PrimeWest Health System, H2926
Dual Eligible (Medicare Zero Cost-Sharing) Special Needs Plan

Model of Care Score: 99.38%
3-Year Approval **January 1, 2012 – December 31, 2014**

Target Population

Prime Health Complete (PHC) HMO SNP serves a subset of dual eligible Medicaid recipients. The targeted population, as defined in PrimeWest Health's Special Needs BasicCare (SNBC) contract with the Minnesota Department of Human Services (DHS) and the Centers for Medicaid & Medicare Services (CMS) Medicare Advantage contract must be: eighteen (18) through age sixty-four (64) years of age; eligible for Medical Assistance; residing within the service area as defined in the DHS contract; and may include either of the following: certified as disabled through the Social Security Administration (SSA) or the State Medical Review Team (SMRT); or a Person with Developmental Disability for purposes of the DD waiver, as determined by the Local Agency. Less than 0.5 percent are Spanish-speaking. The top coded medical diagnosis is diabetes and the top coded mental health diagnosis is depression related.

Provider Network

PHC provides a contracted comprehensive network of primary care, nursing professionals, mid-level practitioners, rehabilitation therapy specialists, social workers and social services specialists, mental health specialists and medical specialists to target chronic and co-morbid conditions pertinent to the targeted special needs population for the provision of diagnostics and treatment. Specifically, the network consists of acute care facilities, hospitals, and medical centers, specialty outpatient clinics (i.e., kidney, pulmonary, orthopedic), laboratory services and long-term care facilities and skilled nursing facilities (SNFs).

Care Management and Coordination

PrimeWest Health uses four assessment tools to identify the specialized needs of our members. PrimeWest Health requires a health risk assessment (HRA) at the following times: upon initial enrollment; at the time of any significant change in medical condition, mental health status, or living situation, and on an annual basis.

The interdisciplinary care team (ICT) uses the HRA to develop a comprehensive individual care plan (ICP) developed by the assigned county case manager (CCM). The ICP incorporates the essential elements to meet the needs identified by the HRA in the domains of medical, psychosocial, functional, and cognitive needs, and mental and medical health history. Specific goals, interventions, treatment objectives, and outcomes are identified. Methods for monitoring the outcomes/goals and treatment follow-up are incorporated. The ICP is designed to incorporate the disability, cultural/religious and linguistic needs, range of services, and benefits to be furnished. It addresses the amount, frequency, and duration of each service and the type of provider furnishing the services. The ICP identifies informal community support services as well

as the member's and/or legal guardian’s health care preferences and rights and appeals procedures.

At a minimum, members of the ICT, including the member and/or legal representative and identified specialists, meet annually based on the assessed needs unless there is significant change in health status, the ICT will then meet to evaluate and address the additional needs. Composition of the member’s ICT is determined by the medical, specialty, mental health, public health, and social needs of the member and is evaluated annually or when any changes in service needs or staffing are identified. Team members may include, but are not limited to, the member, member’s family or responsible party, skilled nursing facility (SNF) staff and other specialties as appropriate.

The notification process includes communication with the member and the ICT, including all identified health care providers, using multiple communication tools such as documentation from the ICP, phone conferences, care conferences, ICT meetings, written correspondence, and secure email transmissions. Interaction and visit frequency by the CCM and ICT with the member is determined based on an assessment of the member's level of needed care.

This MOC summary is intended to provide a broad overview of the SNP’s MOC. Although the full extent of any MOC cannot be conveyed in a short summary, this summary provides the reader with a general overview of how the SNP addresses beneficiary needs.

For more information about this health plan refer to the Special Needs Plan’s website at: http://www.primewest.org/Members/PHC_HMO.aspx