MINNESOTA ASSOCIATION OF
County Health Plans

The Minnesota Association of County Health Plans (MACHP) is an association of Minnesota county-based purchasing (CBP) organizations operating in affiliation with the Association of Minnesota Counties. Members of MACHP are individual counties or county joint-purchasing boards that have been designated as CBP organizations under Minnesota law. Currently, this includes:

- **Itasca Medical Care** (IMCare) – serves approximately **6,000 members** in Itasca County. IMCare is based in Grand Rapids. For more information visit: www.imcare.org
- **PrimeWest Health** – serves **20,000 members** in 13 rural counties in western and northern Minnesota, including Beltrami, Big Stone, Clearwater, Douglas, Grant, Hubbard McLeod, Meeker, Pipestone, Pope, Renville, Stevens, and Traverse. Prime West is based in Alexandria. For more information visit: www.primewest.org
- **South Country Health Alliance** – serves **24, 000 members** in 12 rural counties in southeastern and northern Minnesota, including Brown, Dodge, Freeborn, Goodhue, Kanabec, Morrison, Sibley, Steele, Todd, Wabasha, Wadena, and Waseca. South Country is based in Owatonna. For more information visit: www.mnscha.org

County-based Purchasing (CBP) allows county governments the option of serving as the managed care organization for Minnesota Health Care Programs. County governments that have chosen this model believe that health plan decision-making and care management work best if done locally. CBP adds value to state health care programs compared to private managed care plans in a number of important ways:

- **Improves prevention and wellness** programs by tailoring them to individual member health and wellness needs and coordinating with local health improvement efforts.
- **Improves public accountability** because of the greater transparency of county-based health plans and the role of locally accountable elected officials in governing the managed care plan.
- **Improves member access** to local health care providers and the full scope of services covered by Minnesota Health Care Programs.
- **Enhances health care quality and clinical improvement** through coordination with members' primary health care providers, case managers, and all other caregivers involved in an individual's care and treatment.
- **Stabilizes and supports local providers** and allows closer partnerships with them.
- **Is responsive to local community needs** because the managed care organization is locally operated and has close ties to the community and local providers.
- **Is coordinated with county services**, including social services, public health, housing, corrections and other public services.

Health coverage products offered by CBP plans. The products offered by PrimeWest, South Country Health Alliance and Itasca Medical Care varies by county, but the following products may be available for eligible enrollees:

- ***Prepaid Medical Assistance Program (PMAP)*** – Provides coverage for health care for low income families and pregnant women and newborns.
- ***MinnesotaCare*** – subsidized health insurance program for residents in the service area who do not have access to affordable health care coverage. To be eligible for MinnesotaCare, individuals must meet income limits and satisfy other requirements related to residency and lack of access to health insurance.
- ***Minnesota Senior Care Plus (MSC+)*** – *Medical Assistance program for people age sixty-five (65) and over.* Provides Medicaid benefit set and includes Elderly Waiver services for enrollees who qualify and 180 days of Nursing Facility care.
- ***Minnesota Senior Health Options (MSHO)*** - Health care program for seniors age 65 and over that provides integrated Medicare and Medicaid services. MSHO includes Elderly Waiver services for enrollees who qualify and 180 days of Nursing Facility care. Through MSHO, the health care and support services seniors need are coordinated to make it easier for people to get these services.
- ***Special Needs Basic Care (SNBC)*** - a Special Needs Basic Care program designed for people ages 18 to 64 with disabilities who live in the service area ***and*** are eligible for Medical Assistance only or are eligible for Medical Assistance and Medicare Parts A and B. SNBC provides Medicaid services and/or integrated Medicare and Medicaid services. The State Medical Review Team or Social Security Administration must certify individuals as disabled.

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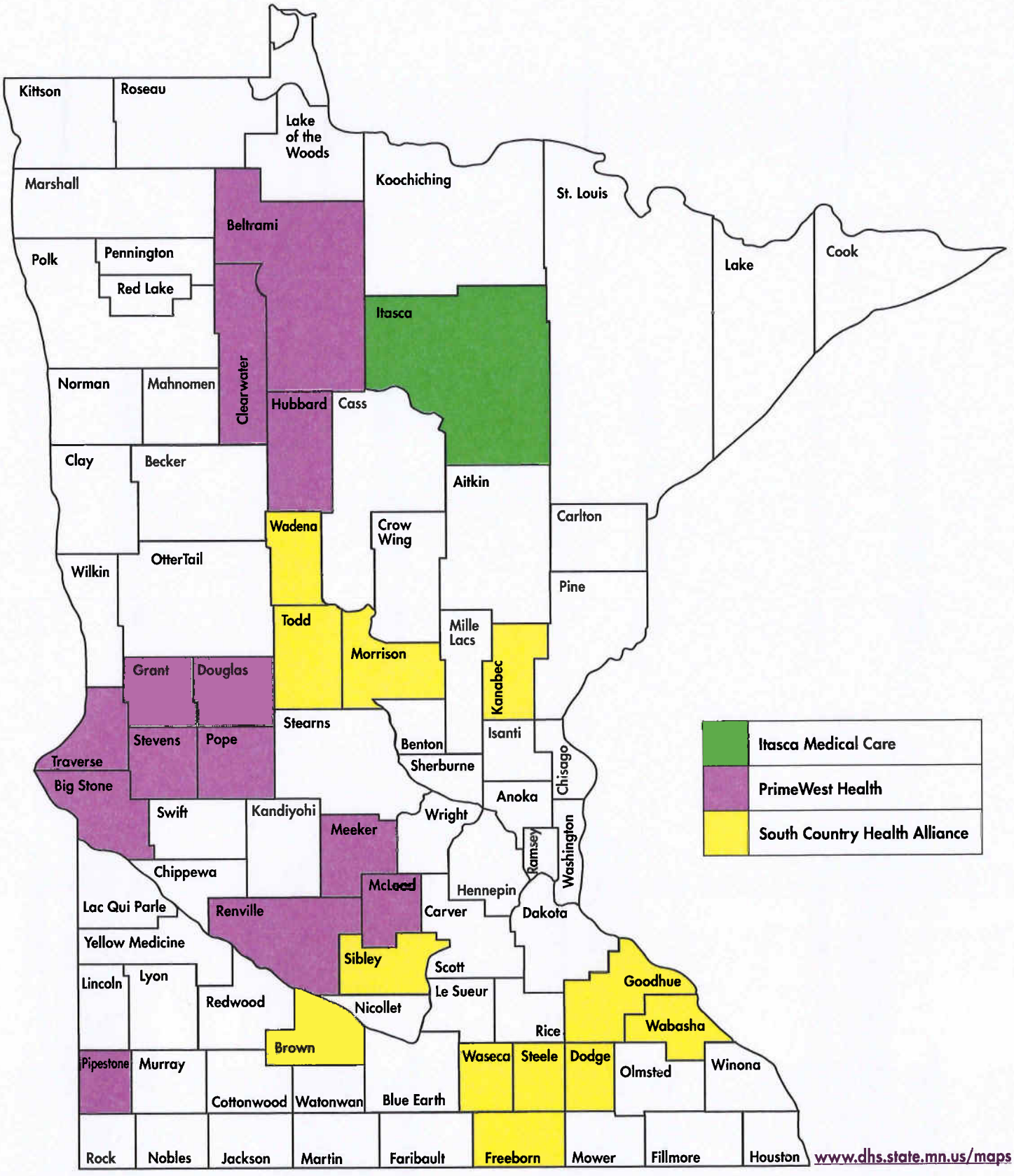
Minnesota Department of **Human Services**

Managed Care County-based Purchasing (CBP)

Effective Jan. 1, 2011



www.dhs.state.mn.us/maps

MINNESOTA ASSOCIATION OF
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Recommendations for Health Care Reform in Rural Minnesota

The unique characteristics of rural areas require special approaches and models for health care reform in rural communities:

1. **Health care is local.** Each local community is different, therefore new models under health care reform should be flexible so they can be adapted and tailored to local needs and circumstances and allow variations of general reform strategies that will work in rural communities. Unfortunately, state and national reforms have tended to be designed with metropolitan areas in mind rather than for the unique circumstances of rural communities.

2. **Program reforms should support rural providers.** Payment and care delivery reform concepts, including health care homes and Accountable Care Organizations ("ACOs") need to be specially adapted to the circumstances of rural health care systems. The unique characteristics of rural communities need to factor into the development of new care delivery models. Rural areas have fewer providers, and predominantly smaller, independent providers, not large integrated hospital and clinic systems. New care delivery models must be designed to encourage, facilitate and support participation of smaller, independent providers such as those prevalent in rural communities and those who serve low-income, uninsured and disadvantaged patients.

3. **Fair payment rates for rural health plans and providers.** Payment reform strategies should be comprehensive, pay adequate and fair rates to health plans and providers, and treat rural plans and providers fairly in comparison to statewide and metropolitan organizations. Currently, government programs pay less than adequate rates to providers, sometimes even forcing organizations to provide services at a loss. Different payment methods are needed that will create incentives for providers to help their patients live healthy, manage their health conditions well, and use efficient and cost-effective services when they do need treatment.

4. **Health care should be coordinated with local public health and social services**. Non-medical factors such as safe housing, transportation, a nutritional diet, employment, the support of friends and family, and opportunities for physical activity are very important to a person's health. Increasingly, policymakers recognize that the "medical model" alone will not produce optimal outcomes. Health care coverage and services should be coordinated with other local services affecting a person's health and treatment outcomes. County-based purchasing (CBP) provides an example of the effectiveness and efficiency of this type of coordination.

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MINNESOTA ASSOCIATION OF
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Administrative Cost and Paperwork Reduction for Managed Care Organizations

Managed Care Organizations (MCOs) are regulated by four different State and federal agencies, which together require more than 1,000 reports, data files, and certifications to be prepared and submitted by MCOs each year, as summarized in the table below:

Sum of Reports Per Year**		
Reported To*	Total	% of Total
CMS	210	19.6%
DHS	754	70.2%
DOC	6	0.6%
MDH	104	9.7%
Grand Total	1,074	100.0%

*CMS = Centers for Medicare and Medicaid Services (federal). DHS = MN Dept. of Human Services. DOC = MN Dept. of Commerce. MDH = MN Dept. of Health.
**Some report volumes approximate and subject to annual variation based on plan activity, agency requests, or other factors

Many of these reports, data files, and certifications are duplicative and unnecessary, and the cost to the MCOs of preparing them increases the overall costs of health coverage. Health care administrative costs can be reduced without harming quality or safety by consolidating duplicative reporting requirements and eliminating unnecessary reports. The following are draft principles for identifying MCO regulatory and reporting requirements that may be eliminated, reduced, or streamlined. The principles are intended to be generally complementary and could be adopted in whole or in part.

1. CMS requirements deemed sufficient. MCOs under contract with the Centers for Medicare and Medicaid Services (CMS) for Medicare Advantage are subject to contractual and regulatory requirements that cover most of the same topics as State contracts and regulations. The purpose of CMS requirements of MCOs is generally the same as comparable State requirements, namely, to ensure: (a) sound general management; (b) access to services; (c) quality of care; and (d) sound finances and reimbursement. *As a principle, CMS requirements that are considered satisfactory for Medicare should also be deemed sufficient for Medicaid.* To add to or modify CMS requirements, a State agency should be required to demonstrate clear and compelling State policy or administrative reasons based on differences in the Medicaid program that are not adequately addressed by CMS requirements alone.

2. Same standards for MCOs and State-administered coverage. The Minnesota Department of Human Services (DHS) performs the same or similar functions as MCOs in their direct administration of coverage on a fee-for-service basis for certain programs and eligibility groups, the largest of which is Medicaid disabled beneficiaries. *As a principle, requirements should not be applied to MCOs that DHS does not deem sufficiently important to apply on an equivalent basis to its own comparable administrative activities.*

3. Outcomes over process. A high proportion of State MCO regulations and reports apply to process rather than outcome measures. Many of these requirements are very detailed and prescriptive, and tend toward a "micro-management" level of oversight. *As a principle, State MCO requirements should be structured primarily or exclusively as outcome measures whenever possible.* Process measures should be applied only in limited circumstances, such as where outcome measures are incomplete or unavailable, or on a temporary basis for MCOs subject to a targeted corrective action plan. An emphasis on outcome measures would allow MCOs to pursue a greater variety of care management approaches that are more effective, better adapted to their circumstances, and less costly than are currently possible under process measure regulations.

4. Selective over intensive reviews. Many State MCO regulations and reports are more comprehensive, detailed, and/or frequent than necessary for effective oversight and protection of public interests. These types of intensive requirements place the same level of oversight and associated costs on competent, well-managed MCOs as on the far less common cases of problem MCOs. It would be more efficient and equally effective to target intensive regulatory review on problem cases, and apply selective checks and audits in the majority of cases. More in-depth reviews could be pursued where problem areas are identified through more selective and random checks, audits, or consumer complaints. *As a principle, State MCO requirements should be structured to apply selective checks and audits as the primary means of oversight, with more intensive reviews focused on problem cases.*

5. No redundancy. Many State MCO regulations and reports are very similar, and in some cases identical, to other State regulations and reports. Redundancy exists both across multiple State agencies, and sometimes within the same agency. *As a principle, State MCO requirements should not be redundant.* To add a new regulation or report, a State agency should be required to demonstrate that it has reviewed existing State (and CMS, if applicable) requirements, and can verify that a comparable requirement does not already exist. If a similar but not identical requirement already exists, whether from the same or a different agency, there should be a presumption that a State agency would be expected to modify or refine the existing regulation or report rather than adding an entirely new and separate requirement.

6. Reasonable cost / benefit. Many State MCO regulations and reports provide no public benefit, or a benefit that is small compared to the cost. Examples include: (a) reports that were added by statute or rule many years ago, and now continue automatically with little review or use; and (b) reports that could be prepared directly by State agencies using data that the MCOs are required to submit to them, but where it is more convenient and/or sparing of the agency budget to require the MCO to prepare it (but not sparing of MCO administrative costs). *As a principle, State agencies should be required to perform a cost / benefit analysis for all MCO requirements on a regular cycle; requirements with more cost than benefit would be "sunsetted."*

PrimeWest Reports, Data Files, Certifications Required by State and Federal Agencies -- Partial List, March 2010

Major Area	Specific Area	Report, Data File, Certification	Reported To*	Reports Per Year**	Notes
General		Business Continuity Plan Report	DHS	1	
General		Emergency Preparedness Response Coordinator Report	DHS	1	
General		Integrity Program Report	DHS	1	
General		MCO Disclosure of Ownership Report	DHS	1	MCO = Managed Care Organization
General		MCO Stakeholder Group Agendas Report	DHS	2	
General		MCO Stakeholder Group Minutes Report	DHS	2	
General		MCO Subcontractor Disclosure of Ownership Report	DHS	1	
General		Subcontractor Agreements Report	DHS	4	Varies depending on number of subcontractors, agreements
General		Subcontractor Corrective Action Report	DHS	4	Varies depending on number of CAPs
General		Subcontractor Delegation Report	DHS	4	General and claims-specific for MDB, PT
General		Subcontractor Performance Review Process Report	DHS	1	
Access	Complaints	Adverse Coverage Determination Appeals Report	CMS	4	
Access	Complaints	Complaints and Disputes Report	CMS	4	
Access	Complaints	Grievances During Period Report	CMS	4	
Access	Complaints	Part C Grievances Report	CMS	4	
Access	Complaints	Part D Grievances Report	CMS	4	
Access	Complaints	Pharmacy Appeals Report	CMS	4	
Access	Complaints	Reconsiderations and Denials Report	CMS	4	
Access	Complaints	DTR Report	DHS	4	
Access	Complaints	MCO Grievance System Changes Report	DHS	2	Varies depending on number of modifications in year
Access	Complaints	Reporting of Appeals	DHS	4	
Access	Complaints	Reporting of Grievances	DHS	4	
Access	Complaints	Subcontractor DTR Notice Approval	DHS	1	DTR = Denial, Termination or Reduction (in benefits)
Access	Coverage	Annual Notice of Change (ANOC) Report	CMS	2	
Access	Coverage	Drug Benefit Analysis Report	CMS	12	
Access	Coverage	Drug Formularies by Plan	CMS	2	
Access	Coverage	Drug Formulary Changes	CMS	12	Varies depending on number of modifications in year
Access	Coverage	Formulary Exceptions Report	CMS	4	
Access	Coverage	Pharmacy Member Transition Report	CMS	4	
Access	Coverage	Summary of Benefits Report	CMS	2	Separate for each CMS program
Access	Coverage	Certificate of Coverage and Addendums Reports	DHS	10	Varies depending on number of programs, addendums
Access	Coverage	Drug Formularies by Plan	DHS	2	
Access	Coverage	Drug Formulary Changes	DHS	12	Varies depending on number of modifications in year
Access	Coverage	Exclusions and Convicted Persons Report	DHS	4	Upon request or based on incidence
Access	Coverage	Integration of Medicare / Medicaid Benefits Report	DHS	1	For SNP plans
Access	Coverage	Membership Cards Report	DHS	4	Varies depending on number of modifications in year
Access	Coverage	Newborn Report	DHS	1	Upon request or based on incidence
Access	Coverage	Recipient Fraud and Abuse Report	DHS	12	Upon request or based on incidence
Access	Coverage	Restricted Enrollee Report	DHS	1	
Access	Coverage	Provider Contracts and Amendments	MDH	12	Varies depending on volume of contracts, amendments
Access	Marketing	Agent Compensation Structure Report	CMS	1	
Access	Marketing	Agent Training and Testing Report	CMS	1	
Access	Marketing	Enrollment Requests Report	CMS	4	
Access	Marketing	Licensed Agents Report	CMS	2	
Access	Marketing	Marketing and Sales Events Monthly Report	CMS	12	Varies depending on number of events
Access	Marketing	Plan Oversight of Agents Report	CMS	4	
Access	Marketing	Enrollee Communications Reports	DHS	12	Varies depending on volume of communications
Access	Marketing	Marketing Materials Reports	DHS	12	Varies depending on volume of marketing materials
Access	Marketing	Website Information Report	DHS	4	Varies depending on number of modifications in year
Access	Network	Extended Day Supply Pharmacy Contract Report	CMS	1	
Access	Network	Home Infusion Network Pharmacy Access Report	CMS	4	
Access	Network	Long Term Care Network Pharmacy Access Report	CMS	4	
Access	Network	Pharmacy Directory for Medicare Program	CMS	2	Separate for each CMS program
Access	Network	Pharmacy Electronic Prescription Capacity Report	CMS	1	
Access	Network	Pharmacy Network Access Report	CMS	1	
Access	Network	Primary Care Provider (PCP) and Specialists Report	CMS	1	
Access	Network	Provider Directory Report	CMS	2	Separate for each CMS program
Access	Network	Provider Network Adequacy Report	CMS	1	
Access	Network	Retail Pharmacy Access Report	CMS	4	
Access	Network	Dental CHIP Provider Data Files Submission	DHS	4	CHIP = Children's Health Insurance Program Reauthorization Act of 2009
Access	Network	Enrollment Data by Care System Report	DHS	1	
Access	Network	HCBS and Nursing Facility Provider Report	DHS	1	HCBS = Home and Community Based Services
Access	Network	Health Care Homes Reports	DHS	4	New report, frequency TBD
Access	Network	Integrated Pharmacy Directory Report	DHS	1	Varies depending on number of modifications in year
Access	Network	Material Modification of Provider Network Report	DHS	1	Varies depending on number of modifications in year
Access	Network	Mental Health Provider Report	DHS	1	Upon request or based on incidence
Access	Network	Participating Provider Report	DHS	2	
Access	Network	Primary Care Network List (PCNL)	DHS	6	Separate for each coverage program
Access	Network	Provider Access Changes Report	DHS	1	Varies depending on number of modifications in year
Access	Network	Provider Directory Report	DHS	5	Separate for each DHS program
Access	Network	Provider NPI/UMPI Registration Request	DHS	12	NPI = National Provider Identifier, UMPI = Unique MN Provider Identifier
Access	Network	Provider Termination Report	DHS	4	
Access	Satisfaction	Access Survey and Results Report	DHS	1	
Access	Satisfaction	Additional Satisfaction Survey Report	DHS	1	
Access	Satisfaction	Consumer Feedback Activity Mechanism Report	DHS	4	Upon request or based on incidence
Access	Satisfaction	Disenrollment Survey Report	DHS	1	
Access	Satisfaction	Enrollee Satisfaction Survey Report	DHS	1	
Financial	Rates	Anti-Fraud, Waste and Abuse Report	CMS	1	
Financial	Rates	Clean Claims Report	CMS	2	
Financial	Rates	Direct and Indirect Renumeration (DIR) Report	CMS	1	
Financial	Rates	Long Term Care Pharmacy Rebates Report	CMS	4	
Financial	Rates	Medicare Part C Bid Desk Review Response Request	CMS	6	Varies depending on desk review issues
Financial	Rates	Medicare Part C Bid Submission	CMS	2	Part C = Medicare Advantage plan covering Parts A (hospital) and B (prof.)
Financial	Rates	Medicare Part C Documentation	CMS	2	
Financial	Rates	Medicare Part D Bid Desk Review Response Request	CMS	6	Varies depending on desk review issues
Financial	Rates	Medicare Part D Bid Submission	CMS	2	Part D = Medicare prescription drug coverage

Major Area	Specific Area	Report, Data File, Certification	Reported To*	Reports Per Year**	Notes
Financial	Rates	Medicare Part D Documentation	CMS	2	
Financial	Rates	Medicare Plan Benefit Package (PBP) Submissions	CMS	2	
Financial	Rates	Pharmaceutical Manufacturers Rebates Report	CMS	4	
Financial	Rates	Pharmacy Discounts and Price Concessions Report	CMS	4	
Financial	Rates	Pharmacy Overpayments Report	CMS	4	
Financial	Rates	Pharmacy Rebates and Discounts Report	CMS	1	
Financial	Rates	Plan to Plan (P2P) Pharmacy Transaction Report	CMS	12	
Financial	Rates	Prescription Drug Event (PDE) Report	CMS	12	Data files
Financial	Rates	Risk Adjusted Payment System (RAPS) Report	CMS	8	Data files
Financial	Rates	Risk Adjustment Data Attestation	CMS	1	
Financial	Rates	Additional Benefits and Premiums Report	DHS	1	
Financial	Rates	Certification of State Plan Benefits	DHS	2	
Financial	Rates	Chemical Dependency Room and Board Services Report	DHS	4	
Financial	Rates	Copayment Reimbursement for NF Stays Report	DHS	4	NF = Nursing Facility
Financial	Rates	Critical Access Dental Claim Reports	DHS	4	Data files
Financial	Rates	Critical Access Dental Provider Eligibility Report	DHS	1	
Financial	Rates	Data Certifications - Non-Encounter	DHS	18	Based on standard 1 per month plus additional 6 per year for other misc.
Financial	Rates	Encounter Data Reports - DHS	DHS	473	Includes 837I, 837P, 837D, NCPDP data files and certifications
Financial	Rates	FQHC/RHC Data Files	DHS	4	FQHC = Federally Qualified Health Center. RHC = Rural Health Clinic.
Financial	Rates	HCC Risk Adjustment Report	DHS	1	HCC = Hierarchical Condition Categories
Financial	Rates	Healthcare Services Expenditures Report	DHS	1	
Financial	Rates	Inpatient and Outpatient Expenditures Report	DHS	1	
Financial	Rates	Medicare Part C Bid Submission	DHS	2	To DHS actuary
Financial	Rates	Medicare Part D Bid Submission	DHS	2	To DHS actuary
Financial	Rates	Medicare Plan Benefit Package (PBP) Submissions	DHS	2	
Financial	Rates	Provider Fraud and Abuse Report	DHS	4	Varies
Financial	Rates	Provider Payment Rates Report	DHS	1	
Financial	Rates	Rate Development Data and Reports	DHS	3	Variable annually
Financial	Rates	Recoveries and Cost Avoided Report	DHS	4	
Financial	Rates	Third-Party Liability Report	DHS	12	
Financial	Rates	Health Plan Financial and Statistical Report (HPFSR)	MDH	1	
Financial	Rates	Prescription Drug Purchases Report	MDH	1	
Financial	Solvency	Audited Financial Statement	CMS	1	
Financial	Solvency	Fiscal Soundness Report	CMS	4	Via HPMS--annual and quarterly
Financial	Solvency	Quarterly Financial Report	CMS	3	Via HPMS (Health Plan Management System, CMS communications system)
Financial	Solvency	Annual Financial Report	DHS	1	NAIC format
Financial	Solvency	MCO Solvency Standards Report	DHS	1	
Financial	Solvency	Annual Financial Report	DOC	1	NAIC format
Financial	Solvency	Audited Financial Statement	DOC	1	
Financial	Solvency	Quarterly Financial Report	DOC	3	NAIC format
Financial	Solvency	Risk Based Capital Report	DOC	1	NAIC format
Financial	Solvency	Annual Statement Supp. #1 -- Financials by Program	MDH	1	
Financial	Solvency	High-FIve Salary Report	MDH	1	
Quality	Credentialing	Audit of Provider Compliance	DHS	1	
Quality	Credentialing	Clinical Laboratory Improvement Amendments Report	DHS	1	Upon request or based on incidence
Quality	Credentialing	Qualifications of MH and CD Providers Report	DHS	1	MH = Mental Health. CD = Chemical Dependency.
Quality	Improvement	Generic Drug Utilization Report	CMS	4	
Quality	Improvement	Vaccines Report	CMS	4	
Quality	Improvement	Annual Performance Measure Reports	DHS	4	Upon request or based on incidence
Quality	Improvement	Annual QA/PI Program Evaluation	DHS	1	QA = Quality Assurance. PI = Performance Improvement.
Quality	Improvement	Child and Teen Checkup Reports	DHS	12	Data files
Quality	Improvement	EQRO Annual Technical Report	DHS	1	EQRO = External Quality Review Organization
Quality	Improvement	Final Performance Improvement Program (PIP) Report	DHS	1	
Quality	Improvement	Health Outcomes Survey (HOS) Report	DHS	1	
Quality	Improvement	Practice Guidelines Report	DHS	4	Upon request or based on incidence
Quality	Improvement	Annual Statement Supp. #2 - #5 -- Various Topics	MDH	5	
Quality	Improvement	Encounter Data Reports - MDH	MDH	78	Claim and enrollment data files submitted for the 2009/10 cycle
Quality	Improvement	HEDIS Quality Reports	MDH	5	HEDIS = Healthcare Effectiveness Data and Information Set
Quality	Management	Initial Assessment and Reassessment Report	CMS	1	
Quality	Management	MTM Program Participation Report	CMS	1	MTM = Medication Therapy Management
Quality	Management	Pharmacy and Therapeutics Committee Changes Report	CMS	1	
Quality	Management	Pharmacy Prior Authorization Report	CMS	4	
Quality	Management	Annual Quality Assurance Work Plan	DHS	1	
Quality	Management	Care and Case Management System Changes Reports	DHS	1	
Quality	Management	Care Coordination Systems Report	DHS	1	
Quality	Management	Care Plan, CCM, and Care System Audits Reports	DHS	1	CCM = County Case Management
Quality	Management	Change in Service Plan Report	DHS	1	Varies depending on number of modifications in year
Quality	Management	Disease Management Program Report	DHS	4	Upon request or based on incidence
Quality	Management	Initial Health Risk Screening Data	DHS	1	
Quality	Management	Medication Therapy Management (MTM) Report	DHS	1	
Quality	Management	MTM Programs Report	DHS	1	
Quality	Management	New Performance Improvement Project (PIP) Proposal	DHS	1	
Quality	Management	Physician Incentive Plans Report	DHS	1	
Quality	Management	Special Health Care Needs Report	DHS	2	
Quality	Management	Utilization Management Description Report	DHS	1	
Quality	Management	Utilization Management Summary Report	DHS	1	

*CMS = Centers for Medicare and Medicaid Services (federal). DHS = MN Dept. of Human Services. DOC = MN Dept. of Commerce. MDH = MN Dept. of Health.

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