Hennepin County's Success with a Public HMO

Providing Managed Care for Public Sector Clients

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Managed care has existed for more than 20 years, giving traditional insured populations a system of care that is cost-effective and enhancing. Over the last 10 years, managed care has expanded to include populations in publicly funded programs: Medicaid, Medicare, General Medical Assistance, programs for the uninsured, and public employees. Market trends and legislation at the federal and state levels indicate that this movement is intensifying. The mechanism to serve public clients is usually a privately run, for-profit or nonprofit health maintenance organization (HMO)—a kind of entity that often is unfamiliar with the special needs of public clients.

There are a few government-owned and -operated HMOs around the country, however, that offer their clients years of experience in serving public populations. Metropolitan Health Plan (MHP), the HMO developed and run by Hennepin County, Minnesota, is one example. A discussion of MHPs' formation, experience to date, advantages, challenges, and future direction may offer local governments an innovative option when deciding how best to serve their public clients in an evolving health care system.

Genesis of the Program

MHP was formed to ensure the continuing viability of the county's medical center. In 1982, the Minnesota Department of Human Services applied for and received a waiver from the federal government, pursuant to Section

1115 of the Social Security Act, to develop and conduct a prepaid medical demonstration project in three counties: one urban, one suburban, and one rural.

The point of the waiver was to allow Medicaid recipients to be enrolled in managed care health plans. From the state's perspective, the purposes of the project were to bring Medicaid costs under control and to improve access to services and benefits without limiting eligibility. The state hoped to make Medicaid costs more predictable and to create an incentive for providers to deliver services more efficiently.

The state had begun a voluntary HMO enrollment program for clients of Aid to Families with Dependent Children (AFDC) in the early 1980s. Thereafter, the Hennepin County Medical Center (HCMC) began losing money on Medicaid recipients enrolled in private managed care plans because these recipients were enrolling in private plans that did not include HCMC in their networks. They still were coming to HCMC (particularly to the emergency room), however, for their care. HCMC was no longer able to bill either Medicaid or the health plan and was forced to absorb these costs.

In addition to the financial concerns at HCMC, another reason to form an HMO was that the county ideologically supported the managed care concept and believed that it should participate. County leaders saw many advantages of enrolling Medicaid clients in managed care. If their enrollment in health plans was allowed, clients would receive a health plan card like those carried by members of commercial health plans, thereby making their Medicaid status invisible to most providers and removing much of the associated stigma. The county always had looked for ways to preserve the dignity of its clients.

Based on years of experience serving low-income populations, the county also believed that better-coordinated care was needed to serve Medicaid clients appropriately—particularly those clients on AFDC who were receiving duplicate services from multiple providers. Under the Medicaid fee-for-service system, clients were given a freedom of choice of providers that made coordination of services next to impossible.

For example, a client would receive care from an emergency room and then later go to a physician's office, often for care of the same condition. The physician would not know of the emergency room visit and often would repeat services done in the ER; costs and quality would suffer. Managed care, with its primary-care gatekeeper system, was a promising vehicle for achieving coordinated care.

A further problem was that the voluntary managed care enrollment program threatened to take much of HCMC's client base. HCMC had a reputation as a high-cost hospital because of its preponderance of high-risk patients and its status as a teaching hospital. With the voluntary program, all Medicaid clients enrolled in managed care would go elsewhere, and those who continued to use HCMC would not be reimbursed. The county felt the need to compete for these patients, and MHP was born.

MHP Begins

In 1983, Hennepin County received a federal waiver, and in October of that year, the state of Minnesota certified the county's new HMO. In March 1984, MHP began enrolling its first AFDC members on a voluntary basis and by year-end had 786 enrollees. This number had escalated to 20,000 by year-end 1993, partly due to mandatory enrollment in managed care starting in 1990.

By 1987, MHP had seen steady growth for several years. *Modern HealthCare's* 1993 survey of 43 hospital-based HMOs ranked MHP as the second fastest-growing HMO by revenue.[1] As of January 1, 1994, MHP had a total enrollment of 32,582, compared with 31,965 in 1992, 18,025 in 1990, and 5,735 in 1988.

The enrollment process for the Medicaid demonstration was led by the Minnesota Department of Human Services (DHS), which hired an independent broker to educate and enroll clients for the first two years of the demonstration. The broker did not renew its contract, however, and DHS took over the enrollment process in October 1987. Clients were notified of the project by mail and were educated by phone or at sessions in community centers. If clients did not select a health plan, they were assigned to one randomly.[2] When the managed care program for Medicaid clients moved from demonstration to permanent status, the enrollment procedure was directed by county staff at the time of application, in an effort to reduce the random assignment rate.

The state originally contracted with seven health plans to serve the county's demonstration clients: four health maintenance organizations (HMOs); one preferred provider organization (PPO); one noncertified, primary-care independent practice association (IPA); and one nonprofit services plan. Over the life of the project, four plans have withdrawn.

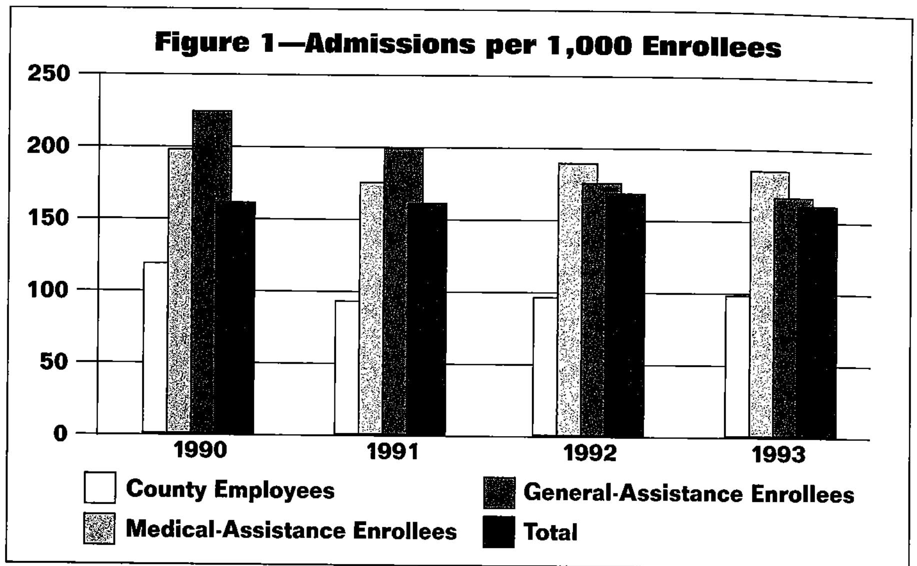
Provider Network. The anchor of MHP's provider network is the county's public hospital in downtown Minneapolis, Hennepin County Medical Center (HCMC). In addition to inpatient and ER facilities, HCMC has primary-care clinics in medicine, pediatrics, and obstetrics/gynecology. MHP's network also includes three primary-care clinics in the northern and western suburbs of Minneapolis, a primary-care center in the northern section of Minneapolis, a community clinic consortium consisting of five clinics in

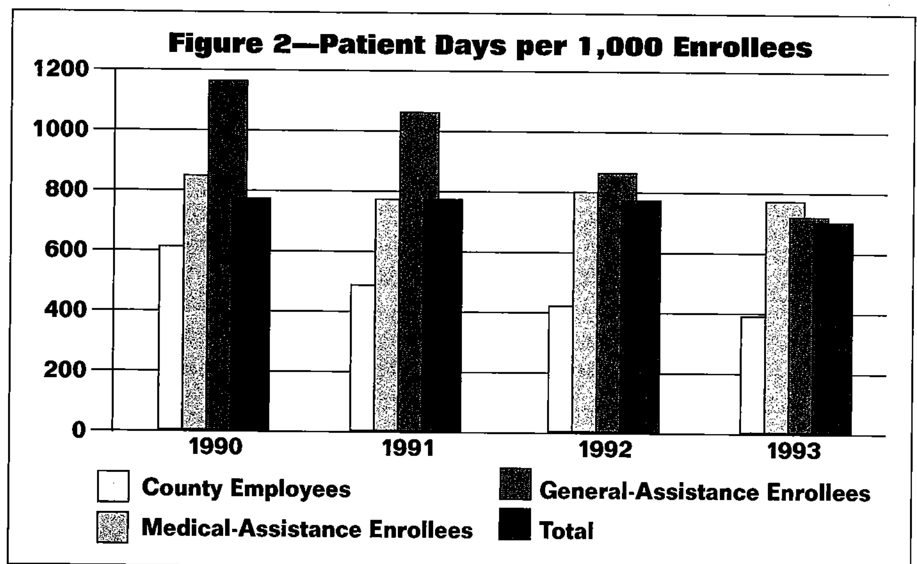
southern Minneapolis, women's and children's clinics, health assessment and promotion clinics, and health care provision for the homeless and for Native Americans.

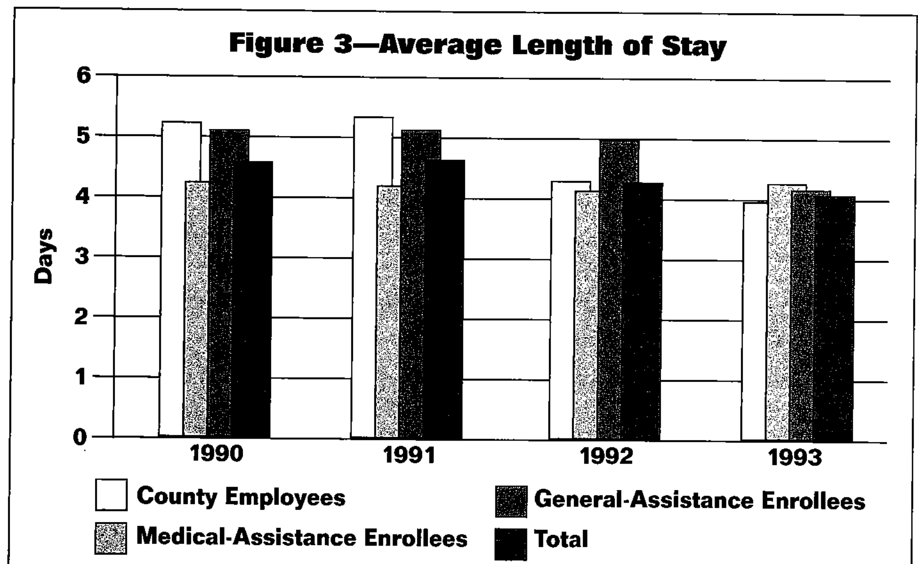
Managing Care. High priorities for MHP were to decrease the number of unnecessary ER visits and to place greater emphasis on primary and preventive care. Accordingly, MHP extended the hours of its outpatient clinics and contracted with several neighborhood clinics to provide additional services. MHP also established a patient education newsletter called *Lifelines* and a telephone service called HealthLine, staffed 24 hours a day by nurses trained in triage techniques and patient education.

Teaching hospitals tend to be resource-intensive. To help address possible overuse of services, MHP developed a system whereby referral physicians must report back to the attending physician regarding tests and treatments ordered. This system is designed to reinforce an attending physician's accountability for overall patient care and to heighten a physician's cost-sensitivity.

Utilization rates for publicly funded clients tend to be higher than those for commercial enrollees. Hospital admissions can be particularly high. However, MHP has succeeded in lowering admissions for Medicaid clients from 200 per 1,000 enrollees in 1990 to 184 per 1,000 enrollees in 1993; for general-assistance clients, admissions have been lowered from 225 to 170; and for county employees, from 116 to 100 (see Figure 1). MHP also has worked to lower patient days and average length of stay, succeeding in both efforts. Patient days for the three population groups have decreased from an average of 778 in 1990 to 695 in 1993, and length of stay has declined from 4.68 days to 4.15 days (see Figures 2 and 3). Both these decreases can be attributed, in part, to MHP's case management strategies.







From the beginning, MHP has established strong access support services and case management services to respond to the special needs of vulnerable populations. For instance, it has supplied bus tokens and cab vouchers for its clients, currently providing this service for an average of 9,000 rides per quarter. Crucial to adequate access to care for non-English-speaking people is interpretive services. To help patients communicate with their providers and understand their health plan and delivery system, MHP offers written information in seven languages and has translators available by phone or in person during physician visits.

MHP also has developed specific outreach programs for case management. For example, MHP staff have noticed that a significant number of clients could not be reached by phone to follow up on care or to remind them of upcoming appointments. Further investigation has revealed that many clients did not have phones for economic reasons and that installing phones would be problematic in some cases because of bad credit. Therefore, staff decided to purchase cellular phones for clients, particularly pregnant women, for whom appropriate prenatal care is necessary. The phones are preprogrammed to dial only provider and health plan numbers.

The women-in-need (WIN) program was formed to reduce and prevent adverse birth outcomes for pregnant women who are substance abusers. WIN offers housing and food assistance, as well as financial assistance in buying maternity and newborn clothing. These services are designed to serve as incentives for the women to establish healthy lifestyles and to obtain appropriate medical services. As of April 1994, 84 percent of the women participating in the program had delivered a drug-free baby.

Advantages and Challenges Of a Public HMO

For Enrollees. From the viewpoint of Medicaid clients, the county HMO has had distinct advantages. Physicians and other providers in the network have a history of serving high-risk populations and are aware of and seasoned about the additional services needed to ensure appropriate care. The county already had had interpreter services in the hospital for more than 20 years before the HMO's formation and had been affording transportation to providers for needy patients for more than 10 years. The county did not have to wait for a crisis to know that these services were necessary.

By contrast, when a privately owned health plan in the metropolitan area began serving Medicaid clients, it did not provide interpretive services or transportation. Complaints were rampant, and the plan was forced to add these services after several adverse experiences for enrollees, providers, and the plan.[3]

Hennepin County could draw from a wider range of services and experience than the usual plan services network. For example, such public health services as tuberculosis clinics, women and children clinics, and clinics set up specifically in underserved areas were all part of the county "network" before a formal HMO was formed. The county was used to serving mental health clients and was prepared for the additional time, expertise, and complex service needs often required by this population. Years of experience and expertise were immediately available to the county's HMO that typically are not found in a commercial HMO just beginning to serve public clients.

On the other hand, it was difficult for some enrollees to adjust to the HMO. Many were not accustomed to using a provider network and did not remember to bring their cards when they saw providers. It also was difficult for many patients to break the habit of using the emergency room for nonemergency care; they had to learn that the ambulance was not the only transportation available to them. Subsidized bus tokens and cab fares were available, but the transition proved difficult for some clients.

Adding county employees to the HMO in 1987 created other sensitivities. Confidentiality of records was an issue because the enrollee's employer, as the owner of the health plan, now potentially had access to medical records. Also, county employees were faced with using the same services that their clients used, and there was some stigma attached to this circumstance.

Overall, the most significant advantage of providing MHP to county employees was the increased competition, which resulted in lower prices. Before MHP, all other health plans serving county employees (except one) had dropped them. With only one plan available, the county had no check on premium charge increases. But with the entrance of MHP, the other health plans consistently have held prices to competitive levels.

For the County and Its Providers. Entrance into managed care has forced the county to streamline its services. In implementing the HMO, the county began looking at how services were delivered and whether they were necessary. For example, before managed care, every HCMC client, regardless of need, received a special foam-rubber "eggshell" mattress that cost $40. When the county developed MHP and with it more rigorous and defined parameters for care delivery, protocols were written and enforced as to who should and should not get these more expensive mattresses.

Physical therapy is another example. Before MHP, physical therapy was given to nursing home clients daily, at $20 per session. MHP's arrival brought with it prior authoriza-

continued on page 13

continued from page 12

tion requirements, and physicians and physical therapists began to realize that medical necessity should drive therapy, rather than availability of service and patient. The county continues to develop protocols for increased quality and cost-effectiveness.

Providers, particularly HCMC and the physician network, have benefited from a county health plan in several ways. The different care delivery units now have become more closely linked. They share a medical record and are forced to increase collaboration. More information is available about total care because community clinics, social services and public health clinics, and hospitals and physician services are all part of the managed care delivery system.

There also have been drawbacks to a county-run HMO, of course. At first, the county's board of commissioners was concerned about putting 100 percent of the Medicaid population into managed care, so it insisted that only one-third be allowed to enroll for the three-year demonstration. This situation caused confusion for providers, who were unclear about which clients were under which arrangements, who needed prior authorization, whom to bill, and how coordination of care would function based on which type of insurance the client had. In 1990, 100 percent of Medicaid clients were enrolled in managed care.

MHP's formation also served to break longstanding barriers with the city of Minneapolis's public health department, which is separate from that of the county. This department was not used to contracting with managed care entities and was generally not aware of managed care expectations; there was considerable fear and skepticism about managed care in general. Having a government in charge of the new health plan—a government that understood and had experience in serving the same high-risk populations as the city served—made the transition and its attendant communication and coordination efforts smoother.

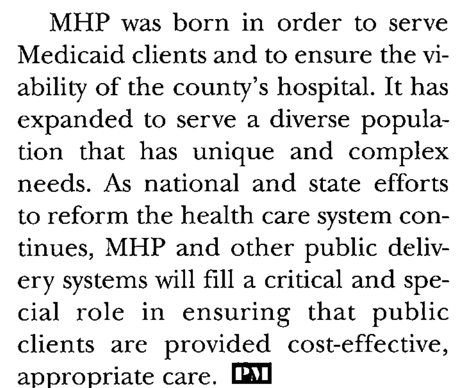
Future Challenges

Network configuration continues to be an issue. Like health care delivery systems across the country, MHP believes it should have a greater number of primary-care providers, but the number of these providers is limited. The current provider network is weighted toward specialty care. The challenge is how to increase the number of primary-care providers without losing specialists and without making the network so big that administrative costs go up and cost containment strategies and coordination suffer. (As noted, MHP's administrative costs were 7.4 percent of revenue in 1993, compared with a state average of 9.1 percent.)

MHP faces the continual challenge of deciding whether and how to expand its service area. Currently, MHP serves the core metropolitan area of Hennepin County and has a market share of 50 percent in the city of Minneapolis. As competition increases in an era of reform, however, MHP must maintain its current client base and must evaluate whether to market to other areas. Deciding to expand the client base would necessitate expanding the physician network. Currently, MHP's providers are located in the central and northern parts of the metropolitan area. If it were to move west, where the city's population is migrating, it would have to contract with physician groups in the western suburbs, where there is fierce competition for clinic contracts.

A question is whether to expand to other types of clients. MHP's delivery system is configured specifically to meet the needs of its current client mix: Medicaid, general assistance, and county employees. The state of Minnesota's progress in health care reform, however, provides new opportunities. For example, MinnesotaCare, the insurance program for those who cannot afford or who have been excluded from insurance, plans to enroll its members in managed care during 1995. This program potentially could serve more than 10,000 enrollees in the metropolitan area alone.

Entrance into this market would mean a new kind of client: people who are unemployed, sick, and/or without previous insurance. Little is known about the possible costs of this population, which poses a risk for MHP and therefore for the county budget as a whole. But if MHP is to grow and remain viable in an increasingly competitive arena, it must take on these challenges and realize its own potential for increased market share.



MHP was born in order to serve Medicaid clients and to ensure the viability of the county's hospital. It has expanded to serve a diverse population that has unique and complex needs. As national and state efforts to reform the health care system continues, MHP and other public delivery systems will fill a critical and special role in ensuring that public clients are provided cost-effective, appropriate care. PM

[1]Kenkel, P. J., "Provider-Based Managed Care Plans Continue Growth Trend," *Modern HealthCare* (May 10, 1993).

[2]Hennepin County Medicaid Demonstration Project Office, *The Medicaid Demonstration Project in Hennepin County, Minnesota* (December 1988), p. 4.

[3]Comment made by David Strand, senior vice president/general counsel, Medica, at Hennepin County Safety Net Summit, December 1992.

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