also includes provisions on cooperative membership and governance, the sale of stock, and the distribution of income by a cooperative.

Licensed health care providers, including physicians and hospitals, may form a cooperative. Health care provider cooperatives allow providers to work together collectively without merging their assets, and also have potential tax benefits (Matthews, 1994). The health care cooperative statute authorizes health care provider cooperatives to contract with licensed health plan companies such as CISNs, ISNs, non-profit health service plans, HMOs, health insurance companies, and with other

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<sup>3</sup> The Act also authorized the establishment of health care network cooperatives. A network cooperative is a health plan that is licensed as either a CISN, ISN, HMO, or non-profit health service plan corporation as well as being incorporated as a cooperative. To date, no health plans have applied for licensure as network cooperatives.

<sup>4</sup>Minnesota Statutes, Chapter 308A governs cooperatives in general. The health care cooperative statute is Minnesota Statutes, Chapter 62R.

purchasers, including the State of Minnesota and units of local government. These contracts must provide for payment on a "substantially capitated or similar risk-sharing basis."

In addition to the antitrust protection available to health care providers through the exemption process established in the 1992 and 1993 MinnesotaCare laws, the health care cooperative statute also provides antitrust protection specifically to provider cooperatives. The statute specifies that contracts or agreements between a provider cooperative and its members regarding prices, the allocation of gains and losses among members, or the delivery, quality, allocation, or location of services to be provided "are not contracts that unreasonably restrain trade."

The statute contains several provisions aimed at ensuring competitive functioning of cooperatives in the market. A provider may not be prevented from becoming or remaining a member of a provider cooperative as a condition of securing or retaining a contract for health care services. Health plan companies may not boycott or refuse to deal with providers based on their actual or potential participation in a cooperative. Cooperatives, in turn, are prohibited from requiring that their members deliver health care services exclusively to or through the cooperative. A cooperative also cannot boycott or refuse to deal with any health plan company that is seeking to contract with the cooperative on a competitive, reasonable, and non-exclusive basis.

MDH has the authority to review contracts between provider cooperatives and purchasers for the purpose of determining whether the contract provides for payment



on a substantially capitated or risk-sharing basis, and to determine whether the contract constitutes an unreasonable expense for the purchaser. Other than the authority to invalidate a contract that does not meet these requirements, neither MDH nor the Minnesota Department of Commerce, which regulates health insurers, has any regulatory authority over health care provider cooperatives. MDH has not seen a need for additional regulation of provider cooperatives as long as the cooperative provides health care services through a contract with a licensed health plan company, since those plans are subject to state regulation regarding quality assurance and financial solvency. However, provider cooperatives have expressed interest in contracting directly with self-insured employers, whose health plans are exempt from state regulation under federal ERISA preemption provisions. Shortly after the health care cooperative law was passed, the Department of Commerce and MDH issued an administrative bulletin stating the two agencies' position that a provider cooperative cannot contract directly with a self-insured employer without being licensed as an insurance company (Minnesota Department of Commerce and MDH, 1994).

Legislation to allow direct contracting between provider cooperatives and self-insured employers was introduced in the 1995 session, but did not pass. Instead, the Legislature granted contracting authority on a demonstration basis to the first provider cooperative incorporated in the state, Quality Health Alliance (Laws of Minnesota 1995, Chapter 234, Article 10, Sections 1-11). The legislation requires that self-insured employers that contract with the cooperative maintain a certain level of stop loss insurance, and that each contract be structured so that the cooperative's financial

risk does not exceed 50 percent of an employer's expected annual costs. MDH is required to report to the Legislature on the status of the demonstration project in January 1999, and the demonstration authority sunsets at the end of 1999.

## **COMMUNITY INTEGRATED SERVICE NETWORKS AND HEALTH CARE PROVIDER COOPERATIVES IN MINNESOTA**

### **The Status of CISN and Cooperative Development**

As of November 1995, four entities were licensed as community integrated service networks (CISNs): Central Minnesota Group Health Plan, New Pioneer Health Plan, and PreferredOne Community Health Plan, and Dakota Community Health Plan. Three organizations were legally incorporated as health care provider cooperatives: Quality Health Alliance, the Minnesota Rural Health Cooperative, and Southwest Health Alliance.

Central Minnesota Group Health Plan (CMGHP) was licensed as a staff model HMO from 1979 until 1994, when it became licensed as a CISN. CMGHP officially began operating as a CISN on January 1, 1995. The service area for CMGHP is ten counties surrounding the St. Cloud metropolitan area (MA) in central Minnesota, just northwest of the Twin Cities. CMGHP has approximately 22,000 members, and is a subsidiary of Group Health, Inc., a Twin Cities-based HMO.

New Pioneer Health Plan (NPHP) started operating as a CISN on April 15, 1995. NPHP was created by a joint venture between Affiliated Medical Centers, a multi-specialty medical group based in Willmar, and Blue Cross/Blue Shield of Minnesota

(BCBS). The plan has a primary service area of 20 counties in west central and southwestern Minnesota.

The third CISN, PreferredOne Community Health Plan, has a provider network of 2,517 primary care providers at 2,474 locations, and provides hospital services at 54 locations. The service area for the PreferredOne Community Health Plan is 47 counties, including the 10 county Twin Cities metropolitan area, and portions of southeastern and central Minnesota. The PreferredOne Management Corporation is owned by the Twin Cities-based Fairview Healthcare System, North Memorial Hospital, and PreferredOne Physician Associates. PreferredOne also operates a PPO that currently serves more than 450,000 members and has a provider network of 6,000 physicians and 60 hospitals in six Upper Midwest states.

The fourth CISN, Dakota Community Health Plan (DCHP), is a joint venture of Dakota Clinic, which is based in Fargo, North Dakota, and BCBS. The plan was licensed in November 1995. Its service area includes eight entire counties and portions of eight additional counties in northwestern Minnesota. DCHP plans to begin providing coverage to enrollees in January 1996.

Quality Health Alliance was the first organization to be incorporated as a health care provider cooperative in November 1994. As of September 1995, cooperative members included 155 physicians and 10 hospitals in a nine county service area in south central Minnesota. The Minnesota Rural Health Cooperative was incorporated in February 1995, and has an 18 county service area in southwestern Minnesota. As of mid-August 1995, the cooperative had 43 physician and 14 hospital members.

Southwest Health Alliance was also incorporated as a health care provider cooperative in February 1995. Its service area includes communities in eight southwestern Minnesota counties, as well as areas of South Dakota and Iowa. As of early August 1995, the cooperative had signed agreements with eight hospitals and approximately 30 physicians from Minnesota, as well as the Sioux Valley hospital and about 100 physicians in the Sioux Falls, South Dakota area.

The next section of the paper describes in more depth two of the three currently licensed CISNs, New Pioneer Health Plan and Central Minnesota Group Health Plan, and the three health care provider cooperatives that have been incorporated, Quality Health Alliance, Minnesota Rural Health Cooperative, and Southwest Health Alliance. The descriptions are based on interviews conducted with key individuals in these organizations during July, August and September 1995, public information from CISN licensure applications, and materials provided by the organizations, such as mission statements, articles of incorporation, and bylaws. Additional information was also obtained through interviews with state health officials responsible for regulation and policy development regarding CISNs and health care provider cooperatives, and with providers in northeastern Minnesota that extensively explored the feasibility of developing a CISN, but decided not to proceed with a CISN application.

New Pioneer Health Plan was chosen for a case study because it is the only one of the initial three CISNs that is not based in a metropolitan area, and because its partnership with Blue Cross/Blue Shield of Minnesota appears to have potential as a model for replication in Minnesota and in other rural areas of the country. CMGHP is

of interest as an example of an existing, staff model HMO that made the transition to a CISN, and as a model of an urban-based plan that serves rural areas. Quality Health Alliance (QHA), the Minnesota Rural Health Cooperative, and Southwest Health Alliance were chosen as different models of locally developed, rural-based provider organizations that use cooperative structures. QHA also has legislative authority to conduct a demonstration of a cooperative's ability to contract directly with self-insured employers. The Minnesota Rural Health Cooperative built on the several years of experience that member hospitals gained as part of a hospital consortium, Medi-Sota. Southwest Health Alliance is of interest as a case study that involves provider relationships across state borders.

## **CISNs**

### Central Minnesota Group Health Plan

#### *Background and Initial Development*

Central Minnesota Group Health Plan (CMGHP) operated as a staff model HMO from 1979 to 1994. CMGHP had several reasons for applying for CISN licensure in 1994. The plan had its origins as a community initiative established by interested consumers, and felt that the change to CISN licensure would emphasize its recommitment to the community. CMGHP already met the CISN regulatory requirements. The plan saw health care reform heading in the direction of ISNs and CISNs and away from HMOs, and felt that it made sense to move ahead with CISN licensure. The change to CISN licensure also opened up new product capability for the

plan, i.e., it could offer a managed care product with a deductible that it felt could better compete on price and benefits with commercial insurance products, especially in the small employer and individual markets. (At the time that CMGHP applied for CISN licensure, HMOs did not have this capability; however, the 1995 Minnesota Legislature extended the deductible product capability to HMOs).

As an existing organization, CMGHP did not face many of the hurdles faced by newly forming CISNs such as obtaining capital to meet net worth requirements and developing provider networks. It was required to submit a CISN application and go through a review process, but did not experience any major problems in becoming the first CISN. The plan was able to negotiate an agreement with MDH for a "voluntary suspension" of its HMO license. This agreement will allow CMGHP to retrieve its HMO license, assuming that it still meets the HMO requirements, if the Legislature should decide at a future date to repeal the CISN legislation.

The service area for CMGHP covers the St. Cloud MA and surrounding rural areas of central Minnesota, the region of the state with the most rapid rate of population growth over the last decade (Rural Development Board, 1993). The 1990 population of St. Cloud totaled 48,812. CMGHP has over 22,000 members and serves about 2,000 fee-for-service patients. The vast majority of members (98 percent) are commercial enrollees, including large and small employer groups and individuals; the plan also has a small number of Medicare non-risk enrollees. A 489 bed hospital and a broad range of specialty services are available in St. Cloud, where about three-fourths of CMGHP members live.

### *Organizational Structure, Governance and Management*

CMGHP is governed by a fifteen member board of directors; eight of the directors reside in the CISN service area. The plan has had a board election with some changes in board membership since becoming a CISN; however, the changes have not been major. CMGHP already had majority consumer membership on its board prior to becoming a CISN, and will maintain a consumer majority. The plan is trying to address diversity issues through its board committee processes.

Legally, CMGHP is a subsidiary of Group Health Inc. (GHI), a Twin Cities- based HMO, which in turn is a subsidiary of HealthPartners. CMGHP became a subsidiary of GHI in 1988. At that time, the plan had lost about \$1.5 million. MDH judged the plan to be undercapitalized, and required CMGHP to take action to increase its financial reserves. CMGHP used an RFP process, and chose to become a subsidiary of GHI, which it felt had a similar philosophy as a staff model HMO with a community orientation. GHI/HealthPartners guaranteed part of CMGHP's financial reserves, and continues to do so now that CMGHP is a CISN. In its 1993 Annual Statement, CMGHP reported total annual revenue of \$28.2 million, total expenses of \$27.6 million, and a net worth of \$2.45 million (MDH, 1994).

In addition to assistance in meeting its financial reserve requirements, CMGHP believes that its linkage with GHI/HealthPartners provides the plan with several advantages of a larger organization while allowing CMGHP to maintain its local community focus. The relationship with GHI/HealthPartners gives CMGHP access to all of the specialty and hospital contracts GHI/HealthPartners has in the Twin Cities,

but does not limit the plan's use of other specialists. About 25 percent to 30 percent of CMGHP members are enrolled in the plan as a result of purchase decisions by large Twin Cities-based employers that have an agreement with GHI/HealthPartners. Their employees in the St. Cloud area are served through a contract with CMGHP. CMGHP pays GHI/HealthPartners a management fee, and can make use of some of the larger organization's resources and expertise (e.g., legal services) that it could not afford to have on its own staff.

### *Mission, Services and Functions*

CMGHP defines its mission to "provide quality, cost-effective health services in a caring environment." Since obtaining CISO licensure, CMGHP continues to be primarily a staff model organization that employs most of its providers and contracts with a small number of affiliated clinics. The plan delivers primary care through 20 FTE employed providers, including physicians, physician assistants and nurse practitioners. It also has contractual arrangements with a wide range of specialists in the St. Cloud area and through the GHI/HealthPartners' network of contracted providers. All physician providers in the service area who meet the plan's credentialing standards, are willing to work for negotiated fees, and agree to the plan's contract provisions have been included in its network. The plan also contracts with a limited number of optometrists, geographically dispersed through the service area, and uses a statewide credentialing and utilization review management company to arrange for chiropractic services.



CMGHP believes that the conversion from an HMO to a CISN will affect the community positively, because more health plan products (e.g., products with deductibles) will be available to community residents. The plan is considering ways to become more "community oriented" as a CISN, such as focusing more attention on health education activities, and working with local public health departments to help achieve public health goals for the community.

#### New Pioneer Health Plan

##### *Background and Initial Development*

Affiliated Community Medical Centers (ACMC) is a 94 physician multi-specialty medical group that is based in Willmar, and has eight additional clinic sites in west central and southwestern Minnesota. ACMC and Blue Cross/Blue Shield of Minnesota (BCBS) had a long-standing provider-insurer contractual relationship when the two organizations agreed in 1993 to create a new corporation to deliver integrated health care in a 15 county area. They established a for-profit development corporation, Pioneer Health Systems, which was later renamed Affiliated Community Health Network (ACHN). ACHN was capitalized by BCBS and ACMC, with ACMC contributing land, buildings, and equipment, and BCBS providing a cash match.

The decision to develop New Pioneer Health Plan (NPHP) as a CISN was based on a belief that the CISN model was "community-focused" and compatible with their goal of delivering integrated health care to a defined population. NPHP was licensed as a CISN on December 21, 1994, and began operations on April 15, 1995. As the first CISN to be developed as a new organization, NPHP was in the position of

raising CISN regulatory issues that had not previously been considered. However, the plan did not experience any major problems in developing the CISN, and felt that MDH was very supportive during the CISN application and review process.

Currently, NPHP's primary service area covers 20 rural counties in west central and southwestern Minnesota. The region is dominated by agriculture, and characterized by a declining population and the highest percentage of elderly in the state (Rural Development Board, 1993). Historically, the southwest region has had very low HMO penetration; most of the counties in the region have less than one percent of their residents enrolled in HMOs (MDH, 1994). The service area has 23 hospitals, including 21 hospitals with fewer than 50 beds, and the hospitals in Willmar and Marshall, which have 136 and 62 beds, respectively. All 23 hospitals serve NPHP enrollees through a provision in their standard BCBS contracts. The 138 primary care physicians in NPHP's service area were offered an opportunity to participate in the CISN network, and approximately 95 percent have signed provider contracts with the plan. As of September 1995, the plan had been sold to 92 small employer groups and had a total of approximately 1,200 members. The plan anticipates having 2,000 enrollees by the end of its first year of operation.

#### *Organizational Structure, Governance and Management*

New Pioneer Health Plan is currently governed by a fifteen member Board of Directors that consists of six consumers, four administrators, four providers, and two directors at large. Thirteen of the fifteen directors are residents of the health plan's service area. The board has a five member Executive Committee. As required by the

CISN regulations, a new board will be elected by the enrollees when the plan has a sufficient number of enrollees.

NPHP's administrative staff consists of two chief operating officers, a medical director and a secretary. One of the co-chief operating officers is a vice president at Blue Cross/Blue Shield, and the other is a clinic administrator at AMC. Both are also chief operating officers of ACHN and members of the NPHP board.

NPHP is contracting with Blue Cross and AMC for administrative services such as claims processing, marketing, quality assurance and utilization review.

NPHP is meeting its CISN net worth requirements through a financial guarantee from its parent corporation, ACHN. ACHN will cover the large employer, self-insured employer, and individual markets in the service area, while NPHP will continue to focus on the small employer market. ACHN is also interested in the Medicare and Medicaid markets, and will be the organization used by Blue Cross/Blue Shield and ACMC for other ventures in the service area, which may include physician recruitment and clinic management services.

#### *Mission, Services and Functions*

NPHP's parent organization, ACHN, describes its mission as follows:

"Affiliated Community Health Network, Inc. exists to advance and strengthen the resources of rural health care delivery and financing systems. The fragile nature of the rural delivery system requires innovation, collaboration, and integration to preserve access to affordable, high-quality health care. Affiliated Community Health Network, Inc. will develop the consultative and leadership resources necessary to promote the health of our rural delivery systems and the people they serve."

NPHP offers coverage through several plan options, all of which require enrollees to select a primary care clinic. The point-of-service and point-of-service deductible plans provide the highest level of benefits for care provided in the primary network. Enrollees in these two plans are also allowed to self-refer to an extended network of providers arranged by BCBS, and to non-participating providers, but they receive a lower level of benefits, and are not covered for some services, such as mental health and chiropractic care, if they are received from non-participating providers. The copay plan has copayments of \$15 for office visits, \$50 for emergency room visits, and \$300 for inpatient stays; the deductible plan has deductibles of \$500 per person and \$1000 per family. The copay and deductible plans do not cover care provided outside the primary network, except for emergency care, ambulance services, and prescription drugs.

ACHN has a two part strategy to continue existing referral patterns from the service area to Sioux Falls, South Dakota and to the Twin Cities. Prairie Health Systems has been established through a joint venture with McKennan Hospital and Central Plains Clinic in Sioux Falls. ACHN owns 50 percent and the two Sioux Falls organizations own 25 percent each of Prairie Health Systems. Through the joint venture, the Sioux Falls providers serve as members of the primary care network and as tertiary care providers for NPHP, and may also be referral providers for future ACHN products as they are developed. In early September 1995, ACHN also formed a partnership with HealthSystem Minnesota (HSM, which is Park Nicollet Medical Center and Methodist Hospital). HSM will be ACHN's "preferred relationship" for specialty

care in the Twin Cities, and, when necessary, will coordinate care from other specialty providers. Both of ACHN's referral partners will also be providing outreach specialty services at local sites in the service area.

Primary care physicians and specialists providing care to NPHP enrollees are paid on a discounted fee-for-service basis. Hospitals are paid according to the payment structure used by BCBS to pay for all of its hospital business, including CISNs. NPHP believes that the delivery of care in its service area will improve because the CISN will provide care that is primary care based and directed, and is integrated throughout the spectrum of care. The plan is implementing a number of standard health plan quality review mechanisms, including surveys to measure enrollee satisfaction with the health care product, the network, clinics, and individual physicians.

## **Health Care Provider Cooperatives**

### **Quality Health Alliance**

#### ***Background and Initial Development***

The administrators of several hospitals in south central Minnesota began meeting to discuss health care reform issues in 1993; they were joined by clinic administrators from the area in 1994. When the state health care provider cooperative legislation passed in May 1994, the group decided to organize as a cooperative. Quality Health Alliance (QHA) was incorporated as a health care provider cooperative in November 1994.

QHA's service area consists of nine rural counties in south central Minnesota with a total combined population of 216,321. About one-fourth of the population lives in Blue Earth County, where Mankato, the major population center of the service area, is located. The area has a diverse economy that is predominantly agriculturally-based, but also includes a substantial proportion of manufacturing industries (Rural Development Board, 1993).

Two sources of funds provided the investment for development of the health care provider cooperative: the sale of stock and donations that QHA requested from large health plans. The total authorized capital stock of the cooperative is 51,000 shares, consisting of 1000 shares of common stock at \$15 a share (500 shares to be purchased by physician members and 500 shares by hospital members), and 50,000 shares of preferred stock at \$25 a share to be sold to physician and hospital members, and to other parties. HealthPartners purchased \$450,000 in preferred stock to help the cooperative set up its management information system. Blue Cross/Blue Shield and Allina each donated \$50,000 to QHA.

#### *Organizational Structure, Governance and Management*

Acute care hospitals located in the nine county area and physicians that reside in the area are eligible to become cooperative members by purchasing an amount of stock based on their net revenues. As of September 1995, ten hospitals and 155 physicians were members, and the hospitals and clinics in Fairmont and LeSueur were the only ones in the service area that did not belong to the cooperative. The clinic in Fairmont was recently acquired by the Mayo Clinic. Because the hospital in LeSueur

is experiencing financial difficulty, it felt that it could not afford the cost of joining the cooperative.

The cooperative is governed by a twelve member board of directors, with six seats for physicians, five seats for hospital representatives, and one seat for an allied health representative. QHA's bylaws specify that three of the physician directors and two of the hospital directors be from Mankato, and the remaining physician and hospital directors represent other communities in the nine county area. Physician directors are elected by physician shareholders, and hospital directors by hospital shareholders at the annual meeting. The allied health representative director position on the board was recently filled by a registered nurse, who is employed by HealthPartners. The Board meets monthly.

From June 1994 through June 1995, the administrator of the Sioux Valley Hospital in New Ulm, a QHA member hospital, was QHA's interim executive director. The administrator was loaned to QHA by Allina, which owns the Sioux Valley Hospital. QHA's current staff consists of three full-time staff: a permanent executive director, a director of operations, and a secretary; and a part-time volunteer medical director.

#### *Mission, Services and Functions*

QHA's mission statement describes the cooperative as "a consumer-oriented partnership of locally-based health care providers dedicated to controlling the cost of care by improving the health of our communities." The cooperative's quality-related strategies include implementation of practice guidelines, continuous quality improvement methods, and attention to patient satisfaction. QHA plans to contain

costs through improved contracting for tertiary care, decreased administrative overhead for participating providers, increased coordination of care, and risk-sharing agreements for providers. The cooperative intends to provide "integrated delivery of health care services" to large self-insured employers, small to medium employers, individual purchasers, and beneficiaries covered by government programs.

QHA has begun to negotiate contracts with health plans on behalf of its provider members. As of September 1995, QHA had negotiated an agreement with HealthPartners, and was in discussions with U Care Minnesota (a Medicaid HMO) and Allina. QHA plans to pay primary care physicians, specialists, and hospitals according to fee schedules established by the cooperative. Its long term goal over the next several years is to move toward partial or fully capitated payments to providers.

QHA has been working with local public health agencies in its service area, and two public health directors are co-chairing one of its committees. The cooperative surveyed 10,000 residents of the service area regarding lifestyle issues, and helped, with the Minnesota Department of Health, to fund a joint public health plan for the nine county region.

QHA has developed a partnership with a health care business coalition of 24 employers in the nine county area that self-insure their employees' health benefits. The participating businesses range in size from about 50 to more than 8,000 employees, and have a total of about 18,000 covered lives. Using demonstration project authority received from the 1995 Minnesota Legislature, QHA plans to contract directly with a number of these self-insured employers. Six self-insured companies are



committed to offering a QHA plan as one of their health insurance options this year; another twelve companies plan to offer it in another year; and about six more have not yet made a decision.

QHA will offer employers a managed care delivery system that is based on an in-network option of providers, with out-of-network services controlled through referrals by primary care clinics in the network. Each employer can develop its own benefit plan, but QHA has asked the employers to consider the following elements in designing their plan option: 1) reduction in the employee-paid medical premiums compared to the standard benefit plan; 2) inclusion of certain preventive care services at 100 percent coverage levels; 3) a differential of 10 percent or more in favor of using in-network providers; 4) a shift away from deductibles toward copayments, and 5) and a copayment for emergency room services that do not result in a hospital admission.

Initially, QHA considered selecting a single large partner to provide administrative services and tertiary and specialty care. They interviewed four of the large systems in Minnesota, but decided against the strategy of choosing a single partner because it would have split the providers in the region. Instead, they chose to contract with multiple entities, using RFP processes. HealthPartners was selected as QHA's administrative services partner. They also contributed capital for development of the cooperative's MIS. QHA's agreement with HealthPartners involves utilization review, network development, financial models, triaging protocols, clinical pathways, assistance with quality assurance, and medical director expertise. Abbott-Northwestern Hospital in Minneapolis and the Mayo Clinic in Rochester were selected

as preferred providers for tertiary care not provided by cooperative members. QHA is finalizing agreements with these two organizations.

QHA's management information system (MIS) will establish computer connections between all the clinics and hospitals in the cooperative in three phases. The first phase will involve the clinics' and hospitals' existing billing systems, and the second phase will be electronic mail. The cooperative anticipates that it will take three to five years to implement the third phase, sharing of clinical information, which will involve the development of procedures to handle patient confidentiality.

#### Minnesota Rural Health Cooperative

##### *Background and Initial Development*

In March 1994, a small group of physicians met with representatives of Medi-Sota, a consortium of 20 rural hospitals in southwestern Minnesota, to talk about the impact of health care reform. At the request of the organizers, this meeting and several subsequent meetings were facilitated by the director of the State Office of Rural Health. The group brought together about 70 providers, including public health, physicians, and hospitals, at a meeting in June 1994. About 25 providers then met from August to October 1994, and authorized a steering committee to proceed with incorporation as a health care provider cooperative. The Minnesota Rural Health Cooperative was incorporated at the end of February 1995.

The cooperative's service area covers eighteen rural counties in the southwestern region of Minnesota, with a total combined population of 273,854. The initial development of the cooperative was financed by the Medi-Sota hospital

consortium, through a federal Rural Health Transition Grant to three hospital members. The hospitals received a total of about \$117,000 in the first two years of funding, and hope to receive a third year of funding starting in September. The project director, who has been on loan to the cooperative from Medi-Sota, has been paid with grant funds.

### *Organizational Structure, Governance and Management*

Member solicitation began in June 1995. The cooperative sent a letter to all the hospitals and physicians in the 18 county service area, inviting them to join the cooperative. As of mid-August 1995, 43 physicians and 14 hospitals had become members of the Minnesota Rural Health Cooperative by purchasing common stock. The cooperative has sold two types of common stock: hospital stock, which is based on a value of \$150 per licensed bed, and physician stock, which is based on value of \$1000 per physician. No preferred stock has been sold.

Six physician members and five hospital representatives constitute the cooperative's 11 member board. The president of the cooperative is a family physician; the vice president and treasurer are both ophthalmologists; and the secretary is a hospital administrator. Elections will be held at the first annual meeting of the cooperative next year, but only part of the board will stand for election so that some continuity of leadership will be assured.

The cooperative organizers intended to have local public health representatives on the board, but found that local public health agencies are prohibited by state law from using state dollars to purchase stock in a cooperative. Consequently, the three

public health representatives have non-voting seats on the board. The Minnesota Rural Health Cooperative itself has no paid staff, but is staffed by a project director, who is on loan from the Medi-Sota hospital consortium. One of the next steps for the cooperative will be to develop a stable administrative structure.

### *Mission, Services and Functions*

The Minnesota Rural Health Cooperative's mission statement describes the organization as "a cooperative effort of physicians, public health agencies, and hospitals to preserve and maintain health care resources and access with local community choice and control for member communities in southwestern Minnesota." The cooperative also adopted several goals, which include encouraging community-based local decisions in maintaining access to health care; preserving individual patient choice to the extent possible; assisting in recruitment and retention of health care professionals; providing a vehicle to analyze managed care offerings and respond as a group to contract negotiations; and providing a vehicle for marketing of cooperative services.

The cooperative plans to provide several functions for members, including legal consultation regarding contracting with insurers; access to risk management services and stop loss insurance; group marketing of health care services to purchasers; collecting and analyzing data in support of contract negotiation; and development of management information systems and business support services. The cooperative also plans to establish benchmarks and to develop a continuous quality improvement (CQI) system to evaluate its performance. Services being considered for development in the

next year include joint billing and joint administrative services. As of August 1995, the cooperative had not yet negotiated any contracts with HMOs or health plans on behalf of its members, but expected to begin doing so within 60 days.

### Southwest Health Alliance

#### *Background and Initial Development*

The development process for the Southwest Health Alliance began in May 1994, at a meeting on MinnesotaCare for affiliates of Sioux Valley Hospital in Sioux Falls, South Dakota. The development of the cooperative was coordinated by North Central Community Health Network, an initiative established by VHA North Central about two years ago to assist providers in developing health provider cooperatives and CISNs in the five state area. A steering committee for the cooperative met from July to October 1994, when an interim executive committee was appointed to finalize plans for the second phase of cooperative development. Southwest Health Alliance was incorporated in February 1995.

Southwest Health Alliance's service area includes the communities of Luverne, Slayton, Canby, Windom, Jackson, Tracy, and Westbrook in southwestern Minnesota, as well as areas of South Dakota and Iowa. As of early August 1995, the cooperative had signed agreements with eight hospitals and approximately 30 physicians from Minnesota, as well as the Sioux Valley Hospital and about 100 physicians in the Sioux Falls, South Dakota area.

The cooperative's two year operating budget has been funded by the sale of shares and dues assessed on members. The total authorized capital stock of the

cooperative is 2,500 shares, including 1000 shares of Class A common stock, which physicians can purchase at \$500 per share; 500 shares of Class B common stock, which hospitals can purchase at \$2,500 per share; and 1,000 shares of preferred stock, which can be purchased by physicians, hospitals, and other persons at \$1,000 per share. Physicians pay an equal amount of dues each, while the amount paid by hospitals varies depending on the number of physicians in the community.

#### *Organizational Structure, Governance and Management*

The cooperative invited all licensed hospitals and physicians in the service area to join by purchasing stock. Hospitals in Minnesota, South Dakota or Iowa and physicians that meet the credentialing requirements of the cooperative are eligible to become cooperative members by purchasing stock.

Southwest Health Alliance is currently governed by a six member interim board. Three members are Minnesota physicians, two members represent Minnesota hospitals, and one member is from the Sioux Valley Service Corporation, a subsidiary of Sioux Valley Hospital. The full cooperative board will have ten members, with one member elected from each of the five physician and five hospital districts in the service area. One hospital and one physician district are in South Dakota, so the full board will have two members from South Dakota. When the board is fully operational, it will have a committee structure consisting of an administrative committee to approve contracts with managed care plans, a credentialing committee, and a quality management committee.

The cooperative is currently staffed by an interim executive director, through a contract arranged by North Central Community Health Network, at the request of the cooperative. Additional administrative support for the cooperative is provided by the staff and medical director of North Central Community Health Network.

### *Mission, Services and Functions*

Southwest Health Alliance's mission statement describes it as "a health provider cooperative, under MinnesotaCare which is dedicated to contain health care costs, improve the quality of health care and increase access to care to improve the health status of the communities served." The cooperative has adopted several principles of operation. These principles stress the importance of providing health care in the local community "as much as possible and appropriate;" having local physician and hospital ownership of the initiative; and working toward a partnership with local employers and community leaders. Several principles are quality-related, and describe the cooperative's commitment to continuous quality improvement, the development of tools such as critical pathways, and reporting of outcomes to the communities that are served.

Southwest Health Alliance is trying to finalize all of its provider agreements before starting to negotiate contracts with health plans. The cooperative's goal is to have enrollment in plans through contracts with the cooperative starting in January 1996. The cooperative plans to pay providers according to a fee schedule, using a resource based relative value scale (RBRVS) type methodology to pay physicians and

a diagnosis related group (DRG) methodology to pay hospitals. They plan to contract with other providers such as mental health and pharmacy.

Actuarial support and claims processing for the cooperative will be provided through third party contracts. Southwest Health Alliance is working with the Health Care Outcomes Institute on quality assurance activities, including a patient satisfaction survey process that is already underway in member clinics. The cooperative is in the process of evaluating management information systems, and plans to begin implementing a MIS by the end of 1995. Its goal is to have providers submit claims electronically, and to generate clinical reports that can be disseminated to the physicians.

VHA North Central has had a long standing group purchasing program for its hospitals, and now is implementing a physician supply buying program that clinics in the cooperative may participate in. A consultant has been hired to perform an operational review of the clinics in the cooperative, and to prepare clinic management recommendations. Southwest Health Alliance has met with local public health agencies in the service area, and plans to work collectively with them in the future on community health issues.

## **POLICY ISSUES RELATED TO FUTURE DEVELOPMENT OF RURAL COMMUNITY INTEGRATED SERVICE NETWORKS AND HEALTH CARE PROVIDER COOPERATIVES**

### **CISN Models**

Three CISN models have been implemented in Minnesota. One rural model is a joint venture between Blue Cross/Blue Shield (BCBS), and a large, multispecialty



clinic in a relatively well-populated rural area (e.g., New Pioneer Health Plan, and Dakota Community Health Plan). Another model for CISN development is the conversion of an HMO to a CISN, as the consumer-governed, staff model Central Minnesota Group Health Plan (CMGHP) has done. The third model uses a provider network developed by a Twin Cities corporation for its preferred provider organization (PPO). Its strategy is to build enrollment in its CISN, PreferredOne Community Health Plan, and then convert the plan to an ISN (Minnesota Medical Association, 1994).

At this time, the CISN model that appears to have the greatest potential for replication in rural areas of Minnesota is the joint venture between BCBS and a large clinic. BCBS's large financial base, extensive provider network, and long history of contractual relationships with providers in rural areas are all advantages in developing joint venture CISNs with clinics. BCBS is the largest health insurer in the state, and the majority of its enrollees are rural. In 1993, 70 percent of BCBS's 1.3 million enrollees resided outside the Twin Cities metropolitan area (Nichols, et al., 1995). The use of a large multi-specialty clinic as a partner in this model also makes the process of establishing a provider network much easier than contracting entirely with solo and small group practices.

The potential for converting HMOs to CISNs in rural areas along the lines of the CMGHP model is fairly limited. Most of the other HMOs in the state have significantly more than 50,000 enrollees and, except for First Plan HMO in northeastern Minnesota, they are all based in metropolitan areas. Although Minnesota has high overall penetration of managed care, HMOs are largely an urban phenomenon in the state.

The number of HMO enrollees in rural areas of the state has actually declined over the past several years. Total HMO enrollment outside the Twin Cities metropolitan area (including the MAs of Duluth, St. Cloud, and Rochester as well as rural areas of the state) decreased from 217,855 in 1987 to 131,173 in 1993 (MDH, 1988; MDH, 1994).

With the exception of the BCBS joint ventures, the large urban-based HMOs and integrated delivery systems in Minnesota have not yet established rural CISNs, but may do so through models similar to the BCBS model that build on their base of rural enrollees. Allina's HMO, Medica, has the largest non-metropolitan HMO enrollment in the state; in 1993, it had 35,794 enrollees outside the Twin Cities metropolitan area (MDH, 1994). Allina has developed a "strategic partnership" with the Fargo, North Dakota-based MeritCare Health System to develop a regional integrated care network in northwestern Minnesota, and plans to set up a series of regional ISNs throughout the state (The Integration Sensation, 1994).

### **Rural CISN Development and Implementation**

The 1995 Legislature's repeal of both the Regulated All Payer Option (RAPO) and the requirement that all health plans become CISNs or ISNs clearly reduced the urgency many rural providers initially felt to develop CISNs. Several additional factors also appear to have limited the development of rural CISNs. Many rural providers view HMOs negatively and perceive little difference between HMOs and CISNs. They are unfamiliar and somewhat uncomfortable with assuming the role of insurer. The

difficulty of competing directly with health plans that are already well-established in the market has also discouraged provider-based CISN development.

The lack of a sufficient population base to spread risk and to cover the administrative costs of operating a CISN has also hampered CISN development in some rural areas of the state. An actuarial study conducted for the potential CISN in northeastern Minnesota, for example, predicted that the CISN would have about 7,500 enrollees, considerably fewer than the 20,000 to 30,000 enrollees that the actuaries had determined a CISN would need to be financially feasible. The potential enrollee base for the CISN depends not only on the overall population in a given rural service area, but also on the demographics of the population, the type of health insurance that area residents currently have, and the willingness of employers to purchase a CISN plan. The minimum population needed may also depend on the type of CISN model chosen. Christianson, et al., (1988) note that rural-based group practice HMOs that are much smaller than 20,000 to 30,000 enrollees have survived, and that IPA model rural-based HMOs are clearly feasible at lower enrollment levels. However, recent research has found that the cost of producing a member month of non-Medicare coverage falls as HMO size increases, and then levels off at about 50,000 enrollees (Wholey, Feldman, and Christianson, 1995).

Local groups of providers have experienced difficulty in obtaining the capital necessary to meet CISN financial requirements without relying on guarantees from a large insurer or HMO. The three cooperatives described the large amount of capital needed to meet CISN net worth requirements as a reason for their selection of the

cooperative model over the CISN model, and the provider group in northeastern Minnesota cited it as a major reason for their decision not to proceed with CISN development. The currently licensed CISNs have taken advantage of some of the alternative methods for meeting net worth requirements (e.g., two CISNs are using the three year phase-in) but have not used others (e.g., the "accredited capitated provider" provisions). Although the CISN financial requirements are more flexible than the HMO requirements in terms of alternative methods for meeting net worth requirements, they are more restrictive in that CISNs are not allowed to use buildings and equipment as admitted assets in calculating net worth. Although this restriction was not a problem for his organization, the CEO of CMGHP believes that it could be a problem for clinics that want to establish CISNs, and may leave them with no other option than partnering with a large organization that has substantial financial reserves.

A reduction in CISN net worth requirements might encourage development of more rural CISNs, but would place the CISNs at greater risk of insolvency, and provide less protection for enrollees in the event of an insolvency. States vary considerably in their HMO reserve, capital and deposit requirements. However, as a result of state regulators' concerns about the financial status of many HMOs, the general trend since the early 1980's has been toward increased state financial regulation of HMOs. Christianson, Wholey and Sanchez (1991) found that between 1976 and 1990, forty-five states experienced at least one HMO failure, and twenty states had five or more failures. Expanded HMO regulation may be justified on consumer protection grounds, but, as Christianson, et al. note, it may also limit entry of new health plans to the

marketplace. In Minnesota, a number of HMOs have merged in recent years, but only one new HMO (a metropolitan area Medicaid HMO) was licensed from 1987 to 1994.

### **Health Care Provider Cooperative Models**

In contrast to the CISN statute, the health care cooperative statute allows providers more flexibility in defining the governance and organizational structure of the cooperative. The three health care provider cooperatives incorporated to date were developed as joint hospital and physician ventures, but they have taken somewhat different organizational forms depending on the commitment to local control and previous affiliations of the entities involved.

Southwest Health Alliance has equal numbers of physician and hospital representatives on its governing board; QHA and the Minnesota Rural Health Cooperative have physician majorities on their boards. Membership in the Southwest Health Alliance is open to South Dakota and Iowa providers, while the Minnesota Rural Health Cooperative and QHA limit membership to providers from their service areas. Both QHA and the Southwest Health Alliance have established procedures to ensure geographic representation within their service areas on their boards.

Southwest Health Alliance and the Minnesota Rural Health Cooperative cover basically the same service area in southwestern Minnesota. Generally, hospitals in the northern part of the service area that are members of the Medi-sota hospital consortium have joined the Minnesota Rural Health Cooperative, while those in the southern part of the service area that have affiliations with Sioux Valley Hospital in

South Dakota have joined Southwest Health Alliance. One hospital is a member of both cooperatives, and a few other hospitals in the central part of the service area are considering joining both cooperatives, although it is not clear what the need for dual membership or its practical impact will be if the two cooperatives negotiate contracts with the same health plans. The service areas of the two cooperatives also overlap substantially with that of New Pioneer Health Plan. All of the hospitals and most of the primary care physicians in the area have signed provider contracts with the CISN, and the majority of hospitals and a number of the non-Affiliated Community Medical Center physicians in the area have also joined one of the two cooperatives.

The cooperatives, unlike the CISNs, have chosen not to align themselves with a single large partner. All three cooperatives plan to negotiate contracts with multiple health plans. Their choice of this strategy appears to be motivated at least in part by the fact that providers in their service areas have historical referral patterns and affiliations with multiple tertiary care providers. In addition, a cooperative does not have statutory financial requirements like a CISN does, so it does not need a large partner to help it meet those requirements.

A cooperative, however, needs capital for start-up costs. All three cooperatives obtained capital through the sale of stock shares to members, but have pursued different strategies for obtaining additional funds. QHA solicited donations from two large health plan companies, and sold preferred stock to a third health plan company. Southwest Health Alliance has assessed dues on members, and the Minnesota Rural Health Cooperative has relied on federal transition grant funds awarded to member

hospitals. The cooperatives are also making use of resources such as legal and management services available to them through members' organizational affiliations, e.g., Southwest Health Alliance's relationships with the North Central Community Health Network and VHA North Central.

The cooperatives believe that the major benefit they offer to a health plan is access to a network of organized providers through a single contract, thus eliminating the need for a plan to negotiate individually with each physician group and hospital in the service area. A basic test of cooperative success will be the extent to which cooperatives are able to negotiate contracts with health plans on terms that are beneficial for the cooperative members as well as the plan (e.g., contracts that provide for an acceptable distribution of risk between the cooperative and the health plan).

As of August 1995, only one cooperative (QHA) had negotiated any contracts with health plans, although the other two cooperatives were planning to begin negotiations in the near future. QHA has found that it is easier to contract with health plans that are new to its service area and do not already have a network in place, such as HealthPartners.

Blue Cross/Blue Shield has had individual contracts with the providers in the QHA service area for many years. It recently developed a joint venture with the Mankato Clinic, the largest physician group in QHA, and plans to develop a managed care product through the joint venture. The impact of the BCBS joint venture on the Mankato Clinic's participation in other managed care plans is not yet known (Howatt, 1995).

One of the most difficult aspects of implementing a capitation agreement is determining how providers will be compensated. The three cooperatives are still determining how providers should be paid, and how risk should be shared among cooperative members. Two cooperatives have decided to pay their physicians and hospitals according to fee schedules while they continue to develop and refine risk-sharing methods; the third cooperative has not yet decided on a payment mechanism.

### **Rural Cooperative Development and Implementation**

The flexibility of the cooperative model is a major source of its appeal to rural providers. However, the lack of specificity in the statutory definition of a cooperative has caused uncertainty for cooperatives, and resulted in disagreements between providers and state regulators regarding a cooperative's legal authority to engage in certain types of activities. The statute requires that contracts between provider cooperatives and plans be on a "capitated or similar risk-sharing" basis, but does not define these terms. MDH plans to consider the statutory CIGN definitions of "capitation" and "capitated basis" in evaluating whether the cooperative contracts meet this requirement (Minnesota Department of Commerce and MDH, 1994). However, MDH has not issued any guidelines regarding the amount of risk a cooperative should bear under these contracts.

Another problematic issue for provider cooperatives has been direct contracting between cooperatives and self-insured employers. Self-insured employers are potentially a substantial market for provider cooperatives, given that forty-six percent



of all private sector employees in Minnesota are enrolled in self-insured plans (MDH, June 1995). However, QHA is currently the only cooperative with authority to contract directly with self-insured employers. The other health provider cooperatives believe that direct contracting with self-insured employers is a cost-saving measure for the health care system, and that the Legislature should extend the authority to all provider cooperatives. MDH remains concerned that direct contracting between provider cooperatives and self-insured employers could result in insufficient consumer protection if the cooperative or the employer became financially insolvent.

Direct contracting between provider cooperatives and self-insured employers is one aspect of a broader national policy issue related to provider risk-sharing arrangements. The National Association of Insurance Commissioners (NAIC) recently issued a bulletin warning state insurance commissioners that some health care providers in physician-hospital organizations, integrated provider organizations, and provider-sponsored networks were engaged in risk-sharing arrangements that amounted to selling health insurance without a license. NAIC wants to have state health insurance solvency and consumer-protection laws applied to these arrangements; the American Hospital Association is advocating the development of solvency and consumer-protection standards for self-insured employers (Aston, 1995).

## **CONCLUSIONS**

Although Minnesota passed its first health care reform legislation in 1992, the first CISN only began operating on January 1 of this year. The first health care

provider cooperatives were incorporated in November 1994 and February 1995, and are just now negotiating contracts with health plans. It will be some time before the CISON or cooperative models can be evaluated to determine whether or not they have improved the delivery of health care in rural areas and the health outcomes of the populations they serve. However, it is possible to reach some tentative conclusions about likely trends in rural CISON and health care cooperative development in the future, based on the legislative and regulatory framework established by the state, and implementation efforts to date.

- **CISON regulatory requirements and the pattern of CISON development to date suggest that local development of CISOs in rural areas of the state is unlikely to occur without the financial assistance of a large health plan or tertiary care provider.**

Christianson and Moscovice (1993) suggest that the ways in which rural networks develop are likely to depend in part on geographic considerations and in part on prior collaborative relationships among rural providers. They conclude that integrated rural networks are most likely to develop in rural areas that are in proximity to urban areas and relatively densely populated, and that these networks may develop either through contracts with urban-based health plans that may already serve residents of their communities, or by building upon existing collaborative arrangements among rural providers.

CISON development in Minnesota appears to be following this pattern. The initial CISOs have developed either as expansions or conversions of urban-based HMO or PPO plans or as joint ventures between a large health insurer and a large, multi-

specialty clinic in a relatively well-populated area. Central Minnesota Group Health Plan, PreferredOne Community Health Plan, and Dakota Community Health Plan are all based in metropolitan areas, and New Pioneer Health Plan and the potential CISN in Mankato are located in the two non-MA counties in the state with the highest number of physicians. Both the CISNs and cooperatives have built on existing collaborative arrangements between providers, including large group practices, physician-hospital organizations, and hospital consortia.

Local providers trying to develop CISNs are facing many of the same problems that have historically limited HMO development in rural areas, such as acquisition of start-up financing and achieving financially viable enrollment levels (Christianson, et al., 1986). Consequently, local ownership of a CISN or ISN does not appear to be a realistic prospect for many rural providers. In a recent survey of Minnesota hospitals, sixty-five percent of hospitals outside the Twin Cities area reported that they expect to contract with a CISN or ISN by the year 2000, but only twenty-one percent think that they will be part owners of a CISN or ISN (Minnesota Hospital Association and Metropolitan Healthcare Council, 1995).

- **Health care provider cooperatives appear to have more potential than CISNs for developing as locally owned and controlled organizations in rural areas. However, cooperatives still need to prove that they can successfully negotiate contracts with health plans, implement satisfactory provider payment mechanisms, and manage risk.**

Like CISNs, health care provider cooperatives face initial organizational and financial hurdles. However, the cooperative model is more flexible and less regulated than the CISN model. Rural provider interest in the cooperative model has been fairly

strong, especially among rural hospitals and small physician group practices. In the hospital survey cited above, for example, sixty percent of the Minnesota hospitals outside the Twin Cities area indicated that they expect to be part of a health care cooperative by the year 2000. However, the health provider cooperatives need to prove that they can successfully perform three functions. First, the cooperatives need to negotiate capitated contracts with multiple health plans on terms that are beneficial for the cooperative members as well as the health plans. Second, they need to develop and implement provider payment mechanisms that will make providers, including both small and large providers in their service area, want to join the cooperative and remain members over time. Third, the cooperatives must successfully manage the risk that they assume under the "capitated or similar risk-bearing" contracts required by the cooperative statute.

- **Additional public sector involvement may be necessary if community-based CISNs, health care provider cooperatives, or alternative health care delivery and financing models are to be successfully implemented in less densely populated rural areas of the state.**

The Minnesota Legislature has expressed its support for locally based and controlled CISNs and health care cooperatives. However, the current incentives do not appear to be sufficient to encourage local CISN development in many rural areas of Minnesota. If the Legislature remains committed to implementation of community-based CISN models, especially in less densely populated rural areas of the state, it may need to provide more significant incentives such as broader regulatory flexibility, grants, loans, or expanded technical assistance, and to specifically target the

incentives to community-based CISNs. Policy issues related to the provision of such incentives have been discussed extensively elsewhere (Casey, Wellever and Moscovice, 1994). Alternatively, the Legislature may need to support the development of additional rural health care delivery and financing models beyond CISNs and health care provider cooperatives.

- **Minnesota's experience with CISNs and health care provider cooperatives in rural areas will be of interest to policymakers considering current Medicare reform proposals.**

Congress is currently considering Medicare reform proposals to expand the number of Medicare enrollees in managed care plans, and allow provider service networks to contract directly with the Medicare program to provide health care services to Medicare enrollees. The proposed Medicare Preservation Act of 1995 would allow provider-sponsored organizations (PSOs) to qualify as eligible organizations for Medicare managed care contracts (Congressional Research Service, 1995). Many of the policy issues raised by the Medicare legislation are similar to those Minnesota has faced regarding the development of CISNs and health care provider cooperatives in rural areas. State policy in Minnesota is clearly still evolving on these issues. However, policymakers can learn valuable lessons from Minnesota's attempts to define appropriate roles for government, health care providers, health insurers and HMOs in a restructured rural health care delivery system, as well as its efforts to address regulatory issues involving the assumption of financial risk by CISNs and provider cooperatives and the protection of health care consumers.

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