



“Values Health”

*Insuring the wellness and covering the care of the
uninsured and underinsured*

PrimeWest Health, Alexandria, Minnesota

Abstract

Premise

- The **growing number of uninsured individuals** in Minnesota creates serious problems for those who are not covered, for health care providers who treat individuals without getting paid, and for the state's population as a whole, who must absorb the cost of treating the uninsured either through increased private insurance premiums or increased enrollment in publicly funded health care programs and providers.
- The problem of the uninsured is one symptom of a **health care system in crisis**. More and more individuals and businesses cannot afford health care, and government alone cannot afford to step in to help. Economic access to health care can only be assured by **addressing the underlying problems in health care finance and delivery** that are increasing the number of uninsured and decreasing the value of the health care dollar, two inescapably related trends.
- Values Health will test the proposition **public-private community partnerships**. If individuals, communities, private businesses and government work together cooperatively to reengineer the health care system, then 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**.
- Value Health **extends health care coverage** to the growing number of **individuals who cannot private insurance yet are ineligible for publicly funded programs** such as Medicaid and MinnesotaCare.
- As a health plan owned by 13 rural Minnesota counties, **PrimeWest Health** is uniquely positioned by its **community-based ownership and local proximity** to administer and govern the program in a community-responsive and cost-effective manner.

Development Background

Values Health is rooted in the grass of Greater Minnesota, starting with community support and participation of 13 county governments, nine hospitals, 32 local employers that collectively provide over 700 jobs, 10 integrated multi-specialty and primary care clinics/physician groups, 10 school systems and a third-party payer, PrimeWest Health. The group formed the West Central Minnesota Community Collaborative to Cover the Uninsured. The architects of Values Health include experienced and highly qualified health care administration, system development, finance and delivery, and policy experts.

Guiding Principles

The name of the 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 Values Health model:

- Access
- Affordability
- Accountability
- Wellness and prevention
- Choice
- Personal Responsibility
- Portability
- Consumer-directed
- Consumer empowerment
- Quality and optimal care outcomes
- Integration
- Transparency
- Evidence-based
- Health care finance reform
- Equity
- Competition
- Individual or patient-centered
- Continuity
- Outcome-oriented
- Private-public partnership
- Universality

The Values Health model is constructed upon two value-based health care premises:

1. The cost of health care should relate directly to the level of health care quality (patient’s health care experience and care/treatment 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/treatment outcomes in the most cost-effective manner.

Model Overview

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**
 - Extends coverage to 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 and education and support, including health care consumerism and effectively navigating the health care system for greatest value.
2. **Health Assessment and Screening**
 - Comprehensive health status and health risk assessments (medical, mental health, chemical dependency, social, wellness)
 - Early identification of health conditions and health risks
3. **Care Coordination and Service Delivery**
 - Triage and care coordination pathways
 - Interdisciplinary care management
 - Health Care (medical) Home

- Outcome-based care planning and care plan service delivery
- Disease management
- Integrated medical-mental health care management/service delivery
- Evidence-based medicine
- Individualized wellness and prevention management
- Cooperative integration of health care providers
- Centers of excellence
- Consumer-directed provider choice and service delivery
- Value-based provider/service utilization decision making
- Electronic medical records interconnectivity
- Real-time service utilization tracking (through smart card technology)
- Workplace environmental health improvement
- Provider and member accountability

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 co-pay and deductible schedules
- Payer accountability
- Administrative efficiency

The Values Health model applies commonly desired health care values and an integrated set of proven health care delivery and finance approaches to achieve the following:

Access to care through a set of covered health care services comparable to both public and private health coverage programs for uninsured and underinsured individuals.

Integration of medical care, mental health care, wellness and prevention, county public health, county social services, other county and local community resources, and school and worksite health services to give people the help they need to maximize their health and independence.

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.

Value-based health care and provider information that helps people make wise decisions about their health and health care service utilization/purchasing.

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.

Electronic Health Information Technology, including tele-health, consumer web-based access to information to support wellness and efficient health care delivery, and Participant Identification Smart Cards for portable electronic health information; inter-coverage program transferability; and individual out-of-pocket health care cost payment tracking and recordkeeping.

Transparency to allow all stakeholders to view the financial and operational components of Values Health.

Accountability facilitated by transparency to ensure Values Health operates within the intent of public interest and the wise-use of public resources, holding the health plan, the health care provider and health care consumer accountable for patient wellness and care/treatment outcomes..

Portability to provide program participants a safety net of coverage in the event disenrollment from Values Health due to life changes.

Consumer empowerment that provides the consumer a vested and informed role in personally maintaining his/her health and utilizing health care resources appropriately, including Health Savings Accounts.

Adaptability to allow the pilot project model to be used in a wide variety of community settings, including both rural and urban areas.

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, state and federal tax bases.

Cost-effective administration to ensure more dollars for health care and less on program administration.

Financing

“Multi-Share” Financial Model: Values Health proposes to utilize a “four-share” approach to financing utilizing individual, employer, community, and state and/or federal government contributions.

- The **individual’s** financial commitment will be determined through a **sliding fee scale** determined by the individual’s verifiable income status.
- Participating **employers’ financial contribution** also will be on a sliding fee scale based on the size and audited financial position of the company.
- The **community’s** share will include money raised through financial commitments from health care providers, local government, civic organizations, and individual and organization benefactors.
- The **state and/or federal** portion would come through funds available for advancing health care reform and health care coverage for all residents.

Program Performance Monitoring

Values Health will identify and quantify all of the outcomes, costs and savings associated with providing services to the uninsured in as many places and service areas as possible. Evaluation measures include: demographic and socio-economic enrollment data, 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.

Conclusion

Values Health will provide continuous health coverage to a greater number of uninsured residents that will not be disrupted even as circumstances and eligibility changes. Values Health integrates proven wellness, health improvement, and health care delivery approaches to improve individual health status and treatment outcomes and the value of the health care dollar spent to achieve these outcomes.

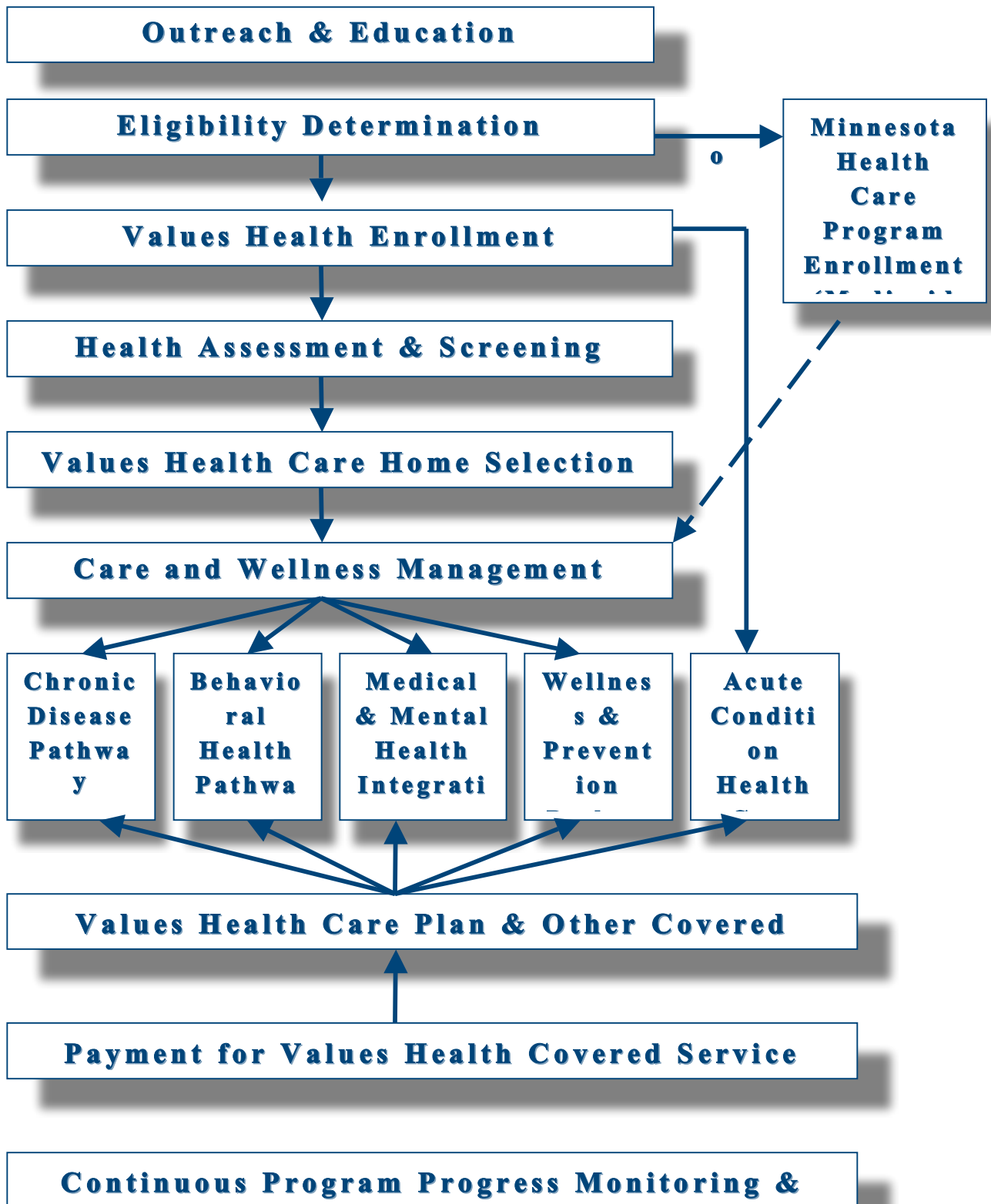
Approaches contained in the Values Health model have been assessed for plausibility and feasibility. Plausibility was assessed through research of various health reform approaches and/or based on PrimeWest Health's experience in applying the approaches in serving its current public program members (Medicaid, Medicare Advantage and MinnesotaCare). Both the capacity and financial feasibility of the model were also assessed. PrimeWest Health already is either applying the approaches contained in the model or has the infrastructure to implement such approaches -- many of which are now emerging as reform recommendations at the state and national levels. 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. The analysis showed a strong likelihood of cost containment and reduction over the first five years of the program. If adequately funded at during the first five years, Values Health could remain financially viable with reduced state and/or federal support.

In order for Values Health to succeed as a value-based coverage program for the target population, stakeholders must embrace change in how we approach health, how we use health care services, how we deliver them, and how we pay for them. In essence, the consumer, provider, employer and policy maker must demonstrate he/she *values* health – and not just health *care*, and if we truly do, then assuredly the personal and financial cost of sickness will go down.

For the complete Values Health description, contact:

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The Values Health Uninsured/Underinsured Coverage Model



Values Health

The Four-Share Financing Model

