Models of Care

PrimeWest Health

Special Needs Plans

PrimeWest Senior Health Complete (HMO SNP)

*PrimeWest Health’s Minnesota Senior Health Options (MSHO) program for members with Medicaid and Medicare through PrimeWest Health*

Prime Health Complete (HMO SNP)

*PrimeWest Health’s Special Needs BasicCare (SNBC) program for members with Medicaid and Medicare through PrimeWest Health*
Approval and Changes

• PrimeWest Health’s revised Models of Care (MOC) were approved by the Centers for Medicare & Medicaid Services (CMS) in 2020; approval is through the end of 2020.

• 2020 changes include:
  – Updated organizational chart
  – Updated position descriptions
  – Updated process by which counties communicate county case manager assignments to PrimeWest Health
  – Updated process to show care plan signature page is a required care plan attachment
  – Removed unnecessary language related to MnCHOICES certified assessor training
  – Updated to show inpatient notifications are now communicated to counties daily via secure file transfer protocol
  – Added the Post-Hospitalization Home-Delivered Meals supplemental benefit
## Chapter 1: Description of the SNP Population

<table>
<thead>
<tr>
<th>PrimeWest Senior Health Complete</th>
<th>Prime Health Complete</th>
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</thead>
<tbody>
<tr>
<td>• Age 65 or over</td>
<td>• Ages 18 – 64</td>
</tr>
<tr>
<td>• Eligible for Medical Assistance (Medicaid) and Medicare parts A and B or Medical Assistance (Medicaid) only</td>
<td>• Eligible for Medical Assistance (Medicaid)</td>
</tr>
<tr>
<td>• Resident of a PrimeWest Health county</td>
<td>• Resident of a PrimeWest Health county</td>
</tr>
<tr>
<td>• Eligible to enroll in Minnesota Senior Care Plus (MSC+)</td>
<td>• Certified disabled or developmentally disabled</td>
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PrimeWest Senior Health Complete Member Characteristics

- Average age is 83
- Single (widowed)
- White
- Female (73.36%)
- English-speaking
- Below the poverty level (all PrimeWest Senior Health Complete members are Medical Assistance [Medicaid]-eligible)

- Top five medical conditions:
  - Cardiovascular
  - Neurological
  - Mental Health
  - Respiratory
  - Diabetes
- 94.5% have two or more medical comorbidities
- Average of 10 prescriptions

- High probability of receiving additional Home and Community Based Services (HCBS), such as homemaking and Meals on Wheels, to allow the member to live in a community setting and avoid institutionalization
- Potential for physical or emotional problems affecting social activities
- 25% take high-risk medications
- 59.44% have a mental health diagnosis
- 5.02% have a substance use disorder
- 62% live alone in the community
PrimeWest Senior Health Complete Member Characteristics (continued)

- 84.8% do not smoke
- 74.7% do not use the Internet
- 60% have high school education or greater
- 21.4% have 8th grade education or lower
- Lower than the national average probability of having caregiver support
- High probability of difficulty walking
- High probability of transportation issues
- Perceives excellent and timely access to necessary services, including primary and specialty care and Part D
- Low probability of overutilization of services
- Ranks chosen county case manager and/or PrimeWest Health care coordinator as helpful with member concerns (over 98.5% satisfaction)
PrimeWest Senior Health Complete Member Characteristics (continued)

- Very low probability of identified gaps in service provision between Medicare and Medical Assistance (Medicaid) services
- 23.4% experience acute care transition
- 10.3% experience a transition into a Skilled Nursing Facility (SNF)
- 15% have diagnosis of hearing loss (1% tinnitus)
- High probability of rating quality of life as excellent to very good
- 33% have diagnosis of dementia
- 5% have diagnosis of a developmental disorder
- 50% have some form of visual impairment
- 10% have glaucoma
- 18% have cataracts
Prime Health Complete
Member Characteristics

• Average age is 51
• Single
• White
• 53.88% are female
• English-speaking
• Below the poverty level (all Prime Health Complete members are Medical Assistance [Medicaid]-eligible)
• 76.60% have a mental health diagnosis
• 44.06% have two or more chronic conditions
• Average of nine prescriptions
• Low probability of having a chemical health concern
• High probability of living in a community setting
• High probability of receiving additional non-health plan-covered waiver services from the county of residence
• Potential for physical or emotional problems affecting social activities
• 82.8% have three or more chronic conditions
• 57% reported they do not smoke
Prime Health Complete Member Characteristics
(continued)

• 4% have lower than an 8th grade education
• 86% have graduated from high school
• High probability of difficulty walking
• Lower than the national average probability of having caregiver support
• Very low probability of identified gaps in service provision between Medicare and Medical Assistance (Medicaid) services
• 55.1% have a diagnosis of hypertension

• Perceives timely access to necessary services, including primary and specialty care, above the Minnesota average
• Ranks chosen county case manager and/or PrimeWest Health care coordinator as helpful with member concerns (over 98% satisfaction)
• High probability of rating quality of life as excellent to very good
Prime Health Complete Member Characteristics (continued)

- 41% have a diagnosis of arthritis in knee and/or hip
- 31.4% have a diagnosis of diabetes
- 46% reported they needed help with transportation
- 4% are identified as having a diagnosis of hearing loss
- Probability of perceiving their overall mental or emotional health to be unchanged from previous year
- 17.9% have episode of acute care admission
- 5.6% experience an SNF placement
Most Vulnerable Sub-Population

- This population is identified by the following:
  - Frequency of hospitalization
  - Readmissions to the hospital within 30 days of discharge
  - Lengths of stay greater than four days
  - Six emergency room visits in previous three months
  - 10 or more office visits in previous three months
  - $100,000 or more in medical expenses (includes pharmacy), including hospitalization in the last year
  - Three or more chronic conditions
Chapter 2: Care Coordination

• The first section of this chapter identifies all key staff, describes their roles and responsibilities, and outlines the training provided on the MOCs

  − Administrative: enrollment, Member Services, claims, pharmacy benefit manager, Appeals and Grievances, and provider relations
  − Clinical: care coordination, county case management, disease management
  − Administrative/clinical oversight: medical directors, Care Management, Quality & Utilization Management, site visits, Manager of Reporting & Data Analytics, Performance Improvement Project (PIP) Coordinator, utilization management, Corporate Compliance/HIPAA Privacy Officer
Chapter 2: Health Risk Assessment

- PrimeWest Health uses four assessment tools to identify the specialized needs of our members
  - PraPlus
  - Long-Term Care Consultation (LTCC)
  - PrimeWest Health Person-Centered HRA (PWH-HRA)
  - Skilled Nursing Facility (SNF) Comprehensive Assessment Tool

Each tool is standardized, reliability tested, and validated to meet State and/or Federal criteria for all our members.
Chapter 2: Person-Centered Individualized Care Plan

- This section defines the following:
  - Personnel developing the person-centered individualized care plan
  - Essential elements of the care plan
  - Care plan review and frequency
  - Care plan documentation and maintenance process
  - Communication of the care plan
Chapter 2: Interdisciplinary Care Team

• PrimeWest Health utilizes an interdisciplinary approach to ensure comprehensive and holistic services to our SNP members

• This section defines the following:
  – Composition of the Interdisciplinary Care Team (ICT)
  – Facilitation of members’ participation in the development of their care plan
  – Operation and communication of the ICT
Chapter 2: Care Transition Protocols

- PrimeWest Health follows approved transition of care policies, procedures, and protocols to ensure continuity of care for SNP members. Each member is assigned a county case manager/care coordinator who is responsible for identifying that a transition is pending or has occurred and then facilitating a safe transition. PrimeWest Health’s contracted providers are required to notify PrimeWest Health of planned and/or unplanned transitions of care within 24 hours of the transition.
  - Description of personnel responsible for coordinating the transition
  - Process of accessing protected health information (PHI) to facilitate communication
  - Member education about conditions and development or improvement of self-management activities
  - Communication with identified point of contact
Chapter 3: Provider Network

- PrimeWest Health provides a contracted comprehensive network of primary care providers, specialists, and facilities with the specialized clinical expertise pertinent to the targeted special needs population for the provisions of diagnostics and treatment.

- Network monitoring through:
  - Credentialing and recredentialing of practitioners
  - Assessment of organizational providers that includes a system of communication and care coordination
• This chapter outlines the following:
  – Specialties that make up our provider network
  – Member access to the provider network
  – PrimeWest Health’s licensing and competency determination
  – Organizational provider network oversight
  – Individual practitioner oversight
  – Coordination of services and specialized services for the special needs population
  – Network coordination with the ICT and member
  – Evidence-based, nationally recognized clinical practice guidelines and protocols
  – Ensure providers follow clinical practice guidelines and contract requirements
  – MOC training for providers
Chapter 4: Quality Measurement and Performance Improvement

- PrimeWest Health has a comprehensive quality improvement system for collecting, analyzing, reporting, evaluating, and acting on recommendations for improving the MOC. It includes the following:
  - Healthcare Effectiveness Data and Information Set (HEDIS®) evaluation
  - Quality improvement projects
  - Focus studies
  - Member satisfaction surveys
  - Provider surveys
  - Peer review activities
  - Care management audits
  - Program integrity audits
  - Utilization management reports
  - Medical record reviews
Chapter 4: Measurable Goals & Health Outcomes

• Goal 1 – Access for the SNP Population
  – Upon enrollment, all Prime Health Complete and PrimeWest Senior Health Complete members will have access to essential services, including medical, mental health, and social services, through the maintenance of a comprehensive network of contracted providers who meet stated regulatory accessibility requirements.
Chapter 4: Measurable Goals & Health Outcomes

(continued)

• Goal 2 – Affordability for the SNP Population

  – Based on State and Federal regulations, PrimeWest Health ensures all contracted providers accept PrimeWest Health’s negotiated rates as payment in full and do not balance bill PrimeWest Health members for services rendered. The process through which this is accomplished includes, but is not limited to, the following: Residential Services (RS) tool pricing documentation, Service Authorization processes, member Grievances, and member education and communication. All PrimeWest Health members are enrolled in the State’s Medical Assistance (Medicaid) program and subsequently have minimal or no out-of-pocket costs associated with obtaining health care and services.
Chapter 4: Measurable Goals & Health Outcomes
(continued)

• Goal 3 – Coordination of Care and Delivery of Service
  - PrimeWest Health has developed a comprehensive care management system that works to engage the member as soon as possible after enrollment in Prime West Senior Health Complete or Prime Health Complete by assigning a county case manager as the point of contact within 10 days of notification and notifying the member of this assignment. This process ensures that the member has direct contact with an individual who will assist him/her in navigating the continuum of care and with obtaining benefits and services. The county case manager ensures that a health risk assessment (HRA) is completed within 30 days of contact, completes a comprehensive interdisciplinary care plan (ICP) within 30 days of the HRA, and works with the member and caregiver to establish an ICT during the HRA. PrimeWest Health assesses the member’s functional status in physical, mental, and social domains at least annually and works to help members develop skills and goals to allow them to remain in the least restrictive environment possible. ICTs work with members to ensure they manage as much of their own care as possible with consideration given to their special needs. All PrimeWest Health members have their HRA, ICP, and ICT integrated so that all services align. This integration ensures that members are accessing all needed supports and services.
Chapter 4: Measurable Goals & Health Outcomes
(continued)

• Goal 4 – Care Transitions Across All Health Care Settings

  – PrimeWest Health provides a structured process for members, health care providers, and Public Health and Human Services agencies to interact and communicate as an ICT to address the social, economic, environmental, and behavioral risk factors affecting member health at the individual and community levels during the transition. The ICT provides a seamless transition across the continuum of care for PrimeWest Health members.
Chapter 4: Measurable Goals & Health Outcomes

(continued)

• Goal 5 – Assuring Appropriate Utilization of Services
  – PrimeWest Health monitors current pharmacy and medical utilization trend data to identify actual or potential opportunities to improve medical care, mental health care, and social service provisions. PrimeWest Health strives to improve health outcomes of members through maximization of preventive health services and care for chronic care conditions as documented for their assessed needs on the care plan.
If you would like a complete copy of the Model of Care, please call the Provider Contact Center at 1-866-431-0802 (toll free)