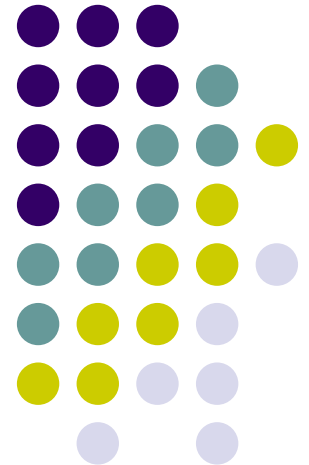


South Country Health

Alliance providing consumer focused
community-based health care services to Minnesota
residents.

Expanding the options for
purchasing health care services



Who is South Country Health Alliance (SCHA)?



- SCHA is one of Minnesota's County-based Purchasing Programs
- County-based purchasing program is based on MS 256B.692 "County boards or groups of county boards may elect to purchase or provide health care services on behalf of persons eligible for medical assistance and general assistance medical care who would otherwise be required to or may elect to participate in the prepaid medical assistance or general assistance medical care programs according to sections MS 256B.69 and 256B.03. Counties that elect to purchase or provide health care under this section must provide all services included in the prepaid managed care programs....."
- Counties that elect to purchase or provide health care services must meet the same requirements as other managed care organizations participating in State Public Managed Care Programs.

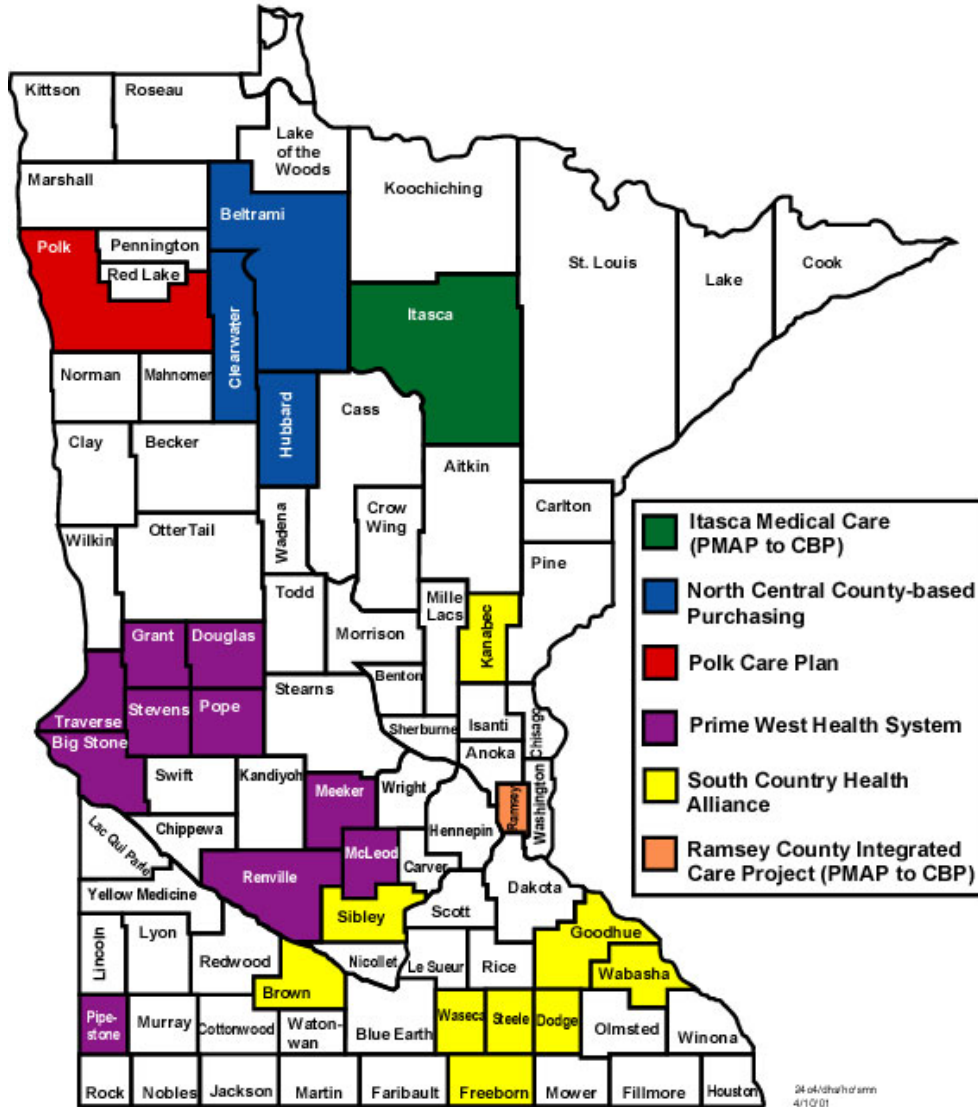


Who is SCHA? continued

- SCHA received CMS approval to begin operations in November 2001.
- SCHA is governed by a Joint Powers Board operating under MS 471.59.
- Membership on the Joint Powers Board consists of an elected County Commissioner appointed by the local County Board of Commissioners.



County-based Purchasing



Member Counties:

- Brown
- Dodge
- Goodhue
- Freeborn
- Kanabec
- Sibley
- Steele
- Wabasha
- Waseca

Who do we serve?

Person's eligible for the following programs:



- Pre-paid Medical Assistance Program- 10,000-11,000 members
 - Children and Families
 - Pregnant Women
- General Assistance Medical Care- 700 to 800 members
- Minnesota Care – 15 members
- Minnesota Senior Care Plus – 191 members
- SeniorCare Complete – 1963 members
- AbilityCare – Approx 421 members

Counties and Health Care



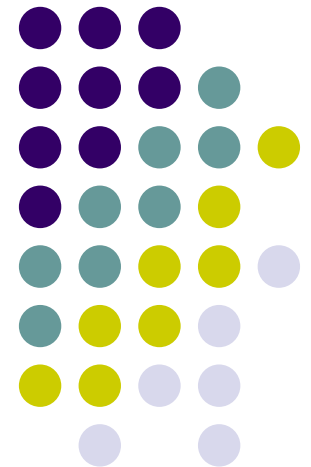
- Purchaser/provider
 - County staff
 - Services for county residents
 - Mental Health Authority
 - Public Health Authority
 - Safety Net
 - Uncompensated Care
 - Case Management/Care Coordination



External Pressures

- Medicare Modernization Act
- Medicare Part D
- Continued increasing costs for health care
- Mental Health Reform
- Long Term Care Reform
- Baby Boomers

Can we sustain the rising costs of
health care without major system
reform?

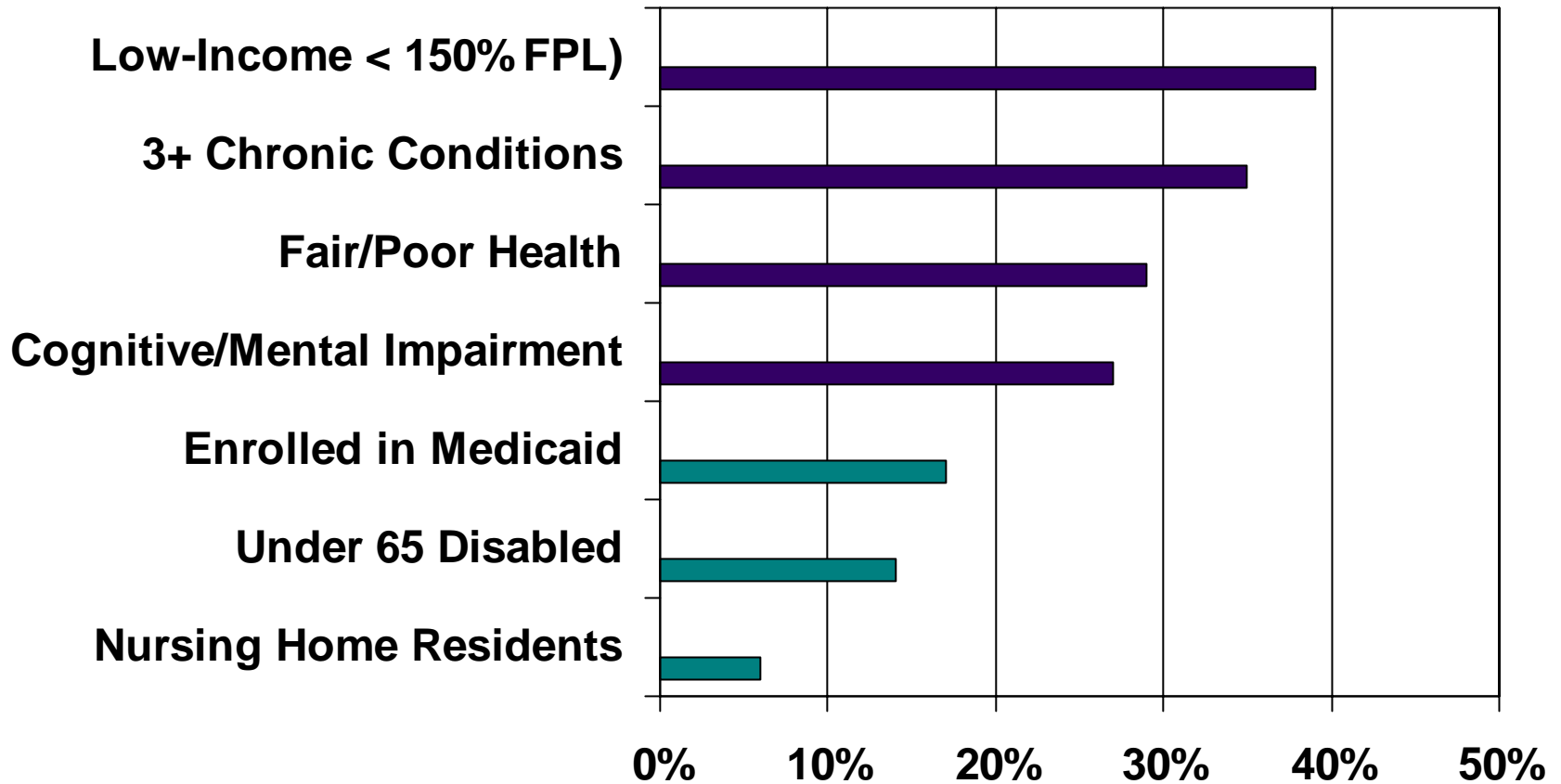


Medicare

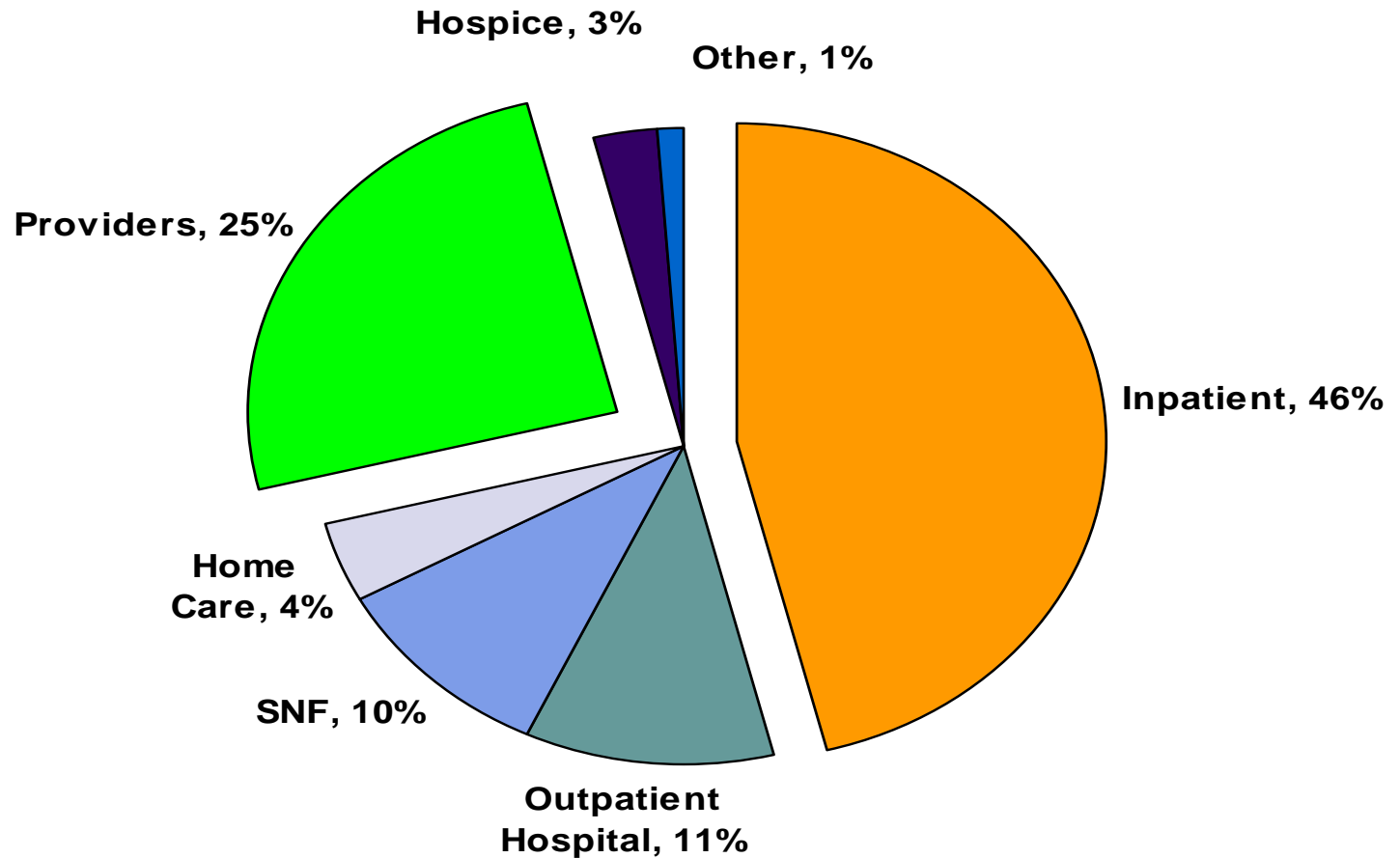


- Enacted in 1965 to provide health coverage for seniors
- Now covers nearly 42 million people
- \$325 billion for Medicare benefits in 2005
 - Administered by Centers for Medicare and Medicaid Services (CMS)
 - Federal Government (tax payers) bears full risk for all medical expenses

Characteristics of the Medicare Population



Medicare \$ by Type of Service



Medicare



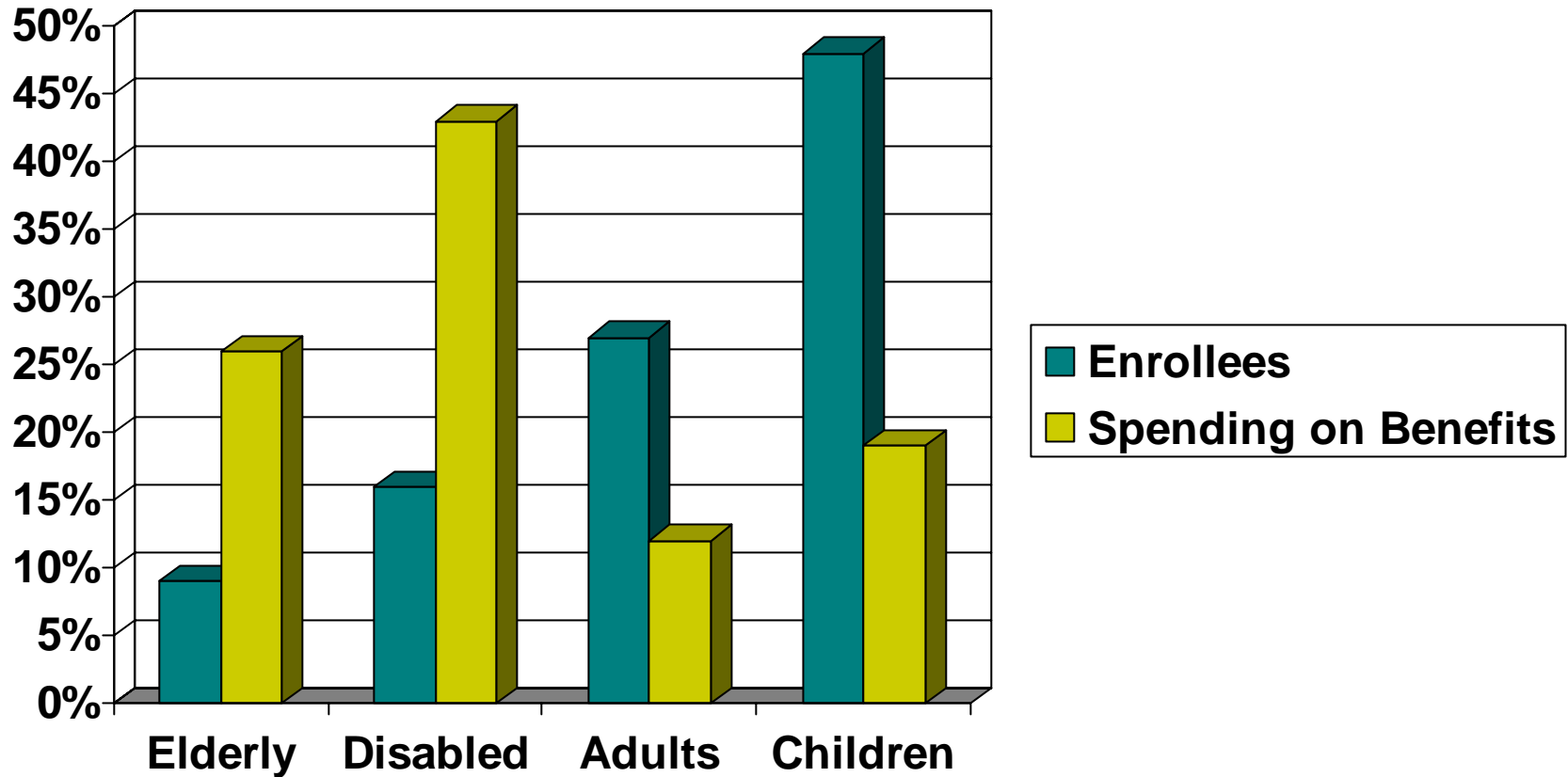
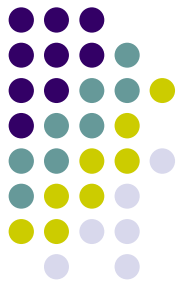
	Part A	Part B	Part D (2006)
Benefits	<ul style="list-style-type: none"> ● Inpatient Hospital ● Skilled Nursing Facility (SNF) (short-term) ● Home health care; ● Hospice care; 	<ul style="list-style-type: none"> ● Physician Services; ● Outpatient Hospital ● Preventive Services ● Lab/X-Rays ● Other ambulatory 	<ul style="list-style-type: none"> ● Outpatient Prescription Drugs
Premium	None	\$ 78.20 / mo for 2005	Per Part D plan
Cost-Sharing	<ul style="list-style-type: none"> ● Deductible applies for inpatient admits; ● Co-Insurance for SNF stay 	<ul style="list-style-type: none"> ● Annual deductible ● Co-Insurance 	<ul style="list-style-type: none"> ● Deductible ● Co-Insurance (TrOOP)
Limitations	<ul style="list-style-type: none"> ● No Long-term care benefits after 100 days 	<ul style="list-style-type: none"> ● No coverage for: ● Eyeglasses; hearing aids, dental care 	<ul style="list-style-type: none"> ● No coverage until 2006

Medical Assistance: Overview

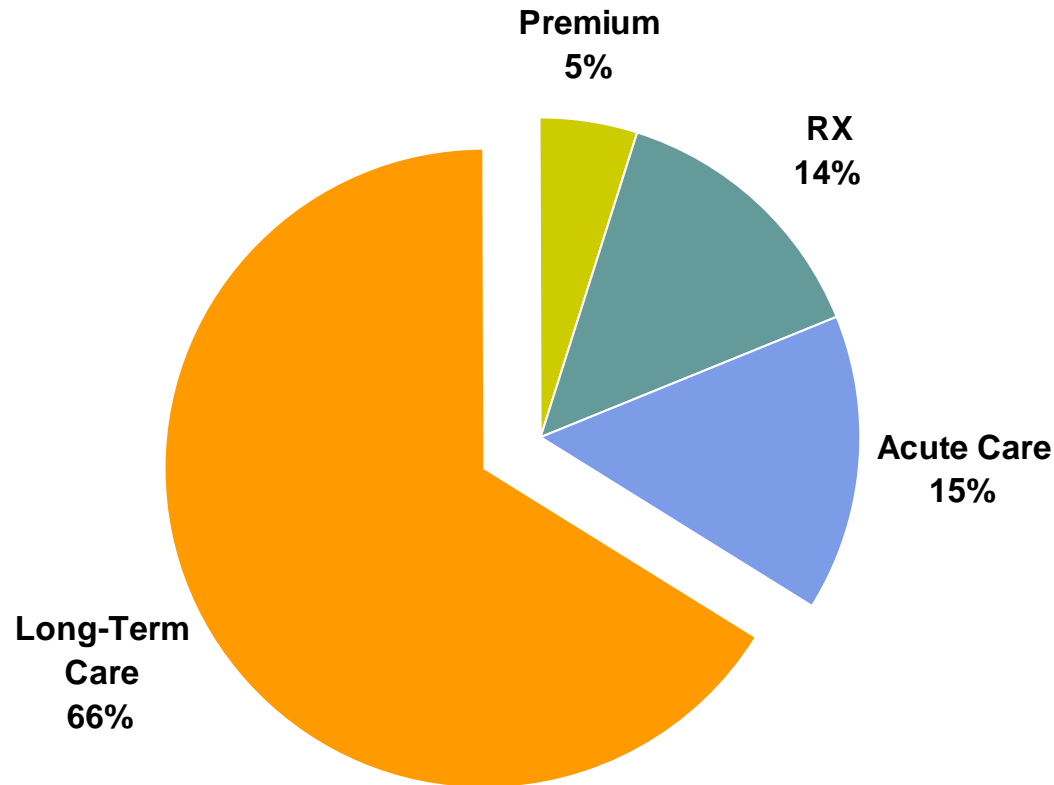


- Enacted in 1965 as companion legislation to Medicare
- Established an entitlement program
- Included mandatory services and gave states options for broader coverage
- Provides health and long-term care coverage for 52 million people
- Pays for nearly 1 in 5 health care dollars and 1 in 2 nursing home dollars

Medical Assistance: Spending vs. % of Eligible



Medical Assistance: Distribution of Health care \$

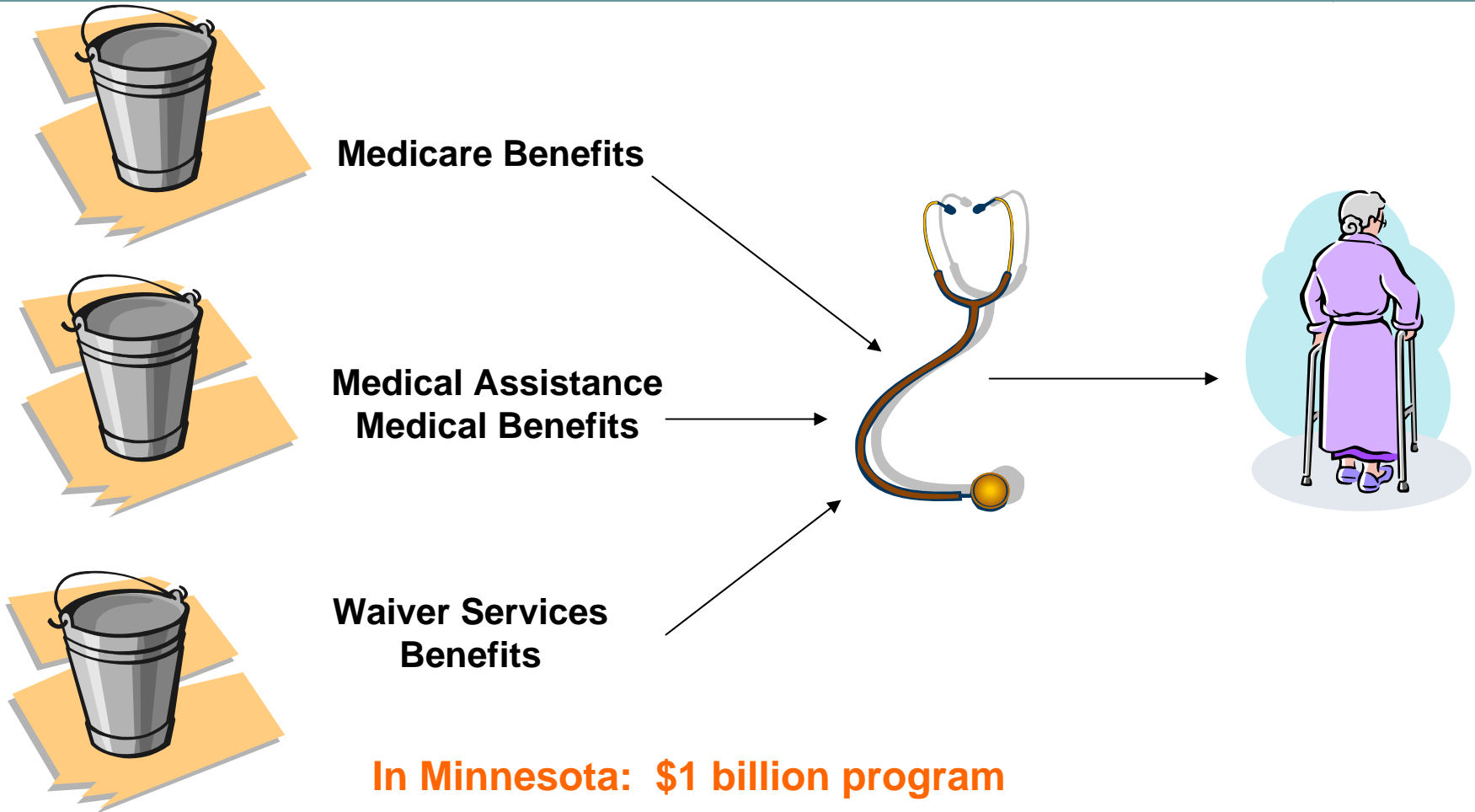




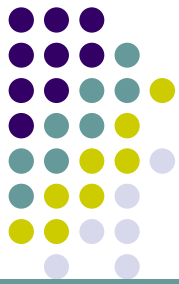
Dual Eligible's

- Enrolled in both Medicaid and Medicare
 - Low income seniors, and
 - People with disabilities
- Rely on Medicaid as 2nd payer for
 - Medicare premiums and cost-sharing
 - non-Medicare covered benefits
- SCHA has two programs for duals
 - MSHO-enrollment of persons age 65 and over
 - SCHA AbilityCare – enrollment of persons who are dual eligible and who are disabled

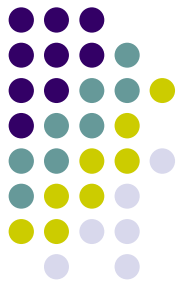
Duals: Sources of Financing



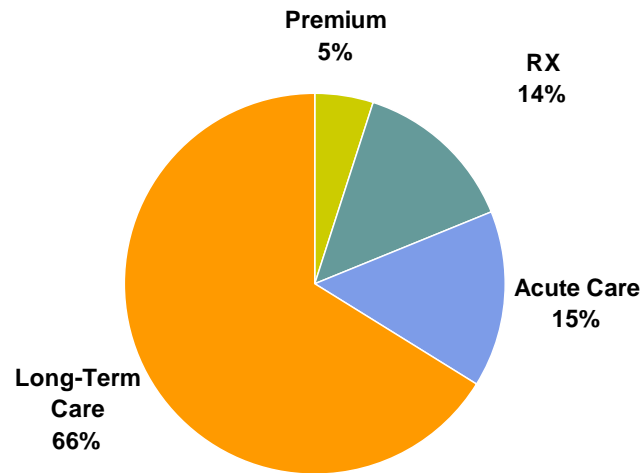
BENEFITS for Dual Eligible's



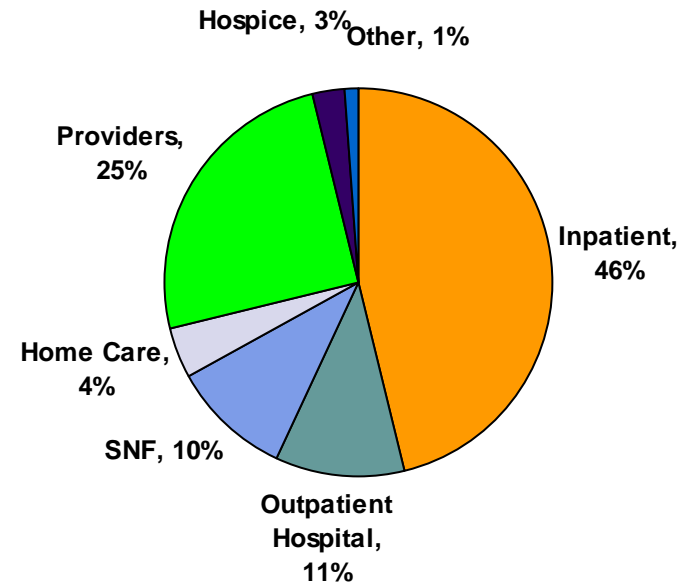
	Medicare			Medical Assistance
	Part A	Part B	Part D (2006)	
Benefits	<ul style="list-style-type: none"> • Inpatient Hospital • SNF (short-term) • Home care; • Hospice; 	<ul style="list-style-type: none"> • MD (prof) Svcs; • OP Hospital • Preventive • Lab/X-Rays • Other ambulatory 	<ul style="list-style-type: none"> • Outpatient Prescription Drugs 	All Medicare + <ul style="list-style-type: none"> • Additional Nursing Home days • Eyeglasses • Hearing Aids / batteries • Dental Care • Transportation • Personal Care Attendants • Respite • Elderly Waiver Services
Premium	None	\$ 78.20 / mo for 2005 Paid for by Medical Assistance	Per Part D plan Paid for by Medical Assistance	None + Medical Assistance covers Medicare Part B premium
Cost-Sharing	Deductible applies for inpatient admits; Co-Insurance for SNF stay	Annual deductible Co-Insurance	Deductible Co-Insurance (TrOOP)	None. Medical Assistance covers Medicare cost-sharing
Limits	No Long-term care benefits after 100 days	No coverage for: Eyeglasses; hearing aids, dental care	No coverage until 2006	Additional LTC days



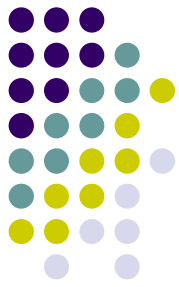
Duals (Seniors & Disabled): Where \$\$ will be Spent



Medicaid Spending



Medicare Spending



What could Counties do?

- Implement County-based purchasing
- Partner with current Minnesota Managed Care Organization to provide health care services – shared risk arrangement
- Contract with Minnesota Managed Care Organization to provide selected services, i.e. case management
- Contract with Third Party Administrator to perform necessary services

County-based Purchasing



- Must meet same requirements as any other managed care organization – MS 256B.692 and related statutes
- Requires significant investment to build necessary infrastructure-provider network, claims processing, data reporting to regulators, staff
- SCHA member counties invested nearly \$1M in planning process
- Must deal with significant regulatory agencies
- Must do your homework – good actuary analysis, financial projects, and risk management strategies

CBP



- Single Plan vs. Competition
- Public vs. private
- Current Minnesota Managed Care Organizations have operated State Public Programs since early 1990's and have been profitable but have had years with losses
- Current CBP programs have shown it can be done
- Most CBP programs focus on integration of care at the local level, keep health care dollars in the system, support local health care system
- Focus on preventive care, early identification and intervention

Joint Existing County-based Purchasing program



- New counties need to be full partners
- Must be willing to invest in share of risk based capital requirements – this can be substantial investment to be equal to current counties
- Mergers are not necessarily easy
- Many policy issues
- Current CBPs are doing well financially – we will have a bad year
- Must be willing to accept the risk

Contract with MCO with shared risk arrangement



- Select health plan that has worked well with the county
- Shared risk arrangements – up side and down side
- Need to understand the health plan and assist the plan with understanding the county operations.
- Must be willing to share information, resources and risk.
- Some small projects are working but not on a full benefit basis
- Potential opportunity with providing managed care program for persons with disabilities

Contracted provider for health plan



- Current arrangements for providing case management under Minnesota Senior Health Options
- Must be able to negotiate the true cost of services
- Potential for cost shifting/subsidizing case management
- Must understand processes within health plan
- Address issues of risk/rewards

TPA Arrangement



- Contract with CBP or health plan to provide necessary health plan functions
 - Meet regulatory requirements as a risk bearing entity
 - TPA provide services county or group of counties do not want to provide, i.e. contacts with health care providers, claims processing, regulatory reporting
 - Must be a Special Needs Plan to include Medicare benefits
- Pay administrative fee to TPA, county at risk for some or all medical care risk
- Recommend shared risk arrangement of both up side and down side
- Current model of this is AXIS HealthCare and Family Care in Wisconsin
- Model could be done for all public programs but suitable for disabled



Or do none of the above

- Not all county residents will be in managed care programs – county needs to provide some services to individuals
- Counties will need to continue to serve people not eligible for public programs
- Unit of service costs increase due to small numbers
- Other creative solutions

Contact



- Member of the SCHA Joint Powers Board
 - Chairman, Commissioner Jerry Peterson
- Marian Brandt, Exec. Director, 507-444-7771 or mbrandt@mnscha.org
- Leota Lind, Director of Operations, 507-444-7772 or Llind@mnscha.org
- Alice Laine, Director of Quality & Compliance Management, 507-444-7773, alaine@mnscha.org