H2926 PrimeWest Central County-Based Purchasing Initiative
Dual-Eligible (Dual Eligible Subset-Medicare Zero Cost Sharing) Special Needs Plan

Model of Care Score: 100.00 %

3-Year Approval **January 1, 2015 – December 31, 2017**

Target Population

Prime Health Complete (PHC) is a subset of the PrimeWest Health's Special Needs BasicCare (SNBC) contract which serves members ages 18 to 64, eligible for Medicaid, reside within the service area and have either of the following: disabled through Social Security Administration (SSA) or the State Medical Review Team (SMRT) or have a Developmental Disability (DD) for purposes of the DD waiver, as determined by the local state agency. PWHC serves 13 counties in Minnesota (Beltrami, Big Stone, Clearwater, Douglas, Grant, Hubbard, McLeod, Meeker, Pipestone, Pope, Renville, Stevens and Traverse). The majority of the members reside within their own home or home-like environments such as an adult foster home. The top five chronic conditions are diabetes (29 percent), heart diseases (43.5 percent), depression (49.7 percent), chronic obstructive pulmonary disease (COPD) (13.5 percent) and asthma (14 percent). The average age of members is 51 with the majority being female (55.24 percent) versus male at 44.76 percent.

Provider Network

PHC's provider network consists of more than 7,500 health and social services practitioners and more than 1,700 organizational providers in Minnesota and its border states. Specifically, the network includes but is not limited to: acute care facilities, hospitals, and medical centers, specialty outpatient clinics (e.g., kidney, pulmonary, or orthopedic), laboratory services, long-term care (LTC) facilities and skilled nursing facilities (SNFs), pharmacists and pharmacies, radiography facilities, rehabilitative facilities, primary care providers (PCP), specialist (e.g. endocrinologist or cardiologists), nursing professionals, mid-level practitioners, rehabilitation therapy specialists, social workers, mental, dental and oral health specialists, durable medical equipment (DME) providers, home and community based providers, public health and telemedicine providers.

Care Management and Coordination

PHC utilizes four assessment tools to identify care needs of members. Each tool is standardized, reliability tested, and validated to meet State and/or Federal criteria for all members. These face-to-face assessments review the medical, functional, cognitive, psychosocial status and mental health needs of the member. The health risk assessment tool (HRAT) is completed within 30 days of the member's enrollment, annually thereafter and within three days of a health status change. The results of the HRAT are provided to the interdisciplinary care team (ICT) and used to develop the individualized care plan (ICP).

The composition of the ICT is determined by the assessed medical, mental health, public health, and social needs of the individual member. However, the ICT is comprised of but not limited to: the member, the member's caregiver, 24-hour living arrangement staff, representatives of tribal organizations, the veteran's administration, and/or county social, services and case management systems, primary care provider (PCP), health care/home (HCH) care coordinator, and other specialists as needed. Goals are designed to focus on the strengths of the member. Interventions are designed to provide specific actions to help the member and/or caregiver achieve the individual goals. The ICT reviews all goals on a scheduled and ad hoc basis to ensure that the interventions in place are those best suited to meet the health outcomes and improve and/or maintain the health status of the member.

The ICP incorporates essential components to meet the member's assessed needs as identified by the HRAT and designs the member's self-management plan of care that includes member goals and objectives, the caregiver's interventions, and the ICT interventions. The primary domains are medical, psychosocial, functional, and cognitive needs, as well as mental and medical health history. The manager monitors and documents the progress toward achieving members' outcomes/goals, which include the members' self-management goals. At minimum, members of the ICT meet annually based on the assessed needs of the member. If there is a significant change in health status, the ICT will meet to evaluate and address the member's health, function, and additional needs. These meetings take place face-to-face, telephonically, or, if necessary, through written or virtual correspondence.

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 member 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.