MINNESOTA COUNCIL of HEALTH PLANS

Helping Minnesotans maximize their managed care health plans

A Healthy Partnership:

The critical role managed care plays in Minnesota health care programs

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Minnesota is a national leader when it comes to health care delivery. Home to world-renowned clinics like Mayo, leading research facilities such as the University of Minnesota and nationally recognized health plans, Minnesota and its people have a tradition of collaborating to ensure residents a level of health care rarely experienced anywhere in the country.

A case in point is the collaboration between the State of Minnesota and its nonprofit health plans. What began as a voluntary pilot initiative to bring mainstream provider access to Minnesota Health Care Program enrollees in one county quickly grew to a statewide partnership that is positively impacting health care access and quality. Thanks to this partnership, there have been numerous system improvements and impressive health care cost savings. By collaborating on ways to improve the health of those insured by the state, the State of Minnesota and Minnesota's nonprofit health plans have created a 20-year healthy partnership that is even healthier for its residents.

That partnership includes providing access, services, high quality care, targeted programs, financial stewardship and targeted efforts around future improvements.

Access for Minnesota Health Care Program Enrollees

Of all the benefits the state receives from its partnership with health plans, the greatest may be that health plans guarantee access to providers.

Years ago, Minnesota health care program enrollees struggled to find a doctor in their county who would see them. Minnesota Department of Human Services (DHS) staff invested significant human and financial resources traveling throughout the state meeting with clinic staff, working to encourage them to treat new public health care program enrollees, especially pregnant women. Unfortunately, DHS lacked the leverage to change the practice environment or hold providers directly accountable.

Changing this environment and improving access were primary goals of moving state program enrollees to managed care. That goal has been accomplished. Today state health care program enrollees are guaranteed access to the same physicians and other health care providers as commercial enrollees.

Through a health plan's contracting agreements, providers see all patients who are members of a health plan. The health plan validates the provider's education and training through credentialing activities, negotiates payment rates and places providers in the care network. Statewide 80 to 99 percent of physicians are in a health plan's provider network, depending on the area served.

Providing Critical Services

In addition to ensuring access, health plans perform other critical services for the state and health care program enrollees. Not only do health plan administrative costs pay claims and manage enrollment as DHS does in its traditional fee-for-service arrangements, but health plans also offer additional services. Many of the following services are funded through administrative expenses.

Overall Health Education and Access to Care

- Bilingual trained customer service representatives
- Interpreters and translated materials
- Enrollment packet, handbook
- Newsletters
- Advisory committees
- Grievance & appeals process
- Outside review of challenged coverage decisions
- Identifying non-health plan resources available to members
- Toll free nurse lines
- Health promotion
- Health education
- Immunization and preventive care, smoking cessation, etc
- New mother programs
- Targeted incentive programs
- Timely immunizations
- Appropriate prenatal care
- Timely check-ups
- Car seat safety
- Cell phones that directly call providers for people in crisis without phones
- Health fairs
- Health assessments
- Transportation for medical appointments
- Mobile dental unit
- Hosting dedicated clinic times for people enrolled in public programs

Coordination, Support and Condition-Specific Education

- One-on-one coordination from a nurse
- Home and nursing home visits
- Arranging for interpreters, personal care attendants, transportation to medical appointments or ordering medical equipment
- One-on-one support managing chronic conditions
- Making appointments, communicating with physicians
- Specialized care improvement initiatives
- Identification of special health care needs

Services for Doctors and Clinics

- Cross cultural training for physicians and office staff
- Provider hotline
- Provider manual
- Formulary guide
- Administer complaints & appeals
- Electronic billing and payment
- 24-hour availability
- On-line services to verify eligibility, check claims and request authorizations

Collaborative Efforts

- MN Partnership for Action Against Tobacco (MPAAT) – Health Plan Partners Group
- American Lung Association – MN Asthma Coalition, Controlling Asthma in American Cities Project
- Clinical Trials Work Group
- MDH Communicable Disease Rule Advisory Committee
- MDH Comprehensive Cancer Control Planning Project – Steering Committee
- MDH MN Am. Cancer Soc. Cancer Surveillance System (MCSS) Advisory Group
- MN Diabetes Collaborative, Stratis Health
- MN Heart Disease & Stroke Prevention Steering Committee
- MN Medical Assn. – Obesity Task Force
- Steps to a Healthier MN – Minneapolis: Community Consortium (diabetes)
- MDH Metro Outreach Coalition (Breast/Cervical Cancer Prevention)
- Child & Teen Checkup regional and Multicultural Groups
- Cover All Kids
- Hennepin County Alliance for Families and Children, Public Health Task Force
- MDH Maternal and Child Health Advisory Task Force
- MDH MN Childhood Lead Poisoning 2010 Elimination Plan Advisory Workgroup; Minneapolis Health Dept. Lead work group; MN Collaborative Lead Education & Assessment Network (MCLEAN)
- Northeast MN Public Health Cooperative
- Regional Immunization Groups
- Collaborative for a Healthy Population
- Partnership for Adult Immunization-Stratis: SE MN
- Children's Mental Health Partnership
- DHS State Advisory Council on Mental Health
- MN Mental Health Action Group (MMHAG)
- March of Dimes Prevention of Prematurity Task Force
- Prairie Regional Health Alliance
- Twin Cities Healthy Start Collaborative
- Community Health Worker Project
- MDH/DHS Health Care Disparities Task
- MN Joint Purchasing Coalition
- MN State Council on Disabilities
- Multilingual Health Resource Exchange
- Be Active Minnesota

Assuring Qualified Providers and Quality Care

- Fraud and abuse detection
- Medical director oversight
- Pay-for-performance programs
- Credentialing providers
- Individual provider site visits
- External accreditation
  – NCQA
  – URAC
- Focused clinical studies
- Quality improvement plans
- Health care standards, policies and practice guidelines
- Provider infrastructure grants program
- Identification of over and under utilization of services

Providing Data and Public Accountability

- Reports to state agencies, including Departments of Health, Human Services and Commerce
- Utilization
- Paid claims
- Grievance & complaints
- Provider network
- Physician incentives
- Audited HEDIS reports, quality of care indicators
- Quarterly & annual financial reports
- Enrollee satisfaction survey
- Provider satisfaction surveys

Providing Administrative Expertise

- Legal services
- Human resources
- Accounting
- Communications, marketing

Investing For Community-Wide Benefits

MN Community Measurement
- Institute for Clinical Systems Improvement
- Economies of scale: commercial payors share the costs
- E-health initiatives
- $16.4 million in foundation grants, teaching and charitable contributions (2004)
- $239 million to health promotion
- $30 million for technology for community clinics

In Minnesota, 90 percent of every health care dollar goes to clinics, hospitals and others who provide patients care. While administrative costs have risen 1 to 2 percent in recent years due to the increase in care coordination, disease management, patient education efforts and health care premium taxes and government assessments, they remain some of the lowest in the nation. Historically, administrative spending has been under 10 percent in Minnesota. At national plans, administrative costs top 14 to 20 percent.

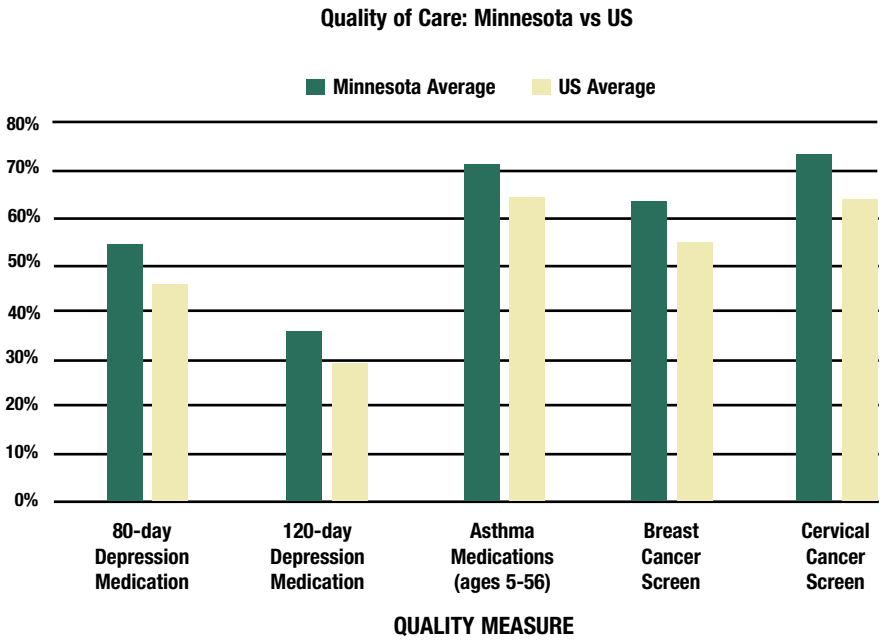
A Closer Look: History and Progress

When the state began its partnership with managed care organizations, goals for the state included moving toward a more controlled and predictable budgeting process, and transferring primary financial risk away from the state to health plans and providers. The state's plan required health plans to provide the full array of services to all clients and create incentives for providers to use preventive health practices. Progress has been made toward achieving these goals, as the facts that follow demonstrate.

Delivering Quality & Satisfaction

Monitoring and reporting on quality-of-care results is one of the important services managed care provides. These results are not monitored in a fee-for-service arrangement. Measuring and reporting is the first step in improving results.

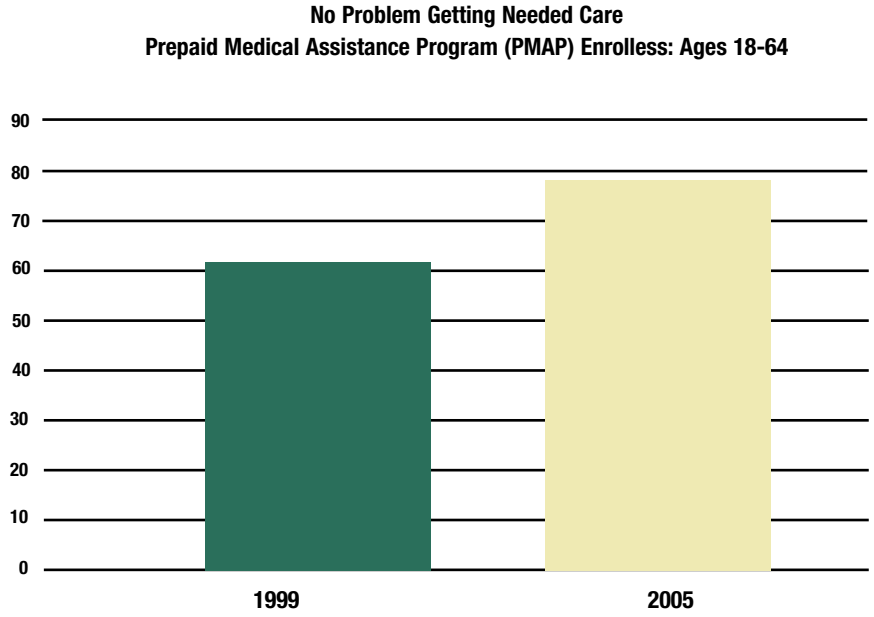
Local health plans have been recognized nationally for providing Minnesotans with access to necessary care. Plans have also created specific efforts targeted at increasing preventive care services and supporting safety efforts.



Data Source: National Committee on Quality Assurance (NCQA), Health Employer Data and Information Set (HEDIS) (2004)

Serving People with Disabilities

Minnesota Disability Health Options (MnDHO) is among the first managed health care delivery systems in the country designed specifically for working-age adults with physical disabilities. The demonstration project led by UCare Minnesota featured care coordination and support services. Preliminary survey data shows this specially designed managed care program is significantly improving both quality and experience for enrollees with disabilities.



Data Source: National Consumer Assessment of Healthcare Providers and Systems (CAHPS) Benchmarking Database. 2005

Highlights include:

- 90 percent report higher overall satisfaction than with their previous coverage.
- 100 percent report being treated with respect.
- 82 percent report receiving needed information.
- 85 percent report formal care coordination was available only after enrolling in MnDHO.
- 80 percent felt more comfortable with their ability to obtain needed services than they did with their previous coverage.
- 100 percent report being involved as much as they want in health care decisions. Forty-five percent report not being adequately involved prior to enrolling in MnDHO.
- 60 percent report that the MnDHO program made it easier to encourage their health care providers to deliver services in ways that they preferred.

Specialized Support for Seniors

Poor seniors in Minnesota benefit from the health plan partnerships. Most seniors enrolled in Minnesota Senior Health Options (MSHO) qualify both for Medicare and Medicaid services. The program combines separate health programs and support systems into one package. Health plans, along with Stratis Health, have teamed up to address many issues through effective care coordination and care improvement initiatives. MSHO enrollees are assigned a care coordinator who helps them find the health care and related support services they need. Care coordinators also play a key role in helping doctors and other providers share information. Highlights of this work include:

Medication management

Between 2002 and 2005, care coordinators conducted coordinated medication reviews (CMR) as part of their assessment of members during home visits. The goal of this project was to develop consistent medication management approaches across health plans and care systems. The CMR process has now become part of the usual practice. Issues related to medication use are being identified and addressed. Of the 1,426 members evaluated:

- Home visits identified an average of 6.9 medications – the range was 0 to 46.
- Issues were identified for 325 medications (3.3 percent).
- A resolution was made in 208 cases (66 percent) where an intervention was recommended.
- At least one issue was identified for 196 (14 percent) of participating members.

Diabetes care

A diabetes care intervention project has been underway since 2004 to help prevent complications. Goals included increasing the percent of members with a timely comprehensive diabetes visit, increasing the percent of members who receive appropriate tests and increasing the percent of members living in nursing homes who receive necessary eye exams. Results over a one-year period include a:

- 47 percent increase in cholesterol testing
- 56 percent increase in kidney function testing
- 10 percent increase in eye exams
- 5 percent increase in blood sugar over time testing

Heart failure care

The heart failure initiative worked to better identify and treat heart failure due to left ventricular failure (LVF) dysfunction. Results show that care coordinators have a key role in improving care. The percent of members who had an LVF assessment, as well as the percent who had appropriate medications prescribed, both increased. While the number of hospitalizations remained consistent, there was great improvement in the percent of members who were hospitalized just once.

Depression screening

Screening for depression is an important care improvement initiative due to the high incidence of depression in elderly people living in nursing homes. Studies show that just 60 percent of enrollees were screened for depression with a tool that is valid for this age group. Of those whose screening showed depression, the majority did not have evidence of a clinical assessment following the screening. The goals of the depression initiative are:

- Screen new members within 30 days of enrollment, using an age appropriate screening tool.
- For those who have had a positive screen, work to improve the number of people who receive the clinical assessment within 60 days.

Pneumonia vaccination

Federal data show that each year 175,000 Americans are hospitalized with pneumococcal-caused pneumonia. In addition, the germ causes more than 50,000 blood infections and up to 6,000 cases of meningitis. Pneumococcal disease kills about 40,000 people each year in the United States, with more than 90 percent of the deaths occurring in senior populations. Baseline information shows that only 21 percent of seniors have received the vaccine. The goal of this effort is to achieve 90 percent coverage by incorporating the services of MSHO care coordinators, primary care providers, home health care providers, community clinics and the statewide immunization registry to work toward the goal.

Calcium and vitamin D supplements

Plans are underway for a calcium and vitamin D supplement initiative that will launch in 2007. The group is tackling the topic of bone health with the goal of increasing the number of members taking calcium and vitamin D supplements in order to reduce bone fractures. Currently, a team is reviewing literature and putting together a detailed design of the project in preparation for the state's approval process.

Financial Performance: A Long-Term Approach

Assuring access and high quality care requires fiscally solvent plans, says the Kaiser Commission on Medicaid and the Uninsured. In Minnesota, the rates DHS pays to the health plans to provide coverage to Medical Assistance enrollees must be actuarially sound and stable – meaning they can't be too little, nor can they be excessive.

The state has saved money while improving care by moving Minnesotans from a government-supported fee-for-service arrangement to managed care. Early on, DHS paid health plans 5 to 10 percent less than what it paid out in fee-for-service care. The assumption was that because health plans are designed to provide health care coverage, they would be able to be more efficient and effective than the state in providing the coverage. The assumption was correct.

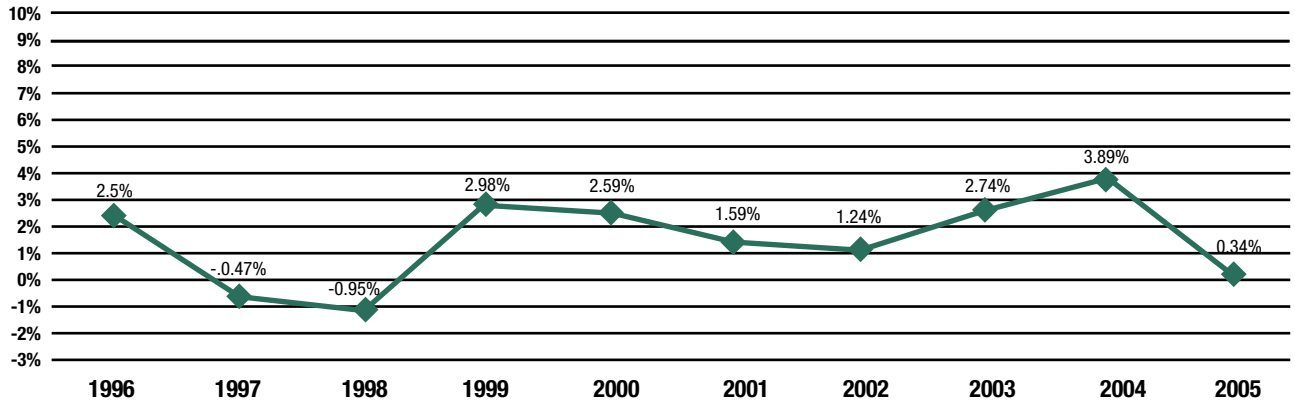
Studies demonstrate that Medicaid managed care generates cost savings. In the first five years of Minnesota's program, the state saved more than $28.4 million, according to a DHS analysis of cost savings. Nationally, while the percent saved varied widely (from 2 to 19 percent), nearly all the studies demonstrated a savings in the managed care setting. In addition, findings in studies across the nation show that managed care efforts improve access and quality while at the same time producing program savings. (Lewin Group, 2004)

As with any insurance market, financing is cyclical – containing highs and lows from year to year. Consequently, results reviewed one year, one product at a time, give an incomplete picture. A long-term focus is necessary so that sweeping changes aren't made each year – changes that would disrupt services to health plan members and providers. Because they are committed to serving all Minnesotans, Minnesota's health plans accept the uncertainty in the public programs market. The state's continued commitment to a rate-setting process with a long-term focus assures continuity of coverage and care for many Minnesotans. This approach helps assure the long-term solvency of health plans, enabling them to develop programs and services to meet growing and changing needs.

DHS aims for an operating margin of under 2 percent when developing its payment systems. Between 1995 and 2005, the average margin was 1.6 percent. Expenses kept pace with revenues resulting in a fairly flat overall net operating gain/loss.

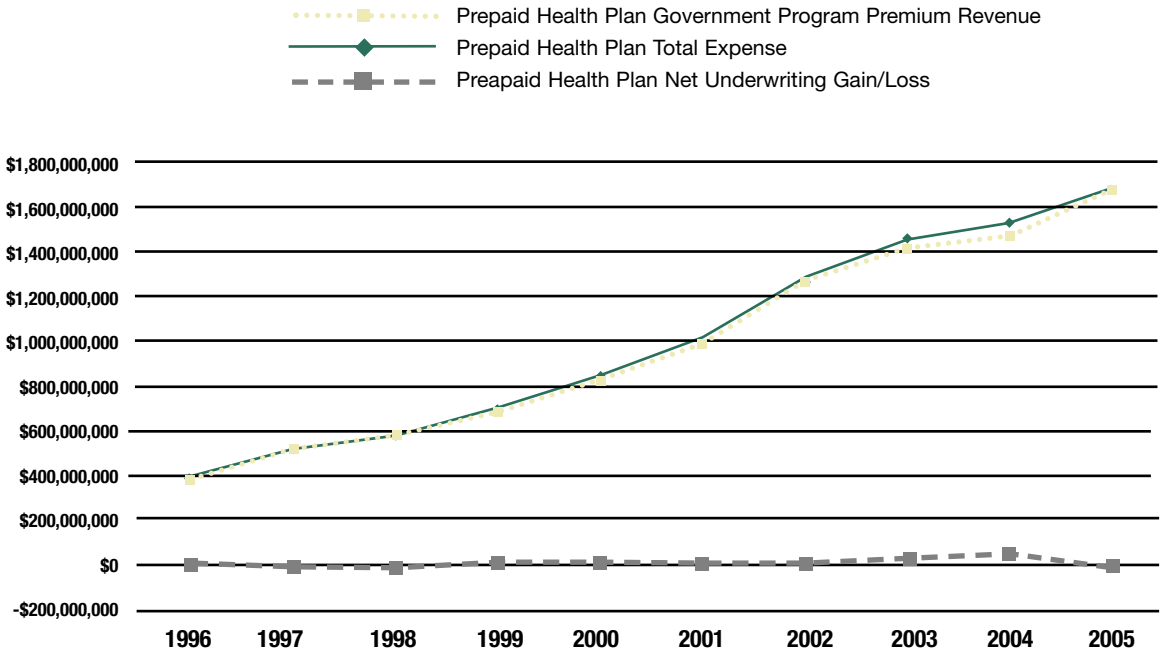
Net Operating Gain/Loss on GAMC, MNCare and PMAP
for Minnesota's Managed Care Plans
1996-2005

10-year Average Operating Gain/Loss as a % of Revenue = 1.65%



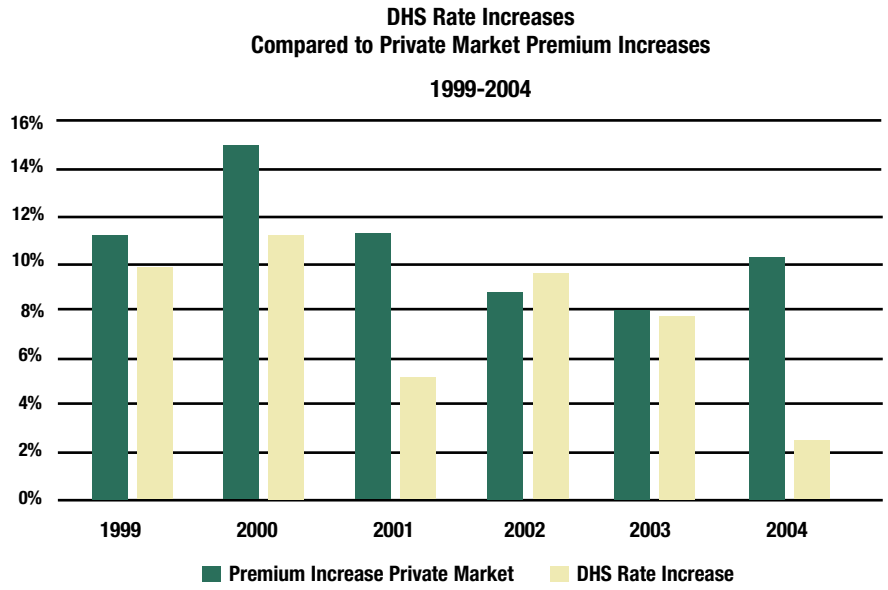
Source: Health plan data compiled by MCHP.

Minnesota Health Plans Revenue, Expense, Operating Gain/Loss
GAMC, PMAP and MinnesotaCare
1995-2005



Source: Health plan data compiled by MCHP.

The graph below shows that during the past six years, rate increases paid to the health plans by the Minnesota Department of Human Services have been lower than private market premium increases in all but one year.



Data Source: MN Dept. of Human Services

Minnesota Health Plan Innovation: A Model for the Nation

In 2004 health plans received national recognition for their innovative efforts to improve care for people in government-supported programs. Five of the 26 plans recognized for these efforts were from Minnesota. These health plans serve 64 percent of Minnesotans who are enrolled in Medical Assistance, Minnesota's Medicaid program. Efforts recognized include:

Preventive care for teens

A HealthPartners analysis of children's visits for checkups found that as children aged, they were less likely to visit clinics and receive critical checkups. In an effort to get adolescents necessary care, HealthPartners conducted a pilot program in Hennepin and Ramsey counties that included reminders during the month of the teen's birthday and an incentive to make and keep the appointment. The reminder included the name and phone number of the teen's clinic. A gift certificate was offered to those who completed the preventive care visit. Teens in both the intervention and control group received more checkups during the period, but the increase was 5.5 percent greater among those receiving birthday incentive reminders. Overall, the rates for preventive care visits increased 19 percent between 2000 and 2003.

Support for seniors in rural Minnesota

Effective community-based care for seniors is the goal of a program supported by the State of Minnesota, Blue Cross and Blue Shield of Minnesota and its HMO BluePlus, four Minnesota counties, two regional Area Agencies on Aging and the Volunteers of America. The initiative first focused on elderly people who had diabetes and who qualified for both Medicaid and Medicare. An assessment found that in order to better care for these people, communications had to improve among the health plan, clinic and social service providers. BluePlus worked with its partners to develop a communication tool, "Closing the Loop," that county case managers and patients use to communicate with medical care providers. The 14 physicians participating in the project report that as an initiative to improve communications "Closing the Loop" is effective in providing them with insight of their patients' needs. Health plan members indicate that the discussion planning sheets, along with working with an advocate, help them better articulate their needs and concerns. Whereas previously they would often forget important information in the rush of a doctor's visit, they now have the opportunity to share this information in a relaxed setting with a social worker with whom they have a trusted, ongoing relationship.

Dental care

UCare Minnesota took innovative steps to improve access to dental care. Since 2002, the UCare Tooth Care mobile dental unit conducted over 16,000 dental cleanings and checkups for more than 3,500 UCare Medicaid and MinnesotaCare members. UCare also launched the See-A-Dentist Guarantee. By the end of 2003, 80 percent of clinics saw members with urgent needs within 48 to 72 hours, and 82 percent saw members with emergency needs within 24 hours. All Medicaid members calling the UCare See-A-Dentist Appointment Hotline have received an appointment for routine care within 30 days.

Checkups for children

Noting that 14 percent of children had not visited a doctor in the past year, UCare established an outreach program reaching both health care providers and health plan members. Providers joined the effort though telephone outreach, chart flags and other tools. Special efforts were made to reach the Hmong population since their child visit rates are historically low. Members received gift certificates if their children kept up-to-date on immunizations and blood lead tests. UCare saw a 65 percent increase from 2001 to 2004 in the number of child members receiving a well-child checkup, and the number of children who had at least one doctor visit (of any type) in the previous year increased by more than 1,000. In the Hmong population, the percentage of children under the age of 20 who did not receive medical care dropped from 29 percent in 2002 to 20 percent in 2004. Finally, the number of children receiving blood lead level screening between age 1 and 2 increased by 48 percent between 2001 and 2004.

Home visit checkups for children

Medica implemented a children's home visit program aimed at increasing the rate of well child screenings. Initially, the program focused on English speaking families in Hennepin County, and later expanded to focus on children over age 2, regardless of the language spoken in the home. It also moved to include western portions of Ramsey County. Phone calls were made to introduce the program and obtain permission for a visit from a public health nurse. Along with performing the check up, the visiting nurse works with the adult to identify a primary care clinic for the family. More than 1,600 children have received a visit through this program since 2001, and the number of well-child visits among Medica's public program members has increased substantially each year.

Asthma care
UCare Minnesota's Asthma Action Program helps children and adults manage their disease on an ongoing basis thus avoiding emergency room and hospital care. Asthma nurses work with patients to develop asthma action plans and goals, including medications and actions to take when breathing becomes difficult. Program members receive educational mailings and information via the phone. Persistent asthma patients receive more intense case management. Between 1999 and 2004, the number of asthma-related hospital admissions fell from 121 to 90 per 1,000 members. The number of members taking controller medications as recommended increased 12 percent between 2001 and 2004. Ninety-five percent of members responding to UCare's patient satisfaction survey report being highly satisfied with the program.

Preventive care
Metropolitan Health Plan and Medica, along with the Allina Foundation established Mothers Advocating Their Children's Health (MATCH) program to help promote well-child health screenings. The program started as a grassroots partnership with community clinics and Baptist churches where mothers educated peers about the importance of well-child checkups. The program has grown into CATCH (Congregations Advocating Their Communities' Health) and includes more than 16 faith communities – Baptist, Lutheran, Catholic and Muslim organizations – that advocate and educate on well-child health screenings. CATCH outreach efforts led to approximately 120 well-child visits for children up to age 20 in 2004. Materials on preventive care screening are being translated for congregations serving non-English speaking immigrant families, and plans are underway to recruit additional congregations. Several congregations have expanded their outreach efforts to promote services beyond well-child screenings, such as cancer screening, smoking cessation, and mental health and substance abuse education.

Preventive care
In an effort to increase use of preventive care screenings and increase access to care, Medica formed The Way to Better Health. This incentive-based program developed from member focus group reports and a review of efforts by health plans nationally. The program's focus included disease prevention, childbirth education, and healthy lifestyles and care safety promotion. Members receive information about the program through mailings, newsletters and the Internet. The heath plan provides gift cards to members who complete recommended prenatal visits, ensure their children receive recommended preventive care, receive preventive cancer screenings, take childbirth classes or complete smoking cessation programs. From 2000 to 2004, rates for cancer screening, well-child visits and prenatal care increased. For example, the number of Medicaid and MinnesotaCare members receiving prenatal care increased 10 percent; the percent of children with six or more well child visits in the first 15 months increased 7 percent and rates for breast cancer screening increased 7 percent. Eighty-six percent of members surveyed about The Way to Better Health in 2002 were satisfied with the program and rated it as "good." Seventeen percent of program participants said they would not have taken action without the incentives.

Continuous Improvement: Better Service for Individuals

While Minnesota's health care system is strong and remains a model for many states, much work remains. Policy makers, regulators, health plans, counties, providers, advocates and individuals must work to create a system that is more focused to meet an individual's specific needs and eliminate disparities.

The system must be simplified and become more transparent. Health plans are committed to working collaboratively to develop partnerships and programs that serve Minnesotans. These efforts will improve access across the state and ensure that people new to Minnesota Health Care Programs are welcomed into a system that is working together to improve their lives.

Partners in System Improvement

Minnesota's health care market is the envy of many states. While the market is competitive, the community as a whole continues to focus on learning from each other and improving care. Minnesota Health Care Program enrollees, along with all residents of the state, benefit from these efforts. Examples include:

- Physicians who develop and promote evidence-based guidelines commit to developing their own improvement efforts in their clinics and then share results through the Institute for Clinical Systems Improvement.
- Physicians, employers, health plans and community members working to improve quality and give consumers free information through MN Community Measurement.
- Employers and health plans rewarding improvements in quality through pay-for-performance initiatives.
- Health plans and community-based experts offering cultural competency training to clinic staff.
- Health plans and providers working to improve systems and documentation around preventive care visits for children.
- Department of Health, health plans, providers and pharmacists working to decrease the inappropriate use of antibiotics through work with the MARC, the Minnesota Antibiotic Resistance Collaborative.
- Hospitals, health plans, providers, employers, and state leaders improving patient safety through efforts of the Minnesota Alliance for Patient Safety.
- Counties, health plans, community groups, schools and others working through collaborative efforts to improve health in rural communities.
- Health plans, community clinics, university organizations and health care organizations developing population-specific health improvement initiatives, and efforts focused on new immigrants.
- Providers, health plans, the Department of Health and others working through the adult immunization coalition, promoting immunizations and reducing infectious disease