

Community Collaborative Grant Program

Community Initiatives to Cover the
Uninsured and Underinsured

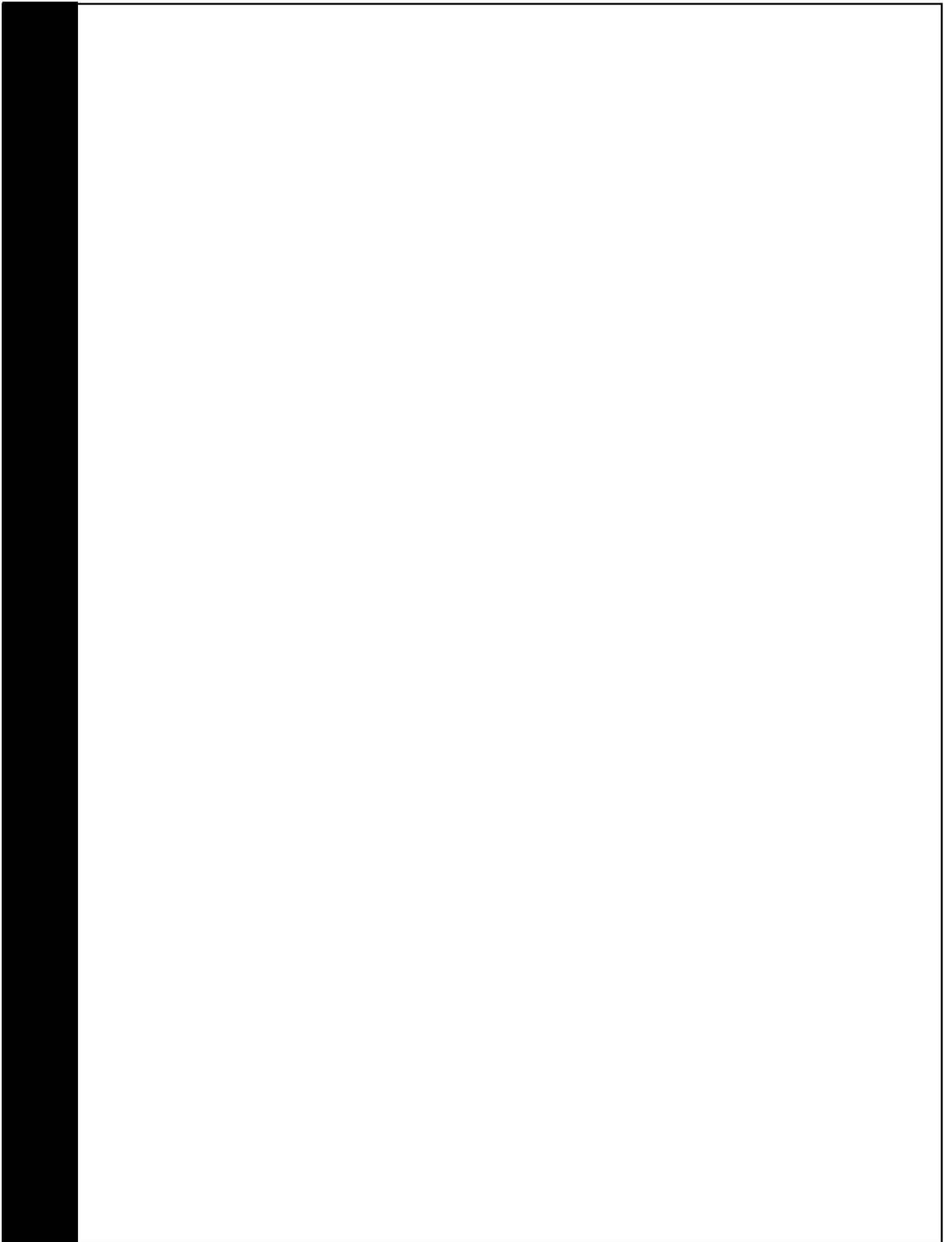
Report to the Minnesota Legislature 2008

Minnesota Department of Health

February 15, 2008



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COMMUNITY COLLABORATIVE GRANT PROGRAM

Community Initiatives to Cover the Uninsured and Underinsured

Executive Summary

The growing number of uninsured and underinsured individuals in Minnesota creates serious problems—certainly for those who are not covered, but also for health care providers who are not getting paid, and for those absorbing the costs through increased private insurance premiums or increased enrollment in publicly funded health care.

The increasing numbers of the uninsured is one symptom of a health care system in crisis. The problem of the uninsured can only be addressed by repairing those parts of the health care system that are not working or are inadvertently contributing to the increasing number of uninsured and the rising cost of health care, two inescapably related trends.

Legislative Authority

The 2007 Minnesota Legislature M.S. 414.22 authorized the Commissioner of Health to provide planning grants for up to three community partnerships to develop integrated community initiatives for providing affordable health care services to uninsured and underinsured individuals with chronic health conditions. This program was titled the Community Initiatives to Cover the Uninsured and Uninsured in Chapter 147, Article 15 of the 2007 Minnesota Legislative Session Laws. The Commissioner of Health was authorized to provide \$300,000 in fiscal year 2008. This is expected to be a one time only appropriation.

The partnerships were required to develop proposals to provide comprehensive, affordable health care services to uninsured and underinsured individuals with chronic health conditions through an integrated community partnership system. The applicants were required to provide a narrative summarizing the role and impact of each applicant in the management structure to ensure a cohesive project.

Applicants Required to be Part of a Consortium

To be eligible to receive a planning grant, a community collaborative was required by the enabling statute to include one or more counties, at least one local hospital, at least one local employer who collectively provides at least 300 jobs in the community, at least one school system, a third-party payer, which may include a county-based purchasing plan, an employer, or a health plan company and at least one or more integrated health care clinics or physician groups; or one or more health care clinics or physician groups with one or more mental health clinics.

Criteria for Grant Award Selection

In awarding grants, the Commissioner of Health was to give preference to proposals that:

- Had broad community support from local business, providers, counties, and other public and private organizations
- Proposed to provide services to uninsured or underinsured individuals of every age who have or are at risk of developing multiple, co-occurring chronic conditions
- Would integrate or coordinate resources from multiple sources and
- Could demonstrate how administrative costs for health plan companies and providers can be lowered through greater simplification, coordination, consolidation, standardization, reducing billing errors or other methods.

The Minnesota Department of Health was required to identify the community partnerships that received a planning grant and to summarize their respective planned initiatives.

Awards

The Minnesota Department of Health, Office of Rural Health and Primary Care received and reviewed applications for funding by PrimeWest Health System in Alexandria, Minnesota and Portico Healthnet in St. Paul, Minnesota. Based upon their applications, PrimeWest was awarded a planning grant for \$201,000 and Portico for \$99,000.

Both PrimeWest and Portico submitted reports to the Department of Health in late December 2007 describing the results of their planning grant efforts. This report summarizes their respective proposals, their proposed operations and cost.

Summary of Portico Healthnet Proposal (PorticoPlus)

PorticoPlus, a community collaborative pilot project, is intended to provide targeted and cost effective health care services to uninsured individuals in Ramsey County. It is specifically designed to address the unique health care needs of the growing Latino community, including programs to intervene early and to better manage chronic health conditions such as obesity, diabetes and depression.

The PorticoPlus pilot project would expand on Portico Healthnet's current coverage model for the uninsured and includes five main components:

1. Identifying and enrolling uninsured/underinsured individuals in Ramsey County, with a special focus on serving uninsured Latinos
2. Screening all program participants for medical, mental, chemical and oral health issues and encouraging all participants to undergo physical examinations
3. Integrating and coordinating community-based early intervention and chronic care management for participants who are identified as being overweight or having diabetes or depression
4. Connecting participants with additional services in the community as needed

5. Providing coverage for primary and preventive care as well as specialty care, prescription medications, outpatient procedures, outpatient mental health services, and medical interpreter services when needed.

By providing specific health care services, early intervention and care management programs, and integrated medical, mental and chemical health services, PorticoPlus aims to reduce the overall cost by (1) assisting the uninsured avoid chronic health conditions; or (2) keeping their chronic conditions under control; and (3) encouraging appropriate use of health care facilities and services.

The PorticoPlus program will be evaluated on an ongoing basis to quantify the return on investment, including offset savings in the reduced use of emergency rooms, hospitals and other high-cost health care services; reduced uncompensated care; increased worker productivity; and lower governmental costs for social services, education, health care and economic assistance programs. Information learned from this pilot project might provide valuable data on the impact of health promotion, early identification and treatment of emerging chronic disease, and the use of an integrated health care home for uninsured/underinsured urban culturally diverse populations.

Portico Healthnet estimates that the five-year cost for the PorticoPlus Initiative would be \$5,821,420 largely financed with new funds from the State of Minnesota.

Summary of PrimeWest Proposal (Values Health)

PrimeWest Health's Proposal entitled Values Health would test the proposition that if individuals, communities, businesses and government work together cooperatively to re-engineer the health care system it will be possible not only to cover the uninsured, but also to give those who have insurance a better value for their health care dollar.

Through this five-year pilot project, Prime West proposes to extend the eligibility reach of the MinnesotaCare program in a 10-county area in west central Minnesota, and to repackage the participation cost structure to make it a more affordable health coverage option for a greater number of economically vulnerable uninsured/underinsured residents.

Values Health maintains wellness and achieves optimum outcomes in a cost-effective manner through:

1. Eligibility and Enrollment – assertive outreach and comprehensive enrollee education regarding benefits and navigating the health system
2. Health Assessment and Screening – comprehensive health status and risk assessments (medical, mental health, chemical dependency, social, wellness)
3. Care Coordination and Service Delivery – triage and care coordination pathways with interdisciplinary case management including creation of a medical home, outcome-based care planning and care plan service delivery for disease management, integrated medical-mental health care management/service delivery, individualized wellness and prevention management and programming, and provider/member accountability

4. Payment and Financing – Pay-for-Performance, health savings accounts, multi-share (member, employer, community and state) combined with a sliding copay and deductible schedule
5. MinnesotaCare Foundation – integrated health services to all eligible uninsured and underinsured children and adults in 10 counties in western Minnesota, as well as members already enrolled in MinnesotaCare and GAMC.

PrimeWest proposes a four-share approach to financing. This approach uses individual, employer, community and state contributions during the five-year pilot phase, then phases out the state share for participants whose incomes/assets exceed the threshold for Minnesota Health Care Program coverage. The individual's financial commitment to the program will be made in the form of a sliding scale. Participating employers' shares would go toward the premium. The community will contribute through money raised by fundraising, commitments from health care organizations and other sources. The state will contribute a portion of the cost of services and part of the costs of research and evaluation of the program. The state share during the pilot phase is essential to: a) help offset the costs anticipated with triaging and treating pent-up health care needs of the uninsured; b) allow the program time to test and refine cost containment strategies, begin to realize health status improvement results (and cost reductions associated with these results) of longer term health improvement strategies (wellness, disease management, etc); and c) allow the model time to adapt for long-term sustainability.

PrimeWest estimates that the five-year cost for the Values Health Initiative would be \$43,136,630 with approximately \$41.9 million of this from the State of Minnesota (\$23m of which would be funding above current state funding for public pay health programs).

Conclusion

While many pilot projects to cover the uninsured are designed to close specific gaps in health coverage, they also add complexity to an already complex health coverage environment. Instead of creating a new program, the Portico and PrimeWest proposals propose continuous health coverage to a greater number of low-income and uninsured residents, which would not be disrupted even as circumstances and eligibility changes.

Portico and PrimeWest assessed their proposals through research of health reform approaches and/or based on organizational experience in serving its current program members. The administrative cost efficiency of the two models is based on the concepts and approaches emerging from the Legislative Commission on Health Care Access and the Governor's Transformation Task Force.

Both Portico and PrimeWest are confident that their respective pilot project proposals would provide participants access to high quality, medically necessary health care that emphasizes personal responsibility and prevention through the optimization of the management of existing chronic disease.

Salient excerpts and summaries from each proposal follow. PorticoPlus and HealthWest's complete proposals are online at www.health.state.mn.us/divs/orhpc/funding/index.html.

PORTICO HEALTHNET

PorticoPlus Community Collaborative Project

As the only organization in the Twin Cities formed explicitly to help the uninsured obtain health care, Portico Healthnet has seen the increasing number of uninsured in the area as well as the need to address disparities in access and care for the growing Latino population. Portico currently offers an affordable coverage option for uninsured low-income individuals and families who do not qualify for Minnesota Health Care Programs. For the past 12 years, Portico has provided health care coverage for over 6,000 low-income uninsured East Metro residents and has helped enroll another 5,000 uninsured Minnesotans into public coverage programs. As of December 2007, Portico was providing health care services for approximately 1,000 people, and approximately 600 additional eligible individuals are on the program waiting list.

PorticoPlus, a community collaborative pilot project of Portico Healthnet, proposes to provide targeted and cost effective health care services to uninsured individuals in Ramsey County. The PorticoPlus coverage program is specifically designed to address the unique health care needs of the growing Latino community, including programs to intervene early and better manage chronic health conditions such as obesity, diabetes and depression.

The PorticoPlus pilot project expands on Portico Healthnet's current coverage model for the uninsured and includes five main components:

1. Identifying and enrolling uninsured or underinsured individuals in Ramsey County, with a special focus on serving uninsured Latinos
2. Screening all program participants for medical, mental, chemical and oral health issues and encouraging all participants to undergo a physical examination
3. Integrating and coordinating community-based early intervention and chronic care management services for participants who are identified as being overweight or having diabetes or depression
4. Connecting participants with additional services in the community as needed and
5. Providing all participants with coverage for primary and preventive care as well as specialty care, prescription medications, outpatient procedures, outpatient mental health services, and medical interpreter services when needed.

By providing specific health care services, early intervention and care management programs, and integrated medical, mental and chemical health services, PorticoPlus aims to reduce the overall cost to the community by helping the uninsured avoid chronic health conditions or by keeping their chronic conditions under control and by encouraging appropriate use of health care facilities and services.

The PorticoPlus program proposal includes an evaluation to quantify the return on investment to the community, including offsetting savings in reduced use of emergency rooms, hospitals and other high-cost health care services, reducing uncompensated care, increasing worker productivity, and lowering governmental costs for social services, education, health care and economic assistance programs. This pilot project will provide valuable real-world data on the

community and individual impact of health promotion, early identification and treatment of emerging chronic disease for an uninsured, urban and culturally diverse population.

Introduction

The proposed pilot project, “PorticoPlus” builds upon the existing Portico Healthnet (Portico) to provide a seamless continuum of care for uninsured individuals, particularly those from the growing Latino community, who have or are at risk for developing chronic conditions such as obesity, diabetes and depression. The primary goal of the PorticoPlus pilot project is to provide preventative and other cost-effective health care services for uninsured persons in Ramsey County. In addition, this program aims to reduce the overall cost to the community by helping the uninsured avoid chronic health conditions or keeping their chronic conditions under control, and by encouraging appropriate use of health care facilities and services.

PorticoPlus proposes to test ways to provide targeted health care services to uninsured persons with health problems such as diabetes, obesity and depression which, if left untreated, could escalate until the person can no longer work and requires extensive and costly health care treatment. This program is based on the premise that providing health care services, along with individual care management services to uninsured persons will provide a return on investment that exceeds the cost of providing the additional services. Offsetting savings are expected in reduced use of emergency rooms, hospitals and other high-cost health care services; reduced uncompensated care costs for local providers; continued employment; lower costs to counties for social services, health care and other services; and savings to state health care and economic assistance programs.

Community Collaborative Description

In response to legislation passed in 2007, Portico, in conjunction with a number of community partners, responded to a Request for Proposals issued by the Minnesota Department of Health for a planning grant. Portico established a Community Planning Committee to develop the pilot project model and identify the chronic conditions on which to focus. The Community Planning Committee included representatives from Portico Healthnet, Salud Integral Clinic and Comunidades Latinas Unidas En Servicio (CLUES), HealthEast Care System and St. Joseph’s Hospital., Saint Paul-Ramsey County Department of Public Health and Saint Paul Public Schools.

Target Population Demographics

The proposed target population is uninsured individuals living in Ramsey County, with a special focus on serving the uninsured Latino community in the St. Paul area. Within the seven-county metropolitan area, Ramsey County experiences the highest rate of uninsurance at 9.1 percent (9.5 percent of St. Paul residents are uninsured). Latinos are disproportionately represented among the uninsured. Nationally, 37 percent of Latinos are uninsured; this is more than double the percent for whites. Similarly, in Minnesota, more than one in three (34.2 percent) Latinos are uninsured. One reason is that, as a group, Latinos are more likely to work in seasonal or temporary jobs, which are less likely to offer health coverage to employees. Language, cultural

barriers and immigration status also play a major role in the high rate of uninsured among Latinos.

The vast majority of Portico's current program participants are from the St. Paul area and more than half of the participants (63 percent) are Latino. During 2006-2007, Portico provided health coverage for 1,244 individual participants in 536 households. The uninsured population Portico serves is generally young, working and poor. Children between the ages of 0-19 comprise 36 percent of Portico's enrollees. Seventy-seven percent of Portico participants work either full or part time and 73 percent of enrollees' income levels are below 175 percent of Federal Poverty Guidelines.

Health Care Needs of Target Population

Between December 2006 and February 2007, team members from Wilder Research met with Latino leaders to identify key issues affecting the Latino community in the Twin Cities. Access to and quality of health care was a major concern. Health needs identified by the Latino community leaders included:

- More Spanish-speaking employees in health care settings
- Public health education and services targeted toward Latino youth
- Access to health insurance
- Access to culturally-competent services
- An information liaison that can link parents to service agencies through the schools
- Additional funding of mental health services.

The lack of access to health care coverage, coupled with language and cultural barriers and socioeconomic factors, has resulted in significant health disparities for Latinos:

- Latinos are about twice as likely as whites to die of diabetes-related causes
- Inadequate or no prenatal care rates are four times higher for Latinos than for whites (12.2 percent versus 3 percent)
- Twenty-nine percent of reported tuberculosis cases in 2005 occurred among Latinos, representing the single largest percentage among all racial/ethnic groups
- Although the rate of mental disorders among Latinos is similar to that of whites, only 24 percent of Latinos with depression and anxiety receive appropriate care compared to 34 percent of whites.

Portico participant health assessment data shows that at the time of entry into Portico's coverage program many uninsured individuals are already dealing with a chronic condition. According to initial health assessment data:

- 36 percent report having asthma
- 15 percent report having concerns about depression, anxiety or nervousness
- 6 percent report having hypertension

- 4 percent report having diabetes.

The PorticoPlus pilot project is designed to prevent illness, identify health issues as early as possible, and provide the care and services necessary to promote and maintain optimal health and independence.

Participant survey data from current Portico enrollees, as well as observations made by community partners who serve the target population, indicate that obesity, diabetes and depression are three chronic conditions that need to be more effectively addressed, especially within the Latino population, in order to positively affect both short and long term health outcomes.

Obesity: Portico currently does not collect information on the body mass indices (BMI) of its enrollees; however, all members of the Community Planning Group identified obesity as a significant challenge for this target population. This concern mirrors what Minnesota is seeing in its general population. Since 1990, the prevalence of obesity in Minnesota increased from 10.2 percent to 24.7 percent of the population. National data also demonstrates that certain groups, including Hispanics, non-Hispanic Blacks, American Indians, and children in low socioeconomic groups, are particularly affected by obesity and these disparities appear to be growing. National data finds that 21.1 percent of Hispanic children between the ages of 6 and 11, and 18.6 percent of Hispanic children between the ages of 12 and 19 are overweight.

The increasing rate of obesity threatens the health of children and younger generations, placing them at much greater risk for future development and early onset of a wide variety of chronic diseases and health conditions. Evidence-based, culturally appropriate intervention activities are needed to prevent the short and long term risks associated with being overweight and obese.

Diabetes: Only 4 percent of current Portico enrollees indicated during their self-reported family health assessment that they have diabetes. It is very likely, however, that a much greater percentage of the Portico enrollee population actually has diabetes or is at risk for developing it, but that the individual is unaware of the condition. According to data from the Centers for Disease Control and Prevention's (CDC), the age-adjusted diabetes prevalence among Hispanics was approximately twice that among non-Hispanic whites (9.8 percent versus 5.0 percent). According to the Minnesota Department of Health (MDH) data, one in four Minnesotans either have diabetes or are at high risk of developing it, and each year more than 26,000 Minnesotans are newly diagnosed with the disease.

Diabetes is the sixth leading cause of death in Minnesota and costs Minnesota \$2.3 billion annually, including medical care, lost productivity and premature mortality. The MDH Report "Disparities in Diabetes by Race/Ethnicity" found that populations of color and American Indians die younger from diabetes. Over 30 percent of all diabetes deaths among Hispanic/Latino Americans occur before age 65, compared with 17 percent among non-Hispanic whites (NHW). Furthermore, Minnesota birth certificate data indicate that diabetes diagnosed prior to pregnancy is increasing four times faster among Hispanic/Latina mothers than among NHW mothers.

Depression: Nationally, approximately 5.3 percent—one out of 18 people—have depression, and 4 percent of adolescents get seriously depressed. National studies conducted to identify the rates of psychiatric disorders among adults in the United States found that Mexican Americans

and white Americans had very similar rates of psychiatric disorders. However, when the Mexican American group was separated into two sub-groups, it was found that those born in the United States had higher rates of depression and phobias than those born in Mexico. According to Portico participant data, 15 percent of current Portico enrollees indicated that they have concerns about depression, anxiety, nervousness or feeling blue.

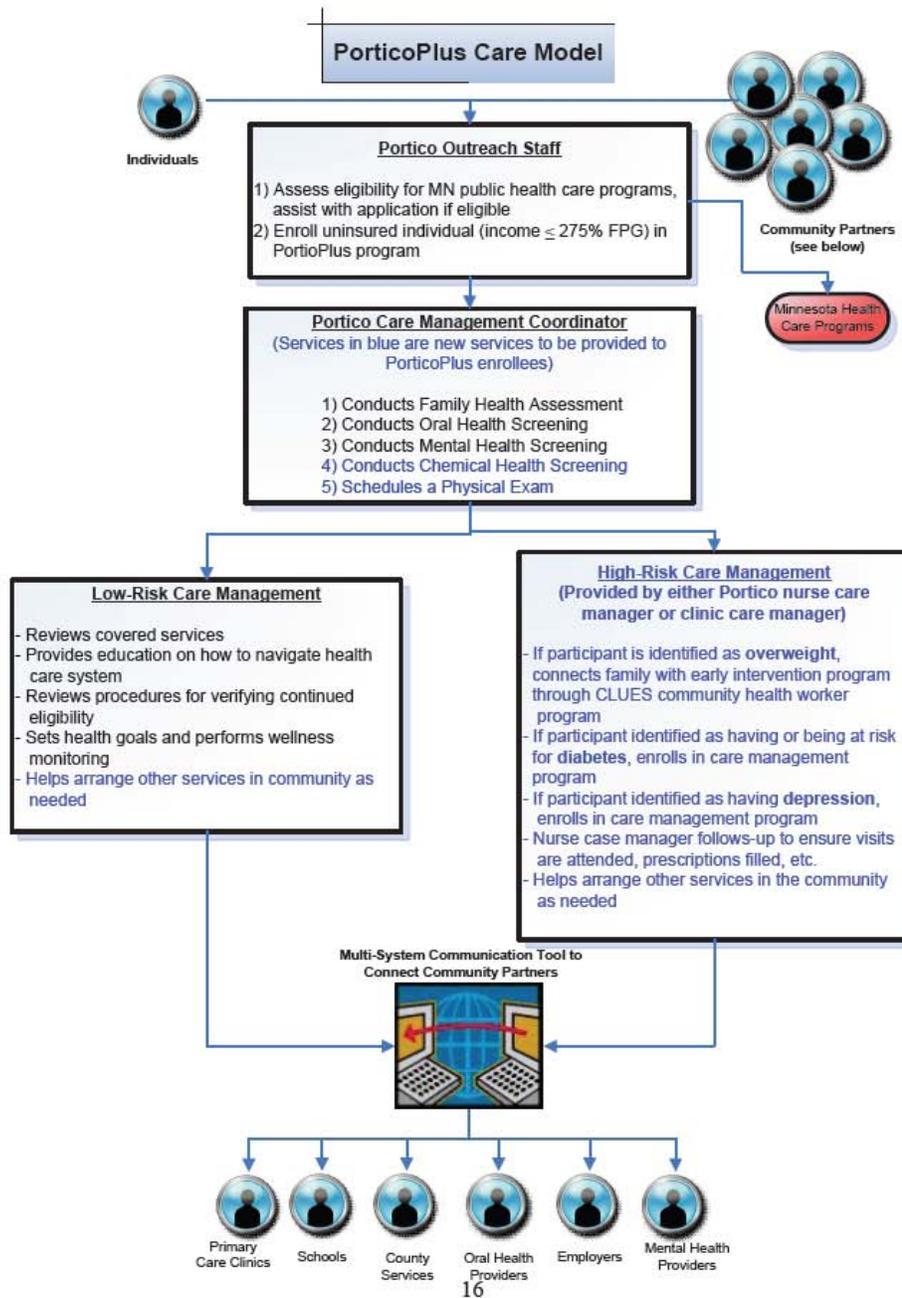
Health Care Services Access

At the time of entry into the Portico coverage program, only 53 percent of enrollees report having been able to get necessary medical treatment when they were uninsured. When asked about their usual source of care while uninsured, 29 percent reported that they did not seek any care because they could not afford it. Only 38 percent of participants reported that they had a complete physical exam in the past 12 months, and 18 percent reported that they were unable to purchase needed medications when they were uninsured. Portico's participant survey data demonstrates that when individuals and families are without health care coverage, they are more likely to wait for a medical crisis before seeking care, often presenting at an advanced stage of illness or with complications.

Coverage status also affects a worker's productivity. Among Portico's participants, the average number of days missed from work prior to enrollment was almost 50 percent higher compared to when they were on Portico's coverage program.

The 1999 Surgeon General's report on mental health reported only 24 percent of Hispanics with depression and anxiety received appropriate mental health care, compared to 34 percent of whites. In addition, among Hispanic Americans with mental disorders, less than 1 in 11 contact mental health care specialists and less than 1 in 5 contact general health care providers. This may be due to the negative social stigma associated with receiving mental health care. Because Latinos are more likely to seek mental health services in primary care settings, improving detection and care within the general health care sector will be important for improving access for this population.

Research also suggests that the ethnic match of provider and consumer can be important. One study found that ethnically matching providers to patients resulted in longer duration and better patient response to treatment based on a global indicator of functioning. However, there are few Spanish-speaking and Latino mental health providers. A recent national survey found 29 Latino mental health professionals for every 100,000 Latinos in the U.S. population. For whites, the rate was 173 white providers per 100,000. Clearly, Latino consumers have limited access to ethnically and linguistically similar providers.



PorticoPlus Care Model

The proposed pilot program (PorticoPlus) expands on Portico's current coverage model and includes five main components:

1. Identifying and enrolling uninsured or underinsured individuals in Ramsey County, with a special focus on serving uninsured Latinos
2. Screening all program participants for medical, mental, chemical and oral health issues and encouraging all participants to undergo a physical examination
3. Integrating and coordinating community-based early intervention and chronic care management services for participants who are identified as being overweight or having diabetes or depression
4. Connecting participants with additional services in the community as needed
5. Providing all participants with coverage for primary and preventive care as well as specialty care, prescription medications, outpatient procedures, outpatient mental health services, and medical interpreter services when needed.

Identifying Potential Uninsured or Underinsured Individuals

In cooperation with its community partners, the proposed pilot program will utilize multiple entry points to identify and enroll eligible individuals:

Portico Healthnet. Reaching over 10,000 uninsured individuals each year, Portico will be able to identify uninsured individuals who may be appropriate to participate in the pilot project. Portico outreach staff have ongoing connections with many organizations through regular community meetings and presentations about Portico's services. As a result, over 200 organizations referred uninsured individuals to Portico during fiscal year 2007.

The Salud Integral Clinic and Comunidades Latinas Unidas En Servicio (CLUES). Both organizations serve Latino participants in Portico's coverage program. Salud Integral provides primary medical care and CLUES provides mental health services. In addition to serving Portico's participants, for whom Salud and CLUES receive reimbursement for services, both clinics serve a growing population of uninsured Latinos. Salud was established by HealthEast Care System in 2005, in response to the growing Latino population in the St. Paul area. Staffed entirely by bilingual, bicultural personnel, Salud is able to provide culturally-competent care in the native language of Latino patients. The clinic was established in partnership with CLUES, which is located in the same building.

For the past 25 years, CLUES has provided mental health services for the Latino community. CLUES is a leader in providing culturally-proficient and linguistically appropriate behavioral health services for Latinos in Minnesota. In 2006, CLUES became the first culturally competent provider to offer language appropriate co-therapeutic, dual-diagnostic services in the areas of mental health and chemical health for Latinos.

HealthEast Care System and St. Joseph's Hospital. HealthEast, as a care system, began in 1987 when four east metro hospitals joined with several clinics, long term care

centers and other health-related organizations to form St. Paul's largest nonprofit health care system. The history of HealthEast extends much further back through its member hospitals, several of which have been providing health care to community residents for over a century.

In response to the growing Latino population, HealthEast created Salud Integral, the primary care clinic. In addition, HealthEast also increased its Spanish-speaking staff at St. Joseph's Hospital, where most Salud patients receive inpatient care. HealthEast serves 100,000 patients each year and has felt the impact of the growing number of uninsured in the St. Paul area. HealthEast will identify uninsured patients for the project.

Saint Paul-Ramsey County Department of Public Health. Portico has long served uninsured residents through its outreach efforts at the Department of Public Health Center and WIC sites, as well as by working with other county entities, including Ramsey County Adult Intake, Ramsey County Correctional Facility, Ramsey County Human Services, and the Ramsey County Library. Saint Paul-Ramsey County Department of Public Health will participate by identifying uninsured residents for the pilot project.

Saint Paul Public Schools (SPPS). SPPS serves over 40,000 students in the city of Saint Paul and is one of the country's most diverse urban districts. Almost 40 percent of the district's students are English Language Learners, including recently-arrived Latino children. SPPS recently implemented a wellness policy and is actively supporting nutrition and physical activity. SPPS will identify uninsured students for the pilot project.

Local Employers. Portico and its community partners plan to approach local companies who employ large numbers of Latino workers to assess their willingness to participate in this project. These employers could provide referral information about the Portico pilot program to their uninsured workers and support the chronic care management programs and early intervention programs developed for PorticoPlus enrollees. Potential employer partners may include those in the cleaning and building maintenance service areas, home cleaning, roofing and landscaping sectors. Various members of the pilot project advisory committee already have good relationships with many of these businesses. CLUES, for example, has helped over 9,000 people secure jobs through its Employment Department and has offered to make connections with receptive employers as needed. Employers will participate as a referral source for the pilot project and through exploration of their potential role as a funding partner.

Enrollment Process

Uninsured: Once an uninsured individual is identified and referred to Portico, bilingual community health workers first assess the eligibility of the individual for any public health care programs. For those individuals who are eligible for public programs, community health workers provide one-on-one assistance with enrollment. If individuals are not eligible for public health care programs and their incomes are below 275 percent of federal poverty guidelines, they are enrolled in the PorticoPlus pilot project.

Underinsured: Currently, underinsured residents are also eligible for the Portico program if their only form of insurance is a catastrophic policy with a deductible of \$10,000 or more. In addition, if eligible for MinnesotaCare but unable to afford the MinnesotaCare premium, they would be eligible for the Portico coverage program. Portico also plans to investigate the feasibility of adding a series of questions to its eligibility questionnaire that would allow Portico to uncover more information from those individuals who are eligible for coverage but who choose not to enroll because they believe the public health care programs are not affordable. The responses to these questions will provide valuable data to the state that could be used to determine an affordability threshold for health coverage for the target population.

Integration and Coordination of Medical and Mental Health

Currently, Portico's Care Management Coordinators are licensed social workers who meet with participating households upon enrollment and, using a Family Health Assessment tool developed by Portico, help participants to identify and prioritize their family's health concerns. The Care Management Coordinators also conduct an oral health assessment and help participants connect with a low cost oral health provider. Care Management enables uninsured individuals, who are often unfamiliar with regular medical care, to access and navigate the health care system. Participants also learn the importance of primary and preventive care, the proper use of urgent and emergency department care, and basic practices for disease prevention and general good health.

In addition to these services, Portico proposes to offer additional care management and early intervention services for its enrollees. All enrollees will also undergo a mental and chemical health screening at the time of enrollment and be required to complete a physical examination with a primary care provider. Once Portico has collected baseline health status through the screening tools and physical examination findings, individuals will be directed to choose a primary care provider and be assigned a case manager based on their level of health risk. This model provides a "medical home" for each participant, ensuring timely and well-organized care. Individuals considered to be low-risk for chronic health conditions will meet regularly with their Portico case manager to establish a number of health and wellness goals based on health conditions identified in the family health assessment and to connect with any additional services needed in the community such as housing, transportation, day care.

Participants who are identified as being overweight, diabetic or depressed will receive additional high-risk case management from a Portico nurse case manager or be enrolled in a family intervention program to manage and/or prevent further complications from their conditions. All Portico enrollees will receive coverage for primary and preventive care as well as specialty and urgent care, prescription medications, outpatient procedures, outpatient mental health services, and medical interpreter services when needed.

Intervention # 1) Overweight/obese: To help participants avoid the negative health consequences associated with being overweight or obese, Portico proposes to partner with a successful Community Health Worker (CHW) program. This program has been developed at CLUES to design an evidence-based, "family centric" obesity intervention program. A family centric approach is important because the entire family must modify eating and activity patterns

if weight loss or maintenance is to be achieved, especially for overweight children. This approach provides a sense of ownership in the program on the part of all family members, which may result in increased compliance.

An obesity prevention initiative for the uninsured Latino community that expands the role of community outreach workers should be an effective way to reach overweight and obese Portico enrollees. Research has shown that CHWs have been especially effective in Latino communities because they address the issues of social isolation as well as cultural and language barriers. CHWs tend to serve the same community they live in and often share the same language, socioeconomic status and cultural background as the patients they serve, thus overcoming many of the trust and cultural appropriateness issues that other health care providers face. The CLUES Community Health Worker program has a proven track record in developing culturally and linguistically appropriate interventions.

Intervention # 2) Diabetes: Portico plans to partner with Salud Clinic to develop a coordinated diabetes management program for those enrollees identified as having, or at risk for developing, diabetes. All identified individuals will be encouraged to select Salud Clinic as their medical home. In order to build a culturally competent diabetes care management program, Portico and Salud Clinic will retain an outside consultant with expertise in developing training programs to facilitate organizational change in diabetes care. These consultants will assist the Salud Integral Clinic in performing a needs assessment and chart audit to collect data and establish a baseline of diabetes care.

Facilitators will then guide a consensus-building process to customize a primary care-based diabetes management plan at Salud. Using the baseline data, the diabetes team will set priorities, identify outcome goals, and develop an action plan. The plan will recognize diabetes self-management education as an integral component of care. In developing the plan, consideration will be given to the patient's age, school or work schedule and conditions, physical activity, eating patterns, social situation and personality, cultural factors, and presence of complications of diabetes or other medical conditions. A Portico nurse care manager would work with the Salud primary care providers to ensure all enrolled patients with diabetes receive health services and tests in accordance with clinical practice guidelines from the American Diabetes Association.

Intervention # 3) Depression: Portico proposes a number of activities to provide integrated and coordinated mental health services.

1. **Conduct a needs assessment for the enrollee population.** At this time there is no baseline information available regarding the extent and nature of mental health treatment (e.g., psychotherapy, medication and the extent of treatment provided by mental health professionals versus primary care professionals), nor of chemical health treatment at the partner clinics. There is a need for a data analysis that clarifies the overlap of treatment of medical and mental health/chemical health disorders in this population. Implementing improved mental and chemical health screening tools and a baseline data-mining analysis of the treatment information could establish this information. Currently, UCare performs the claims processing for Portico enrollees, and UCare may be able to assist in this analysis. In addition, data analysis of pharmacy data by Prime Therapeutics, Inc.,

Portico's pharmaceutical third party administrator, will enable Portico to answer important integrated care questions such as:

- Percentage of patients on diabetes medication also on antidepressants
 - Percentage of psychiatric medications written by psychiatrists versus primary care providers.
2. **Implement improved mental and chemical health screening tools.** The 12-item mental health questionnaire that Portico currently uses will be improved to more effectively screen for mental health problems. For adults, the PRIME-MD is a tool that could be considered, and the Pediatric Symptom Checklist could be considered for children. The CAGE screening test for alcoholism will be part of the intake form. If there is evidence of a problem, a more thorough tool such as the Michigan Alcohol Screening Test (MAST) could be used.
 3. **Increase provider capacity development.** It is essential to build the capacity of mental health clinics with the ability to serve Hispanics in a culturally competent way. Portico's partner clinic, CLUES, currently does not have the capacity to serve additional patients at its St. Paul facility unless additional funding is secured to recruit bilingual and culturally competent mental health providers.
 4. **Work with Salud Integral to integrate mental health care with primary care services.** All individuals who are identified through the screening process as being depressed will be encouraged to select Salud Clinic as their medical home. Salud clinic staff will be trained and educated on how to integrate medical and mental health care services and how to better diagnose and treat patients with mental and chemical health issues. Mental health integration activities will establish:
 - In-service presentations for continuing medical education on mental health
 - Consultation and referral relationships from psychiatrists
 - Care management program for complex clients (see #5)
 - Telephone/tele-psychiatry support
 - On-site mental health diagnostic and treatment services in the medical clinics
 - On-site chemical health screening.
 5. **Implement a depression care management program.** An evidence-based care management program for depression, based on a collaborative care model such as the DIAMOND (Depression Improvement Across Minnesota – Offering a New Direction) project, will be implemented for PorticoPlus enrollees at Salud Clinic. Patients who are found to have evidence of depression on initial screening will be referred for diagnostic evaluations, preferably by mental health professionals. If there is evidence of severe depression with the risk of suicide, crisis intervention and immediate assessment with possible referral for hospitalization will take place. Following the diagnostic evaluation, all Portico enrollees who are identified as having clinical depression will be assigned to a mental health care manager. The care manager will work with the patient, the clinic and

Portico to ensure that the patient has access to appropriate treatment services, the patient understands the nature of the diagnosis and proposed treatment, and that compliance with treatment is maintained.

Depression often coexists with medical and chemical health disorders. Research on treatment costs indicate that an individual with depression and diabetes costs twice as much to treat as one with diabetes only, and when depression, diabetes and chemical dependency are all present, the costs are four times as much. For these patients with one or more co-morbid conditions, more comprehensive care management is necessary. In situations where the patient has depression and a concurrent medical disorder (e.g., diabetes), the mental health care manager will work with the medical care manager to facilitate communication with the primary care physician and ensure that medical and mental health services are integrated. Patients who have mild to moderate depression will have their depression treated by the primary care physician, whereas those with more severe depression will be referred to a psychiatrist. The mental health care manager will also work with the patient to determine whether chemical health problems are also an issue. If alcohol or drug problems are present, the care manager will facilitate a referral, ideally to a dual-diagnosis mental health/chemical dependency program.

The most complex patients (medical, mental health and chemical health disorders) will require coordinated care management from the mental health and medical care managers, along with oversight and guidance provided by the clinicians in their health care home and at Portico. The care manager will participate in periodic reassessments after treatment has begun. Specific care management duties will include education, self-management support, coordination of care with primary care and behavioral health providers, and facilitation of changes in treatment. Psychiatric consultation will be available to the care manager and to the primary care physician on an ongoing basis. This will include periodic contacts to discuss patients who are not improving, with subsequent changes made in the treatment regimen as indicated.

Care management outcome measurements will parallel those done through the DIAMOND project, with response and remission rates at three months, six months and one year. Care management will be tailored to each patient's unique needs. Some patients will have a rapid response to treatment that reaches full remission, whereas others may have complex, multiple diagnoses with treatment resistant symptoms. Therefore, managers will provide a spectrum of services, based on the severity, complexity and treatment responsiveness of each patient.

Communication and Coordination Among Sectors

The PorticoPlus chronic care intervention project will be designed to functionally integrate with resources available through Portico's community partners, such as the SPPS chronic disease model for students, county public health resources and programs, and Salud and CLUES clinic services. This integration is important because frequently social services, corrections, special education, medical and mental health systems share clients, and these clients tend to have complex needs. Ideally, each system would have a thorough understanding of its clients' needs, and be able to coordinate services with other systems, when appropriate. However, many local and state systems suffer from fragmentation, multiple silos, and a lack of coordinated knowledge about their clients.

In order to achieve true integration and coordination among the various health, social service and education “silos” that currently exist, functional communication and information protocols and procedures must be established with the partners. Portico proposes to develop a web-based communication tool so that with the appropriate releases of information, partners in different sectors can share information and track the needs of an individual and the various community resources available to that individual through a centralized, simplified mechanism.

Program Evaluation

To quantify the return on investment of this program, Portico proposes developing a predictive model that will compare the actual costs for serving enrolled, uninsured persons to the predicted costs that would have been incurred in the absence of early intervention and consistent treatment to prevent or manage a chronic condition. Portico proposes working with researchers at the University of Minnesota to design a cost comparison evaluation model and an evaluation tool that would look at various outcome measures over short, medium and long terms. The evaluation tool may examine measures such as:

- Specific health outcomes
- Number of missed days of work/school for enrollees
- Rate of employee turnover at partner employers
- Ability of enrollees to seek and access health care without delaying needed care
- Number of out-of-home placements for enrolled children
- Number of referrals made to special education for enrolled children
- Reductions in ER visits and hospitalizations (lower uncompensated care costs)
- Reports of simplified processes for connecting uninsured individuals with health care coverage.

Conceptual Financial Model

A multi-share approach is envisioned as the financial model for this five-year pilot. Each participating household will pay a participation fee, which in Portico’s current coverage program ranges from \$25 to \$50 a month per household (PMPM), based on household size and income. Because Portico’s coverage program is not insurance, the participation fee does not cover the cost of care, but helps fund the care management and participant education components of the model. Medical expenses are financed by hospital partners, which Portico bills monthly for reimbursement of services provided for participants. Each hospital partner makes an annual commitment of support, for which Portico provides stewardship, ensuring funds are used efficiently for effective care of the uninsured. Portico has been able to provide affordable health care services for uninsured individuals at an average cost of less than \$1,000 per member per year. To supplement these funding sources, Portico may ask employers in the community to contribute to the project.

Portico also plans to seek funding from the state to help cover the additional health services that will be provided to pilot project enrollees such as chronic disease care coordination services, mental health integration and coordination services, and early intervention and prevention

activities designed around obesity, diabetes and depression. In addition, Portico is seeking funds to develop a web-based multi-system communication tool to operate among the different community partners, and funds to cover the costs associated with the program evaluation development.

Five-year PorticoPlus Budget Items

Item	Description	Quantity	Total
Health care services for enrollees on waiting list	(600 people x 85 PMPM x 4 years)		\$2,448,000
Physical exam at entrance for all enrollees	Year 1: (\$75/physical exam x 70% of 1600 enrollees) Years 2- 4: (\$75/physical exam x 70% of 200 new enrollees x 3 years)	84000 31500	\$115,500
Increased utilization of health services through PorticoPlus	Year 1: 3% increase = (\$2.55 x 1600 enrollees x 12 months) Year 2: 2% increase = (\$1.7 x 1600 enrollees x 12 months) Year 3: 1% increase = (\$0.85x 1600 enrollees x 12 months)	48,960 32,460 16,320	\$97,920
Portico Nurse Care Manager	(\$85,000 salary plus benefits = \$100,000 x 4 years)		\$400,000
Obesity Intervention Program Development	(\$30,000 to develop and provide initial training + \$60,000 (1 FTE x 4 years)		\$270,000
Diabetes Care Management Program Development	(\$30,000 to develop + \$20,000 initial training + \$10,000/year for ongoing costs)		\$90,000
Mental Health Integration Needs Assessment/Data Analysis	(\$12,000 for data analysis and needs assessment)		\$12,000
Mental Health Integration Training	(\$10,000 for training)		\$10,000
Mental Health Provider Capacity Development	(\$5,000 to recruit psychiatry services)		\$5,000
Upgraded Screening Tools	(\$3,000 for identifying and implementing upgraded tools)		\$3,000
Depression Care Management Program	(\$85,000 salary + benefits = \$100,000 for care manager x 4 years + \$20,000 program development and oversight)		\$420,000
Web-Based Multi-system Communication Tool	(\$300,000 for web-based tool)		\$300,000
Program Evaluation Tools	(\$500,000 for evaluation tool development and analysis)		\$500,000
Funding for SPPS	(\$30,000 x 5 years)		\$150,000
PorticoPlus Administrative Costs	(\$200,000 x 5 years)		\$1,000,000
		TOTAL	\$5,821,420

PorticoPlus Budget Narrative (Five Year Budget) \$5,821,420 in new funds

Health Care Services for Enrollees on Waiting List: \$2,448,000

Provision of health care services to an additional 600 eligible uninsured residents who are currently on the Portico waiting list, at a rate of \$85 PMPM.

Physical Exam at Entrance: \$115,500

Costs associated with physical exams for all enrollees in the PorticoPlus program. It is assumed 70 percent of all Portico enrollees (new and current) will receive a physical exam in year one at a

cost of \$75 per exam. In years two-four it is assumed that 70 percent of all new enrollees (estimated to be 200 individuals) will receive a physical exam.

Increased Utilization of Health Services: \$97,920

The costs associated with the increased utilization of health services that will result from identifying health problems earlier through the required physical examination at entrance. A 3 percent increase in Portico's total costs of health care (\$85 PMPM) will be applied the first year, then 2 percent the second year, then 1 percent the third year.

Additional Portico Nurse Case Manager: \$400,000

This will cover the costs associated with hiring 1.0 FTE nurse practitioner to provide care management for individuals assigned to the high-risk pathway. It assumes \$85,000 salary plus benefits = \$100,000 per year.

Obesity Intervention Program Development: \$270,000

This will cover the costs necessary to develop an obesity intervention program in collaboration with Community Health Workers at CLUES clinic (\$30,000 to develop the program and provide initial training). In addition this will cover the costs associated with hiring 1.0 FTE position to continue training, update the program, manage the program and coordinate services at \$60,000 per year.

Diabetes Care Management Program Development: \$90,000

The costs to develop and implement the diabetes care management program through Salud Clinic. It assumes costs of \$30,000 to develop the program, \$20,000 for initial training, and \$10,000 per year for ongoing training.

Mental Health Integration Needs Assessment/Data Analysis: \$12,000

This will cover the costs of an analysis of present Portico patient diagnostic and pharmacy data, plus data generated from the new Portico Plus clients' medical/mental health screening, diagnostic and treatment information to assess mental health integration needs and readiness.

Mental Health Integration Training: \$10,000

This will be provided in meetings with clinics, administrators, physicians, nurses, support staff and Portico care management staff, and will outline the key issues of dual diagnosis screening, diagnosis, treatment, care management, collaboration with outside systems, patient education, health plan oversight, etc.

Mental Health Provider Capacity Development: \$5,000

This is based on a time estimate of recruiting for consulting psychiatry services, expanding mental health services for PorticoPlus clients, coordinating services with the county for high risk individuals (case management, respite care, etc.).

Upgraded Screening Tools: \$3,000

This includes the identification and implementation of culturally-sensitive, valid, reliable, and specific tools that identify evidence of medical, mental health and chemical health disorders in children, adolescents and adults.

Depression Care Management Program: \$420,000

This is based on the DIAMOND model of care managers with caseloads of approximately 150 clients, with the cost of the salary and related expense for each care manager being \$85,000. It is anticipated that one depression care manager would handle the needs of the PorticoPlus population, based on demographic projections of depression prevalence. Psychiatric consultation and oversight costs are estimated at \$20,000. The care manager's role would also include management of co-morbid chemical health conditions for PorticoPlus patients.

Web-Based Multi-System Communication Tool: \$300,000

This is the estimated cost of developing multi-system communication software with a consultant and the Department of Informatics at the University of Minnesota.

Program Evaluation Tools: \$500,000

This will cover the costs associated with designing an evaluation program, developing a predictive modeling tool, collecting annual evaluation data, and performing periodic data analysis throughout the project.

Support for a St. Paul Public School (SPPS) Staff Member: \$30,000

This will allow a SPPS staff member to continue to serve on the Community Planning Committee, identify and refer potential enrollees, provide Child and Teen Check-ups and refer for services, and provide care management for student enrollees identified with mental health conditions including Attention Deficit Hyperactivity Disorder.

Portico Administrative Costs: \$200,000 per year

Portico administrative costs associated with implementing PorticoPlus includes costs to update infrastructure and database systems, and provides salary for 1.0 FTE administrative program coordinator.

Conclusion

The Minnesota Department of Health anticipates that PorticoPlus will demonstrate that targeted and cost-effective prevention and wellness services and evidence-based, integrated health care and mental health services provided to an urban, uninsured, culturally diverse population will produce a return on investment to the community and the individuals and families served that will justify the additional costs. Information learned from this pilot project will provide valuable real-world data that will help guide state and national efforts to both address the problem of the uninsured and re-engineer the health care system to provide better value for the dollars spent.

PRIMEWEST HEALTH

Values Health Project

OVERVIEW

PrimeWest Health (PrimeWest), a county-based organization health plan owned by 13 rural counties in west central, southwest and northern Minnesota counties, is uniquely positioned by organizational structure and local proximity to administer and govern the proposed Values Health pilot project.

PrimeWest is proposing Values Health test the proposition that if individuals, communities, businesses and government work together cooperatively to reengineer the health care system, it will be possible not only to cover the uninsured, but also to give those who *have* insurance a better value for their health care dollar.

Through this five-year pilot project, PrimeWest proposes to extend the eligibility reach of the MinnesotaCare program in a 10-county area, and to repackage the participation cost structure to make it a more affordable health coverage option for a greater number of economically vulnerable uninsured/underinsured residents.

Guiding Principles and Objectives of Values Health

The name of the pilot program represents the conceptual framework in which the program was designed. Values Health encompasses the health and health care values commonly held by patients, providers, payers and policymakers—health care’s four stakeholders.

The Values Health model applies value-based health care based on two premises:

- **The cost of health care should relate directly to the level of health care quality** (patient’s health care experience and care outcomes).
- **Compensation for health care providers should relate directly to the value of their role** in helping a patient maintain wellness or achieve optimal care outcomes in the most cost-effective manner.

The Values Health model was constructed based on commonly held health care values, stakeholder input, and an evaluation of both plausible and feasible approaches for improving health care delivery and individual health status to achieve the following:

1. **Access** to covered health care services, comparable to both public and private health coverage programs, for economically vulnerable uninsured and underinsured.
2. **Integration** of medical care, mental health care, county public health, county social services, other county and local community resources, and school and worksite health services to help people maximize their health and independence.
3. **Health Care Delivery Efficiency** through application of concepts that have been shown to produce optimum care and wellness outcomes in a cost-effective manner,

- including health care homes, disease management, evidence-based medicine, care coordination, and individualized wellness programming.
4. **Value-based Health Care and Provider Information** that helps people make wise decisions about their health and health care service utilization/purchasing.
 5. **Health Care Financing** to reward providers and enrollees for wellness and realizing optimum care outcomes in a cost-effective manner, and re-aligning reimbursement structure for improved financial support of primary care and prevention.
 6. **Electronic Health Information Technology**, including tele-health, consumer web-based access to information to support wellness and efficient health care delivery.
 7. **Public Program Coverage Optimization** to enroll more uninsured/ underinsured individuals who are currently eligible for, but not enrolled in, Minnesota Health Care Programs or other programs, and to maximize utilization of low-cost county services for prevention and health promotion (from annual immunizations to heating assistance to public safety to WIC).
 8. **Transparency** to allow all stakeholders to view the financial and operational components of Values Health.
 9. **Accountability** facilitated by transparency to ensure Values Health operates within the intent of the Legislature and interests of its stakeholders.
 10. **Portability** to provide program participants a safety net of coverage in the event of disenrollment from Values Health due to life changes.
 11. **Consumer Empowerment** that provides consumers with a vested and informed role in personally maintaining their health and utilizing health care resources appropriately, including Health Savings Accounts.
 12. **Adaptability** to allow the pilot project model to be used in a wide variety of community settings, including both rural and urban areas.
 13. **Economic Development** to promote employment and increased earnings of uninsured individuals, allow greater job mobility, reduce individual dependence on public programs, and increase individual contributions to the local and state tax base.
 14. **Cost-effective Administration** to ensure more dollars for health care and less on program administration.

Model

Values Health integrates and applies numerous proven and emerging concepts for maintaining wellness and achieving optimum care outcomes in a cost-effective manner. These concepts are found throughout the four major elements of the model.

1. Eligibility and Enrollment

- Coverage for economically vulnerable uninsured/underinsured
- Assertive outreach
- Multiple points for eligibility determination for Values Health and other coverages
- Values Health member identification and multi-purpose smart card
- Comprehensive enrollee education regarding benefits and navigating the health system

2. Health Assessment and Screening

3. Care Coordination and Service Delivery

4. Payment and Financing

- Value-based provider reimbursement
- Wellness and prevention provider reimbursement emphasis
- Pay-for-Performance
- Member empowerment and self-responsibility tools and incentives
- Health Savings Accounts
- Multi-share financing (member, employer, community and state)
- Dynamic and sliding copay and deductible schedules
- Payer accountability
- Administrative efficiency.

MinnesotaCare. Values Health's goal is to provide integrated health services to all eligible uninsured and underinsured children and adults in 10 counties in western Minnesota, as well as members already enrolled in MinnesotaCare and General Assistance Medical Care (GAMC). Values Health would be designed to fill the gaps to provide coverage for more of the uninsured. The program is built upon the MinnesotaCare foundation, including its principles, safeguards and benefit set, but modifies and integrates other MinnesotaCare elements through Values Health in order to:

- **Extend coverage** to a greater number of economically vulnerable uninsured/underinsured residents
- **Re-align member and provider incentives** for participation and for value-based application of covered services, including primary care and preventive emphasis
- **Facilitate greater enrollee empowerment and personal responsibility** in maintaining health and utilizing health care services
- **Allow multi-share financing** to shift responsibility for sustaining the program from the state to those stakeholders who stand to gain from the program and
- Incorporate proven and emerging approaches of **cost-effective, optimal care** management and service delivery.

Financing

Multi-Share Financial Model: Values Health proposes a four-share approach to financing utilizing individual, employer, community and state contributions during the five-year pilot phase, then phasing out the state share for Values Health participants whose incomes/assets exceed the state's threshold for Minnesota Health Care Programs (MHCP) coverages.

- The **individual's** financial commitment to the program will be made in the form of a sliding scale.
- Participating **employers'** share would go toward the premium.
- **The community** will contribute through money raised by fundraising, community benefit commitments from health care organizations, and other sources.
- The **state** will contribute a portion of the cost of services and part of the costs of research and evaluation of the program. The state share during the pilot phase is essential to:

- help offset the costs anticipated with triaging and treating pent-up health care needs of the uninsured
- allow the program time to mature in order to test and refine cost containment strategies, begin to realize health status improvement results (and cost reductions associated with these results) of longer term health improvement strategies (wellness, disease management, etc) and
- allow the model time to adapt for long-term sustainability while anticipating needing little or no state support after the pilot phase ends for Values Health members with incomes exceeding the MinnesotaCare income threshold.

Implementation and Pilot Project Timeline

Phase-in/Phase-out. Values Health can begin providing coverage to the uninsured as soon as 2009, while simultaneously ramping up new program features. The model will be continually refined and improved over the pilot project timeframe. The state's financial contribution will be significantly reduced or phased out for Values Health enrollees who do not meet the eligibility criteria for other MHCP at the end of Year 5. Member contributions, employer premiums and the community share will financially sustain the program after the pilot period, following a financing methodology similar to the "3-Share" coverage programs such as Access Health in Muskegon, Michigan.

Program Evaluation

Values Health will identify and quantify all of the outcomes, costs and savings with providing services in as many places and service areas as possible.

Possible evaluation measures may include: changes in MHCP enrollment; provider participation and satisfaction; improvements in screening and education; improvements in early identification and intervention; success in developing care and wellness plans; individual care/wellness plan objective achievement rate by participant type and care plan service providers; participant wellness and health care knowledge improvement testing; preventable hospital admission rate tracking; annual cost-benefit analysis of state portion of program financing; trending annual health care expenditures by provider and/or service type basis and by major diagnosis categories; care coordination and service delivery integration effectiveness (costs and outcomes); administrative effectiveness and cost tracking; individual health status (short and long term); improved quality of provider services; hospital uncompensated care costs; comparing annual costs associated with managing specific chronic diseases against national or state (if available) average health care costs attributable to these chronic disease; work and school absenteeism; member and stakeholder satisfaction, and employer participation.

Cost-Benefit Summary

Program design features designated with a minus sign (-) are intended to reduce costs, while features designated with a plus sign (+) require increased investment. The design features projected to achieve the most significant savings and efficiencies (-), or that will require the greatest investment (+), are also designated with an exclamation point (!).

Benefits

- Standard MinnesotaCare, subject to:
 - Consumers cost sharing tiers (- !)
 - Consumers HSA (- !)
 - Expanded benefit for assessments/exams at intake (+ !)
 - Expanded benefit for individualized care plan development (+)
 - Community forum exercises if needed to trim benefits to reach budget target (-)

Service Volume and Intensity

- Consumers cost sharing tiers (- !)
- Consumers HSA incentives for medical necessity awareness (- !)
- Providers health care home (- !)
- Providers centers of excellence (- !)
- Providers care coordination/integration, improved care plan adherence (- !)
- Plan active case management (-)

Service Prices

- Consumers HSA incentives for price awareness (- !)
- Providers higher payments to targeted provider: health care home, centers of excellence (+)
- Providers payment levels for targeted providers subject to competitive bidding, “steerage” incentive (-)
- Providers standard Minnesota Department of Human Services fee schedule payments to all other providers (-)

Administrative Costs

- Active outreach to uninsured to facilitate enrollment (+ !)
 - Potential for federal matching funds related to Medicaid administration (- !)
- Modest business cost savings for health care providers due to coverage consolidation (-)
- Evaluation and outcomes tracking (+)
- Smart card investment: cards, readers, server/support (+)

Premiums/Funding

- Consumers sliding scale, more generous than standard MinnesotaCare (+ !)
- Employers 3-share opportunity (- !)
- Community grants, targeted aid (-)
- State primary funding source, consistent with MinnesotaCare

Preliminary Financial Estimates (\$43,136,630 over 5-Years)¹

Enrollment and Premium²

Full Enrollment ³	\$	10,350	
Premiums PMPM ⁴		373,360	
Premium Revenue – Annual		46,383,473	100%
Enrollee Share of Premium ⁵	\$	3,512,661	7.6%
Employer Share of Premium ⁶		993,600	2.1%
State Share of Premium		41,877,213	90.3%

Expenses and Savings

Administrative Expenses ⁷	\$	3,246,843
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Medical Expenses - Baseline⁸	\$	43,136,630
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Targeted Savings⁹

Medical Expenses Savings – Short Term	\$	2,156,832	5.0%
Medical Expense Savings – Medium Term		4,313,663	10.0%
Medical Expense Savings – Long Term		6,470,495	15.0%

Conclusion

While many pilot projects to cover the uninsured are designed to close specific gaps in health coverage, they also add complexity to an already complex health coverage environment. Instead of creating a new program to fill a gap, the expanded and redesigned MinnesotaCare Program, as envisioned by Values Health, proposes providing continuous health coverage to a great number of low-income and uninsured residents, which will not be disrupted even as circumstances and eligibility changes.

The approaches contained in the Values Health model and described in this document have been assessed for plausibility and feasibility by PrimeWest. Plausibility was assessed through research of various health reform approaches and/or based on PrimeWest’s

¹ \$23m would be new funding from the state for higher enrollment in MinnesotaCare (\$13m) and \$10m for an increase in sliding fee reimbursement for participants.

² For first year of operation at full enrollment. Costs based on 2007 experience with no trend factor.

³ Full enrollment subject to timing of transition from current program enrollment, outreach efforts, and other factors. Full enrollment includes members formerly on MinnesotaCare and GMAC, uninsured currently eligible for MinnesotaCare or GAIV and uninsured eligible for Values Health based on expanded MinnesotaCare eligibility criteria.

⁴ Based on MinnesotaCare benefits with projected Values Health enrollment mix.

⁵ Based on alternative sliding scale proposed for Values Health, and estimated income tiers by eligibility category.

⁶ Based on estimated 10 percent of members sponsored by employers, at average \$80 PMPM.

⁷ Significant additional enrollee cost-sharing would be associated with Health Savings Account benefit design.

⁸ Based on 7 percent of premium, based on administrative cost estimates for Values Health Program features.

⁸ Based on 93 percent loss ratio.

⁹ Based on increasing impact over time of Values Health Initiatives and design features to achieve efficiencies.

experience in applying the approaches in serving its current Minnesota Health Care Program members. Both the capacity and financial feasibility of the model were also assessed. PrimeWest already is either applying the approaches contained in the model or has the infrastructure to implement such approaches.

PrimeWest also studied the feasibility of applying other concepts and approaches emerging from the Legislative Commission on Health Care Access and the Governor's Transformation Task Force, and many of these emerging recommendations are consistent with either the approaches included in Values Health or within the PrimeWest operational capacity to implement. In addition, a preliminary financial and actuarial analysis was conducted for the model, and the analysis produced a financial feasibility/sustainability threshold that accounts for the four-share revenue streams and anticipated health care costs. If funded at the proposed level during the pilot phase, Values Health will be financially viable during the pilot phase and sustainable with little or no additional state funding after the pilot phase concludes.

PrimeWest is confident that Values Health will provide an opportunity to access high quality, medically necessary health care that emphasizes personal responsibility and prevention and optimizes the management of existing chronic disease. To succeed as a value-added program, it will be necessary for all stakeholders to embrace change and to invest adequate time and resources to enable Values Health to mature and evolve.

See a more in-depth look at the PrimeWest proposal in the following section.

Introduction

PrimeWest comprises partners from counties, hospitals, local employers, integrated health clinics/physician groups, school systems and a third-party payer, PrimeWest Health System. PrimeWest, a county-based purchasing health plan that provides coverage for people eligible for government health care programs in 13 rural west central Minnesota counties, will administer and govern the pilot project, Values Health.

Values Health will provide services to uninsured and underinsured persons of all ages in the community, with a special focus on preventing and effectively managing chronic disease and other persistent conditions in the target population, particularly persons who have or are at risk of developing multiple chronic conditions. Because of PrimeWest's role and the strong commitment of community partners, Values Health is uniquely situated to offer participants a sustainable, integrated package of health care, social services, educational services, and wellness programs tailored to their unique needs.

Although this program is initially proposed for the uninsured and underinsured, it is designed to be replicable and transferable to provide an eventual seamless integrated system of care for any interested applicants in either the public or private health insurance systems.

Problem Statement

The lack of affordable health coverage is a major public health problem for the proposed county service area of Values Health. The overall rate of un-insurance in Values Health's service area, at 8.6 percent, is higher than the overall state rate of 7.4 percent. Unfortunately, there are signs that this trend in un-insurance is continuing to rise. Increasing numbers of local employers can no longer afford to offer health insurance benefits to their employees, and many self-employed individuals, including farmers, cannot find or afford individual health insurance policies. As a result, more and more people who need care do not receive it. While there is little data available that directly measures the impact of the uninsured on the 10 proposed counties, a growing body of national research has shown that the uninsured use fewer preventive and screening services, are more severely ill when diagnosed, receive fewer therapeutic services, have poorer health outcomes (higher mortality and disability rates), and have lower annual earnings because of poorer health.

If the uninsured do not have health coverage and cannot afford to pay for services, rural doctors, hospitals, and other providers must bear the costs of uncompensated care. In 2005, uncompensated care costs totaled \$191.2 million for hospitals in Minnesota, a 26 percent increase over 2004. Minnesota physician clinics provide over \$100 million of uncompensated care each year. Those costs are eventually passed on to all citizens in the form of increased taxes and higher health care premiums.

Community Service Area Overview

The proposed geographic service area for Values Health comprises 10 Minnesota counties: Big Stone, Douglas, Grant, McLeod, Meeker, Pipestone, Pope, Renville, Stevens and Traverse. All 10 counties are rural, non-metropolitan statistical areas. These are also the Joint Powers counties of the county-based purchasing ownership of PrimeWest Health System. PrimeWest's Joint Powers counties recently expanded to include Beltrami, Clearwater and Hubbard counties in northern Minnesota. These rural counties joined PrimeWest after the submission of the original grant proposal to MDH, and there was not enough time to form the local collaborative and conduct the assessments necessary to include them in the report by the statute-prescribed deadline. However, while not considered in this report, PrimeWest does hope to expand to include these three rural counties once the project has been funded, implemented and tested in the original 10 counties.

Target Population Demographics

Values Health's proposed target population is all uninsured and underinsured residents of these counties up to age 65 who are below 350 percent of the Federal Poverty Guideline (FPG). This will include persons who are ineligible for government health care programs, and persons who are eligible but have not enrolled for a variety of reasons. To simplify administration and enhance program effectiveness, enrollment will also be extended to persons currently enrolled in MinnesotaCare and GAMC.

Values Health will screen uninsured individuals for potential eligibility for coverage through existing Minnesota Health Care Programs (MHCP) or other sources. Research of uninsured residents in these counties indicates that the majority of persons uninsured at a point in time are likely to be eligible for other coverage through employment or a public program. Values Health will strongly encourage these individuals to enroll in programs for which they are eligible through Values Health's eligibility determination process, outreach, and education. Beyond these initial services, Values Health will not provide health care services to individuals who are eligible for government health care programs other than MinnesotaCare and GAMC. Preliminary estimates show that 21.8 percent of the uninsured individuals in the 10-county service area, or about 2,954 individuals, are not eligible for other coverage.

Chronic Disease

The total target population of Values Health is projected to be 5,600 local uninsured residents, 4,750 currently enrolled in MinnesotaCare and GAMC, and an additional number of underinsured individuals yet to be determined. A major focus of Values Health will be assessment and individualized care management for uninsured individuals who have, or are at risk for developing, a chronic disease.

Mission, Guiding Principles and Objectives

The name of the pilot program represents the conceptual framework in which the program was designed. “Values Health” encompasses the health and health care values commonly held by patients, providers, payers and policymakers—health care’s four stakeholders. The following values provided the conceptual framework for the development of the Values Health model:

Access	Affordability	Consumer empowerment
Accountability	Wellness	Fiscal responsibility
Choice	Personal Responsibility	Compassion
Portability	Universality	Quality
Consumer-directed	Prevention	Coordination
Prevention	Value	Transparency
Compensated care	Community Standards	Equity (for all stakeholders)
Competition	Efficiency	Continuity
Individual or patient-centered	Outcome-oriented	

The Values Health model applies value-based health care based on two premises:

1. **The cost of health care should relate directly to the level of health care quality** (patient’s health care experience and care outcomes).
2. **Compensation for health care providers should relate directly to the value of their role** in helping a patient maintain wellness or achieve optimal care outcomes in the most cost-effective manner.

Values Health Objectives

Values Health will incorporate proven or emerging value-based care and wellness management and health care service delivery concepts in pursuit of its mission and goals:

1. To provide affordable access to health care services to economically vulnerable uninsured and underinsured individuals.
2. To manage and provide for care and services to Values Health members in a manner that produces optimum wellness and care/treatment outcomes cost-effectively.
3. To be accountable and transparent to the stakeholders of the Values Health program.
4. To implement, test and refine a sustainable and replicable coverage program for economically vulnerable uninsured and underinsured individuals.
5. To reduce the financial burden of uncompensated and low-compensated care on health care providers, privately insured individuals and the Minnesota taxpayer.
6. To administer the program in a fiscally prudent and publicly responsible manner.

Eligibility

Minnesota has relatively encompassing programs to assist low-income persons to obtain health coverage. These are collectively referred to as “Minnesota Health Care Programs” (MHCP), and include Medicaid (Medical Assistance or MA), General Assistance Medical Care (GAMC), MinnesotaCare, and Special Needs BasicCare (SNBC). Additional programs are available for persons age 65 or greater (MSC and MSHO). The state has also established a high-risk pool for persons who have been unable to purchase coverage in the private market. This coverage is provided through the Minnesota Comprehensive Health Association (MCHA).

Despite the availability of these programs, many individuals who appear to be eligible for MHCP have not enrolled and remain uninsured. Others fall outside the MHCP eligibility criteria, but at low-to-moderate incomes cannot afford the increasing cost of private health coverage. Obtaining health coverage is especially challenging for persons without access to subsidized health coverage through their own or a family member’s employment.

Values Health’s goal is to provide integrated health services to all eligible uninsured and underinsured children and adults in 10 counties in western Minnesota, as well as members already enrolled in MinnesotaCare and GAMC. Values Health would be designed to fill the gaps in health coverage in order to provide coverage for more of the uninsured. The program is built upon the MinnesotaCare foundation, including its principles, safeguards and benefit set, but modifies and integrates other MinnesotaCare elements in order to:

1. Extend coverage to a greater number of economically vulnerable uninsured/underinsured residents
2. Re-align member and provider incentives for participation and for value-based application of covered services, including primary care and preventive emphasis
3. Facilitate greater enrollee empowerment and personal responsibility in maintaining health and utilizing health care services
4. Allow multi-share financing to relieve financial pressure on state and vest other stakeholders that stand to gain from the program with greater responsibility for sustaining the program and
5. Incorporate proven and emerging approaches of cost-effective optimal care management and service delivery.

Values Health Modifications to MinnesotaCare

- Current income levels for MinnesotaCare will be the primary eligibility criterion.
- No disqualification based on assets.
- No disqualification based on availability of coverage through an employer, if employer is 1) helping to sponsor Values Health for employees or sponsoring insurance that is unaffordable to certain employees who fall within the income eligibility range of Values Health.

- Eligibility for Values Health will begin at the upper limit of Medical Assistance eligibility and be expanded to up to 350 percent of the federal poverty guideline (FPG).
- Eligibility for Medicaid, Medicare, or other subsidized public programs takes precedence, but provides Values Health the regulatory ability to assist in enrolling eligible uninsured individuals into these programs. As noted below, MinnesotaCare and GAMC enrollment would be integrated with Values Health on a “single plan” basis.
- More dynamic use of copays and deductibles as incentives to encourage enrollment, value-based health care utilization and greater personal responsibility, including a sliding scale will be adjusted as necessary to a level where 20 percent or fewer of those eligible to enroll decline based on perceived un-affordability.
- MinnesotaCare participant premium will be converted to a Health Savings Account contribution.
- Coverage will be provided for persons at higher income levels who are unable to secure affordable private health insurance because of pre-existing health conditions, i.e., the MCHA population.
- Employer-sponsored versions of the program will be available.
- Residents in counties comprising the PrimeWest service area will be eligible for Values Health.
- Single plan program administration integrating currently enrolled MinnesotaCare population served by multiple plans in 10-county service area with expanded number of eligible participants will:
 - eliminate duplicative multi-health plan administrative costs, freeing up more money for health care
 - facilitate program and coverage continuity and portability
 - achieve optimal cost-effective coordination of service delivery for optimum care management and service/treatment outcomes.
 - test efficacy of reform concepts included in Values Health and those proposed by the Legislative Commission on Health Care Access and the Governor’s Transformation Task Force more easily.

If these modifications and integration elements are approved, then the specific target population eligibility criteria for Values Health will include:

- Uninsured or underinsured, or enrolled in MinnesotaCare or GAMC
- Ineligible for other public coverage programs such as Medical Assistance or Medicare
- Incomes up to 350 percent FPG with less stringent asset criteria so as to allow individuals in common rural occupations that require significant non-liquid assets to generate income to qualify (e.g., farmers, small business sole proprietors)
- Incomes higher than 350 percent FPG but uninsured due to pre-existing health conditions
- Reside in the PrimeWest purchasing service area
- Age 0 through 64 years.

Enrollment

Many uninsured residents in the Values Health 10-county service area are likely to be eligible for PMAP or the current MinnesotaCare program. These residents remain uninsured despite eligibility for PMAP or MinnesotaCare for one of the following reasons:

1. Unaware of their eligibility for PMAP or MinnesotaCare
2. Aware of their eligibility but the perceived stigma attached to these programs discourages their enrollment
3. Aware of their eligibility for MinnesotaCare but cannot or will not make the financial commitment (premium) required for participation
4. Aware or unaware but perceive themselves as not needing health coverage.

Values Health will apply the AIDA (raise Awareness, create Interest and Desire, and motivate Action) communication/marketing concept for informing uninsured individuals of Values Health and MHCP. This will be achieved through:

1. Targeted mass media utilization
2. Communication with/through target population key informant/opinion leader interpersonal communication methods (providers, church leaders, educators, social service and financial aid workers, etc.)
3. Place-based communication at locations commonly frequented by target population (job service, churches, schools, grocery stores, etc.)
4. Communication at health care access points (ERs and other providers commonly used by uninsured for acute care, etc).
5. Outreach through organizations/entities serving target population (farmers' cooperatives and grain elevators, county extension agencies, landlords, utility companies, chambers of commerce, economic development agencies, banks, etc).
6. Communication at places of employment not offering health benefits.

Access and enrollment points. Access will be promoted through the strategies described above using marketing materials that make the program indistinguishable in terms of financing from other health insurance products. The enrollment access points include:

1. A central 1-800 call center
2. Point-of-Purchase. Enrollment information will be located at provider locations, including clinics, drug stores and hospitals. These providers will be educated on assisting uninsured individuals enroll in Values Health. Coverage commences on the date enrolled.
3. Health Fairs. PrimeWest will sponsor enrollment locations at health fairs and other community events attended by the target population.
4. PrimeWest. Uninsured individuals may enroll using the PrimeWest Web site, or with a PrimeWest member services representative, or at the PrimeWest offices located in Alexandria, Pipestone, Litchfield and Bemidji.

5. Churches, Schools and Employers. Individuals will receive Values Health enrollment information and assistance through trained church workers, school health, and employers as well as through periodic enrollment visits by PrimeWest member services representatives. Schools will be particularly receptive for often the school is a payer of last resort for children with special needs requiring mental health and social services to support education delivery, and in the absence of other coverage, the school is the primary payer.

Public program screening and enrollment assistance. Regardless of the entry point, screening for eligibility of public insurance programs (Medical Assistance, GAMC, MinnesotaCare, etc.) will take place, and enrollment assistance will be provided whenever possible. Program entrance will be coordinated by a consortium of managers from multiple systems, with oversight provided by the leadership of each system with support and coordination from PrimeWest.

Enrollment. Upon successful enrollment, the member will receive a Values Health new member packet. This packet will include:

- Values Health Member Identification Smart Card
- Certificate of Coverage
- Instructions and materials to make value-based decisions for maintaining wellness and accessing health care services/providers
- The Values Health Provider Network Directory.

A PrimeWest member services representative will then meet with the member to go over the information in the packet and provide instructions on the next steps: completing a Health Assessment and selecting a Health Care Home Provider.

Values Health Enrollment Projections. Enrollment in Values Health is projected to be 10,350. This would include 4,750 individuals expected to be enrolled at the start-up of Values Health. The remaining 5,600 individuals are expected to be enrolled in stages over the first 12 months of operation.

The current MinnesotaCare sliding scale would be adjusted to a target level where 80 percent of those now uninsured but eligible would elect to become enrolled. A new sliding scale for Values Health, the combined costs of the sliding scale premiums and maximum out-of-pocket costs under the Health Savings Account (HAS), and the comparative percent of income under the current MinnesotaCare sliding scale is proposed for Values Health pilot project.

MinnesotaCare Monthly Premiums (July 2007-June 2008)

Gross Monthly	MinnesotaCare Premium	Annual Income	% of FPG	Premium as % of Income
\$ 638	\$12	\$7,658	75%	1.9%
\$ 851	\$19	\$10,210	100%	2.2%
\$1,064	\$38	\$12,763	125%	3.6%
\$1,276	\$55	\$15,315	150%	4.3%
\$1,489	\$79	\$17,868	175%	5.3%
\$1,702	\$108	\$20,420	200%	6.3%

Values Health Covered Services

In an effort to gain a better understanding of what the residents of the Values Health service area desired in an uninsured program, PrimeWest conducted four meetings across the 10-county service area. Attendees were a mix of small business owners, uninsured individuals and community development stakeholders.

Benefits framework. The results of these meeting have helped guide the benefit set design. The goal of Values Health is to cover all care/treatment services, including certain wellness and prevention services that are not typically covered under most health plans, and any medically necessary acute services required outside these plans within a “value-based benefit set.”

In order to make enrollees cost-sensitive enough to make value-based decisions PrimeWest has designed a coverage program that financially encourages or rewards members for healthy and wellness behaviors and for choosing health care services that are evidence based and cost-effective. Individuals would still be able to purchase coverage for marginally beneficial interventions, but would have to use their own money to do so. Scientific, expert consensus, and cost-effectiveness data will guide the creation of a system of financial incentives, which will promote the use of high value interventions and discourage—but not prohibit—the use of low-value, marginal interventions. For example, interventions that are highly effective and that reduce overall health costs could be covered without copayments or deductibles. Conversely, low-value services that provide only marginal benefit at high cost would have high copayments or other forms of cost-sharing to reflect their limited value in the patient population.

Evidence-based practices. Limiting the overuse of inappropriate services and encouraging the use of clinically effective services can be hindered by the limited knowledge available to guide decisions. Based on community research and financial feasibility testing, PrimeWest determined that the MinnesotaCare benefit set best meets the criteria for an affordable/sustainable base set of covered services, if used with the value-based application standards, components and processes.

MinnesotaCare “Expanded” benefit set will apply to pregnant women and children, and the MinnesotaCare “Basic Plus Two” benefit set will apply to adults, subject to the following modifications:

- Copays, coinsurance, or other member cost sharing that would otherwise apply under the MinnesotaCare benefit sets will be replaced by cost sharing through the HSA feature (described in next section).
- A two-tier cost-sharing design will apply based on members’ options to participate in individualized wellness and care plans. Lower cost-sharing will apply for members who participate in their plans and higher cost-sharing for those who elect not to participate. The cost sharing will be administered through the HSA feature.
- Higher cost-sharing will not apply to members who are institutionalized or who are diagnosed with specified behavioral health conditions.
- MinnesotaCare benefits covered by the Minnesota Department of Human Services (DHS) on a fee-for-service basis, such as nursing home and ICF-MR services, will continue to be covered directly by DHS rather than through Values Health.
- If necessary to meet budget targets for Values Health, benefits may be reduced based on decisions reached through membership forums facilitated by PrimeWest.

The current comprehensive MinnesotaCare coverage is the Values Health starting point. A uniform benefit set is preferred to the various other MinnesotaCare benefits sets (Limited, Basic Plus, Basic Plus One) to simplify program administration (and reduce associated administrative costs), and to allow uniform application of an alternative cost-sharing design under the health savings account (HSA) model.

Tiered cost-sharing. The two-tier cost-sharing design is intended to give members a clear choice and stake in their own health while also contributing to long-term lower health care costs. Individualized wellness and care plans will be developed for each member based on their assessments and physical exams. Members who follow through on their individualized plans receive Values Health Points, which can be used to place them in a lower tier of cost-sharing. Conversely, members who elect not to pursue their plans receive the higher tier of cost-sharing because their actions/decisions may affect costs to other members. Members will be given educational and other support resources to help them follow their plans, but it will ultimately be a matter of choice.

Values Health’s Health Care Home

The Health Care Home (or Medical Home) model is an emerging reform trend designed to improve care outcomes in a cost effective manner. Care will be coordinated and/or integrated across all elements of the health care system, and will ensure that patients get the indicated care when and where they need and want it, and that it is culturally and linguistically appropriate.

Health Care Home Implementation

1. Create Health Care Home Structure Within the Values Health Provider Network

The Values Health Care Home designation and selection process begins by assigning each enrollee a Case Manager and PrimeWest Care Coordinator who specializes in health areas related to the enrollee's health issues identified through the health assessments.

2. Selection of Member's Values Health Care Home

Following the health assessment process, the enrollee's assigned PrimeWest Care Coordinator or Case Manager will work with the enrollee to select a specific primary care provider (PCP) from a list of qualified Health Care Home PCPs within the Values Health Provider Network. Qualified Health Care Home providers will include all local PCPs who agree to take an active role in enrollees' care and wellness management as defined by the American College of Physicians.

In selecting a Values Health Care Home provider, the enrollee, Case Manager and Care Coordinator will utilize the Health Care Home Match (HCHM) tool developed by PrimeWest. This tool involves a matrix that matches enrollee health information identified through the health assessment with the professional/practice characteristics of qualified Health Care Home PCPs gathered through a provider questionnaire by PrimeWest. Characteristics include the Health Care Home PCP's geographic location(s), practice interests/emphasis (e.g. pediatrics, women's health, sports medicine), most common referral providers (specialists, allied health professionals, and tertiary facilities), the hospitals where they have admitting privileges, and the PCP's overall cost of service rating.

As the Health Care Home concept involves more than just having a personal physician, HCHM departs from the traditional public program approach of selecting/assigning a PCP to an enrollee where the default selection/assignment criterion is often geographic proximity. While proximity is important, HCHM provides the enrollee additional information upon which to make a more weighted and informed choice of provider. Finally, by making a more involved effort in finding the "right" Health Care Home for themselves, enrollees are actually taking the first step toward more personal involvement, control and management of their own health and health care.

3. Values Health Care Home Provider Compensations

Qualified Health Care Home providers will be reimbursed at a higher rate for care plan services rendered to enrollees and also will be eligible for pay-for-performance (P4P) incentives tied to the enrollees' successful completion of care plan objectives. Care plan objectives will require the Health Care Home provider's active participation in coordinating services among various providers of services included in the plan in order to achieve the objectives and receive the P4P incentive. The higher reimbursement rate compensates for the additional work involved in being a Health

Care Home provider for enrollees and involves a fee-for-service payment methodology.

4. Values Health Care Home Provider Performance Standards

The effectiveness of each Health Care Home Provider will be objectively assessed on an annual basis. If the performance is sub-standard, PrimeWest will provide Values Health Care Home Providers assistance, support and resources to help them improve their effectiveness. Values Health Care Home Providers who consistently fail to meet their performance expectations and/or responsibilities will be discontinued and reimbursement rates returned to the lower standard level. New members will not be given this provider as a Values Health Care Home Provider option. Values Health members who previously selected the discontinued provider may continue using this provider or select a new Values Health Care Home Provider.

All Values Health Care Home Providers, regardless of effectiveness, will be re-designated every two years based on performance. Performance evaluation criteria include 1) quality of care using the PrimeWest Quality Management and Provider Credentialing programs that follow Minnesota Statutes and guidelines; 2) enrollee satisfaction; 3) overall care plan objective success rate across all enrollees under their care; and 4) overall level of cooperation in conducting Health Care Home provider responsibilities.

Values Health Care Coordination Model Overview

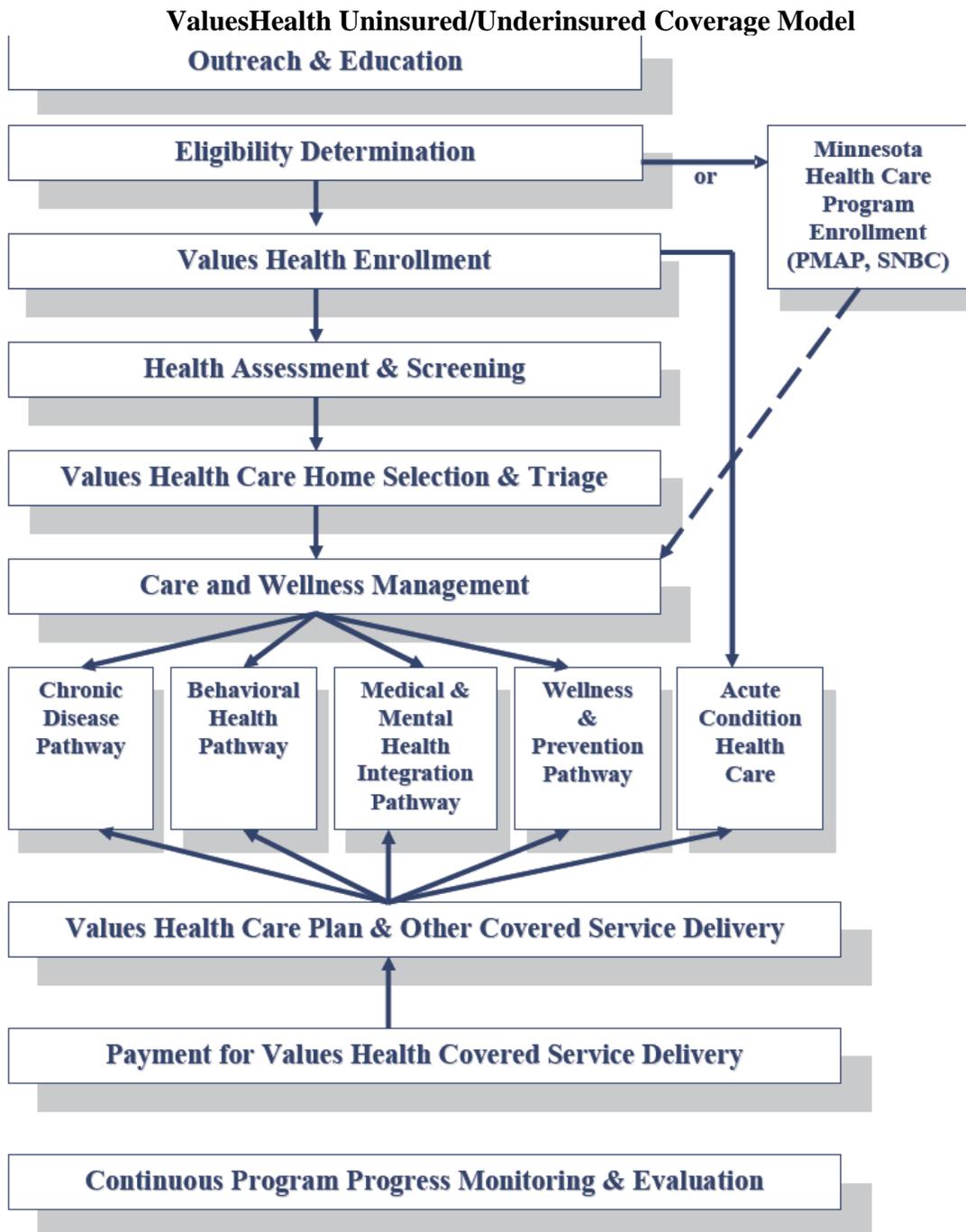
The Values Health Care and Wellness Management program will consist of the following elements and approaches:

1. Health Team formation
2. Triage
3. Care Plan Development
4. Care Coordination, including case management and disease management integrated with the Health Care Home
5. Integrated Service Delivery
6. Wellness and Prevention Service Delivery and Management.

Health Team. Values Health care coordination applies an interdisciplinary care management approach. The composition of the interdisciplinary team is based on the results of the member's health assessment. The Health Team includes the member, the Health Care Home provider, case manager and care coordinator. The Health Team may also include additional providers of services included in the member's Care Plan.

Triage. Once the health assessment results are shared with the Health Care Home provider, the provider, case manager and care coordinator will identify the most appropriate care management pathway for the member, and meet with the member to begin the individualized Values Health Care Coordination process and program. Based on the results of the assessment and triage steps, the Health Team will select the most appropriate care coordination pathway.

Care Plan and Care Coordination. Once the pathway has been selected, the Health Team, including the member, will develop the care plan. Care Plans are developed based on the assessments and include both medical and social services to address need and risk. PrimeWest-county organizational integration provides flexibility and diversity in coordinating care of participants.



Values Health Disease Management

Values Health will apply and integrate with the Health Care Home, a disease management (DM) process that complies with all aspects of professional standards.

The success of this approach requires a high level of interaction among a specific set of providers and stakeholders and with the patient's primary care provider serving as communications central. Rural health, by necessity, is streamlined and cost conscious and primary care based. Rural health providers often provide services with neighbor-like concern. Furthermore, rural health providers typically possess well-established and trusted referral networks with specialists/tertiary facilities that their patients prefer and produce positive outcomes. The result is a tight relationship among providers and between primary care provider and patient. All aspects of the DM effort will be reviewed on a regular basis with a constant goal to adapt to changes—to improve plans as well as performance.

Integrated Medical and Behavioral Health Services and Care Management

PrimeWest has already begun a broad-based integration program in the mental health, chemical health, primary care, social services, corrections and education systems, which will serve as a foundation for the integrated care model in Values Health. The first step in the integration process is the identification, when present, of mental health and/or chemical health disorders. Referrals for diagnosis and treatment, followed by open lines of communication between public system staff and mental health professionals will lead to effective treatment of the underlying disorders and to care coordination among the systems. The 10 PrimeWest member counties, with Prime West's support, are already initiating a plan to provide voluntary mental health screening for all clients seen in the corrections, social services, public health and special education (emotional/behavioral disorders) programs. The Values Health medical and mental health screening program is designed to dovetail into this process by utilizing the same screening and assessment instruments. The community's goal is to ensure that all of its citizens, regardless of their insurance status, have the opportunity to benefit from wellness interventions, and from diagnostic and treatment targeted toward their level of need.

Based on PrimeWest's work, the key components for integration and coordination of medical, mental health and chemical dependency care and service delivery include:

1. **Co-location** of mental health professionals and primary care clinics
2. **Consultation** between psychiatry or child and adolescent psychiatry and primary care physicians and advanced practice nurses will be an integral part of the program so that the primary care physician will have ready access for questions on assessment, diagnostic considerations, treatment possibilities, community resources, medication choices and risks of specific medications, and also the appropriate ongoing case management
3. **Collaboration or "Shared Care"** of the patient between psychiatry and primary care will also be a key component so that the patients with an identified mental illness are assessed to determine if they should be managed primarily by a primary care physician with access to consultation if needed, managed by psychiatry or other

- mental health specialty team members, or managed in a shared manner but with ongoing open communication.
4. **Continuing Medical Education** will be provided to the primary care physicians and advanced practice nurses on common mental illnesses.
 5. **Emergency Psychiatric Appointment Availability** will be available for adults and children and adolescents so that individuals who are being managed by the primary care physicians can be seen in a timely manner when their status rises to the emergent level.
 6. **Applications of Integrated Behavioral Health Care Model to Medical Conditions** will be implemented as broader applications to the identification and management of other chronic medical conditions as well such as diabetes, asthma and COPD, hypertension and heart disease, and also obesity.

Integrated Service Delivery

Values Health will organize its delivery model by integrating and coordinating providers and services around the member's wellness and health care needs. Many clients are served in multiple systems (e.g., educational, medical, mental health, corrections, social services), and services tend to be fragmented into "silos of care." This results in duplication of services, poor role definitions of various providers, redundancy of payments and inefficient service delivery. Values Health plans to integrate its service delivery on three levels: organizationally, operationally and cooperatively.

Organizational Integration

Values Health will be administered and governed by PrimeWest. PrimeWest is organized as a "Joint Powers" (multiple governments) and authorized to conduct County-based Purchasing (CBP) of health care services under Minnesota Statutes. CBP is the marriage of health plan or managed care organization (MCO) and county government. As a CBP, PrimeWest's health plan functions are organizationally integrated with the Values Health target counties. Such integration provides the optimum environment for coordinating care because of experienced county public health and social services case management resources. This also organizationally links PrimeWest to other county-sponsored services designed to improve and protect the quality of local residents' lives. The County-based Purchasing structure enables PrimeWest to deliver interdisciplinary case management services at minimal administrative costs without sacrificing the benefits associated with directly employed case managers.

Cooperative Integration

Local and regional providers of covered services are largely independent and/or private sector entities. While some providers offer a limited degree of service integration (i.e., integrated hospital and clinic), most are single service-type providers in nature (i.e., primary care clinic, critical access hospital, nursing home). This type of health system does not structurally lend itself to organization and coordination of a comprehensive set of services. Furthermore, many of these providers are competitors. In the absence of a shared organizational structure, PrimeWest has been cultivating another environment or process for managing care and coordinating services with private sector providers called "Cooperative Integration."

Administratively, cooperative integration provides a shortcut to health system development by flipping the health system paradigm. Traditional health care delivery has patients coming to the system, and, hopefully, that patient fits into the system whether integrated or not. Cooperative integration, on the other hand, fits and integrates the system according to an individual member's needs.

Values Health Wellness and Prevention Management

Another approach to be used in Values Health is emphasizing and re-aligning provider and member incentives around wellness and prevention. Currently, the difficulty in assessing the long-term value of wellness and prevention activities may serve as a disincentive for engaging in and supporting such practices. The return on investment may be too delayed to be a motivating factor for individuals, providers and payers alike to expend resources on prevention activities today.

Values Health believes investments in prevention will produce long-term improvements in individual health status and cost reductions that will benefit many in Minnesota, whether it is another payer, the provider, or state and local taxpayer.

PrimeFitness is an individualized fitness program, which will include exercise prescription, nutrition programming, and stress management using evidence based behavior modification techniques. Currently only the exercise component has been developed. PrimeWest's PrimeFitness team has planned and budgeted for the continued research and development of the other components, preparing for future implementation.

The goal of PrimeFitness is to address the *individual* needs of each enrollee through individualized education, guidance, empowerment and support. Collaboration will occur between PrimeWest members and their families, fitness professionals, PrimeWest network physicians, PrimeWest disease management coordinators, PrimeWest care coordinators, county public health directors and nurses, county case managers, community education directors and instructors, school district physical education and health education teachers, and directors of community exercise facilities.

Access and the Values Health Provider Network

PrimeWest's "inside-out" strategy of identifying providers for contracting and inclusion preserves, and builds upon, existing inter-provider professional relationships. PrimeWest first engages all local providers of covered services, and then engages non-local referral providers (typically specialists and tertiary facilities) where local providers most frequently refer patients. This strategy results in optimal local access to care and preserves existing referral relationships. Values Health will further enhance provider network development to support service coordination and care management delivered through its Health Care Home model. For example, certain Health Care Home providers will be sought out to be Centers of Excellence for specialty care of specific chronic diseases and other complex conditions.

Through the Center of Excellence, Values Health will balance enrollees' desire for choice of providers with the integrated structure needed for service delivery coordination and care management. Individualized care plans will detail the services the enrollee requires and will recommend the appropriate center of excellence as the provider of the specialized services. Although the center of excellence is reimbursed at a higher rate than other specialist providers in the network; the enrollee's share of the cost (deductible) will be less if they use the center.

Consumer Direction, Empowerment and Responsibility

Limited Time Spent with the Physician. Values Health's Health Care Home and Health Management Team approaches increases the number, duration and quality of interpersonal interactions between the enrollee and health care providers/professionals. The Care Coordination process ensures the efforts of the team and enrollee are focused and coordinated around achieving the mutually agreed upon care plan objectives.

Lack of Value Information. Values Health will provide both provider quality and price information to enrollees. Initially, the quality information will be a rating system broadly based on reimbursement rates. As the program matures, more service-specific pricing information based on claims data will be included.

The Values Health Savings Account

Values Health will incorporate a Health Savings Account (HSA) design. The HSA will serve as the primary cost-sharing mechanism to build consumer awareness and engagement of health care costs and value. The HSA will take the place of copayments that currently apply in MinnesotaCare. Cost-sharing through the HSA will also be used to reduce (but not eliminate) member premium cost-sharing through the MinnesotaCare sliding scale. The HSA will emphasize consumer engagement in the cost and value of health care at the point of service.

The Values Health HSA will be similar to commercial insurance plans in pairing the HSA with a comprehensive deductible—such as \$2,000. Above the deductible, all services are covered at 100 percent. The HSA will be used to fund a portion of the costs under the deductible on a shared cost or coinsurance basis. The majority of costs under the deductible will be paid through the HSA, but the member will share in a percentage of the costs up to the deductible. At the end of a plan year, unused balances in the HSA can be carried forward to apply to member coinsurance in future years. The size of the deductible and coinsurance percentages are intended to create reasonable incentives to consider the cost and value of care, but at levels consistent with member affordability to avoid creating disincentives for the use of care.

The Values Health HSA will be different from common commercial insurance plan HSA designs in the following ways:

1. **Varies by income tier** – The funding level of the HSA and the member coinsurance rates will vary by income tier, to ensure that care is accessible and incentives proportional to ability to pay. For example, the coinsurance rate under the deductible may be only 5 percent for members with incomes under 50 percent of the federal poverty guideline, with 95 percent of the HSA funded for them. The coinsurance rate would increase to 7.5 percent for members at 51-75 percent of FPG, up to 35 percent at the 326-350 percent of FPG.
2. **Varies by care plan participation** – Coinsurance rates will double for members who elect not to participate in their individualized care and wellness plans. For example, for lowest-income members, the coinsurance rate would increase from 5 percent to 10 percent and annual HSA funding would be correspondingly reduced from \$1,900 to \$1,800. At 326-350 percent of FPG, the coinsurance rate would increase from 35 percent to 70 percent, and annual HSA funding would be reduced from \$1,300 to \$600.
3. **Prevention and care plans excluded** – The deductible and HSA will not apply to specifically designated preventive and disease management check-ups and tests associated with individualized care and wellness plans. These services will be covered at 100 percent. The deductible and HSA will apply to hospital services, surgery, pharmaceuticals and professional services not specifically included in a member's care and wellness plan.
4. **Separate HSAs for each member** – To facilitate tracking of care and wellness plan participation, a separate HSA will be established for each covered person in a family, including children. To prevent a regressive impact on family affordability from separate HSAs for each individual, the premium sliding scale will be adjusted to diminish as a percentage of income with increasing family size (currently, the MinnesotaCare sliding scale has a percentage of income by family size).
5. **Minimal paperwork burden** – The HSA would be administered in a highly automated fashion, with minimal paperwork burden for members.
6. **For health care services only** – HSA balances would be applied only to services included in the benefit set. HSA balances could not be applied to supplemental health services that are not part of the benefit set, as is the case with certain Flexible Spending Account (FSA) plans.
7. **Portable within the region** – HSA balances would remain available to members leaving Values Health to fund their expenses under the deductible of commercial plans.

8. **Carry forward** – Unused balances in members’ Health Savings Accounts would carry forward to the next Plan Year. These carry forward balances are applied to reduce the coinsurance rate that would otherwise apply.

Consumers tend to be relatively unaware of the costs of health care. Use of Health Savings Accounts within Values Health is intended to make consumers more aware of the costs and value associated with health care services. It is also intended to provide a tangible and meaningful incentive to participate in the individualized care and wellness plans.

Empowering Members through Information, Education and Culture

For individuals to accept and assume greater personal responsibility for their wellness and health care choices, they must have the knowledge, training and self motivation to carry out their responsibilities. The HSA, copay, deductible and Values Health Points program will provide value incentives. The Values Health Provider Directory will be in a simple, value-based format, including brief information regarding the various providers’ health emphasis/specialties, and quality/cost information using the star rating system.

Values Health Financial Management and Costs

Provider Reimbursement Structure

Values Health proposes a value-based provider reimbursement structure that mirrors the individual’s, community’s, and state’s desires to provide health care services that maintain the highest level of health and wellness in a cost-effective manner. This approach requires providers to do more and/or do things differently, therefore the reimbursement structure must also do more and in different ways in order to support those providers. The Values Health proposed budget accounts for this exchange, and is the driving force behind why Values Health’s health care costs may *initially* exceed MinnesotaCare costs associated with providing health care to the same size population.

1. All Values Health Network Providers start at the base PrimeWest MinnesotaCare reimbursement schedule, which is higher than the state fee-for-service (FFS) schedule.
2. Network Providers of demonstrated value-based health care delivery (realized or potential) will be paid based on a percentage of charges or other desired methodology adequate enough to ensure profit if care is delivered in an optimal and cost-effective manner.
3. Health Care Home Providers and Centers of Excellence Providers will be reimbursed in the same manner as #2 above, but will receive incentive or pay-for-performance (P4P) for carrying out specific additional functions appropriate to their special provider designations and for meeting mutually agreed upon performance objectives, including members achieving their care plan objectives. In developing this payment

methodology, PrimeWest spoke with numerous providers regarding its efficacy, and the support was overwhelming.

Multi-Share Financial Model

Values Health plans to use a health care financing model similar to that employed by *Access Health*, a successful community health coverage program in Muskegon, Michigan. *Access Health* utilizes a three-share approach to financing the participant benefit set: individual, employer and community. To compensate for the financial resources that were available in Muskegon, Values Health proposes a “four share” approach, with the state being the fourth share. This multi-share arrangement adequately finances health coverage and establishes a vested interest in the program’s ongoing success by all those who benefit.

Individual Share. The individual’s share of the Values Health multi-share model does not directly finance the program but will be directed to the member’s HSA, which will encourage more cost-effective utilization of health care services and reduce overall health care spending.

Community Share. The community share cannot be projected at this time, but Values Health intends the Community Share to be:

- A share in the savings derived from a reduction in provider uncompensated care attributable to Values Health
- A share of health care cost savings realized by counties attributable to Values Health. For example, reduction in county health care costs incurred by inmates of the county jail.
- A share of the State Provider Tax generated by local Values Health Network Providers would be used to fund incentives for value-based health care delivery.
- Consolidation of uncompensated care programs. For example, integrating Values Health with counties/communities charitable uncompensated care fund programs.
- Organized fundraising
- Surplus revenues realized through PrimeWest/Values Health operations.

Employer Share. The Employer Share of Values Health will:

- Create incentives for employers who do not offer coverage now to do so in a more affordable way.
- Assist employees to participate in employer-sponsored plans where it would otherwise be too expensive for them to do so.
- Reduce the total costs of Values Health by leveraging potential employer subsidies.
- Support job retention, lower turnover, and promote general economic development by enabling employers with a high proportion of lower-income workers to offer health coverage.

Based on the experience of the Muskegon program and other initiatives, many employers are interested in sponsoring health coverage but cannot afford to do so. Under Values Health, employers who do not currently offer health coverage will have the opportunity to sponsor

coverage that would be branded as their own employee benefits program. Qualifying employees with lower incomes (under 350 percent of FPG) would be eligible to receive a coverage subsidy through Values Health, and the employer must also contribute toward the cost of coverage as follows:

Employee Income	Monthly Employer Contribution
100% of FPG or less	\$40
101 – 150% of FPG	\$60
151 – 200% of FPG	\$80
201 – 250% of FPG	\$100
251 – 300% of FPG	\$120
301 – 350% of FPG	\$140

The employer contribution will be 25 percent in order to reduce the employee contribution that would otherwise be required under the Values Health sliding scale. The other 75 percent would be allocated to reduce the remaining costs of the coverage subsidy. Employers with a high proportion of lower-income employees are most likely to participate in the program, since no subsidy would be available for employees with incomes above 350 percent of FPG.

For employers who do offer coverage now, the only category for which erosion is likely to be a significant concern are those which are locally owned and have a high proportion of lower-income employees. Employers that are regionally or nationally owned and/or with multiple locations are less likely to discontinue coverage based on the availability of Values Health, since most such employers prefer to maintain a uniform corporate benefits program across all locations. For locally-owned employers with a range of employee incomes, it is also less likely that erosion would occur since this would mean dropping coverage for higher income as well as lower-income employees.

To the extent that some locally-owned employers with mainly low-income workers did elect to participate in Values Health rather than maintain their own benefits program, this would be an acceptable trade-off to promote broader employer participation across other categories. This concern is mitigated by the fact that, in general, employers with mainly low-income workers are less likely to offer health coverage at all. Nonetheless, Values Health will enforce employer participation standards that discourage migration of employers from existing private coverage to Values Health.

State Share. The following financial summary provides preliminary estimates of expected costs and savings, including costs to cover those currently eligible for MinnesotaCare.

Preliminary Financial Estimates (5 Year Budget) \$43,136,630¹⁰

Enrollment and Premium ¹¹

Full Enrollment ¹²	\$	10,350	
Premiums PMPM ¹³		373,360	
Premium Revenue – Annual		46,383,473	100%
Enrollee Share of Premium ¹⁴	\$	3,512,661	7.6%
Employer Share of Premium ¹⁵		993,600	2.1%
State Share of Premium		41,877,213	90.3%

Expenses and Savings

Administrative Expenses¹⁶ \$ 3,246,843

Medical Expenses - Baseline¹⁷ \$ 43,136,630

Targeted Savings¹⁸

Medical Expenses Savings – Short Term	\$	2,156,832	5.0%
Medical Expense Savings – Medium Term		4,313,663	10.0%
Medical Expense Savings – Long Term		6,470,495	15.0%

Health Care and Premium Costs

The Values Health program will incorporate features to improve member health and wellness, management of chronic conditions by providers and members, and more efficient use of health care resources. On a per member basis, these reforms are projected to result in medical expense savings in the range of 5-10 percent in the short term, with the potential for 10-15 percent over a longer period. Given the number of program design changes and innovations recommended, the savings estimate is rough.

Compared to standard MHCP levels, administrative costs to implement new program features are projected to increase in the range of 10-15 percent. Based on a standard MHCP ratio of

¹⁰ \$23m would be new funding from the state for higher enrollment in MinnesotaCare (\$13m) and \$10m for an increase in sliding fee reimbursement for participants.

¹¹ For first year of operation at full enrollment. Costs based on 2007 experience with no trend factor.

¹² Full enrollment subject to timing of transition from current program enrollment, outreach efforts, and other factors. Full enrollment includes members formerly on MinnesotaCare and GMAC, uninsured currently eligible for MinnesotaCare or GAIV and uninsured eligible for Values Health based on expanded MinnesotaCare eligibility criteria.

¹³ Based on MinnesotaCare benefits with projected Values Health enrollment mix.

¹⁴ Based on alternative sliding scale proposed for Values Health, and estimated income tiers by eligibility category.

¹⁵ Based on estimated 10% of members sponsored by employers, at average \$80 PMPM.

Significant additional enrollee cost-sharing would be associated with Health Savings Account benefit design.

¹⁶ Based on 7.0% of premium, based on administrative cost estimates for Values Health Program features.

¹⁷ Based on 93.0% loss ratio.

¹⁸ Based on increasing impact over time of Values Health Initiatives and design features to achieve efficiencies.

approximately 90 percent medical expenses to 10 percent administration, this would offset medical expense savings in the range of 1-1.5 percent. Program reforms to enhance access to care, such as increased outreach, expanded eligibility criteria, and a more affordable sliding scale, will also require increased administrative expenditures and premium subsidies.

Enrollment Projection

Single Plan. To be implemented effectively, it will be necessary for Values Health to be the single plan serving eligible members in the 10-county region. This structure is already in place for the majority of Minnesota Health Care Programs (MHCP), including Medicaid, General Assistance Medical Care, and Minnesota Senior Health Options. Single-plan administration would be extended to MinnesotaCare and the expanded eligibility proposed for Values Health. Single-plan administration is necessary to ensure the effectiveness and continuity of incentives targeted to members and providers. Consolidated administration also allows more efficient administrative investments across the relatively small populations in a rural area.

Enrollment Categories. Based on single-plan administration, enrollment in Values Health is projected to include:

- 4,300 now enrolled in PMAP (Prepaid Medical Assistance Program, or Medicaid)
- 450 now enrolled in GAMC (including “transitional MinnesotaCare”)
- 3,200 (80 percent of those now uninsured but eligible for MinnesotaCare)
- 1,250 (80 percent of those now uninsured, eligible for employment-based coverage, and for Values Health program under expanded criteria)
- 1,150 (80 percent of those now uninsured, not eligible for public or employment-based coverage, but eligible for Values Health program under expanded criteria).

10,350 total projected enrollment

At start up of Values Health, 4,750 are expected to be enrolled. The remaining 5,600 are expected to be enrolled in stages over the first 12 months of operation, reaching full enrollment of 10,350 at the end of the first year.

Sliding Scale. As shown, to expand access to coverage, the current MinnesotaCare sliding scale would be adjusted to a target level where 80 percent of those now uninsured but eligible would elect to become enrolled. A portion of the additional subsidy expenditures for current MinnesotaCare enrollees would be recouped through member cost sharing in the Health Savings Account benefit. Additional expenditures would be required for members currently eligible for MinnesotaCare but not enrolled, as well as for expansion of eligibility up to 350 percent of FPG and removal of restrictions related to assets and employment status.

Premium Costs

The Values Health program will include a blend of members currently enrolled in GAMC and MinnesotaCare, and currently uninsured individuals. Compared to current MHCP enrollees, the uninsured have a higher proportion of adults and fewer children. As a result, average costs for the blended population will be somewhat higher based on demographic differences. A preliminary estimate of the average total premium is in the range of \$360-\$380 per month. These

total costs are based on current MHCP benefit designs, standard service volumes and price ranges, and administrative costs. The net savings projected for Values Health are 5-10 percent over the short term, and 10-15 percent over a longer period.

Benefits

The following are the primary benefit design differences for the Values Health program compared with the standard MinnesotaCare benefit design:

- Coinsurance tied to income tiers would be paired with a \$2,000 deductible and HSA. Designated preventive care and individualized care and wellness plan services would be covered 100 percent and excluded from cost sharing.
- The coinsurance would double for members who elect not to participate in their individualized care and wellness plan. This is intended to provide a strong incentive for participation, and has been shown to be effective in the Muskegon plan.
- All members would receive a physical exam and health assessment upon initial enrollment. The results would be used for development of individualized care and wellness plans. The provision of these services, and tracking individual participation in care and wellness plans, represent a significant additional expenditure compared to standard MinnesotaCare benefits. These services would include a mix of health care and administrative expenses.
- If total savings were not achieving budgeted targets, a CHAT community exercise would be applied to trim benefits to reach budget target, consistent with members' standards and priorities.

Premiums/Funding

Primary premium funding will be based on the same formulas currently applicable to MinnesotaCare. Members in Values Health will contribute to the costs of premiums on a sliding scale basis. The design of the sliding scale will be modified to reduce barriers to entry in the form of initial enrollment, while increasing coinsurance through the HSA benefit design feature. Employers will also contribute to premium costs through the opportunity to brand Values Health as an employee benefits program, with a minimum required employer contribution for lower-income employees who qualify under the sliding scale. Finally, community grants and donations will be solicited to meet unique needs and circumstances of individual members to maintain continuous enrollment and care/wellness plan adherence.

Administrative Costs

Administrative cost reduction and health care cost containment are key objectives for Values Health. Potential administrative cost-saving components identified to date include:

1. **Administrative Economy of Scale** – Because PrimeWest already serves these same 10 counties' prepaid MHCP populations, many of the fixed costs associated with conducting a program like Values Health are already accounted for in the present

PrimeWest budget. PrimeWest's current administration costs average around 9 percent of total revenues annually, placing it among the most cost-efficient health plans in the state. Projected administrative costs due to economy of scale alone will be significantly less than 9 percent.

2. **Portable Electronic Medical Records** – Portable electronic medical records (EMR) through Values Health identification smart cards will reduce reporting and utilization review administrative costs and potentially reduce health care delivery costs by helping to prevent duplication of services among various providers involved in a participant's care and treatment.
3. **Electronic Data Interface** – 100 percent Provider Network electronic data interface (EDI) between provider and PrimeWest, which includes electronic claims submission, transparent adjudication, remittance advice and payment through electronic funds transfer. A condition of provider participation will be the ability to submit claims electronically. PrimeWest is already working on providing its entire provider network web-based electronic claims submission and adjudication monitoring access, which will make EDI a reality for even the smallest provider entity.
4. **Health Care Home and Case Management** – Because the PrimeWest Care Coordination model is built upon county case management working in coordination with Health Care Home Providers, PrimeWest requires no employed case managers and fewer care coordination personnel than is typical among managed care organizations and health plans, which reduces administrative personnel costs without compromising member contact and care management quality.

The budget is based on Values Health being administered in the manner PrimeWest currently administers MHCP and the ability to integrate the program into PrimeWest without additional regulatory requirements beyond those now satisfied by PrimeWest. Additional requirements such as special program reporting, state-mandated performance improvement projects, any Values Health withhold criteria either blended with MCHP or stand-alone, Minnesota Department of Health pre-operation approvals and so on will dramatically increase administrative costs, especially in the first two to three years of operation. According to PrimeWest financial management analysis, over 50 percent of its administrative expenses are directly attributable to complying with state statutes and DHS MHCP contract provisions.

The projected administrative cost to administer the Values Health program for approximately 10,000 members is \$3.3 million in year one, including all necessary program administration personnel and support systems. This is approximately 7 percent of projected revenues. The Year One administrative expenses are likely to be the highest as the program purchases/deploy necessary technology (e.g., smart cards) and develops the value-based system expertise and delivery infrastructure. Further, this administrative budget includes expenses that may be considered health care and/or capital under general accounting standards, which if applied, would further reduce the actual administrative expense-to-revenues ratio. The administration-to-

expense ratio is expected to range around 5-6 percent in subsequent years of operations. This is significantly below the MHCP health plans' average administration expense-to-revenue ratio.

Values Health Program Evaluation and Monitoring

Values Health's goal is to identify and quantify all of the costs, savings and health outcomes associated with maintaining wellness while providing services to members in as many places and service areas as possible. In order to accomplish this, Values Health will use a predictive model that can be used to compare the actual cost of services provided to uninsured residents to the cost of services they would be expected to incur if they had not received services through the program. In addition, based on the initial baseline data collected through the health risk assessment and physical exam, this predictive model would allow program evaluators to compare health outcomes that are observed as a result of providing health care services to the uninsured with health outcomes expected for those same individuals if they had not received health care services.

ACCESS

- 1. MHCP enrollment**
- 2. Provider participation**

OUTCOMES

- 3. Screening and education**
- 4. Care and wellness plans**
- 5. Mental health integration**
- 6. General service integration**
- 7. Improve member health**
- 8. Improve quality of provider services**

COSTS/VALUE

- 9. Lower service costs**
- 10. Uncompensated care costs**
- 11. Work absenteeism**

ENGAGEMENT

- 12. Personal health record (PHR)**
- 13. Member and stakeholder satisfaction**
- 14. Employer participation**

Conclusion

While many pilot projects to cover the uninsured are designed to close specific gaps in health coverage, they also add complexity to an already complex health coverage environment. Instead of creating a new program to fill a gap, the expanded and redesigned MinnesotaCare Program, as envisioned by PrimeWest (Values Health), provides continuous health coverage to a great number of low-income and uninsured residents who will not be disrupted even as their circumstances and eligibility changes.

PrimeWest assessed the approaches in the Values Health model for plausibility and feasibility. Plausibility was assessed through research of various health reform approaches and/or based on PrimeWest's experience in applying the approaches in serving its current Minnesota Health Care Program members. The capacity and financial feasibility of the model are main contributors to the administrative cost efficiency of the model. PrimeWest also studied the feasibility of applying recommendations emerging from the Legislative Commission on Health Care Access and the Governor's Transformation Task Force, many of which are consistent with the Values Health approaches or within the PrimeWest operational capacity to implement. In addition, a preliminary financial and actuarial analysis was conducted for the model, and the analysis produced a financial feasibility/sustainability threshold that accounts for the four-share revenue streams and anticipated health care costs. If funded at the proposed level during the pilot phase, Values Health will be financially viable during the pilot phase and sustainable with little or no additional state funding after the pilot phase concludes.

PrimeWest is confident that Values Health will provide access to high quality, medically necessary health care that emphasizes personal responsibility and prevention and optimizes the management of existing chronic disease if all stakeholders embrace change and invest adequate time and resources to enable Values Health to mature and evolve.

