COMMUNITY SNAPSHOTS PROJECT

Fargo, N.D./West Central Minnesota

Site Visit Report

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Overview

A declining population and a shrinking economic base have led to many of the changes in the health care system of rural northwest Minnesota. Increasing technology has made small family farms economically infeasible. Younger families have left the rural farming communities, and primarily middle-age and elderly people living on fixed incomes remain. The combination of a decreasing and aging population has significantly contributed to many of the region's small rural hospitals becoming financially unstable or closing. At the same time, local nursing homes are full, and the demand for home health services is increasing.

The fate of these rural communities' health care systems is closely tied to actions taking place in Fargo/Moorhead, an urban center situated on the border of Minnesota and North Dakota. Competition is increasing between the two major Fargo/Moorhead-based health provider systems—MeritCare and Dakota/Heartland—and they are reaching out to rural areas for referrals. The two systems have both bought or contracted exclusively with physician practices and provide specialty care to rural communities with rotating physicians. Since patients needing inpatient care are increasingly using Fargo/ Moorhead hospitals, many rural hospitals have closed or are in financial trouble. This has reduced access to local inpatient care, but residents of rural communities seem to experience an increase in access to primary and speciality care. Transportation to emergency and tertiary care can still be a major problem for rural residents, however, especially in the winter and for the elderly.

Over the past three to five years, the Fargo/Moorhead area has seen substantial consolidation among hospitals, and hospitals and physician groups are more closely integrated. This has strengthened the interdependence between rural providers and those in Fargo/Moorhead. The composition of the hospital sector has changed from five independent hospitals, not including the VA Hospital, to three hospitals, which are organized into two competing health systems. Hospital-led networks that include vertical integration with physician groups and expansion into rural areas have developed as a result. With some reluctance, physicians are merging or affiliating with one of the two hospital systems or looking for partnerships with insurers. The completely independent physician is rare in this market. Most physicians have joined group practices connected to large physician-based clinic systems based in Fargo or Grand Forks, North Dakota. Physicians gain access to patients who are increasingly steered to these clinics through contracts between the clinic systems and insurers.

These changes are attributable to not only competition among hospitals and physicians for a declining base of patients, but also growing demands by payers (both employers and insurers) for lower-cost contracts. Although the

HMO penetration rate remains quite low, preferred provider organizations (PPOs) are gaining in popularity. Insurers are lowering prices by negotiating discounted fees with hospital systems and physician group practices rather than capitating providers or performing strict utilization review. While providers are not eager to assume risk, they recognize that capitation and direct contracts with employers are on the horizon. Provider groups are preparing by investing in information systems that will help them share risk.

Health care policy developments in Minnesota and North Dakota are not major reasons for change in this market. The Minnesota government has enacted a set of comprehensive reforms over the past four years—MinnesotaCare legislation—including those specifically targeted to supporting rural providers, but they have had little effect so far. This legislation may have spurred consolidation of health plans in the Twin Cities, but the consolidation of hospitals and physicians in this region appears to be driven more by market forces. In contrast, the North Dakota government has done far less in health care policy than Minnesota has.

Some developments are considered likely, but there is much uncertainty about the future. Competition between the two health care systems is expected to increase, and more public and commercial enrollees are expected to join managed care plans. This does not necessarily mean significant HMO growth. Employers may follow the lead of one of the largest employers in the area by contracting directly with providers who can offer an integrated, managed system of care. In an area heavily dependent on Medicare revenue and agricultural price supports, federal actions could change the landscape of the health care system in this region.

▼ ▲ ▼ Community and Health System Background

Demographics and the Economy

Fargo/Moorhead is the urban center for surrounding rural communities in Minnesota and North Dakota.[1] Farmland, wooded lake regions, and small rural communities of fewer than 2,500 people characterize the region. Fargo's 1990 population was approximately 77,000, and Moorhead's was about 32,300. The combined metropolitan area had a population of nearly 158,000.

Population in many rural communities is declining. Between 1980 and 1990, the population of the rural communities surrounding Fargo/Moorhead dropped by 10 to 20 percent, while the population of Fargo/Moorhead itself increased by as much as 10 percent. As rural residents migrated to the metro-

[1]The site visit examined Fargo/Moorhead and four rural Minnesota communities within a 50-mile radius in Norman, Grant, and Otter Tail counties in west central Minnesota.

politan area, the percentage of elderly residents in the rural communities grew. By 1990, 15 to 25 percent of the population in Norman, Grant, and Otter Tail counties was older than age 65; while just 10 to 14 percent of the Fargo/Moorhead population was this age. During the summer months, some rural communities have a population increase of several thousand when migrant farmworkers arrive to harvest crops and tourists visit the region's lakes.

In rural communities, farming and tourism dominate the economy. Rural hospitals and nursing homes are also major employers in communities where they are located. For those communities dependent solely on agriculture, survival and economic growth are tenuous; growth is based heavily on federal agricultural legislation affecting farm price supports and international trade. An average of 40 to 49 percent of the population lives below 200 percent of the poverty level in rural communities, compared to the national average of 36 percent and the statewide average of 30 percent.

Health care is the major industry in Fargo/Moorhead; more than 6,800 people are employed by private hospitals, clinics, and insurers. The three colleges, including one run by Minnesota State, employ another 4,700 people. Other major employers in the metropolitan area include the two city governments and American Crystal Sugar, which processes the main agricultural crop of sugar beets and employs about 2,000 people. A number of large companies (e.g., Cargill) have recently moved some of their operations to the area, leading to what one observer called the "nationalization of Fargo." Unemployment in the Fargo/Moorhead area was 3 to 5 percent, compared to a rate of 6 to 9 percent in rural areas. However, many jobs are in the service industry, where earnings are low.

Health System History

In the past, communities in rural Minnesota often had their own community hospital and a small physician group practice. Many of the rural hospitals were affiliated with a nursing home, usually offering more beds than the hospital and often operating at full occupancy. When federal swing bed[2] legislation was approved in 1985, most rural hospitals seized the opportunity and converted inpatient beds to swing beds. However, the state has not permitted new nursing home beds to be built since 1983, and this has prevented full-fledged conversion of inpatient beds to long-term care beds.

Over the past ten years, rural hospitals' financial status has become more precarious. Since 1989, one hospital located in Moorhead closed; four hos-

[2]Swing beds are inpatient beds that can be used to provide post-hospital extended care services.

pitals in the outlying rural areas have closed over the last 10 years. Three of these five hospital closings occurred between 1991 and 1994, indicating that financial pressures have become more intense in the recent past. More rural hospitals and physician practices have become linked through ownership or contracts with provider-sponsored systems based in Fargo/Moorhead.

The Fargo/Moorhead health system has traditionally had a high percentage of hospitals and physicians practicing in the area. Until about ten years ago, most hospitals were owned by Catholic or Lutheran church groups. Over the past six years, the number of hospitals in metropolitan Fargo/Moorhead has declined from four independent hospitals to three, all of which belong to two private health systems.[3] One of the two private systems, MeritCare Health System, was formed by a merger in the early 1990s between St. Luke's Hospital (along with an affiliated Children's Hospital unit) and the Fargo Clinic, a multispecialty group practice. The other major system, Dakota Heartland Health System, owns two hospitals and was purchased in 1992 by Texas-based Champion Health Care, a for-profit hospital chain.

There is very little managed care in the area, with no more than 5 percent of the insured enrolled in HMOs. In the mid-1980s, MedCenters HMO, based in Minneapolis/St. Paul, and the Fargo Clinic, before it merged with St. Luke's Hospital, collaborated on a Medicare risk product. However, the arrangement proved unprofitable for the HMO and the medical group. The HMO abandoned the Medicare risk contracting business as well as the area, and members were forced to make other choices. That experience left a bad impression of managed care with many area residents. More recently, there has been limited acceptance of managed care, but HMO enrollment remains low.

▼ ▲ ▼ Health System Change

Public Policymakers

Policy developments have not had a major impact on this market. Even those provisions of Minnesota's legislation that were specifically designed to address rural health care problems have only had some impact on rural hospitals or other providers. Two sets of provisions in the Minnesota reforms appear to have had some effect on the Fargo/Moorhead health care system. One provision made it easier for rural providers to compete with large, urban-based health plans. The other provision provides state-subsidized health coverage for working low-income families. Future market changes are expected as managed care programs for all publicly sponsored patients are implemented.

[3]There is also a VA hospital in the area.

North Dakota has not enacted any major health policy changes over the past few years. The state enacted some small group market reforms (closely patterned after the National Association of Insurance Commissioners [NAIC] model act) and expanded Medicaid coverage for pregnant women and children. These reforms are much less significant than Minnesota's efforts, so it is not surprising that interviewees failed to mention them during our discussions. These policies appear to have had very little impact on market behaviors.

MinnesotaCare, the state's health care reform legislation, was first enacted in 1992 and has been changed every year thereafter. The legislation includes several major features: (1) a program that provides state-subsidized health coverage for the working poor (also called MinnesotaCare, which causes some confusion) and a commitment to achieve 96 percent coverage by the year 2000; (2) insurance reform for employers with fewer than 30 workers, as well as individuals; (3) reconfiguration of the delivery system to create Integrated Service Networks (ISNs) that would provide a defined set of benefits to enrollees on a prepaid, capitated basis; and (4) regulatory control of spending growth through per-patient revenues and insurance premium limits.[4]

In addition, the 1994 MinnesotaCare law supported the creation of Community Integrated Service Networks (CISNs), which were designed to give smaller, rural health providers an opportunity to create health plans with less capital and fewer enrollees. CISNs were conceived as "home-grown" networks that could accept risk before all health plans are required to become ISNs. CISNs were licensed two years before ISNs and were limited to enrolling no more than 50,000 people. CISNs were designed to take into account the needs of rural, community-based providers, according to the following criteria:

- Exemption from several HMO regulatory provisions not consistent with future ISN requirements;
- Ability to phase in financial solvency requirements and put up reserves through "accredited capitated provider arrangements," which require providers to deliver contracted services if the plan gets into debt;
- Requirement to offer the same benefit package an HMO does, but allowed to charge a higher deductible;
- Requirement to have 51 percent of its governing board members in residence within the CISN service area, compared to 40 percent for HMOs;

[4]Further information on the MinnesotaCare legislation is available in the Community Snapshots Site Visit Report on Minneapolis/St. Paul.

- Requirement to participate in publicly funded programs, such as Medicaid and MinnesotaCare; and
- Protection from antitrust lawsuits through state action immunity for providers who come together to assume financial risk.

Only three CISNs have been licensed so far by the state, and only one application has come from the Fargo/Moorhead and rural northwest Minnesota area. The Dakota Clinic and Blue Cross and Blue Shield of Minnesota have considered the possibility of applying for a CISN license. At the beginning of August 1995, they submitted an application for CISN designation for the Dakota Community Health Network to include the Dakota Clinic, but not specifically any one of the hospitals. The provider systems do not appear eager to develop their own ISNs or CISNs. This may be because of 1995 legislation repealing the RAPO provisions.[5]

The second set of reform provisions that have affected the area increased coverage of low-income uninsured people through the MinnesotaCare subsidy program. Families with children who earn below 275 percent of the federal poverty line are eligible for the subsidies. Subsidies vary based on income. Approximately 80,000 people across the state are currently enrolled in the program; about 9,300 enrollees live in the 14-county northwest rural Minnesota region. This is about 12 percent of all enrollees statewide, an indication of the area's higher proportion of low income people. Local community-based providers agree that the program is vital to cover many otherwise uninsured people. However, the numbers enrolled are still too small to have a noticeable effect on revenues.

Two other provisions of Minnesota's health care reform legislation may affect the area more significantly. Minnesota's Section 1115 waiver application, which sought federal authorization to mandate managed care enrollment for Medicaid recipients throughout the state, was approved in April 1995. This permits the state to expand its Prepaid Medical Assistance Program (PMAP—the Medicaid managed care program) to rural areas of the state. Clay County (which includes Moorhead) was expected to join the program in November 1995. The waiver also allows the state to require current MinnesotaCare beneficiaries to enroll in managed care plans. This means that Medicaid and MinnesotaCare enrollees will represent an increasing portion of HMOs' and providers' business in the coming years.

[5]The 1995 MinnesotaCare law delayed the requirement that all health plans become certified as ISNs until 1997. It also repealed the regulated all-payer option (RAPO), which would have required state rate setting for all providers not reimbursed through ISNs or CISNs. Repeal of RAPO lessened the pressure for providers to become part of CISNs or ISNs, and many believe that even the ISN legislation may be repealed in the future.

The 1995 MinnesotaCare legislation authorized a pilot program for two health care cooperatives (provider-led organizations) to contract directly with self-insured employers, as some physician-hospital organizations (PHOs) seek to do elsewhere.[6] Employers in the area are interested in direct contracting, so the results may have important implications.

Purchasers

Purchasers have not traditionally had great influence on the local health care market, but they are beginning to hold down employee health costs. Employers are taking advantage of increased competition among providers and insurers to negotiate discounts. While not organized to do group purchasing, employers have formed a coalition so they can share information on costs and payments for different procedures. State and local government purchasers are also pushing the market toward managed care plans and seem to be moving toward contracting directly with providers.

Employers and Employer Coalitions

According to interviewees, almost all employers, even small ones, provide health insurance to employees. The coverage usually consists of a conventional indemnity plan with cost sharing or PPOs. Blue Cross and Blue Shield dominates the market in both product lines.

More sophisticated purchasers are moving into the area, and those indigenous to Fargo/Moorhead are gaining greater savings. Self-insured employers tend to favor managed PPO networks (those with utilization controls) rather than HMOs to offer employees more provider choice. Employers prefer to deal with one health plan/insurer/administrator, and PPOs can provide employees with a choice of providers at lower cost than indemnity plans. They can also preserve current benefits, which is important to labor unions. A few of the larger employers are also beginning to examine the quality of care delivered by providers within the PPO network to make their choices among health plans. As more companies express an interest in direct contracting, hospital systems have started to market their services to employers.

Employers are also moderately successful in negotiating prices with indemnity plans. Some of the larger employers have maintained flat premiums or negotiated small rate decreases; others have extended the contract period

[6]Such cooperatives, similar to PHOs, are already authorized by Minnesota law. Cooperatives allow providers to consolidate administrative functions, offer a single point of contracting with health plans (not self-insured employers), and permit the creation of a more integrated provider network that might ultimately be able to take on risk.

and guaranteed rates. To keep premiums level, several employers have also increased co-payments and deductibles. Some employees seem willing to make this concession if premiums are held down and services remain constant.

A few years ago, eight of the largest employers in Fargo/Moorhead created the Northwest Coalition as a way to share information on health care costs and charges for various procedures. All employers in the Coalition are self-insured, although this is not a requirement for participation. The Coalition does not negotiate prices, primarily because individual company labor union contracts limit its ability to bargain as a group for a common benefit package. The group has become an important source of trend data on costs, practice patterns, utilization, and prices. Several of the purchasers collect and share data on diagnosis-related group (DRG) prices, which they use to negotiate premiums with insurers.

State and Local Government as Purchasers for Low-Income People

State and local governments are some of the most aggressive and sophisticated purchasers in this market. Minnesota state government employs numerous residents at the state university in Moorhead, at various regional offices of state government, and at a state psychiatric hospital in Fergus Falls. Because the state restricts employee choice to either HMOs or PPOs, some Minneapolis/St. Paul plans have tried to enter the Fargo/Moorhead market with competitively priced plans. The city of Fargo began to contract directly with both provider systems on a discounted fee-for-service basis. When it did so, its health care costs were reduced significantly.

Contracting directly with providers could become much more popular since the city of Fargo and the state have taken the lead.[7] Some Coalition members anticipate that direct contracting will be part of their future strategy to achieve greater price discounts. Large employers may go straight from indemnity insurance to contracting directly with providers who have integrated, managed systems of care. The state's Medicaid and MinnesotaCare managed care strategy could also contract directly with integrated systems. The state believes this can be appropriate as a way to introduce capitation to providers in less populated areas where there may be no HMOs.

[7]The state employee benefits program recently announced that it had joined the Twin Cities-based Business Health Care Action Group, which has publicly indicated its intent to pursue direct contracting starting in 1997. For further information, see the Minneapolis/St. Paul Site Visit Report.

Providers[8]

Hospitals and physician groups create the most change in this market. By the late 1980s, it became clear that providers needed to consolidate resources. The area was experiencing a declining and aging population base, an oversupply of hospital beds, reduced lengths of stay (and payments) because of DRG-based reimbursement used by Medicare and both states' Medicaid agencies and shifts toward greater use of outpatient surgery, and scrutiny of hospital admissions. These factors and others contributed to financial troubles and dropping occupancy rates. The three major physician groups did not collaborate with the hospitals and in some cases actively competed with them over contracts with insurers. Twin Cities health plans had begun to scout the area for new provider affiliations.

Rather than be controlled by outside insurers or HMOs, the providers merged or sought strategic alliances to consolidate their strength. The resulting shake-ups included two hospital consolidations, one hospital-physician group merger, the buy-out of one hospital by an out-of-state for-profit hospital chain, the closing of one urban hospital and four rural hospitals, and the expansion of Fargo/Moorhead-based physician groups into rural areas. Two health systems are now competing with each other to provide low rates to purchasers and insurers and serve a growing number of rural communities.

Hospitals

Rural hospitals face the classic problems of an aging population base, trouble recruiting and retaining physicians, closing hospitals, deteriorating physical plants, obstacles to capital, and low Medicare and Medicaid reimbursement rates. Many remaining hospitals have entered into mutually beneficial cooperative arrangements rather than mergers with the Fargo/Moorhead hospital-based systems and physician-led clinics.

Most rural communities want to keep their local hospital. Therefore, rural hospitals struggle to survive on their own rather than allying with larger systems. Mergers and rural network developments are not as popular as they are in other rural areas. Community members' creativity has led to the continued operation of some hospitals against adversity. In one community, one particularly energetic couple (he the sole physician, she the hospital administrator) were the only reason a particular hospital was saved.

[8]Because of their dominance in the system, the providers section appears in this report before the insurer section.

Rural hospitals' survival strategies include reducing hospital inpatient beds, converting beds to long-term care use, providing home health services, and developing expanded outpatient clinic capacity. In one community, a satellite clinic was established in a neighborhood that recently lost its hospital. Many hospitals have obtained rural health clinic designation for their clinics to qualify for cost-based reimbursement to strengthen the financial standing of their outpatient centers. Rural hospitals have also expanded care in ambulance and emergency services, cardiac rehabilitation, respite care, hospice, and home health care. In other communities, expansion into home health care represents a threat to the county health department, which has traditionally been the sole provider of this service.

While rural hospitals may not want mergers with hospitals in Fargo/Moorhead, they appear to welcome certain types of affiliations. Hospital systems in Fargo have begun sending affiliated specialist physicians on a rotating basis to surrounding rural communities to offer specialty clinics and expand their referral base. Large hospital systems are also offering management support services; several hospitals have management agreements with MeritCare, for example. Affiliations with a larger center allowed a rural hospital to reduce administrative staff and has given it access to business expertise and technical assistance, greater access to specialists, continuing education, public relations, marketing, and quality assurance programs. Expensive technologies are now more available as a result of affiliations with a larger, wealthier health system.

Numerous hospitals in Fargo/Moorhead have merged. Direct competition in a more concentrated area seems to have left them with few other options. Over the last six years, the number of private tertiary care hospitals in Fargo/Moorhead has been reduced from four independent facilities to three facilities organized into two hospital systems. Some observers believe that the community needs only one hospital system to serve the regional population, but this may not be possible because of antitrust considerations.[9]

Both major provider-based systems have extensive links with rural physician group practices and clinics. MeritCare Health System, which consolidated Fargo-based St. Luke's Hospital and Children's Hospital with a large multispecialty physician group practice called the Fargo Clinic, owns 5 clinics in Fargo and 25 clinics in rural Minnesota. This year, the Dakota Heartland Health System was formed through a merger of Heartland Health System (which is a merger of two hospitals: St. John's Hospital in Fargo and St. Angstar hospital in Moorhead) and Dakota Hospital in Fargo.[10]

[9]Significant consolidation among providers prompted an investigation by the Federal Trade Commission (FTC) into possible antitrust violations. According to local sources, the FTC concluded that consolidation into two major systems did not threaten fair competition.
[10]Dakota Heartland is now seriously considering closing the Heartland Hospital.

Dakota Heartland owns Heartland Network, Inc., a loosely structured independent practice association (IPA) that contracts with approximately 90 physician members in eight clinics in Fargo/Moorhead, as well as scattered physicians throughout the surrounding rural areas. To compete more effectively with its major rival (MeritCare), Dakota Heartland is also trying to forge a closer partnership with the multi-group practice, Dakota Clinic, whose members provide outpatient services in 18 health centers in the region.

Through vertical integration, MeritCare has become better positioned to negotiate with insurers and, like the rural hospitals, maintain its independence. For example, MeritCare Health System has negotiated contracts with two large health plans based in Minneapolis/St. Paul. MeritCare's clinics were already in the Blue Cross and Blue Shield managed care network, and the system is exploring the development of its own managed care product. Dakota Heartland and Heartland Network IPA have also obtained some contracts with insurers. They have not been as successful, partially because they lack a closely integrated physician group.

Competition between the two systems has forced a number of changes in internal operations as both hospital systems look for ways to cut costs and improve their competitive advantage. Both systems have attempted to eliminate duplication of services, reduce administrative overhead, and discontinue unnecessary staff positions. Each system is also closely monitoring such business indicators as staffing ratios and standardizing clinical practice protocols to minimize inpatient days. One hospital system is investigating technologies such as information systems to position itself to assume risk under capitation. It is not clear how these changes will affect the two systems' rural operations.

Physicians

Physicians in the Fargo/Moorhead area are changing their practice patterns in response to market pressures to maintain their patient base. In rural communities, the situation is very different. Norman, Grant, and Otter Tail counties are all designated as Medically Underserved Areas and Health Professional Shortage Areas. Specialty care is generally referred to Fargo, Minneapolis/St.Paul, or Rochester, Minnesota. Because of the shortage of physicians and a perception of lower quality care, younger people are particularly inclined to travel to Fargo/Moorhead to receive what they believe to be higher quality medical care. There was a noticeable increase in the use of mid-level practitioners, because of their lower cost. In 1985, one hospital employed 3 to 4 midlevels; now that hospital has 35 physicians assistants or nurse practitioners on staff and is recruiting more.

Some rural hospitals have hired physicians under the J1 visa program, which gives foreign-trained physicians an opportunity to practice in this country. Others are looking at telemedicine to reduce the isolation commonly experienced by physicians practicing in a rural community. One rural center is

using telemedicine to work with a major tertiary care hospital in Minneapolis. The rural physician at this center is very satisfied with the technology. From a clinical perspective, he can confer with specialists on particular cases; from an educational perspective, he can participate in grand rounds and other educational presentations conducted at the Minneapolis hospital.

To reduce the burdens and lessen the isolation associated with solo practice, most physicians who remain in small rural towns organize into groups that have become part of the large multispecialty group practices based in Fargo/Moorhead. Purchasers favor contracts with the large physician groups, so becoming part of one of the large groups has become more critical to ensure access to patients. Network affiliation often determines the hospital where a physician practices. Since each network has a relationship with a particular hospital, physicians feel their access to a hospital may be threatened if they are not affiliated with at least one network.

In this region there are three network choices: Dakota Clinic, the Heartland Network, Inc., or MeritCare. The largest of the three is MeritCare Clinic, which merged with the MeritCare Health System in 1993 and employs nearly 250 physicians. The Dakota Clinic, a 175-physician multi-specialty group, offers services at 18 regional health care centers. While it admits patients primarily to Dakota Hospital, the Dakota Clinic remains independent from the Dakota Heartland Health System. To compete with the Dakota Clinic and MeritCare, more than 90 independent physicians signed up with Heartland Network IPA.

Dakota Heartland Health System has also acquired some physician practices and then subcontracted with the physicians for particular services, including referral to their hospital. This strategy has been used to develop closer alliances with the physicians who remain independent. As a result of this arrangement, physicians lose some control of their time and income but gain the administrative efficiencies of the larger system. They may also obtain financial support when resources are needed.

While MeritCare's hospitals and physicians contract as one entity, Dakota Clinic physicians and those affiliated with Heartland Network remain free to establish their own contracts with insurers. Unable to resolve difficulties with Dakota Hospital, Dakota Clinic physicians have concentrated on partnership with Blue Cross and Blue Shield, with whom they have proposed a CISN, and other possibilities. The Heartland Network IPA, a partner of the Dakota Heartland Health System, offers employer discounts and participates in managed care contracts.

There is not much risk sharing or capitation of physicians in this market, but physicians are becoming more aware of costs. While they are not ready for capitation, physicians are accepting reduced fee-for-service in order to participate in various PPO panels. Physicians fear the loss of control of clinical decision making and the possible deterioration of the physician-patient rela-

tionship under a capitated managed care system. This makes recruitment and retention of physicians an issue. One group that applied for a CISN license found it very difficult to recruit area physicians into its proposed capitated program.

Public Providers

Although this area traditionally is associated with a small population of uninsured, as well as the attitude that individuals can and should take care of themselves, there is a demonstrated gap in service delivery. The needs of uninsured and underserved people are met primarily by a half dozen federally qualified health centers (FQHCs) and several public health departments. As Medicaid and MinnesotaCare programs plan to convert enrollees throughout the state into managed care systems, public providers are preparing to participate in the networks that serve these people.

Because of the low unemployment rate and the tendency of most employers to provide health insurance, few people in the Fargo/Moorhead metropolitan area are uninsured. However, in some residential areas, more than 60 percent of the residents are uninsured. Language is also a barrier to health care for migrant farmworkers, who are increasingly likely to stay all year in the Moorhead area.

In rural areas, hospitals are committed to serving uninsured people. In the metropolitan area, the commitment to the uninsured is less evident. The amount of uncompensated care provided by the hospitals may not have changed as a result of hospital consolidation and competition. But the hospital systems have not collaborated with the safety net providers to increase access to care for underserved populations, other than by placing physician residents from the University of North Dakota with the safety net providers to care for the underinsured.

Before 1994, uninsured people in Moorhead relied on care by private providers. To address what was widely regarded as great unmet need, a number of people in Moorhead received federal funding to open a federally qualified health center (FQHC). In 1994, its first year of operation, the center served more than 6,000 people; that number is rising during the second year. Twenty-five percent of the health center's first-year patients were uninsured, but center administrators believe this percentage will increase as more uninsured people learn about the center.

Migrant health care is provided during the growing season in rural farming areas. Communities receive federal support for providing outreach activities and special clinics for farmworkers. Although funding has remained stable so far, people are concerned about the future under federal block grant scenarios. The seasonal migrant farmworker population is declining in rural areas as farming becomes more automated. Even so, more workers are settling year-

round in Fargo/Moorhead looking for other kinds of work. This may increase the need for care.

Managed care has not yet arrived for safety net providers, but Medicaid managed care may be implemented in this part of the state within the next several years. The Section 1115 waiver expands the current Prepaid Medical Assistance Program to rural areas. Under the waiver, FQHCs and federally qualified Rural Health Clinics can apply for status as an essential community provider (ECP) and continue to receive cost-based reimbursement for MinnesotaCare and Medicaid enrollees during a three-year transition period. After the transition period, health plans can contract with ECPs as they would contract with other providers.

Public providers are preparing for these changes. They are pursuing relationships with hospitals, improving their information systems to monitor costs and utilization, strengthening quality assurance procedures, and training staff about managed care issues. Developing partnerships with other providers appears to be more difficult in the metropolitan area than in rural areas. Fargo/Moorhead providers appear more threatened by such collaborations since they are afraid they might jeopardize their own funding sources. All safety net providers share legitimate concerns that government funding cuts or block grants could increase competition for scarce resources among health and social service programs serving vulnerable populations.

Insurers and Health Plans

Public and private purchasers prefer PPOs, making them the most popular product in this market. Even though health plans based in Minneapolis/St. Paul are making inroads in the market, the most popular insurer remains Blue Cross and Blue Shield. Insurers are bargaining with hospitals and physician groups for rate discounts, but they have do not appear to have had much success through capitation or other methods.

In 1992, Blue Cross and Blue Shield of Minnesota reported a PPO enrollment of about 110,000, one-third of the entire population in a 33-county area. Only 5,900 in the area are enrolled in the Blue Plus HMO plan or in Medica, a Twin Cities-based HMO.[11] According to a plan representative, some of the large employers in Fargo and Grand Forks prefer the Blues plan because they employ workers across the country and the Blues offer consistent products. Blue Cross and Blue Shield of North Dakota also has a very strong presence in the area, and the two plans coordinate their marketing efforts.

[11]Most of the Blue Plus enrollees in the area are members of its Medicare plan, while most of Medica's enrollees are in commercial accounts.

Recently, however, HMOs have begun to move into this area from a competitive, saturated market in Minneapolis and St. Paul. HMO enrollment is expected to increase in 1995 because of the greater marketing efforts of the three large Twin Cities-based health plans: Allina, Blue Cross and Blue Shield, and HealthPartners. There is also a new HMO, Northern Plains Health Plan, which is jointly owned by the Grand Forks Clinic (a multi-specialty group) and United Hospital in Grand Forks, North Dakota, about 30 miles to the north of Fargo/Moorhead. This plan recently received its Minnesota HMO license and offers managed care to businesses in northwest Minnesota and northeastern North Dakota.[12] While it may be able to generate more business because the current HMO enrollment is only around 2 or 3 percent of the total population, it is not clear whether even a doubling or tripling in these numbers will cause significant changes in the market.

The primary marketing strategies of insurer/health plans concentrate on developing strategic alliances with one or both of the two major health systems (MeritCare or Dakota-Heartland) and/or one or more of the three major physician groups. Blue Cross and Blue Shield of Minnesota appears to have the advantage because of its high penetration in the indemnity and PPO markets. However, because of competition from HealthPartners and Allina, Blue Cross and Blue Shield has become more aggressive to keep its share of the insurance pie. For example, to keep prices down, the Blues are negotiating price discounts with providers. They have also extended their reach into North Dakota recently and are forming a preferred partnership with Dakota Clinic. The Blues see this as an opportunity to test new products and care management strategies. They are also diversifying services by enhancing their delivery of management support services, such as data management and utilization review, for hospitals and clinics.

Meanwhile, HealthPartners and Allina (which offer HMO and PPO products on an insured and self-insured basis) have developed agreements with MeritCare Health System over the past two years. HealthPartners chose MeritCare as its provider network to serve the growing number of employees in the region who work for companies that are members of the Business Health Care Action Group (the large self-insured employer coalition based in the Twin Cities). In the fall of 1994, MeritCare and the Allina health systems announced a joint partnership that brings MeritCare into Allina's provider network and gives Allina a presence in rural Minnesota. Once it becomes fully

[12]A 1994 Minnesota Hospital Association report indicated that the Northern Plains Health Plan's "biggest obstacles involve dealing with differing regulatory environments in Minnesota and North Dakota and adapting to the Minnesota market." This is one of the few indications that differences between the two states' regulations cause problems. However, they may be confined to new HMOs since this was not mentioned by the Blues' plans.

operational, this partnership will likely offer a broad range of products, from capitated managed care to fee-for-service indemnity coverage, to employers in the area. However, it is difficult to see how the two health plans will distinguish themselves if they are using the same provider network.

Insurers tend to pay discounted fee-for-service rates even to providers under contract in their HMO plans. In some cases, amounts may be withheld from the fee schedule and returned at the end of the year based on overall plan and individual physician performance. So far, hospitals are not paid on a capitated basis.

Currently, there is very little Medicare risk contracting, and the state has not implemented managed care for Medicaid or MinnesotaCare enrollees in this area yet. Capitation rates are relatively low. The 1995 adjusted average per capita cost (AAPCC) in Grant and Otter Tail counties was about $250, and in Fargo it was about $298. This compares to a rate of $363 in Minneapolis, which is also considered to be very low. Only Medica and the Blue Plus Medicare plan remain in the Medicare risk contract product line, but they have very few enrollees.

Consumers

Today's consumers are more knowledgeable about health care issues, ask more questions of providers more frequently, and are more involved in monitoring their care. They are also aware of the changes in the delivery system. Even so, they do not perceive any significant changes in the quality of care.

Access to care remains a problem for many rural residents of this area. There are inadequate public transportation systems, and patients must travel very long distances to obtain certain types of care. These problems have been exacerbated in recent years by hospital closings and a dwindling supply of physicians as many physicians retire or move to metropolitan areas. Select groups of people, such as migrant farmworkers, also experience barriers to care because of lack of translation services.

Many rural residents are also disappointed about the closing of some rural hospitals and would prefer to have their own local hospital. They recognize that this may no longer be possible but emphasize the need for certain health services to be available locally, especially trauma and rehabilitation services. As hospitals close and services become less available, transportation becomes an even more critical issue, especially for the elderly. Despite these access problems, access to primary care and some specialty services seems to have improved through telemedicine and rotating specialists.

Other issues, such as recipients' attitudes, affect access to care for uninsured and underinsured populations. While MinnesotaCare coverage is available for low-income uninsured residents, many reported to be very reluctant to apply for this aid. Accepting public support is often perceived as a

humiliating experience by some residents of the rural communities in this region.

For those who do receive Medicaid, their choice of providers may be very limited. Some providers do not accept Medicaid patients because of its low reimbursement rates, burdensome administrative paperwork, or an abundance of privately insured patients. In some cases, providers are also limiting uncompensated care because of the pressures of the competitive market.

Another factor associated with choice of providers is physicians' economic and lifestyle choices. North Dakota income taxes are lower, and Fargo and Grand Forks have a greater supply of upper income housing. This seems to lead more physicians to locate on the North Dakota side. This can make it difficult for low-income people, especially those with limited transportation, to find nearby providers.

Consumers also notice the same or lower premiums. They attribute this to their plans' ability to obtain discounts on provider fees. Lower premiums are appreciated, but there are complaints about higher deductibles, which may lead moderate-income people to delay seeking care.

▼ ▲ ▼ Future Developments

The health care system in Fargo/Moorhead and surrounding rural areas will become even more competitive, especially as the two hospital systems seek greater control of the market. Managed care activity in the public sector and commercial markets will probably increase, although this does not necessarily mean significant HMO growth. As employers are able to hold down costs, they may also be able to contract directly with providers to further contain costs.

Hospital consolidation will probably lead to one of the three hospitals in Fargo closing within the next several years, causing increased competition between the remaining two. Doctors not aligned with one of the two major systems would be at some disadvantage. With current trends toward vertical integration, physicians may be forced to align themselves with a hospital system through PHOs and may find their salaries and clinical decisions under more management control. Providers are likely to be more concerned with the costs of care than ever before.

With fewer rural hospitals, those that are left will become geographically regionalized to maintain a critical mass of patients to operate efficiently. Hospitals with very strong community support and leadership are most likely to survive. Rural systems will probably emphasize primary care, emergency care, rehabilitation, and home health care. Hospital systems will make more use of technologies such as telemedicine and automated medical records to maintain critical connections.

HMOs and PPOs in the area will probably increase as health plans move from Minneapolis and St. Paul and as the state pursues managed care enrollment for Medicaid and MinnesotaCare beneficiaries. Providers are likely to develop the infrastructure to assume risk and operate under a capitated system. If the federal Medicare program is changed to encourage greater managed care enrollment, Medicare risk contracting may return to the area.

As purchasers are able to minimize price increases, they are becoming more interested in direct contracting with providers. Purchasers expect to rely more on data from the Northwest Coalition to monitor health care costs, practice patterns, utilization, and premium prices. Purchasing decisions based on quality of care and outcome measures may become more common when quality measures are better understood.

Consumers may lose some choice, particularly as a result of more managed care, but they are likely to have better access to primary care as providers strengthen clinic services in the rural areas. To hold down costs, there will be a growing emphasis on wellness. Insurers will increasingly hold consumers more accountable for their health status. For the uninsured, financial barriers may get worse if the MinnesotaCare program is not modified to make it more acceptable to consumers.

Overall, future predictions reflect a wariness about changes in the health care system. Managed care may be good and improve the quality of care, but how will this affect physician choice? Hospital consolidation and closures may reduce costs, but how will staff reductions affect the local economy? Integration of rural clinics with large hospital systems may improve access to specialty care, but will larger regional hospitals be sensitive to local community needs? Legislation affecting Medicare and Medicaid reimbursement is a serious concern to everyone in the region. It is very difficult to conduct long-range planning in this environment of change.