A greater Minnesota health plan™

Prime Health Complete (HMO SNP)

2017 Model of Care

H2926

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Chapter 1: Description of the SNP Population

The identification and comprehensive description of the SNP-specific population is an integral component of the MOC because all of the other elements depend on the firm foundation of a comprehensive population description. It must provide an overview that fully addresses the full continuum of care of current and potential SNP beneficiaries, including end-of-life needs and considerations. The description of the SNP population must include, but not be limited to, the following:

Clear documentation of how the health plan staff determines or will determine, verify, and track eligibility of SNP beneficiaries.

Determining Eligibility for Potential and Current Members[1] for Prime Health Complete (HMO SNP)

The parameters, systems, and data collection methodologies PrimeWest Health uses to determine eligibility include, but are not limited to, the following:

- The Minnesota Department of Human Services (DHS) contract with PrimeWest Health, which specifies program eligibility criteria for Prime Health Complete
- PrimeWest Health Enrollment Services Policies and Procedures
- The DHS enrollment file
- Enrollment reports created in Crystal Reports®, an all-encompassing database that includes PrimeWest Health enrollment data
- The Minnesota Medicaid Information System (MMIS)
- DHS secure website (MN-ITS) for member enrollment
- Medicare enrollment file
- County of residence Medicaid (Medical Assistance) eligibility determination processes
- DHS third party administrator (TPA) enrollment agreement with PrimeWest Health for Prime Health Complete

All Prime Health Complete potential and current members must meet both Medicaid (Medical Assistance) and Medicare eligibility criteria. All Medicaid (Medical Assistance) eligibility is determined at the county level with no involvement from PrimeWest Health. Each month, DHS provides PrimeWest Health with an enrollment file of people eligible for membership. PrimeWest Health accepts all eligible people who choose or are assigned to PrimeWest Health (determined by DHS based on county of residence) without regard to physical or mental condition, health status, need for or receipt of health care services, claims experience, medical history, genetic information, disability, marital status, age, sex, sexual orientation, national origin, race, ethnicity, color, religion, or political beliefs. PrimeWest Health will not use any policy or practice that has the effect of such discrimination. American Indians can continue or begin to use tribal and Indian Health Service (IHS) clinics. We will not require prior approval or

[1] In general, both PrimeWest Health and the State of Minnesota refer to health plan enrollees as "members," so throughout this submission we will use the term "member" rather than “beneficiary.”

impose any conditions for the member to get services at these clinics. If a doctor or other provider in a tribal or IHS clinic refers the member to a provider in our network, we will not require the member to see his/her primary care provider prior to the referral.

Prime Health Complete serves a subset of dual eligible Medicaid (Medical Assistance) recipients. The targeted population/eligible member requirements, as defined in PrimeWest Health's Special Needs BasicCare (SNBC) contract with DHS and the Centers for Medicare & Medicaid Services (CMS) Medicare Advantage contract, require that the individual must be as follows:

1. Ages 18 – 64
2. Eligible for Medicaid (Medical Assistance)
3. Residing within the Managed Care Organization's (MCO) service area as defined in the DHS contract
4. Either of the following:
    a. Certified as disabled through the Social Security Administration (SSA) or the State Medical Review Team (SMRT)
    b. A person with Developmental Disability (DD) for purposes of the DD waiver, as determined by the Local Agency

Once Minnesota Medicaid (Medical Assistance) eligibility is established, eligibility for the Prime Health Complete dual eligible product is determined and submitted to CMS by DHS, as our TPA for enrollment. Enrollment in Prime Health Complete can occur when Medicaid (Medical Assistance) eligibility is determined or at any time after a member is enrolled in Medicaid (Medical Assistance). If the member mails the application directly to PrimeWest Health, a PrimeWest Health Enrollment Specialist will date-stamp the application and fax it to DHS. When applications to enroll in Prime Health Complete are received at DHS, a DHS TPA Enrollment Coordinator verifies the member's Medicare eligibility by checking the Medicare Advantage and Part D (MARx) Inquiry system. Medicare eligibility for both Parts A and B are verified as active for the month of enrollment. In addition, Medicaid (Medical Assistance) eligibility is again verified by DHS TPA Enrollment Coordinators through MMIS before the enrollment record is sent to CMS. Prime Health Complete enrollment documents are not considered complete until the recipient's record reflects Medicaid (Medical Assistance) eligibility at first capitation, six working days prior to the end of the month. This is validated by DHS through a comparison process as they create the enrollment transaction file that is sent to CMS. If a member is identified as not being eligible for Medicaid (Medical Assistance) or Medicare, the application is denied or a request for additional information is sent to the member to complete the application or confirm eligibility. If a member is eligible for Medicaid (Medical Assistance) but CMS rejects the application (for example if the member has ESRD), the enrollment will be denied. The denial of enrollment will be received on the Daily Transaction Reply Report (DTRR) from CMS and the member will be moved to fee-for-service through the State.

Verifying Eligibility for Potential and Current Members for Prime Health Complete
The parameters, systems, and data collection methodologies PrimeWest Health uses to verify eligibility include, but are not limited to, the following:

- PrimeWest Health Enrollment Services Policies and Procedures, including desktop processes
- The DHS enrollment file
- Enrollment reports created in Crystal Reports, an all-encompassing database that includes PrimeWest Health enrollment data
- Minnesota Medicaid Information System (MMIS)
- DHS secure website (MN-ITS) for membership enrollment
- Medicare enrollment file

A PrimeWest Health Enrollment Specialist verifies member eligibility according to PrimeWest Health Desktop Process EDM – 4E File Comparison Report Process. This desktop process is summarized below.

Each month, DHS sends a full enrollment file of all members who have Medicaid (Medical Assistance) eligibility and are enrolled in a PrimeWest Health plan. A monthly reconciliation by program is conducted by a PrimeWest Health Enrollment Specialist to ensure that all Prime Health Complete members have current Medicaid (Medical Assistance) eligibility. Each member on the report is assigned to a division depending on his/her program qualifications and living arrangements. For example, a member over age 21 who has Medicare, resides in a nursing home, and elects to enroll in PrimeWest Health's integrated Dual Eligible Special Needs Plan (D-SNP), Prime Health Complete, is assigned to division SNBC01-0013. If a member loses Medicaid (Medical Assistance) eligibility, a termination record is received with the DHS enrollment file during the month the member loses eligibility. This record includes a termination date that is three months in the future. This is noted and tracked in the PrimeWest Health membership system within the claims system (Amisys). If the member does not reestablish eligibility for Medicaid (Medical Assistance), he/she will remain a member of PrimeWest Health until that three-month termination date or until the member enrolls in another Medicare Advantage/Part D plan. This allows the member time to transition to another Medicare Advantage product or back to Medicare fee-for-service with a separate Part D plan if needed.

All new members received on the DHS enrollment file are reconciled against the DTRR received from CMS by a PrimeWest Health Enrollment Specialist to verify that the members' records were accurately sent to CMS and the members were enrolled on the Medicare side.

In addition, each month a PrimeWest Health Enrollment Specialist verifies that we have received Medicaid (Medical Assistance) capitation for the Prime Health Complete program for the month of eligibility and have accurate eligibility recorded in our membership/claims system (Amisys). This ensures ongoing eligibility in Medicaid (Medical Assistance).

Tracking Eligibility for Potential and Current Members for Prime Health Complete
The parameters, systems, and data collection methodologies PrimeWest Health uses to track eligibility include, but are not limited to, the following:

- PrimeWest Health Enrollment Services Policies and Procedures
- Enrollment reports created in Crystal Reports, an all-encompassing database that includes PrimeWest Health enrollment data
- Minnesota Medicaid Information System (MMIS)

- DHS secure website (MN-ITS) for membership enrollment
- Medicare enrollment file
- CareConnect (CCNT)

PrimeWest Health tracks member eligibility according to PrimeWest Health Policy and Procedure EDM03: Medicare Only Group (MOG). The process is summarized below.

Tracking of Currently Eligible Members

All members are eligible for Medicaid (Medical Assistance) on a month-to-month basis. Members who are currently enrolled in Prime Health Complete are tracked by a PrimeWest Health Enrollment Specialist for ongoing eligibility and status changes. For example, county case managers notify a PrimeWest Health Care Management Specialist when a member has elected or disenrolled from hospice. The information received from the case manager is then entered into a hospice assessment in CCNT by a PrimeWest Health Care Management Specialist. This process allows the hospice eligibility information to be tracked by a PrimeWest Health Enrollment Specialist. This report is an automated process and can be accessed as needed. Each week, a report of all hospice status updates recorded in CCNT the previous week is pulled by Care Coordination staff. Status updates are then noted in our membership/claims system (Amisys) and reconciled by a PrimeWest Health Enrollment Specialist with the statuses received on CMS DTRRs. This status is also sent through an automated process to our Pharmacy Benefit Manager (PBM) on the daily eligibility file so that Part D claims are paid appropriately. The county case managers will also alert Care Coordination staff when a member is deceased. This is noted in Amisys by a PrimeWest Health Enrollment Specialist so that medical claims will not pay if they are submitted with a date of service after the date of death.

Tracking of Members When Eligibility Is Lost

When a Prime Health Complete member loses Medicaid (Medical Assistance) eligibility, the member is identified through a Crystal report. The report is run and processed each month by a PrimeWest Health Enrollment Specialist. The report indicates that we received a termination record for a member who has lost Medicaid (Medical Assistance) eligibility. The termination date will be three months in the future to allow time for the member to regain Medicaid (Medical Assistance) eligibility or enroll in another Part D plan. This is important because our members often have short-term lapses in eligibility. The most common reason members lose Medicaid (Medical Assistance) eligibility is because they have not completed and/or submitted the necessary paperwork. Once that is accomplished, they often regain eligibility.

For tracking purposes, when a member loses eligibility, a PrimeWest Health Enrollment Specialist moves the member to a separate program division noting that he/she has lost Medicaid (Medical Assistance) eligibility. Using the example above, the member would be moved to SNBC01-0009, the Loss of Medicaid division. The member will be given a three-month future termination date to allow him/her time to transition to a new plan or regain Medicaid (Medical Assistance) eligibility. If the member regains Medicaid (Medical Assistance) eligibility, he/she will be re-enrolled without a break in coverage and moved out of the Loss of Medicaid division back into their previous division, which is determined by the living arrangement and age category. An Enrollment Specialist forwards a copy of the Crystal report to the Care Management Project Coordinator in the PrimeWest Health Care Management department

indicating which members have a three-month future termination date. Through a secure network, the Care Management Project Coordinator sends an email to the assigned county case manager with the name of the member who may be losing eligibility and asks the county case manager to follow up with the member and provide an update to the Care Management Project Coordinator regarding continued enrollment. The update provided by the county case manager is attached in the member's electronic file in CCNT and also communicated back to a PrimeWest Health Enrollment Specialist via the internal/secure spreadsheet documentation report kept by the Membership and Program Development department.

Reinstatement Process for Previously Eligible Members

PrimeWest Health receives a daily reinstate file from DHS via MN-ITS (the DHS secure website) with a list of members who have regained Medicaid (Medical Assistance) eligibility. Through an automated process, this file is downloaded from MN-ITS and put into a PrimeWest Health enrollment database through a process created by our Business IT Research & Development staff. An automated electronic script is run that updates the member's Medicaid (Medical Assistance) eligibility and removes the future termination date. The following day, a PrimeWest Health Enrollment Coordinator reviews an audit report to update eligibility that could not be processed by the automated script.

If the member does not regain eligibility within the three months, DHS, as our TPA, will send a disenrollment transaction to CMS to remove the member from our Medicare enrollment file.

TPA Delegation and Oversight

Annually, PrimeWest Health's Enrollment Manager works with the Corporate Compliance Officer to perform a delegation audit on DHS. The audit serves to ensure that all enrollment functions are performed in accordance with applicable standards and as stated in the Memorandum of Agreement, which specifies the delegated activities and reporting responsibilities of DHS acting on behalf of PrimeWest Health. PrimeWest Health has established consistent criteria to identify acceptable performance for a delegate as well as consequences if the delegate does not fulfill all delegated activities. The standards used to establish the review criteria are those established by the National Committee for Quality Assurance (NCQA) for delegation, which are understood to be the community standards.

A formal evaluation of DHS is completed to measure performance against PrimeWest Health's expectations, regulatory requirements, and NCQA standards. The evaluation takes place either through a site visit or through telephone consultations, documentation review, and/or committee meetings. Enrollment and disenrollment files are also reviewed against the standard requirements in Chapter 2 – Enrollment and Disenrollment of the Medicare Managed Care Manual. PrimeWest Health uses the NCQA standard "8/30" methodology to review the files. File reviews are quantified in the final report to demonstrate total files reviewed and number of files found to be deficient.

Upon completion of the audit, a report is drafted with the findings. The report includes any recommended corrective action if deficiencies or mandatory improvements are identified. A corrective action plan (CAP) is not requested for recommendations but is noted in the final report. The preliminary report is provided to DHS for review. DHS then has the opportunity to

provide feedback and any additional evidence if appropriate. The PrimeWest Health Enrollment Manager and Corporate Compliance Officer consider DHS' responses and prepare the final report with any CAPs deemed appropriate.

The final report with any needed CAPs is presented to DHS. It is also presented to the Compliance and Security Oversight Committee (CSOC), the Quality and Care Coordination Committee (QCCC), and the PrimeWest Health Joint Powers Board (JPB).

If a CAP is requested, DHS is responsible for developing the CAP. DHS will determine the root cause of any deficiencies and/or mandatory improvements and the specific interventions most appropriate to make corrections and obtain the desired outcome. If DHS fails to comply with an agreed upon CAP, PrimeWest Health may impose a financial sanction when allowable under law or contract terms and/or terminate the contract. PrimeWest Health encourages collaborative, positive, problem-solving approaches for remediation of the CAP.

Compliance with any CAP expectations is evaluated with DHS at quarterly meetings to ensure DHS is moving toward remediation. Additional current operational concerns or daily work processes are also discussed during these meetings.

A detailed profile of the medical, social, cognitive, environmental, living conditions, and co-morbidities associated with the SNP population in the plan's geographic service area.

PrimeWest Health uses various data sources to identify medical, social, cognitive, and environmental elements, living conditions, and comorbidities that contribute to the Prime Health Complete population profile. A detailed profile ensures the appropriate care coordination services are available for our members. Data sources include, but are not limited to, the following:

- DHS enrollment report data
- Minnesota and individual county demographic data, including census data
- Minnesota and individual county economic and housing information
- PrimeWest Health claims data (medical, mental health, and dental)
- Care plan documentation and audit analysis
- Health risk assessment database
- Medical record review reports
- Health Effectiveness Data Information Set (HEDIS®)[2] evaluation results
- Quality focus studies
- Quality improvement project results
- Health Outcomes Survey (HOS)
- Disease Management/Chronic Care Improvement Program (DM/CCIP) data
- Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[3] results
- County case manager (CCM) satisfaction survey results

[2] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA)
[3] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ)

Every other month, the PrimeWest Health Care Management team, Administration, Provider Network Administration, Membership & Program Development, and Compliance staff meet with the 13 county Public Health and Human Service (PH/HS) agencies operated by the counties that own our health plan, PrimeWest Health. The Human Services agencies are the mental health and local housing authority for the Medicaid (Medical Assistance) population. PrimeWest Health relies on the 13 Human Service agencies to provide insight about the housing, mental health, and other socioeconomic needs and/or concerns for Prime Health Complete members. PrimeWest Health relies on the 13 Public Health agencies to help identify population health initiatives and collaborates with them on care management activities for preventive care initiatives such as chronic disease management, immunizations, etc. Together with the data sources listed above, our collaboration with the PH/HS agencies provides us with a detailed profile of the Prime Health Complete member population, ensuring that appropriate care coordination services are provided.

Medical Factors Associated with Identifying a Detailed Profile of a Prime Health Complete Member

PrimeWest Health defines the medical profile of the Prime Health Complete population based on utilization of services. This includes, but is not limited to, emergency room use, office visit frequency, and ambulatory care sensitive conditions (ACSC). In addition, the profile identifies cultural needs, special needs, and the vulnerable member population.

To accomplish this, PrimeWest Health uses a comprehensive claims and care management data warehouse that provides medical, mental health, pharmacy, dental, and chemical health data.

1. Claims data
    a. Monthly utilization management (UM) monitoring report for programs or services provided
        i. More than $100,000 in paid medical claims in the previous year
        ii. 10 or more office visits in the previous three months
        iii. Six or more emergency room visits in the previous three months

    b. Three or more chronic conditions
    c. ACSC
    d. Emergency room use, based on diagnosis
    e. Mental health/chemical dependency
    f. ESRD

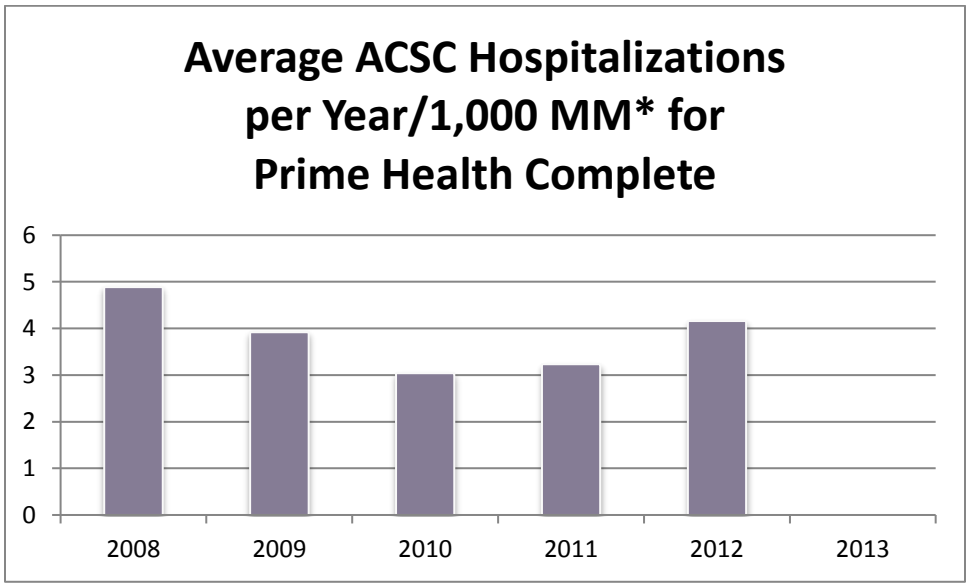
2. Pharmacy data—more than nine prescriptions per month
3. Data collected through the PrimeWest Health UM process
    a. Precertification data
    b. Concurrent review data
    c. Prior authorization data
    d. Hospital admission/discharge data

4. Care management data
    a. Inpatient stays longer than four days
    b. Skilled Nursing Facility (SNF) admissions and continued stays

c. Hospice care
d. Acute or long-term rehabilitation (inpatient services)
e. Previous case management involvement
f. Members injured in major accidents—serious trauma
g. Members who have had strokes requiring long-term rehabilitation
h. Members requiring long-term chemotherapy, radiation, or oncology
i. Spinal injuries
j. Members with complex chronic health problems
k. Members with ESRD
l. Members requiring transplants
m. Members with conditions prone to acute exacerbations such as asthma
n. All-cause readmission rates within 30 days

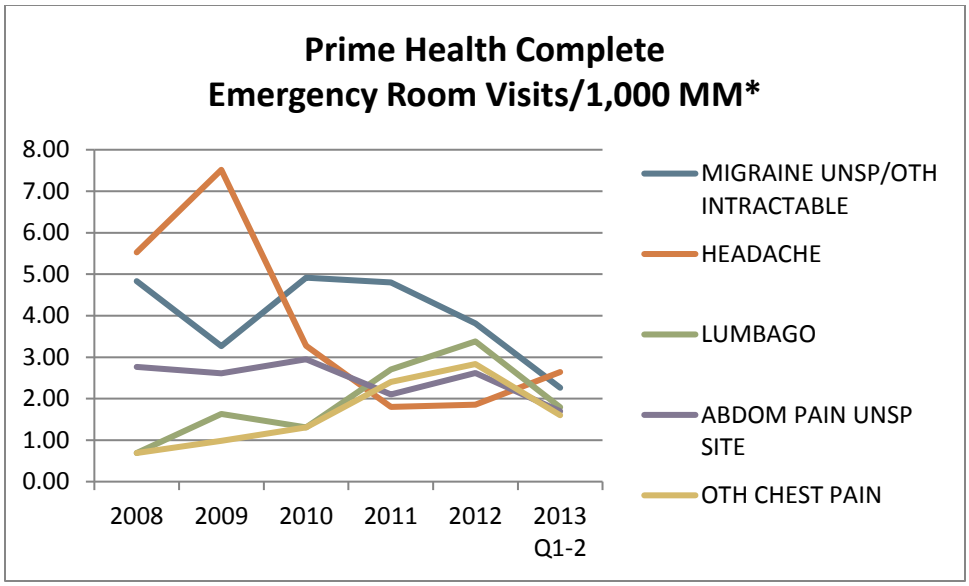
Medical Profile
Each year, PrimeWest Health evaluates its profile data against the previous year's data and when similar State and Federal data is available, we use this data as a benchmark for comparison.

The following chart shows the frequency of hospitalizations of Prime Health Complete members over five and a half years. Prime Health Complete experienced 4.16 ACSC hospitalizations/1,000 member months in 2012. As the chart shows, there were no ACSC admissions for Prime Health Complete members for the first six months of 2013.



**MM = member months*
Data Source – Utilization Management Report January 2008 – June 2013

The following chart shows the top five ACSC-related emergency room visits and the frequency. The most common reason for the visit is a urinary tract infection (UTI).



**MM = member months; UNSP = unspecified; OTH = other; ABDOM = abdominal*
Data Source – Utilization Management Report through June 2013

The following table demonstrates potential member frequency for experiencing a transition of care event based on the top four transitions of care types.

Transition Event	Percentage of members who experienced the transition
Members experiencing a transition into an acute medical hospital	23.7%
Members experiencing a transition into an SNF	3.6%
Members experiencing a transition into a 24-hour care setting (excludes SNF)	3.1%
Members experiencing a transition into an acute mental health hospital	8.2%

Data Source – Special Needs Plan (SNP) Prime Health Complete (HMO SNP) Analysis of Admission Rates for Member Admissions to Facilities and Emergency Departments (July 2012 – July 2013)

The following table describes the prevalence of chronic medical conditions for Prime Health Complete members. Because the Prime Health Complete population is fewer than 500, the HOS is not required, however PrimeWest Health performs the survey voluntarily for frailty factor calculations as this is a Fully Integrated Dual Eligible (FIDE) SNP. As such, national comparison numbers are not available in the Baseline reports.

2012 Cohort 15 Baseline Prevalence of Chronic Medical Conditions for Prime Health Complete

	Prime Health Complete	
Medical Condition	**Number**	**Percent**
Hypertension	42	53.2%
Arthritis – Hip or Knee	32	40.0%
Arthritis – Hand or Wrist	27	33.8%
Diabetes	28	35.4%
Sciatica	19	23.8%
Other Heart Conditions	7	8.9%
Osteoporosis	11	13.8%
Pulmonary Disease	19	23.8%
Any Cancer (except skin cancer)	6	7.5%
Coronary Artery Disease	6	7.7%
Myocardial Infarction	3	3.8%
Congestive Heart Failure	6	7.6%
Stroke	6	7.7%
Gastrointestinal Disease	5	6.3%

Other Health and Medical Data Included in Determining the Prime Health Complete Profile

Number of Prescriptions per Month
The 2011 Prime Health Complete average number of prescriptions per month, including over-the-counter (OTC) prescriptions, was eight. Averages from 2012 and 2013 were nine per month. The average number of prescriptions per month for Medicare Advantage members was 3.9 (Medicare Payment Advisory Commission, Medpac.gov).

Visual Impairment
All Prime Health Complete members are assessed for visual impairment during their initial health risk assessment and/or annual reassessment. A random sample of 15 percent of all 2013 Prime Health Complete care plans were reviewed and 46.7 were identified as having some type of a visual impairment corrected with corrective lenses. Because Prime Health Complete members are certified disabled, PrimeWest Health has broad criteria for determining visual impairment and includes all corrective lenses. This is to ensure that eye care needs (including eye exams and eyeglasses) are identified and addressed on the member's individualized care plan (ICP).

Hearing Impairment
All Prime Health Complete members are assessed for hearing impairment during their initial health risk assessment and/or annual reassessment. A random sample of 15 percent of all 2013 Prime Health Complete care plans were reviewed and 6.7 percent of these members were identified as having a hearing impairment.

Activities of Daily Living (ADL) and Independent Activities of Daily Living (IADL) Assessment
Each year, PrimeWest Health analyzes the member HOS results. For 2012, the composite Physical Component Summary (PCS) (physical functioning, pain, and general health) score was 33.8, The Prime Health Complete Mental Component Summary (MCS) (vitality, social functioning, and emotional and mental health) was 44.0. The PCS and MCS correspond with levels of functioning, with a higher score representing a higher level of functioning. As the Prime Health Complete population doesn't meet the enrollment threshold to be required to perform the HOS, PrimeWest Health performs it because this is a FIDE SNP population and we need to use it to calculate a frailty score. As such, baseline reports received from CMS do not contain national or State benchmarks for the Prime Health Complete population. Walking was identified as the number one impairment (46.2 percent), with getting out of a chair (39.7 percent) and difficulty bathing (39.7 percent) and/or dressing (24.4 percent) rounding out the top four ADL deficits. Upon initial assessment, annual reassessment, and as indicated by member need, ADLs and IADLs are assessed and documented on the member's ICP and the services needed to achieve member goals are provided.

Social Factors Associated with Identifying a Detailed Profile of a Prime Health Complete Member
PrimeWest Health analyzes other, related non-medical data to profile members, such as responses to survey questions. This data is self-reported.

Physical and Emotional Health Ratings

- Consumer Assessment of Healthcare Providers and Systems (CAHPS)
  The CAHPS is a survey conducted to assess the experiences of members. In 2013, the survey response rate was 47 percent. The results are shown in the following tables.

  Member Rated Perception of Overall Health

	Excellent	Very Good	Good	Fair	Poor
Prime Health Complete	4.9%	16.7%	33.8%	33.8%	10.8%

  Data Source – 2013 CAHPS

  Member Rated Overall Mental or Emotional Health

	Much better than one year ago	Somewhat better than one year ago	About the same	Somewhat worse than one year ago	Much worse than one year ago
Prime Health Complete	11.9%	14.5%	56.1%	15.1%	2.3%

  Data Source – 2013 CAHPS

- HOS Baseline 15 Member Survey Responses
  In addition to the CAHPS, PrimeWest Health reviews data from member surveys such as the HOS, which assesses PrimeWest Health's ability to maintain or improve the physical and

mental health of its members over time. The survey covers areas of physical functioning, bodily pain, general health, vitality, social functioning, emotional functioning, and mental health, along with questions to gather information about case mix and risk adjustment, race, ethnicity, primary language, gender, and disability status. More information on the HOS is available in Chapter 4, Section B: Measurable Goals & Health Outcomes for the MOC.

One question on this survey asked, "During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?" As the following table indicates, although 27.3 percent of members responded that physical or emotional problems interfere with their social activities some of the time, 25.3 percent responded that physical or emotional problems do not interfere with their social activities.

Amount of Time Physical Health or Emotional Problems Interfered with Social Activities

	All of the time	Most of the time	Some of the time	A little of time	None of the time
Prime Health Complete	5.1%	25.3%	27.8%	16.5%	25.3%

- County Case Manager Member Satisfaction Survey Results
  Each year, PrimeWest Health surveys all Prime Health Complete members to find out how satisfied they are with their assigned CCMs. The survey includes a question asking the member to rate their overall quality of life. Despite the average Prime Health Complete member's age, poor socioeconomic status, and health conditions and comorbidities, 90 percent of surveys returned indicated that members rated their overall quality of life as excellent, very good, or good in 2013. The survey return rate was 32 percent.

  Results of Member Rated Quality of Life

	Excellent	Very Good	Good	Fair	Poor
Prime Health Complete	29%	37%	24%	9%	1%

Tobacco Use

The 2013 CAHPS reflected that 30.9 percent of Prime Health Complete members smoke or use tobacco every day while 8.8 percent reported they use it some days. 59.7 percent reported they do not use tobacco at all.

Tobacco use has significant and documented health consequences, therefore it is important that health care providers address and track members' tobacco use. In 2013, overall PrimeWest Health provider compliance with required medical record documentation regarding tobacco use was 51 percent, up from 47 percent in 2012.

The following 2013 claims data illustrates the percent of Prime Health Complete members who have tobacco use-related diagnoses of lung cancer, emphysema, bronchitis, and Chronic Obstructive Pulmonary Disease (COPD) as compared to the total PrimeWest Health membership.

Prevalence of Tobacco-Related Diseases

Diagnosis	Lung Cancer	Emphysema	Bronchitis	COPD	Total
Prime Health Complete	0%	7%	21%	22%	35%
Total PrimeWest Health Population	0.12%	0.62%	5.57%	3.72%	8.18%

Internet Access and Use

According to the CAHPS Survey administered by DHS, which is similar to the MA-PD CAHPS, but doesn't include questions about Part D, 35.2 percent of Prime Health Complete members responded that they never use the Internet. CCMs, PrimeWest Health Member Services staff, and PrimeWest Health care coordinators use alternate forms of communication with members, such as face-to-face contact and telephone calls. If written materials are provided through member mailings or newsletters, PrimeWest Health care coordination staff share information contained in these mailings with the CCMs so they can share it with members.

Internet Use

Internet Use	Prime Health Complete	PrimeWest Health Population
Never	35.2%	41.2%
Less than once a month	8.3%	5.6%
1 – 3 times each month	7.3%	6.4%
1 – 3 times each week	13.3%	11.2%
Every day	35.9%	35.6%

Data Source – 2013 CAHPS

Transportation and Social Isolation

Given the rural, remote geographic location and harsh climate of PrimeWest Health's 13 counties and the fact that all of the Prime Health Complete members have disabilities, transportation can be an identified issue. Lack of access to transportation can make it difficult to meet basic needs (getting medications and medical or other necessary services, grocery shopping, attending social gatherings, etc.) without assistance in both arranging for transportation and actually getting to the transportation. This, in turn, has additional physical and mental health implications. Members are assessed for transportation needs upon initial enrollment, annually, and as needed. In 2013, health risk assessment data indicated that 40 percent of Prime Health Complete members reported needing transportation assistance. Common carrier, specialty, and emergency transportation are covered benefits for Prime Health Complete members and access is available in all 13 counties. County Human Services agencies in the 13 PrimeWest Health counties are contracted to assist members with transportation arrangements.

Cognitive Factors Associated with Identifying a Detailed Profile of a Prime Health Complete Member

PrimeWest Health considers cognitive factors to include education level, dementia diagnosis, and developmental disabilities.

Level of Education

Almost 40 percent of Prime West Senior Health Complete members reported having a high school education or some high school and 5.5 percent reported having an 8th grade or lower education. This is relevant because members may not understand the verbal or written medical instructions given to them by health care providers, which can affect their ability to comply with their plan of care.

Education Level for Prime Health Complete Members

Highest level of education completed	Prime Health Complete	PrimeWest Health Population
8th grade or lower	5.5%	7.9%
Some high school	13.4%	12.9%
High school graduate or GED*	46.5%	40.7%
Some college/2-year college	29.1%	31.5%
4-year college	5.0%	5.3%
More than 4-year college	0.5%	1.6%

**General Educational Development (GED) certification*

Data Source – 2013 DHS CAHPS

To help ensure that Prime Health Complete members are able to understand the information as written, PrimeWest Health Communications staff ensures that all PrimeWest Health member materials are written in a 7th grade or lower reading level using Flesch-Kincaid Readability Statistics Scores. In addition, all Prime Health Complete members are assigned a CCM upon enrollment. This is either a registered nurse (RN) or a social worker, based on their identified needs. The CCM is the first identified point of contact for the member and his/her role is to help the member navigate the health care continuum. Written member materials and related health information are presented and reviewed with the member during face-to-face case management visits and/or through telephone calls. CCMs have been trained by PrimeWest Health care coordination staff to implement the teach-back method to ensure member comprehension. The CCM's role is further described in Chapter 2, Section A: SNP Staff Structure.

Dementia and Developmental Delays

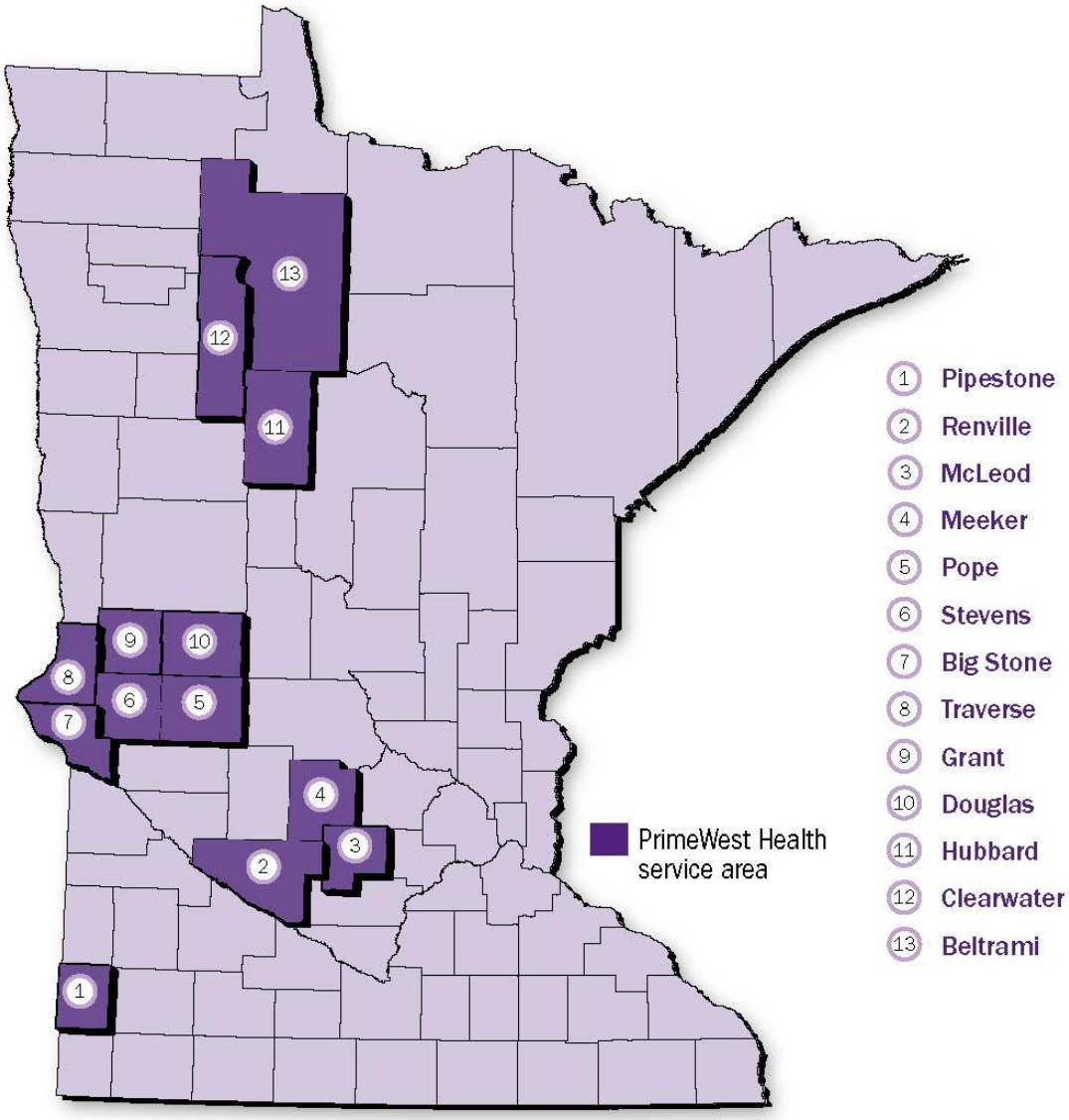
Nearly 8 percent of Prime Health Complete members (15) show a diagnosis of dementia in claims and 24.4 percent (47) have a diagnosis of developmental delay. Both diagnoses can interfere with a member's ability to understand the verbal or written medical instructions given to them by health care providers, which can affect their ability to comply with their plan of care.

Environmental Factors Associated with Identifying a Detailed Profile of a Prime Health Complete Member

Environmental factors play a role in the member's overall health. Environmental factors PrimeWest Health tracks include, but are not limited to, analysis of geographic location, landmass and population, drinking water, and air quality.

Geographic Location

The PrimeWest Health service area consists of 13 counties. Three of the PrimeWest Health counties (Beltrami, Clearwater, and Hubbard) are located in the north central region of Minnesota. Six counties (Douglas, Stevens, Traverse, Pope, and Big Stone) are in the central to western edge of Minnesota. Three counties (Meeker, Renville, and McLeod) are in the south central region and one county (Pipestone) is in the southwestern corner of Minnesota. The distance between Pipestone and Beltrami County is approximately 312 miles and takes approximately 5 hours and 20 minutes to drive. This gives some indication of the considerable geographic spread of the Prime Health Complete membership. PrimeWest Health's integrated relationship with local PH/HS agencies in each PrimeWest Health county plays an important role in ensuring access despite our large geographic area.



Landmass and Population

The total landmass of Minnesota counties is 81,689 square miles. PrimeWest Health counties total 10,525 square miles. This is comparable to the size of Massachusetts, which has 10,255 square miles. As noted previously, PrimeWest Health's relationship with its counties plays an important role in ensuring access.

PrimeWest Health 13 Counties' Square Mileage

PrimeWest Health Counties	Square Miles	% of State
Beltrami	2,501	3.06%
Big Stone	490	0.60%
Clearwater	1,000	1.22%
Douglas	647	0.79%
Grant	546	0.67%
Hubbard	932	1.14%
McLeod	503	0.62%
Meeker	619	0.76%
Pipestone	464	0.57%
Pope	718	0.88%
Renville	979	1.20%
Stevens	558	0.68%
Traverse	568	0.70%
All PrimeWest Health counties	**10,525**	**12.88%**
All MN counties	**81,689**	**100%**

County Population Statistics

The 13 PrimeWest Health counties are home to 4.28 percent of the total population of Minnesota. Six of the 13 PrimeWest Health counties—Beltrami, Clearwater, Grant, Pipestone, Renville, and Traverse—have areas designated as health care professional shortage areas (HPSA) for primary care services. All 13 counties are designated HPSAs for mental health. As such, PrimeWest Health has partnerships and arrangements with all 13 PH/HS agencies and uses alternative methods of treatment delivery including, but not limited to, telehealth, mobile dentistry, and additional outreach services.

County Population Statistics			
County	**2012 Census**	**% of Minnesota State Population**	**Prime Health Complete**
Beltrami	45,325	0.84%	0
Big Stone	5,164	0.10%	2
Clearwater	8,713	0.16%	0
Douglas	36,412	0.68%	90
Grant	5,950	0.11%	14
Hubbard	20,359	0.38%	0
McLeod	36,104	0.67%	25
Meeker	23,056	0.43%	16
Pipestone	9,394	0.17%	16
Pope	10,897	0.20%	17
Renville	15,389	0.29%	12
Stevens	9,751	0.18%	12
Traverse	3,471	0.06%	4
TOTALS	**229,985**	**4.28%**	**208**
Total Minnesota Population	**5,368,972**		

Drinking Water

Approximately 70 percent of all Minnesotans rely on groundwater as their primary source of drinking water, and one million Minnesotans rely on private wells. While most of the state has access to abundant groundwater, the geology of five PrimeWest Health counties in southwestern and northeastern Minnesota limits the amount of groundwater available for domestic use and economic development.

Primary groundwater quality concerns in Minnesota include naturally occurring arsenic and radium, and human-produced pesticides, fuel oils, industrial chemicals, and sources of nitrate (e.g., fertilizers, animal wastes, and human sewage).

Based on existing monitoring data, it is now estimated that about 10 percent of all private wells in Minnesota have arsenic levels of 10ug/L or more. This includes 11 of the 13 PrimeWest Health counties.

PrimeWest Health 13 Counties Private Well Arsenic Levels

County	Arsenic Levels ug/L
Beltrami	11 – 20 ug/L
Big Stone	6 – 10 ug/L
Clearwater	11 – 20 ug/L
Douglas	11 – 20 ug/L
Grant	21 – 30 ug/L
Hubbard	1 – 5 ug/L
McLeod	31 – 45 ug/L
Meeker	21 – 30 ug/L
Pipestone	1 – 5 ug/L
Pope	11 – 20 ug/L
Renville	21 – 30 ug/L
Stevens	21 – 30 ug/L
Traverse	21 – 30 ug/L

Data Source – 2012 Minnesota Department of Health Statewide Health Assessment, p. 18

Air Quality

Air pollutants can affect an individual's health and quality of life. The metropolitan area of Minnesota experiences approximately 11 – 17 unhealthy air quality days per year compared to 1 – 5 days in any one of the 13 non-metropolitan PrimeWest Health counties. Elevated levels of air pollution in the central six counties (Douglas, Pope, Traverse, Grant, Stevens, and Big Stone) and southwestern four counties (Pipestone, Meeker, McLeod, and Renville) is attributed to agriculture, pesticides, and fossil fuel; however, according to the National Cancer Institute State Cancer Profiles, there does not appear to be any statistical correlation demonstrating an increase in respiratory diseases or lung cancer in the Prime Health Complete population when compared to Minnesota as a whole.

PrimeWest Health Counties Annual Average of Unhealthy Air Quality Days

County	Annual Average Unhealthy Air Quality Days
Beltrami	1 – 2 days
Big Stone	5 days
Clearwater	1 – 2 days
Douglas	5 days
Grant	5 days
Hubbard	1 – 2 days
McLeod	3 – 7 days
Meeker	3 – 7 days
Pipestone	3 – 7 days
Pope	5 days
Renville	3 – 7 days
Stevens	5 days
Traverse	5 days

Data Source – 2012 Minnesota Department of Health Statewide Health Assessment, p. 21

Living Condition Factors Associated with Identifying a Detailed Profile of a Prime Health Complete Member

Living conditions play a role in the member's overall health. PrimeWest Health living condition factors that are assessed and analyzed are poverty level, housing, and food security and nutrition.

Percent of PrimeWest Health Population At or Below Minnesota Poverty Level

Within the 13 PrimeWest Health counties, an average of 12 percent of the overall county population is at or below poverty level using current Minnesota Medicaid (Medical Assistance) guidelines. This is slightly above and comparable to the Minnesota state average of 11.8 percent. All Prime Health Complete members are deemed eligible for Minnesota Medicaid (Medical Assistance) and therefore all are below the poverty level.

PrimeWest Health 13 Counties Percent of Population At or Below Poverty Level

County	% of population at or below poverty level
Beltrami	20.40%
Big Stone	9.0%
Clearwater	18.9%
Douglas	10.8%
Grant	10.4%
Hubbard	14.1%
McLeod	8.2%
Meeker	9.3%
Pipestone	12.7%
Pope	10.3%
Renville	11.1%
Stevens	13.3%
Traverse	12.4%
PrimeWest Counties Average	**12.0%**
Minnesota Average	**11.8%**

Data Source – **http://quickfacts.census.gov/qfd/states/27000.html**

Housing

The majority of Prime Health Complete members live either in their own home (170 members) or in a home-like environment such as 24-Hour Supervised Housing or an Adult Foster Home. CCMs assess housing needs and determine placement during the health risk assessment, annual reassessment, and as needed. Housing plays a critical role in members' health and those who live independently are at a higher risk for unmanaged health care needs. The following table shows the 2013 data for unique members by housing type.

Living Arrangement	# of Prime Health Complete members	% of Prime Health Complete members
Nursing Facility	7	3.33%
ICF DD	8	3.81%
Rule 203 – Adult Foster Home	20	9.52%
GRH (not foster care or Rule 36)	3	1.43%
Rule 36 under 17 Bed (Not IMD)	2	0.95%
Community	170	80.95%
Total	**210**	**100.00%**

ICF=Intermediate Care Facility; DD=Developmental Disabilities; GRH=Group Residential Home; IMD=Institutions for Mental Diseases

Living Arrangements
Nearly 81 percent of Prime Health Complete members are in the Community Living arrangement designation compared to 19 percent that are in 24-hour care settings. This is important to note because members living in the community are at a higher risk for unmanaged health care needs as opposed to members living in a controlled environment where their health care is being managed 24 hours a day by a caregiver.

Food Security and Nutrition
In 2010, more than 11 percent of Minnesota households struggled to afford food. Of these, just over 4 percent were categorized as "very low food security," meaning they sometimes skimped on meals or completely skipped them for lack of money. Food insecurity is greater in rural Minnesota than in the metropolitan area; some rural Minnesota counties have food insecurity rates of 12 – 14 percent. The 13 PrimeWest Health Counties had food insecurity percentages between 7.9 – 14 percent, which indicates that although there are food security issues, they are low on scale of 0 – 100.

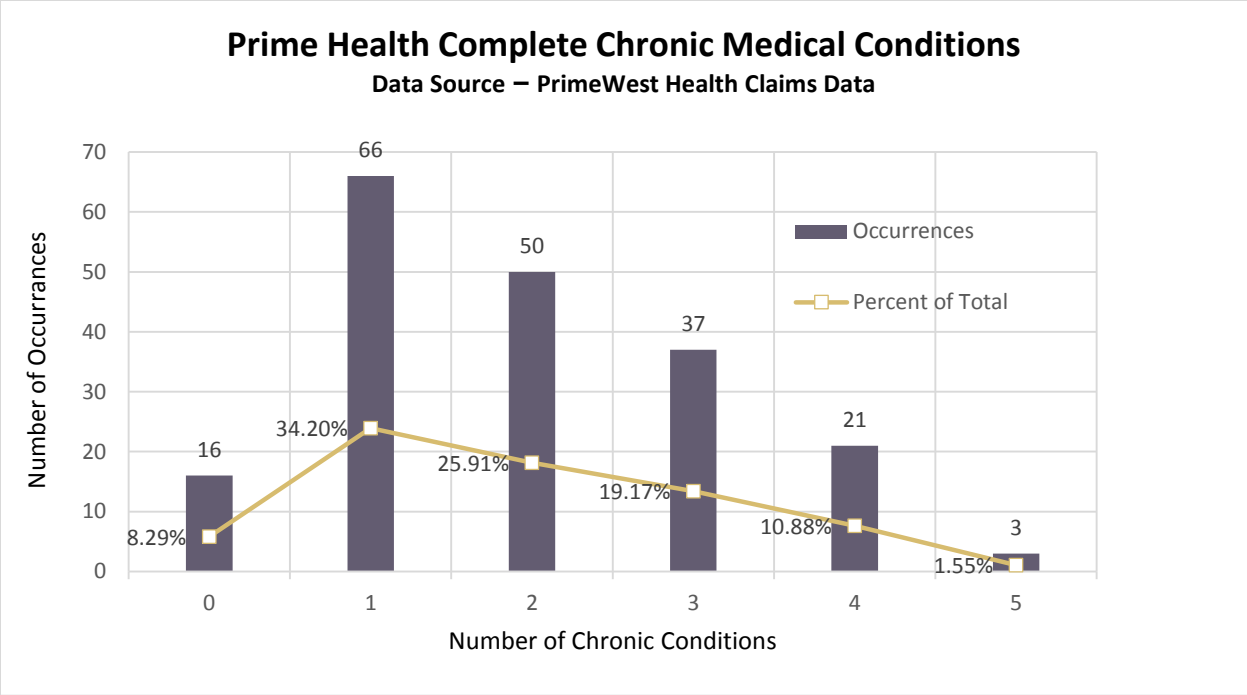
PrimeWest Health 13 Counties Food Insecurity Percentages

County	Food Insecurity Percentages
Beltrami	13.0%
Big Stone	9.1%
Clearwater	14.2%
Douglas	9.1%
Grant	10.1%
Hubbard	10.7%
McLeod	9.2%
Meeker	9.2%
Pipestone	9.2%
Pope	8.0%
Renville	9.2%
Stevens	9.5%
Traverse	7.9%

Data Sources – 2012 Minnesota Department of Health Statewide Health Assessment, pp. 28 – 29; Feeding America (2011) Map the Meal Gap, **http://feedinggameerica.org/hunger-in-america/hunger-studies/map-the-meal-gap.aspx**.

Comorbidity Factors Associated with Identifying a Detailed Profile of a Prime Health Complete Member

Comorbidity Profile
The following chart shows the percentage of Prime Health Complete members who, through claims review and/or chart review, have been identified with 0 – 5 medical and comorbid conditions. Approximately 57.51 percent of Prime Health Complete members have two or more medical comorbidities and only 8.29 percent do not have a medical condition identified.



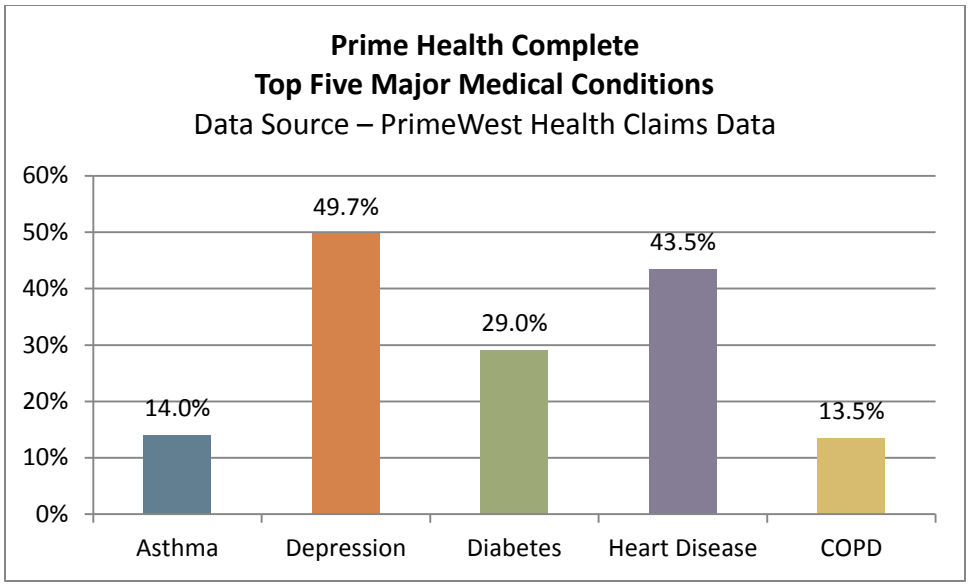
Identification and description of the health conditions impacting SNP beneficiaries, including specific information about other characteristics that affect health such as, population demographics (e.g. average age, gender, ethnicity, and potential health disparities associated with specific groups such as: language barriers, deficits in health literacy, poor socioeconomic status, cultural beliefs/barriers, caregiver considerations, other).

Identification of the Health Conditions Affecting Prime Health Complete Members

To serve the needs of the Prime Health Complete members, it is critical to identify and understand the various health conditions that will affect our members. PrimeWest Health focuses on some of the broad categories including the top five major medical conditions, ACSCs, and behavioral health conditions, which fall under the realm of health conditions and can play a major role in our members' overall health.

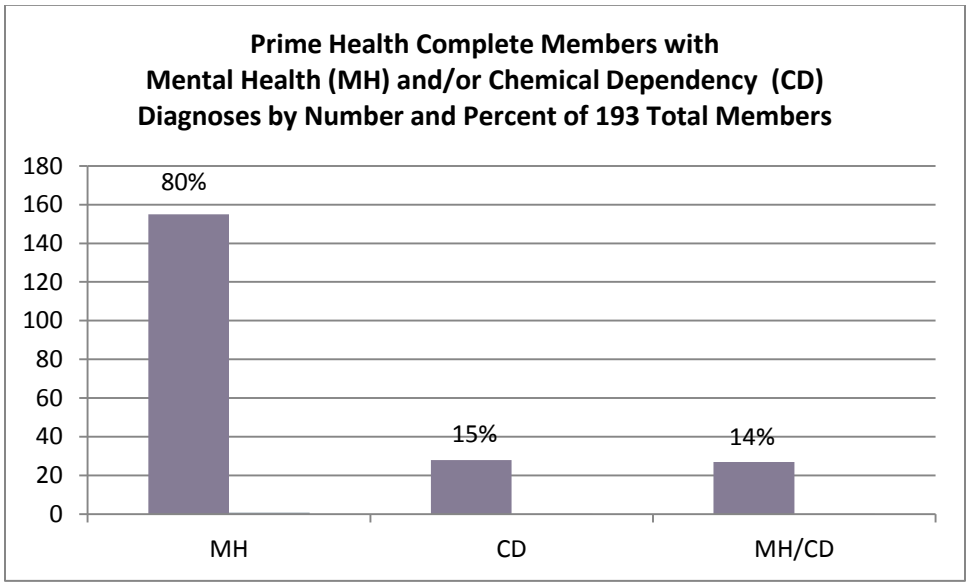
Top Five Major Medical Conditions

The following chart identifies the top five major medical conditions associated with Prime Health Complete members.



Ambulatory Care Sensitive Conditions (ACSC)
ACSCs are very specific conditions for which preventive measures can be implemented to reduce the risk of hospitalization, emergency room use, and exacerbation of the condition. PrimeWest Health identifies asthma, pneumonia, congestive heart failure (CHF), COPD, dehydration, hypertension, urinary tract infections, and septicemia as our ACSC diagnoses that generate the highest utilization of medical services (i.e., hospitalizations).

Behavioral Health Conditions
The following chart identifies the prevalence of mental health and chemical dependency conditions, as well as number of members who have both mental health and chemical dependency conditions.



Data Source – PrimeWest Health Claims Data Queried from October 2012 – September 2013

Description of the Health Conditions Affecting Prime Health Complete Members
PrimeWest Health Care Management staff monitors, analyzes, and manages the data to ensure that opportunities to improve overall health outcomes for all members are identified and opportunities for improvement are implemented.

Top Five Medical Conditions
Among Prime Health Complete members, 57.5 percent have two or more comorbidities. 31.6 percent have a primary medical diagnosis that co-occurs with a minimum of two comorbidities. Data clearly shows that the majority of these members have multiple medical conditions. Based on claims submitted for heart disease and/or associated diagnoses, approximately 49.7 percent of Prime Health Complete members suffer from depression, making it the leading diagnosis. Depression is followed by heart disease, diabetes, asthma, and COPD.

Heart Disease
The incidence of heart disease among Prime Health Complete members is 43.5 percent. This is higher than the Minnesota average, which is 6.8 percent, the national Medicare average, which is 12 percent, and the PrimeWest Health total population average, which is 16.83 percent. (Data Source – Minnesota Department of Health – Heart Disease and Stroke in Minnesota Report)

Diabetes
The incidence of diabetes among Prime Health Complete members is 29 percent. This is lower than the Minnesota average, which is 33.2 percent, and is higher than the national Medicare average, which is 26.9 percent. It is lower than the PrimeWest Health total population average, which is 35 percent. (Data Source – Minnesota Department of Health – Diabetes in Minnesota Report)

Depression
The incidence of depression among Prime Health Complete members is 49.7 percent. This is much higher than the Minnesota average, which is 5.9 percent, as well as the national Medicare average, which is 10 percent.

Chronic Obstructive Pulmonary Disease (COPD)
The incidence of COPD among Prime Health Complete members is 13.5 percent. This is higher than both the Minnesota average, which is 4.1 percent, and the national Medicare average, which is 6.1 percent.

Asthma
The incidence of asthma among Prime Health Complete members is 14 percent. This is twice the Minnesota average, which is 7 percent, and above the national average of 9.1 percent.

Disease	% of Prime Health Complete Population	Minnesota Average	% of Medicare Advantage Population
Heart Disease	43.5%	3.5%	12%
Diabetes	29.0%	33.2%	26.9%
Depression	49.7%	5.9%	10%
COPD	13.5%	4.1%	6.1%
Asthma	14.0%	7%	9.1%

Behavioral Health Conditions

Mental Health and Chemical Dependency
80 percent of Prime Health Complete members have a mental health diagnosis but only 15 percent have an identified chemical dependency diagnosis. The dual diagnosis of mental health and chemical dependency affects 14 percent of this population.

The PrimeWest Health Data Coordinator, under the direction of the Chief Senior Medical Director and Director of Quality & Utilization Management, identifies medical, comorbid, mental health, and chemical dependency conditions through claims data and from chart reviews. The Data Coordinator queries the PrimeWest Health database using the International Classification of Diseases (ICD-9 or ICD-10), Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), and other standardized code sets to generate UM reports each quarter. Data is tracked over time to monitor and/or respond to any identified trends.

Population Demographics
Demographics for Prime Health Complete members are broken out by age and gender in the following tables.

Age	All Prime Health Complete members
Average age in years	51.02
Average age of female members	51.73
Average age of male members	50.14

Gender	# of Prime Health Complete members	% of Prime Health Complete members
Female	116	55.24%
Male	94	44.76%
Total	**210**	**100.00%**

Age Range	# of Prime Health Complete members	% of Prime Health Complete members
15 – 19	0	0.00%
20 – 24	1	0.48%
25 – 29	6	2.86%
30 – 34	11	5.24%
35 – 39	18	8.57%
40 – 44	14	6.67%
45 – 49	36	17.14%
50 – 54	41	19.52%
55 – 59	40	19.05%
60 – 64	34	16.19%
65 – 69	8	3.81%
70 – 74	1	0.48%
75 – 79	0	0.00%
Total	**210**	**100.00%**

Data Source – PrimeWest Health Enrollment Database

Language/Ethnicity

The following tables show the language and ethnicity profile of Prime Health Complete members.

Language	# of Prime Health Complete members	% of Prime Health Complete members
English	210	100.00%
Laotian	-	0.00%
Russian	-	0.00%
Spanish	-	0.00%
Vietnamese	-	0.00%
Other	-	0.00%
Unknown	-	0.00%
Total	**2,529**	**100.00%**

Data Source – PrimeWest Health 2013 Enrollment Data

Ethnicity	# of Prime Health Complete members	% of Prime Health Complete members
American Indian/Alaskan Native	2	0.95%
Asian	1	0.48%
Black or African American	1	0.48%
White	206	98.10%
None	-	0.00%
Unable to Determine	-	0.00%
Total	**210**	**100.00%**

Data Source – PrimeWest Health 2013 Enrollment Data

Prime Health Complete members are predominately white at 98.1 percent of the population and entirely English speaking at 100 percent. There is a very small number of Native Americans (0.95 percent) accounting for less than 1 percent of the population. Although the Prime Health Complete population is predominately white and entirely English speaking, PrimeWest Health assesses needs that may be affected by ethnic affiliation and language spoken and provides appropriate services to meet any needs documented on the care plan and through the Interdisciplinary Care Team (ICT) notes/meetings.

Potential Health Disparities Associated with Language Barriers
PrimeWest Health recognizes language as the means by which our members access the health care system, learn about services, and gather information to make informed decisions about their health. Language is also the means by which health care providers are able to learn about members' beliefs about health and illness. Therefore, communication is key to providing appropriate and necessary care and improving health care literacy. If members cannot understand what is being taught or explained to them by health care providers, they will not be able to comply with treatment plans or recommendations.

Language and Interpreter Needs

	Prime Health Complete members	All PrimeWest Health members
Speaks English at home	99.7%	99.2%
Needs interpreter to communicate with health care providers	2.1%	1.9%

Data Source – 2013 Minnesota Department of Human Services CAHPS results

There were no claims for interpreter services associated with this population in 2012 and none in 2013. Although Prime Health Complete member population is entirely English-speaking, any language barriers identified during the initial and annual health risk assessment process are addressed on the member's care plan with appropriate interventions detailed in order to ensure covered services are accessible and provided to the member.

PrimeWest Health follows the US Department of Health and Human Services Culturally and Linguistically Appropriate Standards (CLAS) for members identified with cultural or linguistic needs. CLAS requirements are implemented as follows:

- All required written member materials are submitted to DHS and CMS for review and approval prior to dissemination/communication to members
- Member communications are written at or below a 7th grade reading level, using the Flesch-Kincaid Readability Statistics score as determined under MN Stat. sec. 72C.09. All written materials are printed in 12-point font or larger.
- All non-required written member publications, including website text and the member newsletter, ***PrimeLines***, also follow font and reading level requirements and are submitted to DHS for review and approval or as a courtesy, and CMS if required.
- Written material for participants in Prime Health Complete includes both Medicare and Medicaid (Medical Assistance) information when required.
- PrimeWest Health ensures provision of member materials, including the ***Evidence of Coverage***, in alternate formats as required by DHS, free of charge, upon request of the member or county PH/HS staff on behalf of a member.
- PrimeWest Health ensures that non-English-speaking members receive information in their primary language at no charge by providing oral interpretation.
- All printed member communication includes the State-approved language block. The language block instructs members in English and 10 other languages how to contact PrimeWest Health to access free interpreter services, ensuring that we can communicate effectively with members regardless of their primary language.
- PrimeWest Health maintains compliance with MN Stat. sec. 62D, subd.8 and applicable rules and regulation promulgated by the Minnesota Commissioner of Commerce and Health.
- Member materials that reference access to covered benefits or the PrimeWest Health network explain the right of American Indians to access out-of-network services at tribal and Indian Health Service clinics. While not required, PrimeWest Health also added a section to the ***Primary Care Network Listing*** and ***Provider Directory*** listing with the IHS clinic listing and confirms the accuracy of the listing with each clinic at least once each year.

Potential Health Disparities Associated with Deficits in Health Literacy

More than one third of all adults are considered to have basic or below basic health literacy skills, and adults with disabilities are more likely to have basic or below basic health literacy skills than those not disabled. Forty-nine percent of people with less than a high school education will fall into the below basic literacy skill category. In addition, compared to privately insured adults, both publicly insured and uninsured adults have lower health literacy skills.

The ability to obtain, process, and understand basic health information and services is necessary in order to make appropriate health decisions. Lack of familiarity with medical terms or the inability to accurately interpret numbers, lab values, or service results, all pose potential additional risks to a person's ability to make appropriate health care decisions. Members with disabilities may experience confusion or have difficulty remembering what their health care provider says to them about their condition or may have multiple conditions to deal with.

The following description is considered a typical profile of a Prime Health Complete member. The average age of a Prime Health Complete member is 51 and all are disabled, which makes them at risk of being in the lowest health literacy level. Almost six percent of Prime Health Complete members have 8th grade or less education, putting them in the below basic literacy skill category. 92 percent of all Prime Health Complete members have one or more chronic conditions, 58 percent have two or more chronic conditions, 31.6 percent have three or more chronic conditions, and 80 percent have some type of a mental health diagnosis. Finally, all Prime Health Complete members are publicly insured. (Data Sources – U.S. Department of Health & Human Services Office of Disease Prevention and Health Promotion; 2013 CAHPS; and PrimeWest Health Claims Database)

Potential Health Disparities Associated with Poor Socioeconomic Status
Education, income, and occupation are all indicators of socioeconomic status and are factors that play a key role in the health status of the Prime Health Complete member group.

Education
Lack of education is usually associated with low health literacy, which in turn (as discussed earlier) inhibits members' ability to comprehend information related to health care and their ability to comply with treatment and/or care plans and recommendations.

PrimeWest Health has identified that 18.9 percent of our Prime Health Complete members have self-identified as having less than a high school education and 81.1 percent have completed high school or higher education.

Highest level of education completed	Prime Health Complete Population	PrimeWest Health Population
8th grade or less	5.5%	7.9%
Some high school	13.4%	12.9%
High school graduate or GED	46.5%	40.7%
Some college/2-year college	29.1%	31.5%
4-year college	5.0%	5.3%
More than 4-year college	0.5%	1.6%

Data Source – 2013 DHS CAHPS

Income
All PrimeWest Health Prime Health Complete members are of poor economic status. The 13 PrimeWest Health counties average 12 percent poverty level compared to 11.8 percent of Minnesota.

Economic Status of PrimeWest Health Counties and as a Percent of the Population At or Below Poverty Level

County	% of population at or below poverty level
Beltrami	20.4%
Big Stone	9.0%
Clearwater	18.9%
Douglas	10.8%
Grant	10.4%
Hubbard	14.1%
McLeod	8.2%
Meeker	9.3%
Pipestone	12.7%
Pope	10.3%
Renville	11.1%
Stevens	13.3%
Traverse	12.4%
PrimeWest Health Counties Average	**12%**
Minnesota Average	**11.8%**

Occupation

Eligibility criteria for Prime Health Complete require members to be age 18 – 64 and disabled and be eligible for Medicaid (Medical Assistance). Members of Prime Health Complete are within the age range of most working adults and several hold jobs in occupations such as retail store greeters and fast food restaurants workers.

Potential Health Disparities Associated with Cultural Beliefs

The ethnic culture of the Prime Health Complete population is a subset of rural Minnesota. The 13 PrimeWest Health counties are populated primarily with people of Scandinavian, Irish, German, and Polish heritage, with the northern three counties (Beltrami, Hubbard, and Clearwater) having the highest percentage of Native Americans (1 percent). Minnesota's metropolitan area and larger non-rural areas have a significant number of other ethnic groups, such as Somali and Hmong, but no Prime Health Complete members belonging to these ethnic groups have been identified in our enrollment files in 2013. In addition, there are counties in Minnesota with a significant Hispanic population, particularly migrant agricultural workers. While this has some impact on the PrimeWest Health Medicaid (Medical Assistance) population in one of our 13 counties (Renville), where 6.6 percent of the population is Hispanic, there are no members who identify themselves as Hispanic in Prime Health Complete.

Rural Minnesota culture is typical of rural American culture, in the sense that people maintain strong ties to their community and share a set of beliefs and values. This includes the philosophies of neighbors caring for neighbors, buying local, supporting community schools, involvement in local politics, and the church being the center of most social gatherings. Protestantism is adhered to by the majority of Minnesotans (various Lutheran denominations),

while Roman Catholics are the largest single denomination in Minnesota. Approximately one-third of Minnesotans state they do not have any religious affiliation. This is consistent with PrimeWest Health's 13 counties.

As part of the Prime Health Complete health risk assessment process, all members are assessed for cultural and religious beliefs upon initial assessment and annually thereafter. Any identified cultural and/or religious needs are documented on the member's ICP with associated goals and interventions. The 2013 care plan audit indicated that 50 percent of Prime Health Complete members identified additional cultural and/or religious needs or considerations.

Potential Health Disparities Associated with Caregiver Support
According to the National Alliance for Caregiving, 29 percent of the United States adult population provides important societal and financial contributions toward maintaining the well-being of those they care for. A review of the Prime Health Complete care plan audit identified that only 63.3 percent of Prime Health Complete members have identified caregiver support, the lack of which correlates to a potential for a higher rate of health disparities. This is not unexpected and probably due to the disability of the member.

Define unique characteristics for the SNP population served. D-SNP: What are the unique health needs for beneficiaries enrolled in a D-SNP? Include limitations and barriers that pose potential challenges for these D-SNP beneficiaries.

Unique Characteristics of the Prime Health Complete Population
From the available data sources described above, PrimeWest Health defines the unique characteristics of the Prime Health Complete member as follows:

- Average age is 51 years
- Single
- White
- English-speaking
- Almost equal chance of being male or female
- Below the poverty level (all Prime Health Complete members are Medicaid [Medical Assistance]-eligible)
- Probability of having one or more chronic conditions (depression, primary) with high probability of heart disease
- Low probability of having a chemical health concern
- High probability of eight prescriptions per month (includes over-the-counter)
- 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
- Considers themselves to be of Christian faith (Lutheran denomination or Catholic)
- Probability of being a smoker or past smoker
- High probability of being a high school graduate
- Low probability of having a hearing impairment, average probability of needing corrective lenses for vision impairment

- 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 Medicaid (Medical Assistance) services
- Perceives timely access to necessary services, including primary and specialty care, above the Minnesota average (see DHS CAHPS results in the following table)
- Ranks chosen CCM and/or PrimeWest Health care coordinator as helpful with member concerns (over 98 percent satisfaction)
- High probability of rating quality of life as excellent to very good
- Probability of perceiving their overall mental or emotional health to be unchanged from previous year
- Moderate probability of needing transportation services

DHS CAHPS Results for Prime Health Complete

2008	2009	2010	2011	2012	2013	2013 MN
Getting Needed Care						
-	91.5%	95.2%	89.3%	90.6%	86.6%	83.7%
Getting Care Quickly						
-	91.9%	87.8%	87.1%	91.4%	84.0%	81.8%

Unique Health Needs for Prime Health Complete Enrolled Members

Utilizing the unique characteristics for this population, PrimeWest Health has identified the unique health needs for this population to include, but not be limited to, the following.

Management and Coordination of Multiple Conditions

PrimeWest Health has identified that Prime Health Complete members require more complex care or coordination of care. These members may require more frequent face-to-face visits with case managers, primary care providers, and/or specialists to address their multiple chronic conditions and, at times, 24-hour care or other formal support services are needed.

Presence of Informal Caregiver Support

Based on care plan data, many Prime Health Complete members have low informal caregiver support. This means they do not have family, friends, or neighbors near them who can help with their activities of daily living.

Mobility/Transportation

Members' ability to get in and out of vehicles and office settings may be another unique health issue. Claims data show that many members use specialty transportation to help in this area. Members often do not have reliable sources of transportation, which can make it difficult for them to adhere to their treatment plan. The inability to navigate within the community or have personalized visits from family or friends may increase feelings of isolation.

Nutrition

The affordability of healthy food is a unique health need as all Prime Health Complete members qualify for Medicaid (Medical Assistance), which means they are at or below the poverty level. Healthy foods are often more expensive then unhealthy processed choices.

Health Literacy

Prime Health Complete members have a high probability of low health literacy. Members with low health literacy may have difficulty understanding the health care information provided to them by their primary care provider if medical terminology is used in a technical format. PrimeWest Health provides member and educational materials to members that are written at a 7th grade or lower reading level.

Religious/Cultural Beliefs

A small percentage of Prime Health Complete members are American Indian and consider a traditional spiritual healer to be their primary health care source. This tradition/cultural belief does not follow traditional western medicine or practices.

Low Socioeconomic Status

Because Prime Health Complete members live at or below the poverty level, they may have inadequate housing. Members' inability to heat or cool homes to a reasonable temperature during very cold or hot weather may exacerbate health conditions. Members' inability to maintain cleanliness in their home due to physical or psychological reasons may also exacerbate certain health conditions.

Average Number of Medications

Due to complexity of their health needs, many Prime Health Complete members need assistance in coordinating their multiple prescriptions. PrimeWest Health offers Medication Therapy Management (MTM) to members who qualify.

Potential for Fresh Water Issues (Well System Access)

The average Prime Health Complete member has a moderate probability of being located in a county that has higher than recommended arsenic in their groundwater. This could lead to adverse health effects like skin damage or problems with the circulatory system, and may lead to an increased risk of cancer.

Limitations and Barriers

PrimeWest Health ensures that each member has a barrier assessment conducted in conjunction with the initial and annual health risk assessment and as appropriate. The barrier assessment addresses the following areas:

- The member's understanding of his/her condition(s) and treatment
- The member's desire to participate in the care management plan
- The member's belief that participating will improve his/her health
- The member's financial or transportation limitations that may hinder participation in care

- The member's mental and physical capacity to participate in care (includes cognitive limitations, i.e., dementia or developmental disabilities)
- The member's cultural or spiritual beliefs or barriers that may limit his/her ability to participate in conventional health care provision or services
- The member's visual or hearing impairments

A summary assessment of Prime Health Complete members' potential barriers revealed a number of findings as outlined below.

Health Literacy

A November 2010 paper, titled "Health Literacy Implications of the Affordable Care Act,"[4] stated that health literacy can be a significant issue for the Medicaid (Medical Assistance) population as they face "serious communication barriers related to limited literacy, language, culture and disability." Using the Prime Health Complete care plan audit, we were able to determine that 21.8 percent of the Prime Health Complete population refused to participate in all recommended treatment and services. While there are other reasons that a member may refuse all treatment and services, it may be a reasonable assumption that lack of health literacy may play a part in such a decision. PrimeWest Health has identified this as a barrier that poses a challenge for this population.

Participation in Care Management Plan

All Prime Health Complete members have case managers assigned to them based on county of residence. Prime Health Complete members may choose and/or change their case manager at any time. This population is highly encouraged to be active participants in their care management, but they always have the choice whether to participate in the case management services; members are never forced to take an active role in their care if they choose not to. Prime Health Complete has 21.8 percent of members who have refused case management services, demonstrating a low to nonexistent desire to participate in care management. See further detail regarding members who refuse case management services Chapter 2, Section B: Health Risk Assessment Tool (HRAT). PrimeWest Health does not perceive this to be a barrier to the majority of the population.

Belief That Participating Will Improve Their Health

Care management takes an investment of time, attention, and commitment from members. Over 78.2 percent of members actively participate in the care management plan, which would reasonably demonstrate that Prime Health Complete members believe the care management plan will help them improve or at least maintain their current health. This is supported by the PrimeWest Health Case Management Survey Results, which indicate that 98 percent of respondents feel that their CCM is helpful and 98 percent state they have been receiving the covered benefits they need. In view of these results, PrimeWest Health does not perceive this to be a barrier to the majority of the population.

[4] Stephen A. Somers and Roopa Mahadevan, "Health Literacy Implications of the Affordable Care Act." November 2010. Center for Health Care Strategies, Inc. Accessed February 20, 2014, http://www.iom.edu/~/media/Files/Activity%20Files/PublicHealth/HealthLiteracy/Commissioned-Papers/Health%20Literacy%20Implications%20of%20Health%20Care%20Reform.pdf

Financial or Transportation Limitations

All Prime Health Complete members qualify for Minnesota Medicaid (Medical Assistance), meaning that 100 percent of our members have financial limitations. Through care plan evaluations, we found that 40 percent of this population needs assistance with transportation. PrimeWest Health has identified this as a barrier that poses a challenge for this population.

Mental and Physical Capacity to Participate in Care

PrimeWest Health identified a total of 33.2 percent of Prime Health Complete members as having has mental, physical, and cognitive capacity barriers that may impede their ability to effectively participate in their care. Prime Health Complete has 18 percent of members who are diagnosed with a serious and persistent mental illness (SPMI) and have significant identified barriers. 7.8 percent have a diagnosis of dementia and 24.4 percent have a diagnosis developmental delay. Finally, 1 percent are completely unable to participate in their care at any level. PrimeWest Health has identified these as barriers that pose a challenge for this population.

Cultural or Spiritual Beliefs

PrimeWest Health assesses cultural and spiritual beliefs during the initial and annual health risk assessment and also during any transition or change in the plan of care. It has been identified that 50 percent of the designated community well population have identified barriers in participation and service provision due to cultural and spiritual beliefs. Some examples are tribal members who identified that their traditions needed to take priority over scheduling of health services, members who noted that family dinners were important and no scheduling of services during this time was possible, and cultural dietary needs. The Native American population may have cultural and spiritual healing needs that are not always available in traditional western medicine outside their communities. However, since 2006, PrimeWest Health has only had one request for a traditional medicine man, which was honored, but it was not for a member of Prime Health Complete. PrimeWest Health has identified this as a barrier that poses a challenge for this population.

Visual or Hearing Impairments

Given that the average age of the Prime Health Complete member is 51 and disabled, it is not surprising that visual and hearing impairments are elevated. Hearing impairment is identified as a barrier in 6.7 percent of the population and visual impairment affects 46.7 percent of members. Note: visual barriers are assessed and reviewed with consideration for the impact they have on the member's ability to function. For example, losing a pair of reading glasses may seem minor until you consider the written information that the member has to read on a daily basis, such as prescription instructions on a pill bottle or discharge instructions from an inpatient setting. Members' individual barriers are evaluated at a minimum annually, with systems and supports put in place to eliminate or reduce their impact. PrimeWest Health has identified this as a barrier that poses a challenge for this population.

Most Common Barriers and Limitations

Through our assessment, PrimeWest Health has identified the following barriers as the most commonly shared among the Prime Health Complete population:

- Health literacy
- Financial or transportation limitations
- Mental and physical capacity to participate in care
- Refusal to participate in case management services

A. Sub-Population: Most Vulnerable Beneficiaries

As a SNP, you must include a complete description of the specially-tailored services for beneficiaries considered especially vulnerable using specific terms and details (e.g., members with multiple hospital admissions within three months, "medication spending above $4,000"). Other information specific to the description of the most vulnerable beneficiaries must include, but not be limited to, the following:

A description of the internal health plan procedures for identifying the most vulnerable beneficiaries within the SNP.

Because PrimeWest Health Care Management and Quality & Utilization Management staff delineate and identify the most vulnerable Prime Health Complete members through various scheduled and standard utilization review reports generated from a comprehensive database. These reports are based on specific utilization management criteria aimed at identifying members with long-term, complex, or catastrophic illnesses, conditions, or circumstances that usually involve high-cost treatment or service provisions. Report specifications are identified and determined using State Medicaid (Medical Assistance) and Medicare best practice guidelines and NCQA Complex Case Management criteria requirements. Criteria are initially developed by Care Management staff, including medical director guidance, and then presented to QCCC for discussion and recommended to the JPB for final approval. Criteria are reviewed no less than annually by QCCC with final approval by the JPB.

PrimeWest Health uses a comprehensive claims and care management data warehouse that provides medical, mental health, pharmacy, dental, chemical health, and PH/HS provision data to identify the most vulnerable sub-populations. The following criteria are applied to the reports that are generated from the above-mentioned data repositories to assist PrimeWest Health's review and coordination of care for this most vulnerable population. Members who meet one or more of the following criteria are included in this most vulnerable sub-population.

Utilization Management (UM) Criteria Used to Identify the Most Vulnerable Sub-Population

- Frequency of hospitalization – three hospitalizations in three months (3 members identified in 2013)
- Readmissions to the hospital within 30 days of discharge (3 members identified in 2013)
- Lengths of stay greater than four days (16 members identified in 2013)

- Six emergency room visits in previous three months (2 members identified in 2013)
- 10 or more office visits in previous three months (18 members identified in 2013)
- $100,000 or more in medical expenses (includes pharmacy), including hospitalization in the last year (8 members identified in 2013)
- Three or more chronic conditions (61 members identified in 2013)

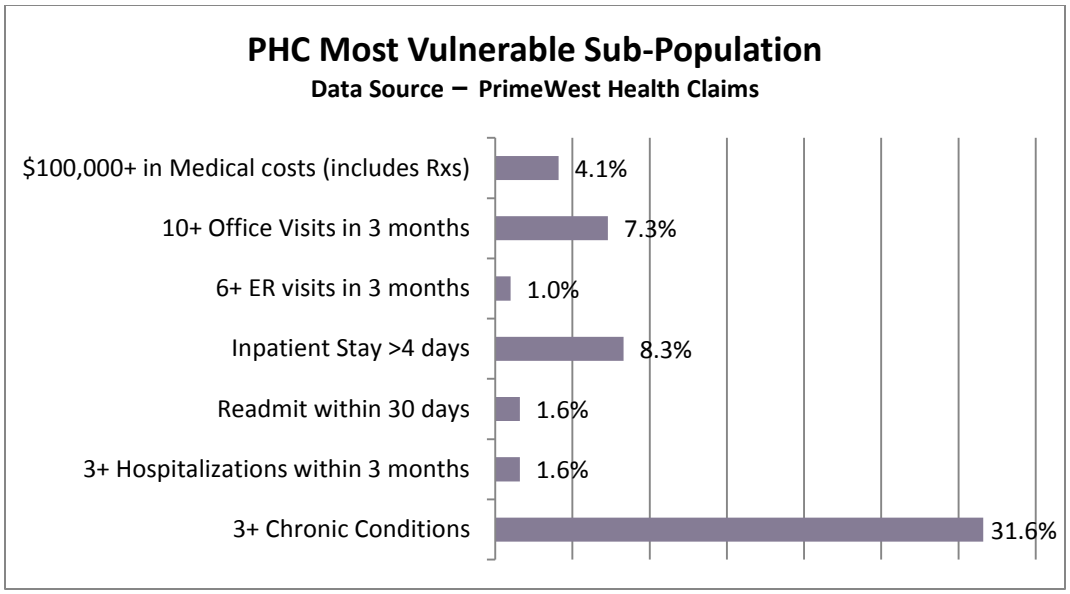
UM reports are generated on a scheduled basis (monthly, quarterly, and annually) by the PrimeWest Health Data Coordinator in collaboration with PrimeWest Health's Financial & Data Management department. These reports are auto-generated and sent to the Complex Care & Disease Management Manager who disseminates the information to the Care Management (CM) Care Coordinator for review.

A description of the relationship between the demographic characteristics of the most vulnerable beneficiaries with their unique clinical requirements. Explain in detail how the average age, gender, ethnicity, language barriers, deficits in health literacy, poor socioeconomic status and other factor(s) affect the health outcomes of the most vulnerable beneficiaries.

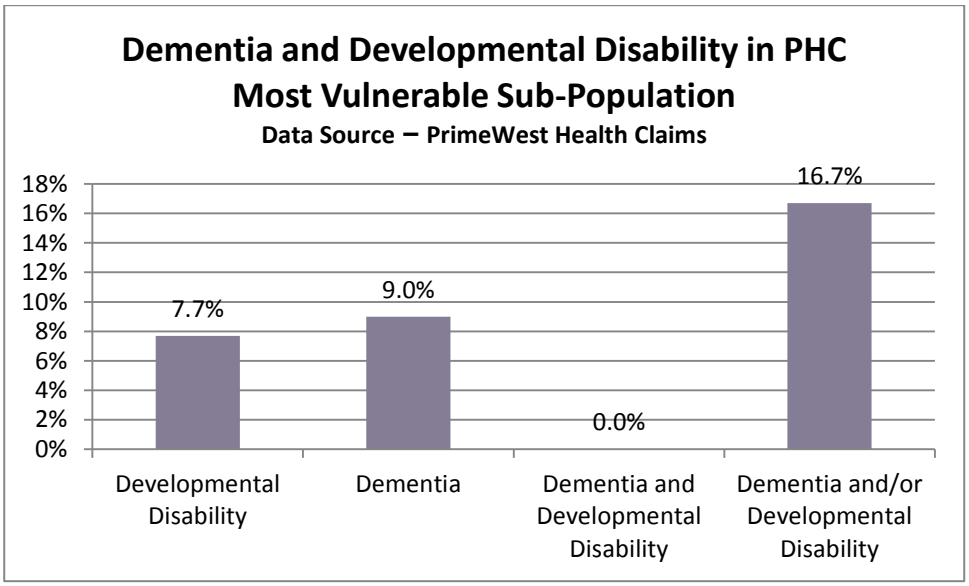
The demographics of the most vulnerable members are reviewed and analyzed at least annually. This review includes the average age, gender, ethnicity, and language spoken. Our members are disabled and have poor socioeconomic status, which automatically places them as a vulnerable sub-set of the Minnesota population. In addition, 31.6 percent have three or more chronic conditions, 65.4 percent have a mental health diagnosis, 80.6 percent have mental health and/or chemical dependency diagnoses, 93.6 percent have dementia, and 16.7 percent have dementia and/or developmental disabilities.

Below, we make a correlation between the demographic characteristics of the most vulnerable sub-population and the unique clinical requirements that affect member health outcomes.

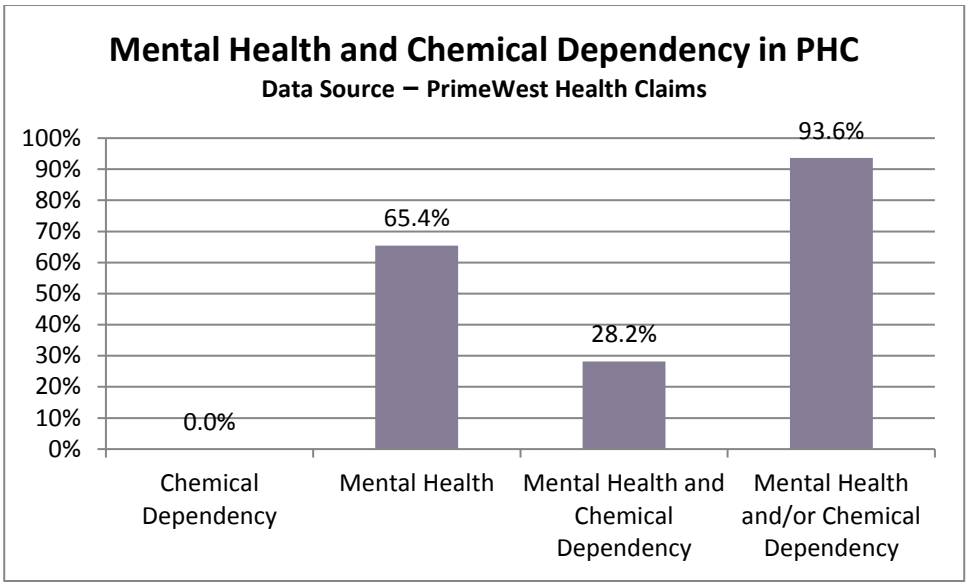
As shown in the following chart, the most vulnerable sub-population is identified and categorized by the identifying factors listed in the previous section. This chart demonstrates the percentage of the Prime Health Complete population that fell within these high-risk categories during 2013. Based on this data, 40.4 percent of the Prime Health Complete (PHC) population is identified as being in the most vulnerable sub-population. Having three or more chronic conditions has the highest prevalence within the sub-population.



The following chart shows the percentage of the most vulnerable sub-population with dementia and/or developmental disability diagnoses during 2013.



The following chart shows the percentage of the most vulnerable sub-population with mental health and chemical dependency diagnoses during 2013.



Average Age

According to PrimeWest Health UM reports, the average age of this vulnerable sub-population is 52.6. As such, it is likely that these members will be affected by chronic diseases, injuries, mental health problems and depression, overweight, pain, and fatigue, as these occur more often among people with disabilities. Generally, adults with disabilities are more likely to have poorer overall health, less access to adequate health care, and higher smoking rates and physical inactivity. Data gathered on PrimeWest Health's most vulnerable sub-population supports this: 31.6 percent have three or more chronic conditions and 65.4 percent have a mental health disorder. This correlates to needing a higher level of enhanced case management, higher frequency of office visits/clinical monitoring, and having a high potential to need a 24-hour care setting or caregiver support.

Gender

Gender demographics for this most vulnerable sub-population are gathered from PrimeWest Health UM Reports. According to the CDC, women are more likely to be disabled then men with 11.5 percent of women reporting a disability as compared with 10.3 percent of men. However, our profile indicates that men are more significantly represented in the PrimeWest Health most vulnerable sub-population.

Gender Data for Most Vulnerable Sub-Population

Gender	% of most vulnerable
Male	59%
Female	41%

Ethnicity and Language

The ethnicity and language of the entire Prime Health Complete population is representative of the most vulnerable sub-population. Members are primarily white and all are English-speaking. Ethnicity and language does not appear to affect the health outcomes of the Prime Health Complete population at this time. However, interpreter services and alternative formats for

member materials have occasionally been requested and are accommodated through established policies and procedures and systems.

Deficits in Health Literacy

The deficit in health literacy of the entire Prime Health Complete population is similar to that of the most vulnerable sub-population. Members with cognitive issues (e.g., dementia, developmental disabilities, brain injuries) are most likely to have health literacy deficits. Of this sub-set of the most vulnerable, 16.7 percent have a diagnosis of dementia and/or developmental disabilities. Therefore, the health literacy deficit affects the majority of this population, which can lead to poor health outcomes. This demonstrates the need for enhanced case management to provide caregivers with education on health literacy for members who are cognitively unable to process health information themselves. For those who can understand their health condition and demonstrate compliance, education is provided through enhanced case management.

Poor Socioeconomic Status

The entire population is classified as having a poor socioeconomic status. Eligibility criteria for the Prime Health Complete population require that members qualify for Minnesota Medicaid (Medical Assistance) which classifies them as being of poor socioeconomic status. Poor socioeconomic status can lead to noncompliance because a member may not be able to afford medical interventions. Research demonstrates that poverty leads to poor health outcomes. Enhanced case management connects members to community services and programs that can help them meet their physiological needs such as food/housing/heating assistance, transportation, and companion services.

Specially Tailored Services

In response to this sub-population's risk for adverse health outcomes, PrimeWest Health responds with specially tailored enhanced case management and/or care management and other identified services to meet the individual clinical requirements and needs of its members. With enhanced case management and/or care management activities, heightened collaborative care management efforts are implemented with the member's primary care provider, Chief Senior Medical Director, identified specialists(s), pharmacist, PrimeWest Health's Complex Care & Disease Management Manager (having responsibilities for Prime Health Complete). The Director of Quality & Utilization Management may also be involved in the process.

Based on the criteria previously described, the CM Care Coordinator receives various utilization management reports identifying the most vulnerable sub-populations and compares the members on those reports to a report of which members are currently receiving case management services and to another report of which members have refused case management services. All Prime Health Complete members are assigned a CCM and CM Care Coordinator upon enrollment into the plan. The member may choose to refuse the county case management service, but the CCM is always assigned to the member should the member choose to accept the service at any point (life changing event, transition of care episode, etc.). Historical health outcome data indicates members who have accepted case management services have better health outcomes than members who have refused.

Enhanced Case Management and/or Care Management for Prime Health Complete Members Who Initially Declined Case Management Services

After a member who has previously refused county case management is identified in any of the most vulnerable population utilization management reports, the CM Care Coordinator carries out the following activities:

- Reviews any and all available CCM or care coordinator notes, any documented care planning activities, including the individualized interventions and member goals (even if a member has refused an initial assessment, all Prime Health Complete members must have a care plan)
- Reviews documented formal and informal support services
- Conducts an all-inclusive claims review for medical, mental health, and pharmacy profile as well as currently implemented services

Based on the utilization management report data and initial research of available documentation and claim history, the Prime Health Complete Coordinator then contacts the assigned CCM either by email or phone to discuss the member's identification on one (or more) of the most vulnerable sub-population utilization management reports. The CM Care Coordinator may request the assigned CCM make an additional attempt to contact the member to offer a face-to-face assessment and case management services. The CCM attempts to educate and engage the member in understanding and accepting case management services based on their demonstrated needs. Once the member accepts an assessment, enhanced case management/care management services proceed as described below.

Role of CM Care Coordinator with Enhanced Case Management/Care Management Services

The CM Care Coordinator's role is as follows:

- Monitors CCM notes and care planning activities
- Reviews the updated care plan for identified service provision based on assessed needs to ensure the utilization report data is being addressed
- Reviews current living arrangements and caregiver support with CCM
- Reviews current available and/or necessary community support services
- Ensures primary care and/or identified specialty care involvement by reviewing the ICT composition. Intervenes on behalf of the CCM if indicated.
- Engages other appropriate PrimeWest Health staff, such as the Chief Senior Medical Director, Pharmacy Manager, etc.
- Recommends potential additional health screenings and/or assessments (chemical and/or mental health)
- Encourages and assists with arranging ICT meetings, including active participation
- Offers assistance in identifying potential additional and/or other supporting covered benefit services (identified below) and other PH/HS community services, including Medicaid Managed Disability Waivers
- Assists the primary care provider and CCM initiate any service provisions such as Service Authorizations for requested additional services, e.g. specialty care, special and/or emergency transportation arrangements, transition of care requirements, etc.
- Discusses with the CCM the need to increase in-home, face-to-face contact and primary care until stabilization

- Assures appropriate clinical guidelines and care maps (diabetes, congestive heart failure, etc.) and/or fast track interventions (urinary tract infection [UTI], skin breakdown) are implemented when utilization reports indicate unplanned emergency room visits and inpatient transitions
- Assists CCM with planned and/or unplanned transitions
- Recommends Medication Therapy Management (MTM) and pharmacist involvement when indicated

Role of CCM with Enhanced Case Management/Care Management Services
The CCM provides individual attention and brings in outside community supports and services as needed, such as housing assistance, food/energy/heating assistance, spiritual supports, and support groups. Further community support and integration is described in greater detail in the next section of this chapter. The CCM's role in enhanced case management includes, but is not limited to:

- Accompanying members to health-related appointments
- Providing member education related to specific and indicated needs (medical, social, etc.)
- Arranging for ICT meetings, including in an inpatient setting if indicated
- Assisting with coordination of discharge planning from inpatient settings
- Face-to-face meetings
- Increasing communication and monitoring of the member's status to as often as five days a week if needed
- Encouraging compliance with the treatment plan, including medication compliance
- Assures all non-health plan-covered county waiver services are coordinated with covered health plan benefit
- Coordinates targeted case management activities with disability care management responsibilities
- Assists with any/all transitions from the Prime Health Complete program to the PrimeWest Senior Health Complete program for age-appropriate members when/if indicated
- Assures seamless transition of care processes

Enhanced Case Management/Care Management Services for Prime Health Complete Members Who Continue to Refuse County Case Management Services
If and when a Prime Health Complete member continues to refuse CCM services but continues to be identified on one or more of the most vulnerable sub-population utilization management reports, the CM Care Coordinator implements enhanced care management activities and assume a more active role in collaboration with the member's primary care provider. Activities include, but are not limited to, the following:

- Coordinates and communicates care management activities with primary care provider and other identified appropriate ICT members
- Concurrently monitors and reviews updated care plan for identified service provision based on assessed needs to ensure the utilization report data is being addressed
- Reviews current living arrangements and caregiver support
- Reviews current available and/or necessary community support services

- Ensures primary care and/or identified specialty care involvement by reviewing the ICT composition
- Encourages ICT meetings, including active participation
- Engages other appropriate PrimeWest Health staff such as the Chief Senior Medical Director, Pharmacy Manager, etc., if indicated
- Recommends potential additional health screenings and/or assessments (chemical and/or mental health) in collaboration with the primary care provider
- Offers assistance in identifying potential additional and/or other supporting covered benefit services (identified further below) such as PH/HS community services i.e., Targeted Case Management (TCM) and MLTSS. Coordinates these activities with county agency.
- Assists the primary care provider with initiating any service provisions such as Service Authorizations for requested additional services, e.g., specialty care, special and/or emergency transportation arrangements, transition of care requirements, etc.
- Assures transportation arrangements are coordinated with needed medical/mental health office visits
- Collaborates with primary care provider in ensuring that any identified medical/chronic care provisions are met
- Assists primary care provider with planned and/or unplanned transitions
- Recommends MTM when indicated
- Assures all non-health plan-covered county waiver services are coordinated with covered health plan benefit
- Assists with any/all transitions from the Prime Health Complete program to the PrimeWest Senior Health Complete program for age-appropriate members when/if indicated
- Assists with coordinating seamless planned or unplanned transitions

Enhanced Case Management and/or Care Management for Prime Health Complete Members Who Are Currently Receiving Case Management Services and Have Been Identified on One or More of the Most Vulnerable Sub-Population Utilization Management Reports

Based on the most vulnerable sub-population utilization management report data and initial research of available documentation and claim history, the CM Care Coordinator contacts the assigned CCM to discuss potential reasons why the member has been identified on one (or more) of the utilization management reports. The Disability Coordinator may request the assigned CCM make an additional face-to-face assessment visit.

All other enhanced case management/care management processes for members with existing case management services are as described previously for members who initially refused case management services but then agreed to the service.

Health Care Home

Regardless of whether the member has accepted or refused case management services, if the member's primary care provider clinic is designated as a Health Care Home (HCH), case management and care coordination processes are coordinated with the HCH. If the member has refused case management services, the CM Care Coordinator will collaborate with the HCH in assuming a more active role in meeting the identified member's needs. The PrimeWest Health

care management team supports the HCH by approving and helping to arrange covered benefit service provisions as well as any additional identified services. This includes collaborating with PH/HS agencies for needed community-based services. PrimeWest Health has embedded PHNs in the two HCH clinic sites within our 13 counties. This process has been valuable for bridging medical services with needed community-based services. When the HCH assumes additional care management activities, PrimeWest Health care management staff continue to monitor utilization management reports generated from the all-inclusive and comprehensive database and communicate utilization management data via secure network to the HCH care coordinator to share with the primary care provider and/or other identified members of the ICT. These two clinics also have access to the PrimeWest Health electronic ICP which allows real-time communication amongst all ICT members.

Medication Reconciliation Post-Discharge

In accordance with Title 42 Code of Federal Regulations (CFR) Part 412, PrimeWest Health has a medication reconciliation post-discharge initiative. For members who are discharged from the hospital to their home or other home-like environment, Prime Health Complete has a Quality Improvement Project (QIP) that focuses on medication reconciliation within 72 hours. This process is carried out in the home by an RN, who is often the CCM. In cases where the CCM is a social worker, he/she arranges for medication reconciliation in the home with a local home care agency. The medication reconciliation visit may lead to additional services that will be coordinated by the CCM. During medication reconciliation, if medication errors or omissions are found, the CCM works with the member's primary care provider to correct them. In additional, CCMs ensure that a follow-up visit with the primary care provider is scheduled and attended within 5 – 7 days of discharge. Using the teach-back method, CCMs ensure members understand their medications and the regimen per their discharge instructions. The CCM will continue with enhanced case management until the member's condition stabilizes.

Mental Health Targeted Case Management (MH-TCM)

Mental Health Targeted Case Management (MH-TCM) provides assistance to adults with serious and persistent mental illness. MH-TCM helps members gain access to needed medical, social, educational, or other services that are vital for recovery. Services are geared towards current diagnosis, mental health treatment history, level of functioning, and risk of mental health hospitalization. The MH-TCM manager is a social worker with at least two years' experience working with individuals with mental health diagnoses and is under the supervision of a mental health professional. These services can be provided in conjunction with enhanced case management with each CCM focusing on his/her assigned area. The CCM connects the member with mental health services appropriate for his/her diagnosis based on recommendations from the diagnostic assessment, which is done by a mental health professional. The CCM monitors the provision of services to ensure the member is getting the intensity of mental health services to improve their opportunity for recovery.

Additional Specially Tailored Services

PrimeWest Health recognizes that some members have multiple factors that make them vulnerable. In additions to those we have already identified as being the most vulnerable, members who fall into the following categories are also identified as needing additional services to meet their unique needs.

People with a Physical Disability and/or Chronic Illness
Services for this group include in-home services and neurological assessments. The in-home assessments may lead to an authorization request for durable medical equipment (DME) or other home adaptations that may be recommended but are normally outside the member's benefit set. PrimeWest Health reviews these requests on a case-by-case basis to provide individualized care.

Beneficiaries with Language Barriers
All PrimeWest Health counties have interpreter availability. PrimeWest Health reviews all Service Authorization requests related to necessary services and/or additional benefits for members with language barriers. If PrimeWest Health identifies a significant request for a specific service or item for members with language barriers, it will reassess its benefit set for inclusion in covered services.

Cultural and Racial Minorities
Culturally appropriate services rendered by providers with special expertise in the delivery of health care services to the various cultural and racial minority groups will be provided to the greatest extent possible within the PrimeWest Health service area. When needed, PrimeWest Health makes exceptions for rules around Personal Care Assistance (PCA) services so that members can receive care from providers with identified cultural expertise.

Dually Mentally Ill/Developmental Disabled and Mentally Ill/Chemically Dependent
Services for this group include comprehensive assessments and diagnostic and treatment services provided by staff trained to work with members with multiple disabilities and complex needs. PrimeWest Health also provides integrated dual disorder treatment, which is an evidence-based practice that treats co-occurring severe mental illness and substance use disorders and helps members to address both disorders simultaneously.

Lesbians, Gay Men, and Bisexual and Transgender People
PrimeWest Health and its CCMs work with its providers to develop care that is sensitive to the social and family issues unique to lesbians, gay men, bisexuals, and transgender people.

Hearing Impaired
PrimeWest Health and its CCMs provide access to TTY technology and interpreter services for hearing impaired members through the State Relay Service whenever a member needs and requests assistance to obtain covered services. PrimeWest Health reviews all Service Authorization requests related to necessary services and/or additional benefits for members with language barriers. If PrimeWest Health identifies a significant request for a specific service or item for members with hearing barriers, it will reassess its benefit set for inclusion in covered services.

Members in Need of Gender-Specific Mental Health and/or Chemical Dependency Treatment
Members are given the opportunity to receive mental health and/or chemical dependency services from a same-sex therapist and the option of participating in all-male/all-female group therapy programs if requested and available. PrimeWest Health attempts to find services that are

acceptable to members and/or that are appropriate to each member's needs as determined by a qualified therapist.

Developmentally Disabled (DD)
Services for this group include specialized mental health and rehabilitative services and other appropriate services covered in the member's benefit set. These services are designed to maintain or increase function and prevent further deterioration or dependency. After an initial assessment, an individualized service plan (ISP) is developed for the member, when appropriate. The treatment plan is coordinated with available community resources and support systems, including the member's county DD case manager.

Members Who Are Near End-of-Life
Services for this group include hospice services and palliative care. PrimeWest Health makes exceptions to standard benefit sets for payment of palliative care and/or hospice services that may not be in the Medicare/Medicaid (Medical Assistance) benefit set.

American Indians
PrimeWest Health provides culturally appropriate services rendered by providers with special expertise in the delivery of covered services to various tribes. American Indian members can access services provided by any facility of the IHS or a facility operated by a tribe or tribal organization.

Rehabilitative Care
Rehabilitative care is a covered benefit. PrimeWest Health has lifted Service Authorization caps for rehabilitative care, such as inpatient physical therapy (PT) treatment. Arrangements for such services are in collaboration with the CCM as part of the member's individualized care plan (ICP). PrimeWest Health reviews all Service Authorization requests related to necessary services and/or additional benefits for members in need of rehabilitative care. If PrimeWest Health identifies a significant request for a specific service or item for members in need of rehabilitative care, it will reassess its benefit set for inclusion in covered services.

Durable Medical Equipment (DME) and Assistive Technology
DME and Assistive Technology are covered medical supplies, equipment, and appliances suitable for use in the home. DME must be medically necessary, ordered by an eligible health care provider, documented in an ICP that is reviewed and revised as medically necessary by an eligible health care provider at least once a year, and provided to the member at the member's own place of residence, which must be a place other than a nursing facility or intermediate care facility/facility for the developmentally disabled (ICF/DD). PrimeWest Health reviews all Service Authorization requests related to necessary services and/or additional benefits.

Dental Services
PrimeWest Health believes dental care is important to primary care prevention. Dental services are covered benefits for members. PrimeWest Health employs a Dental Services Coordinator who works closely with the CM Care Coordinators and CCMs to ensure that dental care is provided to members in a timely manner. In addition, PrimeWest Health has contracted with a mobile dental unit that visits surrounding counties' SNFs to maximize access.

SNF Members at Risk for Mental Health Hospitalization
Mobile crisis services for individuals in SNFs are a covered benefit for PrimeWest Health members. Mobile crisis services allow for mental health practitioners and mental health professionals to go to a nursing home to provide services in the facility to stabilize and make recommendations and provide education to help manage a member's mental health symptoms to prevent them from escalating.

The identification and description of the established partnerships with community organizations that assist in identifying resources for the most vulnerable beneficiaries, including the process that is used to support continuity of community partnerships and facilitate access to community services by the most vulnerable beneficiaries and/or their caregiver(s).

PrimeWest Health contracts case management services to the county of the member's residence; this includes both Public Health and Human Services to ensure necessary access to both public health nurses and social workers. PrimeWest Health partners with the member's waiver case manager to ensure that the member is receiving the necessary community-based services, thus allowing members to maintain their independence and safety in a community setting. The PrimeWest Health network maintains local, community support service provision, which is congruent with social and cultural expectations. The PH/HS agencies in rural areas tend to be the business epicenters that house most programs designed to assist people who are vulnerable and/or socioeconomically disadvantaged, mentally ill, chemically dependent, and/or court-committed. CCMs are well versed in available and necessary community resources and provide the conduit to identified ICP-assessed services for the Prime Health Complete member. PrimeWest Health Community Reinvestment resources have been allocated and made available to local communities for the unmet needs of the population using local committees and funding such as Local Advisory Committees, Mental Health Initiatives, and Palliative Care Programs.

PrimeWest Health helps members access providers trained to meet their individual and unique assessed needs. When providers go through the contracting and credentialing process, any specific expertise, specialty, and/or certification are identified at that time. PrimeWest Health keeps that information and record of their credentials in our database. When members have special needs, we are then able to match them up with providers who can provide the appropriate care. Through this process, we are able to meet the unique needs of the most vulnerable sub-population of an already complex special needs population.

PrimeWest Health conducts member stakeholder meetings that providers, members, and caregivers attend to address any specific need or any partnerships that need to be developed or enhanced. In 2013, specific partnerships were developed between a clinic, clinic/hospital, public health, and human services. CCMs are embedded directly in the clinic and hospital to better coordinate care. PrimeWest Health refers to this demonstration project as Accountable Rural Health Care (ARCH). ARCH agreements simply expand the currently approved Prime Health Complete Model of Care by embedding a public health nurse (PHN) and/or social worker into the primary care clinic as a means of enhancing primary care provider involvement in the ICT process.

Because PrimeWest Health is owned by its 13 counties, the strength of the continuity of community partnerships remains consistent and is not expected to change. PrimeWest Health PH/HS agencies are embedded within our local communities. Their staff has first-hand knowledge of the demographics of our members and the resources available to ensure their unique needs are met, including the development of community partnerships. Participation and representation from local PH/HS agencies on committees within our communities plays a large role in the continuity and development of partnerships to not only identify, but develop additional resources to meet the needs of our members both at the social and health care levels. For example, PrimeWest Health staff sit on several boards and committees, which keeps us engaged with the ongoing operations of many of our community partners. Examples include, but are not limited to, the following:

- State and local hospice committees
- Local advisory boards for the mentally ill
- Adult mental health initiative committees

Chapter 2: Care Coordination

Care coordination helps ensure that SNP beneficiaries' healthcare needs, preferences for health services and information sharing across healthcare staff and facilities are met over time. Care coordination maximizes the use of effective, efficient, safe, and high-quality patient services that ultimately lead to improved healthcare outcomes, including services furnished outside the SNP's provider network. The following MOC sub-elements are essential components to consider in the development of a comprehensive care coordination program; no sub-element must be interpreted as being of greater importance than any other. All five sub-elements below, taken together, must comprehensively address the SNPs' care coordination activities.

A. SNP Staff Structure

PrimeWest Health employs and contracts with staff and organizations to ensure that it meets all administrative and clinical oversight functions within the organizational structure. PrimeWest Health's job titles and descriptions articulate and define roles and responsibilities for individuals participating in the health and social care of the dual eligible Prime Health Complete (HMO SNP) member[5]. The job title and descriptions are reflective of the individual's primary duties of care coordination for Prime Health Complete members, whether directly or indirectly. Accurate job titles and descriptions ensure the organization has meaning in critical functions. Education, training, and professional experience are required in medical and/or clinical practice.

Fully define the SNP staff roles and responsibilities across all health plan functions that directly or indirectly affect the care coordination of beneficiaries enrolled in the SNP. This includes, but is not limited to, identification and detailed explanation of:

Specific employed and/or contracted staff responsible for performing administrative functions, such as: enrollment and eligibility verification, claims verification and processing, other.

PrimeWest Health employs staff and contracts with vendors to perform the following administrative functions:

Eligibility and Enrollment Verification

1. **Enrollment Third Party Administrator (TPA) –** Through a formal delegation agreement, eligibility verification and enrollment for Prime Health Complete members are delegated to the Minnesota Department of Human Services (DHS) as our TPA.

[5] In general, both PrimeWest Health and the State of Minnesota refer to health plan enrollees as "members," so throughout this submission we will use the term "member" rather than "beneficiary."

2. Enrollment Coordinator

Overall Description of Responsibilities:

A. Coordinate monthly DHS eligibility file load process, ensuring timely processing of all related reports.
B. Interact with Pharmacy Benefits Manager (PBM) on pharmacy eligibility for all programs. Process Centers for Medicare & Medicaid Services (CMS) and DHS eligibility reports and update the membership system when needed.
C. Review daily re-enroll audit file.
D. Keep abreast of DHS and CMS regulatory changes and recommend appropriate changes to current processes.
E. Comply with departmental policies, procedures, and workflows. Act as lead or support on Membership & Program Development projects and initiatives as assigned.
F. Collaborate with other departments on issues related to member eligibility and enrollment and disenrollment processes.

Experience Requirements: Experience with Medicare is a plus.
Educational Requirements: Requires, at minimum, a BA degree in business or a health-related field of study or five years of experience equivalent to the position requirements.

3. Enrollment Specialist

Overall Description of Responsibilities:

A. Process monthly DHS eligibility file into PrimeWest Health's membership/claims system, Amisys.
B. Enter and manually update enrollment records after the monthly enrollment file has been processed.
C. Process reports received from DHS, CMS, and internal discrepancy reports, updating member records as needed.
D. Process Medicare enrollment applications per policy. Reconcile member eligibility monthly according to desktop processes.
E. Provide enrollment and disenrollment reports to internal departments per process.
F. Keep abreast of DHS and CMS regulatory changes affecting enrollment and disenrollment.
G. Research eligibility and enrollment issues and respond to members as appropriate.
H. Comply with departmental policies, procedures, and workflows.

Experience Requirements: Experience with Medicare is a plus.
Educational Requirements: Requires, at minimum, an associate degree in business or a health-related field of study, or three years of experience equivalent to the position requirements.

4. Enrollment Manager

Overall Description of Responsibilities:

A. Responsible for managing member enrollment for all products (includes PrimeWest Senior Health Complete and Prime Health Complete).

B. Collaborate with county agencies and PBM on all enrollment and eligibility issues. Possess knowledge of Medicare and Medical Assistance (Medicaid) eligibility requirements.
C. Keep abreast of DHS and CMS regulatory changes.
D. Make policy and procedure changes and recommendations based on State and Federal government requirements.
E. Monitor Prescription Drug Event (PDE) data for eligibility issues.
F. Monitor PDE reprocessing for financial impact to members. Conduct annual audit for the DHS TPA agreement to ensure accurate processing of Medicare enrollments and disenrollments.

Experience Requirements: Requires in-depth knowledge of Medicare Advantage programs.
Educational Requirements: Requires, at minimum, a BA/BS in business or a health-related field of study or five years of experience equivalent to the position requirements.

Claims Verification and Processing

5. Claims Examiner

Overall Description of Responsibilities:

A. Review pended claims, ensuring timely and accurate adjudication of claims.
B. Process all types of medical claims per established departmental production and accuracy standards.
C. Develop and utilize knowledge of Medicare, Minnesota Medical Assistance (Medicaid), and PrimeWest Health internal policies and procedures for the purpose of accurately processing health care claims.
D. Perform accurate claims adjustments as needed. Identify system processing issues and communicate to appropriate staff for resolution.

Experience Requirements: This position requires expertise in understanding and executing internal PrimeWest Health claims processing procedures, including those for dual eligible members.
Educational Requirements: Requires, at minimum, a high school diploma or General Educational Development (GED) certification and one year of experience as a health care claims processor or one year of experience in a medical facility.

Other Administrative Staff

6. Member Services Contact Center Specialist

Overall Description of Responsibilities:

A. Increase member satisfaction by providing professional, accurate, and timely responses to all incoming inquiries from callers.
B. Apply appropriate customer service skills when dealing with all members. Follow all State and Federal operating standards regarding received calls and comply with all State, Federal, and Health Insurance Portability and Accountability Act (HIPAA) laws and regulations for general operations.
C. Maintain strict confidentiality of all sensitive information. Maintain an up-to-date and thorough knowledge of PrimeWest Health's products and guidelines.

D. Properly document all calls/contacts as required by department standards in a clear and concise manner.
E. Provide accurate research and resolution to member issues in accordance with established PrimeWest Health policies and procedures, including, but not limited to, Appeals and Grievances and Service Authorizations.
F. Refer unresolved issues to the next level and/or appropriate area when necessary.

Educational Requirements: Requires an associate degree and/or a minimum of three years of experience in customer service in a health care or related field.

7. Pharmacy Benefit Management (PBM)
Overall Description of Responsibilities:

A. PrimeWest Health delegates PBM services to MedImpact Healthcare Systems, Inc. (MedImpact). Delegated services include the following: pharmacy claims processing; coverage determinations and exceptions; drug utilization; quality assurance; electronic prescribing; pharmacy access; pharmacy credentialing; formulary; transition process; Pharmacy and Therapeutics (P&T) Committee; directing member Grievances to PrimeWest Health; pharmacy call center; member call center during times when PrimeWest Health call center is closed; and Medication Therapy Management (MTM) program.

8. Complaints, Appeals & Grievances Specialist
Overall Description of Responsibilities:

A. Manage Appeals and Grievances system in compliance with DHS and CMS requirements.
B. Administer member Appeals and Grievances and the Part D process. Possess a comprehensive knowledge of Medical Assistance (Medicaid) and Medicare regulations including: Title 42 Code of Federal Regulations (CFR) Part 438, Subpart F; 42 CFR 422, subp. M; 42 CFR 423, subp. M; ***Medicare Managed Care Manual***, Chapter 13; ***Medicare Prescription Drug Benefit Manual***, Chapters 5, 6, and 18; and DHS contracts, Article 8. Monitor CMS Complaints Tracking Module (CTM) and Health Plan Management System (HPMS) complaints.
C. Resolve Immediate Action complaints. Update Appeals and Grievances policies and procedures as needed. Remain abreast of current CTM standard operating procedures. Document all Appeals and Grievances required by DHS and CMS standards. Attend all State Fair Hearings. Compile and submit to the State a quarterly electronic report of written Grievances and oral and written Appeals.
D. Compile and submit to the State a quarterly summary report of oral Grievances. Compile Part C and D reports for CMS including Grievances as well as Reconsiderations (Part C) and Redeterminations (Part D).
E. Increase member satisfaction by providing professional and accurate responses to complaints regarding benefits, eligibility, authorizations, claims, and pharmacy issues. Handle Appeals and Grievances as necessary, ensuring that all concerns are responded to and resolved appropriately.
F. Maintain strict confidentiality of all sensitive information. Work closely with care coordinators and financial workers.

G. Stay current on all new legislation and statutes, as well as amendments and interpretation, to ensure compliance.

Educational Requirements: Requires, at minimum, an associate's degree or diploma in Administrative Assistance or two years experience equivalent to the position requirements.

9. Provider Relations Coordinator

Overall Description of Responsibilities:

A. Facilitate positive, professional relationships between providers and PrimeWest Health through effective communication, education, and problem resolution relating to complex provider claims and contracting issues.
B. Coordinate contracting and network activities for PrimeWest Health providers and maintain up-to-date knowledge of the contracting process of PrimeWest Health's network.
C. Assist Director of Provider Network Administration and Provider Relations Manager in establishing and maintaining relations with health care providers.
D. Possess up-to-date knowledge of regulatory and contractual requirements related to areas of responsibility.
E. Review and determine outcome of provider Appeals per procedure and keep a document summary for Appeals that require a higher level of determination

Educational Requirements: Requires an associate degree in a health care-related field or a minimum of two years related work experience and/or training.

10. Care Management Specialist(s)

Overall Description of Responsibilities:

A. Assist the Director of Care Management (CM), and CM staff with scanning and attaching documents into the CM documentation system.
B. Complete and enter Minimum Data Set (MDS) risk summaries received from Skilled Nursing Facilities (SNFs) into care management software.
C. Assist and collaborate with county case managers, supervisors, the Complex Care and Disease Management Manager, and Information Systems & Technology (IS&T) staff to resolve program issues or concerns with the electronic care plan.
D. Coordinate meeting schedules.
E. Complete member mailings.
F. Assist in pre-audit preparation for all CM audits.
G. Follow direction from the Director of Care Management to ensure that all clerical needs of the CM program are met.
H. Maintain CM forms on the PrimeWest Health website.
I. Assist with preparing quarterly reports for mammogram screening, influenza, and disease management (DM).
J. Enter screening documents into the State's Medicaid Management Information System (MMIS).

Educational Requirements: Requires, at minimum, an associate degree or diploma in Administrative Assistance or two years experience equivalent to the position requirements.

11. Care Management Project Coordinator

Overall Description of Responsibilities:

A. Assist the Director of Care Management and CM staff with coordinating, planning, tracking, managing, and assuring timely implementation of all projects that flow through the CM department. Activities include the following:
   i. Pull data and incorporate the data into tables and/or graphs.
   ii. Ensure that reports and data are consistent.
   iii. Create and monitor JIRA[6] issues that are needed for new and/or existing reports.
   iv. Ensure timeliness of CM reports needed for DHS, CMS, and the National Committee for Quality Assurance (NCQA).
   v. Assist the PrimeWest Health staff member who is assigned as the lead for NCQA accreditation to ensure maintenance of NCQA Health Plan (HP) accreditation documentation.
   vi. Provide collaborative support to appropriate PrimeWest Health departmental owners to ensure all documents applicable NCQA HP accreditation standards, elements and factors are completed.
   vii. Assist the CM department with maintenance of documents, policies and procedures, workflows, reports, and files to ensure they are updated in a timely manner for NCQA.
   viii. Start, modify, or update projects for the CM department.
   ix. Collaborate with all other PrimeWest Health departments to plan, schedule, and implement projects and/or reports.

Educational Requirements: Requires, at minimum, an associate degree or diploma in Administrative Assistance, with knowledge in project management and NCQA, or two years experience equivalent to the position requirements.

Employed and/or contracted staff that perform clinical functions, such as: direct beneficiary care and education on self-management techniques, care coordination, pharmacy consultation, behavioral health counseling, other.

PrimeWest Health employs staff and contracts with vendors to perform clinical functions including, but not limited to, direct member care and education on self-management techniques, care coordination, pharmacy consultation, and behavioral health counseling.

1. Care Management Care Coordinators

All PrimeWest Health's care coordinator positions are responsible for implementing a care management program that focuses on improving the health of PrimeWest Health members, engagement of the member in health care decisions through person-centered planning, and reduction of health care costs through the coordination of health and wellness services provided by PrimeWest Health's contracted health care providers.

[6] JIRA is PrimeWest Health's issues tracking software.

Overall Description of Responsibilities:

A. Coordinate person-centered care for Prime Health Complete members, focusing on their expressed choices, quality of life, strengths, abilities, interests, and goals; and provide information to members and their families to help them make choices that are aligned with their values and preferences. Coordination includes, but is not limited to, the following activities:
   i. Facilitate and implement members' choices and provide information about how and where to access services that meet their individual needs.
   ii. Provide education to members regarding employment opportunities that align with their preferences, if applicable.
   iii. Involve the members and their families in the application of person-centered principles.
   iv. Encourage and promote members' involvement along the continuum of care.
   v. Promote members' engagement in the direction and self-management of their care.
   vi. Ensure that best practice guidelines are adhered to in all areas, including those related to disability and mental health.
   vii. Collaborate with the assigned county case manager (CCM) and/or primary care provider/specialist across all settings and providers. This includes collaboration with identified, certified, and contracted Health Care Homes (HCH) or HCH alternatives and Accountable Rural Community Health (ARCH) facilities, including the facilitation and coordination of care management activities that support members assigned to these facilities. Collaborative activities also include ensuring continuity of care to reduce duplication of and gaps in care and services.
B. Implement person-centered care management, chronic disease management, and population health management processes.
C. Ensure the coordination and integration of primary, acute, long-term, and dental services; community services (including community employers); public health and human services; and/or mental and behavioral health services to improve health outcomes for Prime Health Complete members.
D. Facilitate access to specialists and therapies in coordination with Utilization Management (UM) staff and the CCM.
E. Provide training and oversight to CCMs.
F. Know and understand DHS and CMS requirements to ensure correct implementation of all guidelines.
G. Ensure protocols for care management of people with disabilities and behavioral health diagnoses are met.
H. Participate in PrimeWest Health efforts to meet Performance Improvement Project (PIP) and Healthcare Effectiveness Data and Information Set (HEDIS®)[7] measures, improve HEDIS outcomes, and develop the yearly clinical guideline report.
I. Participate in conducting audits.
J. Follow all HIPAA requirements to ensure compliance and ensure maintenance and sharing of health care records in accordance with all State of Minnesota and CMS regulations and policies.

[7] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA)

Experience Requirements: Care coordinators are required to have experience working with people who have disabilities and behavioral health and chemical dependency diagnoses, and be familiar with primary care, nursing, behavioral health, social services, and community-based services.
Educational Requirements: Must be a graduate of an approved school of nursing or a licensed social worker. Preference is for a BS/MS degree and expertise in assigned area of responsibility.

2. County Case Managers (CCM)

CCMs are responsible for implementing care management programs that focus on improving the health of PrimeWest Health members, engagement of members in health care decisions through person-centered planning, and reduction of health care costs through the coordination of health and wellness services provided to members.

Overall Description of Responsibilities:

A. Coordinate person-centered care for Prime Health Complete members, focusing on their expressed choices, quality of life, strengths, abilities, interests, and goals; and provide information to members and their families to help them make choices that are aligned with their values and preferences. Case management activities include, but are not limited to, the following:
   i. Facilitate and implement members' choices and provide information about how and where to access services that meet the members' individual needs.
   ii. Educate members about employment opportunities that aligns with their preferences, if applicable.
   iii. Involve the member and caregiver in the application of person-centered principles.
   iv. Actively encourage member and family engagement along the continuum of care.
   v. Promote members' engagement in the direction and self-management of their care.
   vi. Provide information to members and their caregivers about how to make choices that are aligned with their values and preferences.
   vii. Implement a person-centered, collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates options and services required to meet members' health and human services need.
   viii. Request consultation and diagnostic reports from specialists as appropriate.
   ix. Ensure member experience smooth transitions of care, whether planned or unplanned, paying attention to the needs and values they and/or their caregivers identify.
   x. Ensure the care provided is safe, effective, member-centered, culturally and linguistically sensitive, appropriate, timely, efficient, and equitable.
   xi. Implement a CM process characterized by advocacy, communication, and resource management that promotes quality, cost-effective interventions and outcomes.
   xii. Serve as the primary point of contact for members and their Interdisciplinary Care Teams (ICTs).

B. Collaborate with the PrimeWest Health Care Management care coordinators to facilitate and coordinate care management activities with the HCH (or HCH alternative) and ARCH providers, when applicable. Activities include the following:
   i. Ensure continuity of care to reduce duplication of and gaps in care and services.
   ii. Implement person-centered care management, chronic disease management, and population health management processes that effectively facilitate the coordination and integration of primary, acute, long-term, and dental services, community services (including community employers); public health and human services; and/or mental and behavioral health services to improve health outcomes for Prime Health Complete members assigned to an HCH and or ARCH facility
C. Conduct initial and annual member assessments and Person Experience Assessments for Prime Health Complete members residing in the community and/or SNF members through the health risk assessment (HRA) process.
D. Triage members' care needs based on results of HRAs and members' health care preferences.
E. Create and implement the person-centered plan of care.
F. Arrange for translation services for the member and/or legal representative as necessary.
G. Attend and/or schedule provider appointments, including follow-up visits and services upon request or as deemed appropriate.
H. Monitor the provision of services and benefits to ensure follow-up and ensure clinical services are appropriate and timely.

Experience Requirements: CCMs are required to have experience working with individuals with disabilities. The CCM must have knowledge in the areas of primary care, nursing, behavioral health, social services, and community-based services.
Educational Requirements: Required to be one of the following, at minimum:
a. Public Health Nurse (PHN) or Registered Nurse (RN) licensed under MN Stat. sec. 148.171 – 148.285; or
b. A graduate of an accredited four-year college with a major in social work, psychology, sociology, or a closely related field; or be a graduate of an accredited four-year college with a major in any field and one year experience as a social worker in a public or private social service agency. Social workers must also be eligible through the Minnesota Merit System or a county civil service system in Minnesota. Standards are authorized under MN Rules part 9575.0010 – 9575.1580. Authority to set personnel standards is granted under MN Stat. sec. 256.012.

3. Complex Care and Disease Management Manager

The Complex Care and Disease Management Manager ensures the implementation of a person-centered care management program that focuses on improving the health of PrimeWest Health members, engagement of the member in health care decisions through person-centered planning, and reduction of health care costs through the coordination of health and wellness services provided to the member.

Overall Description of Responsibilities:

A. Directly responsible for all aspects of care coordination duties related to PrimeWest Health's Disease Management/Chronic Care Improvement Programs (DM/CCIP) and all Special Needs Plan (SNP) programs.
B. Under the direction of the Director of Care Management, develop, implement, and monitor all SNP policies and procedures to ensure State, Federal, and NCQA requirements are addressed.
C. Oversee all CM audits in collaboration with the Director of Care Management.
D. Develop and oversee all corrective action plans (CAPs) in collaboration with the Director of Care Management.
E. Oversee staff assigned to him/her.
F. Collaborate with PrimeWest Health care coordinators, CCMs, providers, and other identified individuals assigned to members' cases as indicated.
G. Monitor and follow up regarding utilization of services pertinent to area of assigned responsibility.
H. Coordinate individual member-centered care that ensures appropriateness, quality, and cost effectiveness of services provided and involvement of a multi-disciplinary team.
I. Monitor effectiveness of care coordination plans through data analysis.
J. Ensure the provision of training on the Model of Care.
K. Implement the SNP Model of Care through telecommunications and direct interaction.
L. Analyze the goals of performance improvement and quality measures identified in the SNP Model of Care and modify or implement new processes as indicated.
M. Implement a process that works toward improving member satisfaction and population health.
N. Apply analytical processes to identify opportunities for reducing overall member costs.
O. Communicate the annual SNP Model of Care Summary along with any recommendations to the PrimeWest Health stakeholders involved in the Model of Care.
P. Collaborate with PrimeWest Health department directors on the outcomes and recommendations following the completion of the annual Model of Care Summary.
Q. Annually assess the need to submit a redline version of the Model of Care to CMS and DHS.
R. Collaborate with the Director of Care Management and PrimeWest Health department directors to develop a redline version of the Model of Care as indicated.
S. Assist in the development and implementation of continuous care coordination and quality improvement plans.
T. Foster collaborative relationships with county partners and providers for mental health care and special needs for SNPs.
U. Assist with the development, implementation, and analysis of mental health outcome measurements for all programs.
V. Assist with the development, implementation, oversight, and evaluation of best practices for mental health and chemical dependencies with county partners and providers.

Experience Requirements: Must have knowledge of and experience in working with waiver services and county structure related to this population.
Educational Requirements: PHN or RN licensed under MN Stat. sec. 148.171 – 148.285; with preferred expertise in assigned area of responsibility.

4. Chemical Dependency Care Coordinator

Responsible for implementing a care management program that focuses on improving the health of PrimeWest Health members, engagement of the member in health care decisions through person-centered planning, and reduction of health care costs through the coordination of health and wellness services provided by PrimeWest Health's contracted health care providers.

Overall Description of Responsibilities:

A. Coordinate person-centered care for Prime Health Complete members who are receiving chemical dependency services that focus on their expressed choices, quality of life, strengths, abilities, interests, and goals; and provide information to members and their families to help them make choices that are aligned with their values and preferences. Coordination includes, but is not limited to, the following activities:
   i. Facilitate and implement members' choices and provide information about how and where to access chemical dependency services that meet their individual needs.
   ii. Involve members and their families (if applicable) in the application of person-centered principles.
   iii. Encourage members' involvement and engagement in the direction and self-management of their care.
   iv. Ensure best practice guidelines are adhered to as they relate to chemical dependency and mental health.
   v. Collaborate with the assigned CCM and/or primary care provider/specialist across all settings and providers. This includes collaborating with identified, certified, and contracted HCHs or HCH alternatives and ARCH facilities, including the facilitation and coordination of care management activities that support members assigned to these facilities. Collaborative activities also include ensuring continuity of care to reduce duplication of and gaps in care and services.

B. Implement person-centered care management, chronic disease management, and population health management processes to ensure the coordination and integration of primary, acute, long-term, and dental services; community services (including community employers); public health and human services; and/or mental and behavioral health services to improve health outcomes for Prime Health Complete members.

C. Participate in PrimeWest Health efforts to meet PIP and HEDIS measures and improve HEDIS outcomes.

D. Ensure updated standards and protocols are in place for care management of people with disabilities who have chemical dependency diagnoses.

E. Participate in conducting audits.

F. Follow all HIPAA requirements to ensure compliance and ensure maintenance and sharing of health care records in accordance with all State of Minnesota and CMS regulations and policies.

Experience Requirements: Required to have experience working with chemical dependency and behavioral health, including with members who have disabilities. Be

familiar with primary care, nursing, behavioral health, social services, and community-based services.
Educational Requirements: Required to have, at minimum, a BA with preference given to a licensed Drug and Alcohol Counselor.

5. RRP & Complex Case Management Care Coordinator
Responsible for implementing a care management program that focuses on improving the health of PrimeWest Health members, engagement of the member in health care decisions through person-centered planning, and reduction of health care costs through the coordination of health and wellness services provided by PrimeWest Health's contracted health care providers.

Overall Description of Responsibilities:

A. Coordinate person-centered care for Prime Health Complete members who are receiving or have received mental health services that focuses on their expressed choices, quality of life, strengths, abilities, interests, and goals; and provide information to members and their families to help them make choices that are aligned with their values and preferences. Coordination includes, but is not limited to, the following activities:
   i. Facilitate and implement members' choices and provide information about how and where to access services that meet their individual needs.
   ii. Educate members about employment opportunities that align with their preferences, if applicable.
   iii. Involve members and their families in the application of person-centered principles.
   iv. Encourage members' involvement and engagement in the direction and self-management of their care.
   v. Ensure best practice guidelines are adhered to as they relate to mental health and chemical dependency.
   vi. Collaborate with the assigned PrimeWest Health care coordinators, CCMs, and/or primary care provider/specialist across all settings and providers. This includes collaborating with identified, certified, and contracted HCHs or HCH alternatives and ARCH facilities, including the facilitation and coordination of care management activities that support members assigned to these facilities. Collaborative activities also include ensuring continuity of care to reduce duplication of and gaps in care and services.
   vii. Collaborate with the PrimeWest Health care coordinators and CCMs for Prime Health Complete members with mental health diagnoses/issues.
   viii. Coordinate Level of Care Utilization System (LOCUS) activity with providers.
B. Assist UM staff with intake responsibilities on all Service Authorization requirements, denials, terminations of service, and reductions in service for Mental Health Targeted Case Management (MH-TCM) for PrimeWest Health members.
C. Perform UM intake on Service Authorization requirements, denials, and terminations of service for Intensive Residential Treatment Services (IRTS), Assertive Community Treatment (ACT), Adult Rehabilitative Mental Health Services (ARHMS), and Crisis Services, as needed.
D. Carry out person-centered care management, chronic disease management, and

population health management processes that ensure the coordination and integration of primary, acute, long-term, and dental services; community services (including community employers); public health and human services; and mental and behavioral health services to improve health outcomes for Prime Health Complete members.

E. Conduct mental health care management activities for Prime Health Complete members.
F. Provide coordination for mental health admissions and assist in the transition of care for Prime Health Complete members.
G. Provide assistance with the coordination of care for adults who are transitioning from Prime Health Complete into PrimeWest Senior Health Complete and have MH-TCM services.
H . Perform audits for MH-TCM services.
I. Attend meetings and participate in initiatives at the community, regional, and statewide level.
J. Conduct person-centered thinking training sessions for PrimeWest Health staff, CCMs, and providers.

Experience Requirements: Must have knowledge of and experience in the area of mental health.
Educational Requirements: Required to be, at minimum, a graduate of an approved school of nursing. Preference is for a BS/MS degree and expertise in assigned area of responsibility.

6. Behavioral Health Care Coordinator

Responsible for implementing a care management program that focuses on improving the health of PrimeWest Health members, engagement of the member in health care decisions through person-centered planning, and reduction of health care costs through the coordination of health and wellness services provided by PrimeWest Health's contracted health care providers.

Overall Description of Responsibilities:

A. Coordinate person-centered care for Prime Health Complete members who are receiving or have received mental health services that focus on their expressed choices, quality of life, strengths, abilities, interests, and goals; and provide information to members and their families to help them make choices that are aligned with their values and preferences. Coordination includes, but is not limited to, the following activities:
    i. Facilitate and implement members' choices and provide information about how and where to access services that meet their individual needs.
    ii. Educate members about employment opportunities that align with their preferences, if applicable.
    iii. Involve members and their caregivers in the application of person-centered principles.
    iv. Encourage members' involvement along the continuum of care.
    v. Encourage members' engagement in the direction and self-management of their care.
    vi. Ensure disability practices, mental health practices, and best practice guidelines are followed by CCMs.

vii. Collaborate with the assigned PrimeWest Health care coordinators, CCMs, and/or primary care provider/specialist across all settings and providers. This includes collaborating with identified, certified, and contracted HCHs or HCH alternatives and ARCH facilities, including the facilitation and coordination of care management activities that support members assigned to these facilities. Collaborative activities also include ensuring continuity of care to reduce duplication of and gaps in care and services.
viii. Collaborate with PrimeWest Health care coordinators and CCMs for Prime Health Complete members with mental health diagnoses/issues.

B. Perform UM intake for Service Authorization requirements, denials, and terminations of service for IRTS, ACT, ARHMS, and Crisis Services, as needed.
C. Carry out person-centered care management, chronic disease management, and population health management processes that ensure the coordination and integration of primary, acute, long-term, and dental services; community services (including community employers); public health and human services; and mental and behavioral health services to improve health outcomes for Prime Health Complete members.
D. Conduct mental health care management activities for Prime Health Complete members.
E. Provide coordination for all mental health admissions and assist in the transition of care for Prime Health Complete members.
F. Provide assistance with the coordination of care for adults who are transitioning from Prime Health Complete into PrimeWest Senior Health Complete and have a mental health diagnosis.
G. Attend meetings and participate in initiatives at the community, regional, and statewide level.
H. Collaborate in PrimeWest Health efforts to comply with PIP and HEDIS measures, improve HEDIS outcomes, and develop the yearly clinical guideline report.

Educational Requirements: Required to be a graduate of an approved school of nursing or a licensed social worker. Preference is for a BS/MS degree and expertise in assigned area of responsibility.

7. Case Management LPN Specialist

The Case Management LPN Specialist is responsible for supporting and helping to implement the Care Management program, which focuses on managing care for PrimeWest Health members across the continuum of care to improve health, enhance the care experience, and reduce health care fragmentation, while empowering members to understand and access quality, cost-efficient health care.

Overall Description of Responsibilities:

A. Make follow-up phone calls to members who refuse case management services.
B. Complete other follow-up phone calls to identified members, as assigned.
C. Enter data into MMIS, as needed.
D. Assist in the administration of the DM/CCIP program.

Educational Requirements: Required, at minimum, to possess an LPN diploma and be currently licensed in the State of Minnesota as an LPN.

8. Utilization Management (UM) Care Coordinator

Overall Description of Responsibilities:

A. Responsible for conducting initial, concurrent, and/or retrospective review of medical necessity for Service Authorization requests according to accepted and approved criteria and following selected NCQA, State statute, DHS contractual, and/or applicable UM and care management regulations. This includes any CMS requirements.
B. Assist members in navigating the health care system to get the right care at the right time and place.
C. Collaborate with medical directors and other members of Quality & Utilization Management.

Experience Requirements: A minimum of two years of experience in medical, surgical, home health, or SNF nursing**.**
Educational Requirements: Required to have, at minimum, an associate degree in nursing, and preferably a BSN.

9. Dental Services Coordinator

Overall Description of Responsibilities:

A. Responsible for responding to requests from Member Services staff, CCMs, PrimeWest Health care coordinators, or directly from members for help in coordinating dental services (often for those who have special needs).
B. Assist members in finding a dental home or a needed dental specialist, removing barriers to attending appointments (i.e., lack of transportation, etc.).
C. Educate members about making timely, respectful cancellations.
D. Advocate for activities that will increase access to dental services for our members.
E. Review and implement dental benefit changes and Service Authorization criteria changes, including legislative and DHS changes or those changes recommended by the Dental Care Director.

Educational Requirements: Required to have, at minimum, an associate's degree or diploma in business or other related field or one year experience equivalent to the position requirements.

Employed and/or contracted staff that performs administrative and clinical oversight functions, such as: license and competency verification, data analyses to ensure appropriate and timely healthcare services, utilization review, ensuring that providers use appropriate clinical practice guidelines and integrate care transitions protocols.

PrimeWest Health employs staff and contracts with vendors to perform the following administrative and clinical oversight functions within PrimeWest Health.

1. Chief Senior Medical Director

Overall Description of Responsibilities:

A. Provide clinical leadership for system-wide quality program through active participation in development and oversight of the implementation of the Quality Assurance Plan,

Annual Assessment, Annual Quality Project Work Plan, and all committee activities that support the quality program.

B. Review encounter data for the appropriateness and timeliness of services. Conduct peer review activities associated with the credentialing process and recommend practitioners to the Peer Review Committee (PRC) and Joint Powers Board (JPB) for review and approval.
C. Ensure and provide oversight for the provider use of clinical practice guidelines within the scope of physician practice oversight.
D. Provide clinical oversight for authorizations and conduct medical chart reviews as indicated.
E. Provide day-to-day supervision to UM staff, participate in UM staff training, monitor for consistent application of UM criteria by UM staff for each level and type of UM decision, and implement corrective actions when needed; review and decide UM cases; participate in UM Committee meetings; monitor UM documentation for adequacy; and be available to UM staff on-site or by telephone.
F. Provide oversight for monitoring the effectiveness of the communication system relating to medical professionals.

Educational Experience: Must be a doctor of medicine (MD) or doctor of osteopathic medicine (DO) with appropriate board certification. Must attend continuing educational sessions; for each three-year cycle, 75 hours of continuing education must be obtained. Must have active credentialing status upon hire and recredentialing every 36 months. Managed care experience is highly preferred.

2. **Director of Care Management**
Overall Description of Responsibilities:

A. In cooperation with the Chief Senior Medical Director, develop, implement, coordinate, and evaluate the system-wide quality program, Model of Care, and safety initiatives, including care coordination and case management, behavioral health, and pharmacy UM as a function of both individual and population-based activities.
B. Oversee care and quality plan operations including the development and implementation of policies and procedures related to Care Management services.
C. Perform analysis of encounter data for appropriateness, timeliness, and cost effectiveness of services.
D. Integrate the PrimeWest Health care coordination plan throughout the member counties.
E. Ensure and provide oversight for the use of clinical practice guidelines within the scope of case management nursing oversight.
F. Provide oversight of staff, provider, and member Model of Care training in coordination with the PrimeWest Health Complex Care and Disease Management Manager.
G. Provide oversight for monitoring the effectiveness of PrimeWest Health's system for communication with members and providers.
H. Provide oversight of member satisfaction surveys Case Management Survey.

Experience Requirements: Must have proven knowledge of and skills in care management as normally acquired through an advanced degree in nursing or patient care administration or BSN/PHN with an advanced degree in business and health care administration. Public Health

and Human Service treatment planning or care coordination/case management to individual patients or clients, including a setting involved in managed care activities preferred.
Educational Requirements: Requires, at minimum, a BSN with a Public Health degree. Current RN license required.

3. **Director of Quality & Utilization Management**
   Overall Description of Responsibilities:
   A. In cooperation with the Chief Senior Medical Director, develop, implement, coordinate, and evaluate the system-wide quality and credentialing program, Model of Care, and safety initiatives and UM activities, including behavioral health (mental health/chemical dependency), medical, dental, and pharmacy UM as a function of both individual and population-based activities.
   B. Oversee quality plan operations, including the development and implementation of policies and procedures related to quality services.
   C. Review encounter data for appropriateness, timeliness, and under- and over-utilization of service provision.
   D. Assure provider credentialing according to State and Federal regulatory requirements. Provide oversight of provider and member training in coordination with department managers and Provider Network Administration.
   E. Provide oversight for monitoring the effectiveness of PrimeWest Health's system for communication with members and providers.
   F. Perform annual evaluation of network adequacy to ensure members have adequate and appropriate access to covered benefits by qualified providers. Oversight of member satisfaction surveys (Health Outcomes Survey [HOS], Case Management Survey, and Consumer Assessment of Healthcare Providers and Systems [CAHPS®][8]) and of delegated and/or contracted agencies as it pertains to Quality & Utilization Management services.
   G. Oversee HEDIS and data certification. Assure member rights are implemented and regulatory requirements for member complaints, Grievances, and Appeals are implemented and followed.

   Educational Requirements: At minimum, an MA/MS in business or a health care-related field or five years of experience equivalent to the position requirements.

4. **Behavioral Health Medical Director**
   Overall Description of Responsibilities:
   A. In cooperation with the PrimeWest Health Chief Senior Medical Director, the Director of Care Management, and the Director of Quality & Utilization Management, provide direction in the development and management of PrimeWest Health's mental health/chemical dependency (MH/CD)-related services for all members of PrimeWest Health.
   B. Develop and implement the PrimeWest Health Quality Plan, Annual Work Plan, and UM Plan, including development, analysis, and interventions of quality studies, standards, outcomes, and systems as they may relate to MH/CD services.

[8] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ)

C. Participate on the PRC and Quality and Care Coordination Committee (QCCC). Provide clinical oversight for MH/CD authorizations and conduct medical chart reviews as indicated.

Educational Requirements: Requires, at minimum, an MD and board certification in psychiatry.

5. **Dental Care Director**
Overall Description of Responsibilities:
   A. In cooperation with the PrimeWest Health Chief Senior Medical Director, the Director of Care Management, the Director of Quality & Utilization Management, and the Dental Services Coordinator, provide direction in the form of advice, consultation, and UM related to the administration of dental services for PrimeWest Health members.
   B. Assist with the development and implementation of the PrimeWest Health Quality Plan, Annual Work Plan, and policies and procedures, including development, analysis, and interventions of quality studies, standards, outcomes, and systems as they relate to dental services.
   C. Serve as a like provider with regards to credentialing matters for consultation.

   Educational Requirements: Requires, at minimum, a Doctor of Dental Surgery (DDS) license without restriction to practice dentistry in the State of Minnesota.

6. **Manager of Quality Management**
Overall Description of Responsibilities:
   A. Ensure that the overall quality program meets or exceeds regulatory and contractual requirements including day-to-day functional activities to support quality, safety, and utilization activities. This includes focus studies, improvement activities, and reviews of encounter data for appropriateness and timeliness of services.
   B. Ensure and provide oversight for the Appeals and Grievances system in compliance with DHS and CMS. Monitor and oversee the PrimeWest Health complaints tracking system for members.
   C. Ensure regulatory compliance with CMS, DHS, and the Minnesota Department of Health (MDH) requirements for the quality program and complaints, Appeals, and Grievances.
   D. Ensure and provide oversight for HEDIS, HOS, CAHPS, and Quality Improvement Program (QIP) in compliance with DHS and CMS. Provide technical assistance and expert consultation to PrimeWest Health member counties and participating providers when requested.
   E. Monitor the effectiveness of communication with internal staff about the programs PrimeWest Health offers for members with special needs and work with the Director of Care Management, Complex Care and Disease Management Manager, Director Quality & Utilization Management, and Chief Senior Medical Director to ensure the effectiveness and continued monitoring of the communication network.
   F. Conduct credentialing functions and ensure compliance with regulatory bodies (NCQA, DHS, and CMS) for the credentialing and recredentialing of practitioners.
   G. Provide oversight of delegated credentialing through monitoring of delegates.

H. Work with the Chief Senior Medical Director to maintain the credentialing function of the PRC, QCCC, and JPB, including verifying licenses and competency of network practitioners. (The Chief Senior Medical Director reports these activities to the PRC, QCCC, and JPB.)
I. Develop policies that ensure the organization is in compliance with standards set forth by regulatory bodies pertaining to practitioner credentialing.

Educational Requirements: Requires, at minimum, a BA/BS with two to four years of related work experience and/or training or equivalent combination of education and experience.

7. **Quality & UM Coordinator**
Overall Description of Responsibilities:
A. Conduct site assessments of PrimeWest Health providers based on criteria identified in PrimeWest Health Policy and Procedure QM05: Provider Office Site Visits and PS17: Assessment of Organizational Providers. Site assessments are conducted for compliance with facility license and program standards, as appropriate, Managed Care Organization (MCO) contract requirements, MDH requirements, and CMS requirements for providers.
B. Perform chart abstraction for adherence to preventive clinical guidelines and other health record requirements as detailed in PrimeWest Health Policy and Procedure QM06: Health Records in accordance with MCO, MDH, and CMS standards and regulations.
C. Conduct DM/CCIP reviews, PIP/QIP reviews, or Focus Study planned reviews as defined by the Balanced Budget Act of 1997 (BBA97).
D. Participate in the development, implementation, assessment, and evaluation of auditing, including outcome reporting.

Educational Requirements: Requires, at minimum, a BA/BS in a health care-related field or five years of experience equivalent to the position requirements

8. **Manager of Reporting & Data Analytics**
Overall Description of Responsibilities:
A. Analyze clinical and financial data and reports that provide the information that drives PrimeWest Health's quality improvement initiatives. PrimeWest Health contracts for basic data reporting services and works closely with TPAs and carve-out providers to assist in data reporting and analysis.
B. Perform appropriate design, sampling methodology, data collection, analysis, and reporting to maintain compliance with all regulatory requirements.
C. Carry out data collection and reporting used to track and trend encounter data for appropriateness and timeliness of services.
D. Compile pharmacy claims and utilization data for review, analysis, and quality improvement projects as required by PrimeWest Health, including CAHPS and HOS surveys.

Educational Requirements: Requires, at minimum, a BA/BS with a preference for an MA/MS in statistics or a related field.

9. **Quality Coordinator**
   Overall Description of Responsibilities:
   A. Assist the Manager of Quality Management with PrimeWest Health's Quality Work Plan and the development, implementation, and assessment of PIPs and QIPs.
   B. Monitor quality activities identified in the Quality Work Plan and develop and monitor PIPs, QIPs, and focus studies.
   C. Coordinate HEDIS data collection and reporting according to HEDIS specifications as well as CMS and State guidance and assist with member survey design and/or vendor selection.

   Educational Requirements: Requires, at minimum, a BA/BS in a health-related field with preferred expertise in assigned area of responsibility.

10. **Pharmacy Manager**
    Overall Description of Responsibilities:
    A. Monitor Medicare Part B and Part D pharmacy utilization, including medication reviews for members.
    B. Serve as primary contact for PrimeWest Health's PBM, develop and communicate recommendations for improvement identified through report analysis and during annual delegation assessment, and monitor activities conducted on PrimeWest Health's behalf including formulary and pharmacy benefit changes.
    C. Collaborate with other PrimeWest Health departments and provide professional advice and recommendations for DM/CCIP, the MTM program, and step therapy and tiering programs.
    D. Review pharmacy claims and utilization for appropriateness.

    Educational Requirements: Required to have a doctor of pharmacy (PharmD) degree.

11. **Director of Membership & Program Development**
    Overall Description of Responsibilities:
    A. Guide member services staff with the goal of increasing member satisfaction by providing professional, timely, and accurate responses to all incoming and outbound customer inquiries.
    B. Collaborate with IS&T on telecommunication and Customer Service Application (CSA) projects to improve efficiencies.
    C. Manage staff effectively including building a team environment.
    D. Stay current on all State and Federal regulations and/or requirements relating to member services including, but not limited to, State and Federal contracts.
    E. Perform monitoring and oversight activities that evaluate the Model of Care and effectiveness, as well as the MA-PD CAHPS results report.
    F. Develop and implement strategies, programs, and initiatives that maximize enrollment.
    G. Assess and analyze program information and provide input on behalf of PrimeWest Health as a participant in State workgroups.
    H. Conduct member stakeholder meetings.
    I. Analyze program marketplace for enrollment trends or threats and respond promptly.
    J. Work closely with Communications department to develop member materials.

K. Conduct county education about PrimeWest Health programs.
L. Act as a liaison for county relationship.
M. Work with Chief Executive Officer (CEO) on Federal and State legislative initiatives that affect enrollment in PrimeWest Health.

Experience Requirements: If the individual does not have a BA/BS in business or a health care-related field, this position requires eight years of experience equivalent to the position requirements. Experience in Medicare is a plus
Educational Requirements: Requires, at minimum, a BA/BS in business or a health care-related field of study.

12. **HIPAA Security Officer/Director of IS&T**
Overall Description of Responsibilities:
A. Direct the technological advancement of PrimeWest Health in the health care field through management of the IS&T department.
B. Collaborate with county partners and providers in maintaining PrimeWest Health as a leader in health care delivery.
C. Lead major technology-centric projects such as the implementation and evolution of telemedicine in PrimeWest Health's 13-county service area.
D. Establish technology-based solutions for data acquisition from county to provider to State.
E. Ensure HIPAA mandates are streamlined and transparent through implementation of secure email systems and direct connections to third parties.
F. Carry out maintenance of technical documents, management of staff and staff training, and integration of HIPAA-compliant software and workflow procedures.

Educational Requirements: Requires, at minimum, a BA in computer science and five years of experience equivalent to the position requirements.

13. **Corporate Compliance /HIPAA Privacy Officer**
Overall Description of Responsibilities:
A. Provide direction and oversight of PrimeWest Health's Medicare and Medical Assistance (Medicaid) Compliance program (Compliance program).
B. Define the program structure, educational requirements, reporting and complaint mechanisms, response and correction procedures, and compliance expectations of all personnel and first-tier, downstream, and related entities (FDR).
C. Identify and assess areas of compliance risk.
D. Prepare and distribute the written Code of Conduct, setting forth the ethical principles and policies that are the basis of the Compliance program.
E. Maintain interdepartmental communication on compliance matters with key PrimeWest Health partners including regulators, TPAs, and providers.
F. Oversee all ongoing activities related to the development, implementation, and maintenance of the PrimeWest Health's privacy policies in accordance with applicable Federal and State laws.
G. Address privacy issues, investigate all privacy incidents and breaches, determine steps to mitigate risk, and summarize and report findings.

H. Develop and conduct training on HIPAA privacy.
I. Review Business Associate Agreements to ensure appropriate provisions regarding protected health information are included.
J. Develop, implement, and administer a corporate-wide request for access/disclosure verification procedure that reasonably verifies the identity of the individual or entity requesting access or disclosure and /or legal authority to request member protected health information.

Educational Requirements: Requires, at minimum, an associate applied science degree and/or BA/BS with Healthcare Compliance Certification.

14. **Provider Relations Manager**
Overall Description of Responsibilities:
A. Oversee and coordinate activities associated with health care provider relations for PrimeWest Health including conducting provider education, contracting, marketing, and promotion, as appropriate.
B. With the Director of Care Management, conduct Model of Care training and training oversight for providers.
C. Ensure a positive, professional relationship between PrimeWest Health and providers through effective communication, education, and problem resolution.
D. Oversee and facilitate provider education on PrimeWest Health policies and procedures.
E. Conduct efficient and consistent resolution of provider complaints and complex claims issues.
F. Identify common problems and gaps affecting the provider network.
G. Work with Provider Relations team and Director of Provider Network Administration to develop solutions and remedies to identified gaps in the network.
H. Oversee and execute provider and facilities satisfaction surveys.

Educational Requirements: Requires, at minimum, a BA/BS with two to four years of related work experience and/or training or equivalent combination of education and experience.

15. **Provider Contracting & Network Manager**
Overall Description of Responsibilities:
A. Oversee and facilitate positive and professional contractual relationships between network providers and PrimeWest Health through effective communication, education, and problem resolution.
B. Through the contracting process, ensure PrimeWest Health provides a comprehensive network of primary care, specialties, and facilities with the specialized clinical expertise necessary for the diagnosis and treatment of the targeted special needs population.
C. Conduct organizational assessment and ensure compliance with regulatory and accrediting body standards for contracted providers and organizations.
D. Develop policies that ensure the organization is in compliance with standards set forth by regulatory and accreditation bodies pertaining to the assessment of organizational providers.

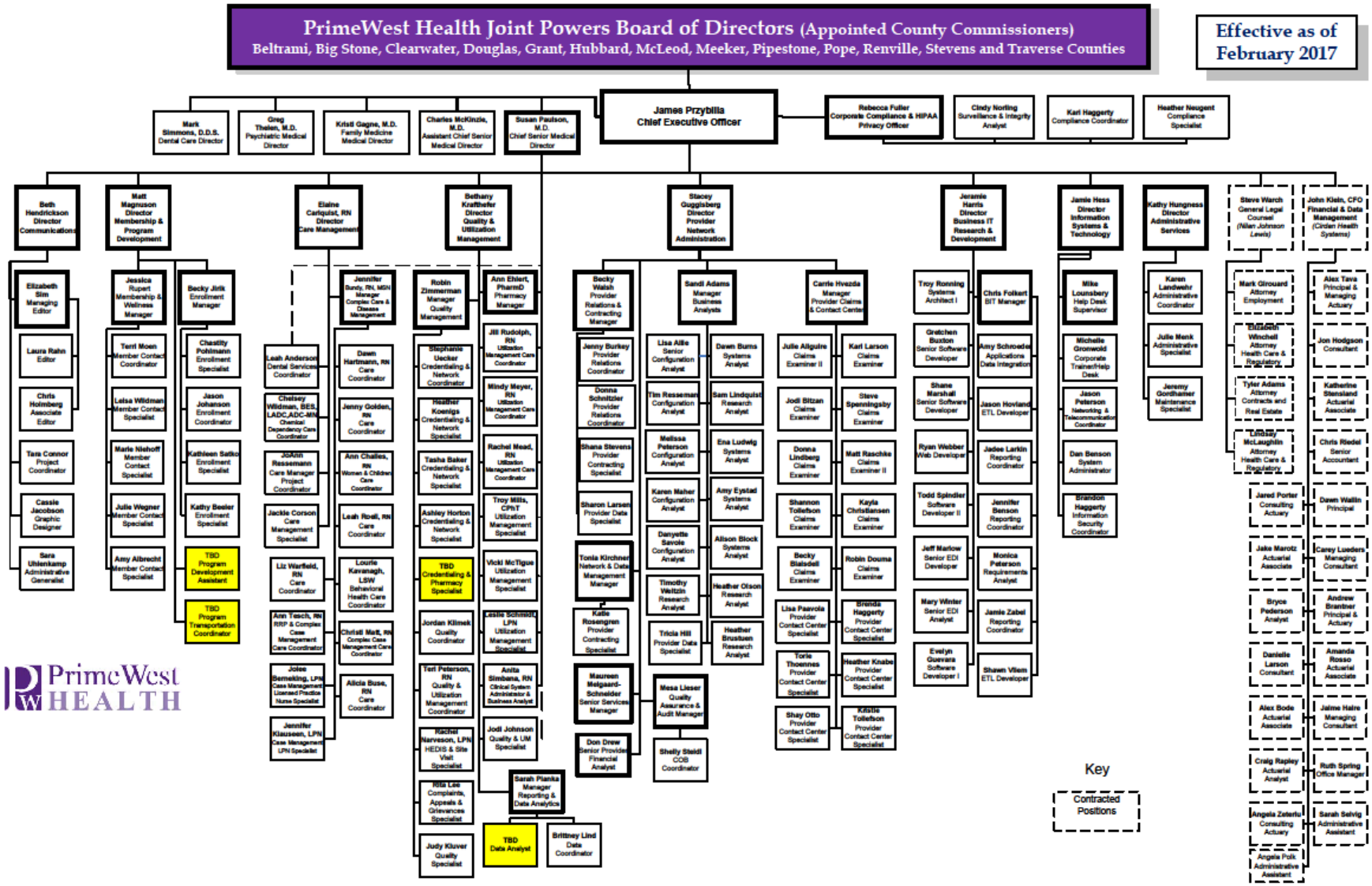
E. Supervise and facilitate the activities associated with provider contracting in the PrimeWest Health network. Supervise and facilitate performance of contracting network activities for all contracted providers.
F. Ensure all provider contracts meet regulatory requirements.

Educational Requirements: Requires, at minimum, a BA/BS with two to four years of related work experience and/or training or equivalent combination of education and experience.

Provide a copy of the SNP's organizational chart that shows how staff responsibilities identified in the MOC are coordinated with job descriptions. If applicable, include a description of any instances when a change to staff title/position or level of accountability was required to accommodate operational changes in the SNP.

PrimeWest Health's JPB has adopted a formal organizational chart that demonstrates how staff responsibilities identified in the Model of Care are coordinated with job descriptions. Please see the organizational chart on the following page.

With the retirement of the former Director of Care & Quality Management in December of 2015, a restructuring occurred to create two smaller departments: Care Management and Quality & Utilization Management. This led to several changes in staff titles and/or positions to accommodate operational changes. Prior to her retirement, the former Director of Care & Quality Management brought all operational changes that were identified as being necessary to the PrimeWest Health Executive Team for discussion and recommendation. These were then brought to the JPB for approval. The organization chart was updated with all of the changes to staff titles and positions.


PrimeWest Health Joint Powers Board of Directors (Appointed County Commissioners)
Beltrami, Big Stone, Clearwater, Douglas, Grant, Hubbard, McLeod, Meeker, Pipestone, Pope, Renville, Stevens and Traverse Counties
Effective as of February 2017
James Przybilla Chief Executive Officer
Mark Simmons, D.D.S. Dental Care Director
Greg Thelen, M.D. Psychiatric Medical Director
Kristi Gagne, M.D. Family Medicine Medical Director
Charles McKinzie, M.D. Assistant Chief Senior Medical Director
Susan Paulson, M.D. Chief Senior Medical Director
Rebecca Fuller Corporate Compliance & HIPAA Privacy Officer
Cindy Norling Surveillance & Integrity Analyst
Karl Haggerty Compliance Coordinator
Heather Neugent Compliance Specialist
Beth Hendrickson Director Communications
Matt Magnuson Director Membership & Program Development
Elaine Carlquist, RN Director Care Management
Bethany Kraftheifer Director Quality & Utilization Management
Stacey Guggisberg Director Provider Network Administration
Jeramie Harris Director Business IT Research & Development
Jamie Hess Director Information Systems & Technology
Kathy Hungness Director Administrative Services
Steve Warch General Legal Counsel (Nilan Johnson Lewis)
John Klein, CFO Financial & Data Management (Circlen Health Systems)
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Chastity Pohlmann Enrollment Specialist
Jason Johanson Enrollment Coordinator
Kathleen Setko Enrollment Specialist
Kathy Beeler Enrollment Specialist
TBD Program Development Assistant
TBD Program Transportation Coordinator
Leah Anderson Dental Services Coordinator
Chelsey Wildman, BBS, LADC,ADC-MN Chemical Dependency Care Coordinator
JoAnn Ressemann Care Manager Project Coordinator
Jackie Corson Care Management Specialist
Liz Warfield, RN Care Coordinator
Ann Tasch, RN RRP & Complex Case Management Care Coordinator
Joice Berneking, LPN Case Management Licensed Practice Nurse Specialist
Jennifer Klausen, LPN Case Management LPN Specialist
Jennifer Bundy, RN, MSN Manager Complex Care & Disease Management
Dawn Hartmann, RN Care Coordinator
Jenny Golden, RN Care Coordinator
Ann Challes, RN Women & Children Care Coordinator
Leah Roell, RN Care Coordinator
Laurie Kavanagh, LSW Behavioral Health Care Coordinator
Christi Matt, RN Complex Case Management Care Coordinator
Alicia Buse, RN Care Coordinator
Robin Zimmerman Manager Quality Management
Stephanie Uecker Credentialing & Network Coordinator
Heather Koenigs Credentialing & Network Specialist
Tasha Baker Credentialing & Network Specialist
Ashley Horton Credentialing & Network Specialist
TBD Credentialing & Pharmacy Specialist
Jordan Klimek Quality Coordinator
Teri Peterson, RN Quality & Utilization Management Coordinator
Rachel Narveson, LPN HEDIS & Site Visit Specialist
Rita Lee Complaints, Appeals & Grievances Specialist
Judy Kluver Quality Specialist
Ann Ehlert, PharmD Pharmacy Manager
Jill Rudolph, RN Utilization Management Care Coordinator
Mindy Meyer, RN Utilization Management Care Coordinator
Rachel Mead, RN Utilization Management Care Coordinator
Troy Mills, CPhT Utilization Management Specialist
Vicki McTigue Utilization Management Specialist
Leslie Schmidt, LPN Utilization Management Specialist
Anita Simbana, RN Clinical System Administrator & Business Analyst
Jodi Johnson Quality & UM Specialist
Sarah Planka Manager Reporting & Data Analytics
TBD Data Analyst
Brittney Lind Data Coordinator
Becky Walsh Provider Relations & Contracting Manager
Jenny Burkey Provider Relations Coordinator
Donna Schnitzler Provider Relations Coordinator
Shana Stevens Provider Contracting Specialist
Sharon Larsen Provider Data Specialist
Tonia Kirchner Network & Data Management Manager
Katie Rosengren Provider Contracting Specialist
Maureen Melgaard-Schneider Senior Services Manager
Don Drew Senior Provider Financial Analyst
Sandi Adams Manager Business Analysts
Lisa Alle Senior Configuration Analyst
Tim Resseman Configuration Analyst
Melissa Peterson Configuration Analyst
Karen Maher Configuration Analyst
Danyette Savole Configuration Analyst
Timothy Weitzin Research Analyst
Tricia Hill Provider Data Specialist
Dawn Burns Systems Analyst
Sam Lindquist Research Analyst
Ena Ludwig Systems Analyst
Amy Eystad Systems Analyst
Alison Block Systems Analyst
Heather Olson Research Analyst
Heather Brusstuen Research Analyst
Mesa Lieser Quality Assurance & Audit Manager
Shelly Steidl COB Coordinator
Carrie Hvezda Manager Provider Claims & Contact Center
Julie Allguire Claims Examiner II
Jodi Bitzan Claims Examiner
Donna Lindberg Claims Examiner
Shannon Tollefson Claims Examiner
Becky Blaisdell Claims Examiner
Lisa Paavola Provider Contact Center Specialist
Torie Thoennes Provider Contact Center Specialist
Shay Otto Provider Contact Center Specialist
Karl Larson Claims Examiner
Steve Spenningsby Claims Examiner
Matt Raschke Claims Examiner II
Kayla Christiansen Claims Examiner
Robin Douma Claims Examiner
Brenda Haggerty Provider Contact Center Specialist
Heather Knabe Provider Contact Center Specialist
Kristie Tollefson Provider Contact Center Specialist
Troy Ronning Systems Architect I
Gretchen Buston Senior Software Developer
Shane Marshall Senior Software Developer
Ryan Webber Web Developer
Todd Spindler Software Developer II
Jeff Marlow Senior EDI Developer
Mary Winter Senior EDI Analyst
Evelyn Guevara Software Developer I
Chris Folkert BIT Manager
Amy Schroeder Applications Data Integration
Jason Hovland ETL Developer
Jadee Larkin Reporting Coordinator
Jennifer Benson Reporting Coordinator
Monica Peterson Requirements Analyst
Jamie Zabel Reporting Coordinator
Shawn Vliem ETL Developer
Mike Lounsbery Help Desk Supervisor
Michelle Gronwold Corporate Trainer/Help Desk
Jason Peterson Networking & Telecommunication Coordinator
Dan Benson System Administrator
Brandon Haggerty Information Security Coordinator
Karen Landwehr Administrative Coordinator
Julie Menk Administrative Specialist
Jeremy Gordhamer Maintenance Specialist
Mark Girouard Attorney Employment
Erica Winchell Attorney Health Care & Regulatory
Tyler Adams Attorney Contracts and Real Estate
Lindsay McLaughlin Attorney Health Care & Regulatory
Alex Tava Principal & Managing Actuary
Jon Hodgson Consultant
Katherine Stensland Actuarial Associate
Chris Riedel Senior Accountant
Jared Porter Consulting Actuary
Dawn Wallin Principal
Jake Marotz Actuarial Associate
Carey Lueders Managing Consultant
Bryce Pederson Analyst
Andrew Brantner Principal & Actuary
Danielle Larson Consultant
Amanda Rosso Actuarial Associate
Alex Bode Actuarial Associate
Jaime Haire Managing Consultant
Craig Rapley Actuarial Analyst
Ruth Spring Office Manager
Angela Zeterlu Consulting Actuary
Sarah Selvig Administrative Assistant
Angela Polk Administrative Assistant
Key
Contracted Positions
PrimeWest HEALTH

Identify the SNP contingency plan(s) used to ensure ongoing continuity of staff functions.

To ensure ongoing continuity of staff functions, PrimeWest Health has developed and implemented a Business Continuity Plan (BCP) that outlines all preparation and activation procedures for any Emergency Performance Interruptions (EPIs), an issued Presidential major disaster or emergency declaration, a declaration of emergency or disaster by a Governor, or an announcement of a public health emergency by the Secretary of Health and Human Services.

1. The BCP lists all Required Emergency Services that need to be continued in the event of an EPI or other disaster event.
2. The BCP contains an outline of roles, command structure, decision-making processes, and emergency action procedures that will be implemented upon the occurrence of an EPI.
3. The BCP includes the reversal process to bring PrimeWest Health back to normal business operations.
4. The BCP includes any information on reviewed exercises and updates that occur on a regular basis.

PrimeWest Health will continue to produce and deliver the identified Required Emergency Services as deemed by CMS and DHS in the event of an EPI, an issued Presidential major disaster or emergency declaration, a declaration of emergency or disaster by a Governor, or an announcement of a public health emergency by the Secretary of Health and Human Services, but absent an 1135 waiver by the Secretary. PrimeWest Health ensures that each county partner and subcontractor that provides a Required Emergency Service to PrimeWest Health members has a BCP in place and determines the appropriateness of the BCP through annual audits, contracts, or other processes.

Continuity of Non-Emergent Staff Functions
PrimeWest Health counties have an internal plan to assure continuity of case management services for CCMs who are on vacation, ill, extended leave, or leave their positions. These plans range from having current case managers temporarily provide coverage when assigned CCMs are absent to hiring a temporary or permanent replacement. The PrimeWest Health Care Management department has a similar plan in place, in which back-up personnel are designated for short-term coverage and, when needed, are in place until new staff can be hired.

Describe how the SNP conducts initial and annual MOC training for its employed and contracted staff including, but not limited to, printed instructional materials, face-to-face training, web-based instruction, and audio/video-conferencing.

PrimeWest Health believes that in order to effectively and efficiently meet our members' needs, all PrimeWest Health staff and others who are involved in the members' care need to have a full and complete understanding of our comprehensive care management model. This is also referred to as our Model of Care.

Initial and Annual Model of Care Training
PrimeWest Health conducts initial and annual Model of Care training for all PrimeWest Health employees, PrimeWest Health JPB members, and appropriate JPB committees (e.g., QCCC).

Initial Model of Care Training

1. **New PrimeWest Health employees** receive Model of Care training during new employee orientation through an online human resources application, Automatic Data Processing (ADP). A PowerPoint presentation describing the Model of Care is used as the tool for the employee training, which includes an emphasis on the importance of the SNP member's health care needs, transition protocols, member preferences for health services, and how employees share a role in the PrimeWest Health Model of Care. New employees are also directed to the Model of Care, which is available on the PrimeWest Health website at **www.primewest.org/providers**. ADP tracks and records successful completion of the Model of Care training, ensuring that those employees who are involved in the implementation of the PrimeWest Health Model of Care meet the requirement.

2. **New JPB members** receive Model of Care training during a monthly JPB meeting. The training includes a PowerPoint presentation on the Model of Care describing the importance of the SNP member's health care needs, transition protocols, member preferences for health services, and how employees share a role in the PrimeWest Health Model of Care. The JPB members can request the Model of Care be provided on compact disc (CD) or in other electronic or paper format. In addition, the Model of Care is available on the PrimeWest Health website at **www.primewest.org/providers**.Upon completion of the Model of Care training, JPB members complete an attestation affirming their review of the Model of Care.

3. **New members of JPB committees (e.g., QCCC)** receive Model of Care training during a monthly committee meeting, when applicable. The training includes a PowerPoint presentation on the Model of Care describing the importance of the SNP member's health care needs, transition protocols, member preferences for health services, and how employees share a role in the PrimeWest Health Model of Care. The committee member can request the Model of Care be provided on CD or in other electronic or paper format. In addition, the Model of Care is available on the PrimeWest Health website at **www.primewest.org/providers**.Upon completion of the Model of Care training the committee members complete an attestation affirming their review of the Model of Care.

Annual Model of Care Training

1. **PrimeWest Health employees** receive annual Model of Care training through ADP. A PowerPoint presentation describing the Model of Care is used as the tool for the employee training, which includes the importance of the SNP member's health care needs, transition protocols, member preferences for health services, and how employees share a role in the PrimeWest Health Model of Care. Employees are also directed to the Model of Care, which is available on the PrimeWest Health website at **www.primewest.org/providers**. The application tracks and records successful completion of the Model of Care training, ensuring that those employees who are involved in the implementation of the PrimeWest Health Model of Care meet the annual requirement.

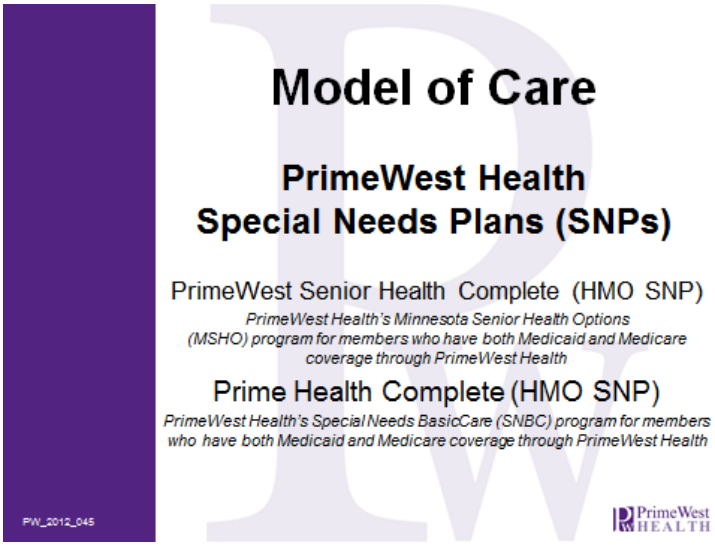
2. **JPB members** receive annual Model of Care training during a monthly JPB meeting. The training includes a PowerPoint presentation on the Model of Care describing the importance of the SNP member's health care needs, transition protocols, member preferences for health services, and how employees share a role in the PrimeWest Health Model of Care. JPB

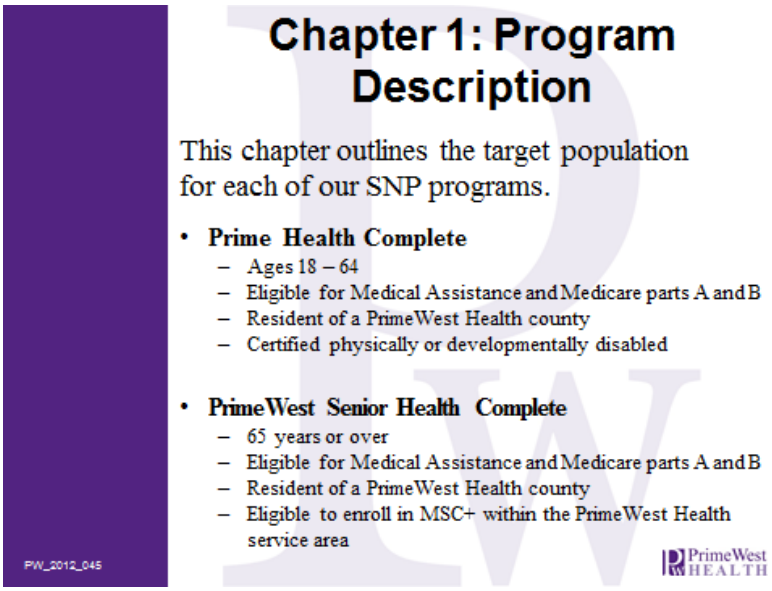
members can request the Model of Care be provided on CD or in other electronic or paper format. In addition, the Model of Care is available on the PrimeWest Health website at **www.primewest.org/providers**.Upon completion of the annual Model of Care training, JPB members complete an attestation affirming their review of the Model of Care.

3. **Members of JPB committees (e.g., QCCC)** receive annual Model of Care training during a monthly committee meeting, when applicable. The training includes a PowerPoint presentation on the Model of Care describing the importance of the SNP member's health care needs, transition protocols, member preferences for health services, and how employees share a role in the PrimeWest Health Model of Care. The committee member can request the Model of Care be provided on CD or in other electronic or paper format. In addition, the Model of Care is available on the PrimeWest Health website at **www.primewest.org/providers**.Upon completion of the annual Model of Care training, committee members complete an attestation affirming their review of the Model of Care.

Additional Training Strategies to Support the Model of Care
If updates are made to the Model of Care, trainings will be provided through the following methods:
1. Webinars
2. Face-to-face training
3. Teleconferencing
4. Video conferencing
5. Newsletters and brochures
6. Website (option for self-study)
7. Other printed materials
8. Email notification

The following are examples of PowerPoint slides using during Model of Care training presentations:





Describe how the SNP documents and maintains training records as evidence to ensure MOC training provided to its employed and contracted staff was completed. For example, documentation may include, but is not limited to: copies of dated attendee lists, results of MOC competency testing, web-based attendance confirmation, and electronic training records.

Assurance and Documentation of Completion of Training

The PrimeWest Health Director of Care Management ensures that PrimeWest Health staff, JPB members, and members of JPB committees, as appropriate, have completed training on the PrimeWest Health Model of Care. All education and training sessions are included on agendas, sign-in sheets, handouts, and formal minutes.

1. For all face-to-face trainings, PrimeWest Health maintains a record of attendees and minutes of the training curriculum.
2. For webinar trainings, PrimeWest Health requires that all attendees send an email of attendance, to ensure completion.
3. Training reports are analyzed by the Complex Care & Disease Management Manager at least annually and more frequently if needed to ensure the pertinent care management staff has been trained on the PrimeWest Health Model of Care.

Oversight of Model of Care Training

The PrimeWest Health Director of Care Management is responsible for ensuring that quality and timely Model of Care training has occurred for PrimeWest Health employees, JPB members, and members of JPB committees, as appropriate. This responsibility is supported by the PrimeWest Health Complex Care & Disease Management Manager. Oversight is monitored through the ADP application, which tracks and records successful completion of the Model of Care training by generating a report of training completed and not completed. Lists of JPB and JPB committee attendees are reviewed and compared to the roster to see who was in attendance and determine if a make-up training is appropriate. Training documentation is also reviewed as needed to ensure

curriculum is current and up-to-date. Training documentation is maintained at the PrimeWest Health office and retained for a minimum of 10 years.

Explain any challenges associated with the completion of MOC training for SNP employed and contracted staff and describe what specific actions the SNP will take when the required MOC training has not been completed or has been found to be deficient in some way.

Challenges in Completing the Model of Care Training

Challenges identified with ensuring that employees are properly trained on the PrimeWest Health Model of Care are minimal. As part of the new employee orientation and annual training schedule, all employees are provided notice to complete the Model of Care training through the PrimeWest Health internal online notification system. PrimeWest Health utilizes an online system for training to minimize difficulties for remote employees or those who travel or manage conflicting schedules. This allows all staff the option to access the Model of Care training as their schedules permit and complete it within the defined time frame.

Action for Noncompliance with Required Training

Actions and strategies for ensuring completion of relevant training and/or consequences for noncompliance are developed through collaborative efforts of PrimeWest Health staff.to ensure that the Model of Care training requirements are met. Actions that PrimeWest Health takes in response to noncompliance with required Model of Care training include, but are not limited to, the following:

1. Notifications: As the first step in the escalation process, PrimeWest Health makes one attempt to contact the employee to ensure satisfaction of the training requirement.
2. Education: Additional education is provided to those who have not completed the training to emphasize the importance of applying this model for PrimeWest Health members. In addition, employees are referred to PrimeWest Health policies and protocols.
3. CAP or individual disciplinary action plan: This is the last step in our escalation process. If all other avenues have been exhausted, PrimeWest Health may implement a CAP or disciplinary action.

B. Health Risk Assessment Tool (HRAT)

The quality and content of the HRAT should identify the medical, functional, cognitive, psychosocial and mental health needs of each SNP beneficiary. The content of, and methods used to conduct the HRAT have a direct effect on the development of the Individualized Care Plan and ongoing coordination of Interdisciplinary Care Team activities; therefore, it is imperative that the MOC include the following:

A clear and detailed description of the policies and procedures for completing the HRAT including:

Description of how the HRAT is used to develop and update, in a timely manner, the Individualized Care Plan (MOC Element 2C) for each beneficiary and how the HRAT information is disseminated to and used by the Interdisciplinary Care Team (MOC Element 2D).

Health Risk Assessment Tool (HRAT) Use to Develop and Update the Individualized Care Plan (ICP)

PrimeWest Health uses five assessment tools to identify the specialized needs of our Prime Health Complete members. These comprehensive tools include the PraPlus, the Long-Term Care Consultation (LTCC), MnCHOICES, Developmental Disability (DD) Screen, and the 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. These face-to-face assessments include provisions for assessing the medical, functional, cognitive, and psychosocial status and mental health needs of the member to meet State and Federal annual health risk assessment (HRA) requirements. The HRAT is completed within 30 days of the member's enrollment, annually (every 365 days), and within three days when a significant status change has occurred. A significant status change is defined as an event that changes a member's need for services, changes interventions needed to ensure health and well-being, or changes the member's living arrangement; these changes may include, but are not limited to, entry into hospice care, pain, acute event, or injury. Once the HRA is completed with the member, the ICT reviews all the domains of the assessment and determines where needs were identified. The ICT develops the care plan based on the assessment results and develops goals, interventions, and a member self-management plan. The area each HRAT assesses is described below.

1. PraPlus
   PraPlus is an HRA tool used to determine the immediate individual needs of Prime Health Complete members and indicates the urgency of the need for services. The assessment provides stratification for further in-depth evaluation and assessment. This document is available in both paper and electronic versions.

   Data gathered directly from the member for the PraPlus includes the following scored questions:
   a. Member's perception of his/her general health status

b. History of previous overnight hospitalizations within the 12 months prior to enrollment
c. Number of physician/clinic visits within the previous 12 months
d. Medical history
e. Social status – the availability of a friend, relative, or neighbor to care for the member if necessary
f. Current medical treatments for any of the listed conditions
g. Current living arrangements
h. Rating of ability to perform Activities of Daily Living (ADLs)
i. Number of medications currently taken
j. Assessment of eyesight
k. Any history of weight loss without trying
l. Experiencing feelings of being "sad" or "blue"

The following additional questions are not scored:
a. Home care services received including, but not limited to, Personal Care Assistant/Home Health Aide (PCA/HHA), Skilled Nursing Visits (SNV), and homemaker services
b. History of concussion or head trauma
c. Number of emergency room visits in the last 12 months
d. Number of cigarettes smoked per day

2. Initial HRA (MnCHOICES)
MnCHOICES is the initial assessment that is conducted by a State-certified MnCHOICES assessor. This assessment is conducted in person and the assessment form is completed online. It not only assesses members' needs, but identifies which programs of service the member is eligible for. MnCHOICES will be used when DHS authorizes and trains PrimeWest Health staff to use this tool. As of the last quarter of 2015, the anticipated date of this occurring is fall of 2016. The assessment that is used in place of MnCHOICES is the current reassessment HRA tool (LTCC) identified in this Model of Care as meeting CMS standards of assessment.

Areas and domains assessed by the MnCHOICES HRA are as follows
a. Assessment of health status, frailty, and physical functioning, including the following:
    i. Health
    ii. Prevention
    iii. Medication use
    iv. Medical treatments
    v. Therapies
b. Psychosocial risks including, but not limited to, depression/life satisfaction, stress, anger, loneliness/social isolation, pain, or fatigue
c. Behavioral risks, including, but not limited to, tobacco use, physical activity, nutrition and oral health, alcohol consumption, sexual practices, motor vehicle safety (seat belt use), and home safety
d. ADLs

e. Instrumental activities of daily living (IADLs)
f. Safety/self-preservation
g. Behavior and emotion
    i. Injurious to self
    ii. Aggression towards others (physical and verbal)
    iii. Socially unacceptable behavior
    iv. Property destruction
    v. Wandering/elopement
    vi. Legal involvement
    vii. Pica
    viii. Difficulties regulating emotions
    ix. Susceptibility to victimization
    x. Withdrawal
    xi. Agitation
    xii. Impulsivity
    xiii. Intrusiveness
    xiv. Injurious to others
    xv. Anxiety
    xvi. Depression
    xvii. Psychotic behaviors
    xviii. Manic behaviors
    xix. Weapon assessment
h. Caregiver interview

3. Long-Term Care Consultation (LTCC) Reassessment
This is a reassessment that is completed after the initial MnCHOICES assessment for all Prime Health Complete members. This reassessment is conducted within 365 days (or earlier if needed) of the previous assessment and is completed face-to-face.

Areas and domains reassessed by the LTCC include the following:
a. Independent living – IADLs
b. Caregiver supports/social resources
c. Caregiver assessment
d. Health assessment
    i. Heath conditions
    ii. Medication use
    iii. Special equipment/assistive devices
    iv. Medical treatment/therapies
    v. Alcohol/tobacco/substance use
    vi. Medical utilization
    vii. Nutrition
e. Functional assessment – ADLs
f. Emotional and mental health
    i. Emotional assessment
    ii. Mental status evaluation
g. Self-preservation and safety

   i. Environmental assessment
   ii. Abuse/neglect screen
h. Assessment results, recommendations, and member choice

4. Developmental Disability (DD) Screen
   This assessment is completed for Prime Health Complete members who have a developmentally disabling diagnosis and are on a county DD waiver. The DD Screen is used in conjunction with the HRA. This form is available in paper and electronic versions.

   Areas and domains assessed by the DD Screen include the following:
   a. Medical
   b. Vision
   c. Hearing
   d. Seizures
   e. Mobility
   f. Fine motor skills
   g. Expressive communication
   h. Receptive communication
   i. Self-preservation
   j. Vocational
   k. Functional assessment (independent living skills)
      i. ADLs
      ii. IADLs
   l. Level of support and services
   m. Challenging excess behavior scales
   n. Risk status
   o. Assessment result and recommendations
   p. Special support services needed

5. SNF Comprehensive Assessment Tool
   This assessment is completed for Prime Health Complete members who reside in SNFs. This assessment is conducted face-to-face and incorporates SNF medical record data for completion. This tool is available in paper and electronic versions. Data is obtained from the member's face sheet, Minimum Data Set (MDS) information, diagnosis list, medication list, and existing SNF and/or hospice care plan information.

   The SNF Comprehensive Assessment Tool incorporates the following domains:
   a. Fall/post-fall risk assessment
   b. Pain assessment
   c. Current MDS
   d. History and physical (H&P), clinical résumé
   e. Cognitive assessment
   f. Immunization records
   g. PHQ-9
   h. Braden scale (predicts risk of pressure sore)

i. Tissue tolerance test
j. Tardive Dyskinesia Identification System

Although all PrimeWest Health risk assessments are in electronic or paper format, the member is not asked or required to physically complete any part of the assessment as the assessment is done face-to-face. It is only done telephonically when face-to-face is not possible. The member (or member's family member and/or guardian) is requested and encouraged to actively participate in the assessment process to identify specific needs for the development of the ICP.

HRAT Information Dissemination to ICT
Once the HRA is completed with the member, the ICT reviews all the domains of the assessment and where needs were identified. The ICT develops the ICP based on the assessment results and develops goals, interventions, and a member self- management plan. The HRA results are communicated to the ICT members through face-to-face meetings, secure email, fax, and/or mailed written correspondence. Any feedback supplied by any ICT member is incorporated as appropriate into the ICP. The ICP, which contains the results of the HRA, is disseminated to all appropriate ICT members within 30 days of all significant status changes and updates, improvements, or instances of status maintenance

HRAT Information Utilized by the ICT
Once the HRA is completed, the member's ICP is developed by the ICT. It outlines needs identified by the HRA and includes the following: individual treatment objectives; monitoring of outcomes/goals; treatment follow-up; disabilities; cultural/religious and linguistic needs; type of service(s) to be furnished; amount, frequency, and duration of each service; and the type of provider furnishing the services, including informal community supports. All areas in the ICP are based on the results of the HRA and collateral information provided by the ICT.

Detailed explanation for how the initial HRAT and annual reassessment are conducted for each beneficiary.

Conducting Health Risk Assessments
Prime Health Complete members are identified through an enrollment file provided by DHS. County Public Health and Human Service (PH/HS) agencies of residence are notified by PrimeWest Health via secure electronic means when a member enrolls and when the member is due for the annual reassessment. The county has 10 days after notification from PrimeWest Health about enrollment to assign a CCM to the member. The name of the CCM is then communicated to PrimeWest Health via secure electronic means. PrimeWest Health Care Management care coordinators document the name of the CCM(s) in CCNT. The CCM then contacts the member via a phone call and/or follow-up letter to introduce him/herself and the care management program to the member. The CCM requests a time/date to conduct the initial HRA at the member's residence. The member always has the right to refuse the assessment and/or case management. Specific time frames for both initial and annual HRAs/reassessments are outlined below.

PrimeWest Health requires an HRA at the following times: upon initial enrollment; as needed at the time of any significant status change in medical condition, mental health status, or living situation; and every 365 days. A significant status change is defined as an event that changes a member's need for services, changes interventions needed to ensure health and well-being, or changes the member's living arrangement; these changes may include, but are not limited to, entry into hospice care, pain, acute event, or injury. The assessment follows a defined process conducted by qualified professionals to consistently identify health risks for the members.

1. **Initial HRA**
   The initial HRA is completed within 30 days of enrollment. The county assessment team, which may include a Public Health Nurse (PHN)/registered nurse (RN) and/or a social worker (SW), will conduct an initial MnCHOICES, LTCC, or SNF Comprehensive Assessment and, if appropriate, the DD Screen or complete a PraPlus to determine each member's health risks. If the CCM is unable to complete the assessment within the 30-day time frame or the member refuses to complete the assessment, clear documentation must be included in the member's care plan. The MnCHOICES or LTCC assessment must be completed face-to-face. The PraPlus can be completed face-to-face or by telephone. The assessment is conducted with the member and/or guardian unless otherwise contraindicated. The assessment tools are available either electronically or in a paper format and can be completed either way depending upon the needs of the member. (Title 42 Code of Federal Regulations [CFR] Part 422.112 [b][4] [i])

2. **Annual HRA/Reassessment**
   A reassessment will be completed within 365 days from the date the previous assessment/reassessment was completed, or more often as needed. This assessment will be conducted by a PHN/RN and/or an SW. The CCM will complete an LTCC, SNF Comprehensive Assessment, or DD Screen as appropriate. This annual LTCC reassessment must be completed face-to-face. The PraPlus can be completed face-to-face or by telephone. The assessment is conducted with the member and/or guardian unless clinically contraindicated. The assessment tools are available either electronically or in a paper format and can be completed either way depending upon the needs of the member.

3. **HRA Due to Change in Health Status**
   A reassessment will be completed within three days of a transition change or significant change in status. A significant change in status is defined as an event that changes a member's need for services, changes interventions needed to ensure health and well-being, or changes in a member's living arrangement; these changes may include, but are not limited to, entry into hospice care, pain, significant medication changes, acute event, or injury. The reassessment for a significant change is conducted face-to-face. The changes in status are identified and updated in the ICP and updates are sent to the ICT within 30 days of the reassessment.

4. **Members Who Decline/Refuse Case Management or Are Unresponsive**
    a. Members are contacted to offer CCM services, including the HRA, via mail or by phone. Members receive three phone calls and a mailing that includes the HRA within the first 90 days of refusal.
    b. Members are still assigned CCMs; however, these CCM's work collaboratively with PrimeWest Health Care Management care coordinators to identify additional opportunities where the CCM can offer the member the opportunity to accept case management services. Identified below are opportunities for members to accept CCM services.
        i. Members who refuse services and experience a transition of care will be contacted within three business days to be offered CCM services and assistance with the transitional event.
        ii. Members are identified through any of the following instances/reports and if a need is identified, the member will be contacted by the CCM and offered assistance and the opportunity to accept case management:
            - Transition event
            - Emergency room report
            - Hospital admission report
            - Utilization management (UM) Report
            - DM/CCIP Report
            - Call center referral for member/caregiver request
            - Call center referral for provider referral
            - ***Ask Mayo Clinic*** Nurse Line Report
    c. If a member has declined/refused CCM services and has requested that there be no CCM contact, the member will not be contacted for routine case management services. However, in the event a member who refused case management is identified as having a transition of care, inappropriate utilization of services, care coordination/case management referral, or high dollar medical and/or pharmacy claims, etc., the CCM will follow up with the member regarding that particular situation. In these cases, the member is assigned a PrimeWest Health Care Management care coordinator to provide necessary coordination of services.

Detailed plan and rationale for reviewing, analyzing, and stratifying the results of the HRAT, including the mechanisms to ensure communication of that information to the Interdisciplinary Care Team, provider network, beneficiaries and/or their caregiver(s), as well as other SNP personnel that may be involved with overseeing the SNP beneficiary's plan of care. If stratified results are used, include a detailed description of how the SNP uses the stratified results to improve the care coordination process.

Personnel and Process for Reviewing, Analyzing, and Stratifying HRAs
CCMs conduct and score the HRAs for risk stratification for Prime Health Complete members. CCMs are RNs or SWs with appropriate degrees and fully documented training requirements. Attestations to their credentials are obtained by PrimeWest Health from the county agency and reviewed during annual audit processes. A full description of their duties

and further technical details on the credentials are located in Chapter 2, Section A: SNP Staff Structure.

PrimeWest Health also implements computer-based risk stratification using an all-encompassing claims data warehouse. PrimeWest Health's Data Coordinator tracks and trends our Prime Health Complete population health risk data through a series of routine (monthly/quarterly/yearly) UM reports and uses customized data management software tools (IMEND and CEER), to identify individual members with chronic disease and additional health care needs. This information is reviewed by the PrimeWest Health Care Management care coordinators and communicated to the ICT via the electronic care planning process with additional care service provisions added as necessary to meet member needs.

Analysis and Stratification of HRA Results Including Rationale for Stratification
CCMs review, identify, and stratify health risks and potential triggers on the PraPlus, MnCHOICES, LTCC, DD Screen, and SNF Comprehensive Assessment. HRA stratification is necessary to determine the level of member risk or unmet need. Stratification results are triaged and prioritized with the member and the ICT to mitigate health risks. The triggers and health risks are documented in the member's ICP. CCM visit frequency for the member is based on the health risk stratification. For example, listed below is the stratification process for the PraPlus tool:

1. If the PraPlus is completed, CCM adds the score to the ICP.
2. If the PraPlus score is greater than 0.5, the CCM will complete an LTCC within 10 business days and the ICT will determine whether visits to the member should be bi-monthly, monthly, or quarterly based on the needs stratification of the assessment.

PrimeWest Health care coordinators and the Complex Care & Disease Management Manager are required to review CCM assessments, level of risk stratification, and care planning activities as they are conducted and documented on the ICP. PrimeWest Health care coordinators provide additional support and input to the ICT care planning development and implementation process with expert knowledge regarding the member's benefit set and access to an all-encompassing claims data warehouse that includes all medical, mental health, dental, pharmacy, social, and public health service provisions.

PrimeWest Health care coordinators and managers conduct an annual (at minimum) Inter-Rater Reliability Assessment to ensure the consistent application of CCM assessment skills. Notable trends or specifically identified issues are addressed on an individual basis with the CCM and his/her county director. This may occur through both informal and formal means (e.g., education and/or a CAP). Trends will be analyzed by the Director of Care Management and the medical directors and communicated to the Public Health & Human Services Committee, the county supervisor group, QCCC, and the JPB.

Communication of Health Risk Assessment Results to the ICT
The notification process includes communication with the member and/or his/her caregivers and the ICT, including all identified health care providers and the Complex Care & Disease Management Manager. Multiple communication tools are used: documentation on the ICP, phone conferences, care conferences, ICT meetings, written correspondence, and secure email

transmissions. Each member and/or his/her caregivers are provided with a hard (paper) copy of his/her ICP that clearly reflects the results of the completed assessment(s) within 30 days of when the assessment(s) was conducted. The ICP is comprehensive and addresses all needs identified in the assessments. The ICP may be mailed to the member and/or his/her caregiver or provided in person.

The CCM ensures that the appropriate individuals on the ICT, including providers involved in the member's care, receive a copy of the ICP and/or summary, which includes the results of the assessment, within 30 days of completion. This document can be provided either on paper or in a secure electronic version (i.e., a PDF document). If a critical need or significant change is identified in the assessment, the CCM will inform and/or provide the appropriate members of the ICT with an update to ensure that accurate and timely notification of concerns is made A significant change in status is defined as an event that changes a member's need for services, changes interventions needed to ensure health and well-being, or changes in a member's living arrangement; these changes may include, but are not limited to, entry into hospice care, pain, significant medication changes, acute event, or injury. This notification can be via telephone, secure email, or in person when appropriate.

The CCM is responsible for documenting on the ICP when and with whom the plan was shared. The ICP is a continuously updated, real-time document that allows PrimeWest Health care coordinators the opportunity to ensure that timely communication regarding the assessment and risk stratification is being provided to all ICT members.

Use of Stratified Results to Improve Care Coordination

Stratification Process for Initial Health Risk Assessment

In the event that the full comprehensive assessment cannot be completed face-to-face within the first 30 days, the following PrimeWest Health stratification process is in place to help the CCM prioritize individual members who are at a higher risk level, based on a telephone HRA. PrimeWest Health CCMs will conduct the initial comprehensive HRA (MnCHOICES) within 14 days if the stratification is at the higher level.

1. If the Prime Health Complete member scores 0.5 or higher on the PraPlus HRA, the CCM conducts the initial comprehensive assessment within 14 calendar days of the Risk Screening completion date. The ICP is completed within 30 days of the PraPlus date.
2. If the Prime Health Complete member scores below 0.5 on the HRA, the CCM conducts a initial comprehensive assessment within 90 days of enrollment or indicates that best effort to complete or contact member and follow-up is documented in his/her care plan and sends notification to the PrimeWest Health Complex Care & Disease Management Manager or care coordinator within 90 days of enrollment. (42 CFR 422.112 [b][4][i]). The ICP is updated within 30 days of the comprehensive initial assessment (MnCHOICES).

This ensures that members have a timely HRA and, based on the results of that assessment, a timely comprehensive risk assessment is conducted within the time frames established. This ensures that the members with the highest specialized needs get the appropriate attention faster.

Stratification for Care Coordination
Case management services are not stratified on a global basis. Frequency of case management visits is based on individualized needs and the level of coordination required to ensure continuity of care and oversight. See Chapter 2, Section D: Interdisciplinary Care Team (ICT), for more information about visit frequency.

C. Individualized Care Plan (ICP)

The ICP components must include, but are not limited to: beneficiary self-management goals and objectives; the beneficiary's personal healthcare preferences; description of services specifically tailored to the beneficiary's needs; and identification of goals met or not met.

Essential Components of the Individualized Care Plan (ICP)
The Prime Health Complete individualized care plan (ICP) incorporates existing care plan information from hospice, Individual Community Support Plan (ICSP), Individual Service Plans (ISP), SNFs, home care, Developmental Disability Group Homes, and adult foster care providers when appropriate. The Prime Health Complete ICP supplements and coordinates the elements in the other plan(s) of care. Each member's ICP is developed through collaborative efforts of an ICT and is based on the results of the HRA.

The ICP incorporates essential components to meet the member's assessed needs identified by the HRA and specifically identifies the member's self-management plan of care that includes member goals and objectives, the caregiver's interventions, and the ICT/CCM/ interventions. Each section of the ICP documents interventions and goals identified if the member has an assessed need in that domain. The primary domains are medical, psychosocial, functional, and cognitive needs, as well as mental and medical health history. Methods for monitoring the outcomes/goals and treatment follow-up are incorporated.

The CCM/care coordinator monitors and documents the progress toward achieving members' outcomes/goals, which include the members' self-management goals. This allows the CCM/care coordinator to evaluate and adjust the timeliness and adequacy of services, including the members' achievement of self-management. At minimum, members of the ICT, including the member and/or caregiver and identified specialists, 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. A significant status change is defined as an event that changes a member's need for services, changes interventions needed to ensure health and well-being, or changes the member's living arrangement; these changes may include, but are not limited to, entry into hospice care, pain, acute event, or injury. During these meetings, the ICT will assess the member's progress against what is currently in the plan and revise as appropriate. These meetings will take place face-to-face, by telephone, or, if necessary, through written or virtual correspondence. The ICT reviews the ICP and revises it as indicated by the member's needs and preferences. The CCM/care coordinator provides the updated ICPs to the member, relevant providers, and the ICT members as appropriate. ICPs are reviewed on every visit with the member. Visit frequency is determined by the ICT and based on member need. Member ICPs are reviewed and revised to support a proactive and preventive approach and

ensure progress towards stated goals. ICPs for Prime Health Complete members are reviewed with every status change and at a frequency determined necessary by the ICT. PrimeWest Health follows Policy and Procedure SNP04: Care Plan Process, to ensure these measures are met.

Roles of the Members' Caregivers
The role of the caregiver if identified by the member is critical in the ICT process. The caregiver is often involved in sections of care delivery either intermittently or daily based on the individual needs of the member. The caregiver is often the key to successful implementation of identified interventions and goal attainment for the member. The caregiver must be identified and verbalize what, if any, of the interventions and goals identified he/she is willing and/or able to provide for the member.

Member Self-Management Goals/Objectives
Each essential component of the plan has a section for the member's self-management goals and responsibilities. These outline what the member will specifically do in each component to either manage or assist with managing the plan and achieving his/her goals.

Member's Personal Health Care Preferences
The ICP is designed to incorporate the member's personal health care preference based on any disability, cultural/religious needs, and linguistic needs; type of services and preference of providers; 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, which includes Health Care Directive information. Grievance and Appeal Rights and procedures are also included. Members are encouraged to contact PrimeWest Health Member Services Contact Center by phone, fax, or mail to file a Grievance or Appeal.

Description of Services Specifically Tailored to the Member's Needs
Review of a member's medical history for immunizations, health risks, health screenings, ADLs and IADLs, wound prevention and management, tobacco and alcohol use, fall risk, medications, mental health, and nutrition is included in the HRA and documented in the ICP. In addition, education, interventions, and preventive treatments to maintain and/or improve function are incorporated in the ICP.

Identification of any risks to health and safety and a plan for addressing these risks must be included in the ICP. This includes providing choices to members to help them manage their own risks and implementation of contingency plans for emergency situations (i.e., crisis planning). The ICP in coordination with the ICT is used to develop a plan to address any crisis that may occur within the Prime Health Complete member's service delivery and/or health status. Following is a list of the specific sections of the ICP where specific service needs are described.

Preventive Care Section
Includes goals, interventions, needs, and identified outcomes related to annual physicals, dental care, immunizations, sensory exams, eye and hearing exams, mobility assessments, and fall prevention.

Health Care Directive Planning
Includes ongoing planning and review, which are carried out based on the member's needs and cultural/religious considerations. Discussion regarding Health Care Directives with a member and/or family member/representative will be initiated upon assessment, continued on an ongoing basis, and reviewed annually. PrimeWest Health follows procedures identified in Policy and Procedure CC26: Advanced Directives.

Lifestyle Health and Habits
Includes environmental and personal safety, caregiver support, and driving assessment information.

Medical
Includes current medical status and medical history and includes goals, interventions, needs, and identified outcomes related to heart disease, respiratory/lung disease, diabetes, neurological, joint/muscle disease, mental health, medication management, nutrition, urinary, palliative care/hospice care, skin integrity/wound care, and pain management. Any applicable preventive care guidelines and/or DM/CCIP guidelines are followed and additional benefits are added, if appropriate, to meet individual member needs. This includes members with disabilities or those near the end of life.

Assessment of Assistance Needed
Includes goals, interventions, needs, and identified outcomes related to IADLs, ADLs, communication, behavioral support, and personal risk management.

Identification of Goals Met or Not Met
All identified ICP goals are reviewed at every ICT meeting and the ICP has an update section where information is added to determine the status of goal progression and also indicate if the goal is met or remains in progress. The CCM is responsible for updating the ICP when the goal is met and identifying the date on which it was met. At this same meeting, goals are reprioritized and documented in the ICT section of the ICP based on the member's current health status. The ICT determines the frequency of the ICT meetings and CCM face-to-face visits. Refer to the Status Change Transition of Care Guidelines table in Chapter 2, Section D: Interdisciplinary Care Team (ICT), to review the PrimeWest Health minimum standards.

When the beneficiary's goals are not met, provide a detailed description of the process employed to reassess the current ICP and determine appropriate alternative actions.

The frequency of the ICT meetings are established and evaluated as needed based on the member's individual care needs. Goals are reviewed for progress by the CCM during visits and by the ICT team during ICT meetings. When member goals are not met within the stated timeline, the ICT reviews the goal and associated barriers to determine whether services, supports, or member/caregiver education need to be addressed. If the member's situation and/or condition has improved or deteriorated to the point where the goal is no longer appropriate, the ICT (which includes member/caregiver input) modifies or creates an entirely new goal that reflects the member's current condition/status. The CCM documents the new goals in the ICP and notes are kept in the ICT tab of the ICP. This process provides historical

documentation to support the rationale for changing the goal and/or services and supports and education. The next evaluation of the changes recommended occurs at the next CCM visit and ICT meeting or upon a significant health care status change.

Explain the process and which SNP personnel are responsible for the development of the ICP, how the beneficiary and/or his/her caregiver(s) or representative(s) is involved in its development and how often the ICP is reviewed and modified as the beneficiary's healthcare needs change.

Personnel Responsible for the Development of the ICP
A comprehensive ICP for each member is developed by the assigned CCM, using an interdisciplinary/holistic approach and collaborating with all identified ICT members based on assessed and individualized need. All care planning efforts are to be documented and notification must be made to the PrimeWest Health Complex Care & Disease Management Manager if the CCM is unable to complete the ICP within the designated time period of 30 days from the date the comprehensive assessment was completed (per 42 CFR 422.112[b][3]).

The CCM utilizes PrimeWest Health's web-based electronic ICP, which uses prompts and required fields to ensure all assessed areas have been addressed. The program prompts the user to save before exiting to make sure all data is saved appropriately. The CCM is the primary contact for PrimeWest Health care management staff when determining who from the ICT will have full or restricted access to the electronic ICP.

Member and/or Caregiver Involvement in the Development of the ICP
The CCM and ICT work in partnership with the member, authorized family member/representative, primary care provider, and other collateral sources to ensure that the member is involved in the ICP process and is making choices based on the needs assessment. Collateral sources can include information located at the SNF, interviews with SNF staff, tribal organizations, the Veteran's Administration, chemical dependency treatment providers, Mental Health Targeted Case Management (MH-TCM), ICSP, or Individual Family Services Plan (IFSP), and other supports and service providers.

1. The member, if able or clinically appropriate, will be present during ICP development and updates.
2. The member, if able, will be encouraged to actively participate in the development and maintenance of his/her ICP.
3. The member's choice and input will be considered in the initial and ongoing development of the ICP.
4. The member or representative must sign the information and signature page indicating that he/she reviewed the ICT composition and understands his/her rights and responsibilities. This form will be kept in the member's file at the county.

Guardians and authorized family participation and input in the development and maintenance of the member's ICP is considered and implemented as appropriate.

Members always have the right to request a change in their CCM if they so choose. They also always have the right to refuse case management. If this happens, the PrimeWest Health Care

Coordinator assumes the responsibilities of the CCM in collaboration with the member's primary care provider to ensure the member's identified needs are being met.

ICP Frequency of Review and Updating

At minimum, members of the ICT, including the member and/or legal representative, primary care provider, and identified specialists, meet annually based on the assessed needs of the member. If there is significant change in health status, the ICT will meet to evaluate and address the member's health, function, and additional needs. A significant status change is defined as an event that changes a member's need for services, changes interventions needed to ensure health and well-being, or changes the member's living arrangement; these changes may include, but are not limited to, entry into hospice care, pain, acute event, or injury. These meetings will take place face-to-face, telephonically, or, if necessary, through written or virtual correspondence. The ICT reviews the ICP and revises it as indicated by the member's needs and preferences. The CCM provides the updated ICPs to the member, relevant providers, and the ICT members as appropriate.

Member ICPs are reviewed and revised by the ICT to support a proactive and preventive approach. ICPs for Prime Health Complete members are reviewed with every status change and at a frequency determined necessary by the ICT. The ICP is reviewed at least annually or at a frequency determined by the ICT and when significant events and health status changes occur. A significant status change is defined as an event that changes a member's need for services, changes interventions needed to ensure health and well-being, or changes the member's living arrangement; these changes may include, but are not limited to, entry into hospice care, pain, acute event, or injury.

The CCM develops the ICP in the web-based secure platform operated by PrimeWest Health's Business IT Research & Development department. PrimeWest Health care coordinators and the Complex Care & Disease Management Manager are required to review CCM assessments, level of risk stratification, and care planning activities as they are conducted and documented on the electronic ICP to ensure progress and/or success toward stated goals. PrimeWest Health care coordinators provide additional support and input to the ICT care planning development and implementation process with expert knowledge regarding the member benefit set and access to an all-encompassing claims data warehouse that includes all medical, mental health, dental, pharmacy, social, and public health service provisions. The ICPs will also be reviewed as the CCM deems necessary based on relevant ongoing assessment of the member. The CCM, along with the PrimeWest Health care coordinators, will review, monitor, and document the progress toward achieving the member's outcomes/goals and evaluate and adjust the timeliness and adequacy of services provided. Currently, PrimeWest Health process allows access to the ICP, which is in a web-based format with security settings set up specifically to ensure that only those who need to have access to the ICP. Access to the real-time ICP through this platform is set up for the ICT to be able to view the most current ICP and, depending on access granted, will allow the ICT member to make changes as appropriate to meet the member's most current needs.

Describe how the ICP is documented and updated as well as, where the documentation is maintained to ensure accessibility to the ICT, provider network, beneficiary and/or caregiver(s).

ICP Documentation and Maintenance Process
The PrimeWest Health Business IT Research & Development department has designed a software system that incorporates the ICP elements, goals, interventions, and member needs into an electronic version referred to as the PrimeWest Health Electronic ICP. The electronic ICP is a web-based ICP so when the CCM completes the ICP they are able to update it in real time from a web browser. The electronic ICP is hosted by PrimeWest Health servers and all information is updated in real time to PrimeWest Health. When the CCM completes the ICP, it is saved and the most current ICP is immediately available to the ICT. Access to the web-based ICP is restricted using role-based security to ensure that only authorized users have access to the data.

All member documentation will be maintained in accordance with industry practices and preserved from destruction at the county office and PrimeWest Health for a minimum of 10 years past the date of disenrollment. All member documentation regarding case management will be kept at the county and will meet all HIPAA requirements. Each CCM retains an electronic and/or paper chart for each member where a copy of the ICP is kept. HIPAA, data protection, and compliance are all included in the annual county audits that PrimeWest Health conducts for each of the 13 PrimeWest Health participating counties. PrimeWest Health does not retain individual hard/paper copies of member charts at the PrimeWest Health office. Pertinent documents related to care management for the member are all stored within the PrimeWest Health care management software system, CCNT. Access to the system is administered by the Director of Care Management who identifies the necessary access and security level for all care management personnel. The PrimeWest Health Director of IS&T monitors this access and notifies the Director of Care Management regarding any potential/existing concerns. All access and security levels are reviewed annually.

The electronic ICP is accessible to the assigned CCM, member/caregiver, and identified members of the ICT. The electronic ICP is available on the web-based platform or can be saved and sent via secure email (PDF format) or as a printed document to the other members of the ICT as they request.

Explain how updates and/or modifications to the ICP are communicated to the beneficiary and/or their caregiver(s), the ICT, applicable network providers, other SNP personnel and other stakeholders as necessary.

Communication of the ICP
The member and/or caregivers, ICT, applicable network providers, PrimeWest Health Care Management personnel, and other stakeholders receive communication regarding the initial ICP and any ICP revisions in a timely manner from the CCM. A copy of the ICP and/or summary is provided by the CCM to the member and his/her legal representative, primary care provider, and other appropriate specialized pertinent providers whenever modifications are developed. The member and ICT determine who will be granted access to the web-based ICP to ensure that they have real-time access to the most current ICP. The PrimeWest Health Director of IS&T monitors

this access and notifies the Director of Care Management regarding any potential/existing concerns. All access and security levels are reviewed annually.

1. The CCM completes the ICP no longer than 30 days after the date of the completed assessment. The ICP is located on a secure web-based platform. Significant changes to the ICP will be sent to PrimeWest Health as soon as they are made but no longer than 30 days from the date the significant change/status change was made. A significant status change is defined as an event that changes a member's need for services, changes interventions needed to ensure health and well-being, or changes the member's living arrangement; these changes may include, but are not limited to, entry into hospice care, pain, acute event, or injury.
2. PrimeWest Health care coordinators are required to review the ICP for completion and areas of identified concern and provide any additional benefit information to the ICP that would enhance the member's ability to achieve stated outcomes. Any additions are communicated to the assigned CCM via telephone or secure email.
3. The CCM ensures that the appropriate individuals on the ICT, including appropriate network providers involved in the member's care, receive a copy of the ICP or notification of the update so they can review the web-based ICP and/or a summary that includes the results of the assessment within 30 days of completion. This document can be received either in paper format or in a secure electronic version (i.e., PDF) as requested. If a critical need or significant change is identified in the assessment, the CCM will inform and/or provide the appropriate members of the ICT with an update to ensure that accurate and timely notification of concerns is made. This notification can be by phone, secure email, or personal delivery when appropriate. Significant ICP changes are to be provided to the ICT as soon as they are identified and documented but will not exceed the 30-day limit.
4. The CCM is responsible to provide the member and/or caregiver with a printed copy of the completed ICP within 30 days after the date of the completed assessment and/or when modifications are made. This can be through postal mail or personal delivery. ICP modifications are to be provided to the member and/or caregiver as soon as they are identified and documented but will not exceed the 30-day limit.
5. The date the CCM disseminates the completed ICP or any significant changes to the ICP is documented on the electronic ICP. Because the electronic ICP is updated in real time, PrimeWest Health care coordinators and case managers have the ability to ensure timely communication with members of the ICT.

PrimeWest Health care coordinators and managers conduct annual (at minimum) Inter-Rater Reliability and ICP audit processes to ensure the consistent application of CCM care planning activities. Notable trends or specific identified issues are addressed individually with the CCM and his/her county director. This may occur on both an informal and formal basis (i.e., through education and/or a CAP). Trends are analyzed by the Director of Care Management and medical directors and communicated to the Public Health & Human Services Committee, the county supervisor group, QCCC, and the JPB.

D. Interdisciplinary Care Team (ICT)

Provide a detailed and comprehensive description of the composition of the ICT; include how the SNP determines ICT membership and a description of the roles and responsibilities of each member. Specify how the expertise and capabilities of the ICT members align with the identified clinical and social needs of the SNP beneficiaries, and how the ICT members contribute to improving the health status of SNP beneficiaries.

PrimeWest Health utilizes an interdisciplinary approach to ensure comprehensive and holistic services for our Prime Health Complete members.

Composition of the Interdisciplinary Care Team (ICT)
The composition of the Interdisciplinary Care Team (ICT) is determined by the assessed medical (including special), mental health, public health, and social needs of the individual member. During the member's initial HRA, the member/caregiver and the CCM discuss the different providers and support systems that the member has in place, and the role they play in the members overall care. The CCM discusses with the member/caregiver what the ICT's function is and what roles providers and support people could play in the ICT as well as recommended services and supports that are indicated by the results of the HRA. With input from the CCM, the member/caregiver determines who would be best suited to be part of the ICT. Each member of the ICT is notified in writing by the CCM of his/her membership in the ICT. Composition of the member's ICT is evaluated annually and when any changes in service needs or staffing are identified. The ICT may include, but is not limited to, the following participants:

1. Member
2. Member's family/caregiver and/or responsible party
3. 24-hour living arrangement staff (SNF, Customized Living, Adult Foster Care)
4. Representatives of tribal organizations, the Veteran's Administration, and/or county social services and case management systems
5. Primary care provider (physician, nurse practitioner, physician's assistant)
6. Identified Health Care Home (HCH) care coordinator if the member is assigned to an HCH (or HCH alternative)
7. Board-certified physicians
8. County social worker
9. County public health nurse
10. Registered nurse (RN)
11. Nurse educator
12. Physical therapist
13. Occupational therapist
14. Speech therapist
15. Mental health professionals (psychiatric, psychological, chemical dependency)
16. Dietitian, nutritionist
17. Pharmacist
18. Disease management specialist
19. Pastoral specialists
20. Preventive health specialist/health promotion specialist
21. Other specialists, as appropriate

Note: Prime Health Complete members may choose to have their specialist, including a psychiatrist, as their primary care provider. In these instances, the specialist would be an integral member of the ICT.

Roles and Responsibilities of ICT Members

Member/Caregiver/Family/Responsible Party (guardian, power of attorney holder, etc.)
The member is the primary person in the ICT along with his/her caregiver, family, and/or other responsible parties. Responsibilities include the following:

1. Participate in all HRAs
2. Participate in the development of the ICP—includes the member's self-management plan
3. Be an active member of the ICT
4. Vocalize needs, barriers, and prioritization of goals
5. Contact CCM and other members of ICT if any questions or concerns arise

ICT Members Aligned with the Identified Clinical and Social Needs of the Prime Health Complete Member
Each member's current conditions are assessed and needs are aligned with the supports, services, and specialty providers needed to ensure that the member lives in the least restrictive environment that his/her conditions and needs allow. The goal of all providers and services is to improve the health outcomes of the member and ensure that services and supports are in place to best meet these goals. The following are providers that are aligned with the clinical and social needs of our Prime Health Complete members.

County Case Manager (CCM)
The CCM is responsible for ensuring that an annual comprehensive assessment and ICP are completed and any identified needs are addressed. CCMs are the communication hub of the ICT and ensure that members of the ICT are kept current with any significant changes and transitions of care, and have a copy of the most current ICP. CCMs are responsible for, but not limited to, the following:

1. Conduct HRA
2. Develop ICP with ICT input and ensure that all members of the ICT have or can access a copy—this includes assisting in the development of the member's self-management plan
3. Conduct oversight and provide coordination for all transition of care events following established PrimeWest Health protocols
4. Schedule and facilitate all ICT meetings and document discussion, changes, and recommendations
5. Remind member of upcoming appointments, when aware
6. Accompany the member to primary and/or specialty care visits when requested (if these are not attended in person, the CCM will request an update from the member/caregiver or provider)
7. Follow up with the member on missed appointments, when notified
8. Collaborate with PrimeWest Health's care coordinators and care management team to ensure smooth transitions for the member, including provider to provider, facility to provider, and provider to facility, and assist member and provider with non-formulary medication requests

9. Provide clarity and education for member and family regarding health and medical conditions
10. Ensure progress is being made toward stated ICP goals
11. Assist the member in navigating the health care continuum
12. Act as the first point of contact for the member

Primary Care Provider
The primary care provider provides a critical role in the ICT as he/she provides continuous care to the member. Responsibilities include the following:
1. Coordinate the member's care in collaboration with the member/caregiver, CCM, and other providers involved in the member's care
2. Help develop a comprehensive approach to the management of the member's disease or illness
3. Help the member/caregiver make health care decisions that are in his/her best interest; this should include discussion about health care directives
4. Help put together the ICT and provide input for the development and ongoing maintenance of the member's ICP
5. Attend or provide input for all ICT meetings
6. Ensure that PrimeWest Health transition of care protocols are followed

Note: Prime Health Complete members may choose to have their specialist, including a psychiatrist, as their primary care provider. In these instances, the specialist would be an integral member of the ICT.

Other Medical Professionals and Specialties
Each member of the ICT shares the responsibility for ensuring that the member's needs in relation to their designated specialty or license are met. For example, the speech therapist's role is to update the ICT on the member's speech needs and progress and make recommendations in the ICP regarding speech/language therapy; the mental health provider is expected to update the ICT on the member's current mental health needs and ensure that the goals and interventions are appropriate to the member's current assessed mental health needs. Responsibilities include the following:
1. Communicate with all ICT members regarding changes in the treatment progress and recommendations
2. Provide input to the ICT regarding the development and ongoing updating of the member's ICP
3. Attend or provide input for all ICT meetings

Note: Prime Health Complete members may choose to have their specialist, including a psychiatrist, as their primary care provider. In these instances, the specialist would be an integral member of the ICT.

Support Services Staff (24-hour living arrangement staff, skilled nurse, PCA, HHA, etc.)
Each member of the support staff has a level of responsibility to ensure that the member's identified health care needs, such as ADLs and IADLs, are delivered according to the member's ICP. Responsibilities include the following:

1. Communicate with all ICT members regarding changes in the treatment progress and recommendations
2. Provide input to the ICT regarding the development and ongoing updating of the member's ICP
3. Attend or provide input for all ICT meetings
4. Ensure that PrimeWest Health transition of care protocols are followed

Other Designated Providers/Team Members
Other identified members who provide social or spiritual supports rather than clinical oversight have the responsibility to ensure that the informal supports they provide are part of the ICP. Responsibilities include the following:
1. Communicate with all ICT members regarding changes in informal supports and subsequent recommendations
2. Provide input to the ICT regarding the development and ongoing updating of the member's ICP
3. Attend or provide input for all ICT meetings

ICT Members Contribute to Health Status of Prime Health Complete Members
As stated previously, support services staff and all providers (primary care and specialty) have access and input to the ICP to improve and/or maintain the health status of Prime Health Complete members. Goals are designed to focus on the strengths of the member. Through evaluation of the goals, the ICT is able to determine how well the member and/or caregiver understand and are able to act on them. Interventions are designed to provide specific actions to help the member and/or caregiver achieve the individual goals. The ICT member who is expected to carry out the intervention is identified in the ICP. 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 ICT composition is established based on the needs and wants of the member, caregiver, and/or responsible party, and their collective primary objective is to improve the health status of the member.

Explain how the SNP facilitates the participation of beneficiaries and their caregivers as members of the ICT.

All Prime Health Complete members are assigned a CCM by the PH/HS agency in the member's county of residence. This may be either a licensed RN if the member has a chronic disease or medical need and/or a social worker if mental health and/or social issues are identified. The role of the CCM includes facilitating communication with the entire ICT and assisting the member through the continuum of care. The facilitation process includes options such as remote participation via Skype, conference call, webinar, and/or arranging transportation for member if needed. This facilitation process is documented in the ICP. A comprehensive ICP for each member is developed by the CCM, using an interdisciplinary/holistic approach. The CCM and ICT work in partnership with the member, authorized family member/representative, primary care provider, other identified ICT members, and other collateral resources to ensure that the member is involved in the care planning process and choices are made based on the needs assessment.

1. The member/caregiver, if able or clinically appropriate, and/or family members will be present during ICP development and updates.
2. The member/caregiver is highly encouraged to actively participate in the development and maintenance of his/her ICP, if able.
3. The member's/caregiver's choice and input is always incorporated into the initial and ongoing development of the ICP.
4. Prime Health Complete members/caregivers have a designated call line for their program to address questions, concerns, Grievances, and Appeals.

Participation of and input from guardians and authorized family members in the development and maintenance of the member's care plan is considered and implemented as appropriate.

Members always have the right to request a change in their CCM. They also always have the right to refuse case management. Should the member refuse case management services, he/she will still be assigned a CCM. The CCM will contact the member to offer case management at least annually and when any needs are identified by PrimeWest Health. In addition, each member is assigned a PrimeWest Health care coordinator who provides care management and collaborates with the member's primary care provider and assigned CCM(s) to ensure the member's identified needs are being met.

PrimeWest Health has several methods of identifying members who may benefit from case management because of special needs. If a member is identified through any of the following instances/reports and a need is identified, the member will be contacted by the CCM and offered assistance and the opportunity to accept case management:

1. The member experiences a transition of care event
2. The member is identified on the emergency room report
3. The member is identified on the hospital admission report
4. The member is identified on the UM report
5. The member is identified on the DM/CCIP report
6. The member is identified on the ***Ask Mayo Clinic*** nurse line report
7. The Member Services Contact Center receives a call from a member or the member's caregiver requesting case management
8. The Provider Contact Center receives a call from the member's provider requesting the member receive case management

If a member has requested no CCM contact, he/she is not contacted if any of these events arise.

Describe how the beneficiary's HRAT (MOC Element 2B) and ICP (MOC Element 2C) are used to determine the composition of the ICT.

The HRAT is completed by the member/caregiver and CCM annually and when the member experiences any significant status change. At this time, all provider information is obtained from the member to determine which providers are currently meeting which assessed needs. The member/caregiver consults with the CCM and primary care provider to determine who would be appropriate members of the ICT to help the member achieve optimal health

outcomes. Recommendations for ICT involvement are made based on the member's assessed needs and the severity of those needs. Each element that is assessed (includes medical, mental, social, and environmental needs, along with ADLs and IADLs) by a certified assessor (CCM) is reviewed by the member/caregiver and CCM in consultation with the primary care provider to determine appropriate members for the ICT based on complexity of needs and the member's self-management plan. Each provider's service and availability is assessed and recommendations for membership are evaluated upon initial assessment and at least annually thereafter. The members of the ICT can participate in person, by telephone, through interactive television (ITV), or by providing written documentation of their input. Each team member is identified on the ICP and receives notice of upcoming meetings and updates that are pertinent to his/her participation in the ICP. Members of the ICT are notified in writing by the CCM of their membership in the ICT and given information about how to contact the CCM as the primary point of contact.

Explain how the ICT uses healthcare outcomes to continuously evaluate established processes to manage changes and/or adjustments to the beneficiary's health care needs.

A member-centered ICP is important to improving health outcomes. CCMs gather updates from providers not able to participate before the ICT meeting. These updates may be provided by telephone, secure electronic email, or mail. The members of the ICT that attend the meeting in person, telephonically, or through ITV provide updates of current health status at the time of the meeting. The member/caregiver provides his/her perception of health status and progress towards goals and identifies any barriers to achieving goals. Health care outcomes, progress towards goals, and members/caregiver's participation in the self-management plan are reviewed during ICT meetings to identify any changes that may need to be made to improve the member's health status. The ICT reviews the assessed needs and interventions currently in place, evaluates their effectiveness and continued appropriateness, and makes any needed updates based on this evaluation. This can and does include clinical interventions, adherence, psychosocial risk factors, and behavioral risk factors, Member outcomes are used to identify either member success or a need to change and/or modify interventions and goals. The ICT monitors the outcomes to improve care by identifying and/or modifying the services and coordination of services that might be needed for individuals with complex problems.

Processes and Operational Functions of the ICT to Manage the Member's Health Care Needs

CCM and ICT interaction and visit frequency with the member are determined based on the member's level of risk and current need. Minimum standards of visit frequency have been established by the current State contract to provide a baseline. The visit frequency guidelines reflect the baseline for the case management and ICT process. These are guidelines, and individual needs must be taken into account through assessment and stratification, as well as the general Prime Health Complete case management process. This process is reviewed annually or more often as needed during the regularly scheduled care coordination team meetings.

1. CCMs are responsible for identifying potential triggers on the MnCHOICES, LTCC, DD Screen, and MDS Risk Summary. The triggers identified by CCMs are documented in the

member's ICP and used to determine the case management visit frequency through stratification of the assessment. This information is also used to set the ICT meeting frequency to establish individual health outcomes and ensure that the member's health goals are being evaluated for progress.

2. Prime Health Complete baseline visit frequency for the CCM and ICT
    a. Non-SNF members
        i. Face-to-face visit or phone contact a minimum of annually or increased frequency as determined by the ICT within six months of any previous face-to-face contact
        ii. Continued attempts for any member who has declined to participate
        iii. Yearly face-to-face visit for reassessment if receiving case management services
        iv. After any status change (see the following Status Change Transition of Care Guidelines chart)
    b. SNF members
        i. Contact member within three business days of admission
        ii. Face-to-face visit at a minimum annually or an increased frequency as determined by the ICT
        iii. Yearly face-to-face reassessment
        iv. After any status change (see the following Status Change Transition of Care Guidelines chart)
    c. Certified disabled members age 65 and over who are enrolled in Prime Health Complete and/or Assertive Community Treatment (ACT)
        i. Contact within six months of any previous contact
        ii. Yearly face-to-face visits
        iii. After any status change (see the following Status Change Transition of Care Guidelines chart)

Status Change Transition of Care Guidelines			
Status Change	**Initial Contact (defined as face-to-face, telephonic, or secure email)**	**Follow-up Contact(s)**	**Notes** *CCMs must triage, as needed, all members who experience a status change*
Hospital admission	Within 3 business days of notification	Within 10 days after initial visit	Additional follow-up visits at the discretion of the CCM; provide written summary to PrimeWest Health Care Coordinator explaining a hospital stay of more than 7 business days. The summary must include: • Status of member • Anticipated date of discharge and transitional plans
SNF admission	Within 3 business days of notification	Attend initial care conference	
Other status change	Within 10 days of notification	Within 10 days after initial visit	
Mental health inpatient admission (includes Intensive Residential Treatment Services and Community Behavioral Health Hospital)	Within 3 days of notification	Weekly contacts after initial visit throughout inpatient stay	Provide weekly update/summary to Care Coordinator via secure email
Court involvement when affects health	Within 3 days of notification	Upon initial contact, CCM will determine if further contact is warranted	If further contact is warranted, provide monthly updates to Care Coordinator
Member who refuses case management	Within 3 business days of notification, at a minimum, contact and follow-up with the member. In addition, CCM will contact hospital within 3 business days and identify him/herself as the member's CCM assigned to assist with the transition of care event.	Based on results of the initial contact with member	• Offer case management • Assess for additional services • Complete the transition of care • Complete LTCC, if member allows • Open to Prime Health Complete case management or waiver services if member allows and is found eligible for waiver services Refer to CCM visit frequency timelines

Identify and explain the use of clinical managers, case managers or others who play critical roles in ensuring an effective interdisciplinary care process is being conducted.

Clinical Managers
The PrimeWest Health Model of Care does not include the use of clinical managers.

PrimeWest Health Care Management Care Coordinator
The PrimeWest Health Care Management (CM) Care Coordinator coordinates care for Prime Health Complete members by collaborating with the assigned CCM to facilitate communication with the ICT across all settings and providers. The CM Care Coordinator is PrimeWest Health's primary point of contact with CCMs and the ICT, which includes collaborating with identified, certified, and contracted HCHs (or HCH alternative) and facilitating/coordinating care management activities that support the member assigned to the HCH. The CM Care Coordinator facilitates access to specialists and therapies in coordination with UM staff and the CCM; monitors care plan activities, EW services, and case management ratios/outcomes for the disability program; and ensures best practice guidelines for the disabled population are followed by CCMs and the ICT.

Case Managers
Case managers/CCMs (social worker and/or RN) are the key staff and are responsible for ensuring that the member is assessed appropriately and in a timely manner, ensuring that services are in place to meet assessed needs, scheduling ICT meetings, assisting with transitions of care, and ensuring that communication to the ICT regarding the member is carried out in a timely manner. The CCM is responsible for ensuring that the ICT reviews any of the member's barriers to better health outcomes, the prioritization of the goals, and the current ICT membership.

Physicians
Physicians play a critical role as they provide continuous care to members. The physician has information regarding the health history of the member and family, as well as information about community resources. He/she is usually the first health care professional that the member will access. Physicians help coordinate the member's care and assist in the development of a comprehensive approach to the management of the member's disease or illness. Physicians play an important role in helping members make health care decisions that are in their best interest. The physician(s) on the ICT has expert knowledge in the areas of health promotion, health maintenance, medical conditions, and a wide range of complex health problems. The physician(s) is experienced in overseeing the care of members with complex multi-system problems. Physician involvement in the ICT may or may not include identified specialists. Prime Health Complete members may choose to have their specialist, including a Psychiatrist, as their primary care provider. If this occurs, the specialist becomes an integral member of the ICT.

Pharmacists
Pharmacists play an important role in ensuring that an effective ICT process is conducted. Because of increasingly complex medication needs and opportunities, pharmacists are crucial in ensuring that members receive optimal medication therapy. Their role is to collaborate with other members of the ICT and ensure that the correct medication treatment plan is in place, that all risk

factors and contradictions to medications are taken into account, and that the member receives the appropriate education regarding medication.

Mental Health Professionals
The mental health professional has a very critical role in the interdisciplinary care process. There are a range of mental health services and supports that may be offered by a variety of providers. The type of service needed is based on needs of the individual and availability of the services. The mental health professional helps ensure that other disciplines (i.e., case manager, psychiatrist, occupational therapist) are identified and included in the plan of care if indicated to help meet the member's assessed mental health need.

This is not an all-inclusive list of the potential members of an ICT. Appropriate ICT composition is an integral part of ensuring that the member moves toward achieving stated ICP goals. Additional ICT members may be needed to address and recognize other needs of the member, as well as work collaboratively with others to improve the member's care and outcomes and improve communication among health care providers and access to health care. Additional members may include, but are not limited to, the following: physical therapists, occupational therapists, specialists, HCH care coordinators, community support service providers, SNF staff, Durable Medical Equipment (DME) providers, clergy, etc.

Provide a clear and comprehensive description of the SNP's communication plan that ensures exchanges of beneficiary information is occurring regularly within the ICT, including, but not limited to, the following:

Clear evidence of an established communication plan that is overseen by SNP personnel who are knowledgeable and connected to multiple facets of the SNP MOC. Explain how the SNP maintains effective and ongoing communication between SNP personnel, the ICT, beneficiaries, caregiver(s), community organizations and other stakeholders.

Communication
ICT meetings are held at least annually and as needed due to a significant status change to evaluate the current status of the member and review the services in place for continued improvement or status maintenance. A significant status change is defined as an event that changes a member's need for services, changes interventions needed to ensure health and well-being, or changes the member's living arrangement; these changes may include, but are not limited to, entry into hospice care, pain, acute event, injury, and/or three unplanned transitions in a month. Meetings will include the member and/or his/her legal representative, applicable providers, and other identified members, including a representative of PrimeWest Health. These meetings occur through face-to-face contact, web-based meeting interface, telephone (conference call), ITV, and/or case rounds. Other methods of meeting will be used as appropriate. Scheduling all meetings is the responsibility of the CCM as noted in the roles and responsibilities defined earlier in this section.

All notifications and communications regarding these meetings follow HIPAA standards of confidentiality. Communication regarding the meetings takes place through face-to-face

meetings, email, fax, written correspondence (i.e., newsletters, bulletins, and letters), and/or web-based notification.

PrimeWest Health's web-based tools include the following:

1. A real-time web-based ICP format with permissions granted at various levels of ICT members. The ICT members can access it at any time, and it will be the most current version.
2. An all-inclusive electronic ICT that can be shared with multiple providers
3. A collaborative partnership with our skilled nursing providers, allowing PrimeWest Health and its CCMs to have access to the members' medical records via secure web-based tools
4. The HealthX web portal, which allows providers to view medical claims they have submitted for specific members. Additional access to claims is available for the ICT and members when needed to assist in follow up and coordination of care.
5. Secure, interactive, fillable forms that can be submitted directly to PrimeWest Health (e.g., *Transition of Care Update* Form, SNF Assessment Tool)

PrimeWest Health has a formal process for addressing member Grievances and Appeals. This process includes Grievances and Appeals related to ICT and care management services. PrimeWest Health has a Member Services Contact Center that is committed to following State and Federal operating standards regarding all received calls and complies with all State, Federal, and HIPAA laws and regulations for general operations.

The documentation processes used to verify that communications have taken place, e.g., written ICT meeting minutes, documentation in the ICP, other.

Reports and ICP information are communicated to ICT members through face-to-face meetings, secure email, fax, and/or mailed written correspondence. The ICP is disseminated to all appropriate ICT members within 30 days of all significant status changes and updates, improvement, or instances of status maintenance. A significant status change is defined as an event that changes a member's need for services, changes interventions needed to ensure health and well-being, or changes the member's living arrangement; these changes may include, but are not limited to, entry into hospice care, pain, acute event, injury, and/or three unplanned transitions in a month. All pertinent member reports are to be communicated to the ICT and other identified stakeholders within 30 days of the service. This is monitored by the CCM and a PrimeWest Health care coordinator. The results of the annual analysis of transitions of care are distributed to the ICT upon completion of the reports. All minutes of the ICT meetings are documented in the ICP along with all who were present and the reason the meeting occurred (i.e., annual review).

The PrimeWest Health Complex Care & Disease Management Manager conducts an annual care plan audit to ensure that all processes and protocols are followed. The audit contains an element that addresses ICT communication and documentation of communication is noted in the ICP.

Record Retention and Dissemination of Reports
PrimeWest Health maintains records for each member. All records meet the requirements under Section 9.4.7 of the 2014 DHS SNBC Contract (including medical, claims, care management, and Service Authorization records). All records are kept for the current contract period plus 10 years.

How communication is conducted with beneficiaries who have hearing impairments, language barriers and/or cognitive deficiencies.

Members are assessed for hearing impairments, language barriers, and/or cognitive deficiencies in their HRA. The severity of the impairment is evaluated and accommodations are made to ensure there is the adequate ability to communicate with and assess the member. Documented assessed needs are recorded on the ICP with appropriate interventions. If the impairment interferes with the ability to conduct the HRA prior to CCM knowledge of impairment, the HRA will be rescheduled when appropriate accommodations can be made.

Accommodations Available

Hearing Impairments
All materials and assessments are made available in writing and, if needed, a sign language interpreter is utilized. TTY technology is used for contacting the member via phone.

Language Barriers
In accordance with DHS requirements, all member materials include the Member Services phone number accompanied by the following statement translated into 10 different languages: "Attention: If you need free help interpreting this document, call the above number." Interpreter services for non-English speakers are provided and arranged for.

Cognitive Deficiencies
Accommodations are made based on the severity of the impairment, for example, multiple reminder calls, written calendar of appointments, keeping communication at a level the member is capable of understanding (i.e., simple language, pictures). If the impairment is at such a level that the member is no longer able to maintain his/her health and safety with reasonable accommodations, recommendations for review of guardianship will be made, and a home assessment for safety will be conducted.

E. Care Transitions Protocols

Explain how care transitions protocols are used to maintain continuity of care for SNP beneficiaries. Provide details and specify the process and rationale for connecting the beneficiary to the appropriate provider(s).

PrimeWest Health follows approved transition of care policies, procedures, and protocols to ensure continuity of care for special needs plan (SNP) members. Each member is assigned a CCM/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. Within 24 hours of the transitional episode, the CCM/care coordinator or contracted providers are required to send the member's ICP to the receiving care setting, as appropriate. When notified by a hospital of any planned and/or unplanned member transition, PrimeWest Health's CM Care Coordinator sends secure email notification to assigned CCMs/care coordinators. The CCM/care coordinator is required to manage the member's care setting transition. This includes contacting the primary care provider to request review and input on the member's ICP. The CCM/care coordinator will update the PrimeWest Health ICP to reflect changes and updates and ensure that the primary care provider and pertinent members of the ICT have a copy as soon as possible, but no later than 30 days after the transition event. The CCM will update and save the web-based ICP within 30 days for any event that: changes a member's need for services; changes interventions needed to ensure health and well-being; or changes the member's living arrangement. These changes may include, but are not limited to, entry into hospice care, pain, acute event, or injury. The CCM operates as the primary point of contact during all transitions to ensure that all parties involved in the care of the member have the most current information and ICP and that all recommended services and follow-up visits are scheduled and completed.

Describe which personnel (e.g., case manager) are responsible for coordinating the care transition process and ensuring that follow-up services and appointments are scheduled and performed as defined in MOC Element 2A.

As described above, each member's assigned CCM is responsible for coordinating care during the transition process. CCMs are responsible to ensure that follow-up services are implemented and follow-up appointments are scheduled as appropriate. The CCM ensures that transportation is in place if needed for any follow-up appointments and services and that medication reconciliation is completed in a timely manner. The CCM is also responsible for communicating with the ICT that a transition has occurred. The primary responsibilities for the CCM during the transition are the following:

- Planning and preparing for the transition
- Coordinating follow-up care following the transition
- Facilitating communication with the member's primary or ordering health care provider regarding the ICP changes to ensure communication between all parties and involved providers
- Updating the member's ICP as appropriate

Explain how the SNP ensures elements of the beneficiary's ICP are transferred between healthcare settings when the beneficiary experiences any transition in care. This must include the steps that need to take place before, during and after a transition in care has occurred.

The CCM/care coordinator is required to manage the member's care setting transition. This includes requesting review and input on the member's ICP from the primary care provider. The CCM/care coordinator will update the PrimeWest Health ICP to reflect changes and updates and ensure that the primary care provider and pertinent members of the ICT have a copy as soon as possible, but no later than 30 days after the transition event. The ICP will be updated and

submitted within 30 days for an event that changes a member's need for services, changes interventions needed to ensure health and well-being, or changes the member's living arrangement. These changes may include, but are not limited to, entry into hospice care, pain, acute event, or injury.

The ICP contains information about the member that facilitates communication, collaboration, and continuity of care across settings. The ICP should be tailored to each member and take member health status into consideration. The ICP may contain, but is not limited to, both medical and non-medical information. The sending care setting must send a copy of the ICP to the receiving setting. Requirements for documentation that should be included for the receiving facility are as follows:

1. Include one or more of the following: ICP, transfer form, discharge papers, and/or elements/summary of the ICP
2. Hospitals should send discharge papers to the receiving setting or member if the member is being discharged home
3. SNFs should send transfer papers with the member or to the receiving setting if being admitted to the hospital or another setting of care or with the member if being discharged home
4. If the sending facility does not have transfer papers or ICP, the CCM/care coordinator will send the PrimeWest Health ICP to the receiving facility
5. If the member is being transferred from home, the PrimeWest Health CCM/care coordinator will send the PrimeWest Health ICP to the receiving facility

Prior to Transition

The assigned CCM/care coordinator is responsible for identifying that a transition is pending or has occurred and facilitating a safe transition. This assignment is made by the PH/HS department of the county in which the member resides. PrimeWest Health's contracted providers are required to notify PrimeWest Health of planned and/or unplanned transitions of care. The CCM/care coordinator or contracted providers are required to send the member's ICP within 24 hours of the transitional episode to the receiving care setting. When notified by a hospital of any planned and/or unplanned member transition, PrimeWest Health's Care Coordinator sends secure email notification to assigned CCMs/care coordinators.

During Transition

During any transition of care event to or from any facility, the ICP is sent to the admitting facility within 24 hours and the CCM notifies the primary care provider of admission. The discharging facility (e.g., SNF) forwards the current ICP to the receiving facility (e.g., acute care facility) to ensure continuity of care and to inform staff of any necessary support services or individualized member needs. This procedure is followed during each transition of care event.

After Transition

After each transition, the CCM completes a *Transition of Care Update* form and sends it to PrimeWest Health. PrimeWest Health monitors the *Transition of Care Update* forms to ensure care transition protocols are being used to maintain continuity of care for the member. The PrimeWest Health Care Coordinator contacts the CCM if there are any discrepancies in the transition of care protocol. The CCM will review and document any noted discrepancies.

Within three days of a transition of care event, the CCM will contact the member or caregiver, either by phone or face-to-face, to discuss the changes that occurred during the transition of care event. The contact includes, but is not limited to, discussion of the following:

- Discharge instructions
- Understanding of instructions and changes to self-management activities (using teach-back method)
- Confirmation that all new prescription are filled
- Medication reconciliation—this is performed or scheduled by an RN within 72 hours of discharge
- Assistance in scheduling a follow-up appointment with the primary care provider within seven days

PrimeWest Health follows the processes described above for all transition of care events, either planned or unplanned.

Describe, in detail, the process for ensuring the SNP beneficiary and/or caregiver(s) have access to and can adequately utilize the beneficiaries' personal health information to facilitate communication between the SNP beneficiary and/or their caregiver(s) with healthcare providers in other healthcare settings and/or health specialists outside their primary care network.

During the initial HRA, the CCM has the member or authorized representative complete and sign a Release of Information that instructs the CCM who is authorized by the member/authorized representative to receive or have access to the ICP. This release is completed at least annually and as needed. During this meeting, the CCM discusses the ICP and how it is used to communicate with the member's primary care provider and any other providers about the array of services being provided and goals. The members of the ICT are discussed with the member/authorized representative, and the member/authorized representative determine who they would like to have access to the ICP. This includes network and out-of-network providers. The network providers will have access to the ICP via a secure web-based platform. The web-based ICP is the most current plan that is available. The out-of-network providers identified on the Release of Information will be provided a copy of the ICP via email or mailed a paper version. If a member of the ICT identified on the Release of Information requests a copy, the ICP will be provided either through access to the web-based version or by other methods, e.g., secure email or mailed a paper version. All ICT members identified on the release of information will be provided with an ICP or ICP summary. All information and private health data, including the ICP, follow HIPAA privacy and security requirements.

Describe how the beneficiary and/or caregiver(s) will be educated about indicators that his/her condition has improved or worsened and how they will demonstrate their understanding of those indicators and appropriate self-management activities.

Education on Health Indicators

A member's CCM and other members of the ICT (including the member/caregiver) use the information and needs assessed on the HRAT to develop the ICP. The comprehensive ICP includes information about all the member's current conditions and records in detail what the

member's, caregiver's, and CCM's responsibilities are in helping the member achieve optimal health status. Items included on the ICP are not only medical conditions, but barriers and prioritizations. The ICP includes a caregiver support plan to ensure that the caregiver is able to maintain needed activities and support and provide optimal care for the member. The ICP also includes a personal risk management plan that outlines the risks of not following the recommendations to help ensure that the member understands how and why it is important to manage risks and to help manage and prevent unplanned transition of care events.

Demonstration of Member/Caregiver Understanding of Indicators
Part of the assessment process is assessing barriers, which includes determining the member's/caregiver's ability to understand and implement self-management activities and to help manage and prevent unplanned transition of care events. If a concern is identified, adjustments are made in the communication to the member to meet the cognitive status and/or abilities of the member/caregiver. This may include providing the information orally, through an interpreter, in larger print, or in the best known way to communicate with the member/caregiver. One of the easiest, most effective ways to close any gaps in communication between a CCM and a member is to employ the "teach-back" method. This is also known as the "show-me" method or "closing the loop" and is a way to confirm that a member has understood what was explained to him/her. This method can also identify communication strategies that may help the individual understand his/her plan of care, for example, asking a member to identify and verbalize three signs and symptoms of hypoglycemia.

Describe how the beneficiary and/or caregiver(s) are informed about who their point of contact is throughout the transition process.

At the initiation of case management services, members and primary care providers are sent a letter that outlines what they can expect from the CCM during the transition process. This letter also includes the CCM's name and contact information. This same information is presented annually and whenever changes occur. Members may also contact the PrimeWest Health Member Services Contact Center, and a Member Services representative will give them with the name and phone number of their assigned CCM. The Member Services phone number is located on all member materials, including the member's identification card, ***Evidence of Coverage***, ***Primary Care Network Listing***, and letters.

Chapter 3: SNP Provider Network

The SNP Provider Network is a network of healthcare providers who are contracted to provide health care services to SNP beneficiaries. Each SNP is responsible for ensuring their MOC identifies, fully describes, and implements the following for its SNP Provider Network:

A. Specialized Expertise

Provide a complete and detailed description of the specialized expertise available to SNP beneficiaries in the SNP provider network that corresponds to the SNP population identified in MOC Element 1.

PrimeWest Health provides a comprehensive contracted network of primary care providers, specialists, and facilities with the specialized clinical expertise pertinent to the diagnostics and treatment of the targeted special needs population. This network is monitored by the Credentialing and Provider Network Administration staff through the process of credentialing and recredentialing practitioners and the assessment of organizational providers. These processes include a system of communication and care coordination to ensure that the assessed needs of PrimeWest Health members are met. They are recommended for approval by the PrimeWest Health Peer Review Committee (PRC) and Quality Care Coordination Committee (QCCC) and approved by the Joint Powers Board (JPB).

Description of Provider Network

1. The PrimeWest Health provider network consists of more than 7,500 health and social services practitioners and more than 1,200 organizational providers in Minnesota and its border states. Our network covers the entire health and social services provider continuum, including both Medicare and Medicaid (Medical Assistance) providers, giving our dual eligible Prime Health Complete members[9] optimum access to and choice of providers.
2. PrimeWest Health has contract arrangements for the following health care and specialty services in our network to meet the needs of the identified Prime Health Complete population:
   a. Acute care facilities, hospitals, and medical centers
   b. Specialty outpatient clinics (e.g., kidney, pulmonary, or orthopedic)
   c. Laboratory services
   d. Long-term care (LTC) facilities and Skilled Nursing Facilities (SNFs)
   e. Pharmacies
   f. Radiography facilities
   g. Rehabilitative facilities
   h. Primary care providers
   i. Specialty providers (e.g., endocrinologists, cardiologists, oncologists, psychiatrists, pulmonologists, chemical dependency providers, mental health providers specializing in geriatrics)

[9] In general, both PrimeWest Health and the State of Minnesota refer to health plan enrollees as "members," so throughout this submission we will use the term "member" rather than “beneficiary.”

j. Nursing professionals
k. Mid-level practitioners
l. Rehabilitation therapy specialists (physical therapists, occupational therapists, and speech therapists)
m. Social workers and social service specialists
n. Mental health specialists(e.g., psychology)
o. Medical specialists to target chronic and comorbid conditions
p. Pharmacists (delegated to Pharmacy Benefit Manager [PBM], MedImpact)
q. Dental and Oral health specialists
r. Durable medical equipment (DME) providers
s. Home and Community Based Services providers
t. Public Health/Human Services (county case managers, care coordinators)
u. Telemedicine providers

3. PrimeWest Health prefers and gives priority to board-certified specialists within our network; however, PrimeWest Health credentialing processes do not require board certification. If a particular provider type with board certification who is not currently contracted within the PrimeWest Health provider network is identified by PrimeWest Health, a member, or a referring provider, and PrimeWest Health determines that members would benefit from the board-certified provider's service provision, PrimeWest Health Provider Network Administration seeks to complete the contracting and credentialing processes.

Provider Network Access

1. Members have direct access (no referral needed) to any contracted provider within the PrimeWest Health network without a Service Authorization unless a Service Authorization is required for that particular service. This direct access applies to the provision of covered benefits.
2. PrimeWest Health will ensure that all members have access to a primary care clinic located within 30 miles of their residence.
3. PrimeWest Health contracts with an extensive network of specialty care providers in the PrimeWest Health geographic area in an attempt to guarantee that members have access to specialty care providers based on their identified need within 60 miles of their residence or the State's generally accepted community standard.
   a. If a member has been referred for specialty care and the PrimeWest Health network does not have at least two like-contracted specialists within 60 miles of the member's residence, PrimeWest Health will review its list of all like-contracted specialists network-wide. If there are at least two like-contracted specialists network-wide, then PrimeWest Health will inform the member of these choices and locations. The member can choose to go in-network and, in that case, no Service Authorization will be required or generated. If the member chooses to go out-of-network, a Service Authorization for out-of-network services will be granted and assistance with transportation needs identified and/or arranged if necessary. The member will be informed that at the end of the authorization period, if PrimeWest Health has at least two like-contracted specialists within 60 miles of the member's residence, the member will be required to choose one of those two specialists for continued care unless doing so would cause undue hardship to the member

or interfere with the established treatment plan.

4. PrimeWest Health will ensure its members have access to health care, including ensuring that emergency care, mental health services, and chemical dependency services are available 24 hours a day, 7 days a week. Contracts with all PrimeWest Health providers, including mental/behavioral health and medical care providers, require that members have telephone access to a medical professional 24 hours a day, 7 days a week. Each participating primary care clinic must have an on-call physician as a backup to the member's primary care provider. This on-call physician, or an alternative provider, must be available to members whenever the primary care provider is not available. PrimeWest Health uses county partners and hospital emergency rooms to provide mental health crisis interventions. Mobile crisis services are an available benefit as needed.
5. Contracted providers within the PrimeWest Health network provide, manage, and assist members with the following services as appropriate:
   a. Assess, diagnose, and treat, in collaboration with the Interdisciplinary Care Team (ICT)
   b. Conference calls with the ICT as needed
   c. Assist with developing and updating the member's individual care plan
   d. Disease Management/Chronic Care Improvement Programs (DM/CCIPs)
   e. Wound management services
   f. Pharmacotherapy consultation and/or medication management clinics
   g. Home visits for clinical assessment and/or treatment
   h. Home safety assessments
   i. Home health services
   j. Hospice care (home-based end-of-life care)
   k. Risk prevention including, but not limited to, fall prevention and preventive/wellness promotion
   l. Telemonitoring and telemedicine
   m. Inpatient acute care services
   n. Hospital or urgent care facility-based emergency services
   o. Long-term facility care
   p. Long-Term Care Consultation (LTCC) Assessment Form
   q. MnCHOICES Assessment

6. All members have access to a 24-hour nurse line for health questions. Each member receives this information verbally from his/her county case manager (CCM) who explains the service, educates the member about when it is appropriate to use it, and encourages its use. Information about how to access the 24-hour nurse line is available upon request and in the following member materials:
   a. Member identification card
   b. ***Evidence of Coverage***
   c. *Notification of Case Management* letter
   d. ***PrimeLines*** newsletter (published quarterly)
   e. Individual care plan

   Information about how to access to the 24-hour nurse line is also on the PrimeWest Health website at **www.primewest.org/members.**

7. Out-of-network utilization management (UM) reports are reviewed each quarter to identify provider referral patterns. If a particular out-of-network provider with specialized expertise is identified as having services that would be beneficial to meet Prime Health Complete members' individualized needs and add to an already robust provider network, the UM Care Coordinator notifies the Provider Relations Manager, who then contacts the provider to initiate the contracting process. Once the contracting process and organizational assessment is complete, Credentialing staff will contact the provider to give direction on the steps necessary to start the credentialing process.
8. Members may also contact the Member Services Contact Center or their CCMs to request that a particular provider be added to the PrimeWest Health network; the contracting process will then be initiated.
9. In the event that a provider with the specialized expertise needed to meet the special needs of a member is not in the PrimeWest Health network, the member or his/her provider can request a Service Authorization. If appropriate evidence of medical necessity is provided by the referring practitioner or provider, the Service Authorization is granted for a minimum of 120 days.
10. If the member has an existing relationship with an out-of-network provider, PrimeWest Health care coordinators will work with the member and provider to establish a standing Service Authorization threshold until the provider is contracted as part of the PrimeWest Health network or the member is satisfactorily transitioned to a contracted PrimeWest Health provider.
11. Prime Health Complete members have **open access** (they may choose any health care provider) to the following services:
    a. Voluntary planning of the conception and bearing of children
    b. Diagnosis of infertility, including counseling and services related to the diagnosis
    c. Testing and treatment of sexually transmitted diseases
    d. Testing for AIDS and other HIV-related conditions

    The Prime Health Complete ***Evidence of Coverage*** lists **open access services** in the *Family Planning Services* section: HIV/AIDS services, medical equipment and related supplies (for family planning supplies), OB/GYN services, and health services.

For additional details on the processes utilized to ensure provider access, refer to Chapter 4, Section B: Measurable Goals & Health Outcomes for the MOC, Goal 1: Access for the SNP Population.

Explain how the SNP oversees its provider network facilities and ensures its providers are actively licensed and competent (e.g., confirmation of applicable board certification) to provide specialized healthcare services to SNP beneficiaries. Specialized expertise may include, but is not limited to: internal medicine, endocrinologists, cardiologists, oncologists, mental health specialists, other.

Organizational Provider and Individual Practitioner Licensing and Competency Determinations

In compliance with PrimeWest Health policies, PrimeWest Health Credentialing and Provider

Network Administration staff maintain processes to ensure network facilities and providers hold current licensure and/or accreditation to perform services in accordance with National Committee for Quality Assurance (NCQA) standards to meet the specialized needs of Prime Health Complete members.

PrimeWest Health Organizational Provider Network Oversight

1. PrimeWest Health's assessment of organizational providers includes confirmation of the following:
   a. The provider is in good standing with State and Federal regulatory bodies; and/or
   b. The provider has been reviewed and approved by an accrediting body; and/or
   c. The provider has a current facility license; and
   d. The provider is verified against the System for Award Management (SAM) and Office of Inspector General (OIG) sanctions list

2. PrimeWest Health conducts a quality assessment site visit to any facility that is unable to prove acceptable accreditation or the successful completion of a Centers for Medicare & Medicaid Services (CMS) survey or State review for credentialing and/or contracting purposes. At least once every three years, PrimeWest Health confirms that the provider continues to meet the established criteria for the services the provider is licensed to deliver.
3. PrimeWest Health may conduct a site visit to any contracted facility at its sole discretion and may do so unannounced. Such site visits are conducted in accordance with PrimeWest Health standards for site visits. All providers must fully cooperate with any site visit request as required by contract for PrimeWest Health network participation.
4. PrimeWest Health includes the following organizations in its assessment:
   a. Hospitals
   b. Home health agencies
   c. SNFs
   d. Free-standing surgical centers

5. PrimeWest Health includes behavioral health providers providing mental health or substance abuse services in the following settings in its assessment:
   a. Inpatient
   b. Residential Ambulatory

6. PrimeWest Health maintains appropriate verification of assessment of the aforementioned contracted medical and mental health care delivery providers.
7. All organizational providers will be required to complete initial assessment forms prior to completing the contracting process and to update that information at least every three years thereafter.
8. Contracting staff will review the initial assessment or reassessment forms for compliance with criteria as listed above.
9. Contracting staff query the Minnesota Department of Health (MDH) Office of Health Facility Complaints regarding facility complaints and appropriate CMS and Office of Inspector General (OIG) sanction lists each month to determine that the provider continues in good standing with State and Federal programs and is not excluded in any way from providing service to Medicaid (Medical Assistance) or Medicare members. The Director of

Provider Network Administration reports on compliance of facility oversight of organizational providers semi-annually to QCCC with JPB approval according PrimeWest Health Policy and Procedure.

PrimeWest Health Individual Practitioner Oversight

PrimeWest Health Credentialing and Provider Network Administration staff determine which practitioners and organizational providers will be accepted and will continue to participate in the PrimeWest Health network. Standards, policies, and processes for the acceptance, discipline, and termination of participating practitioners and organizational providers is developed in accordance with NCQA and Quality Improvement Systems for Managed Care (QISMC) standards or standards otherwise accepted as community standards by MDH. PrimeWest Health's JPB maintains full discretion in accepting, disciplining, and terminating practitioners. PrimeWest Health may deny or restrict participation by a practitioner, terminate a practitioner's participation, or impose other disciplinary action in accordance with the practitioner's written participation agreement, the Credentialing Plan, and the credentialing policies and procedures adopted by PrimeWest Health. The JPB has delegated its responsibility for the credentialing activities of PrimeWest Health to QCCC. QCCC must formally approve credentialing criteria and policies. QCCC has delegated responsibility for PrimeWest Health's credentialing activities to the PRC, including credentialing, recredentialing, discipline, and termination of practitioners and organizational providers. The PRC will make recommendations about credentialing and recredentialing to QCCC.

1. For individual practitioners, PrimeWest Health's Credentialing staff follows the PrimeWest Health Credentialing Plan in accordance with NCQA Credentialing Standards to implement the credentialing and recredentialing process:
    a. Each application is screened to ensure that the applicant meets the required pre-application criteria. Pre-application criteria must be met before PrimeWest Health will accept the application for participation. These criteria must be continuously met during participation with PrimeWest Health unless otherwise allowed:
        i. The practitioner's specialty and practice location satisfy PrimeWest Health's network needs.
        ii. The provider clinic at which the practitioner is or will be in active practice is contracted with PrimeWest Health.
        iii. The practitioner maintains professional liability of at least $1 million per occurrence and $3 million aggregate.
        iv. The practitioner/applicant is currently licensed or registered to practice in the applicant's profession in the state(s) where the applicant is practicing.
        v. The practitioner has signed an unaltered release of information. Acceptable forms of signatures are as follows: faxed, digital, electronic, scanned, or photocopied.
        vi. The practitioner has answered all disclosure statements.
        vii. The practitioner's application has not been denied by PrimeWest Health within the preceding 12 months, nor has the practitioner previously resigned or been terminated by PrimeWest Health within the preceding 24 months, other than for relocation purposes.

b. Initial credentialing includes a written application, primary source verification, a report of disciplinary actions, and confirmation of eligibility for payment under Medicaid (Medical Assistance) and Medicare.
c. Recredentialing is completed at least every three years with updates to information obtained during initial credentialing. PrimeWest Health assesses a practitioner's performance through review of relevant data obtained from various sources including, but not limited to, quality, utilization, and member complaint and satisfaction data. This information shall be considered when making recredentialing decisions to identify whether practitioners are competent to perform services that meet the specialized needs of Prime Health Complete members.
d. The PrimeWest Health credentialing and recredentialing process ensures compliance with the following:
    i. State and Federal requirements that prohibit employment or contracts with individuals (or with an entity that employs or contracts with such an individual) excluded from participation under any State or Federal health care program under Section 1128 or 1128A of the Social Security Act
    ii. Requirements of Title 42 Code of Federal Regulations (CFR) Part 422.220 regarding practitioners who opt out of Medicare

2. Member complaints related to quality are monitored and investigated by the PrimeWest Health Manager of Quality Management and Quality Specialist, with the assistance of the Chief Senior Medical Director, taking into account the severity and nature of the issue. If the complaint threshold is met for complaints related to quality, safety, accessibility, physical appearance, and/or adequacy of waiting and examining room space, PrimeWest Health conducts an onsite office site visit.
3. Credentialing staff query the Medicare/Medicaid (Medical Assistance) Sanction Exclusion list, Office of Inspector General (OIG) website, and Medicare Exclusion Database (MED) each month, and appropriate licensing board for practitioner sanctions or licensure actions at least quarterly or more often as updates become available to determine that the practitioner continues in good standing. Any practitioner identified through ongoing monitoring is reviewed by the Chief Senior Medical Director and Manager of Quality Management and recommendations are presented to the PRC regarding the report reviewed.

Provide evidence that appropriate provider credentialing information is accurately documented, updated, and maintained.

PrimeWest Health determines which practitioners will be accepted and continue to participate in the PrimeWest Health network in accordance with our current Credentialing Plan, Credentialing Policies and Procedures, and NCQA Credentialing Standards. PrimeWest Health Credentialing Network Specialists ensure that provider credentialing information is accurately documented, updated, and maintained according to the PrimeWest Health Credentialing Plan and Policies and Procedures. The PrimeWest Health Credentialing Plan includes, but is not limited to, those processes described below.

Accurate Documentation of Provider Credentialing Information
The Credentialing Plan applies to all practitioners, whether they are applying for initial participation or continued participation as part of the recredentialing process. The Plan outlines the standards, policies, and processes for the acceptance, discipline, and termination of participating practitioners and is developed in accordance with NCQA and QISMC standards or standards otherwise accepted as community standards by MDH. PrimeWest Health will consider each practitioner's potential contribution to the organization's objective of providing comprehensive and quality health care services.

All information obtained during the credentialing process will be maintained in a secure place and kept confidential. Access to the information, including scanning software, hard files, and the file server, will be limited to those authorized individuals who need the information to perform their jobs. Before granting access to secure credentialing information, the Manager of Quality Management reviews the job description of the individual requesting access and determines whether it needs to be granted. Security levels are implemented based on needed access.

In addition, credentialing information will only be released upon receipt of a written request and signed release from the affected practitioner, and as otherwise required or authorized by law. Credentialing information is confidential and treated so through the application of PrimeWest Health's privacy policies. The process used by PrimeWest Health to ensure necessary oversight functions are in place to ensure data accuracy and compliance with applicable standards is outlined below:

1. **Joint Powers Board (JPB)**
   PrimeWest Health's JPB has final authority and responsibility for the manner in which PrimeWest Health operates and serves its constituency, including the adoption of a Credentialing Plan. The JPB has delegated responsibility for the regular oversight and implementation of the Credentialing Plan to QCCC. All credentialing activities of PrimeWest Health including, but not limited to, acceptance, recredentialing, discipline, and termination of practitioners will be reported to the JPB at its monthly meetings at which time the JPB may accept QCCC's recommendations and actions. The JPB's decision will be reflected in the JPB meeting minutes. If, at any time, the JPB determines that additional information about a particular practitioner is needed, the complete file will be reviewed in a closed meeting of the JPB. The JPB will comply with MN Stat. sec. 145.61. Notwithstanding the delegation of the credentialing activities, the JPB retains full authority and responsibility for all credentialing decisions and activities.

2. **Quality and Care Coordination Committee (QCCC)**
   The JPB has delegated its responsibility for the credentialing activities of PrimeWest Health to QCCC. QCCC must formally approve credentialing criteria and policies.

   QCCC membership includes representation from a range of PrimeWest Health's participating practitioners and health care providers. QCCC shall make recommendations for credentialing and recredentialing decisions to the JPB following a review of the recommendations of the PRC. The JPB has final decision-making authority of acceptance of these recommendations.

PrimeWest Health's Credentialing Plan and supporting policies and procedures will be reviewed and submitted to QCCC for approval annually or more often as is deemed necessary to ensure compliance with State and Federal regulations as well as NCQA standards.

3. **Peer Review Committee (PRC)**
QCCC has delegated responsibility for the credentialing activities of PrimeWest Health, including credentialing, recredentialing, discipline, and termination of practitioners, to the PRC. The PRC will make recommendations about credentialing and recredentialing to QCCC.

The PRC shall be a multidisciplinary committee with representation from a range of practitioners and specialties (in accordance with NCQA standards, as applicable).

The Chief Senior Medical Director reviews and makes recommendations to the PRC on individual credentialing and recredentialing applications. The Chief Senior Medical Director has responsibility for detailed review of specific credentialing and recredentialing applications where there is concern over professional competence or conduct. These cases may involve disciplinary actions, professional liability, or other variations from professional criteria. The Chief Senior Medical Director receives and reviews practitioner credentials, giving thoughtful consideration to the required elements before making a credentialing recommendation as described in the Credentialing Plan, Policies and Procedures, and current NCQA Credentialing standards. The Chief Senior Medical Director/Credentialing staff facilitate PRC meetings, schedule meetings when needed, prepare agendas, and provide QCCC staff information for recording minutes. The Chief Senior Medical Director also reviews and makes recommendations to the PRC on individual credentialing and recredentialing applications. NCQA standards state the Chief Senior Medical Director has the authority to determine that a practitioner's file is "clean" (file has no adverse actions and meets PrimeWest Health and NCQA criteria) and sign off on such a file as complete, clean, and approved.

The Chief Senior Medical Director may choose to provisionally credential a practitioner for a period of up to 60 days. Practitioners may only be provisionally credentialed once. All provisionally credentialed practitioners must be presented to the PRC or Chief Senior Medical Director for full review under this Credentialing Plan.

The PRC will review and give thoughtful consideration to all credentialing activities and staff recommendations, keeping within PrimeWest Health's policies and procedures, before making decisions about a practitioner's status. For practitioners with "clean" files, the credentialing effective date is the date the Chief Senior Medical Director signs off on the "clean" file. For those practitioners with "variations" indicated, the effective date is the date the PRC makes its decision. If, at any time, the PRC cannot come to a decision regarding a practitioner, the PRC may table its decision until it can be presented to QCCC for review and recommendation. The QCCC decision regarding the tabled practitioner will be the final decision.

A quorum, 51 percent of active membership sitting on the committee, is required for PRC action on credentialing decisions. If a quorum is not present, no action can be taken on credentialing activities.

The PRC's discussion regarding practitioners will be reflected in meeting minutes and presented to QCCC for review and recommendations.

PRC meetings and decision making may take place in the form of real-time virtual meetings through video conferencing or web conferences with audio. PRC meetings will not be conducted through email alone. PrimeWest Health maintains processes to ensure network providers are competent and hold current licensure through Primary Source Verification (PSV) in accordance with NCQA credentialing standards. PrimeWest Health Credentialing Network Specialists review credentialing and recredentialing applications for completeness to ensure NCQA credentialing standards are met. The credentialing file is then scanned and securely sent onto our Credentialing Verification Organization (CVO) to primary source verify information provided on the application. Once the PSV is received back from the CVO, the Credentialing Network Specialist reviews the application and PSV for accurate information. The review is tracked in our preliminary file checklist. Once the preliminary file review is complete, the application, PSV, and preliminary checklist are forwarded onto another Credentialing Network Specialist to complete the final checklist process, which includes verifying the information on the application and confirming that the PSV is accurate and that NCQA standards are met. Once this is finished, the file is presented to the Chief Senior Medical Director for review and approval. Once the Chief Senior Medical Director reviews the file, he recommends it to the PRC for approval. The above-described process is how PrimeWest Health validates that network providers are currently licensed and are board-certified, if applicable, to provide the services and meet the specialized needs of Prime Health Complete members.

Updating of Provider Credentialing Information

PrimeWest Health ensures that data provided in member materials such as the ***Provider Directory*** and website are consistent with information collected during the credentialing and recredentialing process as described above. Additional information, such as provider education, training, board certification, and designated specialty, is provided on the searchable online provider directory search tool. PrimeWest Health uses NCQA standard "8/30" methodology to perform all quality assurance (QA) checks of practitioner data. The information collected on the credentialing and recredentialing applications is stored in the PrimeWest Health Provider Management Application (PMA), which is the source for the information we include in our ***Provider Directory*** and our online provider directory search tool.

Any new information a provider gives to PrimeWest Health is updated in PMA and quality checked upon completion of the update. A monthly QA check is performed on all practitioners who were newly credentialed or recredentialed to assure that all data is accurately transferred into PMA from the credentialing and recredentialing application. Regulatory reporting requirements also require PrimeWest Health to perform QA checks of reports that contain provider information monthly, quarterly, and annually. A semi-annual QA check is performed by PrimeWest Health to ensure that data entered into PMA is accurate per the verifications

performed during the credentialing and recredentialing process or upon notification from the provider. Any discrepancies identified are documented and updated in PMA. In the event of significant discrepancies, the Director of Quality & Utilization Management and the Director of Provider Network Administration are notified.

Maintenance of Provider Credentialing Information
PrimeWest Health receives credentialing and recredentialing applications directly via mail, email, and fax, and from the Minnesota Credentialing Collaborative (MCC). The MCC provides a centralized, web-based clearinghouse for information used in the credentialing process. The applications, add/change forms, and PSV are all stored and maintained as described above in a secure location and kept confidential. Access to the information, including scanning software, hard files, and the file server, are limited to certain authorized individuals according to PrimeWest Health electronic health security policies and procedures. Credentialing files are kept for 10 years and PrimeWest Health performs daily back-ups of those systems (PMA, file server, and scanning software) in which credentialing information is stored. Information that is no longer needed and/or falls outside the storage requirements is destroyed in accordance with our privacy policies.

Describe how providers collaborate with the ICT (MOC Element 2D) and the beneficiary, contribute to the ICP (MOC Element 2C) and ensure the delivery of necessary specialized services. For example, describe: how providers communicate SNP beneficiaries' care needs to the ICT and other stakeholders; how specialized services are delivered to the SNP beneficiary in a timely and effective way; and how reports regarding services rendered are shared with the ICT and how relevant information is incorporated into the ICP.

Provider Collaboration with the ICT and the Member
All assessed needs are incorporated into the member's individual care plan (ICP) through the collaboration of the ICT. PrimeWest Health utilizes CCMs as the central point of contact for the Prime Health Complete population and the CCMs interact with the member's primary care provider or specialist to ensure the needs of the member are met. The member's assigned CCM will assist the member as appropriate in managing and accessing the needed specialized services and will serve as a communication hub between the various members of the ICT. PrimeWest Health has an all-inclusive electronic ICP that is in a real-time-web-based format with permissions granted at various levels for the ICT members. The electronic ICP allows providers, CCMs, and ICT members to readily access and document activities in the member's ICP, enabling real-time communication to the care team. Use of electronic ICPs is routinely monitored.

The PrimeWest Health Care Coordinator is available to assist with this process. The members of the ICT (member, providers, specialists, CCMs, and caregivers; see Chapter 2, Section D: Interdisciplinary Care Team [ICT] for full details of ICT members) are apprised of any significant changes in needs or updates to the ICP as appropriate and clinically indicated. The CCM and/or member work with the PrimeWest Health CM care coordinator and utilization management care coordinators to find available network providers and ensure follow-up is completed.

PrimeWest Health works collaboratively with all providers identified on the ICP as needed to ensure that members receive appropriate care as detailed below and ensure progress towards stated health care outcomes is achieved. To ensure such progress, PrimeWest Health conducts a comprehensive care plan audit at least annually. The audit of PrimeWest Senior Health Complete care plans ensures that there is documentation of coordination with the ICT and that assessed needs are being addressed on the ICP.

County Case Manager Collaboration

The CCM assigned to the member sends letters to the primary care provider of each member. This letter communicates to the provider the contact information for the CCM assigned to the member. The letter informs the provider of the role of the CCM as the main point of contact and the person assigned to help the member navigate the health care continuum and coordinate all services. The letter also specifies when the primary care provider is expected to contact the CCM. The member and identified primary caregiver are also given verbal and written instruction on how to contact the CCM within the first 10 days of notification of enrollment.

All network providers and CCMs have access to the PrimeWest Health provider web portal for the monitoring of claims to review what services the member is currently receiving, which provider is providing the service, and how frequently the service is provided. The CCM will communicate with any provider involved in the care of the member to ensure that the ICT and the member have any information from specialist providers. Communication with the assigned CCMs is available through secure email, provider portal, telephone, fax, and mail. The CCM is the ICT member responsible for communicating with the other ICT members and appropriate stakeholders in the delivery of services to the member and/or caregiver. This communication is completed via secure email, telephone, fax, and mail, as well as through the electronic ICP. PrimeWest Health's all-inclusive electronic ICP is in a real-time, web-based format with permissions granted at various levels for the ICT members. The electronic ICP allows providers, CCMs, and ICT members to readily access and document activities in the member's ICP, enabling real-time communication to the care team. Use of electronic ICPs is routinely monitored.

Primary Care Collaboration

The primary care provider and/or specialist play a critical role, as he/she provides continuous care to the member, typically through provider visits and follow-up phone calls to both the member and his/her assigned CCM. The primary care provider is an important team member, who helps coordinate the member's care and assists in the development of a comprehensive approach to the management of disease or illness. He/she also plays an important role in helping the member make health care decisions that are in his/her best interest and, based on these decisions, assist in the creation of the ICT and the development of the member's ICP.

ICT meetings are held on a regular basis, or as needed due to a significant status change, to evaluate the current status of the member and review the services in place for continued improvement or status maintenance. A significant status change is defined as an event that changes a member's need for services, changes interventions needed to ensure health and well-being, or changes the member's living arrangement; these changes may include, but are not limited to, entry into hospice care, pain, acute event, injury, and/or three unplanned transitions in

a month. Meetings include the member and/or his/her legal representative, applicable providers, and other identified members, including a representative of PrimeWest Health. These meetings occur through face-to-face contact, web-based meeting interface, telephone (conference call), interactive television (ITV), and case rounds. Other methods of meeting are used as appropriate. Scheduling all meetings is the responsibility of the CCM. In addition to meetings, PrimeWest Health uses an all-inclusive electronic ICP, which is in a real-time web-based format with permissions granted at various levels for the ICT members. The electronic ICP allows providers, CCMs, and ICT members to readily access and document activities in the member's ICP, enabling real-time communication to the care team. Use of electronic ICPs is routinely monitored.

Specialty and Other Care Collaboration

Specialists and other providers provide services for the member based on need. These providers may or may not be part of the ICT and may include, but are not limited to, the following:

- Disease-specific specialist
- Pharmacist
- Mental health provider
- DME provider
- Out-of-network providers
- Health Care Home (HCH) care coordinators
- Clergy
- Physical/occupational therapists (PT/OT)
- SNF staff
- PrimeWest Health care coordinators
- Medical director(s)

These providers will have access to the member's ICP if they are identified to be part of the ICT. If they are part of the ICT, their responsibilities mirror that of the primary care provider. If they are not part of the ICT, they will provide reports to the primary care provider who then collaborates with the CCM to update status and recommendations in the ICP.

Member/Caregiver Collaboration

The CCM highly encourages the member (and/or family/caregiver) to actively participate in the care management process upon enrollment. This includes active participation in the assessment and care planning activities (including goal setting), choice of providers, and ongoing monitoring and evaluation of progress towards achieving optimal outcomes. It also includes active participation with and input to the ICT. The primary care provider and CCM provide critical services to the member, as they are the main points of contact for the coordination of and recommendations for care. The primary care provider communicates with the member during office visits, by telephone, and through written communication. The primary care provider and CCM communicate through face-to-face visits, by telephone, or through written communication and summaries of care recommendations and status. The CCM communicates with member on an established visit frequency schedule, which requires face-to-face visits and can be augmented with telephone follow-up and written communication.

Methods of Collaboration

- ICT Meetings (Face-to-face, ITV, or conference call)
- Secure electronic communication (email, fax, portal, medical record system)
- Sharing of information (letters, records, notes, reports)
- Electronic ICP

All notifications and communications regarding these meetings follow Health Insurance Portability and Accountability Act (HIPAA) standards of confidentiality. Communication regarding the meetings takes place through face-to-face meetings, email, fax, written correspondence (i.e., newsletters, bulletins, and letters), and/or web-based notification. In addition, PrimeWest Health uses an all-inclusive electronic ICP, which is in a real-time, web-based format with permissions granted at various levels for the ICT members. The electronic ICP allows providers, CCMs, and ICT members to readily access and document activities in the member's ICP, enabling real-time communication to the care team. Use of electronic ICPs is routinely monitored.

Provider Contribution to the ICT

Providers contribute to the ICT by ensuring that the member's needs related to their designated specialty or license are met (i.e., the speech therapist's role is to update the ICT on the member's speech needs and progress and make recommendations in the ICP regarding speech/language therapy; the mental health provider is to ensure that the ICT is updated on the member's current mental health needs and that the goals and interventions are appropriate to the member's current assessed mental health needs). Responsibilities include the following:

1. Communicate changes in the treatment progress and recommendations to all ICT members
2. Provide input to the ICT about the development and ongoing updating of the member's ICP
3. Attend or provide input to all ICT meetings

Provider contributions ensure that a member-centered ICP is developed that addresses individual member needs and that all members of the ICT are made aware of any changes that need to be made. Provider contributions also ensure that all assessed needs and interventions are addressed and member care is maintained or improved through the coordination of services, especially for members with complex problems

Ensure the Delivery of Necessary Specialized Services

Each member is assigned and has access to a CCM who is considered the hub of the ICT and ensures the timely delivery of any needed specialized services. The CCM provides helps the member access the necessary services and ensures their delivery. The CCM works to ensure that the ICP accurately reflects the needs of the member and notifies ICT members, as appropriate. It is the CCM who collaborates and communicates with the providers when a referral for services is needed. The CCM and the providers have access to the PrimeWest Health provider web portal to monitor and identify service utilization.

Network providers and facilities ensure delivery of specialized services in compliance with the PrimeWest Health Provider Participation Agreement. This agreement directs how network providers and facilities deliver efficient services to members. PrimeWest Health's provider agreement language includes, but is not limited to, the following:

Scope of Services. The scope of services covered under the terms of this Agreement is limited to professional medical services that are (a) allowed for under the licensure or certification of the Clinic and Clinic Practitioners, and (b) included as Covered Services described in Appendix B to this Agreement.

Access to Covered Services. Clinic and Clinic Practitioners shall:

Provide or arrange for the provision of Covered Services to Beneficiaries on a 24-hour per day, 7 days per week, 365 days per year basis. All Covered Services shall be provided in accordance with generally accepted clinical and legal standards, consistent with medical ethics governing providers, so as to assure quality of care and treatment.

Provide access to Covered Services to Beneficiaries in terms of appointment setting, waiting times and locations, on the same basis that it provides such access to services to patients who receive coverage under a non-PrimeWest Health benefit plan or health insurance policy.

Cooperation with Care Coordination. Clinic and Clinic Practitioners shall cooperate with PrimeWest Health Care Coordination activities as described in the Provider Manual.

Beneficiary Care Plan Participation. Clinic and appropriate Clinic Practitioners shall cooperate with and actively participate with PrimeWest Health, County Case Managers, the Beneficiary and/or Beneficiary's family or representative in the development, monitoring and follow through of Care Coordination plans for eligible Beneficiaries who have selected or have been assigned Clinic or a Clinic Practitioner as their primary care provider.

Cooperation with Disease and Utilization Management. PrimeWest Health shall define and provide disease and utilization management services with regard to all Covered Services delivered to Beneficiaries. PrimeWest Health's disease and utilization management authority under this paragraph applies to Covered Services provided by both Clinic and Clinic Practitioners to Beneficiaries.

Quality Management Initiatives. Clinic shall cooperate with PrimeWest Health quality management initiatives and programs. This includes providing PrimeWest Health information upon request needed to assess quality, and to participate, cooperate and assist with audit procedures and access standards in connection with the activities addressed in Section 3. Clinic shall provide to PrimeWest Health all data that PrimeWest Health may reasonably request for said activities as further described in Section 3. Clinic shall provide to PrimeWest Health any existing related quality management policies and procedures as may be requested by PrimeWest Health. PrimeWest Health shall follow the quality management standards, policies and procedures of NCQA, CMS, DHS and MDH when developing and conducting its quality management programs and activities.

Routine monitoring of provider compliance and participation in providing specialized services is carried out through the PrimeWest Health Quality Appeals and Grievances and utilization management processes, and by Provider Network Administration staff conducting provider

profiling, satisfaction surveys, and various routine reports such as UM and care planning audits. One example of monitoring of specialized services is the care plan audit. The PrimeWest Health Complex Care & Disease Management Manager, with oversight from the Director of Care Management, reviews claims received for services provided to Prime Health Complete members. The claims information is then compared against the services authorized in the member's ICP. This internal audit ensures that providers are compliant with providing services as authorized in the ICP.

Reports Regarding Rendered Services Are Shared with the ICT

PrimeWest Health care management provides a variety of reports to the CCM to help track services and service utilization. The CCM brings specific member information to the ICT for discussion and modifies the ICP based on input from the ICT.

The PrimeWest Data Coordinator generates reports from hospital notification, claims, and utilization management. The reports and data generated and shared with the CCM include, but are not limited to, the following:

1. Hospital admission report – daily report
2. Claims data – monthly report
    a. More than $50,000 in paid medical claims in the last six months (monthly UM monitoring report for programs or services provided)
    b. Hospital discharge data
    c. Emergency room use – three or more visits in the last six months
    d. Office visits – 10 or more in the last three months

3. Pharmacy data – monthly report
    a. Retroactive drug utilization review report from PrimeWest Health's pharmacy benefits manager (PBM) on controlled substances use in the previous three months
    b. High-risk medications in the elderly report

4. Data collected through the UM process
    a. Hospital admission data – daily

5. Circumstances – information gathered from UM concurrent review, transition of care process, and hospice notification process
    a. Inpatient stays longer than seven days
    b. SNF admissions and continued stays
    c. Hospice services

How Relevant Information Is Incorporated into the Care Plan

The assigned CCM will review the information in the reports noted above and determine the necessary actions based on need and severity. The action will be one of the following.

- Contact member via telephone to discuss the current concerns
- Schedule an ICT meeting in the next two weeks or other appropriate time frame
- Immediately schedule a reassessment and ICT meeting

The CCM will update the ICP with newly gathered and relevant information that affects the safety, care, and services and will notify the ICT via telephone, fax, or secure email that the ICP was updated. An update is required no longer than 30 days after a reassessment is conducted.

As new information regarding the member's care and recommendations for care is gathered, updates are entered into the ICP. ICT members who have editing rights are responsible for ensuring the ICP is up-to-date with the most relevant information. All other members have viewing access and will see the updates as they are added. The CCM has primary responsibility to ensure all ICT members with editing rights have updated the ICP in a timely manner. Further details regarding the ICP and the process for updates and oversight are in Chapter 2, Section C: Individualized Care Plan (ICP).

B. Use of Clinical Practice Guidelines & Care Transitions Protocols

Explain the processes for ensuring that network providers utilize appropriate clinical practice guidelines and nationally-recognized protocols. This may include, but is not limited to: use of electronic databases, web technology, and manual medical record review to ensure appropriate documentation.

Per contracts with the Minnesota Department of Human Services (DHS), PrimeWest Health follows the *NCQA Standards and Guidelines for the Accreditation of Health Plans* standard for Practice Guidelines found in standard QI 9. PrimeWest Health guidelines are adopted based on valid and reliable clinical evidence from available peer-reviewed, evidence-based community standards. To determine practitioner adherence to the selected guidelines, PrimeWest Health conducts annual performance measurements using the Healthcare Effectiveness Data and Information Set (HEDIS), which uses claims from electronic databases as well as medical record reviews provided by the current contracted HEDIS chart abstraction vendor.

Clinical Practice Guidelines and Protocols
For Prime Health Complete, PrimeWest Health has adopted preventive and chronic disease practice guidelines appropriate for members with disabilities, Guidelines are recommended for approval by QCCC to the JPB and reviewed and updated at least every two years. For a detailed description of QCCC and the JPB, as well as more detail about clinical practice guidelines, see Chapter 4, MOC Quality Measurement & Performance Improvement.

1. The guidelines are disseminated to all affected providers and, upon request, to members and potential members. PrimeWest Health ensures that adopted guidelines are used in UM decisions, member education, and service coverage. PrimeWest Health recognizes that clinical practice guidelines are guidelines only and, in some circumstances, members may not benefit from strict adherence to these guidelines. The final decision about clinical practice is left to the practitioner's professional judgment.
2. At the health plan level, PrimeWest Health conducts annual performance measurement using HEDIS, which uses claims from electronic databases as well as medical record review through its contracted HEDIS chart abstraction vendor to determine compliance with the clinical practice guidelines. At the member level, the CCM works with the primary care provider and ICT to ensure that all preventive measures, clinical monitoring, and other

clinical practice guidelines are being used, unless the individual practitioner has determined that the guidelines and protocols are not appropriate based on the unique needs of the member.

3. Guidelines are adopted based on valid and reliable clinical evidence from available peer-reviewed, evidence-based community standards.
   a. Adopted guidelines consider the needs of PrimeWest Health members.
   b. Adopted guidelines are integrated into the member's individualized care plan for communication with and action by the ICT.
   c. Adopted guidelines are not meant to usurp practitioners' medical decisions, but are guidelines only. PrimeWest Health recognizes that members with special needs or other unique circumstances may have care needs that would not benefit from strict adherence to the guidelines.
   d. All guidelines are reviewed at least every two years, but more often if appropriate and approved by the JPB.
   e. Pertinent updates will be communicated by the PrimeWest Health Chief Senior Medical Director and/or the Manager of Quality Management to PrimeWest Health's QCCC and JPB for approval and acceptance.
   f. After updates are approved and accepted, PrimeWest Health will disseminate updated guidelines to providers. Guidelines will be available to members upon request.
   g. Providers also have access to the guidelines in the following ways:
      i. Website links to each of the guidelines are posted on the PrimeWest Health website.
      ii. Providers are reminded of the adopted guidelines through the provider newsletter.
      iii. Copies of the guidelines are available on a compact disc upon provider request.

4. Per PrimeWest Health Clinical Practice Guidelines policy, the following guidelines have been adopted and implemented by PrimeWest Health:
   a. Preventive Care
      i. Adults – Institute for Clinical Systems Improvement (ICSI) guidelines for preventive services (most current), including chlamydia, breast cancer, and cervical cancer screening
   b. Chronic Disease
      i. Diabetes – American Diabetes Association (ADA) clinical practice guidelines (most current)
      ii. Congestive Heart Failure (CHF) – American College of Cardiology Foundation/American Heart Association (ACCF/AHA) guidelines (most current)
      iii. High Blood Pressure – The Journal of the American Medical Association Guideline for the Management of High Blood Pressure in Adults
      iv. Depression
         - Adults – ICSI guidelines for treating depression in adults (most current)
         - Children – American Academy of Child and Adolescent Psychiatry (AACAP) Guidelines for Treating Child Depression
      v. Chronic Obstructive Pulmonary Disease (COPD) – ICSI COPD Diagnosis and Management Guideline (2009)
      vi. Asthma – National Heart, Lung, and Blood Institute (NHLBI) asthma guidelines (most current)

vii. Hypertension – ICSI Guidelines for Hypertension Diagnosis and Treatment (August 2012)

c. Prenatal Care – ICSI prenatal care guidelines, routine (most current)
d. Treating Tobacco Use and Dependence –Agency for Healthcare Research and Quality (AHRQ) Treating Tobacco Use and Dependence Clinical Practice Guideline
e. Chemical Dependency – American Psychiatric Association (APA) guidelines

5. Special needs population-specific guidelines for the following are adopted from the Mayo Clinic, ICSI, and Stratis Health:
   a. Dehydration (potential for)
   b. Fever
   c. Lower respiratory infection
   d. Mental status change
   e. Self-management for COPD
   f. Self-management for heart failure
   g. CHF
   h. Urinary tract infection (UTI)
   i. Preventive care (HEDIS and Best Practices recommendations)
      i. Breast cancer screening
      ii. Cholesterol screening
      iii. Colorectal cancer screening
      iv. Annual flu vaccine

6. PrimeWest Health contracts with our PBM, MedImpact, to provide a comprehensive Medication Therapy Management (MTM) program to our Prime Health Complete members.
   a. Eligibility criteria: A member must meet **all** three criteria below to be eligible for the MTM program.
      i. Multiple chronic diseases: A member must have at least three chronic diseases to meet the MTM program criteria. The chronic diseases included in the program are asthma, COPD, diabetes, osteoporosis, depression, dyslipidemia, heart failure, hypertension, and osteoarthritis.
      ii. Multiple covered Part D drugs: A member must have filled at least six different types of prescriptions that apply to his/her related chronic diseases.
      iii. Incurred cost for covered Part D drugs: The member is likely to incur annual costs of at least $3,000 for all covered part D drugs.

   b. Identification
      i. MedImpact's data analysis group uses claims data from RxClaim software to identify members whose drug claims suggest that they have specific eligible diseases. Later in the MTM process, the member's disease states/conditions are verified by the member and/or providers.
      ii. Pharmacy claims information provides data to determine if the other two program criteria (multiple drugs and annual drug costs of $3,000 or greater) are met.

iii. Once qualified members are identified, the data (medications, adherence, address, phone, etc.) will be pulled into the MTM program's workflow system.

c. Enrollment/disenrollment: This program is an opt-out program.
   i. Enrollment: All MTM-qualified members will receive an MTM program introduction letter, MTM brochure, and reply form. Member communications include the following:
      - An introduction letter is sent to all qualified members to introduce MedImpact's MTM program and invite them to participate.
      - Members use the reply form to either enroll or decline to enroll (opt out). A call specialist will call members who choose to participate to enroll them and verify their information.
      - Members who do not return the reply form may receive a call from a call specialist offering to enroll them.
      - All MTM-qualified members who live in an LTC facility will receive an additional mailer inviting them to participate in the program.
      - LTC members are identified in MedImpact's RxClaim system by the residence code submitted with the claim.

   ii. Disenrollment: A qualified member may choose not to participate or may no longer be qualified to participate due to one of the reasons below. MedImpact's MTM program will store information about all members who are no longer enrolled. Opt-out status will remain in effect until the beginning of the next benefit year. The member status is described below.
      - Opt out by disenrolling from the health plan – If a member switches to a different health plan (not administered by MedImpact), the member's status will be changed to Closed Insurance.
      - Opt out deceased – When a member dies, the member's status will be changed from Open to Closed Deceased.
      - Opt out by request – When an enrolled member asks to be removed from the program for the plan year, the member is removed, and the status is changed to disenrolled.

d. Interventions: MedImpact has implemented an MTM program designed to optimize therapeutic outcomes for targeted members and to be cost-efficient. The components of the MTM program are described below.
   i. PBM Care Management Program for members
      - During January, March, May, August, and October, MedImpact will qualify members for the MTM program. Introduction packets will be mailed to all newly qualified members (identified by the MTM program system) who have met the three initial criteria.
      - Call specialists contact qualified members
        – Members indicate whether they want to participate by completing and mailing the reply form.
        – Upon the receipt of a completed reply form, a call specialist contacts the member to complete the initial care assessment.

- Members who don't return the reply form may receive a phone call from a call specialist following the mailing of the introduction letter to offer a comprehensive medication review (CMR). If the member agrees to participate, he/she is transferred to a clinician or an appointment is scheduled.
- Members who complete a CMR with one of MedImpact's MTM clinicians (e.g. registered nurse, pharmacist) to evaluate their medication regimen will receive a medication action plan and personal medication list. If the clinician is not a pharmacist, then a pharmacist will contact the member's provider to promote better care by using nationally accepted treatment guidelines. When appropriate, an intervention letter will be sent to the member's provider, with a copy to the member.
- During business hours, members and providers can contact MedImpact's MTM staff through a toll-free number.

e. Resources
PBM, pharmacist, licensed practical nurse (LPN), and service specialists

f. MTM staff responsibilities
   i. MedImpact MTM staff include clerks, service specialists, and clinicians (e.g., nurses, pharmacists). They perform the following functions for the MedImpact MTM program:
      - MTM clerks
        - Coordinate all fulfillment of member letters
      - MTM service specialists
        - Process completed and returned MTM reply forms
        - Perform quality review of all mailing/fulfillment
        - Answer incoming member calls
        - Call newly qualified members to describe MedImpact's MTM program and offer enrollment
      - MTM clinicians
        - Perform CMRs
        - Respond to clinical questions
        - Provide additional resources and training for MTM staff

g. In coordination with MedImpact's other clinical programs, MedImpact clients, and CMS, MedImpact's MTM program will perform the following functions:
   i. Provide a Health Insurance Portability and Accountability Act (HIPAA)-compliant link for the information flow between other program(s) and MedImpact's MTM program.
   ii. Provide reports for outside organizations to access information that pertains to their member population (within the parameters of HIPAA).
   iii. Conduct the MTM program in coordination with the Medicare Chronic Care Improvement Programs (CCIPs). MedImpact provides drug claims data to the CCIPs for those members who are enrolled in CCIPs, in a manner specified by CMS. MedImpact also reports any MTM data required by CMS in the manner prescribed by CMS.

h. MedImpact generates reports that measure PrimeWest Health's contracted MTM pharmacists' ability to improve medication management objectives and sends the reports to PrimeWest Health's Pharmacy Manager. Reports are provider-specific. Such reports include, but are not limited to, measuring the following:
   i. Number of members enrolled
   ii. Average medications per member
   iii. Harmful drug interactions
   iv. Evidence of member education
   v. Member compliance rates
   vi. Dosing appropriateness

Define any challenges encountered with overseeing patients with complex healthcare needs where clinical practice guidelines and nationally-recognized protocols may need to be modified to fit the unique needs of vulnerable SNP beneficiaries. Provide details regarding how these decisions are made, incorporated into the ICP (MOC Element 2C), communicated with the ICT (MOC Element 2D) and acted upon.

Challenges with Oversight

PrimeWest Health has found that clinical practice guidelines are not appropriate in 100 percent of the population they are recommended for. The Prime Health Complete population has a high number of members who are unable to tolerate certain procedures or tests (either physically or mentally due to disability) or for whom a service is clinically contraindicated due to the complexity of their condition. For example, a 54-year-old member in the end stages of cancer with a life expectancy of six months would not be considered appropriate for a mammogram. In this example, the decision not to follow the clinical practice guidelines would be reflected in the member's individualized care plan (ICP). PrimeWest Health participation agreements require providers to follow best practices and clinical practice guidelines and protocols when the treatment is appropriate for the member. However, at times, a network provider may need to make clinical judgments that supersede the clinical guidelines to best treat a member's condition and unique needs. Individuals' own health beliefs are another challenge as members may refuse a procedure, test, or behavioral modification that the provider recommends. A member's age and frailty factor as well as health literacy can also present challenges. Quality performance outcome measures (through HEDIS) do not always account for the possibility of member refusal or the judgment of a provider that a service contraindicated.

Decision-Making Process

The member's CCM works with the member and primary care provider or specialist as part of the Interdisciplinary Care Team (ICT) to communicate current issues that that may affect decisions regarding the use of clinical practice guidelines and nationally recognized protocols for the care of the member.

The primary care provider or specialist who has the final decision will take the input received from the CCM into consideration when, in collaboration with the member, making a determination whether to follow the clinical practice guidelines and nationally recognized protocols. The factors considered in this decision are: the member's ability to tolerate the procedure (physically or mentally, due to disability); the member's acceptance/willingness to

have the procedure or undergo behavioral modification; the member's cultural, religious, and personal beliefs; and whether the procedure is clinically contraindicated due to the complexity of the member's condition.

Decision Incorporation into ICP/Communication of Decisions with the ICT
If the ICT decides not to follow clinical practice guidelines or nationally accepted protocols, the rationale behind the decision is documented in the patient's health record and communicated with all members of the ICT via the communication methods listed in the Collaboration of the ICT section of Chapter 3, Section A: Specialized Expertise. The CCM meets with the member and gets updates on recent clinical care the member has received. The CCM then contacts the clinics for verification of the actual clinical findings and updates the ICP with the factors involved in the decision not to follow clinical practice guidelines or nationally recognized protocols. The CCM communicates these decisions with the ICT through the previously outlined communication methods. The providers that are involved in the ICT receive notification from the CCM that the ICP was updated and can be accessed on the web-based platform.

Decisions of ICP Acted Upon
For those members and/or caregivers who have refused to follow the clinical practice guidelines and nationally recognized protocols, the CCM works with the primary care provider and/or specialist to educate the member, caregiver, and ICT members about recommended and appropriate medical interventions with the goal of improving the member's compliance. ICT members are also education to help them understand why the clinical practice guidelines or nationally recognized protocols were not followed and ensure that recommendations are acted upon.

Explain how all SNP providers ensure care transitions protocols are being used to maintain continuity of care for the SNP beneficiary as outlined in MOC Element 2E.

CCMs are the primary individuals who coordinate and ensure that all transition protocols are followed by all providers involved in each individual transition of care event. Each member is assigned a CCM who follows the transition of care protocols outlined in Chapter 2, Section E: Care Transitions Protocols. The CCM provides the primary care provider and member a written outline of PrimeWest Health transition of care expectations within 10 days of notification of the member's enrollment. The letter contains the following instructions and information:

- Member's CCM name and contact information
- Planning and preparation for the transition
- Providing follow-up care following the transition
- Facilitating communication with the member's primary or ordering health care provider regarding ICP changes. This ensures communication among all parties and involved providers.
- Facilitating an ICT conference if necessary
- Updating the member's ICP as appropriate
- A contact number to call if any assistance or more information about a transition of care is needed

After each transition, the CCM completes a *Transition of Care Update* form and sends it to PrimeWest Health. PrimeWest Health monitors the *Transition of Care Update* forms to ensure care transition protocols are being used to maintain continuity of care for the member. The Care Coordinator contacts the CCM if there are any discrepancies in the transition of care protocol. The CCM will review and document any noted discrepancies.

During any transition of care event to or from any facility, the ICP is sent to the admitting facility within 24 hours and CCM notifies the primary care provider of admission. The discharging facility (e.g., SNF) forwards the current ICP to the receiving facility (e.g., acute care facility) to ensure continuity of care and to inform them of any necessary support services or individualized member needs. This procedure is followed during each transition of care event.

Within three days of a transition of care event, the CCM will contact the member or caregiver, either by phone or face-to-face, to discuss the changes that occurred during the transition of care event. The contact includes, but is not limited to, discussion on the following:

- Discharge instructions
- Understanding of instructions and changes to self-management activities (using teach back method)
- Confirmation that all new prescription are filled
- Medication reconciliation – this is performed or scheduled by a registered nurse (RN) within 72 hours of discharge
- Assistance in scheduling a follow-up appointment with the primary care provider within seven days

PrimeWest Health contracted hospitals and SNFs are contractually required to provide notification to PrimeWest Health's UM department within one business day when Prime Health Complete members are admitted to a facility. An automated, on-demand Crystal report is generated biannually and as needed by the Care Management Specialist. This report is reviewed analyzed and recommendations are made by the Special Needs, Disability & Behavioral Health Manager. PrimeWest Health contacts facilities that are not in compliance to remind and/or educate them on the transition of care and timely notification process.

PrimeWest Health monitors compliance with transition of care protocols through the following methods: the *Transition of Care Update* forms and related report, Care Plan audits, and SNF audits to ensure continuity of care. All audits are conducted by the Special Needs, Disability, & Behavioral Health Manager and results are reported to the Director of Care Management who reports to QCCC and the JPB for any action required that may include, but not be limited to, education, corrective action plans (CAPs), or termination of contract.

C. MOC Training for the Provider Network

Explain, in detail, how the SNP conducts initial and annual MOC training for network providers and out-of-network providers seen by beneficiaries on a routine basis. This could

include, but not be limited to: printed instructional materials, face-to-face training, web-based instruction, and audio/video-conferencing.

PrimeWest Health believes that in order to effectively and efficiently meet our members' needs, all providers involved in the members' care need to have an understanding of our comprehensive care management model. This is also referred to as our Model of Care.

Initial and Annual Model of Care Training
PrimeWest Health conducts initial and annual training through a variety of methods and tools for all pertinent care management staff; practitioners; providers; Public Health/Human Services (PH/HS) directors, supervisors, and CCMs; facilities; and any other affected care providers. Any non-contracted providers who see members on a routine basis are contacted by our Provider Network Administration contracting team to offer the option of contracting with PrimeWest Health. If a non-contracted provider elects to initiate the contracting process, the provider will be presented with the initial Model of Care training protocols. In addition, training materials are available to all providers through the PrimeWest Health website or upon request as needed. During the referral and authorization processes, out-of-network providers are given information on the importance of the Model of Care, a summary of the Model of Care, and instructions about how they can access the entire Model of Care via the PrimeWest Health website.

PrimeWest Health provides initial and ongoing training for all providers on the Model of Care through the following venues:
1. Webinars
2. Face-to-face training
3. Teleconferencing
4. Video conferencing
5. Newsletters and brochures
6. Website (option for self-study)
7. Other printed materials

PrimeWest Health Model of Care documents are all posted on the PrimeWest Health website at **www.primewest.org/providers** and updated as needed.

Initial Model of Care Training
1. Newly credentialed providers and contracted facilities receive a summary of the Model of Care along with instructions about how to request a full copy of the Model of Care from PrimeWest Health. Providers can request the Model of Care be provided on compact disc (CD) or in other electronic or paper format. In addition, the Model of Care is available on the PrimeWest Health website at **www.primewest.org/providers**. Out-of-network providers can also view the Model of Care on the PrimeWest Health website and are provided access to the summary document during the Service Authorization and referral processes.
2. New PH/HS directors, supervisors, and CCMs receive individual instruction on the Model of Care and its components from an experienced PrimeWest Health CCM or care coordinator in the same discipline. They also receive a full copy of the Model of Care; PrimeWest Health Special Needs Plan (SNP) policies and procedures, processes, best practices; and DM/CCIP

information, forms, and other related materials. These training materials are also posted on the PrimeWest Health website at **www.primewest.org/providers**.

3. New PrimeWest Health vendors, JPB members, QCCC members, and members of other appropriate committees receive the Model of Care along with training in person and/or electronically (i.e., on CD) that is appropriate for implementation and application of the Model of Care within the scope of their job duties or committee participation. New PrimeWest Health staff members complete their training as part of the PrimeWest Health orientation process.

Annual Model of Care Training

Additional Model of Care training is performed by either the Special Needs, Disability, & Behavioral Health Manager or the Director of Care Management at least annually and as needed throughout the year using the following training strategies:

1. PH/HS directors, supervisors, and CCM meetings are held regularly and any changes or updates to the Model of Care are provided in face-to-face trainings during these meetings.
2. Each CCM is provided with an updated Case Management Training Manual that includes the Model of Care, policies and procedures, best practices, DM/CCIP information, forms, and other applicable information regarding Prime Health Complete as needed.
3. PrimeWest Health provides a minimum of eight hours of training to CCMs annually. The training takes place through newsletters, webinars, or face-to-face trainings and includes Model of Care changes and updates, clinical best practices for case management, and DM/CCIP information. In addition, PrimeWest Health provides regular training including, but not limited to, the following subjects:
    a. Advance Directives
    b. DM/CCIP
    c. Medication Therapy Management (MTM)
    d. Safety in the home
    e. Health Insurance Portability and Accountability Act (HIPAA)/Compliance
    f. Medical oversight
    g. Utilization Management (UM) analysis
    h. Transition of care
    i. Clinical guidelines and best practices
    j. Fast Track Intervention Strategies (FTIS)
    k. Appeals and Grievances
    l. Quality Improvement Program, projects, and annual assessment
    m. Managed Long-Term Services and Supports (MLTSS)
    n. Overview of disabilities
    o. Expectations regarding care management/case management qualifications, roles, and responsibilities
    p. Covered services including home care, mental health, other fee-for-service services (i.e., Personal Care Assistance [PCA]/waiver services not covered by Minnesota Health Care Programs [MHCP])
    q. Inter-rater reliability
    r. Assessment and care planning activities
    s. Interdisciplinary care team (ICT) composition and expectations
    t. Goal writing

u. Vulnerable adult
v. Certified assessment training
w. Consumer satisfaction
x. Health Care Home (HCH)

4. Each month, PrimeWest Health publishes ***PrimePartners,*** an electronic newsletter for CCMs. This document provides updates regarding the Model of Care processes, policies and procedures, clinical guidelines, best practices, and other appropriate education and program updates.
5. All PrimeWest Health staff, contracted staff, JPB members, QCCC members, and members of various other committees will receive the Model of Care and training on the Model of Care in person and/or electronically (i.e., on CD) that is appropriate for implementation and application of the Model of Care within the scope of their job duties or committee participation.
6. PrimeWest Health provides updates and information about changes to the Model of Care to providers through individualized letters, provider updates, email blasts, and through ***PrimePointers***, our quarterly newsletter for providers.

Describe how the SNP documents and maintains training records as evidence of MOC training for their network providers. Documentation may include, but is not limited to: copies of dated attendee lists, results of MOC competency testing, web-based attendance confirmation, and electronic training records.

Assurance and Documentation of Model of Care Training
PrimeWest Health ensures that PH/HS directors, supervisors, and CCMs, as well as all pertinent care management staff, practitioners, providers, facilities, and any other affected care providers who are involved in the application of the Model of Care have been offered training on the PrimeWest Health Model of Care at least annually. Agenda, sign-in/attendance sheets, handouts, mailing lists (if applicable), and formal minutes are standard operating procedure for all scheduled education and training sessions. Training completed ad hoc (e.g., online) is documented through the use of an attestation or email notification system. Upon completion of the training, training certificates are issued upon request.

1. For all face-to-face trainings, PrimeWest Health maintains a record of attendees and minutes of the training curriculum.
2. For webinar trainings, PrimeWest Health requires that all attendees send an email notification of their intention to attend, and a ***Certificate of Attendance*** is sent to each attendee upon completion.
3. The PrimeWest Health Special Needs, Disability, & Behavioral Health Manager retains documentation of all new and existing CCM training curriculum and attendance. PrimeWest Health posts the training sessions on our website for review for those who are unable to attend the face-to-face training. They are then instructed to notify PrimeWest Health that they have completed the training and request a ***Certificate of Attendance***.
4. Training reports are analyzed at least annually and more frequently if needed to ensure that contracted and out-of-network providers who see PrimeWest Health members frequently and pertinent staff have been offered training materials on the PrimeWest Health Model of Care.

As part of the training program, PrimeWest Health requests attestations from contracted providers on completion of the annual Model of Care training.

Oversight of Model of Care Training

The PrimeWest Health Director of Care Management is responsible for ensuring that quality and timely Model of Care training has occurred for PH/HS directors, supervisors, and CCMs, as well as all pertinent care management staff, practitioners, providers, facilities, and any other affected care providers who are involved in the application of the Model of Care. This responsibility is supported by the Special Needs, Disability, & Behavioral Health Manager along with the Provider Relations Manager. See Chapter 2, Section A: SNP Staff Structure.

1. Oversight is monitored through review of all new and existing training curriculum and attendance sheets, returned attestations, and completed ***Certificates of Attendance***. Training documentation is maintained at the PrimeWest Health office and retained for a minimum of 10 years.
2. In addition, the Prime Health Complete annual care plan audit will review the actual implementation of the PrimeWest Health Model of Care. If any corrective actions are required, the Director of Care Management and the Special Needs, Disability, & Behavioral Health Manager will review the assigned CCM's training history. Any concerns about training and/or resulting competency would result in an audit deficiency and/or mandatory improvement and require that a corrective action plan (CAP) be developed by the county. The CAP requires action and evidence of compliance during follow-up review or the next audit.

Explain any challenges associated with the completion of MOC training for network providers and describe what specific actions the SNP Plan will take when the required MOC training has not been completed or is found to be deficient in some way.

Challenges in Completing the Model of Care Training

The primary challenge identified is ensuring that individual practitioners are properly trained on the PrimeWest Health Model of Care. PrimeWest Health contracts at the facility level and credentialing of practitioners is usually completed through interaction with the administrative offices at a facility, so bridging the gap to ensure that individual training is conducted can be challenging. To minimize the risk of missing individual practitioners, PrimeWest Health Provider Network Administration and Credentialing staff ensure the following:

1. Newly credentialed PrimeWest Health network practitioners receive a copy of PrimeWest Health's Executive Summary of the Model of Care with their approval letter.
2. Regular communications to providers outline the importance of the Model of Care and of involving all pertinent providers/staff in the training.
3. Attestations demonstrating the completion of the Model of Care training are requested from all facilities. PrimeWest Health monitors receipt of these attestations and makes up to three follow-up contacts with providers either in writing or by phone. This process has yielded a 90 percent or higher facility response rate.
4. During onsite visits, the PrimeWest Health Provider Relations Manager and Provider Relations Coordinator address the Model of Care and encourage providers and their staff to review it on a regular basis.

5. CCMs who meet with physicians and other providers regularly provide informal education on the Model of Care.
6. If a provider does not comply with the Model of Care training and submit an attestation, a CAP may be issued to bring the provider into compliance.

Action for Noncompliance with Required Training

Actions for ensuring that relevant training is completed and/or dealing with noncompliance are developed through coordinated efforts of appropriate PrimeWest Health staff (Care Management and Provider Network Administration) and providers to ensure that the Model of Care training requirements are met. Actions that PrimeWest Health takes in response to noncompliance with requirement Model of Care training can include, but are not limited to, the following:

1. Notifications: As the first step in the escalation process, PrimeWest Health makes three attempts to contact providers to ensure satisfaction of the training requirement.
2. Education: Additional education is provided to those who have not completed the training to emphasize the importance of applying this model for PrimeWest Health members. In addition, network providers are referred to their contract obligations, which identify the need to follow all PrimeWest Health policies and protocols.
3. CAP or individual disciplinary action plan: This is the last step in our escalation process. If all other avenues have been exhausted, PrimeWest Health may implement a CAP or disciplinary action.

Following the exhaustion of applicable internal policies and procedures and contractual requirements, the PrimeWest Health JPB may make the determination to terminate a contracted provider and/or facility that does not comply with the required training.

Chapter 4: Quality Measurement & Performance Improvement

The goals of performance improvement and quality measurement are to improve the SNP's ability to deliver healthcare services and benefits to its SNP beneficiaries in a high-quality manner. Achievement of those goals may result from increased organizational effectiveness and efficiency by incorporating quality measurement and performance improvement concepts used to drive organizational change. The leadership, managers and governing body of a SNP organization must have a comprehensive quality improvement program in place to measure its current level of performance and determine if organizational systems and processes must be modified based on performance results.

A. MOC Quality Performance Improvement Plan

Explain, in detail, the quality performance improvement plan and how it ensures that appropriate services are being delivered to SNP beneficiaries. The quality performance improvement plan must be designed to detect whether the overall MOC structure effectively accommodates beneficiaries' unique healthcare needs. The description must include, but is not limited to, the following:

The Quality Program supports and promotes the mission, vision, and values of PrimeWest Health through continuous improvement and monitoring of medical care, patient safety, behavioral health services, and the delivery of services to our members[10]. The Quality Program is a system-wide program implemented and delivered through the integration and coordination of services provided throughout the organization, including county partners, providers, and other entities delegated to provide services to our members on behalf of PrimeWest Health. Patient safety is an integral component of providing quality care to our members.

The Quality Program provides mechanisms and processes (scheduled and ad hoc auditing requirements, reporting requirements, identification of responsibility, timelines, consequences for noncompliance, committee involvement, transparency, board approval, staffing requirements, project descriptions, etc.) for ensuring oversight of member receiving services. It ensures alignment of patient safety activities with organizational goals to provide high quality health care and services to our members and helps PrimeWest Health determine if the Model of Care structure effectively accommodates PrimeWest Senior Health Complete members' unique needs. The PrimeWest Health Quality Program is assessed annually and reviewed by the Quality and Care Coordination Committee (QCCC) to determine the overall effectiveness of the program, including the Model of Care, and appropriateness of care and services furnished to Prime Health Complete members. The PrimeWest Health Director of Quality & Utilization Management presents the final recommendation for the Quality Program to the Joint Powers Board (JPB) to complete the annual organizational approval process. The quality assessment includes

[10] In general, both PrimeWest Health and the State of Minnesota refer to health plan enrollees as "members," so throughout this submission we will use the term "member" rather than "beneficiary."

monitoring and evaluation results of compliance with State and Federal standards and performance measurement. The assessment is also consistent with State and Federal regulation and current National Committee for Quality Assurance (NCQA) ***Standards for Accreditation of Managed Care Organizations***.

PrimeWest Health encourages practitioners and providers to participate in quality improvement projects (QIPs) initiated by the Centers for Medicare & Medicaid Services (CMS), the U.S. Department of Health & Human Services (HHS), Minnesota State agencies, and PrimeWest Health quality improvement projects, such as the Medication Reconciliation Post-Discharge QIP as required by CMS. PrimeWest Health's Quality Program incorporates information obtained from member surveys, provider-reported complaints, and member complaints and Grievances into the Annual Quality Work Plan to ensure that quality and safety standards are met. The performance improvement plan is part of the Quality Assurance program, which provides a structured process for monitoring, evaluating, and identifying opportunities for improving the quality and appropriateness of services provided to PrimeWest Health members. The scope of Quality Assurance program activities are monitored through PrimeWest Health's information system, which collects, analyzes, integrates, and reports data to determine member and provider demographics, monitor services furnished to members, and assure accuracy and timeliness of reported data.

The complete process, by which the SNP continuously collects, analyzes, evaluates and reports on quality performance based on the MOC by using specified data sources, performance and outcome measures.

The PrimeWest Health comprehensive data repository is the source for the collection, analysis, integration, and reporting of data to determine member and provider characteristics and services furnished to members. It ensures accuracy and timeliness of reported data; allows screening or editing of the data for reliability, validity, completeness, and comparability; and provides service information in a standardized format.

All collected data are available to the State and CMS upon request, and all communications are conducted in accordance with the Healthcare Quality Improvement Act of 1997, Minnesota State Statutes 145.61 – 67, State government data privacy statutes and rules, and PrimeWest Health's Health Insurance Portability and Accountability Act (HIPAA) policies.

Collection
PrimeWest Health uses several methods and tools to collect data, including electronic data warehousing, interactive web-based collection methods, on-site record reviews, targeted focus studies, and many other manual techniques.

PrimeWest Health uses an extract, transform, and load (ETL) process in our data warehouse. We extract the data from several sources, transform it to fit operational needs, and load it into the end target, otherwise known as the data warehouse. The PrimeWest Health all-inclusive data repository includes: claims data for medical, mental health, pharmacy, dental, community support service, and behavioral health; Public Health and Human Service (PH/HS) provision data: and enrollment data for all member groups. The data warehouse is

fed from many data sources, including Care Management, claims, and provider databases, to one centralized storage facility. From the data warehouse, reports can be generated (routine and ad hoc) to business users in the organization for analysis and, if needed, action for improvement opportunities.

Data is collected by PrimeWest Health based on established reporting processes in accordance with the technical specification requirements for Medicare Advantage Organizations (MAOs) as described in Title 42 Code of Federal Regulations (CFR) Part 422.516 (a). PrimeWest Health has developed an effective procedure to determine the reliability, validity, completeness, and comparability of data collected in accordance with specifications developed by CMS and in the time and manner that CMS requires.

PrimeWest Health implements the most current versions of the CMS Reporting Technical Specifications to assist our organization in requesting, preparing, and submitting datasets to ensure a high level of accuracy in the data reported to State and Federal regulatory agencies and to reduce the need to correct and resubmit data.

In accordance with CMS requirements, PrimeWest Health has contracted with a certified contractor, MetaStar, Inc., to assess the data collection and reporting processes in place and ensure a high level of accuracy is established and maintained for reporting Medicare Part C and D PrimeWest Health data.

PrimeWest Health collects, analyzes, and disseminates data for over 1,000 required regulatory reports per year. These data reports, with various time frame submission requirements, are submitted electronically to the various regulatory agencies such as the Minnesota Department of Health (MDH), Minnesota Department of Human Services (DHS), Minnesota Department of Commerce, and CMS. PrimeWest Health uses an electronic database called JIRA, which is a web-based tool that allows the user to prioritize, assign, track, report and audit project tasks and change requests. JIRA is an extensive platform that can be customized to match business processes. JIRA is used to track due dates, assign staff responsibility, and streamline communication by exposing activities of PrimeWest Health staff, department teams, and inter-departmental teams throughout the development, implementation, and quality review process documented during the report completion.

PrimeWest Health's Business IT Research & Development and Care & Quality Management departments retain staff dedicated to creating operational and data-driven reports based on specifications developed by PrimeWest Health managers and staff. These reports are kept in a repository (Crystal application reporting repository). Reports can be run on-demand or through a scheduling tool depending on need. There are approximately 2,000 on-demand or scheduled reports used for internal operations at PrimeWest Health. Examples include, but are not limited to, the following:

- Care Management and Quality & Utilization Management: utilization management (UM) reports; Service Authorizations; denials, terminations, and/or reduction in services (DTRs); emergency room use; inpatient/readmission rates; care plan activity; transitions of care; fast track interventions; assessment and reassessment data; referrals; out-of-network providers; ambulatory care sensitive conditions (ACSCs);

supply limits on drugs; harmful drug interactions; member enrollment by county; county case management to member ratios; etc.
- Enrollment Services: length of continuous membership for active members, long-term care ineligibility, total enrollment
- Claims: denied claims by code, claims with service dates prior to admission date, claim age report
- Provider Network Administration: active contracted facilities, National Provider Identifier (NPI)/Unique Minnesota Provider Identifier (UMPI) listings, monthly report of paid claims to out-of-network providers

Reports and documentation of all PrimeWest Health quality improvement program activities are securely maintained and backed up electronically. PrimeWest Health uses a number of internal tracking software programs to document the planning, documentation and reporting, analysis, and recommendations identified throughout the organization. Specific programs are used for project development and activity; policy and procedure development, review, approval, and easy access for staff reference purposes; care management system to document and track member communication, health risk information, Service Authorizations, and service utilization provisions; membership; claims processing system; internal staff communication through an intranet system for tracking meeting notes, consistent forms, and documentation throughout the organization; and data systems to collect and extract claims information for more complete analysis of over- or under-utilization, trends, and service and benefit utilization.

To ensure the consistent delivery of care and services to our members, PrimeWest Health collects information and data by completing assessments of contracted network providers and entities. Other data collection tools include: the Healthcare Effectiveness Data and Information Set (HEDIS); member satisfaction surveys, including the Medicare Advantage Prescription Drug Plan Consumer Assessment of Healthcare Providers and Systems (MA-PD CAHPS) and Health Outcomes Survey (HOS); Quality Improvement Projects; Chronic Care Improvement Program focus studies; provider surveys; and peer review activities. The MA-PD CAHPS and HOS surveys are contracted to DataStat as an approved CMS vendor. DataStat provides the raw data to PrimeWest Health via a compact disc. The PrimeWest Health Data Coordinator downloads the information, performs analysis, and creates a summary report. Rates are calculated and statistical significance is applied. Results are compared and are trended with rates from previous years for further analysis.

1. **HEDIS Evaluation**
   HEDIS is a tool that measures the effectiveness of care for the Medicare and Medicaid (Medical Assistance) population by measuring the receipt of appropriate care and preventive health screening and services for the identified sample of members based on administrative and medical record review data collection. HEDIS data is collected on an annual basis. Inovalon™ software is used to process encounter data, clean it, and calculate the rates. Inovalon™ also incorporates the chart chase results that are sent to Optum. Optum is a contracted vendor that conducts the chart reviews for hybrid measures. MetaStar is contracted as the HEDIS auditor. Once the rates have been finalized, they are submitted to MDH and CMS. PrimeWest Health's Data Coordinator

develops internal reports of the rates, comparing them with prior years and with other Minnesota health plans as well as national means and percentiles. Some of the HEDIS data is sent to Minnesota Community Measurement to be included in the State's provider profiling system. PrimeWest Health follows the guidance set forth by CMS and the State each year regarding HEDIS reporting requirements.

2. **Quality Improvement Projects (QIP)**
   Quality Improvement Projects (QIPs) are initiatives focused on one or more clinical and/or non-clinical areas with the aim of improving health outcomes and member satisfaction. Beginning calendar year (CY) 2012, each MAO was required to conduct a QIP focused on reducing 30-day all-cause hospital readmissions over a three-year period. The quality improvement model adopted by CMS and followed by PrimeWest Health for the QIP is based on the Plan-Do-Study-Act (PDSA) quality improvement model. PDSA is an iterative, problem-solving model used for improving a process and carrying out change. PrimeWest Health submitted its QIP for Prime Health Complete in August 2012. Approval of the project was received from CMS in December 2012. Annual updates are provided in accordance with CMS requirements.

3. **Chronic Care Improvement Program (CCIP)**
   A CCIP is a clinically-focused initiative designed to improve the health of a specific group of members with chronic conditions. Beginning CY 2012, CMS required that each MAO conduct a CCIP focused on reducing and/or preventing cardiovascular disease over a five-year period. The quality improvement model followed for CCIP is also the PDSA model. PrimeWest Health submitted its CCIP for Prime Health Complete in August 2012. Approval of the program was received from CMS in December 2012.

4. **Focus Studies** (MN Rules part 4685.1125 and NCQA QI standards)
   PrimeWest Health uses focus studies to gather information in situations where over- or under-utilization, problems, or potential problems have been identified or are likely and/or where additional information is needed to determine if improvement is needed and there is a potential to improve the care and service to our members.

5. **Member Surveys**
   Member surveys provide direct information about member perceptions of actual experiences as a member of PrimeWest Health. Member surveys are conducted by both internal and external entities. For full detail on the surveys and the integration in the Quality Work Plan, see Chapter 4, Section C: Measuring Patient Experience of Care (SNP Member Satisfaction).

   External surveys, which are conducted annually, include the following:
   a. MA-PD CAHPS: PrimeWest Health follows the guidance set forth by CMS about the MA-PD CAHPS survey each year.
   b. HOS: HOS is also used to assess and analyze a health plan's ability to maintain or improve the physical and mental health functioning of its dually eligible members.

Internal surveys, conducted by PrimeWest Health annually, include the following:

a. Case Management System Satisfaction Survey: This survey is used to measure Prime Health Complete members' level of satisfaction with their county case manager(s) (CCMs).
b. Chronic Care Improvement Program Satisfaction Survey: This survey is used to measure Prime Health Complete members' level of satisfaction with the CCIP.

6. **Provider Surveys**
   Provider surveys collect information from providers and support PrimeWest Health's efforts to make improvements in processes and systems that affect providers. PrimeWest Health conducts an annual satisfaction survey with contracted providers and pharmacies. Data from provider surveys are analyzed and reported with the Annual Quality Assessment annually.

7. **Peer Review Activities** (MN Rules part 4685.1110, subp. 1.H)
   PrimeWest Health engages in several activities to ensure that practitioners in the same discipline are reviewing care given by their peers. Peer review is utilized to assess credentialing applications and review member complaints, Appeals and Grievances, focus study review, medical record information review, and site visit results as appropriate. Whenever peer review is conducted, recommendations are protected to the full extent allowed by law in accordance with MN Stat. sec. 145.61 *et seq*., and professional review organizations pursuant to the Health Care Quality Improvement Act of 1986, 42 U.S.C. Section 11101 *et seq*. All documents related to peer-review are marked "CONFIDENTIAL–PEER REVIEW."

8. **Care Management Audits**
   a. Care Plan Audit: PrimeWest Health audits a sample of care plans for members. The goal of this audit is to facilitate an interdisciplinary, holistic, and preventive approach to determine and meet the health care and supportive service needs of PrimeWest Health's members. This is an annual audit, conducted more frequently if deficiencies are identified.
   b. Transition of Care Audit: PrimeWest Health has a comprehensive method of notification and follow-up processes to collect and analyze transition of care information to ensure that seamless transitions are occurring and that the primary care provider and Interdisciplinary Care Team (ICT) are involved and/or notified of the transition. Transition of care completeness is monitored by the PrimeWest Health Care Coordinator on a concurrent review basis as transitions occur. In addition, monthly reports are generated by the PrimeWest Health Data Coordinator to ensure that there are no identified issues with the *Transition of Care Update* forms being completed.
   c. Annual Care System Review: At least annually, PrimeWest Health reviews the Model of Care in its entirety and evaluates current best practices, quality initiatives, and communication structures along with the current DHS, CMS, and NCQA standards and expectations of practice for the Prime Health Complete population. The Model of Care is updated as appropriate to reflect these changes and updated requirements and communicated as appropriate to members, providers, and other required individuals.

9. **Program Integrity Audits**
   PrimeWest Health conducts the following audits: annual and ad hoc audits on Outcome Assessment Information Set (OASIS) outcomes, personal care provider organizations (PCPO), and Medicare skilled services; Skilled Nursing Facility (SNF) audits; and audits based on claims data. PrimeWest Health uses the results of these audits to aid in the development of best practices, identify quality improvement opportunities, and ensure compliance with program requirements.

10. **UM Reports**
    Data sources are reviewed at least quarterly to evaluate the following:
    a. Provision of effective and appropriate care and services to members
    b. Partnership with practitioners and providers, including local PH/HS agencies, to achieve optimum outcomes for members
    c. Evaluation of the delivery and use of services to identify opportunities for improvements
    d. Effective utilization of resources, focusing on both over- and under-utilization of services, and corrective actions proposed when these are identified

11. **Medical Record Reviews** (MN Rules part 4685.13)
    The medical record contains critical information about the delivery of health services to a member. PrimeWest Health assesses the accuracy and completeness of the medical records and monitors the frequency of specific elements of care. Each year, medical records reviews are conducted at contracted network primary care providers seeing the highest volume of PrimeWest Health members. Approximately 5 percent of the total member population charts are reviewed. This process is described in detail in Policy and Procedure QM06: Health Records. PrimeWest Health maintains a medical record retrieval system that ensures that medical records, reports, and other documents are readily accessible.

12. **Model of Care Review and Monitoring Summary Annual Report**
    Annually, PrimeWest Health evaluates the effectiveness of the Model of Care by reviewing the Model of Care Review and Evaluation Worksheet and the results of the Model of Care Review and Monitoring Summary report. Using the Model of Care goals and objectives as criteria, the quality improvement activities for the year are evaluated for appropriateness and effectiveness in assessing and improving the quality of care provided to PrimeWest Health members and meeting the goals established in the Model of Care. The PrimeWest Health annual evaluation is a written document that provides a documented summary of all activities identified in the Model of Care conducted organization-wide. The annual evaluation of the Model of Care is included in the Annual Quality Assessment. The annual review and monitoring process provides a detailed, written report based on measurable data and objectives that address the elements and goals identified in the Model of Care. Each reporting area includes a description of completed and ongoing activities for each chapter in the Model of Care.

Analysis

PrimeWest Health uses the PrimeWest Health Quality Work Plan (Plan) as the framework for monitoring, evaluating, and identifying opportunities for improving the quality and appropriateness of services provided to PrimeWest Health members. The quality program is also used to meet the regulatory requirements for the Special Needs Plans (SNPs). The process uses measurable criteria to identify, prioritize, track, trend, and recommend solutions for quality and service-related issues on an ongoing basis identified through a variety of sources, including feedback from members. This systematic process includes identifying opportunities through a set of routine scheduled and ad hoc reporting processes. Monitoring is conducted through quarterly, annual, and subsequent years of analysis for identifying trends and/or patterns. Evaluation is conducted through a formalized peer review and committee process and by responding to opportunities for improvement propagated through the various committees, such as the PH/HS Committee, the PrimeWest Health Peer Review Committee (PRC), Quality and Care Coordination Committee (QCCC), and the Joint Powers Board (JPB). The Plan is considered a living and breathing document for the entire organization. The Plan is updated and/or modified as the year progresses, but at least quarterly. The electronic repository where the Plan is located is available to PrimeWest Health staff and incorporates personnel and tracking time for updates.

Evaluation

PrimeWest Health's evaluation methods permit tracking of specific complaints, the ability to assess trends and establish and implement a corrective action plan (CAP), and monitoring to ensure that the Plan is effective in improving the identified problem. PrimeWest Health uses reports and actions to evaluate the effectiveness of the Quality Work Plan. PrimeWest Health will use the results of both internal and external data collection processes (completed at least annually) to aid in the development of best practices, identify quality improvement opportunities, evaluate the effectiveness of the Model of Care, and ensure compliance with program requirements. Through the use of data analysis, PrimeWest Health utilizes QIPs/Performance Improvement Projects (PIPs), CAPs, committee review, focus studies, and intervention strategies to modify behavior and manage physical and mental health outcomes. Primarily, PrimeWest Health focuses on the following improvement areas when action is required:

1. Evaluate and improve access to medical, mental health, and social services for our members.

   Example: Out-of-network UM reports are conducted, analyzed, and reported to assess the actual vs. perceived need for additional specialists not currently contracted within the PrimeWest Health network. Annually, PrimeWest Health applies geo-access mapping technology to the PrimeWest Health provider network. Data is collected, analyzed, and reported on determining adequacy of the PrimeWest Health provider network and any identified gaps in coverage by geographic location. PrimeWest Health can identify specific provider types, including specialists, that may be needed to enhance the special needs of members. If a particular provider type is identified, PrimeWest Health Provider Network Administration is contacted to pursue contracting.

2. Evaluate and improve transitions of care through various provider types to facilitate good communication and seamless transitions.
   Example: Through monthly transition of care reports and the concurrent review process, an opportunity to improve the timely notification from hospitals and SNFs of transition of care events was identified. PrimeWest Health improved the provider web portal so hospitals and SNFs can electronically submit the notification form. PrimeWest Health contracted providers demonstrated a 17 percent improvement in notification performance.

3. Evaluate and improve members' access and participation in preventive health care practices.
   Example: As part of our annual quality improvement process, HEDIS rates are evaluated and areas where improvement is needed are identified. Activities in the monitoring process include annual physical, mammogram, colorectal cancer screen, and immunizations including flu.

4. Evaluate and improve the coordination of care with the effective utilization of the ICT.
   Example: PrimeWest Health care coordinators conduct annual care plan audits on various areas of the PrimeWest Health ICP, such as ICT composition, ICT attendance at scheduled meetings, and documentation. An analysis is made of the degree to which the member is achieving stated care plan goals compared to his/her ICT involvement. The PrimeWest Health Care Coordinator notifies the CCM when identified areas of improvement can be implemented.

5. Evaluate and improve the utilization of the Health Risk Assessment (HRA) for appropriate stratification and identification of health risks.
   Example: PrimeWest Health requires that all members have an HRA completed within 30 days from the date of enrollment. The individualized care plan (ICP) is developed based on the HRA results. PrimeWest Health generates monthly reports from the ICP to monitor compliance with the assessment date timelines. In addition, twice a year, MDH generates a report from the Medicaid Management Information System (MMIS) for PrimeWest Health identifying assessment and reassessment timeline compliance. PrimeWest Health evaluates the utilization of the HRA through concurrent review of the ICP and conducting inter-rater reliability testing on the CCM's application of the approved PrimeWest Health assessment tools. Real member examples using redacted member information are provided to CCMs to complete an assessment, including risk stratification and ICP development.

6. Evaluate and improve the implementation of a comprehensive ICP that identifies health risks.
   Example: Audits are conducted by the PrimeWest Health care coordinators on various areas of the ICP. One area is identifying chronic care condition(s) and progress towards goal achievement. The PrimeWest Health care coordinators can identify any unmet needs (HgbA1c, foot exam, eye exam, etc.) for the member. The PrimeWest Health Care Coordinator contacts the assigned CCM(s) and helps him/her coordinate with the primary care provider to ensure identified health risks are addressed to achieve stated outcomes.

7. Evaluate and improve the delivery of services through appropriate staffing and oversight.
   Example: CCM outcomes related to chronic disease management and the ability to help the member get preventive care are compared to county case management ratios and licensure type (registered nurse [RN] or social worker [SW]) per member. There is a requirement that if the member has one identified chronic disease, an RN needs to be involved with the medical management for the member. If the member demonstrates a mental health and/or social issue, the requirement is for a SW to be involved to address such issues. County case management to member ratio reports are produced and reviewed semi-annually. Identified variances from standards are addressed by the Director of Care Management with the respective county agency director for resolution.

8. Evaluate and improve the coordination of care through effective communication and through the effective documentation of the care the member is receiving.
   Example: PrimeWest Health has modified its ICP to have identified fields required. This means the CCM cannot save the ICP to PrimeWest Health without completion of all required fields.

9. Evaluate and improve the member health outcomes.
   Example: PrimeWest Health conducts and analyzes a number of reports to evaluate and improve member health outcomes. These include, but are not limited to, the following monthly reports: HRA report, CCIP reports from UM and the ICP, ICT reports, Advance Directive reports, and transition of care reports. The annual HEDIS, CAHPS survey, and the HOS are also analyzed. Areas of concern or identified additional risk are addressed on the member's ICP and communicated with the ICT as indicated.

10. Evaluate and improve provider network that has specialized expertise.
    Example: Annually, PrimeWest Health applies geo-access mapping technology to the PrimeWest Health provider network. Data is collected, analyzed, and reported to determine adequacy of the PrimeWest Health provider network and any identified gaps in coverage by geographic location. PrimeWest Health can identify specific provider types including specialists that may be needed to enhance the special needs of members. If a particular provider type is identified, PrimeWest Health Provider Network Administration is contacted to pursue contracting.

11. Evaluate and improve providers' implementation of clinical and evidence-based practice guidelines.
    Example: PrimeWest Health follows NCQA ***Standards and Guidelines for the Accreditation of Health Plans*** regarding practice guidelines and conducts annual performance measurement. Identified opportunities for improvement are addressed through one-on-one education, newsletters, and website updates. .

12. Evaluate and improve the coordination and effectiveness of care to the most vulnerable sub-populations through the utilization of and effective documentation in the ICP and through effective follow-up and documentation of the transition of care process.
    Example: PrimeWest Health conducts an annual comprehensive care plan audit on all 13 county agencies. This audit provides a thorough evaluation of every care plan element

that is expected for a PrimeWest Health member. PrimeWest Health also conducts an annual county case management audit on CCMs' documentation performance. Expectations are identified through a contract process with the county agency. In addition, the PrimeWest Health PH/HS Committee agreed upon formalizing a set of standards of practice for the CCMs. This includes, but is not limited to, the following: compliance with care planning requirements, transition of care requirements, ICT requirements, and CCIP requirements. From the concurrent review performed by the PrimeWest Health care coordinators and the monthly reports that are generated, sufficient data is collected to be able to analyze and identify opportunities for improvement. Opportunities for improvement are addressed through additional provider, member, ICT, and/or case management training.

13. Coordination of care through the implementation and participation of the ICT.
    Example: PrimeWest Health care coordinators generate monthly reports from the ICP to determine completeness of documentation. This is in addition to the concurrent review that the PrimeWest Health Care Coordinator conducts. All ICP information, including transition of care information or any modification to the plan of care, is to be documented on the ICP. There is a field on the ICP that designates the date the ICP was updated and the date the ICP was shared, along with who it was shared with. These are required fields, which means that the CCM cannot electronically save the ICP without completing these fields.

14. Evaluate and improve member access to affordable care.
    Example: Monthly Appeals and Grievance reports are conducted, analyzed, and reported on. One of the areas analyzed is whether a member filed a Grievance for a contracted provider attempting to bill the member without having an Advance Beneficiary Notice (ABN) signed. If/when a member Grievance is identified, the PrimeWest Health Complaints Appeals & Grievances Specialist is responsible for resolving the issue with the member. PrimeWest Health Provider Network Administration staff will follow up with the provider and provide education regarding contract language that prohibits from this practice. A note is made in the contracted provider's file and reviewed upon recredentialing to check for a continued pattern of behavior. If one-on-one education with the provider does not resolve the issue, the issue may be escalated to QCCC, PRC, or the JPB for discussion regarding a CAP and/or contract termination.

Reporting

A high level overview of the annual evaluation of the Model of Care is included in the Annual Quality Assessment; a detailed evaluation is presented in the Model of Care Review and Monitoring Summary annual report. The Model of Care results and other quality program activities are reported to State regulators, community partners, committees, boards, and stakeholders. The Model of Care Review and Monitoring Summary has detailed information on the performance and improvement opportunities for the Model of Care identified in the goals and outcomes and PrimeWest Health's performance in obtaining these. In addition to performance, this report includes detailed recommendations for identified opportunities for improvement. This Model of Care Review and Monitoring Summary detailed version is attached to the PrimeWest Health overall Annual Quality Assessment. The

Annual Quality Assessment refers the reader to the appendix where the Model of Care Review and Monitoring Summary detailed version is attached. Both are reported at least annually.

The Annual Quality Assessment summary is reported to the following entities:

- DHS
- MDS
- JPB
- QCCC

The Model of Care Review and Monitoring Summary annual report is reported to the following groups:

- SNP stakeholders group
- PH/HS Directors
- PH/HS Supervisors
- PrimeWest Health CCMs
- JPB
- PrimeWest Health employees
- PrimeWest Health contracted providers
- Minnesota Department of Human Services

If recommending specific actions, consideration is given to the prevalence of the problem, its effect on patient care and safety and professional practice, and the potential ability to effect change. Whenever possible, PrimeWest Health attempts to participate in collaborative activities that have the maximum potential to effect change in partnership with our members, providers, other health plans, and/or PrimeWest Health partners.

In order to ensure continuous quality improvement of Prime Health Complete, PrimeWest Health takes actions to improve the Model of Care through a variety of means. The primary changes that are undertaken include, but are not limited to, the following:

- Measurable objectives for each action
- Time frames for improvement plan
- People responsible for implementation
- Policy and procedure changes
- Changes in staffing patterns (CCM ratios and personnel)
- Changes in provider and facility network
- Changes in the systems of operation
- Communication of results internally and externally

PrimeWest Health uses the PDSA cycle to coordinate continuous quality improvement activities. If initial interventions do not result in the expected improvements to the Model of Care or other quality improvement activities, the plan of action is revised and re-implemented until desired results are achieved or until PrimeWest Health and/or partners and providers are able to otherwise demonstrate the concern has been resolved.

Details regarding how the SNP leadership, management groups and other SNP personnel and stakeholders are involved with the internal quality performance process.

The JPB has delegated responsibility for development and implementation of the Quality Assurance Plan, Annual Assessment, and Annual Quality Project Work Plan to QCCC. QCCC is responsible for all aspects of successful completion of the program and reports the data to all regulatory and non-regulatory bodies. With the assistance of individual staff and department participation, the following contracted and internal quality teams collect, analyze, report, and act on information to evaluate and improve the Model of Care:

1. Cirdan Health – Cirdan Health (Cirdan) is a contracted vendor for Chief Financial Officer (CFO) duties and actuarial services. Cirdan has access to and houses some of PrimeWest Health's data and provides services as the financial management arm of PrimeWest Health. Cirdan collects and analyzes financial data related to the Model of Care and reports to the executive committee, QCCC, and the JPB with recommendations.
2. Stratis Health – Medicare Quality Improvement Organization (QIO) that provides reports on Medicare Part D and provides assistance and guidance to the State of Minnesota and health plans for quality improvement
3. DataStat – Contracted vendor that conducts surveys on the MA-PD CAHPS and HOS member surveys
4. MetaStar – Contracted vendor that conducts the HEDIS Compliance Audit
5. Optum- Contracted vendor that performs HEDIS hybrid chart abstractions for PrimeWest Health
6. **MedImpact –** Contracted Pharmacy Benefit Manager (PBM) that collects and analyzes pharmacy UM and Medication Therapy Management (MTM) program data as well as patient safety reports
7. DHS – Provides oversight and approval of QIPs as required by DHS contract. Reviews and evaluates the annual Quality Work Plan and Assessment submitted by PrimeWest Health. Evaluates required submitted reports including, but not limited to, clinical practice guideline report, special needs report, special needs program overview, and care plan audit.
8. PrimeWest Health Provider Network Administration department – Employs, reviews, generates, and analyzes all reports related to the evaluation of the Model of Care as it pertains to providers regarding access, availability, and satisfaction. The Provider Network Administration department makes recommendations for action to appropriate committees and provides the follow-up in the Quality Work Plan to ensure the recommendations are implemented as approved and appropriate. The Provider Network Administration department also collects and warehouses all data on submitted claims for current members and generates ad hoc and standard reports for distribution to the other departments in PrimeWest Health for analysis and evaluation of the Model of Care.
9. PrimeWest Health Quality staff – Employs quality specialists for the evaluation and implementation of the performance improvement program. The Quality staff provides oversight to all the Quality Work Plan goals and ensures that they are updating and reviewing efforts to improve quality.
10. PrimeWest Health Chief Senior Medical Director – Employed and responsible for reviewing and making recommendations regarding all clinical management service provisions

11. PrimeWest Health Care Coordination staff – Employs, reviews, generates, and analyzes all reports related to the evaluation of the Model of Care. Care Coordination makes recommendations for action to appropriate committees and provides the follow-up in the Quality Work Plan to ensure the recommendations are implemented as approved and appropriate.
12. PrimeWest Health Chief Executive Officer (CEO) and Management Team – Reviews and approves all recommendations for improvement of the Model of Care and makes recommendation to the JPB as needed for approval and review
13. County partners – Review all reports for coordination of care and the evaluation of the effectiveness of the Model of Care through the PH/HS Committee. This group is responsible for ensuring that the recommendations that are approved for application regarding the case management portion of the Model of Care are followed up and implemented within the county system.
14. QCCC – The JPB retains total authority and accountability for PrimeWest Health's Quality Assurance Plan. The JPB has delegated responsibility for monitoring and review of the quality program to QCCC. QCCC is scheduled on a bimonthly basis and provides activity reports and recommendations in an advisory capacity to the JPB at least quarterly.

    The size and membership of QCCC are driven by a commitment to adequately and efficiently represent the interests of each participating county, its members, and its providers. Minimally, QCCC includes participating practitioners or administrative staff to sufficiently represent primary and specialty care, behavioral health, clinical representatives from community service organizations and county PH/HS departments, and consumers. QCCC membership meets the requirements for peer review committees as defined in the Healthcare Quality Improvement Act and Minnesota Statutes.
15. JPB – The JPB is the governing authority over PrimeWest Health. Each county that is served by PrimeWest Health has a county commissioner who serves on this board.

Details regarding how the SNP-specific measurable goals and health outcomes objectives are integrated in the overall performance improvement plan (MOC Element 4B).

Each Prime Health Complete goal utilizes multiple outcomes to determine if the goal has been met or not met. The outcome results are identified using reports, analyses, and processes to determine the health outcome objectives for each of the Model of Care goals. Each outcome has distinct measurement criteria that requires a summary and recommendations for improvement as well as maintenance of the outcome results. Each outcome identified in the Model of Care goals is incorporated into the Quality Work Plan, and the summaries identifying the prior year's performance are added to the Annual Quality Assessment that is completed in April of each year. PrimeWest Health's Quality Work Plan is an integral part of PrimeWest Health's performance improvement plan.

The Quality Work Plan standards require that if an outcome is not met, the root cause/underlying issue is identified, interventions are analyzed and developed, new outcome measures are redefined if appropriate, time frame is established, responsible party is assigned, and routine monitoring of the progress is documented. This process is described in

detail in Chapter 4, Section D: Ongoing Performance Improvement Evaluation of the MOC. The Quality Work Plan is reviewed at least quarterly, and progress towards each part of the plan is evaluated at QCCC meetings.

Goals: Access and Affordability
As identified in our Model of Care goals, PrimeWest Health places an emphasis on maintaining availability of affordable care and access according to regulatory requirements. The Quality Work Plan supports and incorporates the outcomes of these goals in accordance with MN Stat 62D.124 and as part of the PrimeWest Health's quality improvement mission, philosophy, and core values. Details of the criteria can be found in PrimeWest Health policies and procedures.

Goal: Coordination of Care and Service Delivery
As part of our mission, PrimeWest Health offers a comprehensive care management system to assist in the coordination of care for Prime Health Complete members. The foundation of the PrimeWest Health Quality Improvement Plan is the core values and philosophy of the PrimeWest Health Model of Care, which includes the Structure and Process elements related to care coordination and service delivery. Both the Model of Care and the Quality Improvement Plan place coordination of care and service delivery at the core of how care is provided to Prime Health Complete members.

Goal: Transitions of Care
Reducing fragmentation of services and minimizing member disruption during the transition process is one of the goals of the PrimeWest Health Model of Care. The PrimeWest Health Performance Improvement Plan is structured to support this goal through the utilization of transition protocols and standards as identified in the plan and addressed through the Structure and Process elements. In order to provide safe, effective person-centered transitions for all members, PrimeWest Health monitors outcomes related to this goal to ensure member satisfaction.

Goal: Appropriate Utilization of Services
In accordance with MN Rules 4685.1115, subp. 2: A, PrimeWest Health emphasizes maintenance of appropriate service utilization. Ensuring appropriate utilization of services for Prime Health Complete members is part of PrimeWest Health's scope of quality assurance program activities and directly ties to the Model of Care goals related to service utilization. Activities specific to service utilization include monitoring over- and under-utilization and requests for authorization based on established care management criteria, which can also be found in PrimeWest Health policies and procedures.

B. Measureable Goals & Health Outcomes

Identify and clearly define the SNP's measureable goals and health outcomes and describe how identified measureable goals and health outcomes are communicated throughout the SNP organization. Responses should include but not be limited to, the following:

In Section B of this chapter, for each of the five goals, we will identify the goal and then address the following four questions.

- **Identify the specific member health outcomes measures that will be used to measure overall SNP population health outcomes, including the specific data source(s) that will be used**
- **Describe, in detail, how the SNP establishes methods to assess and track the MOC's impact on the SNP beneficiaries' health outcomes.**
- **Describe, in detail, the processes and procedures the SNP will use to determine if the health outcomes goals are met or not met.**
- **Explain the specific steps the SNP will take if goals are not met in the expected time frame.**

Each goal will have the following sections to identify the goal and then correspond with the questions above:

Goal Identification
Measurable Outcomes
Methods to Assess and Track
Processes and Procedures to Determine Outcomes
Action Taken For Goals Not Attained

Model of Care Goals

Specific goals for improving access and affordability of the healthcare needs outlined for the SNP population described in MOC Element 1.

Goal 1: Goal Identification – Access for the SNP Population
Upon enrollment, all Prime 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.

Goal 1: Measurable Outcomes – Access for the SNP Population

- As reported in the Quality Report, all members will have access to an assigned primary care provider, mental health professional, and social services provider within a 30-mile radius while they are enrolled as a member with PrimeWest Health. This outcome will be assessed and measured annually through 2017.

Outcome Attainment
Goal is met through 100 percent compliance with regulatory requirements annually for primary care providers, mental health professionals, and social service providers as identified in this measurable outcome.

2013 Benchmark
Current benchmark demonstrates 100 percent of all members have access to a primary care provider, mental health provider, and social services provider within a 30-mile radius of their current residence.

- As reported in the Quality Report, all members will have access to specialty care within a 60-mile radius while they are enrolled as a member with PrimeWest Health. This outcome will be assessed and measured annually through 2017.

Outcome Attainment
Goal is met through 100 percent compliance with regulatory requirements annually for specialty care as identified in this measurable outcome.

2013 Benchmark
Current benchmark demonstrates 100 percent of all members have specialty coverage within a 60-mile radius of their current residence.

- As reported in the Quality Report, all members will have access to emergency medical services, available 24 hours a day, 7 days a week, and urgent care available for extended clinic hours while they are enrolled as a member with PrimeWest Health. This outcome will be assessed and measured annually through 2017.

Outcome Attainment
Goal is met through 100 percent compliance with regulatory requirements annually for access to emergency medical services as identified in this measurable outcome.

2013 Benchmark
Current benchmark demonstrates 100 percent of all members have access to emergency medical services, 24 hours a day, 7 days a week.

- As reported in the Timely Assignment of Case Manager report, all Prime Health Complete members will have a CCM assigned to them by the appropriate lead agency, either Public Health and/or Human Services (PH/HS), and will be notified via telephone and/or in writing of the CCM's contact information within 10 calendar days from the day the county is notified of the member's enrollment in PrimeWest Health. This outcome will be assessed and measured through December 2016.

Outcome Attainment
Goal is met when all newly enrolled Prime Health Complete members are assigned a CCM (when they choose case management) within 10 days of notification of enrollment.

2013 Benchmark
Current benchmark demonstrates 100 percent of all members are notified of the assigned CCM within 10 calendars days of notification.

- Clinic appointment wait time survey results will be 100 percent compliant with stated requirements in the Clinic Wait Time Survey. This outcome will be assessed and measured annually through 2017.

  Outcome Attainment
  Goal is met through 100 percent compliance with regulatory wait time results annually.

  2013 Benchmark
  Benchmark survey results have shown 100 percent compliance with all stated standards for clinic appointment wait times.

- There will be no documented member Grievances by Prime Health Complete members, as identified in reports to QCCC and the JPB, related to access to services and providers or balance billing. This outcome will be assessed and measured quarterly and annually through 2017.

  Outcome Attainment
  Goal is met with zero Prime Health Complete member Grievances related to identified access categories.

  2013 Benchmark
  Benchmark results indicate there were no Prime Health Complete member Grievances related to access to services and/or providers or balance billing.

- Documented CAHPS Survey composite scores for "Getting Needed Care" and "Getting Care Quickly" will meet or exceed the State composite score. This outcome will be assessed and measured annually through 2017.

  Outcome Attainment
  Goal is met by receiving a composite score that meets or exceeds the State composite score for that audit year for all identified questions.

  2013 Benchmark
  Benchmark demonstrates that, statistically, Prime Health Complete scored above the State average in the 2013 CAHPS survey for "Getting Needed Care" and "Getting Care Quickly."

Goal 1: Methods to Assess and Track – Access for the SNP Population
In evaluating each measurable outcome, PrimeWest Health takes into consideration our rural location, population demographics, clinical needs of the population, and State and Federal standards. We first look to established methods currently in place that would demonstrate we are meeting the measurable outcomes. If we do not currently have methods in place to demonstrate that we are meeting the measurable outcomes (and therefore the goals), PrimeWest Health directors assign staff from each department to review the outcome and develop and design a method of capturing the information that would demonstrate

performance. The following are the methods used to assess and track each identified measurable outcome.

Gaps Analysis: Geo-mapping software identifies potential gaps in the provider network using members' zip codes and mapping all available primary care, mental health professionals, and social service providers available within a 30-mile radius, specialists available within a 60-mile radius, and 24-hour emergency care access.

***Member Grievances*:** Member Grievances are tracked continuously and on-demand reports are available as well as formal annual analyses. The categories that are used as a method of evaluation of this outcome are the following:

- Inability to obtain referral (this includes referrals made to PH/HS)
- Delays in obtaining service
- Delays in appointment scheduling
- Excessive wait times
- Inability to obtain medical information
- Lack of availability of special services
- Inadequate geographic options

***Biennial Disability Access Survey*:** The Biennial Disability Access Survey is conducted by the Minnesota Department of Human Services (DHS) to manage physical access requirements at facilities chosen by DHS. This survey measures provider compliance with access regulations (Americans with Disabilities Act [ADA] requirements) for people with disabilities and monitors at least the following:

- Availability of flexible appointment hours
- Availability of appropriate transfer assistance to exam tables or X-ray equipment
- Scales designed to weigh patients with physical disabilities
- Availability of private waiting areas
- Wheelchair access
- Distance to public transportation
- Parking lot access
- Availability of handicapped-accessible parking spaces
- Availability of assistance to call for transportation
- Availability of an automatic door opener that keeps door open with sufficient time to allow wheelchair entrance
- Availability of elevators with visual and audible signals
- Height of reception desk (chair level)
- Availability of public transportation to the clinic
- Frequency of clinic staff cultural competency training

***Monthly Enrollment Reports*:** Each month, new PrimeWest Health members are assigned a CCM. See also Chapter 2, Section B: Health Risk Assessment Tool (HRAT). PrimeWest Health requires that counties assign new members a CCM within 10 calendar days of the day the county is notified of the member's enrollment in order to facilitate timely PH/HS provisions. The PrimeWest Health Care Coordinator sends each county supervisor a report

containing all of their newly enrolled Prime Health Complete members every month. The county supervisors assign a CCM to each newly enrolled member within the time frame determined by PrimeWest Health. The county supervisor documents on the report the date that the CCM was assigned and the date that the member was notified orally or in writing. If the date is outside of the 10-day time frame, the supervisor indicates the reason for the delay on the report. The PrimeWest Health Care Management Specialist documents the name of the assigned CCM in CCNT and the date the member was notified.

Clinic Wait Time Survey: The PrimeWest Health Provider Network Administration department conducts an annual Clinic Wait Time Survey. Ten percent of providers are surveyed. There is an established rotation of providers to ensure that all providers are surveyed at some point. This survey gathers information on whether clinics are meeting the following criteria for access:

- Scheduled appointment times are not to exceed 45 days from the date of a member's request for routine and/or preventive care
- Scheduled appointment times are not to exceed 24 hours for emergency and urgent care
- Scheduled appointment times for specialty care will not exceed 60 days for regular appointments and 48 hours for urgent care

Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey: This is an annual survey conducted by DHS through a contracted vender, DataStat, for our PrimeWest Health members (including Prime Health Complete) to assess and evaluate their experience with all health care services. This survey identifies specific satisfaction measures on the accessibility of services.

The questionnaire contains questions specifically addressing access to care. The individual question ratings are then grouped under the Health Plan Composite Measures, broken out by product, and compared to the Minnesota average.

Question: "Getting Needed Care"

- In the last 6 months, how often was it easy to get appointments with specialists?
- In the last 6 months, how often was it easy to get the care, tests, or treatment you thought you needed through your health plan?

Question: "Getting Care Quickly"

- In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed?
- In the last 6 months, not counting the times when you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed?

Goal 1: Processes and Procedures to Determine Outcome – Access for the SNP Population

The following processes and procedures were established to determine if the outcome goals are met or not met.

Gaps Analysis: The Provider Contracting & Network Manager completes the analysis of the results of the geo-mapping software at the end of each calendar year and on demand as needed. The analysis and recommendations are completed by the Provider Contracting and Network Manager and if the geo-mapping results demonstrate that primary care providers, mental health professionals, and social services providers are not available within a 30-mile radius, specialists are not available within a 60-mile radius, or 24-hour emergency care access is not available, the Director of Provider Network Administration will create an internal corrective action plan (CAP) that will be monitored by the Corporate Compliance Officer. This report and the results are forwarded to the Complex Care & Disease Management Manager who reviews the results, documents the findings, and evaluates the results in the Model of Care Review and Monitoring Summary.

Member Grievances: Member Grievances are tracked continuously by the Complaints/Appeals & Grievances Specialist. The Complaints/Appeals & Grievances Specialist generates a report at the end of each calendar year and on demand. The Manager of Quality Management then analyzes and makes recommendations to the Director of Quality and Utilization Management regarding the Member Grievance Report, and if necessary, develops a CAP that will be monitored by the Corporate Compliance Officer. This report and the results are forwarded to the Complex Care & Disease Management Manager who reviews the results, documents the findings, and evaluates the results in the Model of Care Review and Monitoring Summary.

***Biennial Disability Access Survey*:** The Biennial Disability Access Survey is conducted by DHS and the results for contracted providers are sent to PrimeWest Health's Provider Relations Manager. This survey measures provider compliance with access regulations for people with disabilities and the results are posted online for members. The Director of Provider Network Administration is responsible for ensuring the results for all contracted providers are reviewed to ensure that each provider meets the ADA requirements for accessibility. If a provider does not meet accessibility requirements, the Director of Provider Network Administration notifies the Director of Quality & Utilization Management and develops an action plan with the provider to ensure they come into compliance in a timely manner. The results are forwarded to the Complex Care & Disease Management Manager who reviews the results, documents the findings, and evaluates the results in the Model of Care Review and Monitoring Summary.

Monthly Enrollment Reports: The monthly report of newly enrolled members is used by county supervisors to document assignment of CCMs to members and the report is returned to PrimeWest Health and reviewed by the Complex Care & Disease Management Manager to determine the percentage of members who were assigned a CCM within the specified time frame.

Clinic Wait Time Survey: The Director of Provider Network Administration conducts the annual Clinic Wait Time Survey and generates a report that includes analysis and recommendations. If a clinic does not meet the wait time standards, the Director of Provider Network Administration will issue a CAP to the failing clinic to remediate the issue.

Goal Attainment – Access for the SNP Population
Goal is considered met if all measurable outcomes related to this goal are met using the processes and procedures identified.

Goal 1: Actions Taken for Goals Not Attained – Access for the SNP Population
If a service gap is identified, PrimeWest Health will re-evaluate its network of providers, attempt to focus on the location of the access problem, and contract with additional providers in that particular geographic area to improve or enhance access.

Clinic Wait Time Survey results are reviewed and analyzed annually upon completion of the survey or more frequently if an issue is identified by a member. Specific clinic or provider issues are addressed on-site with the provider by the PrimeWest Health Provider Network Administration staff. Actions could include, but are not limited to: helping the member with a transition of services to another clinic if needed to ensure the member receives services in a timely manner; notifying the PrimeWest Health Member Services Contact Center of any identified scheduling issues; and/or reevaluating the continued participation of the identified clinic or provider within the PrimeWest Health contracted network until access requirements are met.

Enrollment reports for county case management are monitored monthly. If a member does not have an assigned CCM, the Care Coordinator contacts the county agency to resolve the issue. Should the member refuse case management, the PrimeWest Health Care Coordinator will assume care management responsibilities. The care coordinator will continue to collaborate with the previously assigned CCM and primary care provider for follow-up when needed to ensure the member receives requested and required services to meet his/her individual needs.

PrimeWest Health receives a comprehensive report on the results of the CAHPS survey from DHS. This report is analyzed by the Director of Quality & Utilization Management and other appropriate PrimeWest Health staff such as the Chief Executive Officer (CEO), the Chief Senior Medical Director, the Corporate Compliance Officer, the Director of Membership & Program Development, and the Director of Provider Network Administration. The PrimeWest Health Manager of Quality Management, Enrollment Manager, and Provider Relations Manager are also involved in the review of this analysis. Opportunities for improvement are evaluated for additional information and recommendations. Collaborative efforts to improve member satisfaction scores are documented on the PrimeWest Health annual Quality Work Plan.

Goal 2: Goal Identification – 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: Customized Living (CL) tool pricing documentation, Service Authorization processes, member Grievances, and member education and communication. All PrimeWest Health members are enrolled in the State's

Medicaid (Medical Assistance) program and subsequently have minimal or no out-of-pocket costs associated with obtaining health care and services.

Goal 2: Measurable Outcomes – Affordability for the SNP Population

- There will be no documented member Grievances related to access to services and providers or balance billing. This outcome will be assessed and measured annually through 2017.

  Outcome Attainment
  Goal is met with no reported, documented Prime Health Complete member Grievances related to access to services and/or providers or balance billing.

  2013 Benchmark
  Benchmark results indicate there were no member Grievances related to access to services and/or providers or balance billing.

- Maintain or strengthen current contracted provider network with an enhanced provider reimbursement system that reinvests PrimeWest Health's financial resources back into the PrimeWest Health network to maintain local, affordable, quality care for our special needs members within the communities in which they reside. This outcome will be assessed and measured annually through 2017.

  Outcome Attainment
  Goal is met with no increase in the percentage of contract terminations due to reimbursement rates through 2017.

  2013 Benchmark
  Benchmark results indicated that our current rates meet standards of provider reimbursement and one contract termination out of 18 (5.5 percent) was due to reimbursement rates.

Goal 2: Methods to Assess and Track – Affordability for the SNP Population
Member Grievances: Member Grievances and Appeals are tracked continuously and on-demand reports are available as well as formal annual analyses. The categories that are used as a method of evaluation of this outcome are the following:

- Grievances – Review all Grievances categorized as "Non-appealable claims of billing process issues (i.e., provider charging too much for services)"
- Appeal – Review all Appeals categorized as "Balance billing and co-pay"

Provider Complaints: PrimeWest Health has in place a system that continually tracks and monitors provider complaints (written or during on-site visits or formal provider business office meetings) and classifies and categorizes them into several areas. The classification of complaints that is used to assess and track the outcome is "reimbursement rates."

Provider Termination Summary Report: PrimeWest Health monitors its network of providers and facilities to ensure that we maintain our current level of providers required to

meet the needs of our special needs population. Providers are required to notify PrimeWest Health should they choose to terminate their contract as a PrimeWest Health provider. Reasons for the voluntary termination are tracked and analyzed. This would include terminating the contract with PrimeWest Health due to low reimbursement for provided services. This annual report contains a summary of all terminated contracts and the reason why the termination occurred. To assess this outcome the classification of termination of "contract terminations due to reimbursement rates" will be used.

Goal 2: Processes and Procedures to Determine Outcome – Affordability for the SNP Population

Member Grievances: Member Grievances and Appeals are tracked continuously by the Complaints/Appeals & Grievances Specialist. The Complaints/Appeals & Grievances Specialist generates a report at the end of each calendar year and on-demand. The Manager of Quality Management then analyzes and makes recommendations to QCCC on the Member Grievance Report, and, if necessary, develops a CAP that will be monitored by the Corporate Compliance Officer. This report and the results are forwarded to the Complex Care & Disease Management Manager who reviews the results, documents the findings, and evaluates the results in the Model of Care Review and Monitoring Summary.

- Grievances – Review all Grievances categorized as "Non-appealable claims of billing process issues (i.e., provider charging too much for services)"
- Appeal – Review all Appeals categorized as "Balance billing and co-pay"

Provider Complaints: The Provider Contact Center Manager tracks and monitors provider complaints (written or during on-site visits or formal provider business office meetings) from providers and classifies and categorizes them into several areas on a continuous basis. The Provider Services Contact Center Manager generates a year-end Provider Complaint Report, provides an analysis and recommendations, and, if necessary, develops a CAP that will be monitored by the Corporate Compliance Officer. This report and the results are forwarded to the Complex Care & Disease Management Manager who reviews the results, documents the findings, and evaluates the results in the Model of Care Review and Monitoring Summary.

Provider Termination Summary Report: The Provider Contracting & Network Manager generates a report at the end of each year that contains a summary of all terminated contracts, an analysis of why the termination occurred, and recommendations.

Reimbursement Evaluation: Contracted provider Cirdan (acting in the capacity of Chief Financial Officer [CFO]) conducts a rate structure evaluation to ensure that PrimeWest Health's reimbursement rates are within appropriate ranges of reimbursement This report is provided to the Director of Care Management and forwarded to the Complex Care & Disease Management Manager, who reviews the results, documents the findings, and evaluates the results in the Model of Care Review and Monitoring Summary.

Goal 2: Actions Taken for Goals Not Attained – Affordability for the SNP Population

If a contracted provider is found to be balancing billing a member inappropriately without an Advanced Beneficiary Notice (ABN), the provider will be contacted by the PrimeWest Health Provider Network Administration department and reminded of their PrimeWest

Health contract obligations. Continued compliance is monitored and, if necessary, a CAP may be implemented and/or the contract may be terminated for identified breach.

Repeated complaints (depending upon the severity of the complaint) may result in an audit being conducted on the facility, which will include (at minimum) an audit of the provider's billing and accounts payable process related to PrimeWest Health members. Collaborative efforts may involve both the PrimeWest Health Provider Network Administration department and the PrimeWest Health Corporate Compliance Officer.

If there is an identified concern over payment reimbursement, PrimeWest Health will evaluate its network of providers and their identified concerns to determine if the rates are within reasonable reimbursement structures. If overpayment or underpayment for services is identified, PrimeWest Health will work to remediate and revise the payment structure. If the financial health of PrimeWest Health allows, monies may be reinvested back into the provider network to ensure adequate access for covered benefits and provider satisfaction.

Improvements made in coordination of care and appropriate delivery of services through the direct alignment of the HRAT, ICP, and ICT

Goal 3: Goal Identification – 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 Health Complete by assigning a CCM 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 CCM ensures that a health risk assessment (HRA) is completed within 30 days of contact, completes a comprehensive 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 for 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 works 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.

Goal 3: Measurable Outcomes – Coordination of Care and Delivery of Service

- All members will be assigned a Public Health Nurse (PHN)/Registered Nurse (RN) and/or a social worker as his/her CCM(s), within 10 days of the day the county is notified of the member's enrollment in PrimeWest Health. This outcome will be assessed and measured annually through 2016.

  Outcome Attainment
  Outcome is met when all newly enrolled members have an assigned CCM within 10 days of notification,

2013 Benchmark
Current benchmark demonstrates that 100 percent of all members are assigned a CCM within 10 days of notification.

- CCMs will contact all members within 10 days of the date the county is notified to explain their role as the member's CCM and primary point of contact. This outcome will be assessed and measured annually through 2016.

  Outcome Attainment
  Outcome is met when all members are notified and an explanation of the CCM's role is provided within 10 days of notification.

  2013 Benchmark
  Current benchmark demonstrates that 100 percent of all members are notified of the assigned CCM within 10 days of notification.

- All members will have an HRA conducted by the CCM within 30 days of enrollment. This outcome will be assessed and measured annually through 2017.

  Outcome Attainment
  Outcome is met when 100 percent of all members have an HRA within 30 days of enrollment.

  2013 Benchmark
  Current benchmark demonstrates that 100 percent of all members had an HRA within 30 days of enrollment. Efforts are to maintain this standard.

- During each member's HRA, the member will work with the CCM or existing ICT to establish or review the composition of the ICT and the frequency of meetings established to meet the member's current assessed need. This outcome will be assessed and measured annually through 2016. .

  Outcome Attainment
  Outcome is met when 100 percent of all members have an ICT established or composition of team reviewed during their HRA and the frequency of meetings is established at this time.

  2013 Benchmark
  Current benchmark, based on ICP audit results, demonstrates that 100 percent of members have an ICT reviewed and established as described above. Efforts are to maintain this standard.

- Each member will have an ICP developed and implemented within 30 days of the HRA to ensure assessed needs are met and coordinated. This outcome will be assessed and measured annually through 2016.

Outcome Attainment
Outcome is met when 100 percent of all members have an ICP developed and implemented within 30 days of their HRA.

2013 Benchmark
Current benchmark demonstrates that 100 percent of all members had an ICP developed and implemented within 30 days of their HRA.

- Each member will have the needs identified in the HRA addressed in the ICP and services established and implemented. This outcome will be assessed and measured annually through 2017.

Outcome Attainment
Outcome is met when each member has 100 percent of all identified needs addressed through the ICP.

2013 Benchmark
Current benchmark, based on ICP audit results, demonstrates that three of 11 counties received a deficiency in this area, therefore performance is 72.7 percent.

- PrimeWest Health's members' functional status for physical, mental, and social domains will be assessed at least annually. This outcome will be assessed and measured annually through 2017.

Outcome Attainment
Outcome is met when 100 percent of all members have their physical, mental, and social domains assessed within 30 days of enrollment and within 365 days of their previous assessment.

2013 Benchmark
Current benchmark demonstrates that 100 percent of all members have an initial and annual assessment for all the above domains. Efforts are to maintain this standard.

- Additional service provisions to plan of care will be documented on the member's ICP as identified. This outcome will be assessed and measured annually through 2017.

Outcome Attainment
Outcome is met when all members have 100 percent of additional service provisions documented in the ICP.

2013 Benchmark
Current benchmark, based on ICP audit results, demonstrates that three of 11 counties received a deficiency in this area, therefore performance is 72.7 percent.

- Pain management will be addressed on all PrimeWest Health member ICPs annually and as needed by completing the 0 – 10 pain scale rating. This outcome will be assessed and measured annually through 2017.

  Outcome Attainment
  Outcome is met when the pain management scale is addressed on 100 percent of members' ICPs within 30 days of their initial assessment or within 365 days of their previous assessment.

  2013 Benchmark
  Current benchmark based on the ICT audit results demonstrates that 100 percent of all members had pain management addressed on their ICPs. Efforts are to maintain this standard.

- Advance Directive planning will be completed and documented according to regulations for all PrimeWest Health members during their enrollment with PrimeWest Health. This outcome will be assessed and measured annually through 2017.

  Outcome Attainment
  Outcome is met when Advance Directives are addressed on 100 percent of members' ICPs within 30 days of their initial assessment or within 365 days of their previous assessment.

  2013 Benchmark
  Current benchmark based on the Health Care Directive Summary report results demonstrates that 100 percent of all members had Advance Directives addressed on their ICPs. Efforts are to maintain this standard.

- CAHPS scores for Rating of Health Plan, Rating of All Health Care, and Rating of Personal Doctor will be at or above the State average. This outcome will be assessed and measured annually through 2017.

  Outcome Attainment
  Outcome is met when PrimeWest Health's scores for Rating of Health Plan, Rating of All Health Care, and Rating of Personal Doctor are at or above the State average.

  2013 Benchmark
  Current benchmark scores based on the 2013 CAHPS reflect that Rating of Health Plan was 73.1 percent (Minnesota rate was 74.2 percent), Rating of All Health Care was 74 percent (Minnesota rate was 72.4 percent), and Rating of Personal Doctor was 84.6 percent (Minnesota rate was 83.6 percent).

- As identified in the annual CCM survey, member ratings of their overall health and quality of life are at or above the prior year's levels. This outcome will be assessed and measured annually through 2017.

Outcome Attainment
Outcome is met when the CCM survey of the members' rating of their overall health and quality of life is at or above the previous year's rating.

2013 Benchmark
Current benchmark scores rating overall health, 90 percent rated their health as good, very good, or excellent. In rating their quality of life, 88 percent rated their quality of life as good, very good, or excellent.

- All home care agencies will utilize the Outcome and Assessment Information Set (OASIS) report available through the Centers for Medicare & Medicaid Services (CMS) to identify an area for potential improvement that will increase their State and Federal averages by improving the previous year's benchmark. This outcome will be assessed and measured through 2017.

  Outcome Attainment
  Outcome is met when when all home care agencies have identified and have implemented a quality improvement plan based on their OASIS report and 100 percent of all home care agencies have increased their State and Federal averages over the previous year's rating.

  2013 Benchmark
  Current benchmark demonstrates that home care agencies averaged 6.3 areas where they scored below the State and Federal averages.

- Prime Health Complete Health Outcomes Survey (HOS) Baseline Report collects responses to the following question: "Has your doctor or other health provider done anything to help prevent falls or treat problems with balance or walking?" PrimeWest Health will maintain or improve positive responses (those being answered with a "yes") from the previous year's report. This outcome will be assessed and measured annually through 2017.

  Outcome Attainment
  Outcome is met when the positive responses to the question "Has your doctor or other health provider done anything to help prevent falls or treat problems with balance or walking?" remain at or above the previous year's rate.

  2013 Benchmark
  Baseline 15 Report reflects that 41.6 percent answered "yes" to the question "Has your doctor or other health provider done anything to help prevent falls or treat problems with balance or walking?"

Goal 3: Methods to Assess and Track – Coordination of Care and Delivery of Service
In evaluating each measurable outcome, PrimeWest Health takes into consideration our rural location, population demographics, clinical needs of the population, and State and Federal standards. We first look to established methods that are currently in place that would

demonstrate that we are meeting the measurable outcomes. If we do not currently have methods that are in place to demonstrate that we are meeting the measurable outcomes (and therefore the goals), PrimeWest Health directors assign staff from each department to review the outcome and develop and design a method of capturing the information that would demonstrate performance.

CCM Notification Report: Each month, new PrimeWest Health members are assigned a CCM. See also Chapter 2, Section B: Health Risk Assessment Tool (HRAT). PrimeWest Health requires that counties assign new members a CCM within 10 calendar days of the day the county is notified of the member's enrollment in order to facilitate timely PH/HS provisions. The name of the CCM is then communicated to PrimeWest Health via secure electronic means. PrimeWest Health documents the name of the assigned CCM in CCNT and the date the member was notified of the CCM role. If there are any delays in assignment of the CCM, the Care Coordinator notifies the assigned county of residence and requires immediate assignment. The monthly results and dates of notification and communication are compiled, analyzed, and recommendations are made by the Complex Care & Disease Management Manager.

Assessment/Reassessment Report: Annually, PrimeWest Health receives a report on all members' initial assessments or reassessments and the date that they occurred. This report is generated from Medicaid Management Information System (MMIS) and entries into the system are made by the counties. PrimeWest Health runs an internal report and the two are cross-referenced and verified to evaluate the number of members eligible for an initial assessment within 30 days and those that are entered into the system. This report is uploaded to CMS and DHS and data verified by Cirdan and MetaStar.

Annual Individualized Care Plan Audit and Report: The annual care plan audit is a sampling methodology audit that uses an audit protocol based on best practices and contractual, State, Federal, and National Committee for Quality Assurance (NCQA) requirements. The audit elements that are reviewed and determined to be met or not met in the audit process and that are used to assess and track these outcomes are the following:

- ICT – Documentation in member's chart indicates an ICT was established during the HRA and visit frequency was established based on member's needs
- Initial HRA – Date the HRA is completed is within 30 days of enrollment date
- Annual HRA – Date HRA is completed is within 365 days of previous HRA
- ICP – Date comprehensive ICP is completed is within 30 calendar days of completed MnCHOICES/Long-Term Care Consultation (LTCC)
- Comprehensive Care Plan Specific Elements – If an area is noted on the MnCHOICES/LTCC/HRA as a concern, then there must be documented goals, interventions, and services for concerns or needs identified
- Claims data that directly correlates to services identified in the ICP
- Comprehensive Care Plan – Pain is assessed and documented in the ICP. The assessment of pain is rated using the numerical rating pain score of 0 – 10, and needs are identified and addressed

- Comprehensive Care Plan – If pain is identified and member indicates it is interfering with ADLs or quality of life, there is documentation of a pain management plan in the ICP
- Advance Directive – Documentation of conversation about Advance Directive initiated; or the member refused to complete an Advance Directive; or the ICT determined that an Advance Directive is culturally inappropriate; or the Advance Directive is completed
- Advance Directive – Documentation of Advance Directive is on file at the hospital, in the primary care provider chart, and, if appropriate, with the SNF

Care Planning Activities and ICT Documentation: PrimeWest Health's ICT care plan includes functional, psychosocial, and clinical domains. See also Chapter 2, Section C: Individualized Care Plan (ICP). PrimeWest Health ensures that documentation of the care planning activities occurs because it is functionalized as a required field on the ICP. If the date and time are not completed, the CCM cannot save the ICP to PrimeWest Health due to the electronic requirements of the ICP. Specific care planning areas include, but are not limited to, the following:

- Advance Care planning: Health Care Directives
- Functional measures, Activities of Daily Living (ADLs): bathing, toileting, dressing and grooming, mobility, and eating
- Independent Activities of Daily Living (IADLs): phone use, shopping, meal preparation, housekeeping, laundry, medication management, money management, and transportation. Pain management will be included on an annual or as-needed basis.
- Psychosocial measures: behavioral support, mental health (depression, dementia, Alzheimer's, socialization, anxiety, and Serious and Persistent Mental Illness [SPMI]), communication, alcohol use, caregiver support, gambling, vulnerability, and personal safety
- Clinical domain measures: Diabetes, fall prevention, heart disease, muscle/joint/exercise, medication, neurological, pain management, respiratory, urinary, wound, dental, immunizations, preventive exam, and sensory

Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey: This is an annual survey conducted by DHS through a contracted vendor, DataStat, for all PrimeWest Health members, including Prime Health Complete members, to assess and evaluate their experience with all health care services. This survey identifies overall health plan ratings for the following, which will be reviewed and compared annually:

- Rating of Health Plan
- Rating of All Health Care
- Rating of Personal Doctor

Member Satisfaction with Case Management System: The County Case Management Satisfaction Survey is an annual survey that PrimeWest Health conducts to measure Prime Health Complete members' level of satisfaction with their CCM(s). This is self-reported by the members through the survey tool. The survey results are compiled, analyzed, and

distributed along with recommendations to PrimeWest Health regulatory bodies. The survey comprises 17 questions regarding case management. The questions include the following:

- Rating of overall quality of life: Excellent, Very Good, Good, Fair, and Poor
- Rating of overall health: Excellent, Very Good, Good, Fair, and Poor

Outcome and Assessment Information Set (OASIS) Comparison Report: OASIS is a group of data elements that represent the core items of a comprehensive assessment for an adult home care patient and form the basis for measuring patient outcomes for quality improvement. PrimeWest Health analyzes the OASIS data which includes 22 items from the Home Health Compare results that are found on the CMS website. The results are analyzed for our contracted home care agencies, and areas where the agencies do not meet State and Federal guidelines are reviewed and evaluated.

HOS Baseline Report Analysis: Baseline reports are reviewed and analyzed annually for use in quality improvement activities. PrimeWest Health analyzes the entire report, which includes information and measures performance on fall prevention. Previous year's rates are used as benchmark comparisons; however, Minnesota rates are also used as benchmark comparisons when possible.

Goal 3: Processes and Procedures to Determine Outcome – Coordination of Care and Delivery of Service

The following processes and procedures were established to determine if the outcome goals are met or not met.

CCM Notification Report: Within two business days of receipt of final enrollment data, the Care Coordinator sends the county supervisors a monthly report containing all the newly enrolled Prime Health Complete members. The county supervisors then document on the report the date that the CCM was assigned and the date that the member was notified. If the date is outside of the 10-day time frame, the supervisor indicates the underlying reason. This report is returned by the end of the month and is reviewed by PrimeWest Health Complex Care & Disease Management Manager to review the results. If any counties have members who are not assigned a CCM or notified within the required time frame, a CAP will be issued to the county at that time. At the end of the calendar year, the Complex Care & Disease Management Manager writes a summary of the results and recommendations.

Assessment/Reassessment Report: Annually, PrimeWest Health receives a report from DHS on all members' initial assessments or reassessments and the date on which they occurred. This report is generated from the MMIS database. The entries into this database are made by the CCM after an HRA has been completed. The report is then queried with PrimeWest Health data from the electronic ICP database and Amisys systems. This data is verified to evaluate the number of members eligible for an initial assessment within 30 days in comparison to the eligible members who actually received the initial assessment. This report and the results are forwarded to the Complex Care & Disease Management Manager who reviews the results, documents the findings, and reports the findings to the Corporate Compliance Officer, who submits to MetaStar for Data Validation audit. The Complex Care

& Disease Management Manager evaluates and documents the results in the Model of Care Review and Monitoring Summary.

Annual Individualized Care Plan Audit and Report: The PrimeWest Health Care Management department conducts the ICP audit annually. Off-site audits are an option, unless there is a current CAP in place, in which case an on-site audit is required. PrimeWest Health auditors send each county a list of eight randomly selected members via secure email. The county provides PrimeWest Health auditors with the ICP, including signature page, HRA, and case notes for the member. All documentation in the member's record is used to determine whether the elements are met or not met. If unmet elements are found in the first eight, an additional 22 charts are also reviewed for the unmet elements. Whether a CAP is issued depends on the severity and frequency of the unmet elements according to PrimeWest Health Policy and Procedure SNP08: Annual Care Plan Audit Methodology. The results of the audit are provided to the Complex Care & Disease Management Manager who compiles the results, documents the findings, and evaluates the results in the Model of Care Review and Monitoring Summary.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey: DataStat completes the survey, compiles the results, and provides them to DHS. DHS forwards the results to PrimeWest Health. These results are sent to the Manager of Quality Management in the late fall and are from the previous calendar year. They are then sent to the PrimeWest Health Director of Quality and Utilization Management and the Data Coordinator for analysis. The Data Coordinator compiles a comprehensive summary that includes the following ratings: Rating of Health Plan, Rating of All Health Care, and Rating of Personal Doctor. This report and the results are forwarded to the Complex Care & Disease Management Manager who reviews the results, documents the findings, and evaluates the results in the Model of Care Review and Monitoring Summary.

***Member Satisfaction with Case Management System*:** This survey is conducted by PrimeWest Health annually. Each April, the PrimeWest Health Care Management Specialist sends a satisfaction survey to each member who has accepted case management services. Six weeks is allowed for the surveys to be returned. When the survey is returned, the results are recorded in a spreadsheet that includes a section for all written comments. At the end of the six weeks, the Care Management Specialist totals the number for each of the 17 survey questions. The report with the totals is sent to the Complex Care & Disease Management Manager who reviews the results, documents the findings, evaluates the results and makes recommendations, and records the findings and performance in the Model of Care Review and Monitoring Summary.

OASIS Report: The PrimeWest Health Director of Care Management compiles the OASIS data from the CMS website page Home Health Compare for all contracted home care agencies. Each agency receives an annual audit in which its OASIS results are reviewed. The quality improvement plan for each agency is also reviewed to ensure that all agencies have at least one of their OASIS results that did not meet State and Federal standards addressed on their quality improvement plan. The Complex Care & Disease Management Manager then reviews the audit findings and the OASIS results, documents the findings, evaluates the

results and makes recommendations, and records the findings and performance in the Model of Care Review and Monitoring Summary.

HOS Baseline Report: PrimeWest Health is alerted of the release of its baseline HOS reports via Health Plan Management System (HPMS) memo. The Manager of Quality Management downloads the baseline report from HPMS and then sends the results to the PrimeWest Director of Care Management and Director of Quality & Utilization Management. The results include scores on falls and fall prevention. All results are analyzed by PrimeWest Health staff including the Director of Care Management, Director of Quality & Utilization Management, the Chief Senior Medical Director, the CEO, the Director of Membership & Program Development, and the Director of Provider Network Administration. Areas of improvement are identified and noted on the Quality Work Plan. This report and the results are forwarded to the Complex Care & Disease Management Manager who reviews the results, documents the findings, and evaluates the results in the Model of Care Review and Monitoring Summary. The HOS Baseline Report is analyzed to determine if results regarding fall prevention are at or above the previous year's rate.

Goal Attainment – Coordination of Care and Delivery of Service
Goal is considered met if all measurable outcomes related to this goal are met using the processes and procedures identified.

Goal 3: Actions Taken for Goals Not Attained – Coordination of Care and Delivery of Service
Actions to be developed in collaboration with PH/HS include, but are not limited to, the following:

- Case management education with the assigned CCM and/or county agency director
- County CAP until desired outcome is achieved
- Possible reassignment of assigned CCM with PrimeWest Health Care Coordinator assuming all assigned case management responsibilities
- Ongoing education for members, providers, and CCMs through the following options, which may include, but are not limited to:
  - CCMs and providers will be educated and instructed on clinical best practices, chronic care improvement programs (CCIP), fast track interventions, and other disease management interventions for managing the member's conditions. See also Chapter 2, Care Coordination, and Chapter 3, SNP Provider Network.
  - Education may be on a one-to-one basis with the CCM and/or county director or provider or at the clinic level. Depending upon severity, CAPs may be implemented and/or the CCM may be reassigned.
  - Articles will be published in the member and provider newsletters
- Necessary modifications to the ICP will follow standard care planning process. See also Chapter 2, Section C: Individualized Care Plan (ICP).
- Modifications to the Model of Care will follow the standard committee review process, including review, discussion, recommended changes, and approval by the Chief Senior Medical Director, PH/HS Committee, QCCC, and finally, the JPB.
- Specific provider profiling from chart audits and HEDIS rate review will be addressed on a one-to-one basis with the provider and/or clinic in collaboration with

the PrimeWest Health Chief Senior Medical Director and Provider Network Administration staff

- After implementing a course of action, PrimeWest Health will monitor members identified as having special needs to see how effective interventions were. Referrals to specialists are part of the interventions PrimeWest Health considers. PrimeWest Health reports to the State as part of its annual reporting to identify members with special health care needs, the total number of adults identified, and the total number of assessments completed.

Enhancing care transitions across all healthcare settings and providers for SNP beneficiaries.

Goal 4: Goal Identification – Care Transitions Across All Health Care Settings
PrimeWest Health provides a structured process for members, health care providers, and Public Health and Human Services 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 will provide a seamless transition across the continuum of care for PrimeWest Health members.

Goal 4: Measurable Outcomes – Care Transitions Across All Health Care Settings

- Primary care provider will be notified of the member's transition within one business day. This outcome will be assessed and measured through 2017.

  Outcome Attainment
  Outcome is met if the primary care provider is notified within one business day for 100 percent of transitions.

  July 2012 – June 2013 Benchmark
  Benchmark demonstrates PrimeWest Health notified primary care providers within one business day of each member's transition 100 percent of the time.

- Updated ICPs for all Prime Health Complete members experiencing an unplanned transition will be shared with the primary care provider and other pertinent members of the ICT as soon as possible, but within 30 days of the unplanned transition. This outcome will be assessed and measured annually through 2017.

  Outcome Attainment
  Outcome is met when 100 percent of updated ICPs are shared within 30 days of the update.

  July 2012 – June 2013 Benchmark
  Benchmark demonstrates PrimeWest Health shared the ICP with the primary care provider and pertinent members of the ICT 73 percent of the time.

- All contracted inpatient facilities and SNFs will notify PrimeWest Health of the admission of a member within one business day. This outcome will be assessed and measured annually through 2017.

  Outcome Attainment
  Outcome is met when contracted inpatient facilities and SNFs notify PrimeWest Health within one business day of the admission of a member at a rate 5 percent above the previous year's notification rate.

  2012 – 2013 Benchmark
  Benchmark demonstrates PrimeWest Health providers notified PrimeWest Health within 24 hours of admission 87 percent of the time for inpatient and 75 percent of the time for SNFs.

- Any time a member experiences more than three acute care transitional episodes in a 30-day period, an ICT meeting will be held to evaluate the member's ICP. This outcome will be assessed and measured through 2017.

  Outcome Attainment
  Outcome is met if the ICT meets any time three acute care transitional episodes occur within a 30-day period.

  2013 Benchmark
  Benchmark data indicates PrimeWest Health had no member with three or more acute care transitional episodes within a 30-day period of time.

- Providers and CCMs will be educated on clinical best practices for the top three unplanned admission and readmission transition diagnoses so that an appropriate ICP can be developed based on clinical best practices. This outcome will be assessed and measured by December 2017.

  Outcome Attainment
  Outcome is met when education on the top three unplanned admission diagnoses has been documented for all CCMs and appropriate providers via established training communication practices.

  2012 Benchmark
  Benchmark data indicates education on clinical best practices occurred for all CCMs and appropriate providers. Efforts are to maintain this standard.

Goal 4: Methods to Assess and Track – Care Transitions Across All Health Care Settings

In evaluating each measurable outcome, PrimeWest Health takes into consideration our rural location, population demographics, clinical needs of the population, and State and Federal standards. We first look to established methods that are currently in place that would demonstrate that we are meeting the measurable outcomes. If we do not currently have

methods in place to demonstrate that we are meeting the measurable outcomes (and therefore the goals), PrimeWest Health directors assign staff from each department to review the outcome and develop and design a way of capturing the information that would demonstrate performance. The following are the methods used to assess and track each identified measurable outcome.

Transitions of Care Report: Transitions will be monitored by the PrimeWest Health Care Coordinators through the concurrent review with Utilization Management processes as the unplanned transitions occur. Monitoring includes, but is not limited to, ensuring that all elements of the PrimeWest Health *Transition of Care Update* form are completed. This form is reviewed upon submission to PrimeWest Health by the PrimeWest Care Management Specialist for timeliness and completion of the required elements. If the PrimeWest Health Care Management Specialist identifies missing elements or protocol variations, he/she notifies the Care Coordinator. The Care Coordinator contacts the CCM to complete and resubmit the form and/or provide rationale for variation from established protocol standards. The Care Management Specialist enters information from this form into a transition of care database. In addition to the concurrent review, the Care Management reporting system generates a monthly report from the transition of care database. CCMs are required to document if the ICP was communicated with the ICT. Concurrent review of the member's ICP is conducted by the PrimeWest Health Care Coordinators upon submission to PrimeWest Health, in order to ensure that the updated ICP has been communicated to the ICT in the specified time frame. This report is a final check to ensure that the form is complete and submitted within the required time frame. The report includes an evaluation of whether notification of the primary care provider and update of the ICP occurred within the specified time frame.

Admission Reporting: Every inpatient transition (admission) is to be reported by the contracted admitting hospital or SNF within one business day to PrimeWest Health Utilization Management (UM) staff. Reporting is done by faxing a notification of admission or through the PrimeWest Health provider web portal. The admission is monitored by the PrimeWest Health Care Coordinator. Part of the initial and/or concurrent review process will include, but is not limited to, a review of compliance with medication refills for unplanned and/or planned transitions of care.

Conducting ICT Meetings: CCMs are responsible, with support from the PrimeWest Health Care Coordinators, for identifying the need for, arranging, and conducting ICT meetings regarding unplanned transitions and for formulating a plan with the ICT to address continued unplanned transitions. The ICT meeting may be arranged at any point in the member's care. If there are three documented unplanned transitions in a month, there must be an attempt to coordinate a meeting involving the ICT within 10 business days, or 14 calendar days, of the unplanned transition. All documentation of ICT meetings and their purpose are in the ICP under the ICT tab. Reports are generated from the ICP monthly and transitions of care are monitored by PrimeWest Health. If there are three unplanned admissions within a month, the Care Coordinator contacts the CCM to ensure that an ICT meeting is being scheduled and monitors for compliance.

Training/Education: CCM training and education occur regularly (no less than eight hours per year) through a variety of means, including DHS-sponsored Aging and Adult Services Education. See also Chapter 2, Section A: SNP Staff Structure, and Chapter 3, Section C: MOC Training for the Provider Network. Training topics include identified high-risk factors, including management to reduce unplanned transitional episodes. Training is conducted by the PrimeWest Health Care Coordinators, medical directors, appropriately identified specialists, and/or pharmacists. PrimeWest Health Care Coordinators provide monthly UM reports to each of the 13 counties through secure email, and general data trends are discussed monthly with the CCM supervisors and at scheduled PH/HS Committee meetings. Training reports are generated and analyzed by the PrimeWest Health Director of Care Management at least annually and more frequently if needed to ensure that all contracted providers and pertinent care management staff have been trained on the PrimeWest Health Model of Care and clinical guidelines. Follow up with the individual CCM and/or county agency director occurs to resolve any training issues when discrepancies are noted. PrimeWest Health updates the clinical best practices on the website if and when updates or revisions to the best practices guidelines occur. The information regarding the best practices updates is also communicated to providers through ***PrimePointers*** and ***PrimePartners***, which are newsletters published and disseminated via email to all contracted providers and CCMs. The best practices and clinical guidelines are reviewed at least annually by QCCC in conjunction with the Chief Senior Medical Director and the Behavioral Health Medical Director.

Goal 4: Processes and Procedures to Determine Outcome – Care Transitions Across All Health Care Settings

The following processes and procedures were established to determine if the outcome goals are met or not met.

Transition of Care Report: Upon admission to a SNF or hospital, the contracted facility is required to notify PrimeWest Health via the *Inpatient Admission Authorization Request* form. The notification request is automatically placed into the UM queue upon receipt and is entered into CCNT. Each morning, a report for both the SNF and nursing facility admission notifications is auto-generated by the Crystal reporting system and sent to all Care Coordinators. Each member has a specific care coordinator assigned to him/her. If a care coordinator is absent, another one is assigned to cover his/her members and processes. The Care Coordinator generates a secure email to the assigned CCM with notification of the admission and any clinical information that would assist in the transition process. The CCM then contacts the facility or member within one business day of notification, completes the *Transition of Care Update* form and either faxes it or sends it by secure email it to PrimeWest Health's Care Management Specialist. The *Transition of Care Update* form is placed in a queue for data entry into CCNT. Annually and as needed, the Data Coordinator generates a report compiling the transition of care information, which includes documentation of whether the primary care provider was notified and the updated ICP sent to the ICT and member within 30 days. This report and the results are forwarded to the Director of Care Management who reviews the results, analyzes the data, documents the findings, and evaluates the results in the Model of Care Review and Monitoring Summary.

Admission Reporting: Upon a PrimeWest Health member's admission, every hospital or SNF is required to notify PrimeWest Health of the admission within one business day by faxing an *Inpatient Admission Authorization Request* form or electronic notification via provider portal. The notification request is automatically placed into the UM queue upon receipt and is entered into CCNT. This generates a reminder for the Care Coordinator of the hospital or SNF admission. In addition to this reminder, an auto-generated report is sent to each Care Coordinator each morning. Annually and as needed, the Data Coordinator generates a report that indicates the name of the hospital or SNF, the number of admissions, the date the admission occurred, and the date PrimeWest Health was notified. This report and the results are forwarded to the Care Coordinator who reviews the results, analyzes the data, documents the findings, and evaluates the results in the Model of Care Review and Monitoring Summary with oversight and final review by the Director of Care Management.

Conducting ICT Meetings: CCMs are responsible for tracking the number of transitions of care for each member assigned to them. In addition, PrimeWest Health tracks transitions of care and enters them into CCNT with a reminder to the Care Coordinator. Each month, a transition of care report is generated that includes all inpatient and SNF planned and unplanned admissions. This is a three-month rolling report that identifies each member and the number of unplanned transitions. In addition to this report, PrimeWest Health y Care Coordinators monitor transitions closely and are able to identify in CCNT when a member had three or more unplanned admissions. Both the reports and the disability care coordination monitoring are methods by which to identify the need in preparation for the ICT meeting regarding the unplanned transitions. The Care Coordinator contacts the CCM to formulate a plan with the ICT to address the continued unplanned transitions. The ICT meeting may be arranged at any point in the member's care. If there are three documented unplanned transitions in a month, there must be an attempt to coordinate a meeting involving the ICT within 10 business days or 14 calendar days of the unplanned transition. All documentation of ICT meetings and their purpose are in the ICP under the ICT tab. Reports are generated from the ICP monthly and transitions of care are monitored by PrimeWest Health. If there are three unplanned admissions within 30 days, the Care Coordinator contacts the CCM to ensure that an ICT meeting is being scheduled. The CCM then documents the meeting in the ICP and the care coordinator reviews the ICP to ensure the ICT meeting took place and was documented accordingly. The PrimeWest Health Care Coordinator documents the results of the meeting in CCNT with the note type "Multiple Unplanned Admissions." At the end of the calendar year, the Director of Care Management generates a report from CCNT using that note type to determine how many ICT meetings occurred due to multiple unplanned admissions for Prime Health Complete members. This is then cross matched with the summary of the monthly reports to determine that the numbers match. The Complex Care & Disease Management Manager reviews the results, analyzes the data, documents the findings, and evaluates the results in the Model of Care Review and Monitoring Summary with oversight and final review by the Director of Care Management.

Education/Training: The PrimeWest Health Data Coordinator runs monthly and annual utilization reports, which identify the top three admission diagnoses. The top three diagnoses are reviewed to determine if clinical practice guidelines have already been adopted by the Chief Senior Medical Director. If it is a diagnosis for which PrimeWest Health does not have

clinical practice guidelines in place, the Chief Senior Medical Director will research and review clinical guidelines and best practices and make a recommendation to QCCC. QCCC then reviews for clinical appropriateness and recommendation for adoption. Final adoption of new clinical practice guidelines is approved by the JPB based on the clinical recommendation of QCCC. The top three admission diagnoses are communicated through CCM training and education, which occur on a regular basis (no less than eight hours per year) through a variety of means. Case management training on the top three diagnoses includes, but is not limited to, identification of high-risk factors, signs and symptoms, and self-management plans to reduce unplanned transitions and increase health literacy, health outcomes, and treatment compliance. The training schedule is reviewed annually by the SNP Clinical Care Team, which is comprised of the Director of Care Management, , Complex Care & Disease Management Manager and Care Coordinators. The training schedule is then sent to county supervisors and CCMs. Trainings are scheduled and conducted by PrimeWest Health's Care Coordinator. Other trainers may include medical directors, other professionals, and/or pharmacist. Monthly UM reports are auto-generated and the Care Coordinator sends them to each of the 13 counties through secure email. CCMs identify members who were admitted with one of the top three diagnoses and provide education on the clinical best practices to the member, caregiver, and members of the ICT. This information is then documented in the ICP. The Care Coordinator compiles a report of all training provided, which includes a review of the website verifying that best practices are posted, are current and updated for the top three diagnoses. The Complex Care & Disease Management Manager reviews the results, analyzes the data, documents the findings, and evaluates the results in the Model of Care Review and Monitoring Summary with oversight and final review by the Director of Care Management.

Goal Attainment – Care Transitions Across All Health Care Settings
Goal is considered met if all measurable outcomes related to this goal are met using the processes and procedures identified.

Goal 4: Actions Taken for Goals Not Attained – Care Transitions Across All Health Care Settings
Actions will be developed in collaboration with PH/HS to ensure that the above-identified elements are met. The actions that could take place include, but are not limited to, the following:

- PrimeWest Health will provide education to providers, members (as appropriate), and CCMs regarding management of transitional episodes including, but not limited to, the following:
  - Sharing of the ICP
  - Collaboration with care delivery team
  - Involvement of primary care provider with transitional care episodes and input and development of ICP
  - Prevention of avoidable transitions
  - Clinical practice guidelines for top three diagnoses

  In addition to education, depending upon the severity of the identified issue, CAPs and/or contract termination may be indicated.

Ensuring appropriate utilization of services for preventive health and chronic conditions.

Goal 5: Goal Identification – Assuring Appropriate Utilization of Services
PrimeWest Health will monitor current pharmacy and medical utilization trend data to identify actual or potential opportunities to improve medical care, mental health care, and social service provision. 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.

Goal 5: Measurable Outcomes – Assuring Appropriate Utilization of Services

- All members will have a preventive screen or visit to a health care provider at least annually. PrimeWest Health HEDIS performance will be at or above the HEDIS national mean from the most current published report. This outcome will be assessed and measured annually through 2017.

  Outcome Attainment
  PrimeWest Health HEDIS results in the Adults' Access to Preventive/Ambulatory Care measure will be at or above the national mean.

  2013 Benchmark
  Benchmark data of HEDIS 2013 rates (based on 2012 experience) reflect that the PrimeWest Health HEDIS rate of Adults' Access to Preventive/Ambulatory Care is 99.47 percent and the national mean is 94.59 percent.

- All PrimeWest Health members will have an ICP that includes preventive care and is based on assessed needs and completed within 30 days of the assessment. This outcome will be assessed and measured annually through 2017.

  Outcome Attainment
  PrimeWest Health audits will demonstrate that all members have a completed ICP with preventive care addressed and all assessed needs accounted for in the ICP within 30 days of the assessment.

  2013 Benchmark
  Benchmark data show that audits demonstrated 100 percent compliance in this area.

- PrimeWest Health will demonstrate improvement in the clinical care of members as required in Structure and Process Standard SNP 3: Clinical Quality Improvements. This outcome will be assessed and measured annually through 2017. PrimeWest Health analyzes the reported HEDIS measures for Prime Health Complete members to determine if there are at least two significant improvements for any of the measures in the Effectiveness of Care domain.

Outcome Attainment
PrimeWest Health will obtain a score of 80 percent or greater in SNP 3 Structure and Process submission.

2013 Benchmark
As 2013 Structure and Process submission scores are not available at the time of this report, the 2012 scores will be used. Benchmark data show that the 2012 submission demonstrated a score of 100 percent for SNP 3.

- PrimeWest Health will demonstrate compliance with ***NCQA Standards and Guidelines for the Accreditation of Health Plans*** for Standard QI 9: Practice Guidelines by scoring 80 percent or greater in elements A – D. This outcome will be assessed and measured annually through 2017.

Outcome Attainment
Outcome is met with a score of 80 percent or greater on NCQA Standard QI 9, Elements A – D.

2014 Benchmark
Currently, PrimeWest Health is at 100 percent for NCQA QI 9, Elements A – C. However, we are currently at 50 percent for Element D and will increase that score to 80 percent.

- The Plan All-Cause Readmissions HEDIS Measure (average adjusted probability) will be at or better than the reported national mean. This outcome will be assessed and measured annually throughout 2017.

Outcome Attainment
Outcome is met when the HEDIS Plan All-Cause Readmissions measure (average adjusted probability of readmission) is at or better than the reported national mean.

2013 Benchmark
Currently, the Prime Health Complete benchmark for average adjusted probability of readmission is 0.1901 and the Medicare national mean for average adjusted probability of readmission is 0.1718 (for this measure, a lower probability is better).

- 100 percent of members with chronic care conditions identified through HRAs or claims will have a chronic care improvement plan identified in their ICP. This outcome will be assessed and measured annually throughout 2017.

Outcome Attainment
Outcome is met when all members identified with a chronic care condition have a chronic care improvement plan identified in their ICP.

Benchmark
Benchmark data demonstrate that 100 percent of all members identified as having a chronic care condition have a chronic care improvement plan documented in their ICP.

Goal 5: Methods to Assess and Track – Assuring Appropriate Utilization of Services
Healthcare Effectiveness Data Information Set (HEDIS): PrimeWest Health will utilize Adults' Access to Preventive/Ambulatory Health Services HEDIS measure to demonstrate that members have a preventive screen or a visit to a health care provider at least annually. All HEDIS rates are reviewed and analyzed annually as part of the regular quality improvement process.

- PrimeWest Health will utilize Structure and Process SNP 3 submission to demonstrate that at least two measures in the HEDIS Effectiveness of Care domain have significant improvement as shown through Structure and Process SNP 3 scoring. All HEDIS rates are reviewed and analyzed annually as part of the regular quality improvement process.
- Annually, PrimeWest Health reports the HEDIS Plan All-Cause Readmissions measure. This measure is collected and analyzed annually to determine performance and is compared to national benchmarks as part of the quality improvement process.
- For Clinical Practice Guidelines, PrimeWest Health will measure performance annually against at least two important aspects of the following categories of practice guidelines: acute or chronic medical condition, behavioral health condition, and preventive health. This is done through HEDIS rates and CAHPS survey questions to determine if providers are following clinical practice guidelines and to improve practitioner performance. PrimeWest Health monitors the ICP to determine when these services are not appropriate (i.e., due to disability).

Annual Care Plan Audit and Report: The annual care plan audit is a sampling methodology audit that uses an audit protocol based on best practices and contractual, State, Federal, and NCQA requirements. The audit elements that are reviewed and determined to be met or not met and that are used to assess and track the outcomes are the following:

- Documentation demonstrating that preventive care has occurred in the following areas, or documentation of the member's refusal, or clinical contraindication in any of the following areas of the ICP: annual physical, mammogram, prostate screen, cervical cancer screen, colorectal cancer screen, immunizations (flu, pneumonia, tetanus), annual dental exam, annual eye exam, annual hearing exam, and fall prevention.

Goal 5: Processes and Procedures to Determine Outcome – Assuring Appropriate Utilization of Services
Healthcare Effectiveness Data Information Set (HEDIS): HEDIS data is collected annually and used to evaluate performance as part of the quality improvement process. This includes elements of Structure and Process Standard SNP 3 and clinical practice guidelines.

- Inovalon™ software is used to process encounter data and calculate the rates. Inovalon™ also incorporates the chart chase results that are sent from Optum. Optum is a vendor contracted for conducting chart reviews for hybrid HEDIS measures. MetaStar is contracted as the certified HEDIS auditor. Once the rates have been

finalized, they are submitted to the Minnesota Department of Health (MDH) and CMS. PrimeWest Health's Data Coordinator develops internal reports of the rates, comparing them with prior years and with other Minnesota health plans as well as national benchmarks. Some of the HEDIS data is sent to Minnesota Community Measurement to be included in the State's provider profiling system. PrimeWest Health utilizes appropriate HEDIS measures to demonstrate that members receive a preventive screen or visit to a health care provider at least annually.

- Following the process above, PrimeWest Health will utilize Structure and Process submission SNP 3 to demonstrate that at least two measures in the Effectiveness of Care domain will have significant improvement as demonstrated by a Structure and Process SNP 3 submission scoring of 80 percent or above. All HEDIS rates are reviewed and analyzed annually as part of the regular quality improvement process.
- Following the process above, the Plan All-Cause Readmissions measure is collected and analyzed annually to determine performance and will be compared to national benchmarks as part of the quality improvement process.
- Following the process above and utilizing the specific measures below, PrimeWest Health follows ***NCQA Standards and Guidelines for the Accreditation of Health Plans*** Standard QI 9: Practice Guidelines, to track the outcomes of practice guidelines. PrimeWest Health will measure performance annually against at least two important aspects of the following practice guidelines:
  - A clinical practice guideline for an acute or chronic medical condition
    - PrimeWest Health has adopted American Diabetes Association (ADA) Treatment Guidelines
    - Comprehensive Diabetes Care (CDC) HgbA1c control (<8 percent) HEDIS measure will be used for annual performance measurement
  - A second clinical practice guideline for an acute or chronic medical condition
    - PrimeWest Health has adopted the Journal of the American Medical Association (JAMA) Guideline for the Management of High Blood Pressure in Adults
    - Controlling High Blood Pressure (CBP) HEDIS measure will be used for annual performance measurement
  - A clinical practice guideline for a behavioral health condition
    - PrimeWest Health has adopted the American Psychiatric Association (APA) Chemical Dependency Guidelines
    - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) HEDIS measure will be used for annual performance measurement
  - A second clinical practice guideline for a behavioral health condition
    - PrimeWest Health has adopted the Institute for Clinical Systems Improvement (ICSI) Guidelines for Depression, Adult in Primary Care
    - Antidepressant Medication Management (AMM) HEDIS measure will be used for annual performance measurement
  - A preventive health guideline
    - PrimeWest Health has adopted ICSI guidelines for Preventive Services for Adults
    - Colorectal Cancer Screening (COL) HEDIS measure will be used for annual performance measurement

- A second preventive health guideline
  - PrimeWest Health has adopted ICSI guidelines for Immunizations
  - Flu Vaccinations, which is collected through CAHPS, will be used for annual performance measurement

PrimeWest Health will collect and analyze data to determine practitioner adherence to adopted guidelines and improve practitioners' performance. In many cases the member's individual medical circumstances may indicate the test or services are not appropriate for them. In these cases, the ICP reflects the reason for the variation from the clinical practice guidelines. This is reviewed in the annual care plan audit and report, which is described below.

Annual Care Plan Audit and Report: PrimeWest Health conducts the care plan audit annually. The auditors provide the counties with the option of an on-site or off-site audit. Using the "8/30" review method, PrimeWest Health auditors send each county a list of eight randomly selected members. The county provides PrimeWest Health auditors with the ICP, HRA, and case notes for the member. All documentation is used to determine whether the elements are met or not met. If any element is not met, an additional 22 charts are reviewed to see if that element is not met in additional charts. If more are found, a deficiency is given to the county regarding the unmet element and a CAP is developed by the county to remediate the deficiency. The results of the audit are given to the Complex Care & Disease Management Manager who compiles the results, documents the findings, and evaluates the results in the Model of Care Review and Monitoring Summary.

Goal Attainment – Assuring Appropriate Utilization of Services
The goal for appropriate utilization and preventive and chronic care is if all six measurable outcomes are met using the standards of assessment and evaluation identified for this goal.

Goal 5: Actions Taken for Goals Not Attained – Assuring Appropriate Utilization of Services
Provider compliance with stated preventive care HEDIS measures and clinical guidelines is required through contractual obligations with PrimeWest Health. Provider profiling reports are analyzed for preventive service outliers in conjunction with care plan analysis to identify areas where services are contraindicated due to a member's disability. Issues will be addressed through collaborative efforts involving the PrimeWest Health Chief Senior Medical Director, Corporate Compliance Officer, Provider Network Administration staff, and the identified provider. Additional education and coding practices will be considered. This could include requiring additional education on an individual or clinic basis, or, depending upon the severity of the identified issues, a CAP and/or termination of the provider from the PrimeWest Health contracted network. Areas of improvement identified are added to the Annual Quality Work Plan with interventions and objectives to meet the goal identified.

In addition, general education will be provided to members, providers, and CCMs through several options, which may include, but are not limited to, the following:

- Articles will be published in member and provider newsletters

- Updates will be made on the website
- Individual letters will be sent to members reminding them of the recommended preventive visit(s)
- CCMs will help members access and schedule preventive visits and/or screens

If it is determined that identified outcomes are not being met, PrimeWest Health will conduct medical record audits, continued monthly monitoring of administrative data, and/or development of ad hoc reports. Education will be provided to members, providers, and CCMs through several options, which may include, but are not limited to, the following:

- Articles will be published in member and provider newsletters
- Updates will be made on the website
- Individual letters will be sent to members reminding them of the appropriate age and gender screenings

CCMs (and other identified ICT members) will update the existing ICP and services for the members to ensure that members have the necessary resources and services to manage their conditions effectively. The annual care plan audit and report process includes using the NCQA 8/30 rule to evaluate the care plans. After review, an exit interview is performed to alert each county of the findings, which may include a CAP if necessary. PrimeWest Health's Corporate Compliance Officer assists in formal completion and remedy of the CAP.

All results and actions of the annual care plan audit will be reviewed by the following at least annually:

- PrimeWest Health Management Team
- QCCC
- PH/HS Committee
- JPB
- Providers (at provider meetings)

PrimeWest Health communicates information about the goals and outcomes in two waves. The first wave is regarding the goals of the Model of Care. These are communicated through the Model of Care Training, which is required for all partners and staff within the organization as well as providers. Within PrimeWest Health, the training is provided face-to-face to the following groups:

- JPB
- QCCC
- Stakeholders Committee
- Executive Committee
- PH/HS Directors and Supervisors
- Staff

CCMs receive the training during a live webinar and are required to review the Model of Care available on the PrimeWest Health website, attest to their review, and send a signed copy of the attestation to PrimeWest Health.

The second wave of communication is regarding the outcomes of the Model of Care goals. A Model of Care Review and Monitoring Summary report is completed and documents the outcomes of the goals and performance of the Model of Care. See Chapter 4, Section D: Ongoing Performance Improvement Evaluation of the MOC. This report is reviewed face-to-face with the organizations and entities mentioned previously.

C. Measuring Patient Experience of Care (SNP Member Satisfaction)

Describe the specific SNP survey(s) used and the rationale for selection of that particular tool(s) to measure SNP beneficiary satisfaction.

In addition to the fact that the following surveys are regulatory requirements, PrimeWest Health uses the information to gauge member satisfaction, identification of opportunities to improve, and incorporates the results in the quality improvement process.

Member Satisfaction Surveys
Member surveys provide direct information about member perceptions of actual experiences and guide PrimeWest Health's efforts to make improvements in service delivery at both the system as well as the provider level. Results are reported by the Director of Quality & Utilization Management or Manager of Quality Management to QCCC and the JPB at least annually or when results are available, as in the case of HOS. Member surveys include those conducted both externally and internally.

Surveys Conducted Externally

1. ***Consumer Assessment of Healthcare Providers and Systems (CAHPS)***
   a. The CAHPS is required by DHS. The CAHPS survey is conducted annually by DHS through a certified vendor, DataStat, for all PrimeWest Health populations including Prime Health Complete. The primary goal of Minnesota's statewide survey project is to collect data for the purpose of quality improvement activities.
   b. The CAHPS questionnaire covers the following composites of member experience: Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Customer Service. Additional questions address who helps coordinate care, demographics, Internet use, tobacco use, and flu and pneumonia vaccines.
   c. DHS provides results to PrimeWest Health annually. PrimeWest Health analyzes and compares rates to State benchmarks and determines strengths and areas in need of improvement as part of its regular quality improvement process.

2. ***Health Outcomes Survey (HOS)***
   a. HOS is administered to dual eligible plan members using a CMS-selected sample. It collects information on dually eligible members, age 18 and over, living in the community or institutionalized, to calculate frailty factors that are used by CMS, in addition to the diagnosis-based risk adjustment formula, to determine health plan payment rates. The HOS is also used to assess a health plans' ability to maintain or improve the physical and mental health functioning of its dually eligible members.

b. The survey was designed by CMS and NCQA. CMS determines the sample from members enrolled in Prime Health Complete. The survey is conducted by DataStat, Inc., a CMS-certified organization, on PrimeWest Health's behalf. The data is cleaned and analyzed for dissemination among the health plans. NCQA monitors and assesses survey vendor performance. The survey is administered to a random sample of members at the beginning (baseline survey) and end (follow-up survey) of a two-year period. A new baseline sample is surveyed annually.
c. Physical health status and mental health status are measured in the Medicare HOS 2.0 with the Veterans RAND 12-Item Health Survey (VR-12). The VR-12 consists of 14 items, 12 of which are used in the calculation of the eight health domains and the two summary measures: the physical component summary (PCS) and mental component summary (MCS) scores. The VR-12 measures the same eight health domains as the 36-item health survey: 1) Physical functioning, 2) Role-Physical, 3) Role-Emotional, 4) Bodily Pain, 5) Social Functioning, 6) Mental Health, 7) Vitality, and 8) General Health.
d. Individual member level data is not provided to plans after baseline data collection. However, organizations receive the following from CMS:
    i. HOS Baseline Profile Report: This profile is made available to all plans participating in the previous year's baseline cohort. This quality improvement tool presents an aggregate overview of the baseline health status of each MAO's Medicare members. Using data from the HOS to plan and conduct a QIP may fulfill one of the QI program requirements. All report distribution occurs electronically through HPMS.
    ii. HOS Performance Measurement Report and Data: After the administration of each follow-up cohort, a cohort-specific performance measurement report is produced. Survey responses from baseline and follow-up are merged to create a performance measurement data set. The HOS performance measurement results are computed using a rigorous case mix/adjustment model. The resulting aggregation of these scores across members within a plan yields the HOS plan level performance measurement results. The performance measurement reports and corresponding data results are designed to support MAO quality improvement activities. A HOS performance measurement report is not available for the Prime Health Complete population.

Surveys Conducted Internally

1. ***Member Satisfaction with Case Management System Survey***
    a. This survey is conducted by PrimeWest Health annually to measure Prime Health Complete members' level of satisfaction with their CCM(s).
    b. The survey comprises 17 questions regarding case management. The questions include some of the following:
        i. Do you know how to contact your case manager?
        ii. Does your case manager listen to you and respond to you?
        iii. Does the case manager understand your needs?
        iv. Does the case manager understand the plan benefits and access?
        v. Does the case management help you live in the least restrictive environment?
        vi. What is your overall satisfaction with case management?
        vii. Rate your overall quality of health
        viii. All my health care needs are met

2. ***Chronic Care Improvement Program Satisfaction Survey***
    a. This survey is conducted by PrimeWest Health annually to measures members' level of satisfaction with the CCIP.
    b. The survey comprises eight questions regarding case management. The questions include the following:
        i. Did you get disease-specific information over the last year?
        ii. Did you learn anything new from the information?
        iii. Did you make an appointment with your health care provider because of the information you received?
        iv. Is there anything you would like PrimeWest Health to do to help you learn more about managing your disease?

Survey results, including national and local comparisons, are reported to QCCC on an annual basis. QCCC evaluates results and determines priority areas for improvement that are incorporated into the annual Quality Work Plan.

Rationale for Tool Selection

CAHPS is required by DHS and is implemented statewide. This report has a significant level of detail that provides PrimeWest Health with the ability to compare members' satisfaction and other pertinent information with State levels. The CAHPS provides PrimeWest Health with detail on the members' perception of care in areas like rating of health plan and providers, rating of getting the care needed, communication with their provider, member education level, member access to technology, vaccinations, and their overall perception of their current health. This survey was chosen because it provides information that helps define our members and guides PrimeWest Health's decisions about future projects and program development.

HOS is also required by CMS for plans that meet the enrollment size criteria and is implemented nationally. HOS is utilized to calculate a frailty factor for the Prime Health Complete population. This report also provides a significant level of detail that augments the CAHPS. The HOS includes a different set of questions that focus on pain, ADLs, IADLs, chronic conditions, health and wellness, health literacy, cultural needs, caregiver status, and income. As the Prime Health Complete population does not receive a HOS Performance Measurement Report, but only Baseline reports, State and national comparisons are not available. However, PrimeWest Health can compare rates to previous years for benchmarks. This survey was chosen because it provides members' perception of their health condition and risk factors, which, when coupled with the CAHPS, gives a broader picture of our members and how they are defined. This, in turn, helps guide PrimeWest Health's decisions about future projects, improvement opportunities, and program development.

Member Satisfaction with Case Management System Survey is required by PrimeWest Health's contract with DHS. This survey was designed by the Prime Health Complete Disability Team and focuses on the following aspects of case management services: how they have helped members; whether members know how to access them; are the members' health needs being met; do members know what their benefits are; and how to access case management to maximize their benefits and improve their health. This survey was developed to provide PrimeWest Health

with insight and evaluation of how the current county case management program is working to meet the needs of the members and identify opportunities for improvement and further case management program development.

Chronic Care Improvement Program Satisfaction Survey is required by PrimeWest Health's contract with DHS. This survey was designed by PrimeWest Health Complex Care & Disease Management Manager and focuses on the following aspects of CCIP services and information: how the services and information have helped members; whether members learned more about their diseases from the information and services; if members made appointments with their primary care providers due to the information received; and whether members need any further assistance managing their diseases. This survey was developed to provide PrimeWest Health with insight and evaluation of how the current CCIP is working to meet the identified needs of the members and identify opportunities for improvement and further CCIP development.

These surveys are utilized because they provide direct information about members' perceptions of actual experience and guide PrimeWest Health's efforts to make improvements in service delivery at both the system and provider level.

Explain how the results of SNP member satisfaction surveys are integrated into the overall performance improvement plan, including specific steps to be taken by the SNP to address issues identified in response to survey results.

CAHPS

CAHPS results are reviewed annually with appropriate staff including the Director of Membership & Program Development, Director of Care Management, Director of Quality & Utilization Management, Director of Provider Network Administration, Chief Executive Officer, Chief Senior Medical Director, and their assigned staff. Areas of strengths and weaknesses are identified and interventions are chosen for areas needing improvement. Interventions are added to the annual Quality Work Plan, monitored by the Manager of Quality Management, and reviewed quarterly at QCCC to monitor progress. The Annual Quality Assessment is a written summary of the items in the Quality Work Plan and summarizes the efforts related to interventions identified through the CAHPS. In addition, the Structure and Process measures use information from the CAHPS survey to analyze member satisfaction. During the analysis process, our Data Coordinator identifies the strengths and weaknesses from the results of the survey and formulates a summary report of the CAHPS. The evaluation of the strengths and weaknesses is conducted through a formalized Quality Workgroup. This committee is made up of staff from each department, including directors, managers, and other assigned staff. The Quality Workgroup reviews the report and evaluates the strengths and weaknesses, identifies opportunities for improvement and makes recommendations for improvement opportunities. Recommendations are made for each identified area of improvement and then added to the Quality Work Plan. Each area of opportunity is reviewed for root cause/underlying issue, interventions are analyzed and developed, outcome measures are defined, a time frame is established, a responsible party is assigned, and routine monitoring of the progress is documented. The committee makes recommendations regarding action and these recommendations will follow one of the following avenues of improvement process:

- QIPs/PIPs
- CAPs
- Focus studies
- Intervention strategies

The chosen path for monitoring the progress of the implementation and follow through is documented in the Quality Work Plan and reviewed quarterly by QCCC and the Quality Workgroup. If adequate progress is not being made, the Quality Workgroup reviews, evaluates for barriers to progress, and makes alternative recommendations for an approach that will obtain the desired outcome.

HOS

HOS results are reviewed annually with appropriate staff including the Director of Membership & Program Development, Director of Care Management, Director of Quality & Utilization Management, Director of Provider Network Administration, Chief Executive Officer, Chief Senior Medical Director, and their assigned staff. Areas of strengths and weaknesses are identified and interventions are chosen for areas needing improvement. Interventions are added to the annual Quality Work Plan, monitored by the Manager of Quality Management, and reviewed quarterly at QCCC to monitor progress. The Annual Quality Assessment is a written summary of the items in the Quality Work Plan and summarizes the efforts related to interventions identified through the HOS. The process for analyzing results and the steps to address opportunities for improvement and integration with the Quality Improvement Plan are the same for HOS as they are for CAHPS. See the previous paragraph for details.

Member Satisfaction with Case Management System Survey

The Complex Care & Disease Management Manager compiles the results of the Member Satisfaction with Case Management System Survey into an annual report that includes positive findings as well as potential areas for improvement. PrimeWest Health's Care Management staff review the overall results and compare them with our current case management process to find ways to increase or maintain current benchmarks in the area of member satisfaction with case management services. The identified areas for improvement are reviewed against the current PrimeWest Health benchmarks and are used as part of the quality improvement process to modify the current PrimeWest Health case management practices at the county levels. The Director of Care Management has oversight and final review of the report. This review and modification are used to improve identified areas of member satisfaction. This report, along with the annual Quality Work Plan, is reviewed with QCCC, the Stakeholder Committee, and the JPB for additional input and approval of the recommendations within the report. In addition, the Structure and Process measures use information from the survey to analyze member satisfaction. The Complex Care & Disease Management Manager reviews the results of the survey and identifies any element that scores below 95 percent. These items are then required to have an action plan identified in the Quality Work Plan. Each element requiring action is reviewed for the root cause/underlying issue, interventions are analyzed and developed, outcome measures are defined, a time frame is established, a responsible party is assigned, and routine monitoring of the progress is documented with oversight and final review by the Director of Care Management. The action to be taken is determined through a combined effort of county PH/HS directors and supervisors, and may include the following options:

- Process evaluation and changes
- PIPs
- Focus studies
- CAPs
- Intervention strategies

The chosen path for monitoring the progress of the implementation and follow through is documented in the Quality Work Plan and reviewed quarterly by QCCC. If adequate progress is not being achieved, PrimeWest Health will determine the root cause and develop interventions as appropriate. Results and planned interventions are reviewed by both QCCC and the PH/HS directors at the next scheduled meeting. Alternative recommendations are made, if appropriate, to obtain the desired outcome.

Chronic Care Improvement Program Satisfaction Survey

The Complex Care & Disease Management Manager compiles CCIP Survey results into an annual report that includes positive findings as well as potential areas for improvement. PrimeWest Health's Quality & Utilization Management staff and the Director of Care Management review the overall results and compare them with our previous year's rates to identify opportunities to improve or maintain current benchmarks in the area of member satisfaction with the CCIP. The identified areas for improvement are reviewed against the current PrimeWest Health benchmarks and are used as part of the quality improvement process to modify current PrimeWest Health CCIP practices. This review and modification is used to improve identified areas of member satisfaction. This report, along with the annual Quality Work Plan, is reviewed with QCCC, the Stakeholder Committee, and the JPB for additional input and approval of the recommendations within the report. The Complex Care & Disease Management Manager reviews the results of the survey and identifies if improvements were made from the previous year and whether the satisfaction level is below 95 percent. If so, an action plan is required and integrated in the Quality Work Plan. Each element requiring action is reviewed for root cause/underlying issue, interventions are analyzed and developed, outcome measures are defined, a time frame is established, a responsible party is assigned, and routine monitoring of the progress is documented. The action to be taken is determined through a combined effort of the Director of Care Management and the Manager of Quality Management and may include the following options:

- Process evaluation and changes
- PIPs
- Focus studies
- CAPs
- Intervention strategies

The chosen path for monitoring the progress of the implementation and follow through is documented in the Quality Work Plan and reviewed quarterly by QCCC. If progress is not being made, the Manager of Quality Management discusses at the next scheduled managers' meeting, analyzes for barriers to progress, and makes alternative recommendations for an approach that will obtain the desired outcome. In addition, results of this survey are provided to CMS via HPMS during annual updates to the CCIP.

All of the member surveys, recommendations, and interventions are reviewed by QCCC and the JPB annually. Stakeholders and PH/HS directors and supervisors review these as well.

D. Ongoing Performance Improvement Evaluation

Explain, in detail, how the SNP will use the results of the quality performance indicators and measures to support ongoing improvement of the MOC, including how quality will be continuously assessed and evaluated.

PrimeWest Health uses the following tools to gather quality performance indicators and measures to support ongoing improvement of the Model of Care: the Quality Work Plan, the Annual Quality Assessment, and the Model of Care Review and Monitoring Summary annual report. Each of these tools is described in detail below.

Quality Work Plan
PrimeWest Health develops an annual Quality Work Plan that identifies specific activities, programs, and studies that support the Quality Plan, organizational goals, and objectives. The Model of Care measurable improvement goals are included so they can be tracked and the results and recommendations can be assessed. Many of these activities are carried over from year to year to continuously assess, monitor, trend, and evaluate progress towards goals over time, particularly regulatory measurements and reporting requirements. However, each year, new activities, programs, and studies are added based on new and identified data to support the ongoing health needs of the Prime Health Complete population. Many of these needs are identified in the review and evaluation of the Model of Care and its goals. The annual Quality Work Plan is developed based on current regulatory requirements, the results of the annual quality evaluation, the review and evaluation of the Model of Care, and input from PrimeWest Health committees, providers, and members.

The Quality Work Plan provides documentation and preserves evidence of the program area, goals and objectives, measurements, interventions, identified barriers, staff responsible for specific activities, and the final analysis used to evaluate the effectiveness of the care provided to all Prime Health Complete members.

The Quality Work Plan includes the following activities designed to improve care and access for Prime Health Complete members:

- Monitor elements that can affect access to care or delivery of care
- Improve processes and workflows
- Adjust staffing patterns or personnel
- Improve or expand the provider network

Annual Quality Assessment
Annually, PrimeWest Health evaluates the effectiveness of the quality program by reviewing the Quality Assurance Plan and the results of the annual Quality Work Plan activities. Using the Quality Assurance Plan's goals and objectives as criteria, the quality improvement activities for the year are evaluated by the Director of Quality & Utilization Management and Chief Senior

Medical Director with input from the Director of Care Management, Quality Workgroup, and QCCC for appropriateness and effectiveness in assessing and improving the quality of care provided to Prime Health Complete members. Final recommendations are made by the Director of Quality & Utilization Management to the JPB for final approval. PrimeWest Health's annual evaluation is a written analysis document that provides a documented summary of all activities identified in the Quality Work Plan, conducted organization-wide. A high level overview of the annual evaluation of the Model of Care is included in the Annual Quality Assessment and a detailed evaluation is presented in the Model of Care Review and Monitoring Summary annual report as described per the processes below.

1. The annual evaluation provides a detailed, written report based on measurable data and objectives that address the elements identified in the annual Quality Work Plan. Each reporting area includes a description of completed and ongoing activities; documentation and processes to identify trending of measures to assess quality and safety of clinical care and quality of service; analysis, including barrier analysis; and recommendations for improvement.
2. The results of the annual quality evaluation are reported to all committees that support the quality process and presented to the JPB for final approval.
3. The written Quality Assurance Plan will be amended when there is no clear evidence that the program continues to be effective in improving care and safety of the services provided to Prime Health Complete members.
4. Evaluations and recommendations from regulatory agencies and other external quality review organizations are also considered in assessing the strength of the PrimeWest Health quality program.
5. Mechanisms to identify under- and over-utilization of services are in place, tracked, monitored, and evaluated through various quality committee reviews.
6. Thresholds based on historical data are also established in the UM plan to identify under- and over-utilization of services, or changes in access, structure, or operations that may affect the health care and safety of Prime Health Complete members. This supports the ongoing analysis and evaluation processes for continuous quality improvement with this population.

Model of Care Review and Monitoring Summary Annual Report

Annually, PrimeWest Health evaluates the effectiveness of the Model of Care by reviewing the Model of Care Review and Evaluation Worksheet and the results of the Model of Care Review and Monitoring Summary report. Using the Model of Care goals and objectives as criteria, the quality improvement activities for the year are evaluated for appropriateness and effectiveness in assessing and improving the quality of care provided to Prime Health Complete members and meeting the goals established in the Model of Care. PrimeWest Health annual evaluation is a written document that provides a documented summary of all activities identified in the Model of Care, conducted organization-wide. The annual evaluation of the Model of Care is included in the Annual Quality Assessment.

1. The annual review and monitoring provides a detailed, written report based on measurable data and objectives that address the elements identified in the Model of Care. Each reporting area includes a description of completed and ongoing activities for each chapter in the Model of Care and reviews the following documentation:
    a. Policies and procedures
    b. Member materials

c. PrimeWest Health reports
d. CMS reports
e. DHS reports
f. Workflows
g. Examples
h. Case management documentation
i. PowerPoint presentations
j. Practice guidelines
k. Annual Quality Assessment report

2. The results of the Model of Care Review and Monitoring Summary are reported to all committees that support the quality process and the JPB.
3. The written Model of Care is reviewed and updated at least annually to ensure that it still meets the needs of the members and their caregivers.

PrimeWest Health quality improvement program activities, reports, and documentation, including the Model of Care, are maintained in accordance with regulatory requirement, electronically, for 10 years in the PrimeWest Health data warehouse, which is backed up hourly. PrimeWest Health uses a number of internal software tracking programs to document the planning, documentation and reporting, analysis, and recommendations identified throughout the organization. Specific programs are used for the following purposes: project development and activity; policy and procedure development, review, and approval, and to provide staff access to current policies and procedures; care management system to document and track member activities and Service Authorizations; claims processing system; internal staff communication via an intranet system, which also allows for tracking meeting notes, consistent forms, and documentation throughout the organization; and a data system to collect and extract claims information for more complete analysis of trends and service usage.

PrimeWest Health quality improvement project documents and information are securely stored in an electronic format and are available to CMS, DHS, and MDH per regulatory and contract requirements or upon request.

Describe the SNP's ability to improve, on a timely basis, mechanisms for interpreting and responding to lessons learned through the MOC performance evaluation process.

Any time an area is identified as an opportunity for improvement on the Model of Care Review and Monitoring Summary report or as the data is available for evaluation, the Model of Care Workgroup, which includes representatives from each department, meets to review the results of the summary. In addition, the Model of Care Workgroup ensures processes and Model of Care goals are reviewed and the identified opportunities for improvement are implemented in a timely manner. Through reports, the ongoing evaluation process designed to evaluate outcomes of the Model of Care provides PrimeWest Health with information in a timely manner so a plan can be implemented immediately as needed and as changes occur. The team utilizes the following steps to develop a plan to improve the areas identified:

- Root cause/underlying issues are evaluated
- Interventions are analyzed, modified, and/or developed
- Outcome measures are re-evaluated and redefined if appropriate

- Time frame for accomplishment is specified
- Responsible staff is assigned
- Routine progress monitoring is developed

The Model of Care Workgroup utilizes the PDSA cycle to coordinate continuous quality improvement activities related to the Model of Care goals. If initial interventions do not result in the expected improvements identified through the Model of Care or other quality improvement activities, the plan of action is revised and continued until desired results are achieved as identified earlier in this section. The plan of action identified by the Model of Care Workgroup is then added to the Quality Work Plan.

When the PrimeWest Health Model of Care Workgroup determines that an established goal, process, policy, or plan is not being met at the end of the Model of Care approval time frame, an internal CAP is implemented and the Corporate Compliance Officer is responsible for oversight of the progress towards remediation of the CAP. The director(s) who supervise members of the Model of Care Workgroup who are affected by the CAP are responsible to ensure the plan is developed, implemented, and timelines established.

Lessons Learned
The Model of Care Review and Monitoring Summary report is used as a guide to make necessary modifications to the existing Model of Care via a red-lined version to ensure that processes that are identified as needing to be changed to be effective are fully addressed and the lessons learned are documented and communicated to the appropriate SNP stakeholders.

Describe how the performance improvement evaluation of the MOC will be documented and shared with key stakeholders.

Performance Documented
The performance of PrimeWest Health's Model of Care is documented in a high level overview summary included annually in the Annual Quality Assessment. It is also documented in detail in the Model of Care Review and Monitoring Summary report, which is attached to the Annual Quality Assessment provided to State regulators. A high level summary of this report is available upon request in written format and/or posted on the PrimeWest Health website (member, provider, community, etc.) for stakeholders, with a focus primarily on the goal performance and recommendations for improvement. The full report can be requested by stakeholders from either Provider Network Administration or the Member Services Contact Center and will be sent either electronically or printed and mailed to the requestor.

Shared with Stakeholders
The performance evaluation of the Model of Care is shared internally within PrimeWest Health via all-staff meetings. It is also shared with QCCC, the JPB, PH/HS directors and supervisors, and the Member Stakeholder Group. Members and providers are made aware of this information through various means including newsletters, website postings, targeted mailings, provider trainings, provider portal, and provider email blasts. The ***Quality Improvement Progress Report*** is a provider-specific document that addresses all of the quality activities that PrimeWest Health has completed during the year and their results.

The performance of the Model of Care is summarized and mailed to all contracted providers, posted on the PrimeWest Health website, and providers are sent an email blast alerting them of this posting. The ***Annual Report*** is a member-specific document that addresses the quality activities PrimeWest Health has completed during the year and their results. This is mailed to all members and posted on the PrimeWest Health website.

E. Dissemination of SNP Quality Performance

Explain, in detail, how the SNP communicates its quality improvement performance results and other pertinent information to its multiple stakeholders including, but not limited to: SNP leadership, SNP management groups, SNP boards of directors, SNP personnel & staff, SNP provider networks, SNP beneficiaries and caregivers, the general public, and regulatory agencies on a routine basis.

The PrimeWest Health Director of Care Management, Director of Quality and Utilization Management, and Chief Senior Medical Director are ultimately responsible for ensuring that information related to any and all PrimeWest Health quality activities is communicated in a timely manner to the appropriate SNP stakeholders.

PrimeWest Health SNP stakeholders include the following:

- DHS
- MDH
- CMS
- SNP stakeholders group
- PH/HS directors
- PH/HS county case management supervisors
- PrimeWest Health CCMs
- PrimeWest Health JPB
- PrimeWest Health employees
- PrimeWest Health contracted providers
- PrimeWest Health members

PrimeWest Health communicates all quality program activities, including quality improvement performance results and Model of Care analysis to multiple stakeholders at least annually and more often as indicated. Methods of communication and frequencies are as follows:

- Website postings
- Formal, scheduled routine meetings
  - Every other month PH/HS Committee meetings
  - Monthly JPB meetings
  - Every other month CCM supervisor meetings
  - Monthly PrimeWest Health Quality Workgroup meetings
  - Every other month QCCC meetings
  - Monthly SNP staff and management meetings

  - Weekly executive meetings
  - Provider Lunch and Learn sessions
  - Field site clinic visits conducted by either PrimeWest Health care coordinators and/or Provider Network Administration staff
- SNP stakeholder meetings, twice each year with members, caregivers, and providers (primary care and PH/HS personnel)
- Written communication
  - Monthly CCM newsletter, ***PrimePartners***
  - Quarterly provider newsletter, ***PrimePointers***
  - Formal analysis reports sent annually to providers, QCCC, JPB, and external regulators
  - The ***Quality Improvement Progress Report***, mailed to all contracted providers annually
- Ad hoc communication with stakeholders through other electronic means such as email, the PrimeWest Health web portal, and/or scheduled webinar trainings

PrimeWest Health also communicates its quality improvement performance results at least annually via the ***Annual Report***, which is included in the Summer issue of ***PrimeLines,*** the quarterly member newsletter mailed to all members. ***PrimeLines***, targeted mailings, and website postings are used to communicate other pertinent quality improvement information to members. Annually, Prime Health Complete members receive a summary of the Model of Care focusing on how the Model of Care can be used to improve their health outcomes. Instructions for accessing a copy of the full Model of Care document are included in the summary.

See Chapter 2, Section A: SNP Staff Structure, for additional information on Model of Care training for personnel, and Chapter 3, Section C: MOC Training for the Provider Network, for Model of Care training for providers.

This description must include, but is not limited to, the scheduled frequency of communications and the methods for ad hoc communication with the various stakeholders, such as: a webpage for announcements; printed newsletters; bulletins; and other announcement mechanisms.

The PrimeWest Health Director of Care Management and the Chief Senior Medical Director are responsible for ensuring that information about improvements and quality performance results, including the Model of Care, is made available to providers, members, PrimeWest Health staff, QCCC, the JPB, PH/HS agencies, and all other stakeholders at a minimum of annually and more often if appropriate. PrimeWest Health reports the evaluation and quality improvement performance results at least annually and as changes are identified.

Primary methods to communicate this information and any ad hoc reports include the following:

- Reports to committee meetings committee meetings, scheduled monthly, quarterly, or annually
- Formal member and/or provider newsletters, monthly and/or quarterly
- Intermittent targeted mailings as needed

- SNP stakeholder meetings twice a year
- Monthly on-site clinic/provider meetings or scheduled provider Lunch and Learn sessions
- Electronic communications using PrimeWest Health's website (member, provider, community), provider web portal, and email where available and as needed

Identify the individual(s) responsible for communicating performance updates in a timely manner as described in MOC Element 2A.

The PrimeWest Health Director of Care Management, Director of Quality & Utilization Management, and the Chief Senior Medical Director are ultimately responsible for ensuring that information related to any and all PrimeWest Health quality activities are communicated in a timely manner to the appropriate SNP stakeholders as previously identified.

The following PrimeWest Health staff assist with the responsibility for communicating quality performance updates in a timely manner:
1. Complex Care & Disease Management Manager
2. Manager of Quality Management
3. Corporate Compliance Officer
4. Provider Network Administration representatives
5. Member Service representatives

PrimeWest Health JPB
The JPB provides oversight for any delegated activities to ensure compliance with PrimeWest Health and applicable regulatory requirements. The CEO has been charged with administration of organizational processes and the selection of qualified and capable staff to oversee and manage daily operations, which include the communication of the quality performance results of the Model of Care.

The JPB has delegated monitoring and oversight functions to committees such as QCCC, PRC, and the UM Committee. These groups are structured to include JPB representation, providers, practitioners, community members, and PrimeWest Health staff.

Oversight and monitoring of the effectiveness of the Model of Care is delegated to staff with the expertise, experience, and skills, individually and collectively, to improve performance and to communicate the improvements to identified stakeholders. Staff and committees work together within and across departments to identify opportunities for improvement and to develop intervention strategies to improve the effectiveness of the Model of Care. Detailed staff information is provided in Chapter 2, Section A: SNP Staff Structure. The staff structure and roles detailed in Chapter 2, Section A: SNP Staff Structure, include personnel with oversight responsibility for monitoring and evaluating the effectiveness of the Model of Care.