HealthPartners®

Quality Improvement Program Evaluation 2022

June 2023

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Executive Summary

Mission: Why We Are Here

To improve health and well-being in partnership with our members, patients and community

Vision: Where We Are Headed

Health as it could be, affordability as it must be, through relationships built on trust

Values: How We Act

- *Excellence*
- *Compassion*
- *Partnership*
- *Integrity*

Integration of Quality, Population Health and Utilization Management

To support the Triple Aim values of health, experience and affordability, HealthPartners integrates our quality improvement, population health management and utilization management functions. We can better serve our members because quality, health and experience are integrated across these strategies and programs. To support this approach, we have consolidated our utilization management program into our Annual Health Plan Quality Evaluation. We also include our Utilization Management (UM) Program Description as an attachment to our Quality Program Description. Our Annual Evaluation includes topics demonstrating this integration with UM such as Emergency Department Utilization, Reducing Hospital Admissions and Readmissions, a report on the Experience with the Utilization Management Process and our Financial Affordability/Stewardship initiatives. The HealthPartners Quality Council reviews and approves the Annual Quality Plan, Quality Program Description, Annual Evaluation, Population Health Management Program Description and Population Health Reports at various times during the year. Consistent reporting structure ensures our programs remain aligned. All these reports articulate our Triple Aim approach towards program administration.

HealthPartners approach to improving health equity and offering culturally and linguistically appropriate services (CLAS) aligns NCQA's "Big Idea":

- Quality care is equitable care
- No quality without equity,
- Build equity into all programs

We have structurally aligned service quality improvement and CLAS programs into our existing Service Quality Council rather than creating a separate committee structure or designated specific staff for each of these activities.

Health Improvement Outcomes

Performance on publicly reported measures

- HealthPartners has once again been recognized by the National Committee for Quality Assurance (NCQA) as one of the top-rated health plans in Minnesota and among the highest-rated plans in the nation. We earned a rating of 4.5 out of 5, according to the NCQA's commercial Health Plan Ratings for 2022. This is the 18th year in a row that NCQA recognized us as the highest or one of the highest performing plans in the state.

- The NCQA awarded HealthPartners "excellent" accreditation status for its health maintenance organization (HMO), point-of-service (POS) and preferred provider organization (PPO) commercial plans in April 2020. In September 2020, NCQA transitioned to a new scoring system and HealthPartners NCQA accreditation was updated to “Accredited” which is the highest accreditation level that NCQA now designates.

- Last year, 62% of our commercial HEDIS measures are in the top 25% in the nation, with 31% in the top 10%.

- All HealthPartners Medicare plans were awarded an overall 5 out of 5-Star Rating from the CMS for 2022. These strong results mean all HealthPartners Medicare members across the health plan’s six-state service area – Minnesota, Iowa, Illinois, Wisconsin, North Dakota, and South Dakota – were enrolled in a 5-star plan for 2022.

- Plans that earned a 5-star rating include:
    - HealthPartners® Journey (PPO) and HealthPartners® Robin (PPO) Medicare Advantage
    - HealthPartners UnityPoint Health (PPO) Medicare Advantage
    - HealthPartners® Freedom (Cost)
    - HealthPartners® Minnesota Senior Health Options (MSHO) (HMO SNP)
    - HealthPartners® Retiree National Choice Prescription Drug Plan

Pharmacy quality measures

Due to our ongoing focus on quality improvement related to pharmacy, HealthPartners achieved remarkable results in 2022:

1. Overall unique members who participated in our Medication Therapy Management (MTM) program increased from 8,896 in 2021 to 10,992 in 2022 (23.6%). Total visits also increased from 15,426 in 2021 to 18,389 in 2022 (19.2%). Additionally, 97% of MTM participants would recommend the program to family/friends. This strong performance comes despite struggle with our network providers having sufficient resources to dedicate time to quality related activities.

2. We also saw strong progress reducing opioid use among our membership.
    a. From 4Q2021 through 4Q2022, the rate of chronic high dose (>= 120 mg MME) opioid use among HealthPartners members has decreased 14%.

b. From 4Q2021 through 4Q2022, the rate of chronic high dose (>= 90 mg MME) opioid use among HealthPartners members has decreased 14%.

3. In 2022, over $2 million in savings resulted from clinical interventions on high-cost cases driven by pharmacy spend. Of the $2 million, about $1 million in savings resulted from high-cost case management specifically prioritizing members where site of care or network contracting interventions were appropriate. HealthPartners received a national award for this program in September 2022 from PBMI (Pharmacy Benefit Management Institute), a research institute dedicated to assisting employer groups with optimizing their pharmacy benefits.

4. Effective 1/1/2022, we've expanded our relationship with OncoHealth so that all oncology drug requests are reviewed by an oncologist. This ensures appropriate use of cancer medications, improving quality, safety, and affordability.
    a. This program brings expert oncologists closer to prescribers for case reviews and supports our broader oncology programs and initiatives across the organization.
    b. Identifies alternative therapies with equal efficacy.
    c. Improves evidence-based care by covering drugs with strong literature support; educating providers with peer-to-peer consultations rather than automatically issuing a denial.
    d. Connects members to clinical trials for cancer types in which drug efficacy is not yet well-established.

Behavioral Health Performance and Initiatives

- Targeted Post Discharge Training: Behavioral health, inpatient, and restricted recipient program case managers participated in training with a focus on assessing for safe transitions of care and avoidance of risks related to readmission.

- Behavioral Health Lunch and Learns (PTSD, Borderline Personality Disorders, Depression, Anxiety, Bipolar disorder, Schizophrenia, Trauma Informed Care): Case managers received training on a series of behavioral health conditions to enhance their understanding of complications and risks for readmission.

- The 2022 goal for the behavioral health case management readmission rate was 16.1%. The 2022 measurement period results were 16.7% for members engaged in behavioral health case management. As we didn't achieve our goal, this continues to be an area of focus. All interventions for this initiative have been integrated into standard care coordination processes and this initiative will continue in 2023.

- To increase providers' knowledge of Behavioral Health Case Management as a resource for patients with mental health conditions who may have corresponding needs around social determinants of health, HealthPartners Behavioral Health Case Management leaders and staff presented on the Behavioral Health Case Management program to various primary care network providers and clinics. Throughout these presentations, providers were educated on and reminded of the nature of the HealthPartners Behavioral Health Case Management Program, including efforts Behavioral Health Case

Managers make to collaborate with and facilitate communication between behavioral health and primary care providers of members engaged in the program, and how providers can refer members for Behavioral Health Case Management.

Focusing on Health and Wellbeing

During 2021, we implemented a variety of tactics designed to improve overall member wellness:

1. Expanded myStrength digital resilience solutions to all member plans.
2. Implemented Omada diabetes prevention and condition management programs.
3. Increased Choice Card benefit for select Medicare plans services beyond what Medicare allows (chiropractic, eyewear, over-the-counter pharmacy items)
4. Offered NationsOTC over-the-counter benefit for select Medicare plans - either as a standalone benefit or as part of a Choice Card
5. Implemented an online mental health hub to promote our mental health resources and help members understand the resources available.
6. Added personalized resources within My Pregnancy experience based on member's race, ethnicity, language and/or insurance product.
7. Launched new personalized campaigns connecting members to NowPow and other social drivers of health resources for those who indicated a need via the health assessment.

Health Equity

HealthPartners engages in a broad array of initiatives designed to improve health equity including:

1. To better serve our African American population, HealthPartners has partnered with Healthy Black Pregnancies. This group provides professional expertise; knowledge of prenatal African American maternal and child health issues; knowledge of the African American community; and connections to local, national, and international resources and colleagues. Our Healthy Pregnancy care coordinators make referrals to their DIVA Moms program and other support services. In 2022, HP gifted Healthy Black Pregnancies a $50,000 grant to support the formalization of their structure as a 501c3 and to increase access to their support services.

2. HealthPartners PowerUp program is actively trying to reach and recruit more vulnerable communities to participate in our School Challenge. Using the Center for Disease Control's Social Vulnerability Index, we reassessed our recruitment strategy to target socially vulnerable districts and zips codes through partnerships, outreach, and social media ads. With our increased focus on social needs and health equity, PowerUp convened the newly formed Community Health Education Advisory Council at HealthPartners to review and advise on the PowerUp Family Magazine, distributed to kids and families during the School Challenge. The group provided their perspectives and insights, keeping in mind inclusiveness, cultural relevance, health literacy, physical abilities, body sizes, and social needs.

3. In partnership with CHW Solutions, HealthPartners implemented targeted outreach to our diverse MSHO membership to encourage them to get screened for breast cancer. As trusted members of the community, CHW Solutions staff contacted members in their native language when possible and utilized interpreters when needed. The program engaged members who speak English, Spanish, Hmong, Karen, Oromo, Russian, Romanian, Somali, Swahili, and Vietnamese.

4. HealthPartners systematically collects data on race, ethnicity, language and country of origin directly from patients and members in a variety of ways, all of them voluntary. These data collection sources include healthpartners.com, online through our health assessment, and the electronic medical record in our care delivery system and in our dental group. We've found that collecting this information face-to-face from patients at the point of care or health plan contact is an effective data collection method. Across our care delivery system, we have collected race and language information for over 90% of our patients, with language and race collection rates at our hospitals exceeding 97% in 2022. In addition, we receive data from the Minnesota Department of Human Services, Minnesota Community Measurement, and Minnesota Immunization Information Connection (MIIC) for our members covered by Minnesota Health Care Programs. When we combine all these data sources, we have this information documented for over 97% of our Medicaid members under age 65.

5. Starting in 2022, HealthPartners implemented NCQA Health Equity accreditation standards for our Medicaid products. According to NCQA, this accreditation program focuses on the foundation of health equity work and supports health care organizations in evaluating and elevating the health of the populations they serve. Specific focus areas include building an internal culture that supports the organization's external health equity work; collecting data that helps the organization create and offer language services and provider networks that are mindful of individuals' cultural and linguistic needs; identifying opportunities to reduce health inequities and improve care. HealthPartners achieved accreditation status in March 2023.

6. HealthPartners Human Resources team created and shared a colleague diversity dashboard that detailed the racial experiences of colleagues within the organization. Leaders utilize the findings in the dashboard to create annual plans and DEI goals.

Experience Outcomes

For overall member satisfaction, HealthPartners had the highest member satisfaction among commercial health plans in MN and WI, outscoring other plans in our region for the CAHPS Health Plan Rating for the 15th year in a row. HealthPartners also continues to surpass the national average for customer service.

2022 showed incremental improvement across many measures in our member experience surveys that had experienced declines in the previous year. This includes improvement for key metrics like net promoter score where both commercial and Medicare Advantage surpassed

their 2022 goals. This steady incremental improvement is attributed to an organization-wide focus on experience and service.

The areas of greatest opportunity based on key driver analysis across measurement tools continue to be access to out-of-pocket cost information before receiving care or filling a prescription and understanding your health plan and how to use it. During 2022, we conducted the following activities to improve member experience:

1. Engagement across member email communications was strong and increased from 2021. In 2022, we sent 3.8 million email outreaches and had a 55% open rate and 7% click through rate. Both are well above the industry average (22% open, 2-3% click through). Additionally, those who engaged with our outreach took the recommended action 25% more often than those who didn't open or click through the communication.

2. Created a financial hub that streamlines and brings better visibility to our cost tools for our members.

3. Implemented quarterly get connected campaigns for Medicaid members without web accounts, using department of human services enrollment file, to create online account and go paperless.

4. Updated our online Plan Directory to add ability to search for nursing facilities and surgical centers (instead of just filters), filters for race/ethnicity for doctors, information on language services and added in-network/cost level status plus link to benefits in results list.

5. Implemented the Harper – Digital Chat Assistant experience when members initiate a chat with member services. This chat feature is available 24/7 to members when they are logged into their myHealthPartners account. Harper attempts to assist with various simple and complex questions depending on what the member sends as their chat message.

6. Created online COVID test reimbursement form for eligible members and regularly updated public facing web information with most current details on testing, vaccines, therapeutics, coverage and more.

7. Launched new personalized campaigns connecting members to NowPow and other social drivers of health resources for those who indicated a need via the health assessment.

8. Launched pilot with N1 targeting SNBC members to encourage them to complete a health risk assessment and enroll in care coordination, which increased rates of both.

9. Implemented an automated pharmacy prior authorization process, reducing processing time from 10-20 minutes to less than 20 seconds per case. This auto approval process currently accounts for about 5-10% of the prior authorization volume. Within the next year, roughly 50 additional drugs will be added to this initiative.

10. Beginning in 2022, we used an external vendor (Bolger) to coordinate the order and issuance process for MSHO supplemental benefit items. Members received an order form early in 2022 that included the member's name and ID number. This process eliminated the need for members to call member services to order.

Affordability Outcomes

HealthPartners Triple Aim affordability approach is built on a strong foundation of activities designed to reduce overuse and misuse of resources and to improve the value of services provided to our members. We systematically identify new opportunities and enhance our programs to capture cost savings. In 2022, we identified 37 different affordability strategies encompassing administration, health and care engagement, products and benefits, pharmacy and provider relations. At the end of the year, 25 of these strategies were on track to meet their affordability targets and progress was made on an additional 8 strategies.

Examples of key affordability focus areas include:

- Improve management of high-cost cases by enhancing our ability to support members in their cancer journey through the OncoHealth pilot partnership (Iris Oncology) and through our evolving partnership with our internal pharmacy admin team.

- Implementing, Now Pow a third party managed and updated community resource directory that will enable member facing teams to make referrals with higher likelihood of member follow-through, replacing less robust in-house maintained directory

- Support digital channels for engagement in comprehensive care advocacy services: Better engage members in condition support by connecting members to available online resources for condition management and network navigation, and to close targeted gaps in care (aligned with HEDIS) in Core DM programs.

- Implemented dynamic refill too soon pharmacy processing. Refill too soon limitations are intended to limit stockpiling and waste. The intent is to ensure members are taking medications correctly and as intended by their prescribing physician. The refill too soon edits in our system control excess fills by members who continuously refill medications early. The system calculates at the member and medication level based on the member’s history of accumulation for each medication. The pharmacy sees a point-of-sale (POS) message when a claim rejects for refill too soon. The message includes the date the medication can be refilled, which is based on the member’s fill history.

Leadership Involvement

1. The Board of Directors has final authority and ultimate responsibility for the quality of care and services provided to members of the plan and for oversight of the Quality Improvement (QI) Program.

2. HealthPartners Medical and Executive Leadership are actively involved in the QI program on an ongoing basis. For more than 20 years HealthPartners has been setting ambitious goals about every five years to improve health in our community. The first set

of health goals was developed in 1994. Partners for Better Health Goals 2025 goals are monitored and reported out yearly.

3. Our plan displays commitment to our multiyear goals, through routine publication of an enterprise-wide performance scorecard.

4. The Quality Committee of the Board provides oversight through review of quarterly reports about the progress specific to the QI programs.

5. The Quality Council meets quarterly to actively oversee multiple committees designed to improve quality and Council agendas reflect topics of the QI Annual Plan. The following committees report up to the Quality Council:
    a. Pharmacy QUI (quarterly meetings)
    b. Quality Review Committee (quarterly meetings)
    c. Government Programs QUI (quarterly meetings)
    d. Service Quality Council (quarterly meetings)
    e. Medical Directors Committee (monthly meetings)
    f. Behavioral Health Committee was added in 2020
    g. Additional Enterprise Leadership Committees provide routine reports and support cross-representation on multiple initiatives

6. These committees generally met as scheduled and there was sufficient committee capacity to address their annual objectives.

7. Charters exist for every quality committee noted above and include goals, objectives, or purpose statements and a list of attendees. Charters are detailed in a separate Quality Program Description. Each committee reviews and updates their charter annually

Adequacy and Realignment of Resources

HealthPartners evaluates the adequacy of the Quality Council committee structure, practitioner participation, resources, and leadership at least yearly. Evaluating resource adequacy, staffing and technology are an ongoing part of program development and covers both our quality program and our population health management program. This analysis also supports key elements in the annual budgeting and Return on Investment (ROI) assessments for existing programs. During 2022, HealthPartners acted on multiple opportunities to ensure appropriate staff deployment and make strategic investments in key programs.

Staffing: The following key positions support the program:

- Medical Director and Associate Medical Directors: 5.4 FTEs
- HealthPartners is sunsetting the position of Senior Director, Behavioral Health Strategy which was previously available on a consulting basis to provide strategic direction and adding a Medical Director for Behavioral Health. This position is currently posted.
- President of HealthPartners Institute which leads our Research Foundation and medical education division

The plan supports approximately 540 FTEs across the Quality/Population Health Management program up from 496 FTEs in 2021. This total includes analytical resources which support our initiatives. HealthPartners makes a significant investment in and strong commitment to achieving the Triple Aim. During 2022 we realigned staff to better utilize our resources. HealthPartners made significant program shifts or investments in the following areas:

1. HealthPartners implemented the Health Equity Accreditation Standards and achieve Accreditation status. In second quarter 2022, the organization added a new Senior Compliance Consultant position to facilitate ongoing compliance with the Health Equity standards.

2. In 2022, HealthPartners expanded how we partner with community and gather community input by collaborating with the HealthPartners Institute to create a Community Advisory Council for Research and Evaluation. Council members partner with us to understand the needs of the communities we serve and provide input on ongoing and proposed activities to address those needs. This includes providing ongoing feedback on health plan quality improvement activities to address health equity and improve service.

3. HealthPartners implemented a Health Equity Accreditation Steering Committee in 2020 to oversee progress to achieving accreditation. This model was effective and in 2023, we will continue to use this structure to assess implementation of the Health Equity Plus standards.

4. We are implementing a new technology platform that offers best in class clinical workflow automation and simplifies the documentation process, improves reliability of interventions/decisions, and supports the dynamic needs and dynamic relationships with members, providers, clients, and regulators. This tool supports:
    a. Workflow automation
    b. Clinically driven data to inform clinician interactions
    c. Efficient communication with providers

    Examples of the functions it will support include:
    a. Comprehensive Care Advocacy
        i. Complex medical and behavioral health case management
        ii. Disease Management
        iii. Care Coordination programs including SNBC, MSHO, and MSC+
    b. Utilization Management
        i. New provider portal for providers to submit prior auth requests
    c. Worksite Health
        i. Work Comp managed care

5. HealthPartners has signed a contract with 1upHealth to support electronic data exchange including implementation of FHIR requirements and standards. The organization has chosen data sharing around colorectal cancer screening as a pilot in 2023.

6. HealthPartners is working to create a culture of innovation and joined the Health Plan Innovation Round Table to gain access to new vended solutions offered in the marketplace.

Practitioner Participation

HealthPartners continues to have substantial practitioner participation on our governing board, advisory boards, and QI committees and ad hoc provider advisory groups as needed. This represents input from across the network and a wide range of clinic sites and practitioner specialties. HealthPartners practitioners participate in the planning, design, implementation, and review of the QI and population health management programs. Their activities ensure program alignment with evidence-based care and overall population management between the health plan, care delivery systems and community partners. Network practitioners serve on our:

1. Board of Directors
2. Quality Committee of the Board
3. Minnesota Community Measurement
4. Quality Review Committee
5. Credentials Committee
6. Member Focused Behavioral Health Advisory Committee
7. Pharmacy and Therapeutics Committee
8. New Technology Committee and periodic advisory groups including genetic testing advisory groups
9. Health Equity Accreditation Steering Committee

In addition, ad hoc groups and community collaboratives include provider representatives. HealthPartners also conducts several provider surveys to get broader feedback on key topics including satisfaction with the Utilization Management program and how the health plan can support providers by providing culturally relevant resources to support patients of diverse backgrounds. Organizationally, we feel this robust level of practitioner participation helps us achieve exceptional results and we will continue with this level of involvement during the next plan year.

Quality Connections Forums continue to be a successful strategy to improve quality across our provider network. Sharing tested strategies provides opportunities for the provider groups to use effective interventions for quality improvement.

- Forums are held three times per year to engage network provider groups in quality initiatives to improve publicly reported measures. This group has grown from 5 provider groups in 2012 to 17 in 2022. The meetings offer clinics a forum to share successes, challenges, and results of QI and health equity initiatives. Sharing tested strategies provides opportunities for the provider groups to use tested interventions for quality improvement.

Medical Directors make multiple on-site visits to multispecialty care systems, primary care and specialty care providers to sustain engagement in improving clinical care, member experience and affordability. QIC Quality Consultants are actively partnering with HealthPartners Provider

Relations and Network Management to educate network clinics on Quality Consultant services and to promote safe, evidence-based care initiatives.

Challenges/Barriers to Greater Success

Challenges to greater success in health improvement include:

1. The COVID-19 global pandemic has created confusion and concern about members' ability and/or desire to seek preventive care. The health care community is concerned that delays in preventive screenings could result in later diagnosis of cancers, and delays in immunizations could lead to immunization preventable outbreaks in some communities.
2. Variation exists in the provider's ability to collect race/ethnicity data and language data, which can affect our ability to address disparities regarding preventative care.
3. Higher member costs for health care including prescription drugs used to control chronic conditions. Out of pocket expenses for members are often increasing due to changing deductibles and co-pays.
4. Difficult to focus improvement efforts for members who are not attributed to a specific care delivery system.
5. Improvement targets need to be flexible as measure technical specifications and star rating cut points are updated annually.
6. Community pharmacies continue to struggle with high workloads and staffing shortages coming out of the pandemic. Payment for MTM services needs to be adequate for pharmacies to commit resources to the work.

Challenges to greater success with member experiences are related to:

1. The lingering impact of the COVID pandemic along with staffing shortages and clinic availability continued to impact consumers ability to receive primary and specialty care services as soon as needed.

2. The complexity around healthcare and coverage is a barrier to member satisfaction. Members from all products desire information and tools to help them more fully understand their benefits, coverage, and in-network provider options. Members who do not fully understand their benefits and coverage often have trouble seeing the value of their plan.

3. Network wrong clinic usage complaints were the highest complaint for 2022. Members struggle to understand how to use their network. The member education on these network changes varies by employer so some members understand the change while others do not and may use a clinic not in their plan network. The decision to remove our ability to make customer service adjustments by one of our largest plan sponsors when their members used a wrong clinic also contributed to a higher volume of complaints.

4. Benefit complaints related to preventive and non-preventive services remains within our top five complaints as members struggle to understand the difference between these services.

5. A continued theme for WI Marketplace members' complaints is related to scenarios where HealthPartners does not manage the issue. In these cases (enrollments, disenrollments, demographic changes and tax credit determinations) we must divert the member to the Federally Facilitated Exchange for resolution. Members are dissatisfied when HealthPartners cannot resolve their complaint directly.

6. Medicaid grievances for 2022 included members concerns with their experiences with Ridecare, clinic networks or experience with clinics, coordination with other insurance, provider billing, general benefit concerns and quality of care.

Challenges to greater success with affordability improvement include:

1. As new technologies are striving to increase market share, we see an impact on member requests for specific services, increased expectations of coverage, and third-party vendors appealing on the member's behalf. We expect this will always be a dynamic within the healthcare market, especially as we strive to ensure evidence-based coverage, as vendors are often marketing new technologies once they receive FDA approval, but before the quality evidence regarding effectiveness, safety, and effect on health outcomes is available.

2. We have increasing rates of retirement and interest in part time positions, increasing competition between employers based on salary and benefits. This means we are more challenged with having sufficient resources to support increasing volumes of UM reviews. The increasing volumes are related to prior authorization program changes and additional complexity related to expansion to other regions and changes to other lines of business. COVID-19 has also created resource limitations in addition to challenges with staff burnout and stress from sustained impacts of the pandemic on daily life.

3. Multiple competing priorities of policy development to meet requirements for new technologies, Medicare and Medicaid policies, revision of policies, affordability topics and changes to policies to better support prior authorization programs.

4. Genetic testing rapid pace of new tests, growth of large scale/panel tests, limited clinical evidence, coding and payment challenges.

5. Absence of sufficient evidence on some topics to make an adequate coverage determinations.

2023 Areas of Focus

As this report is being written, the world continues to be challenged by the COVID-19 pandemic. Global unrest, rising inflation and staffing challenges create new barriers to affordability, quality and member experience. Despite this difficult situation, HealthPartners remains dedicated to achieving Triple Aim quality. Areas of focus for 2022 include:

1. Implementing to improve performance on the organization-wide Partners for Better Health 2025 measures and goals and our organizational Health Equity goals

2. Execute our member experience framework, “See Me, Know Me, Hear Me, Partner with Me”. For example, expand use of personalized member messages for preventive services to our members by providing messages that meet the member’s preferences.

3. Assess implementing the Health Equity Plus Standards and if approved begin implementing the requirements.

4. Invest in technology that supports clinical workflow automation, interoperability, data exchange and accessible data to make informed decisions and improve care for members.

5. Continue to build innovation into our business model so we can implement solutions that drive measurable value to our purchasers and members. Focus on implementing simple and affordable solutions designed to address high frequency, high cost, high variability or complexity.

Health – Clinical Quality Improvement

Preventative Services

Accountable Owner

Quality Improvement and Compliance – Courtney McElfresh, BSN, RN

Member Populations Targeted

x	Commercial
x	Medicare Advantage/Cost/PDP
x	Medicaid
x	MSHO
	HPUPH
x	WI Marketplace

Description

Obtaining appropriate preventive care improves health outcomes and can prevent disease in our member population. HealthPartners supports improving the delivery of appropriate clinical preventive services by providing tools and resources to support our members and health care providers.

HealthPartners utilizes a data driven approach to identify members in need of preventive service reminders. This program supports HealthPartners strong performance on NCQA ratings, HEDIS® measures, CMS Stars and Medicaid withhold requirements.

We proactively contact members who have not received best care as defined by evidence-based clinical guidelines established by the U.S. Preventive Services Task Force (USPSTF). Based on member preferences, communications are sent via postal mail, email, and text. Many members have access to a secure web mailbox through their HealthPartners portal which enables them to access messages from both the plan and select care providers. Interactive voice response (IVR) messages and home testing kits have also been utilized to reach members with preventive health messages.

Goals

Our goal is to engage, empower and partner with members, patients, providers, and purchasers to achieve the best health for our members. Our objectives include:

- Educating and facilitating providers and members in the delivery of preventive health care services.
- Empowering members in self-care around incorporating healthy behaviors and seeking preventive care.

Initiatives/Interventions

Preventative Care Member Campaigns:

Internal and external communication channels through targeted campaigns build awareness of the importance of preventative care services for our members. The following preventative care campaigns were deployed in 2022 by HealthPartners:

Campaign	Audience	Products / Regions	Channels	Other Notes
Breast cancer screening reminders	Women age 50-75 who are due for a mammogram. Members (age 45) and member/patients (age 40) are also encouraged to make a mammogram plan.	All products, all regions	Email, web, myHP push notification, direct mail, Member Services talking points Member/patients also get text.	Messages are translated into Spanish, Somali and Vietnamese as appropriate. Members receive max 4/yr. Includes coverage info based on current plan.
Colon cancer screening reminders – all options	Members age 45-75 who are due for a colon cancer screening who are unattributed.	All products, all regions	Email, web, myHP push notification, direct mail, Member Services talking points	Segments for Virtuwell FIT kit, colonoscopy and first-time screening. Member receives max 4/yr. Includes cost info based on current plan.
Colon cancer screening reminders – FIT Kit	Members age 45-75 who are due or overdue for a colon cancer screening.	Commercial (unattributed); Medicare, MSHO, Medicaid (any attribution status); Virtuwell-eligible states	Email, web, Member Services talking points	Encourages member to order an at-home FIT Kit through Virtuwell to complete their screening.
Well child / childhood vaccine reminders	Member-only: Policyholders (member-only) with a dependent age 0-24 mos. overdue for a well-child visit. Member/Patients: Parents/guardians of member/patient dependents age 1 month to 17 years old coming due or overdue for a well-child exam.	Member-only: Commercial, Medicaid, all regions Members/Patients: Commercial, all regions	Email, web, myHP push notification, Member Services talking points Member/Patients also get text	Includes cost info based on current plan.
Adolescent vaccine reminders	Policyholders with a dependent age 11-12 overdue for at least one	Commercial, Medicaid, all regions	Email, web, myHP push notification, Member Services	Includes cost info based on current plan.

Campaign	Audience	Products / Regions	Channels	Other Notes
	recommended immunization.		talking points, direct mail	
Flu shot reminder	Members age 4 mos+ who haven't had a flu shot in the past 6 mos.	All products, all regions	Email, web, myHP push notification; Direct mail sent annually to select members	Sent Sept-Nov annually
Osteoporosis screening	Women age 67-85 with a recent bone fracture.	All products, MN only	Email, web, myHP push notification, Member Services talking points, direct mail	
Pneumonia vaccine reminder	Members age 65+ who haven't had both doses of pneumonia immunization after age 60.	All products, all regions	Email, web, myHP push notification, Member Services talking points	

Preventative Care Member Initiatives:

1. Comprehensive care advocacy case managers review preventative service needs with members who are enrolled in case management to ensure that members are aware of what they are due for and how to access the services.

2. A member survey on cancer screening preventive services identified cost as a barrier for completing the screening. HealthPartners now includes language in our outreach campaigns about cost as most preventive screenings are covered with no cost sharing for nearly all members.

3. Prepaid Medical Assistance Program (PMAP) members are incentivized for completing all adolescent immunizations needed by age 13, for completing all recommended immunizations by age 2 and for completing postpartum care between 3 and 8 weeks postpartum. Members are sent a card following the birth of their baby with information on plan resources, such as the BabyLine, which includes information on both the postpartum incentive and childhood immunization incentive.

4. MSHO members are incentivized to complete a mammogram, colorectal cancer screening, osteoporosis screening and or an annual wellness visit when they are due.

5. In 2022, HealthPartners continued their collaboration with Virtuwell to offer in-home, self-swab chlamydia screening for health plan members.

6. In 2022, HealthPartners continued their collaboration with Virtuwell in a ship direct-to-home FIT Kit campaign. Over 53,000 members were eligible and were invited to request a kit through Virtuwell. Once the kit is completed, members are contacted by a Virtuwell provider who will discuss results and next steps.

7. Childhood well visits and immunizations continue to be available during the COVID-19 pandemic. We utilize member reminders to encourage parents to keep their child on schedule for childhood and adolescent immunizations and instill confidence in the safety of seeking care.

Preventative Care Provider Initiatives:

1. More than half of our contracted care system providers have been trained to, and utilize a proprietary tool, the Patient Management Application (PMA) to help translate opportunities into tangible actions that the provider can take to facilitate improvement related to total cost of care, quality measurement and diagnosis accuracy. The PMA provides patient information that can assist the provider in proactively managing patients, fostering coordinated care, facilitating pre-visit planning and customize care models.

2. Public reporting of comparative provider performance is done through the Minnesota Community Measurement and HealthPartners's specific clinical indicators report.

3. Member-specific registries identify members due for preventative screening and are updated quarterly. Providers are notified and encouraged to access the data.

4. Quality Connections Forums engage HealthPartners network provider groups in quality initiatives to improve publicly reported measures.
    a. Hosted by HealthPartners, the group creates the agenda which includes both preventive and chronic improvement projects as well as process improvements.
    b. Participants share the latest science and best practice methods and share successes and challenges of quality improvement initiatives.

5. Consultations are available from Clinical Quality Consultant RNs for medical groups interested in improving their quality outcome measures. HealthPartners supports network partners virtually as needed to support work on HEDIS/Stars quality measures and initiate discussions around the medical group's CAHPS surveys and health equity work.

Barrier Analysis/Gaps in Care

1. The COVID-19 global pandemic has created confusion and concern about members' ability and/or desire to seek preventive care. The health care community is concerned that delays in preventive screenings could result in later diagnosis of cancers, and delays in immunizations could lead to immunization preventable outbreaks in some communities.

2. Much of our preventative care communications are done through digital platforms which can be a barrier to those members that have a technological deficit.

3. Some member populations are very difficult to contact and engage; this is especially true with our state public programs members.

4. Most, but not all, plans cover preventive services at 100%. Members with health saving accounts (HSA's) and other high deductible plans have a lower completion rate of preventive services than members with low or no deductible plans due to the potential for out-of-pocket costs.

5. Preventive guidelines change which can result in confusion for members to know when to start screening, the frequency of screening, and which screening to have done when there are multiple options.

6. Medical societies publish and promote consensus-based preventive guidelines that may be inconsistent with the evidence or with other endorsed guidelines which can cause patient and provider confusion.

7. Variation exists in the provider's ability to collect race/ethnicity data and language data, which can affect our ability to address disparities regarding preventative care.

8. Providers have limited resources for testing proposed initiatives and the time and resources needed to make systemic change can be costly. By sharing successes and strategies via Quality Connections we support tested interventions for quality improvement.

Opportunities for Improvement: Results/Outcomes

2022 Preventative Care Member Outreach Campaign Results

Outreach campaigns to members are deployed each calendar year and impact HEDIS® results for the next measurement year. Campaigns through the Personalization Pipeline included email, website bell notifications, push notifications for myHP app users, text messages, and member services talking points.

Campaign	Email	Bell	Push Notification	Overall Conversion Rate
Breast Cancer Screening	126,828	135,105	5,780	23.1%
Colorectal Cancer Screening	153,877	158,597	29,722	3.3%
Well Child Exam / Childhood Vaccine Reminder	33,423	33,962	9,605	20.3%
Adolescent Vaccine Reminder	21,090	21,529	0	17.4%
Annual Flu Shot	623,181	628,643	190,758	23.8%
Osteoporosis Screening	134	140	0	19.5%
Pneumonia Vaccine Reminder	24,773	26,555	0	4.0%

2022 HEDIS® Results

A comprehensive list of HealthPartners 2022 HEDIS® results for preventative care can be found under the appendices. The following are notable mentions when comparing HealthPartners 2022 results for our commercial and PMAP members:

1. Cancer screening rates varied across measures and products.
    a. Breast cancer screening rates had a statistically significant decrease for both the commercial and PMAP populations. Commercial rates went from 77.0% to 76.5% and PMAP rates went from 62.9% to 56.7%.
    b. Cervical cancer screening rates had a directional improvement for both the commercial and PMAP populations. Commercial rates went from 73.7% to 77.4% and PMAP rates went from 65.9% to 70.8%.
    c. Colorectal cancer screening results showed a directional decline from 74.3% to 68.5% in the commercial population. Colorectal cancer screening is not a measure for PMAP.

2. Pediatric and adolescent immunization rates decreased in most measures for both the commercial and PMAP populations.
    a. Pediatric Combo 10 rates showed a slight decrease in the commercial population, going from 73.4% to 73.2% and a statistically significant decrease in the PMAP population, going from 49.9% to 38.9%.
    b. Adolescent Combo 2 rates showed an increase in the commercial population from 38.4% to 40.1% and the PMAP population had a decrease from 36.7% to 34.1%.

3. Chlamydia screening rates increased at a statistically significant rate for both commercial and PMAP members, from 45.8% to 48.4% and 61.0% to 63.1% respectively.

4. Postpartum visit rates had a statistically significant decrease for commercial members, going from 92.7% to 86.6% and had a slight increase for the PMAP population from 78.3% to 78.6%.

Commercial Results

HEDIS® Measure	2018	2019	2020	MY 2020	MY 2021
Breast Cancer Screening	79.1%	78.5%	78.9%	77.0%	76.5%
Cervical Cancer Screening	75.9%	80.5%	74.9%	73.7%	77.4%
Colorectal Cancer Screening	69.3%	78.0%	70.3%	74.3%	68.5%
Pediatric Immunization Combo 3	83.9%	86.7%	80.4%	85.4%	81.7%
Pediatric Immunization Combo 10	64.0%	71.4%	66.4%	73.4%	73.2%

HEDIS® Measure	2018	2019	2020	MY 2020	MY 2021
Adolescent Immunization Combo 1	86.6%	88.8%	88.8%	85.4%	88.3%
Adolescent Immunization Combo 2	27.1%	30.4%	36.5%	38.4%	40.1%
Chlamydia Screening	55.5%	55.1%	55.3%	45.8%	48.4%
Postpartum Visit	85.6%	82.2%	90.5%	92.7%	86.6%

PMAP Results

HEDIS® Measure	2018	2019	2020	MY 2020	MY 2021
Breast Cancer Screening	68.4%	65.7%	66.4%	62.9%	56.7%
Cervical Cancer Screening	66.4%	70.6%	67.6%	65.9%	70.8%
Pediatric Immunization Combo 3	75.4%	75.4%	72.3%	69.6%	57.8%
Pediatric Immunization Combo 10	50.9%	52.1%	49.4%	49.9%	38.9%
Adolescent Immunization Combo 1	87.4%	87.4%	85.2%	83.0%	78.1%
Adolescent Immunization Combo 2	33.1%	35.3%	36.3%	36.7%	34.1%
Chlamydia Screening	67.5%	70.1%	69.7%	61.0%	63.1%
Postpartum Visit	72.3%	72.3%	81.8%	78.3%	78.6%

Sustainability of Preventative Care Activities

HealthPartners is committed to building on the efforts noted above to ensure that members are receiving timely preventative care services. The organization will continue to implement strategies that address barriers to preventative care and will also support and engage members in decision making that leads to the best health outcomes for themselves and their families.

Chronic Care

Accountable owner

Quality Improvement and Compliance – Courtney McElfresh, BSN, RN

Member Populations Targeted

x	**Commercial**
x	Medicare Advantage/Cost/PDP
x	Medicaid
x	MSHO
	HPUPH
x	WI Marketplace

Description

With the prevalence of chronic conditions on the rise, proactive management of our member's chronic conditions is imperative to maintaining the overall health of the population. HealthPartners supports chronic care improvement by helping our members achieve optimal care goals and by promoting effective change in provider groups to support evidence-based clinical and quality improvement across a wide variety of health care settings.

HealthPartners uses a data driven approach to identify members in need of chronic condition management. This program supports HealthPartners strong performance on NCQA ratings, HEDIS® measures, CMS Stars and Medicaid withhold requirements.

Goals

Our goal is to improve the health outcomes of members with chronic diseases and to prevent or delay complications of these diseases. Success is measured by improvement in HEDIS® rates and on conversion rates for members who received member outreach through postal mailings, emails and disease or case management services.

HealthPartners goal for commercial members is to achieve Band 1 performance. HealthPartners also has goals related to achieving a 5-Star rating for our Medicare Advantage and MSHO plans. CMS uses these ratings to assess and rate health and drug plan quality, performance, and satisfaction of members. The Star Ratings strategy is consistent with the Triple Aim of better care, healthier people and communities, and lower costs.

Initiatives/Interventions

Chronic Care Member Campaigns:

Internal and external communication channels through targeted campaigns build awareness of the importance of chronic condition management for our members. The following chronic care campaigns were deployed in 2022 by HealthPartners:

Campaign	Audience	Products / Regions	Channels	Other Notes
Get matched with a doctor for your care needs – primary care	Newly enrolled and unattributed adult members. Group must opt in.	Commercial (with some exclusions), Medicaid – MN/Western WI only	Email, web	Runs the 15th of the month. Member receives max 1/yr. See if your group qualifies and opt in on Sales Hub
Regular doctor visit reminder	Members who haven't had an annual wellness or PCP visit in the calendar year.	Medicare, Medicaid, Commercial (individual & small group), all regions	Email, web, myHP push notification, Member Services talking points; Direct mail sent annually to select members	Includes cost info based on current plan.
Diabetes support	Members with diabetes overdue for one or more diabetic-related tests or exams.	All products, all regions	Email, web, myHP push notification, Member Services talking points, direct mail	Includes due dates and last location member got the needed care for easy scheduling. Promotes resources such as Omada, myStrength and nurse support.
Core disease and case management	Adults with 1+ disease mgmt conditions (diabetes, CAD, COPD, asthma, CHF) and children age 5-17 with asthma and/or diabetes.	All products, all regions	Email, web, myHP push notification, Member Services talking points, direct mail	Includes educational and support resources such as Omada, myStrength and nurse support.
DCM nurse engagement	Members identified for DCM nurse support but unengaged after multiple attempts.	All products, all regions	Soft alert (pop up in web experience)	Requests phone number where a nurse can reach member.
Cancer support	All adults and commercial pediatric members with a new cancer diagnosis or episode.	Commercial fully insured, commercial self-insured with buy-up, Medicare, Medicaid; All regions	Email, web, Member Services talking points	
Cancer support – Iris program pilot	Select members in cancer treatment.	Commercial small group, MN and WI	Email, web, myHP push notification Direct mail sent by OncoHealth and shared as talking points	The program provides support through an app that helps with symptom management and emotional health support; a 24/7 oncology-specific nurse line; and other features.
myStrength	Adult members who suffer from tobacco	All products; all regions	Email, web, myHP push notification	Messages are prioritized so

Campaign	Audience	Products / Regions	Channels	Other Notes
	or substance abuse, insomnia, anxiety or depression			members with more than one condition will receive only one message.
Behavioral Health Disease & Case Mgmt – Day by Day	Adult members with a current diagnosis of anxiety and prescription for a benzodiazepine.	Commercial, Medicaid, Medicare Advantage, MSHO/MSC+; all regions	Email, web, myHP push notification, direct mail	Quarterly educational newsletter. Members will stay in campaign as long as they fit the audience.
Behavioral Health Disease & Case Mgmt – Moving Forward	Adult members with a current diagnosis of and prescription related to bipolar disorder or schizophrenia.	Commercial, Medicaid, Medicare Advantage, MSHO/MSC+; all regions	Email, web, myHP push notification, direct mail	Quarterly educational newsletter. Members will stay in campaign as long as they fit the audience.
Behavioral Health Disease & Case Mgmt – On Your Way	Adult members with a new diagnosis of and prescription related to depression.	Commercial, Medicaid, Medicare Advantage, MSHO/MSC+; all regions	Email, web, myHP push notification, direct mail	Series of six monthly newsletters. Member cannot get campaign again for one year after initial six-month series.

Chronic Care Member Initiatives:

1. HealthPartners provides disease management programs for asthma, coronary artery disease, chronic obstructive pulmonary disease, diabetes, heart failure, and rare/chronic diseases for all our product lines including commercial, Medicare, and Minnesota Health Care Program (MHCP) members.
    a. Disease management member materials share condition specific information and education.
    b. Pharmacy plays an important role in assuring members with asthma, chronic obstructive pulmonary disease, coronary artery disease and heart failure are on medications important to their condition and that members refill their medications on time.
    c. Disease and case management nurses work with members to navigate the complexity of care involved with these conditions.

2. HealthPartners has multiple initiatives currently in place and in development to ensure our members with chronic diseases receive the services they need to effectively manage their condition. Historically, there have been separate committees and work groups that oversee commercial and Medicare populations. To ensure effective coordination of our initiatives across product lines, several years ago, HealthPartners enhanced the scope of our HEDIS® oversight committee to also include oversight of CMS Stars measures. To further strengthen the committee, HealthPartners created a sponsor group in 2019 to provide strategic direction. The HEDIS®/CMS Stars Steering committee provides

strategic direction on the many initiatives designed to improve both chronic and preventive care, especially as they relate to HEDIS® and CMS Stars measures.

3. A published FastFacts article included information on disease, case and lifestyle management services available to our members who use high-cost services or have multiple health issues, are in deteriorating health, or are at high risk of hospitalization in the next six to 12 months.

Chronic Care Provider Initiatives:

1. Chronic disease member registries are distributed to providers and highlight missing or overdue services as well as the status of member's participation in a disease management program.

2. Patient Management Application (PMA) is an excel-based tool that is shared with network provider partners. This tool includes the attributed membership for all lines of business, if appropriate for the network partner. The PMA identifies areas of opportunity in cost, utilization, reconfirmation of chronic conditions, annual wellness visit completion and incented HEDIS® measures.

3. The Quality Management Application (QMA) is a Tableau workbook located in the PMA tool which identifies quality performance results and gaps in care for the annual wellness visit, reconfirmation rate and incented HEDIS® measures. The QMA is intended to be accessed at a future date through the provider portal. Currently, HealthPartners provides the QMA report in a PDF format to the incented network partners who are set up in the portal.

4. Registries include race/ethnicity and language data when available.

5. HealthPartners monitors condition specific, evidence-based guidelines aligned with USPSTF to assure programs and measures are consistent with current evidence.

6. Quality Connections Forums engage HealthPartners network provider groups in quality initiatives to improve publicly reported measures.
    a. Hosted by HealthPartners, the group creates the agenda which includes both preventive and chronic improvement projects as well as process improvements.
    b. Participants share the latest science and best practice methods and share successes and challenges of quality improvement initiatives.

Barrier Analysis/Gaps in Care

1. Higher member costs for health care including prescription drugs used to control chronic conditions. Out of pocket expenses for members are often increasing due to changing deductibles and co-pays.

2. Our ability to provide accurate outreach to members is dependent on claims information and thus claims lag can be a barrier to timely identification of gaps in care.

3. Inability to identify all retinal eye exam claims for persons with diabetes due to eye benefits increasingly covered by third party benefit carve-outs.
4. Members who do not have an established relationship with a primary care provider may experience fragmented care and lack of coordination from inconsistent providers.
5. Providers experience ever increasing pressure to attend to numerous health goals in a limited amount of time with patients.
6. Providers have limited resources for testing proposed quality improvement initiatives, and the time and resources needed to make systemic change can be costly.
7. State and federal quality improvement measures such as those related to DHS withholds and CMS Stars measures continue to change and evolve which can make targeted improvement activities challenging.
8. Some member populations are very difficult to contact and engage; this is especially true with our state public programs members.
9. The pandemic continued to strain medical resources with the ongoing COVID-19 variants, pent up demand, and staffing shortages due to illness and burnout. Providers had to shift care to meet the needs of the members which made it more difficult to receive appropriate medical care in a timely manner.
10. Fear of exposure to the virus for those who must use public transportation or while in the clinics.
11. The pandemic has added to already strained staffing resources with many medical staff away from work due to isolation/quarantine requirements. This has led to extended wait times for open appointments in both primary care and specialty care.

Opportunities for Improvement: Results/Outcomes

2022 Chronic Care Member Outreach Campaign Results

Outreach campaigns to members are deployed each calendar year and impact HEDIS® results for the next measurement year. Campaigns through the Personalization Pipeline included email, website bell notifications, push notifications for myHP app users, text messages, and member services talking points.

Campaign	Email	Bell	Push Notification	Overall Conversion Rate
Regular Doctor Visit Reminder	84,957	89,916	0	24.3%
Diabetes Support	21,943	23,363	0	21.8%
Disease and Case Management	30,203	31,685	10,124	N/A
Iris Cancer Support	242	248	75	N/A

2022 HEDIS® Results

A comprehensive list of HealthPartners 2022 HEDIS® results for chronic care can be found under the appendices.

Sustainability of Chronic Care Activities

HealthPartners is committed to building on the efforts noted above to ensure that members are receiving timely chronic care services. Through our HEDIS® results, it is known that improvement can be gradual and non-linear. System and process changes at the provider level leads to the greatest, sustained improvement, and we continue to encourage our network clinics to utilize best practices in their care. Challenges remain in understanding lack of improvement or decreases in goals for chronic diseases. We believe the more we can learn about members and the more strategies we use to connect with members, the more effective we will be. Current activities will continue in the next program year with expanded collaborative efforts with Marketing and Health Informatics to identify members by micro-segments and tailor messages that resonate with member values (i.e., cost and convenience). We believe this will improve our current outreach efforts in improving the health of members with chronic diseases.

Stars Initiatives

Description

The Centers for Medicare and Medicaid Services (CMS) uses a 5-Star rating system to assess health and drug plan quality, performance and member satisfaction. Higher Star ratings can lead to the improvement in the quality of care and general health of Medicare beneficiaries. It supports the effort of CMS to improve the level of accountability for the care provided by physicians, hospitals, and other providers, which drives quality improvements. The contracts for the stars initiatives are as follows: H2462 (Cost-MN, WI, ND, SD), H2422 (MSHO) and H4882 (Journey/Robin).

CMS publishes the Star ratings each year to assist beneficiaries in finding the best plan for them. Reviews are published online in the Medicare Plan Finder.

Star Ratings impact the Medicare Advantage quality bonus payments. Plans with higher Star ratings may be able to offer increased benefits and lower premiums. There is a strong correlation between higher rated plans and enrollment which further perpetuates performance.

The significance of maintaining a higher star rating:

- It supports the Triple Aim
    - Member experience
    - Member health
    - Affordability through improvement
- Ability to retain membership and attract new membership and enroll year-round
- Higher CMS payment for Medicare Advantage plans
- Market differentiator – HealthPartners is a top, high quality plan

Goals

The mission of the CMS Star Ratings Workgroup is to maintain 5 Star ratings or improve measures from current levels that are lower than 5 Stars. Our objectives:

1. Establish year round strategies to ensure 5 Star ratings or improvement to next star.

2. Identify priority measures with key partners to determine strategies for improvement in these measures.

3. HealthPartners is continuing efforts to advance health equity and it is one of six key strategies in the HealthPartners 2025 Strategic Roadmap. HealthPartners is building a strong foundation to address health equity and reducing disparities with a focus on community partnerships and advocacy. HealthPartners has achieved the NCQA Health Equity Accreditation for Medicaid in 2023 which includes the MSHO population. Please refer to the Health Equity Chapter for more details.

Initiatives/Interventions

The CMS Star Ratings Workgroup analyzed health plan performance to identify 2022 priority areas based on current rates, gap to goal, and ability to effect a positive change in rates.

Methodology

Methodology to determine Star rating includes several data sources:

1. HEDIS® (Healthcare Effectiveness Data and Information Set): medical claims data and chart reviews
2. Health Outcomes Survey (HOS): self-reported health status and outcomes
3. Consumer Assessment of Healthcare Providers and Systems (CAHPS):member satisfaction, care accessibility, and network navigation
4. PDE/Pharmacy: Part D drugs claims and medications
5. Other: call center metrics, access and performance problems, appeals, complaints to Medicare and enrollment data
6. Improvement Measures: comparison of current and prior year measure scores; score calculated with and without improvement measures.
7. HEDIS® measures account for approximately 15% of the Star rating and the CAHPS and HOS surveys combined will account for approximately 44% of the Star rating. The CAHPS survey is currently quadruple weighted in measurement year 2022 for the 2024 Star rating year.

Health Plan Member Interventions:

1. 2022 continued focus on Medicare annual wellness visits (MAWV). Those members who signed up to receive email notifications were sent reminders to complete the annual wellness visit. Approximately 85% of the Medicare Advantage population and 50% of the MHSO population currently have authenticated accounts. For those members who do not have an authenticated account, annual wellness visit reminders were sent in Q4.The largest provider group did continue to add the AWV to member visits. The annual wellness visit is beneficial to address health concerns, chronic conditions, obtain needed preventive care and an opportunity to discuss topics like those listed below:
    a. Staying physically active (HEDIS®/HOS)
    b. Reducing risk of falls (HEDIS®/HOS)
    c. Improving bladder control

2. Preventive campaigns continued to run via authenticated accounts. Engagement remains strong across campaigns.
    a. The Silver Sneakers benefit promotes an opportunity to improve or maintain physical and mental health, staying physically active and reduce risk of falling. (HEDIS®/HOS)
    b. Member blogs identifying preparation for appointments and prescriptions.
    c. Falls Prevention Facebook campaign in early fall to encourage members to talk to their doctor about their fall risk. (HEDIS®/HOS)
    d. MSHO supplemental benefits include health education classes, weight management programs. (HEDIS®/HOS). There is a community partnership with

Juniper which hosts a variety of classes in which MSHO members may sign up and attend as part of their plan benefits. Juniper continued to offer online classes in 2022, which had a positive impact for rural beneficiaries and their ability to attend. Please see MSHO supplemental Benefit Utilization 2022 at the end of this document.

e. Members received health assessment mailings which will help determine the health status of members. MyStrength program continues to have above average engagement in 2022. Members are targeted using claims & health assessment (HA) data to identify those with: mental health attributes in the high or medium category (HA results), and/or diagnoses of anxiety, depression, bipolar disorder, PTSD, smoking, substance abuse and insomnia. Targeting aligns with myStrength programs. New members are identified & sent campaigns monthly. Members are sent one per year.
f. Pharmacy Initiatives:
    i. Partnership with MSHO care coordinators to increase MSHO Medication Therapy Management (MTM) engagement has been successful and we will plan to continue in 2023
    ii. Pay for performance program incentivizing Stars engagement across our MTM network
    iii. The Mail Order Pharmacy vendor launched an auto-refill program for Medicare members in Q42022.
    iv. 2022 marked the first year of focused interventions to improve medication adherence across Medicare Advantage products with care coordinator teams; several tools were built to support this work.
g. In 2022 HealthPartners continued to utilize social media, where communication was customized with links to blogs and customer education.
    i. Member HEDIS® specific interventions
        1. Breast cancer screening: Those members who signed up to receive email notifications were sent reminders to complete breast cancer screening.
            a. Screening reminders launched mid October for patients and member/patients
                i. Member/patients have coverage information and online scheduling call to action embedded
            b. MSHO member/patients include incentive language
            c. Three touchpoints:
                i. Awareness (age 40)
                ii. Reminder 1 (one year since last screening)
                iii. Reminder 2 (two years since last screening)
            d. Translated into Spanish, Somali and Vietnamese for MSHO
            e. New patients are identified & sent campaigns weekly. Sent max one per quarter.

f. MSHO Community Health Workers Solutions provided outreach to select individuals to encourage completion of breast cancer screening.

2. Colorectal cancer screening: Those members who signed up to receive email notifications were sent reminders to complete colorectal cancer screening. Preventive care reminders on mobile and blogs, MSHO member incentive. HealthPartners utilized an "opt in" Colorectal FIT Kit Campaign through Virtuwell in 2022 to Medicare members in need of colon cancer screening.
3. Osteoporosis management in women with a fracture: The largest provider group enhanced the electronic medical record (EMR) using a Smartform with questions for identified orthopedic patients which populated a standardized Smartest to include a referral for bone health, a referral for DEXA and appropriate labs. A member letter is sent from the health plan, encouraging members to receive follow-up screenings. QIC sends the list of members with a history of a fracture per QIC process.
4. Diabetes care: Kidney disease monitoring, MSHO Chronic Care Improvement Program (CCIP) focused on diabetic nephropathy and is in it's final year.

h. HealthPartners has submitted comments to CMS regarding the member perception surveys and how they are weighted. CAHPS surveys will continue to be quadruple weighted for 2024 Stars. CMS supports the strong body of evidence that better experience is associated with adherence to treatments across a whole spectrum of diseases which identifies a tight connection to clinical outcomes.

Provider Interventions:

1. Fast Facts article highlighting annual wellness visits and the importance of falls and physical activity discussions.

2. Fast Facts article highlighting the United States Preventive Services Task Force (USPSTF) new colorectal screening recommended guidelines to age 45 for screening.

3. Breast cancer screening: the largest provider group reviewed needed screenings in the care model process and provided outreach.

4. Colorectal cancer screening: the largest provider group reviewed needed screenings in the care model process and provided outreach, FIT Kit campaign coordination with HealthPartners care group as they also identified eligible members for FIT kits,

5. Osteoporosis management in women who had a fracture: the largest provider group conducted fracture follow up to facilitate bone density testing or medication prescriptions to treat or prevent osteoporosis within the 6-month timeframe of the fracture. A quality committee met to determine future strategy. Collaboration with incented providers to

conduct fracture follow up to facilitate bone density testing or medication prescriptions to treat or prevent osteoporosis within the 6-month timeframe. The osteoporosis grant was completed and work continued.

6. Diabetic nephropathy: The largest provider group implemented updated work flows around diabetic nephropathy to increase the frequency of urine testing. Subject matter experts met and determined that the health maintenance alert for the screening should fire eight months after the last screening was complete and turns off when a member turns 86 years old. If due, the microalbumin test is automatically ordered by support staff, which makes it easy to close this gap in care at the visit. This process has been in place for primary care at all HealthPartners Medical Group clinics, and Park Nicollet clinics. This work continued in 2022. This measure retired at the end 2022 and could possibly be replaced by Kidney Health Evaluation for Persons with Diabetes (KED).

7. Falls prevention: HealthPartners Care Group implemented a two question survey for falls risk in the electronic medical record (EMR) Smartset. Providers in the largest provider group have the ability to see the positive falls risk and order a physical therapy order if warranted.

8. HealthPartners continued the incentive program with the network partners with annual wellness visit completion, select HEDIS® measures in 2022, and reconfirmation of chronic conditions as appropriate.

9. HealthPartners met with MA incented network partners in the current incentive program with discussions regarding advancing health equity, member experience as well as more robust interoperability opportunities. The network partners continued to focus on social determinants of health (SDOH) by identifying food insecurities and transportation barriers for vulnerable populations and strengthening community partnerships to address the needs of the population.

Table 1

2022 Priority Measure Results

	COST			MSHO			Journey/Robin		
Priority Measures	**H2462 Star Score 2021**	**H2462 Star Score 2022**	**H2462 Star Score 2023**	**H2422 Star Score 2021**	**H2422 Star Score 2022**	**H2422 Star Score 2023**	**H4882 Star Score 2021**	**H4882 Star Score 2022**	**H4882 Star Score 2023**
Breast Cancer Screening	83% 5	78% 5	76% 4	69% 3	71% 4	62% 3	84% 5	83% 5	80% 5
Colorectal Cancer Screening	86% 5	83% 5	77% 4	76% 4	65% 3	65% 3	83% 5	82% 5	82% 5
Monitoring Physical Activity	45% 2	50% 3	50% 3	60% 5	53% 4	53% 4	52% 4	55% 4	55% 4
Reducing the Risk of Falling	48% 1	45% 1	45% 1	75% 5	77% 5	70% 5	57% 3	52% 2	52% 2
Osteoporosis Management in Women Who Had a Fracture	27% 1	Not enough data	Not enough data	Not enough data	Not enough data	Not enough data	Not enough data	19% 1	30% 1
Diabetes Care - Kidney Disease Monitoring	94% 3	86% 2	91% 2	96% 4	93% 3	96% 4	95% 4	93% 3	97% 5

Color Legend	1 Star	2 Star	3 Star	4 Star	5 Star

Table 2.

Assessment of Results

Measures	Details	Cost	MSHO	Medicare Advantage
Breast Cancer Screening	Star Score	4	3	5
	Change	decrease	decrease	maintained
	Gap to next Star	~1%	7.7%	NA
	Initiatives	NA	CHW solutions outreach	NA
Colorectal Cancer Screening	Star Score	4	3	5
	Change	decrease	maintained	maintained
	Gap to next Star	2.3%	5.6%	2%
	Initiatives	Colorectal FIT Campaign	Colorectal FIT Campaign	Colorectal FIT Campaign
Monitoring Physical Activity	Star Score	3	4	4
	Change	maintained	maintained	maintained
	Gap to next Star	3%	4%	2%
	Initiatives	Added Silver Sneakers	Added Silver Sneakers	Added Silver Sneakers
Improving Bladder Control	Star Score	2	4	3
	Change	increased	maintained	maintained
	Gap to next Star	1.0%	4.0%	1.0%
	Initiatives	Annual Wellness Visit	Annual Wellness Visit	Annual Wellness Visit
Reducing the Risk of Falling	Star Score	1	5	2
	Change	maintained	maintained	maintained
	Gap to next Star	1%	NA	1%
	Initiatives	Falls Facebook Blog (0.09% click through rate)/potential for PT referral	Juniper Classes/Falls Facebook Blog (0.09% click through rate/potential for PT referral	Falls Facebook Blog (0.09% click through rate)/potential for PT referral
Osteoporosis Management in Women	Star Score	NED	NED	1
	Change	NA	NA	maintained
	Gap to next Star	NA	NA	2%
	Initiatives	Osteoporosis Strategy	Osteoporosis Strategy	Osteoporosis Strategy
Diabetes Care-Kidney Disease Monitoring	Star Score	2	4	5
	Change	maintained	increased	increased
	Gap to next Star	2%	1%	NA
	Initiatives	Diabetes Strategy	Diabetes Strategy	Diabetes Strategy

- Reducing the risk of falling maintained a 1 Star rating for Cost but MSHO has maintained a strong 5 Star performance year over year. Medicare Advantage decreased to a 2 Star. Falls Prevention Facebook campaign was completed in September with a reach of 177,089 (total # of people who see the content), 156 clicks, and a click through rate of 0.09%.

Barrier Analysis

1. Inability to monitor the full impact of improvement interventions on hybrid HEDIS® Source Star measures over the course of a measurement period.
2. Inability to monitor impacts of improvement interventions for Consumer Assessment of Healthcare Providers and Systems (CAHPS) and Health Outcomes Survey (HOS) Source Star measures over the course of a measurement period. Additionally, CAHPS measures are member reported which rely on member perceptions.
3. Difficult to focus improvement efforts for members who are not attributed to a specific care delivery system.
4. Improvement targets need to be flexible as measure technical specifications and star rating cut points are updated annually.
5. Access to care continued to be an issue with pent up demand, and staffing shortages due to illness and burnout. Providers had to shift care to meet the needs of the members which made it more difficult to receive appropriate medical care in a timely manner in the early part of 2022.

Opportunities for Improvement: Results/Outcomes

Table 3

HealthPartners 2023 Star Ratings

Market	Product	CMS Contract	2021 Rating	2022 Rating
MN	MSHO (MA SNP)	H2422	5	5
MN | WI	Journey/Robin (MA)	H4882	4.5	5
MN | WI | ND | SD	Freedom (Cost)	H2462	4.5	5

Actions for 2022 (2024 Star Ratings)

- Evaluate annual wellness visit initiatives in the Medicare population

Table 4

Annual Wellness Visit 2022 Completion Rates

Annual Wellness Visit Completion Rates	2019	2020	2021	2022	Statistically Significant Impact 2021 to 2022
H2462 (Cost)	30.7%%	26.00%	29.10%	34.30%	↑5.2%
H2422 (MSHO)	55.90%	50.00%	59.40%	62.40%	↑3.0%
H4882 (Journey/Robin)	60.20%	56.90%	64.50%	68.00%	↑3.4%

- Continue to promote annual wellness visit campaign in an effort to achieve the highest threshold goal for maximum member health outcomes.

Member Outreach Campaigns: Outreach campaigns to members are deployed each calendar year and impact HEDIS® results for the next measurement year. Campaigns through the Personalization Pipeline included email, web bell notifications, push notification for myHP users, and HCSS talking point channels (talking points for when a member calls into Member Services). There is coordination with the largest provider group for outreach campaigns so as not to duplicate messages. The below results represent annual wellness visit completion rates for the Medicare Advantage incented providers.

Table 5

Annual Wellness Visit 2022 Completion Rates for Medicare Advantage Incented Providers

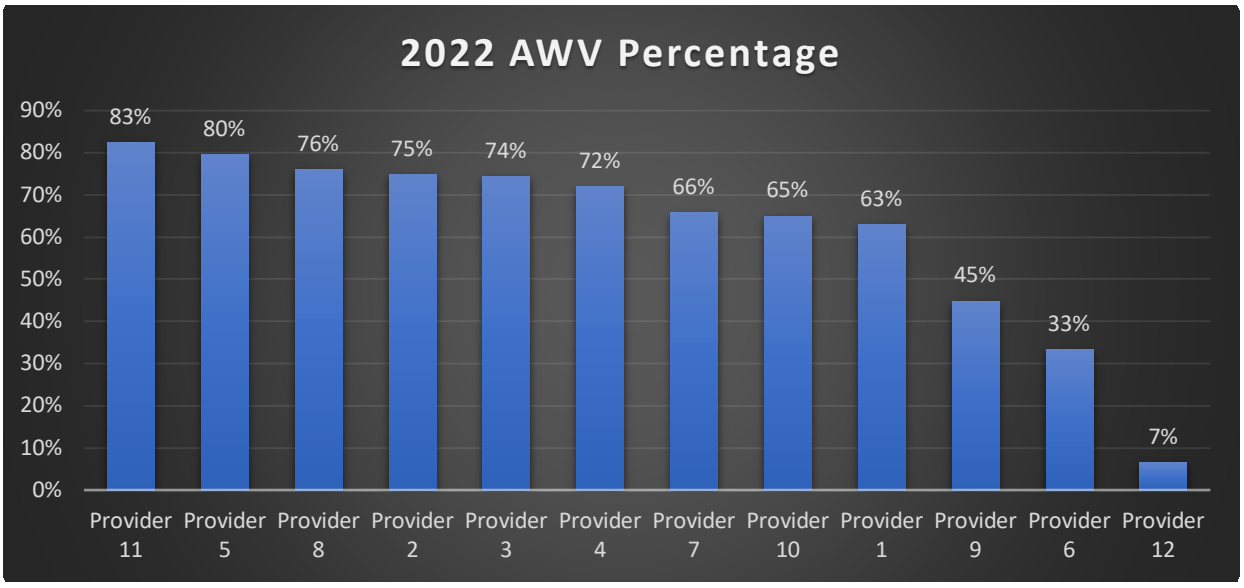


Table 6

Marketing Campaign Results and Trends 2022

Campaign	2022 Results (all plan types)	2022 Results (Medicare)	2022 Results (MSHO)	Conversion driven by campaign	Trends
Breast Cancer Screening (mbr and mbr/pat)	21.6% email 12.9% DM 17.4% Text	30.4% email 18.75% DM 23.3% Text	24.7% email 19.9% DM 13.6% Text	2021: 8.6% 2022: 14.6%	Significant increase in conversion by shifting member/patients to care voice, adding channels and enhancing existing.
Colon Cancer Screening	3% digital	3.1% digital	1.1% digital	2021: 2% 2022: 1.9%	Performance is flat. Access may have some impact. FIT kit results have helped increase conversion.
Osteoporosis Screening	18.9% digital 16.8% DM	19.4% digital 17.4% DM	0% digital 11.1% DM	2021: 2.7% 2022: 5.2%	Only 238 Medicare and 13 MSHO message sent in 2022. Not possible to draw strong conclusions.
Annual Wellness Visit/PCP Visit	23.4% digital 13.1% DM	37.6% digital 19% DM	50% digital 37.9% DM	2021: 17.9% 2022: 15.5%	Conversion change primarily due to several campaign pauses in 2022 (access). Performance is overall steady.
Pneumonia vaccine	3.3% digital	4.1% digital	4.9% digital	2021: 2.5% 2022: 2.3%	Steady performance over tow years. Small volumes.
Flu Shot	19.3% digital 15.5% DM	47.3% digital 36.9% DM	30.3% digital 29.8% DM	2021: 6.2% 2022: 6.5%	Overall steady; Medicare and MSHO conversion rate much higher than overall. 15% Medicare, 11.1 MSHO.
myStrength	52% open rate	56% open rate	0.4	NA	Above average engagement. No 2021 comparison (launched late 2021)

1. HEDIS® Actions
    a. Continue successful member communication outreach campaigns associated with breast cancer and colorectal cancer screening.
    b. Continue and enhance the colorectal FIT opt-in program
    c. Collaborate with HealthPartners largest provider group on initiatives designed to improve performance on the osteoporosis management in women with a fracture measure. Deploy both short and long term strategies to impact this population, develop outreach campaign for eligible members.
    d. The largest provider group implemented updated work flows around diabetic nephropathy to increase the frequency of urine testing. Subject matter experts met and determined that the health maintenance alert for the screening should fire eight months after the last screening was complete and turns off when a member turns 86 years old. If due, the microalbumin test is automatically ordered by support staff, which makes it easy to close this gap in care at the visit. This process has been in place for primary care at all HealthPartners Medical Group clinics, and Park Nicollet clinics and still continues.

2. Consumer Assessment of Healthcare Providers and Systems: member outreach campaign

3. Health Outcome Surveys: member outreach campaign

4. Provider Relations Incentive Program: develop collaborative partnership to focus on increasing or maintaining the health of the members through annual wellness visit completion and select HEDIS® measure incentives

5. Community Actions
    a. Minnesota Community Measures reports on breast cancer and colorectal cancer screenings and osteoporosis management in women with a fracture

The Stars Work Group will continue to monitor progress on efforts to positively impact Stars measures.

Table 7

MSHO Supplemental Benefit Information Comparison

- Process changed in 2022, introduced a checklist order form, stream-lined, increased utilization

Supplemental Benefit		**2021 Usage**	**2022 Usage**
Silver and Fit Fitness Membership	Silver & Fit health club membership and at-home fitness kits.	4,638	
SilverSneakers membership	replaced Silver and Fit		2,091
Wearable activity tracker.	Electronic device to track steps and calculate calories burned.	292	1125
Wellness Classes	Juniper Classes, Diabetes Prevention Program, Living Well with Diabetes, and more.	29	254
Wellness support and education	A tablet with education and wellness tools for members with diabetes, heart disease, cognitive impairment or depression.	291	364
Nutrition Assistance	Home delivery of meals immediately following surgery or an inpatient hospital stay.	49	58
Nutrition Support	Weight Watchers (WW) Weight management program.	44	500
FarmboxRx	Fresh produce boxes filled with fruits and vegetables delivered to members with a qualifying Dx (NOTE: total includes all members and not just those with diabetes)		38,617 boxes

Supplemental Benefit		2021 Usage	2022 Usage
Transportation to health clubs	SilverSneakers		1895 total trips
Transportation to health education classes	Juniper classes, Weight Watchers		134 total trips

Pharmacy

Accountable owner: Pharmacy Administration

Member Populations Targeted

X	Commercial
X	Medicare Freedom (Cost)
X	Medicaid
X	MSHO
	HPUPH
X	WI Marketplace

Description

The HealthPartners Pharmacy Quality and Utilization Improvement Program seeks to fulfill HealthPartners mission and vision by monitoring, promoting, and supporting the appropriate, safe, and efficient use of high-quality and cost-effective medications by our members.

Goals

HealthPartners Pharmacy's goals (as detailed in the 2021 Quality Improvement Annual Plan) included:

1. Continue to align our Medication Therapy Management (MTM) activities for sustainability and expansion.
2. Continue to enhance our opioid safe use program to maintain leadership position.
3. Continue to improve and expand pharmacy opportunities in our Partners in Excellence Program.
4. Enhance partnership between HealthPartners Health and Care Engagement (HCE) with pharmacy for high risk and/or other defined members.
5. Leverage pharmacy navigator program to improve member experience in our Medicare Advantage Program.
6. Continue work to automate prior authorization (PA) and appeals process.
7. Achieve best CMS Star Ratings, Pharmacy Quality Alliance (PQA), and pharmacy HEDIS measures.
8. Increase participation in MTM as percent of eligible members.
9. Evaluate results of Slice of PIE Program(SoP) performed to assist and reward community pharmacies in providing MTM services to HP members.
10. Expand member engagement of our price transparency tool and other apps to improve experience.
11. Alignment with organizational strategies for advancing health equity to address unconscious bias; cultivate cultural inclusion.
12. Be proactive about how we review and present data about the populations we serve. Find disparities where they exist so we can begin to strategize how to address the problems.

13. Expand partnership with OncoHealth to drive appropriate oncology medication therapy that ensures access and affordability to oncology medications.

Initiatives/Interventions

1. **Medication Therapy Management**
    - Implemented electronic health record (EHR) tools to identify patients targeted by the health plan for MTM services which allowed for automated pending of referrals to the MTM program during primary care visits and upon discharge from HealthPartners hospitals.
        - Two new initiatives developed to increase MTM Provider network engagement:
        - The Medicare Stars Partners in Excellence Program(PIE) rewards network providers for engaging high risk members in MTM services.
    - We initiated a "Take-Back" program to reattribute members whose network providers are not adequately engaging members in MTM.
    - 6 new contracted practices were added to the MTM network in 2022: Drilling Morningside Pharmacy IA, Guardian, Lake Region HealthCare, Lewis Drug IA/SD/MN, Mille Lacs Health MN, NuCara Pharmacy IA.
    - In 2023, we expanded our proactive outreach efforts by adding a 0.5 FTE outreach assistant in addition to our existing staff. This significantly increased our ability to proactively connect with and encourage targeted members to schedule MTM visits.
    - In 2022, we experienced membership growth across commercial and government groups, and added enhanced MTM to two new self-insured groups.
    - To market the value of MTM pharmacists, MTM leadership has re-committed to conducting care system site visits to show clinical, experience, and stewardship data related to care provided by MTM pharmacists. Additionally, we provided patient marketing materials to increase awareness. We've also provided these types of materials to network providers upon request.

2. **Opioid Safe Use Program**
    - Provider monitoring programs continue to be used to monitor providers across the network and monitor clinic prescribing patterns.
    - Gold Card Program continues to improve palliative care and oncology providers' access to pain treatment by excluding them from formulary limits. This program is intended to improve service by reducing barriers and improve efficiencies as requests from these providers are generally approved.
    - An update to an opioid audit now allows multiple providers from the same practice location to prescribe a patient opioids. The audit previously flagged and blocked patients receiving opioids from multiple prescribers regardless of clinic location. This update has only been made for Medicare patients thus far.

3. **Health and Care Engagement (HCE) Partnership**
    - MTM pharmacists continue to participate in biweekly MSHO and Medicare Advantage case rounds. MTM adds input on specific HP member cases and provides MTM perspective and in some cases interventions when fitting.

- MTM pharmacists also present to MSHO and SNBC (Special Needs Basic Care) care coordinators to educate on MTM and services provided and encourage referrals.
- Pharmacy participates in complex case review meetings with HCE, behavioral health, and other clinical teams to discuss high risk patient cases and if there is more that can be done to support the member. Pharmacy's involvement may include referrals to MTM, recommendations for drug changes or optimizations for safety or affordability, and more.
- HealthPartners' High-Cost Case Management program identifies high cost pharmacy cases in which opportunities may be present to intervene for clinical appropriateness and cost savings. All cases are reviewed by clinical pharmacists and interventions are carried out with multi-disciplinary groups, including patients and their doctors. These cases may be brought for discussion at complex case review meetings with our Health and Care Engagement teams, as well as the clinical teams of our strategic ACO partners.

4. **Pharmacy Navigator Program**
   - Pharmacy Navigator Program provided additional support for disease and case management, and Riverview Member Services (RVMS) related to affordability questions. RVMS will call the Pharmacy Navigators if they have pharmacy related questions that they are struggling to answer.
   - Increased collaboration with Medimpact to develop plan for times of turbulence in the community, health systems, or drug supply chains.
   - Continuing to collaborate with the internal pharmacy team to overcome drug shortages through temporary authorization of brand/generic equivalent.

5. **Prior Authorization (PA) and Appeals**
   - Continuing implementation of #RFIALT initiative in the prior authorization process that steers prescribers towards our preferred products at the point of PA request. This prevents some unnecessary denials for non-preferred brands or biosimilars, and steers towards clinically appropriate, more affordable medications.
   - ePA auto-approval expansion: increased number of decision trees(DT) tied to auto-approval
   - Re-implementation processes have led to improvement in the automation of NF/NF PA reviews which decreased challenges previously presented by non-formulary drugs and commercial open plans.
   - Appealed medical cases can now be auto-routed. This decreases administrative burden on the DRT/MRB teams as well as the PA team by the avoidance of emails. The entire process is now systematic. This improves efficiency and decreases wait time for patients receiving care.
   - Created first auto approval DT for Medicare patients and currently running quality analysis on its accuracy. This will determine if we can set up more Medicare DTs for auto approval to help further reduce administrative burden on the PA team and decrease time to treatment for members.

6. **Slice of PIE (SoP) Program**

- To continue having community pharmacist participation and engagement in our MTM provider network, enhanced payment rates for our Partners in Excellence Program participants continued.
- A financial evaluation of the SoP program was conducted.

7. Price Transparency Tool

- Continuing to drive member engagement with the Price Transparency Tool though improved accessibility and member awareness.
- Pricing tool is now available for specialty medications for Medicare patients.

8. Health Equity and Disparities

- Continued work with Medimpact, CVS specialty pharmacy and other vendor partners on opportunities to advance health equity. This topic is addressed with all vendors.
- Improving access to healthcare through the Medicare $0 tiers initiative for increased access to vaccines.
- Addressed gender dysphoria with a coverage policy, to ensure appropriate medically indicated coverage based on Standards of Care for the Health of Transgender and Gender Diverse People, Version 8 (SOC-8).
- Making medications accessible for Medicaid members to ensure that prior authorization criteria does not disadvantage any populations.
- Inclusive leader cohort: Diversity Equity and Inclusion(DEI) engagement training for staff, embedding work sessions at the department level for discussing DEI initiatives as well as micro aggression learnings have all been initiated.
- Brought in expert leader in DEI (Barbra Banks) to train and introduce DEI strategy. This laid groundwork for DEI leader engagement on multiple levels including department level work sessions for DEI initiatives and microaggressions.
- Initiated pay for performance to engage providers in Medicaid referrals to MTM based on low utilization in Medicaid population.
- Race has been added to adherence dashboard for MTM. Currently gathering information and identifying opportunities to use this information to further address inequities.
- Initiated work with vendors (Fairview and CVS) to pull race from claims data to identify and address any inequities or disparities that may be present.
- P&T policy and procedures have been updated to reflect its additional function of preventing selection bias or discrimination in HealthPartners' formularies through a non-discriminatory formulary design.

9. OncoHealth

- This program brings expert oncologists closer to prescribers for case reviews and supports our broader oncology programs and initiatives across the organization.
    - Insert oncology expertise into the existing HP prior authorization process.
    - Steer to alternative therapies with equal efficacy.
    - Do not cover drugs with insufficient literature support; peer-to-peer rather than denial.
    - Improve consistency and confidence in drug denials.

    - Connect members to clinical trials for cancer types in which drug efficacy is not yet well-established.
- Effective 1/1/2022, we've expanded our relationship with OncoHealth so that all oncology drug requests are reviewed by an oncologist rather than a generalist. This ensures appropriate use of cancer medications, improving quality, safety, and affordability.
- Worked with top 20 provider groups that care for cancer patients, and worked with them to explain the benefits of making these changes and how to implement this change into their workflow to properly submit prior authorizations.

10. Pharmacy Quality – Medicare Stars, Partners in Excellence

- Continued focus on increasing pharmacy navigator role in supporting our Medicare Advantage members in partnership with our Riverview Member Services representatives to improve member experience.
- Developed new reporting and workflows in support of medication adherence interventions and outreach for our members with MSHO coverage.
- Added PQA/Medicare Stars medication adherence measures and statin use in persons with diabetes measures to our community pharmacy Partners in Excellence Program P4P opportunity.
- Created a pay for performance (P4P) opportunity to incentivize improvement in the Medicare Part D Comprehensive Medication Review completion measure.
- Created P4P opportunity to eliminate DPP4-GLP1 medication concomitant use.

Barrier Analysis

1. Medication Therapy Management

- Testing the components of a risk score to flag patients as well as pulling information out of the risk score has been a difficult process which led to delay in implementing new EPIC tools.
- Improving community pharmacy engagement in MTM relies on funding to implement, leadership support at each individual pharmacy, and efficient platforms to bolster engagement.
- In the ambulatory setting, pharmacists face challenges regarding stereotypes and expectations about what a pharmacist should do and how much they should or can be involved in caring for patients in partnership with the rest of the care team.
- Some pharmacists who practice in clinic have had difficulties finding and keeping a space within their clinic where they can practice; this is due to clinic construction projects, turnover and growth of clinician teams, etc.
- Continue to see missing objective values (BP, A1c, etc.) due to members relying on the telehealth options that were more fully developed during the pandemic. We continue to have high levels of engagement in MTM via phone or virtual visits due to patient preferences. Currently able to take patient-reported BP values but have no way of measuring A1c values besides via lab.
- Ability to proactively sell enhanced MTM to self-insured groups is limited by internal resources.

2. **Opioid Safe Use Program**
    - Medimpact needs coding in place to more effectively run/support the Gold Card Program intended to improve specific provider access to pain treatments for patients.

3. **Health and Care Engagement (HCE) Partnership**
    - Interventions in high-cost case management situations often require buy-in from prescribers and patients, and recommended interventions may be voluntary. Therefore, some potential interventions have been unsuccessful due to provider and patient preferences.
    - Health informatics resources that are required for high-cost case management and building a designated queue for this work.

4. **Prior Authorization (PA) and Appeals**
    - Increasing the number of DTs tied to auto-approval is challenging due to competing priorities for staff working on DT data entry and testing. Currently DTs are reviewed/targeted as they come up for review due to other changes (e.g. formulary changes, suggestions for improvement from staff, compliance concerns, high cost). It is not feasible to complete a larger-scale expansion beyond this due to the need to prioritize other DT changes and competing projects/work of those involved in the DT process(there is no staff dedicated to only DT work).
    - System limitations from MHK still present challenges, although work is currently being done to test new functionality due to a system upgrade in 2023 for multiple overrides.
    - Expansion of the auto approval process into Medicare pharmacy reviews. A pilot in 2022 was started but has yet to be expanded to more DTs. Due to system set-up, Medicare cases continue to need human review and approval for each case, so even with current piloted DTs, human intervention is still needed.
    - Dual coverage still presents a challenge in implementing auto-routing of appeal cases.
    - Appeals Turn-around Time(TAT) differs across different lines of business, so Medhok TAT's are not able to be automated due to the variability of case types, and appeals TAT's.

5. **Slice of PIE Program**
    - Unable to complete ROI evaluation of the SoP program due to losing access to a national commercial claims database that was integral in being able to perform a comparison between the SoP group and a control group. Clinical and engagement results have been positive and ensure the continuation of a SoP cohort for our MTM focused pay-for-performance metrics which provide sufficient incentives for their relatively smaller HP population.
    - Community pharmacies continue to struggle with high workloads and reduced reimbursement coming out of the pandemic. Payment for MTM services needs to be adequate for pharmacies to commit resources to the work.

6. **Price Transparency Tool**

- The pricing tool only takes into account the member's primary insurance. For this reason, members who have dual-coverage without coordination of benefits through HealthPartners do not necessarily receive an accurate price.

7. **Health Equity and Disparities**
   - No national standard or guidance exists related to the role of a health plan, in advancing health equity, addressing unconscious bias, or identifying disparities.

8. **OncoHealth**
   - When in the process of implementing this partnership, provider practice patterns required change. This presented challenges for providers in needing to change their workflow and how they submitted PA requests.

9. **Pharmacy Quality – Medicare Stars, Partners in Excellence**
   - We continue to learn which information is most important for surfacing pharmacy intervention opportunities related to Medicare Star Ratings measures.
   - We continue to work on how frequent to identify and disseminate pharmacy intervention opportunities.
   - We continue to struggle with our network providers having sufficient resources to dedicate time to quality related activities.

Gaps in Care

1. **Medication Therapy Management**
   - Varying levels of success in engaging members are experienced when comparing different MTM providers within our network.
   - Currently most focused on selling the enhanced MTM program to larger groups with most potential to benefit. As the program improves and resources increase, smaller groups will be targeted more often.

2. **Health and Care Engagement (HCE) Partnership**
   - Real-Time Pharmacy Benefits are limited to pharmacy benefit medications only.
   - Not all practices have Real Time Pharmacy Benefits implemented into their EHR.

3. **Prior Authorization (PA) and Appeals**
   - Cannot auto approve for anything for Medicaid that is on the PDL(Medicaid), but drugs where we follow commercial, we can auto approve. This is due to the criteria for non-preferred drugs on the Medicaid list requiring trial failure of other drugs which requires a manual review of chart notes.

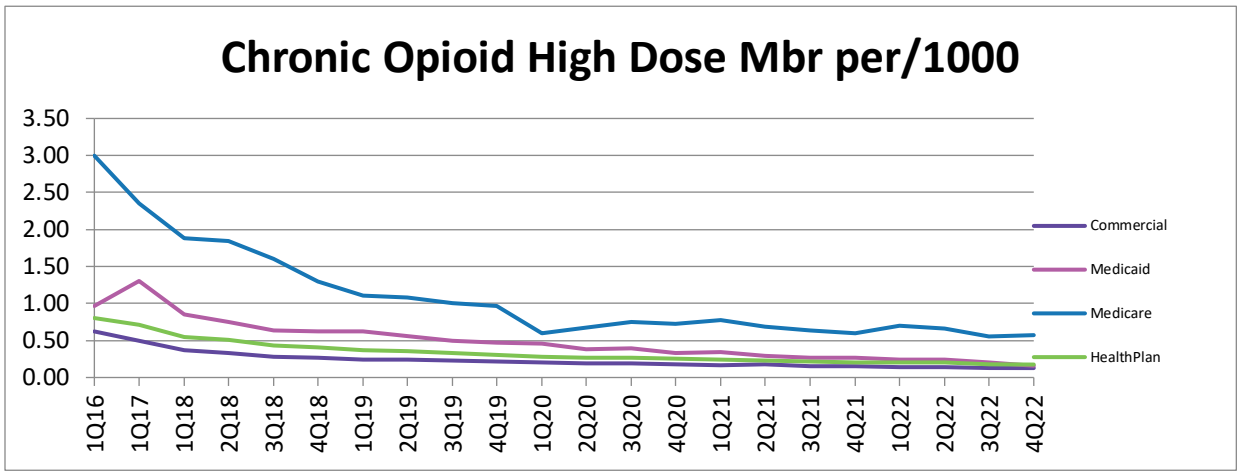
Opportunities for Improvement: Results/Outcomes

1. **Medication Therapy Management**
   - Appointment 'no show' rates increased in the care system from 11.8% (990/8,361) in 2021 to 14% (1,192/8,308) in 2022. This was likely a result of the additional focus on engaging Medicaid members. Medicaid members accounted for 48% of the 'no shows' in 2022 compared to 35% in 2021.

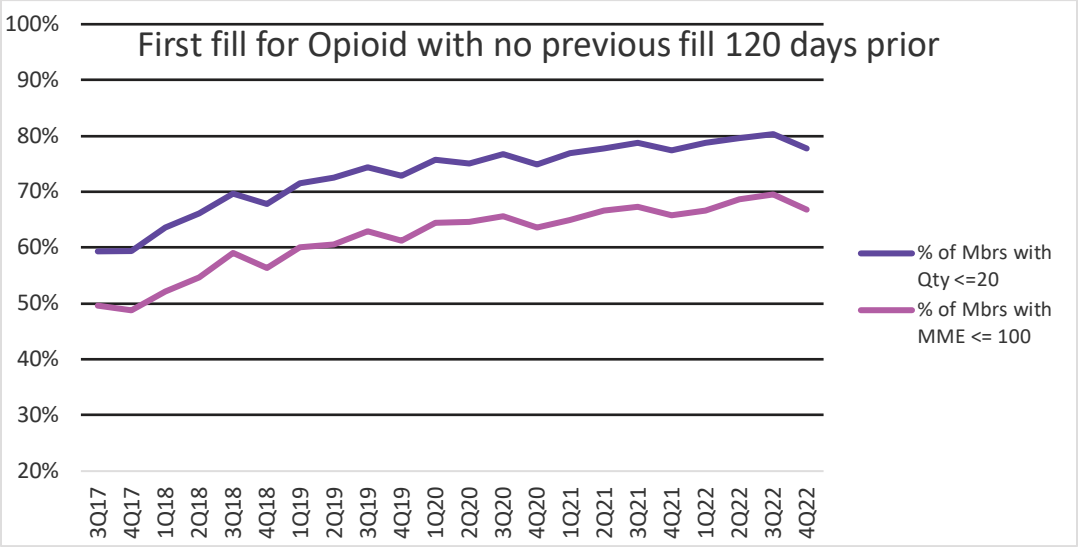
- There is an opportunity to partner with network providers to understand how we can optimally support those with low engagement.
- Community pharmacy engagement in MTM from external provider groups is difficult to increase due to them being autonomous. More frequent touch bases with this group could help improve this.
- Overall engagement of Medicare Stars targeted members increased from 84.6% in 2021 to 86.7% in 2022
    - MSHO and PDP engagement increased to 5 star level
        - 87.5 (2021)>93 (2022)% MSHO
        - 72.3>85.2% PDP
    - Medicare Advantage will remain 4 star level
        - 86.6%>85.3%
    - Expected MTM star ratings based upon modeled cut points (official not available until September 2023)
- Targeted members increased from 22,492 in 2021 to 25,468 (13.2%). The number engaged increased from 5,400 to 8,607 (37.3%). Overall engagement of targeted members increased from 24% to 26.78% in 2022.
- MTM Patient Satisfaction: 97% of MTM participants are willing to recommend to family/friends.
- Network pharmacist visits increased 27.8% year-over-year compared to HealthPartners care system visits increasing by 5.4%.
- Overall (not targeted) unique members with MTM increased from 8,896 in 2021 to 10,992 in 2022 (23.6%). Total visits increased from 15,426 in 2021 to 18,389 in 2022 (19.2%).

2. Opioid Safe Use Program

- Pharmacies are retrospectively reviewed for any outlier patterns of opioid dispensing. This past year there have been no pharmacies that needed to be reported by HP.
- From 4Q2021 through 4Q2022, the rate of chronic high dose (>= 120 mg MME) opioid use among HealthPartners members has decreased 14%.
- From 4Q2021 through 4Q2022, the rate of chronic high dose (>= 90 mg MME) opioid use among HealthPartners members has decreased 14%.



- Among HealthPartners members receiving their first fill of opioid medication (i.e., no prescriptions for opioids were filled in the preceding 120 days), there is an increasing percentage who are receiving low quantities (i.e., fewer than 20 tablets). In 1Q2017, only 56% of members were receiving low quantities; that percentage improved to 78% in 4Q2022.



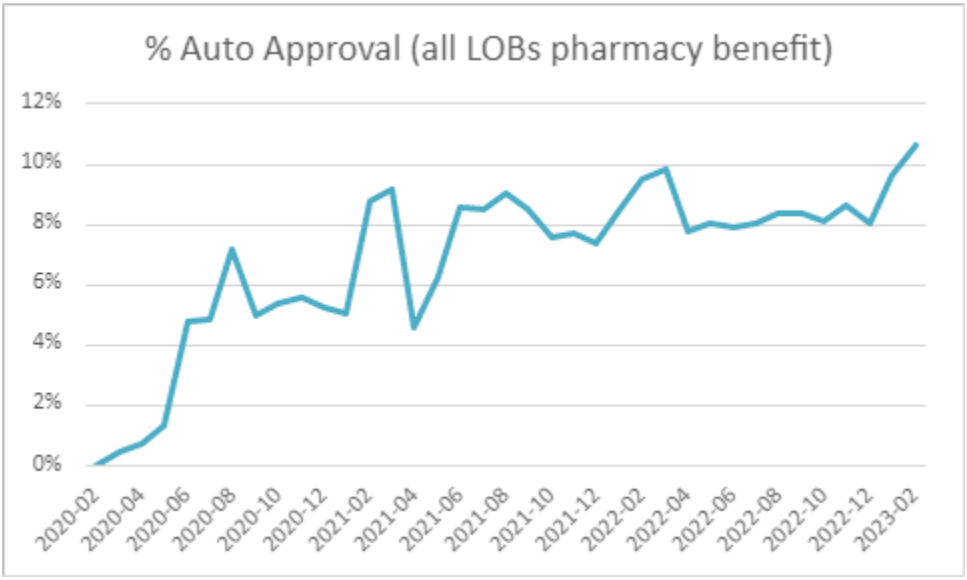
3. Health and Care Engagement (HCE) Partnership

- In 2022, over $2 million in savings resulted from clinical interventions on high-cost cases driven by pharmacy spend. Of the $2 million, about $1 million in savings resulted from high-cost case management specifically prioritizing members where site of care or network contracting interventions were appropriate.
    - HealthPartners received a national award for this program in September 2022 from PBMI (Pharmacy Benefit Management Institute), a research institute dedicated to assisting employer groups with optimizing their pharmacy benefits.
    - Improved queue management of high-cost case management is an area of opportunity for improvement.
- Continued expansion and improvements of the high cost case management program to identify more opportunities and work with our provider community to make positive changes for affordability and clinical appropriateness.

4. Pharmacy Navigator Program

- For 2022, 208 total members that were running into issues with the coupon accumulator program, coupon maximizer program, or medical injectable site of care (MISOC) program have been supported by the navigator program.
- See “Pharmacy Quality – Medicare Stars, Partners in Excellence” section for Medicare Advantage CAHPS performance.

5. **Prior Authorization (PA) and Appeals**
    - 70 brand new DTs were created in 2022. As of March 2023, 734 total DTs are completed or actively being worked on (673 are live in MHK).
    - 6,486 auto approvals were processed in 2022 compared to 5,890 in 2021.
    - Approximately 8.5% of all pharmacy benefit requests were auto approved.
    - Approximately 11.3% of commercial pharmacy cases with a request type of “Pharmacy PA” were processed through auto approval by the end of 2022.
    - Approximately 7.4% of Medicaid pharmacy cases with a request type of “Pharmacy PA” were processed through auto approval by the end of 2022.
    - 134 different drugs are available to be processed through auto approval since the program’s inception
    - 10,217 total cases did not need to go to a human reviewer in 2022. This includes 6,486 auto approvals and 3,731 that were not auto approvals (e.g. dismissed by system or withdrawn by provider).
    - Graph of percent auto approved over time is below.



    - Less than 2% of all PA’s approved for Medicare have missed turn-around time requirements in 2022.
        - Medical claims have a much longer TAT window so when they get to the PA team, the Medhok TAT shows as a miss, but the claim TAT has not been missed.
    - From 2021 to 2022 staff productivity was maintained at about 12 cases per hour
    - Increase comprehensive training of all team members to decrease knowledge gaps resulting from turnover. Cross-trained staff on processes to diversify skillsets. Processes included medical policy, DMR (direct member reimbursement), DCM (denied claim management), RFI, and intake (logging faxed requests).

6. **Slice of PIE Program**
    - 12 community pharmacies have been enrolled.

- 593 patients were provided MTM services as a result.
    - 2 Gold Winners
    - 1 Silver Winner

7. Price Transparency Tool

- Of the 480,519 medical members who logged into their HealthPartners account, 20,371(4.2%) accessed the Medimpact Price Transparency tool in 2022.

8. Health Equity and Disparities

- Increased access to vaccines for all lines of business.
- Engaged 70% more Medicaid members in MTM services in 2022 compared to 2021 as a result of the P4P initiative.

9. OncoHealth

- OncoHealth has exceeded 24 out of 24 timeliness metrics.
- We have seen a reduction in appeals and overturns for cancer drugs since expanding our partnership with OncoHealth.
- For Employer and HP savings, there was $10.7 million in cost avoidance over the course of 2022
- Oncohealth is in the process of updating their platform. This will go live in June 2023. This will align their system capabilities more closely with our custom formulary. This will lead to an improvement in operations and efficiencies.
- OncoHealth will begin reviewing medical exception requests with site of care for oncology drugs which will improve efficiency and quality and safety.

10. Pharmacy Quality – Medicare Stars, Partners in Excellence

	2022 (2024 Stars)*			2021 (2023 Stars)		
	MSHO	PDP	JOURNEY	MSHO	PDP	JOURNEY
Statin Use in Persons with Diabetes	89% (4)	88% (5)	89% (4)	87% (4)	87% (5)	87% (4)
Diabetes Adherence	86% (3)	91% (5)	90% (4)	87% (3)	89% (4)	90% (4)
RAS Antagnonist (ACEI/ARB) Adherence	84% (2)	90% (4)	90% (4)	87% (3)	89% (4)	91% (5)
Statin Adherence	83% (2)	89% (4)	90% (4)	88% (4)	89% (5)	91% (4)
MTM CMR Completion Rate	93% (5)	85% (5)	85% (4)	88% (4)	72% (4)	87% (4)

Green indicates performance improvement from previous year (7 measures)
Red indicates performance decreasing from previous year (6 measures)
Black indicates equal performance to previous year (2 measures)

*All 2022 values are as of 1/1/2023 and are preliminary. MTM measure does not account for hospice denominator exclusion

- We experienced year over year improvement on 7 out of 15 potential Star measures across our Medicare contracts.

ID	Measure Name	MSHO (H2422) 2022	MSHO (H2422) 2023	Med Adv (H4882) 2022	Med Adv (H4882) 2023	PDP (S1822) Score 2022	PDP (S1822) Score 2023
D05	Rating of Drug Plan	86 (3)	87 (4)	85 (2)	87 (4)	86 (4)	88 (5)
D06	Getting Needed Prescription Drugs	89 (2)	88 (2)	91 (4)	92 (5)	91 (4)	91 (4)

- For Medicare CAHPS patient experience measures, which were a focus of our pharmacy navigator effort, we saw:
    - Improvements of 1-2 stars on 4 out of 6 measures and equal performance on the other 2
- MSHO saw significant performance drops. In October of 2022, MSHO adherence became a top priority for our MTM pharmacists in collaboration with the MSHO care coordinators. Effects were not significant due to the late start and limited opportunity to effect final outcomes, but increased knowledge and expertise on how to operationalize the work sets us up well for 2023.
- Out of a potential of 5 community pharmacy Partners in Excellence Community Pharmacy Awards, only 1 award met P4P criteria (CVS pharmacy achieved silver performance for high performance on the 3 Medicare Part D Stars Adherence measures)
- For MTM Partners in Excellence, 4 practices achieved gold level performance and 4 achieved silver level performance.
- For our DPP4-GLP1 concomitant use program, 45 successful interventions occurred in the first 6 months of the program.

Safety

Member Populations Targeted

X	Commercial
X	Medicare Freedom (Cost)
X	Medicaid
X	MSHO
	HPUPH
X	WI Marketplace

Description

Safety is a top priority for the HealthPartners organization. HealthPartners is dedicated to function as a high reliability organization by consistently delivering on the triple aim, providing a culture of safety, and creating a safe and healing environment for everyone. The importance to report all safety events and member feedback is essential to us becoming a high reliability organization.

HealthPartners is committed to eliminating harm due to error in the delivery of medical care. Hospital and patient safety is addressed by many organizations including The Leapfrog Group, The Joint Commission, The Agency for Healthcare Research and Quality, and America's Health Insurance Plans. However, less research has focused on patient safety in the ambulatory setting, including group practices, yet members are receiving the greatest proportion of their care in these settings.

Safety is top priority for our organization. Everyone at HealthPartners plays a role in creating a safe and healing environment. We recognize errors can occur during the care delivery of patients, and that these errors are a source of significant suffering, illness, cost, and death. A "culture of patient safety" is an essential factor in the care delivery model of an organization.

Goals

HealthPartners will demonstrate its commitment by reducing errors for our members and patients wherever they receive care by:

1. Enhancing the knowledge base about safety through our experience and research.
2. Supporting care delivery systems by establishing standards and expectations related to safety.
3. Working collaboratively with government and private groups to improve safety.
4. Establishing safety measures and reporting results to members' physicians and practitioners.
5. Training health care professionals to be competent in health care practices that improve patient safety.
6. Reporting and investigation of quality issues such as medical errors, potential medical errors, patient safety issues, and service issues.

Initiatives/Interventions

1. The 2023 Ambulatory Patient Safety Toolkit was updated and is available at www.healthpartners.com.
2. Completed an annual assessment of member safety, communication of safety improvement opportunities to providers, and updates to safety improvement tools.
3. HealthPartners continues to be involved with the MN Health Plan Collaborative which reduced the rate of new chronic users of opioids in the Medicaid and Medicare population.
4. Implemented a comprehensive approach to pain management.
5. Safety indicators are incorporated in the measures that define the tiered provider networks for member informed decisions about network selection.
6. The Medication Therapy Management (MTM) program continues to expand and improves coordination of care and medication safety of our member and patients.
7. Improved strategies to minimize the abuse of drugs, including a continued focus on pain management.
8. Distributed Agency for Healthcare Research and Quality (AHRQ) Patient Safety indicator comparative results to hospitals.
9. Alerts sent to providers whose prescribing dosages were outside of safe limits.
10. Identified and initiated interventions for overprescribed medications and diversion, such as quantity limits and enhanced prior authorization review requirements.
11. Identified high-risk medications in the elderly and initiated interventions through the MTM program.
12. Identified members using medications newly identified with Food and Drug Administration (FDA) safety concerns and sent safety alerts.
13. Supported a safe network of care through a robust credentialing program.
14. Worked to improve patient understanding of health information by reviewing and simplifying patient education materials, letters, and forms across care delivery clinics and hospitals.
15. Continue to utilize “Keep It Simple” - a glossary of preferred terms to use in member and patient communications and “Teach Back Method” – for patient teaching.
16. Prioritized key communications for updates to improve member understanding.
17. Posted stories about pain and medication management on our social media sites and worked with the local media to raise awareness of the public.

Barrier Analysis

HealthPartners identified three key barriers to patient safety; member awareness and knowledge of best safety practices, practitioner knowledge and the use of improved systems to ensure safe care is delivered.

Member knowledge:

1. Interactive safety tools are available through the Drug Interaction Checker and the Health Information Library online at www.healthpartners.com.

2. HealthPartners broadened access to telehealth and telemedicine services so that members can receive a wider range of services from their providers without having to travel to a healthcare facility.
3. When a member has a new prescription for an opioid and they get a refill, a letter is sent explaining some of the risks of opioids and giving information about other treatments that help manage pain. Members are encouraged to talk to their doctor about their options.
4. Members now have access to MTM services across the county.
5. When Special Needs Basic Care (SNBC) members refill their prescription, their care coordinator will work with them, so the member uses their medications safely.

Practitioner knowledge:

- New and revised USPSTF guidelines and pharmacy alerts are shared with providers via electronic provider communications and Fast Facts Newsletters.
- Electronic prescribing prompts are used whenever possible to steer practitioners to safe and effective first-line medications.
- Physicians and practitioners are encouraged to use the U.S. Preventative Services Task Force (USPSTF) guidelines and other health plan endorsed guidelines as a resource and encouraged to recommend the clinical guidelines for patients to review, which can be accessed on the USPSTF website.

Systems issues in the organization:

1. Quality of care issues involving safety are shared with involved physicians and practitioners and, if warranted, an action plan is requested.
2. Tracking/monitoring of quality-of-care concerns is routinely done to identify areas requiring follow-up.
3. HealthPartners has been a key partner in the development and support of the Minnesota Health Information Exchange; resulting in a statewide source of translated documents providing information on patient medications, easing the task of medication reconciliation, and improving information availability across different care systems.
4. HealthPartners has worked to assure clear communications through support and delivery of interpreter services, translated materials and programs to address low health literacy and promote health equity.
5. A safety and patient feedback reporting and tracking system were implemented across the organization.
6. Pharmacy has implemented new pain prescription guidance documents system wide.
7. Continue to work with our clinics and hospitals to make sure they are using best practices and adopting the Minnesota Opioid Prescribing Guidelines.
8. HealthPartners focuses on ensuring consistent safety across the organization. New roles were created to help align pharmacy and safety protocols across the organization to ensure safe medication administration and alignment with industry standards.

Opportunities for Improvement: Results/Outcomes

HealthPartners MTM Program continues to show an elevated level of patient satisfaction with 97% willing to recommend (agree and strongly agree) our MTM pharmacists in 2022.

HealthPartners members use their pharmacy benefits more often than any other benefit offered by the health plan. As such, pharmacy measures represent a comprehensive and broad-based measure of overall patient safety. HealthPartners has multiple programs to ensure appropriate prescribing. Pharmacy measures help the plan monitor efforts to reduce inappropriate care, ensure best treatment practices are followed and reduce the potential for harm.

Medication Therapy Management (MTM)- Partners in Excellence Program (PIE)

HEALTH: Quality Clusters			
Cluster 1: Appropriate Pharmacologic Therapy **Cluster Weight = 50%**	**Target**		
Measures	1.0 PT	0.5 PT	0 PT
Statin Use in Persons with Diabetes[1]	Rate >= 78.4%	Rate < 78.4% AND Rate >= 76.4%	Rate < 76.4%
Naloxone Dispensing to High-Risk Opioid Users[2]	Rate >= 13.7%	Rate < 13.7% AND Rate >= 8.3%	Rate < 8.3%
Cluster 2: Continued Use of Prescribed Medications **Cluster Weight = 50%**	**Target**		
Measures	1.0 PT	0.5 PT	0 PT
RAS Antagonist (ACEI/ARB) Adherence[1]	Rate >= 88.6%	Rate < 88.6% AND Rate >= 85.3%	Rate < 85.3%
Diabetes Adherence[1]	Rate >= 87.0%	Rate < 87.0% AND Rate >= 82.8%	Rate < 82.8%
Statin Adherence[1]	Rate >= 86.1%	Rate < 86.1% AND Rate >= 83.7%	Rate < 83.7%

AFFORDABILITY			
Affordability Cluster	**Target**		
Measures	1.0 PT	0.5 PT	0 PT
Brand Formulary Adherence Rate[2]	Rate >= 92.5%	Rate < 92.5% AND Rate >= 89.2%	Rate < 89.2%
Generic Dispensing Rate[2]	Rate >= 94.4%	Rate < 94.4% AND Rate >= 93.7%	Rate < 93.7%

MTM Health: Rate of Optimal care for Diabetes and Vascular Conditions – >47% MTM Affordability: MTM Engagement Rate - >40%

The MTM CMR Completion measure (final measure in tables) did not start until 2022 and will be first awarded in 2023.

Other winners as follows:

- Community Pharmacy PIE Cluster 1 – 2 silver winners
- Community Pharmacy PIE Cluster 2 – 2 silver winners
- Community Pharmacy PIE Cluster – Affordability – 2 pharmacies met measure; however, no awards were received based upon the cluster as it is used to move cluster 1 and 2 winners to gold and neither of the pharmacies who met the affordability cluster achieved success in cluster 1 or 2
- MTM Health: Rate of Optimal care for Diabetes and Vascular Conditions – 5 winners
- MTM Affordability: MTM Engagement Rate - 2

HEDIS Results

Commercial	2020	2021	2022
Treatment for Upper Respiratory Infection Appropriate Testing for Pharyngitis (*2020 new spec and age)			
A. Ages 3 - 17	94.0	93.5	88.3
B. Ages 18-64	88.3	83.7	74.6
C. Ages 65+	75.0	65.0	44.4
D. Total	91.5	88.8	79.8
Overuse Appropriateness Use of Opioids from Multiple Providers			
A. Multiple Prescribers	19.5	18.9	18.7
B. Multiple Pharmacies	3.8	3.1	2.2
C. Multiple Prescribers and Multiple Pharmacies	2.5	1.9	1.5

HEDIS Results

PMAP	2020	2021	2022
Treatment for Children with Asthma	69.6	73.2	72.4
Persistence of Beta-Blocker Treatment after a Heart Attack	89.2	90.5	89.1
Antidepressant Medication Management (Effective acute phase)	49.9	48.8	55.8

HEDIS Results

Medicare Cost (*limited membership)	2021	2022
Access to Preventive Health Services	93.7	94.4
Use of Opioids from Multiple Pharmacies	5.4	25.0

HEDIS Results

MSHO	2020	2021	2022
Antidepressant Medication Management (Effective acute phase)	72.1	85.2	83.7
High-Risk medication in Elderly two prescriptions	14.2	19.0	20.5
Harmful drug disease interaction	42.5	33.3	33.7

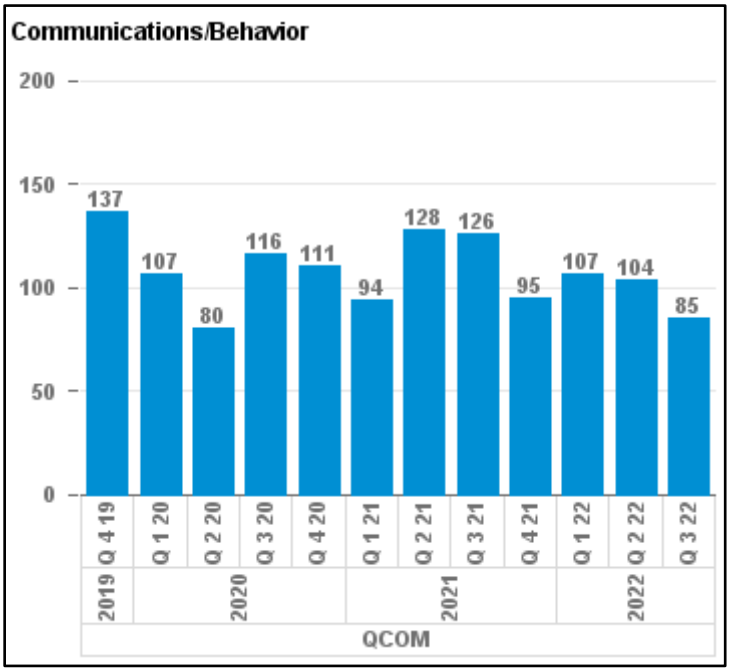
Quality of Concerns and Case Reviews

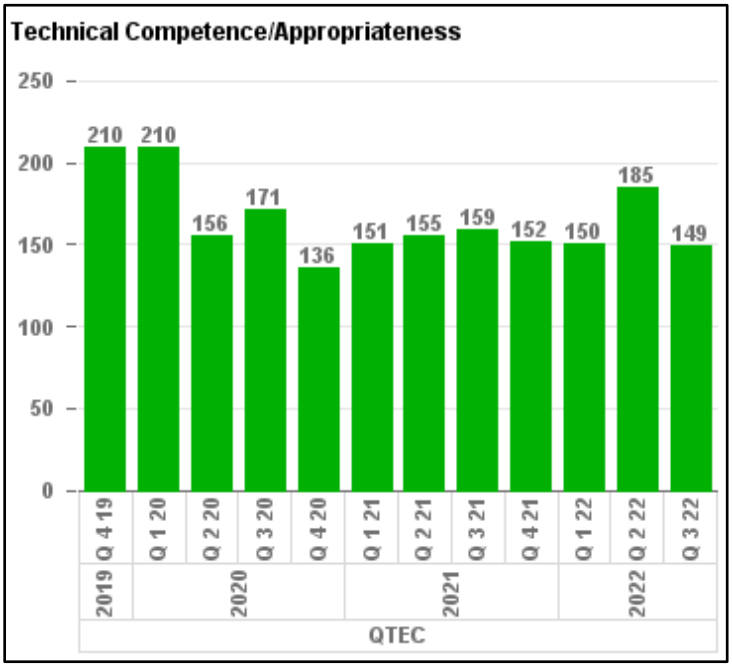
HealthPartners receives verbal and written concerns, categorizes member complaints and quality issues against practitioners and providers. Concerns are categorized as quality of care, access to care, provider communication and behavior, coordination of care, technical competence and issues related to the provider, facility and/or environment affecting patient safety. These categories include concerns regarding quality of service and/or care. HealthPartners conducts quality case reviews on all categories except access.

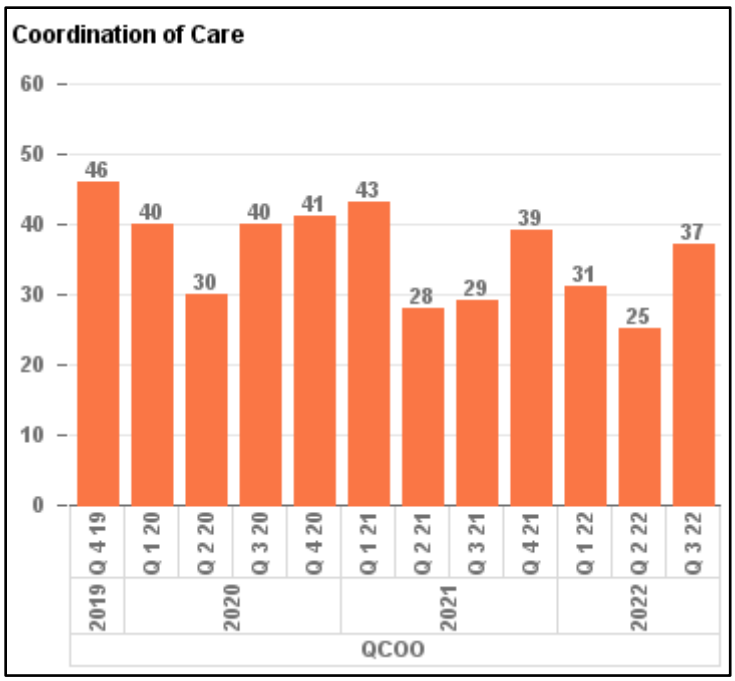
Total number of investigation and evaluation of quality-of-care case reviews

Year	Count SE
2020	1315
2021	1243
2022	1575

Total number of quality concerns received from Member Services in a rolling 36 months






Coordination of Care
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50
40
30
20
10
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46
40
30
40
41
43
28
29
39
31
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37
Q 4 19
Q 1 20
Q 2 20
Q 3 20
Q 4 20
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2019
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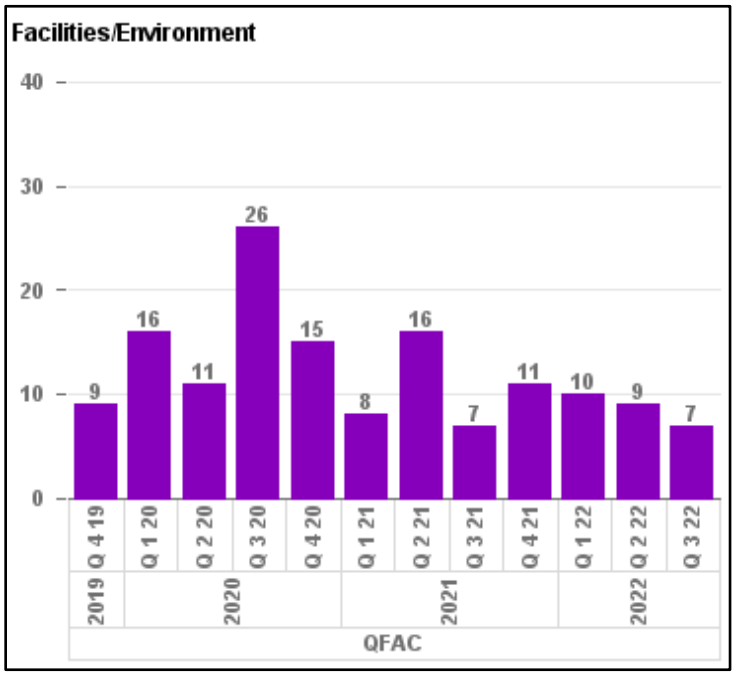
Facilities/Environment
40
30
20
10
0
9
16
11
26
15
8
16
7
11
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9
7
Q 4 19
Q 1 20
Q 2 20
Q 3 20
Q 4 20
Q 1 21
Q 2 21
Q 3 21
Q 4 21
Q 1 22
Q 2 22
Q 3 22
2019
2020
2021
2022
QFAC

Health - Compliance Activities

Withhold: Emergency Department Utilization

Description

Non-urgent use of emergency department (ED)services is a recognized problem, driving high health care costs and preventing continuous primary care. The lack of coordination and continuity of care between emergency departments and primary care providers can lead to lack of follow-up care, redundant testing, and even medical errors. At one time, HealthPartners data suggested that up to 70% of all ED visits fit the categories of either non-urgent or primary care treatable. More recent monitoring of HealthPartners member ED usage shows that the use of the ED for care that could more appropriately be received in another location has decreased significantly for all products (approximately 31% for Medicaid, 24% for commercial and 25% for Medicare Advantage members) but there is still opportunity to improve these rates.

In 2020, the COVID-19 global pandemic dramatically impacted the way that people accessed care across all places of service. At the onset of the pandemic, the Governor's orders impacting medical care, directed that non-essential care should be delayed. At the same time, we saw a significant drop in ED use and care systems ramped up their telemedicine offerings to offer alternatives to in-person care to continue to meet patient needs while mitigating the risk of exposure to COVID-19. Some of these changes were temporary, while others will likely continue to be part of the new normal for health care delivery going forward.

Ensuring that members use a site of care that is appropriate for their condition is directly related to all three objectives of the Triple Aim. Coordination of care and access to the right care at the right time will promote health and improve the member's quality experience. By providing the best care in the most appropriate site, costs reflect care received.

To address this issue, HealthPartners has implemented a multi-pronged approach that addresses the key drivers of avoidable ED visits, while encouraging members' use of services in an appropriate setting and developing a relationship with a PCP. Through the efforts detailed below, the rate of ED use among HealthPartners members has dropped significantly.

Goals

The goal of this project is to decrease non-urgent ED use among all populations with additional emphasis on public programs members

- Reduce avoidable ED visits, to achieve an overall 25% reduction in ED visits to meet the DHS withhold
- Educate members about where to go for care
- Improve access and availability of alternative services
- Create care strategies to reduce avoidable ED visits

Initiatives/Interventions

HealthPartners initiatives focus on three key areas: member education, improving access to primary care, and initiating innovative care strategies.

Member Education

In 2012, our CAHPS scores showed that over 25 percent of Medicaid members did not know where they should go for after-hours care. To address this lack of awareness, HealthPartners launched a member education and communication campaign in partnership with our clinics and community organizations. Using an algorithm developed by New York University (NYU), we identified members with low intensity ED claims or were related to problems that could have been treated in primary or urgent care settings. Members who had two or more low-intensity visits received an outreach call from a nurse. This program continued until late in 2017, when we changed from this reactive approach to educating members about the best location of care to a more proactive approach.

Currently HealthPartners utilizes micro-segmentation analysis to identify members who are at high risk of potentially using the ED and develops personalized messages to educate them prior to ED use.

1. HealthPartners deploys micro segmented communication strategies via e-mail, push notifications into member on-line accounts, through the HealthPartners app and by member services. There are two versions of the message for members who are likely to use the emergency room. One message to members who are more likely to choose urgent care and one to members who are more likely to try on-line care as a replacement to the ED. More than 1,300 members received this outreach in 2022.

2. The urgent care message includes information about the closest urgent care to their home address and is tailored with a sample condition that they are likely to seek care for – such as an ear infection or back pain.

3. Other personalization campaigns that potentially impact ED use include messages about video visits for primary care, extended hours for primary care clinics and a provider match campaign.

4. At the outset of the pandemic, we encouraged our members to establish online accounts to increase the ease of communicating the changing situation. This increase in online accounts allowed us to provide regular communication to members about their options for care. We continue to encourage members to establish online accounts and share their email address to support these outreach efforts.

5. HealthPartners offers the book, What To Do When Your Child Gets Sick to local public health partners. They distribute it to clients at home visits and provide education on how the book can help them make appropriate decisions about their child's care. With the onset of the pandemic, home visits were largely curtailed by family home visiting agencies, so this intervention showed little impact in 2020 or 2021. We will continue to offer these books to local public health through our Government Programs County team.

6. CareLine is our 24/365 nurse line which is a powerful tool to provide access to medical advice outside of regular clinic hours and is a valuable internal partner in supporting members to access the right level of care at the right time. CareLine staff are trained to triage situations and assess medical need for treatment. They can advise to wait until the member is able to be seen by their primary care provider, or they may direct people to the ED.
    a. HealthPartners developed multiple CareLine promotions to educate members about the support provided and how to access it.
    b. Sometimes CareLine nurses encourage members to visit the ED as the most appropriate option for their care needs. Following these ED referrals, nurses contact the family to understand the outcome of the visit and assist with any needed follow-up.

7. Community education is a valuable component when working to change behaviors that have been normalized over a long period of time or when a member is new to the healthcare system and unsure how to get the care they need. HealthPartners has collaborated with community organizations to share key messages and reach those who are connected to those organizations.
    a. HealthPartners distributes a “Resources at Your Fingertips” guide that includes Member Services, CareLine and virtuwell contact information to help members easily seek advice. We share the guide at health fairs, clinics and in the emergency department at Regions Hospital.

Improve Access

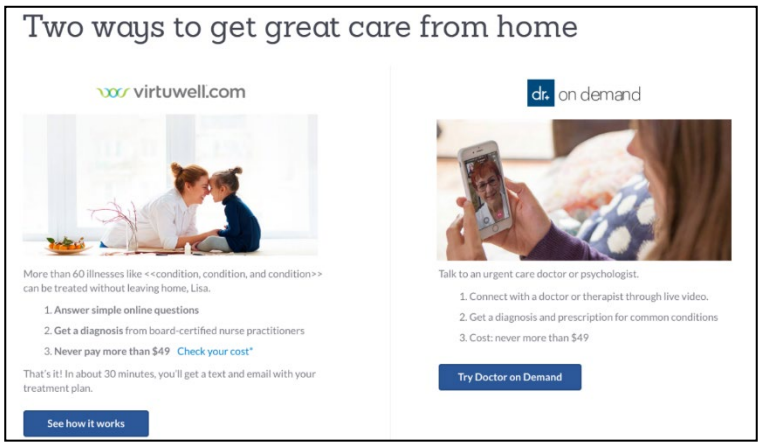
HealthPartners recognizes that many people choose the ED at times when clinics are open because it is more convenient than having to schedule an appointment. To address this behavior, HealthPartners worked to make care easier to access.

1. The health plan continues to fund a Nurse Practitioner at the HealthPartners Medical Group St. Paul Clinic to offer walk-in care. This is a supplemental position to the Urgent Care that operates daytime hours there. When this position was established, we promoted this option by mail to all Medicaid members in the surrounding area.

2. Urgent Care access is an important strategy to ensure people have alternatives to the ED. Urgent care hours have been expanded at almost all of our care group locations to increase the availability of non-emergent care. Extended clinic hours (from 7 a.m. to 7 p.m.) and weekend hours also help us keep members out of ED when a lower level of care is best. This is communicated to patients and members in a variety of ways.
    a. Most of our care group urgent care locations have full day hours that run in-tandem to primary care to increase access to same-day care.
    b. Urgent cares have implemented a “Save My Spot In Line” option. In conjunction with a feature that indicates the estimated wait time, this allows patients to decrease their on-site wait time. Besides being a convenience factor, it also decreases the number of sick people potentially cross-contaminating others in the waiting room.

c. Urgent care locations that do not have the Save my spot in line option have implemented an option to choose a virtual visit as an alternative to in-person care. The virtual visit can be requested with one click on the clinic locator site.

d. Virtuwell and Doctors on Demand are on-line care providers that are available 24 hours a day, seven days a week. Members can access care options instantly without an appointment and certified clinicians typically provide treatment plans within just 30 minutes. We promote these care delivery options in member materials and in a variety of plan communications and have seen steady increases in usage.



Care Strategies

Minimizing the dangers of fragmented care communication between our partner emergency departments and our network clinics is a health plan priority.

- Regions Hospital, Children's Hospitals and Clinics and Methodist Hospital have implemented communication between their ED and HPMG and Park Nicollet Clinics. The hospitals electronically share ED visit summaries including the reason the member sought care and the ED discharge instructions with the patient's primary care provider. Each clinic proactively contacts the member to schedule appropriate follow-up care.

- Regions Hospital expanded this discharge notification to include select community clinics and more are being added to expand this initiative.

- The health plan created an educational tool for residents at Regions Hospital on the efforts around appropriate ED use, education on PMAP and restricted recipients to support residents' understanding of the program.

Barrier Analysis

1. The changing situation with the Covid-19 pandemic may have created unease with the healthcare system and potentially created a situation where members may have felt they needed care but couldn't access their normal source of care.
2. The demand for health care services coupled with staffing shortages at some locations made access to routine care appointments difficult in 2022, which may have compelled people to seek care at the ED when they would normally have gone to their PCP.

3. EDs often “fast track” care to low-intensity patients, making the wait times shorter for those members and limiting the inconvenience factor. These disparate priorities between segments of the health care system send mixed messages to members.
4. Member perception that care received in the ED is higher quality than care received in a primary care clinic.
5. Lack of convenient appointments and keeping scheduled appointments can be a barrier for some members – particularly younger members who seek immediate access.
6. Lack of member knowledge concerning the kinds of services urgent care clinics and convenience clinics offer.
7. Lack of member knowledge of locations of urgent care and hours of operation.
8. Lack of knowledge on when it is appropriate to seek care in the ED and when to seek other options for care.
9. Members are not asked for payment at the ED, making the cost of care a non-issue.

Opportunities for Improvement: Results/Outcomes

By targeting interventions to those areas where the greatest impact can be seen, we have achieved a reduction in our low-intensity ED use as well as the overall rate of ED use and have met the overall reduction goal for this withhold.

The sharp increase in ED use in November 2022 coincides with the sharp increase in RSV and flu activity in Minnesota. This increase is evident in both the Medicaid and commercial populations.

Tables 1 (Medicaid) and 2 (Commercial) clearly show the dramatic decline in ED use in March and April of 2020 at the onset of the pandemic. As the year progressed, and throughout 2021, the usage of the ED did normalize, and has now returned to a more predictable cadence. We will continue to monitor the relationship between all locations of care and the impact to ED usage.

HealthPartners Internal Monitoring
Emergency Room Monitoring Medicaid

Table 2

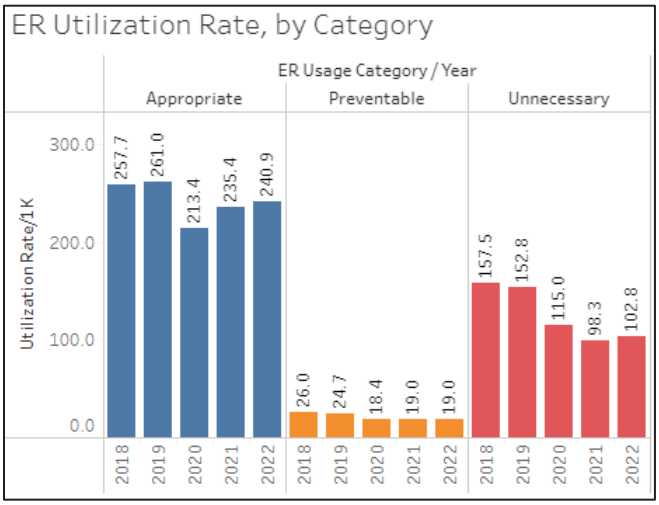
Emergency Room Monitoring Commercial

Table 3

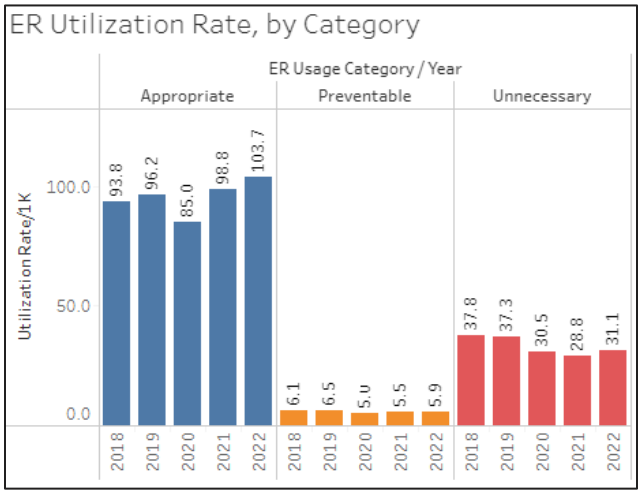
The raw number of ED visits for all products has fluctuated over the past several years due to membership growth. The percentage of all ED visits that are considered non-emergent is an important metric to evaluate ED usage. This measure has consistently trended down across all products until 2022, when both Medicaid and commercial saw a very slight, not statistically significant bump. This could be reflective of the access issues that clinics are experiencing considering staffing shortages. As you can see, the use of the ED among Minnesota Health Care Program members remains higher than among our commercial population. We will continue to monitor the ED use by all populations. Encouraging appropriate ED use has positive

effect on our members as they receive care in the most appropriate setting and costs for unnecessary care is limited.

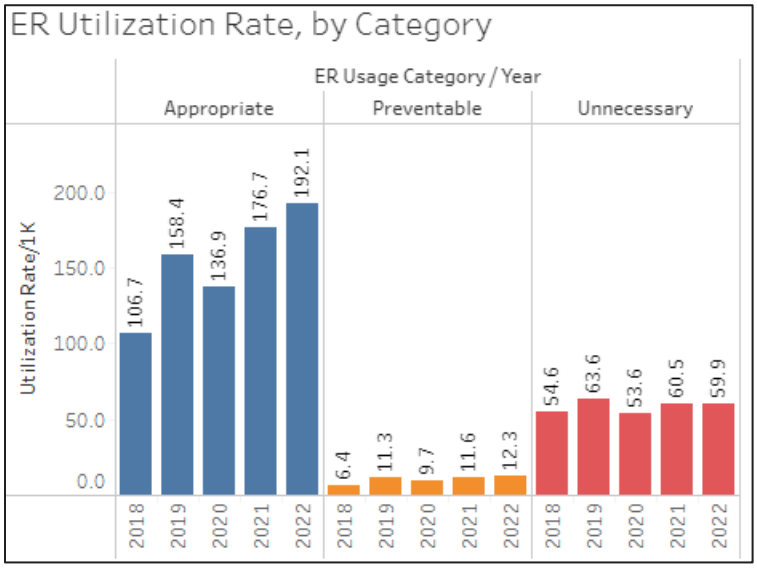
Medicaid



Commercial



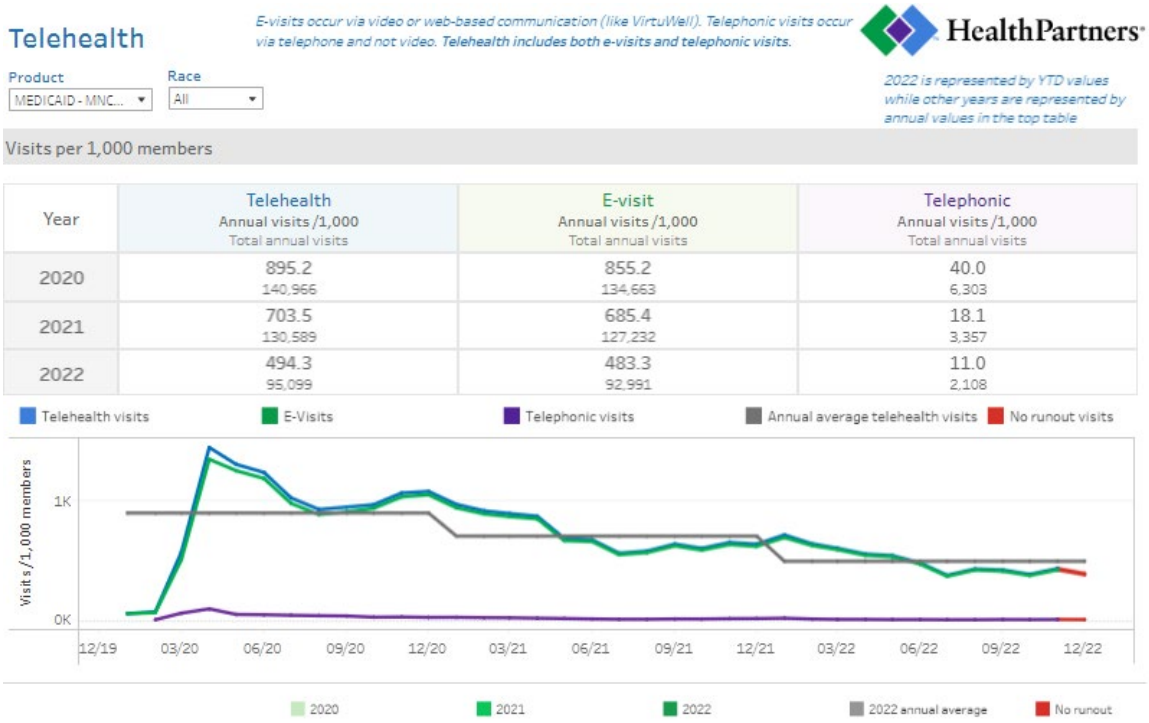
Medicare Advantage



Telehealth

Telehealth visits include both e-visits (on-line care such as virtuwell and Doctors on Demand) and telephonic care which is provided over the telephone without a video component. E-visit use has increased among MHCP members each year, however usage in 2020 escalated quickly at the onset of the pandemic. As the pandemic continues and people's health care usage normalizes, we see that usage of telehealth has trended downward, but is still significantly higher than pre-pandemic usage. This could indicate that for a certain segment of the population, telehealth has become a more comfortable form of care, while others prefer to

return to traditional care. We will continue to monitor these rates and how other locations of care are impacted.



Conclusions/Lessons Learned

The disruption to the health care system during the COVID-19 pandemic cannot be over-stated. It is difficult to draw conclusions on the impact of the traditional interventions employed to encourage members to get care at the best location for the care they need. Recurrent communication around the ever-changing COVID-19 pandemic in 2020 and 2021 supported members in decision making on where to go for care. Now that the immediate crisis of the pandemic has subsided, we will need to stay vigilant to ensure members do not slip back into old habits of care.

Effective communication with members is dependent on our ability to reach them. During the pandemic, we encouraged members to establish an online account and share an email address to facilitate communication. We had limited success with our Medicaid members in establishing online accounts.

- Our Medicaid members are less likely than our commercial members to have an online account for member communication.
- Within the Medicaid population, people of color are less likely to have an on-line account than White members. While this clearly is not causal, members in the Black/African American, Indigenous and Hispanic populations have a higher ED use rate, making our ability to communicate with them more urgent.

Commercial Online accounts	54%	Medicaid ED visits / 1000
Overall Medicaid On-line Accounts	**45.1%**	
Black/African American	39.8%	449.0
Native American	39.7%	607.3
Hispanic	44.4%	418.0
Asian	43.0%	185.4
White	55.1%	318.6

We have learned that some people who utilize the ED for low intensity reasons are open to more appropriate alternatives. However, there are some patients who use the ED for non-urgent care and prefer to continue to use the ED in this way. Based on conversations with the CareLine nurses, many members have indicated that the ED fits their needs, and they will continue to use it for care as they choose.

Partnerships between hospitals and primary care providers enhances communication and improves continuity of care by enabling clinics to contact their patients and coordinate follow-up care.

Personalizing educational messages about alternatives to the ED in a way targeted to member beliefs and motivations effectively changes behavior.

Sustainability of the Activity

HealthPartners is committed to building on these efforts to ensure that members are receiving care in the most appropriate setting. We will continue to implement creative strategies such as virtual care, expand access and walk-in clinics to improve easy access to care. We will also support and engage members in decision making that leads to the best health outcomes for themselves and their families.

Withhold: Admissions and Readmissions

Description

Avoidable hospital admissions and readmissions are a leading driver of health care costs. These rates remain higher in the Medicaid population compared to the Commercial population. HealthPartners closely monitors these measures and builds them into our provider reimbursement methodologies, including our total cost of care model. Since 2012, the Department of Human Services (DHS), per state legislation, has identified these as improvement measures for the managed care organizations that provide Medicaid and MinnesotaCare services, and they are contractual financial withholds. HealthPartners has implemented numerous initiatives designed to reduce avoidable hospital admissions and readmissions and thus achieve our withhold, but more importantly, to improve the health of the members we serve.

Goals

HealthPartners analyzes our performance to understand the trends and drivers behind our hospital admission and readmission rates and identifies strategies to reduce these rates. DHS will provide HealthPartners with our 2022 withhold performance rates in July 2023. DHS will conclude the financial withhold when we achieve a 25 percent reduction from our 2011 baseline rates.

Withhold	2011 Baseline	2014 Rate	2015 Rate	2016 Rate	2017 Rate	2018 Rate	2019 Rate	2020 Rate	2021 Rate	2022 Goal	2022 Rate*	25% Reduction Goal
Hospital Admission Rate/1000	3.33	3.19	3.81	2.82	2.96	2.97	2.82	3.62	2.62	2.88	2.825	2.50
30-Day Readmission Percentage	9.44	11.46	10.27	11.76	11.53	12.71	12.05	16.59	11.29	10.37	13.99	7.08

**HealthPartners internal monitoring rate through 12/2022.*

HealthPartners Health Informatics department tracks admission rates monthly through the Monthly Utilization tableau report which attempts to replicate the measure based on the DHS Technical Specifications. DHS typically provides us with preliminary data quarterly, and we receive our final data in July of the following year, in this case July 2023.

Initiatives/Interventions

Efforts to decrease hospital admissions and readmissions continue to be a challenge for HealthPartners. The Covid-19 pandemic and resulting access issues with the health care system added complexity to these measures. HealthPartners has a designated workgroup to monitor admission and readmission trends, conduct root cause analysis, identify opportunities for improvement and determine next steps. During the pandemic, the activity of this work group was limited due to changes in the nature of admissions and demands of staff due to the COVID-19 pandemic, but renewed focus has been directed to these measures.

The findings of this group have consistently shown that the social drivers of health directly impact utilization of services, including admissions and readmissions. There has been significant research in this area and the workgroup felt it is important to note that impact, especially among our Medicaid members. In addition, as a health plan, we under-utilize our own internal member support resources such as care coordination and MTM services. Automation of referrals into these programs are attempting to improve access and acceptance of these services.

Collaboration between the health plan and our care system to identify high risk members who may be at risk for hospitalization or re-hospitalization provides an opportunity to impact these measures. The admissions/readmissions work group examines existing initiatives and makes recommendations for additions or enhancements as appropriate.

Standard activities continued in 2022 to support our members include Comprehensive Care Advocacy (CCA) Services, Medication Therapy Management, Care Coordination, and Population Health.

Comprehensive Care Advocacy

1. Members identified for CCA services include those with complex medical and behavioral health conditions or poorly managed chronic conditions that are at high risk of future hospitalization. Our goal is to improve member self-management of their complex or chronic conditions. Both Complex Case Management and the Inpatient Case Management programs can directly impact risk of future admissions including readmissions.

   Toward that end, Complex Case Management nurses provide tailored disease management education to members with complex, high risk health conditions to minimize or prevent complex or catastrophic health events.

   Inpatient Case Management helps to coordinate appropriate discharge care and perform post discharge calls and outreach to members who have been hospitalized.

   Included in these efforts are the following targeted interventions:

   a. Post-discharge/transition support for all members participating in Case Management services who experience a hospital admission.
   b. Connection to Medication Therapy Management (MTM) services for members with complex medication regimens or medication adherence concerns.
   c. Holistic assessment and care planning with interventions tailored to address the member's unique needs, barriers, and identified clinical gaps in care.
   d. Enhanced EMR communication, for real time communications with the treating care-team.
   e. Collaboration and coordination with care team members including PCPs and health care home nurses, home care providers, MTM/pharmacy resources, and community- based providers.

f. Inpatient Case Management services to support real time identification and engagement of high- risk members to ensure milestones and care plans are implemented before discharge. Including transition support and referral into CCA services and connection to providers and community-based resources.
g. We partner with Lutheran Social Services (LSS) to outreach and assess high risk PMAP members residing in greater Minnesota whom HealthPartners was unable to reach through our traditional outreach methods. Lutheran Social Services utilized local staff within the geographic areas and conducted telephonic/in-person (during non-pandemic) assessments upon successful contact. Those members reached by Lutheran Social Services were warm-transitioned into our services/programs for ongoing support.
h. We send email appointment confirmations from our engagement specialist to members who have agreed to engage with a nurse for case or disease management. With increased sustainability of engagement of at least 30%, we have an increased ability to impact utilization and improve health.
i. Our health plan and clinic systems use NowPow to connect members with resources to impact social drivers of health.

Medication Therapy Management

1. Our MTM program utilizes a medication risk score to prioritize outreach to members for MTM services.
    a. The score includes calculations intended to identify members who may be at risk of having a medication interaction based on multiple medications prescribed, special dosing instructions and other risk factors.
    b. Flagging the medical record of patients with a qualifying medication risk score began in 2021.

2. Automation of the MTM referral/enrollment process began in October 2022.
    a. Automation ensures that every patient within our care group or discharged from Regions Hospital with a qualifying medication risk score and HealthPartners insurance with MTM coverage will receive a referral to the MTM program.
    b. Utilization of MTM program referrals to connect members/patients with pharmacists to prevent, identify, and resolve medication related problems.

3. **Provider Interventions:** HealthPartners Medical Group (HPMG) and Park Nicollet Clinics receive daily discharge notifications from hospitals. They have implemented outreach processes for post-discharge calls with patients. Care delivery uses an algorithm to identify those who may be at especially high risk for readmission to prioritize patient calls and ensure they are scheduled for follow-up with their clinic in a timely manner.
    a. Transitions in Care is a transitional care management system that was launched in early summer of 2022. A specific billing code is used which not only reimburses providers for treating patients with complex medical conditions during the 30-day post-discharge period but also enables us to identify and closely follow these members/patients that may need additional services.

b. The care group is working to optimize patient after visit summaries to ensure valuable information is passed on to the patient. Ensuring the patient has complete and accurate information about recommendations and follow-up supports the continuity of care plan in EPIC.
c. Communication hand offs to next level of care and follow up appointments are established with the EMR. There is a grid for the common wraparound services and transitional levels of care available to most patients following a discharge. These options are evaluated by the discharge planning team and communicated within the medical record.
d. There are six care coordinators for Medicaid members in the Regions Emergency Department. These care coordinators can help connect members to resources and support them to access resources that can result in avoiding an admission.
e. Park Nicollet care system implemented a text-first communication approach to reach patients following discharge. A text message is sent via a texting platform and asks a series of automated questions to help assess a patient's risk for readmission. Based on the patient's answers, the platform automatically notifies the care team of their responses and nurses prioritize those who need attention.
f. The HPMG/Park Nicollet care system has a predictive analytics tool embedded into Epic. Risk of Unplanned Readmission alerts assist in identifying patients who are at risk of readmission by looking at the following components: age, demographics, diagnosis, medications, order type lookback, lab lookback and utilization. Inpatient case managers document readmission risk in a note prior to discharge for access by the clinic team.
g. The health plan and care group utilize NowPow/UniteUs to connect patients and members with resources to mitigate social drivers of health with referrals to local resources via a comprehensive resource directory.

4. Community paramedic services are coordinated through the care system to provide certain care. Network clinics and hospitals use Community Paramedics (CPs) and EMTs to conduct home visits to support members after discharge and reduce the likelihood of readmission. CPs are experienced 911 paramedics with additional education to provide non-emergency care to members and help manage chronic conditions. We coordinate follow-up to hospital discharge through the hospital, based on individual need; we coordinate additional services with providers as appropriate. We also identify members that may have trouble getting to the clinic for care or could benefit from a home visit. We offer extensive experience running this model through our Regions, Methodist and Lakeview Hospitals and understand the value it brings to the rest of the care team and the member.

   We currently support and pay for community paramedics to perform services, as approved by DHS, including:

   a. Health assessments
   b. Chronic disease monitoring and education

c. Medication compliance
d. Immunizations and vaccinations
e. Laboratory specimen collection
f. Hospital discharge follow-up care
g. Minor medical procedures approved by the ambulance medical director

Current diagnoses that can be referred to our CP program include but are not limited to congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), acute myocardial infarction (AMI), pneumonia, and stroke. As the benefits of these visits are recognized, the diagnoses that are targeted for visits continue to expand, and partnerships with Community Health Workers allow additional needs to be addressed. CP home visits include:

a. Measurement of vital signs
b. Performing physical exams
c. Reviewing upcoming appointments or assistance with scheduling follow-up
d. Medication reconciliation, education, and compliance checks
e. Connecting members to community resources
f. Conducting home safety assessments
g. Reinforcement of dietary recommendations

We currently have a team of 10 Community Paramedics for a total of over 5 FTEs. During 2022 our Community Paramedics worked in two distinct areas of patient care.

a. Community Paramedic Discharge follow-up - our traditional post-discharge hospital follow-up program, aimed at reducing readmission and improving patient safety and satisfaction.
    a. This group of patients completed a traditional hospital stay and then had home visits from our Community Paramedics once or twice a week for up to 4 weeks.

b. Hospital@Home - Community Paramedics are the primary in-person care provider for the Hospital@Home program.
    a. The HealthPartners Hospital@Home program is designed to treat acutely ill patients in their home in lieu of hospitalization. The program admits patients who otherwise would be admitted to the physical hospital and brings the hospital care to the home.
    b. The team includes hospital medicine physicians, nurse clinicians and community paramedics (CPs).
        i. The CPs visit the patient at home twice per day and provide medication administration, lab monitoring and other care, while also facilitating a telemedicine visit with the physician each day.
        ii. Our nurse clinicians provide plan of care phone calls to each patient daily as well as screen, triage and support the admission process.

5. HealthPartners Community Senior Care program offers care for seniors where the patient is located – in their home, a nursing home, transitional care center or assisted living center.
    a. Care At Home sends medical teams to the home of MSHO and Medicare Advantage patients at risk of readmission; this care team includes both Advance Practice Nurses (NP) as well as MDs.
    b. To reduce readmissions due to symptom management, care teams ensure that comfort care appropriate geriatric focused care is provided after discharge at the location the member is going to reduce the likelihood they will be readmitted for symptom or pain management. The medical team works with the staff at the TCU or nursing home to provide the appropriate level of symptom management. The team will also focus on comfort care approaches when appropriate, accessing palliative care and hospices services, which are part of the team. The Community Senior team works in partnership with hospital, specialty, and primary care providers in the care group, utilizing a common medical record insuring safer transitions.

Barrier Analysis

1. The impacts of COVID-19 on the health system in 2020 and continuing through 2022 cannot be overstated.
    a. Members may have been unable to access their primary care clinic to monitor ongoing health issues or were unwilling to go in person to their clinic due to the pandemic. While telehealth visits filled that gap for many members, some conditions require in person labs or other tests that may have been delayed or avoided altogether, resulting in gaps in care for chronic conditions.
    b. Members with pre-existing conditions are at higher risk for poor outcomes if they do have COVID-19 which could result in more likely admissions to our members with chronic disease.
    c. Staffing shortages are widespread across the health care system in Minnesota. This can impact clinics' ability to conduct the routine follow-up with patients after a hospital discharge.

2. Member access, preference, and education are barriers to engaging in care. Members may decline supportive services to enhance their health such as care coordination or home care. Or there may be difficulties in communication to enact those services, such as lack of follow-up to outreach calls or care coordination or bad phone numbers may limit the program's ability to reach out to the member.

3. Members may avoid preventive or chronic care maintenance until a health issue has escalated to the point of hospitalization.
    a. HealthPartners care coordination is delivered telephonically, and this could be a barrier for some members without a phone or who have limited minutes on their phone plan.
    b. HealthPartners continues to conduct member education and outreach regarding preventive care and appropriate ED use.

4. HealthPartners CCA review admissions for members involved in complex case management to identify if there was a point when we could have taken action to improve the outcome and avoid the admission. Case managers also work with members who are having planned admissions to ensure that transitions into the hospital and home again go as smoothly as possible. This transition planning includes medication reconciliation, communicating with the primary care provider or other specialists and assisting with accessing and coordinating additional home resources.

Gaps in Care

Post-discharge follow-up and care is crucial to reduce the 30-day readmission rate. This is a focus for members participating in disease and case management (DCM) services. Additionally, for the broader population, work is already being done with community paramedics, fire fighters, and population health nurses at clinics and hospitals to reduce readmission rates. Inpatient case managers work to increase the coordination between the health plan and our hospital providers to ensure a smooth transition from inpatient to home, to decrease potential readmissions. In addition, to improve care coordination, our hospital case managers can access risk-stratified patient data.

Opportunities for Improvement: Results/Outcomes

Our DHS preliminary results as of January 2023 [for 2022] show our admissions rate at 2.34/1,000 and our 30-day readmission rate at 11.73%. We will continue our internal monthly monitoring of 2022 results with claims run out. We will receive the final report in June of 2023 from DHS which will include full claims run out.

Admissions Data:
Our internal monitoring shows our Medicaid admissions trend at 33.9 for 2022. This is a decrease from the final 2021 rate of 36.9 and aligns with the withhold preview provided by DHS. Final withhold results will be received from DHS in June 2023 which will determine any potential withhold return for this measure.

Table 1

Readmissions Data

Internal monitoring of the 30-day All-Cause Hospital Readmission rate for PMAP and MNCare shows the readmission rate is 1 point higher than the same time last year. Table one shows the variation over time of this measure.

Table 2

Inpatient Readmissions

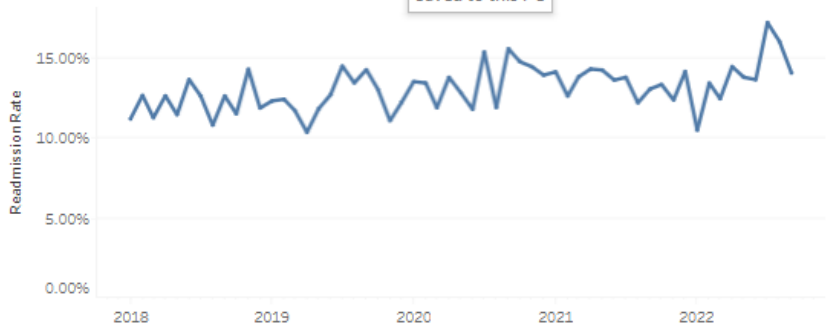
HealthPartners

Product: MEDICAID - MNCARE & P...

Measure: 30 day all-cause readmission

Readmission rate is calculated as % of current period admissions that resulted in a readmission in the following 30/60/90 days with 3-month runout. This measure is similar to CMS readmission measure methodology. Readmission data is not currently available by race.
Example: The readmission rate for the month of June was 10%. This means that 10% of the admissions in June had a readmit in the following 30/60/90 days.

Graph of 30 day all-cause readmission rate



Current 30 day all-cause readmission rate, and historical comparison

Date Label	Month of Perio..	Readmission Rate	Denominator	Numerator
Current	September 2022	13.99%	922	129
Last month	August 2022	15.96%	984	157
Two months ago	July 2022	17.13%	963	165
This time last year	September 2021	12.99%	947	123
Two years ago	September 2020	15.50%	845	131
Three years ago	September 2019	14.20%	817	116
Four years ago	September 2018	12.56%	796	100

Readmissions for Members in DCM

In 2022, a total of 615 Medicaid members participated in CCM care coordination services for at least 60 days. Of these, 374 experienced a hospital admission, and 94 experienced a readmission within 30 days yielding a readmission rate of 25.13%. In 2022 the total number of members participating in CCA support increased slightly but resulted in an increase in the 30-Day All-Cause Readmission rate from 2021 of 17.49%.

Members participating in CCA services are at high risk of readmission due to their complex medical needs, and the unique circumstances. In 2022, while the overall admissions were relatively stable compared to 2021 at 60.8%%, the overall readmission rate increased significantly.

In addition to providing post discharge/transition support to members, CCA nurses collaborate with the care team, members and the CCA Medical Director and psychiatrist for all members experiencing readmissions. CCA nurses review and update each member's care plan to address any gaps or barriers. As well as provide resources for SDOH, and address basic needs, and provide decision support and education.

Sustainability of the Activity

Our internal monthly hospital services report provides ongoing results and analysis. More detailed analysis will occur as triggered by these reports. The work groups will continue to monitor trends in admissions and readmissions and adapt interventions to respond as needed.

Withhold: Annual Dental Visit Dental Service Utilization

Description

Oral health is an important part of overall health and wellbeing. According to the Academy of General Dentistry, there is a relationship between oral health and health complications such as stroke and heart disease as well as prenatal issues.

The Annual Dental Visit (MSHO, MSC+ and SNBC) measure is a contractual withhold for our SNBC and Seniors Contracts with the Department of Human Services (DHS). DHS identified dental measures as a priority for the Medicaid population as many members do not receive their annual dental visit which could impact their overall health. In 2022, the Annual Dental Visit measure has a value of 15 points.

Goals

The specifications for both withholds correspond to the NCQA HEDIS 2018 Technical Specifications for Annual Dental Visit, with expanded ages to include adults 19-64 years of age and seniors 65+.

For each contract year, our goal for SNBC and Seniors is to increase the percentage of members in each age group who receive an annual dental visit by a 10% relative improvement from our baseline rate toward the ultimate goal of 80% of members receiving an annual dental visit.

Annual Dental Visit Withhold Performance Measure	Baseline (2018)	2022 Goal
19-64 Years of Age (SNBC)	47.33%	50.60%
65+ (MSHO/MSC+)	41.72%	46.34%

We monitor our rates monthly through internal reports from HealthPartners Health Informatics Department and with the data provided by DHS in July and October of 2022 and January of 2023. DHS provides our final performance in June of 2023.

Improvement Activities

Access to dental providers has been identified as an ongoing issue for Medicaid members in Minnesota. The reimbursement rate is a well-documented barrier to dental clinic access. HealthPartners is committed to ensuring that our members can receive the dental care they need and have implemented several targeted interventions to support those efforts, and this withhold.

1. HealthPartners Dental Plan continuously works to add additional dental providers to our dental network. Statewide, we have over 900 clinics in our HPCare dental network.

2. To assist members to locate a dentist who is accepting new patients, HealthPartners created a State Public Programs Navigator role within Member Services. Member Services representatives can look to this navigator for assistance with dental support on complex benefits, provider access and as a resource for community services when non-plan benefits are needed.

3. HealthPartners dental staff met with staff interpreters to share information on the importance of dental care and the need for members to get preventive care. This assisted the interpreters in encouraging their clients to seek dental care. Information was shared on how to schedule dental visits. Some interpreters work at clinics where medical and dental services are co-located which allows them to further assist members to make appointments.

4. A product of the collaborative SNBC Dental Project is the Medicaid Dental Services Grid. This grid outlines relevant dental benefits and incentives available to members of the Medicaid health plans and CBOs. It is updated annually and continues to be shared with county staff, our C&TC partners and clinics as requested.

5. SNBC and MSHO Care Coordinators discuss the importance of dental care during their interactions with members and assist the member to find a dentist or schedule an appointment when needed.

Barrier Analysis

In 2022, the actual number of dental visits by members of state public programs increased compared to 2019 pre-pandemic numbers, however the rate per product did not increase due to a much larger number of members eligible to receive dental care.

This reinforces many of the dental clinic-based barriers identified below result in lower rates of care when there are more members eligible for the limited number of services available. For example, limits that dental clinics place on the number of Medicaid members they are willing to see resulting in lower rates when there are more members seeking care. Additionally, the current staffing crisis across the dental care sector contributes to a constrictor of available care for everyone.

Barriers to Medicaid members receiving dental care are well documented.

1. In many areas of the state, there are limited dental clinics, and the clinics may not be accepting new Medicaid members. Providing the Dental Navigator service lessens the burden on the member to make repeated calls to multiple clinics to find an open clinic.

2. Dental clinics identify low payment rates and high appointment fail rates as reasons they limit the number of Medicaid members they serve. HealthPartners hopes that upcoming increases in the reimbursement rate will have a positive impact on this issue.

3. In analysis of our own dental clinics service of Medicaid members, we identified that following outreach efforts, the volume of Medicaid patient visits increased, but the number of unique members did not increase at the same rate. As more members

received preventive care and issues were identified, more visit slots were taken up by follow-up restorative care, potentially causing the unintended consequence of limiting access to more new patients.

4. Dental clinics have long identified high ‘fail rates’ among Medicaid patients as a reason to limit appointment access to that population. If the patient does not complete a scheduled appointment, that is an appointment lost to another patient and lost revenue to the dental clinic. HPDG conducted an analysis of the fail rate at a primarily commercial practice and compared it to a high Medicaid-patient population clinic. The fail rate at the Medicaid clinic was 18% compared to 7% at the commercial clinic for a 12-month period. This data reinforces the concern of failed appointments to this population for dental clinics and combined with the issue of low reimbursement rates helps to explain why they may limit access to Medicaid members.

5. While outreach to Medicaid members results in success in scheduling appointments, staff has identified a lack of correct phone numbers as a barrier.

6. Dental care is often a low priority for seniors; especially those who have dentures. Many believe that they do not need to see a dentist regularly if they do not have their own teeth and only seek treatment if they experience problems. MSHO Care Coordinators educate members about the importance of dental care.

7. The covered benefits for both MSHO and SNBC can also be barriers. Often the services that are needed are not covered by the benefit set.

8. Transportation is often a barrier to care for Medicaid members. If the closest dental clinic with availability is not in their community, RideCare approves transportation outside of the typical distance parameters so they can get to the dental clinic available to them.

9. Language and cultural issues can play a role in members understanding the need for dental care. Even among English-speaking populations, low health literacy related to preventive care is common. The educational efforts with the interpreters used by our dental clinics are a strategy to create opportunities to educate members and help to mediate health literacy gaps.

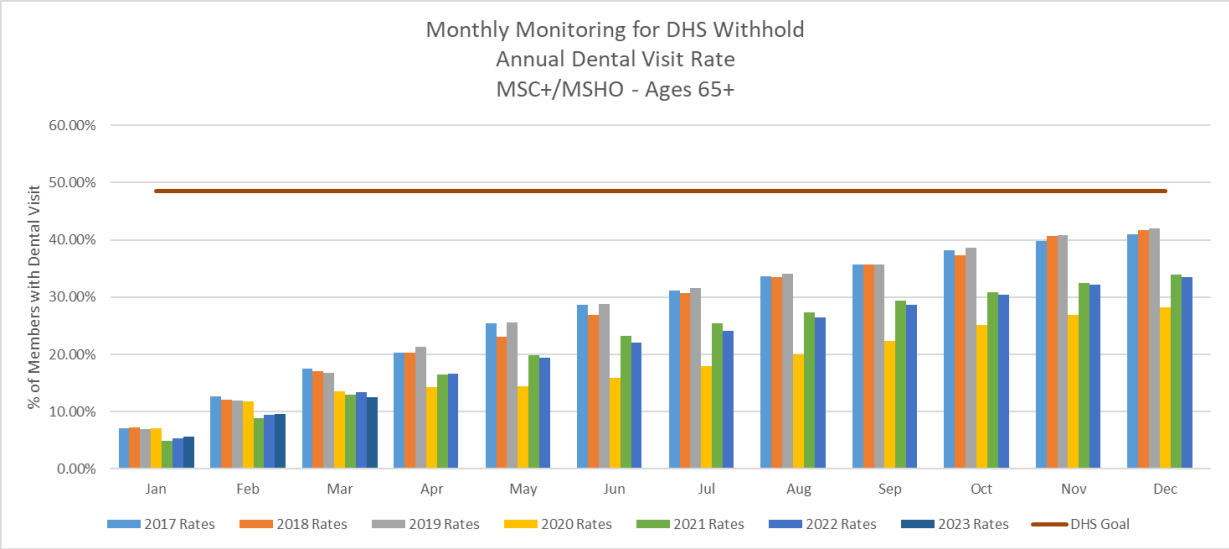
10. Social and financial stressors have a strong impact on a person’s ability to prioritize health care. Members enrolled in Medicaid are by definition low-income and may experience many of the social determinants of health that are barriers to seeking dental care. These may include housing and food instability, lack of transportation, lack of paid time off for appointments, etc. By offering the support of our Dental Navigator, members can get the support they need to navigate the system to schedule an appointment.

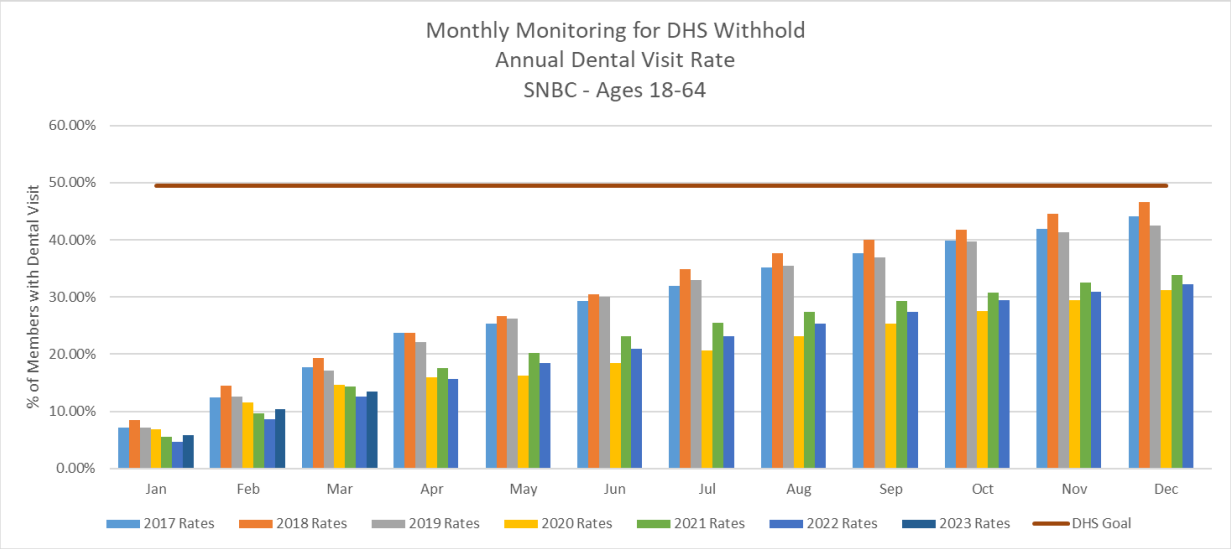
Opportunities for Improvement: Results/Outcomes/Analysis

HealthPartners monitors our withhold rates on a monthly basis. We have a Dental Withhold Work Group which meets to monitor the activities and make recommendations. The withhold is also monitored in the Medicaid Quality Utilization and Improvement (QUI) workgroup and reports up to the Government Programs QUI workgroup.

The data graphs below show HealthPartners internal monitoring of dental visit data for each of the withhold groups. The bar charts show the same information.

	Measurement Year, 2022												
	Jan-22	**Feb-22**	**Mar-22**	**Apr-22**	**May-22**	**Jun-22**	**Jul-22**	**Aug-22**	**Sep-22**	**Oct-22**	**Nov-22**	**Dec-22**	**DHS Target***
MSC+/MSHO - Ages 65+													
Denominator	7,608	7,494	7,562	7,555	7,539	7,522	7,453	7,556	7,488	7,535	7,451	7,646	
Numerator	408	709	1,016	1,259	1,459	1,662	1,796	1,998	2,142	2,296	2,394	2,555	
Rate	5.36%	9.46%	13.44%	16.66%	19.35%	22.10%	24.10%	26.44%	28.61%	30.47%	32.13%	33.42%	**48.48%**
Gap to DHS Target	43.12%	39.02%	35.05%	31.82%	29.13%	26.39%	24.38%	22.04%	19.88%	18.01%	16.35%	15.07%	
SNBC - Ages 18-64													
Denominator	8,560	8,483	8,495	8,455	8,419	8,400	8,346	8,352	8,294	8,291	8,251	8,427	
Numerator	399	728	1,072	1,326	1,549	1,756	1,931	2,112	2,275	2,440	2,552	2,715	
Rate	4.66%	8.58%	12.62%	15.68%	18.40%	20.90%	23.14%	25.29%	27.43%	29.43%	30.93%	32.22%	**49.46%**
Gap to DHS Target	44.80%	40.88%	36.84%	33.78%	31.06%	28.56%	26.33%	24.18%	22.03%	20.03%	18.53%	17.25%	
*Baseline rate plus 10% of the difference between 80% and the baseline rate													





In January 2023, we received a preview of full year withhold data from DHS, reflected in the table below. Full year run-out with final rates will be received from DHS in June 2023 which will determine final status of our withhold achievement.

	CY2019 Baseline [3]			CY2022 Preview: Jan to Dec (12 months) [4]			Performance Targets		
HealthPartners	**Numerator [1]**	**Denominator [2]**	**Rate (%)**	**Numerator [1]**	**Denominator [2]**	**Rate (%)**	**Target Increase over CY2019 Baseline [5]**	**CY2022 Performance Target [5]**	**Overall Target [6]**
Annual Dental Visit									
MSHO/MSC+: 65+ Years	2,068	4,854	**42.60%**	2,360	7,025	**33.59%**	3.74%	46.34%	80.0%
SNBC: 18-64 Years	2,300	4,859	**47.33%**	3,084	8,290	**37.20%**	3.27%	50.60%	80.0%

Sustainability / Plans for Moving Forward

HealthPartners dental contracting continues to work with dental providers to increase our network of available dentists, and with members to access the care they need. HealthPartners is committed to assisting our members to receive the dental care they need.

- We will continue our Dental Navigator program to assist members in finding available dental appointments.
- We will continue to explore innovative ways to reach out to our members through targeted e-mails and/or mailings and direct phone outreach.
- We will continue to make exceptions to standard transportation limits to meet the needs of members to access dental care.

Additionally, HealthPartners has launched a Dental Residency Program to support and enhance the dental workforce. The first class of dental residents began July 2022 and will see a large number of Medicaid members based on the clinics they are located within. Dental residents are primarily located at our HealthPartners Midway Dental clinic. While in the clinics they receive training and experience dealing with a broad cross section of public program patients.

They will see many patients who have complex medical, dental, and mental health needs. Residents will increase their competency, sensitivity, and comfort in addressing the oral health needs of this population. This residency program will increase access to care at our clinics. Another benefit will be increasing our dentists' involvement in community activities that improve the oral health of these populations because they will be rotating through Hope Dental Clinic (providing free dental care) and other volunteer dental activities.

HealthPartners looks forward to continued collaboration with our contracted dental clinics and DHS to meet the dental needs of our members.

Withhold: Health Equity

Accountable Owner: *Patty Graham, QIC*

Member Populations Targeted

	Commercial
	Medicare Freedom (Cost)
X	Medicaid
X	MSHO
	HPUPH
	WI Marketplace

Description

Minnesota consistently ranks as one of the healthiest places to live in the Unites States, data shows that the situation for people of color is very different. According to the Minnesota Department of Health, Minnesota has some of the greatest health disparities in the country between White Minnesotans and BIPOC Minnesotans. Gaps between people on Minnesota Health Care Programs insurance are among the greatest disparities.

In 2022, the MN Department of Human Services (DHS) updated the withholds for our Families and Children's contracts to include equity withholds that aim to close gaps in care for Black, Indigenous, Hispanic, and Asian members compared to white members.

Table 1*: List of Withhold Measures (Performance and Compliance) and Related Details*

Measure	Ages	Points Allocated
*Childhood Immunization Status (CIS) – (i) Combo 10	2 years	14
*Well Child Visits in First 30 Months of Life (W30) – (i) W15; (ii) W30	0 to 15 months; 15 to 30 months	14 (7+7)
*Child & Adolescent Well-Visits (WCV)	All (3 to 21 years)	14
*Prenatal and Postpartum Care (PPC) – (i) Postpartum Care; (ii) Timeliness of Care	All Child-bearing age	14 (7+7)
*Initiation & Engagement of Alcohol, Opioids, & Other Drug Dependence Treatment (IET) – (i) Total Engagement; (ii) Total Initiation	All (13 to 65+ years)	14 (7+7)
*Follow-up After Hospitalization for Mental Illness (FUH) – (i) 7 day; (ii) 30 day	All (6 to 65+ years)	14 (7+7)

Goals

DHS created technical specifications for the intended measurement and shared these along with baseline rates for measurement year 2019 with the MCOs.

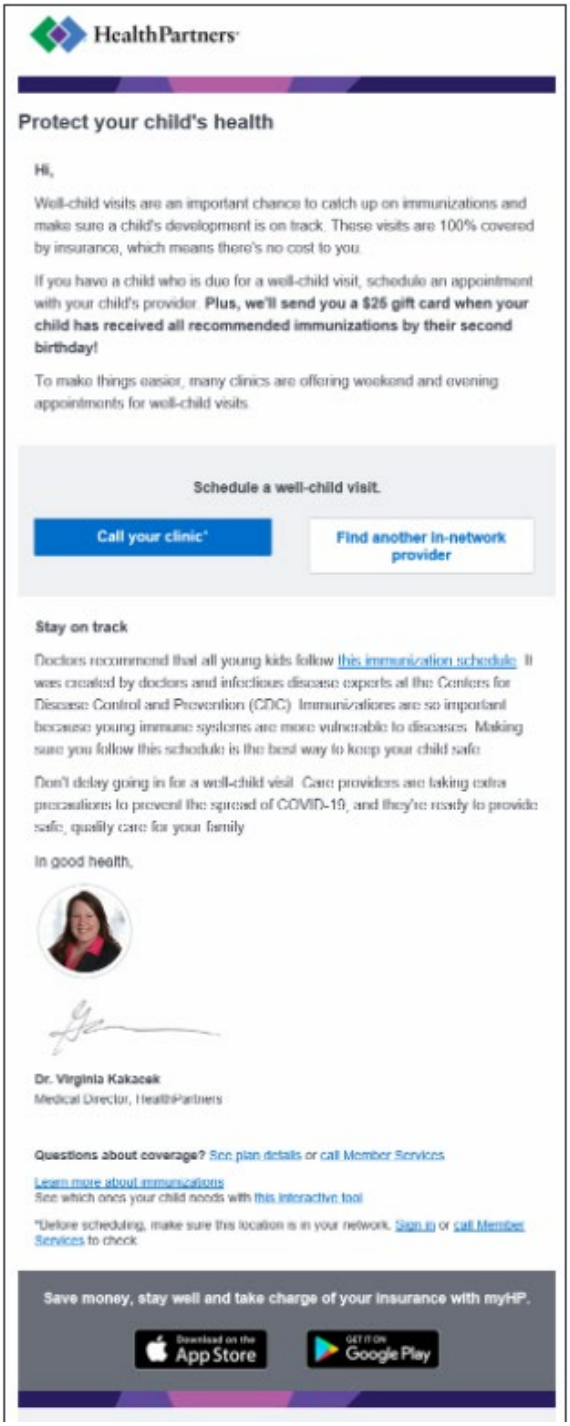
The baseline rates were intended to show MCOs where disparities exist between white members and members of the following race/ethnicity groups:

1. Hispanic
2. Native American
3. Asian/Pacific Islander
4. Black
5. White

If there was a disparity between the white population and the disparate population, the measure would be eligible for points to be rewarded if the gap was closed during the 2022 measurement year. If the gap widened, negative points would be applied and if there were no changes in the gap, no points would be awarded. If there was not a disparity for a specific racial/ethnic group, that measure would not be eligible for points.

Initiatives/Interventions

In an effort to achieve a reduction of disparities on these measures, we implemented a variety of outreach efforts including updating personalization campaigns, phone outreach, partnering with our care group and engaging with a CHW agency to educate members about the importance of care.


HealthPartners

Protect your child's health

Hi,

Well-child visits are an important chance to catch up on immunizations and make sure a child's development is on track. These visits are 100% covered by insurance, which means there's no cost to you.

If you have a child who is due for a well-child visit, schedule an appointment with your child's provider. **Plus, we'll send you a $25 gift card when your child has received all recommended immunizations by their second birthday!**

To make things easier, many clinics are offering weekend and evening appointments for well-child visits.

Schedule a well-child visit.

Call your clinic*

Find another in-network provider

Stay on track

Doctors recommend that all young kids follow this immunization schedule. It was created by doctors and infectious disease experts at the Centers for Disease Control and Prevention (CDC). Immunizations are so important because young immune systems are more vulnerable to diseases. Making sure you follow this schedule is the best way to keep your child safe.

Don't delay going in for a well-child visit. Care providers are taking extra precautions to prevent the spread of COVID-19, and they're ready to provide safe, quality care for your family.

In good health,

Dr. Virginia Kakacek
Medical Director, HealthPartners

Questions about coverage? See plan details or call Member Services.

Learn more about immunizations
See which ones your child needs with this interactive tool.

*Before scheduling, make sure this location is in your network. Sign in or call Member Services to check.

Save money, stay well and take charge of your insurance with myHP.

Download on the App Store

GET IT ON Google Play

HealthPartners has multiple campaigns that deploy letters, emails, push messages, newsletters, and member services staff to deliver messages that educate members about the importance of care or screenings and remind members when they are due for care. These communication channels were utilized to send reminders to members about the importance of care, how to receive extra support services, incentives, and other relevant information.

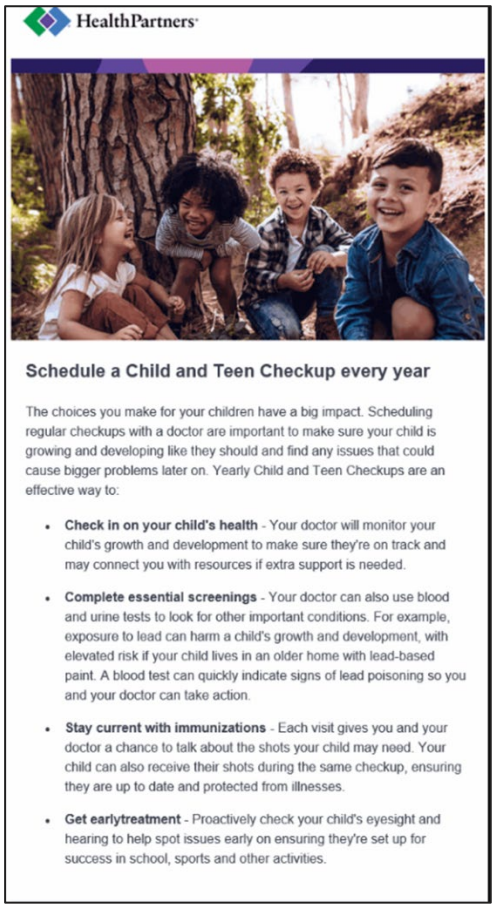
Well-child care across the continuum – We updated and expanded our well-child visits campaigns to include varied messages targeted at specific age groups for children 0 - 18. Members ages 18-21 are included in annual health visit messages.

Well-child care 0 – 2 years old. This campaign focuses on the importance of completing the visits as well as the immunizations recommended by age 2. Utilizing personalization metrics for this outreach, two different messages were developed for the Medicaid campaign.

- Some members received a message that emphasized 'Authority'. A message was delivered by an expert who shared information about why it is important to bring your child in for well care and immunizations.
- Other members received a 'Reciprocity' message. Some parents don't know what shots their child needs, so a printable visual is included to help them.

Both messages also included information about the incentives available to members when they complete all recommended immunizations by their second birthday. If the member doesn't have their own clinic, there is a link to help them find care in the network. These messages are delivered through email, push notification, the landing page when someone logs into their on-line account, and through Riverview Member Services.

The messages for children older than two years varies by the age of the child and the recommendations for that age group:


HealthPartners

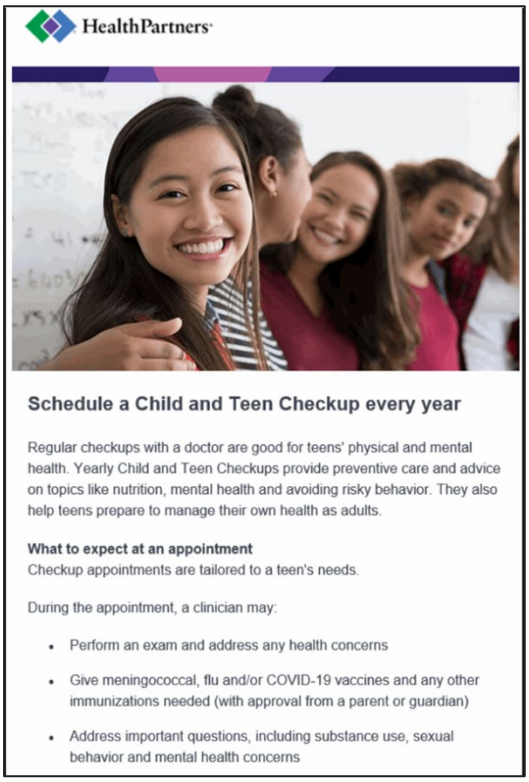
Schedule a Child and Teen Checkup every year

The choices you make for your children have a big impact. Scheduling regular checkups with a doctor are important to make sure your child is growing and developing like they should and find any issues that could cause bigger problems later on. Yearly Child and Teen Checkups are an effective way to:

- **Check in on your child's health** - Your doctor will monitor your child's growth and development to make sure they're on track and may connect you with resources if extra support is needed.
- **Complete essential screenings** - Your doctor can also use blood and urine tests to look for other important conditions. For example, exposure to lead can harm a child's growth and development, with elevated risk if your child lives in an older home with lead-based paint. A blood test can quickly indicate signs of lead poisoning so you and your doctor can take action.
- **Stay current with immunizations** - Each visit gives you and your doctor a chance to talk about the shots your child may need. Your child can also receive their shots during the same checkup, ensuring they are up to date and protected from illnesses.
- **Get earlytreatment** - Proactively check your child's eyesight and hearing to help spot issues early on ensuring they're set up for success in school, sports and other activities.

Ages 2 years through 10 years old is focused on essential screenings, staying up to date on immunizations and monitoring growth and development.

11- and 12-year-olds receive a message specifically focused on the importance of the recommended vaccinations for adolescents and the incentive that is available for completing the series.


HealthPartners

Schedule a Child and Teen Checkup every year

Regular checkups with a doctor are good for teens' physical and mental health. Yearly Child and Teen Checkups provide preventive care and advice on topics like nutrition, mental health and avoiding risky behavior. They also help teens prepare to manage their own health as adults.

What to expect at an appointment
Checkup appointments are tailored to a teen's needs.

During the appointment, a clinician may:

- Perform an exam and address any health concerns
- Give meningococcal, flu and/or COVID-19 vaccines and any other immunizations needed (with approval from a parent or guardian)
- Address important questions, including substance use, sexual behavior and mental health concerns

The message for ages 13 – 17 includes well child exams, immunizations and addressing issues such as substance use, sexual health and mental health concerns.

Community Health Workers

Community Health Workers (CHW) are trusted, knowledgeable front line health personnel who typically come from the communities they serve. CHWs bridge cultural and linguistic barriers, expand access to coverage and care, and improve health outcomes. As critical links between their communities and the health care system, CHWs reduce health disparities; boost health care quality, cultural competence, and affordability; and empower individuals and communities for better health.

HealthPartners implemented a project with WellShare, a local agency with a large cadre of experienced CHWs, to reach out to members in need of well-child visits and childhood immunizations.

1. HealthPartners created scripts for the CHWs who would be making the outreach phone calls.
2. We held an on-line training with the CHWs to clarify the messages to be delivered and background information and resources to support them in their discussions with members.

3. HealthPartners obtained ‘back-door’ scheduling line for our care group to assist in scheduling appointments and gave WellShare staff access to our oral interpreter line for conversations with parents who didn’t speak available languages.
4. We pulled a list of 10,000 members in need of either well care or immunizations (or both), sorted by language and care needed, and shared them with WellShare.
5. WellShare reported back on the success rates of the outreach.
    a. Over five months of outreach. WellShare was able to complete outreach to 77% of the members on the list. Of those:
        i) 18% of the members received education on the importance of the services.
        ii) 801 had invalid contact information.
        iii) 169 were assisted by a CHW in scheduling an appointment for the service with their PCP.

Prenatal and Postpartum Care: HealthPartners offers a Healthy Pregnancy program for pregnant Medicaid members. This program offers individualized 1:1 nurse support to members at high risk for negative pregnancy outcomes. In addition to the Healthy Pregnancy program, we added a robust online digital experience called My Pregnancy as a complement to offer a well-rounded education and support experience for our members that is tailored to meet the needs of each pregnant woman.

Health Informatics identifies members who are pregnant using either enrollment information or claims data and sends an outreach letter to the member inviting them to take a healthy pregnancy assessment. This healthy pregnancy assessment helps to identify current health issues that may be of concern. It also helps us identify the member’s due date and other information such as clinical or social risk factors that may not be identified via claims.

Members can be identified as higher risk either through the pregnancy risk assessment or by utilizing an algorithm which includes current and historical claims when available. These members are reached out to and invited to participate in 1:1 pregnancy care coordination with a Healthy pregnancy program RN. Members can also be referred to this support from their clinician or self-referred.

Typically, the initial outreach is conducted by an outreach specialist and interested members are assigned to a Healthy Pregnancy RN. However, our Native American members have a significantly lower rate of prenatal care compared to other populations, so for those members identified as Indigenous, the nurse is the first contact to attempt to decrease loss of contact during the transition.

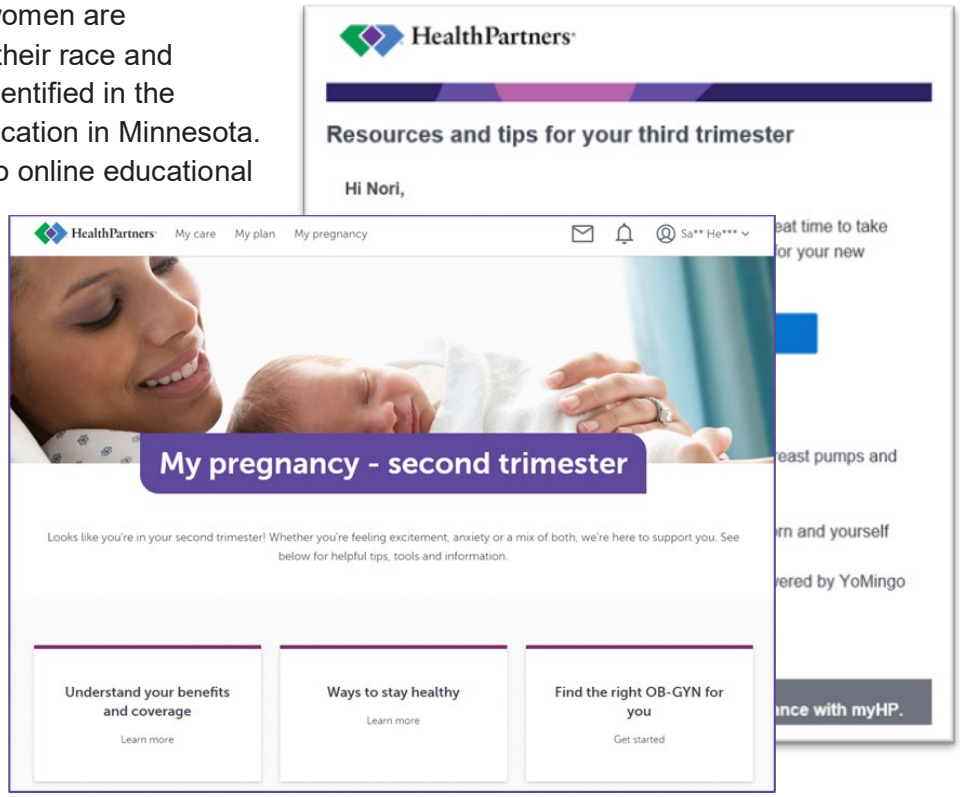
Members receive an incentive for completing the Healthy Pregnancy Assessment, and another incentive if they complete the Healthy Pregnancy Program.

My Pregnancy is an online experience available to all pregnant members regardless of risk scores.

- The content is personalized based on where in their pregnancy the member is at, if they completed the healthy pregnancy assessment, and if they are a member only, or if they are also a patient in our care group.
- Our content for members with PMAP or MN Care includes topics that are important to low-income populations or those with Medicaid coverage. Examples include pregnancy- and post-partum related insurance benefits, such as doula and breastfeeding support, public insurance coverage for newborns, and post-partum birth control options; and content that addresses the health risks facing low-income pregnant women, such as pre-term birth and inadequate nutrition.
- The platform allows members to access personalized information to support their pregnancy, including information about their health insurance benefits and coverage, patient friendly videos and blog content written by HealthPartners' pregnancy experts. To facilitate access to culturally humble resources, the My Pregnancy digital platform surfaces community resources for members based on their identified race, language, and residence. The platform includes search functions to help members identify the type of pregnancy care provider they prefer as well as a provider locator resource to connect with the provider.
- Content on the My Pregnancy platform is personalized to members based on their due date, their residence, needs, and preferences identified via the pregnancy assessment and information obtained through claims.

Figure 1 Samples of Communication from My Pregnancy

- Resources for BIPOC women are personalized based on their race and ethnicity, preferences identified in the assessment and their location in Minnesota. We connect members to online educational materials and videos about pregnancy, including information about nutrition, breast feeding, caring for your newborn, mental health and well-being, and pregnancy complications like preeclampsia and gestational diabetes. Content includes topics like Medicaid coverage for doulas and other prenatal



and childbirth supports; information about WIC and SNAP; and information about our organization's Medicaid-serving partners in the community, such as Everyday Miracles, Hunger Solutions, and others.

- Our Member Services staff and other member-facing teams can see what messages the member has received and can reinforce the referrals, answer questions about benefits or assist the member to the Healthy Pregnancy team for more information.

Doula support is considered a key strategy to support members during their pregnancy and birth experience, and can be especially valuable to Black, Indigenous and other People of Color. In 2022, HealthPartners created a video explaining the value of a doula to help educate members as well as clinicians and others who work with pregnant Medicaid members about this important resource. (34) Value of a Doula - YouTube

- The video has been translated with subtitles into Somali, Spanish, and Hmong. It has been shared widely with partners in the community and across our care network.
- Our Healthy Pregnancy nurses, Member Services and other member facing staff have been educated about doulas and how to help members connect with our primary doula provider, Everyday Miracles.
- The video is surfaced to members who use the My Pregnancy platform.
- As a result of the focus on encouraging Doulas, usage by Medicaid members has increased over 200% since 2019 when we first started tracking this, with 72% of those members being non-white members. With 3,185 births in 2022, this reflects doula support provided for 4.5% of birthing members. This is still a small percentage of total birthing members, but it is encouraging.

Postpartum Outreach: Medicaid members are eligible for a $25 gift card incentive if they complete their postpartum visit. Following delivery, members are sent a congratulations card with information about this incentive and the childhood immunization incentive to encourage these visits. The card is typically sent within 2 weeks after delivery. In 2022, 151 members received the postpartum incentive.

BH Interventions (FUH, IET, AMM)
HealthPartners Behavioral Health implemented activities to focus on the behavioral health measures included in the DHS withholds: Follow-up After Hospitalization for Mental Illness (FUH), Initiation and Engagement of Alcohol, Opioids, and Other Drug Dependence Treatment (IET).

- BIPOC members admitted to inpatient psychiatric care are assigned to a BIPOC Behavioral Health Case Manager for support throughout their admission and upon discharge. This effort is aimed at improving the rate of members who attend an outpatient appointment with a mental health professional within 7 days and within 30 days of discharge (Follow-up After Hospitalization (FUH) measure).
- To support the Initiation and Engagement in Treatment (IET) measure, Medicaid BIPOC members were added to the Screening and Brief Intervention Referral to Treatment (SBIRT) identification process and assigned to a BIPOC Behavioral Health Case

Manager licensed as a LADC to screen the members' substance use and to assist them with them getting connected to appropriate chemical health treatment/support.
- All outreach conducted to members out of our Comprehensive Care Advocacy team, which includes behavioral health case management, includes assessment of social drivers of health and referrals to local resources through the NowPow platform.

Barrier Analysis

HealthPartners feels that the most personal outreach is likely to have the greatest impact in reducing disparities in these important measures. The most common barrier to successful outreach is lack of current contact information. Incorrect phone numbers or mailing addresses make direct outreach unsuccessful. Members who are also patients in our care group are more likely to have current information available, but those who get their care in other systems or are unattributed were difficult to reach.

Data barriers

- The lack of final baseline data until after the actual measurement period meant that we were unable to accurately target our efforts to the right members or race/ethnicity groups for some measures.
- DHS provided us with a member level list with race/ethnicity data, but we were unable to replicate the baseline rates that we received from DHS.
- The complexity of the tech specs made monitoring of our progress difficult. Health Informatics created a monitoring tool in Power BI which includes the Combo 10, FUH and IET. We have used this information to monitor our progress and help guide activities. However, the data in the monitoring tool does not match the data received from DHS in the withhold previews, making it difficult to predict success of the interventions on the withhold calculations. DHS Withhold Monitoring - Power BI

Opportunities for Improvement: Results/Outcomes

We will receive the results of these withholds from DHS in July 2023. HealthPartners will continue our efforts to reduce disparities in these measures and other areas of health for our members.

Focus Study
2021 Performance Improvement Project: A Healthy Start for Mothers and Babies

Accountable owner: *Patty Graham, QIC*

Member Populations Targeted

	Commercial
	Medicare Freedom (Cost)
X	Medicaid
	MSHO
	HPUPH
	WI Marketplace

Description

The project is intended to promote a “Healthy Start” for Minnesota children in the PMAP and MNCare populations by focusing on and improving services provided to pregnant people and infants, particularly in areas exhibiting the most significant racial and ethnic disparities.

Nationally, overall maternal morbidity and mortality have increased over recent decades. So too have the racial disparities in mortality rates with Black women being three to four times more likely to die from pregnancy related causes than white women. In Minnesota, these disparities hold true for populations of color and are reflected in other important birth outcome data such as infant prematurity, low birth weights, and infant mortality. For babies born on Medical Assistance in Minnesota, 7.3% of white babies experience a low birth weight while 13.5% of African Americans do. American Indian babies in Minnesota experience similar disparities as do African American babies.

This disparity continues into childhood and is reflected in the immunization status of children. In general, since the Vaccines for Children program began, immunization rates have risen steadily over the past several years, prior to the pandemic, and racial disparities have decreased, but have not disappeared.

To address these disparities, HealthPartners is working to improve access to prenatal care and supports for pregnant women, especially women of color, and to improve well child visit rates and immunization rates for our members.

Goals

HealthPartners will improve prenatal and postpartum care for women on PMAP and MNCare as measured through administrative data for the HEDIS Prenatal and Postpartum Care measures by 2.5% over the course of the three-year project.

HealthPartners will decrease the disparities in immunization rates for Combo 10 Childhood Immunization rates between white and non-white members by 2.5%.

Methods and Data Limitations

The HEDIS Prenatal and Postpartum Care measure and Childhood Immunization measure are reported using a hybrid calculation. Hybrid measures are measures in which additional information in the medical chart may be sought to compliment claims data in order to provide a full picture of the care/services provided. Thus, a sample of the population is drawn vs. abstracting medical record evidence for the entire measure denominator. Generally, the sample size is 411. Since the project has an emphasis on closing disparity gaps, using the hybrid methodology would not produce an accurate representation of the aimed reduction in disparity. Taking these variables into consideration, HealthPartners has chosen to report on progress for this project utilizing only the administrative rate, which is based on claims and supplemental data (data sharing).

Prenatal and Postpartum Care

This project measurement will follow a modified HEDIS criteria and focus on the percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.

Eligible Population for HEDIS Prenatal and Postpartum Care (Per HEDIS 2020 Technical Specifications.)

> Denominator: Delivered a live birth on or between October 8 of the year prior to the measurement year and October 7 of the measurement year using the Deliveries Value Set.
>
> Continuous Enrollment: We will NOT be using a continuous enrollment qualifier for this measure to capture a larger population.

In seeking to understand the disparities that exist in our populations for the pre and postnatal care measures, we were unable to identify a disparity in prenatal or postpartum care rates using the race data that is available to us. In our analysis of available race data, non-white rates are actually higher than white members for both timely prenatal care and postpartum care. Given broader state and national research about disparities in these areas, this no doubt reflects the lack of complete race data available to us for this population. For these measures, 33.6% of members did not have an identified race, so we believe this missing data is the cause of the lack of disparities. To address this, our interventions will focus on supporting non-white members and increasing overall pre and postpartum rates which should allow us to impact the non-white population.

Table 4 *Baseline Prenatal and Postpartum Measures by Identified Race*

	White	Non-white	Gap	Overall Rate*
Prenatal	81.8%	83.6%	-1.8	82.9%
Postpartum	62.8%	67.3	-4.5	65.5%

*For the overall rate in Table 1, ‘unknown race’ is excluded, making the rates appear higher than our standard HEDIS measure.

Other important metrics for birth outcomes that the health plan can measure are the C-section rate and low birth rate (LBW). While we were unable to identify disparities in the pre and postpartum measures because of lack of data, we did identify disparities in both of these areas despite a lack of race data for approximately 44% of the babies born. Table 2 shows the three-year average (2017-2019) for both the C-Section rate and LBW rate.

2017-2019	**Overall Average**		
Outcome	**People of Color**	**White**	**Gap**
C-Section Rate	28.0%	26.8%	2
Low Birth Weight	4.2%	3.5%	0.7
Avg. Number of Newborns	1,173	442	

Childhood Immunization Status

The Childhood Immunizations Status (CIS) measure looks at the percentage of continuously enrolled children 2 years of age who have received the recommended vaccines by their second birthday. Continuous enrollment for this measure is the 12 months prior to the child's second birthday.

The baseline rates for the CIS measure is the disparity between white and non-white identified children in 2020 HEDIS which reflects 2019 dates of care. The races included in 'non-white' for this measure are:

American Indian or Alaska Native
Asian or Pacific Islander
Black or African American
Native Hawaiian or other Pacific Islander
Another race
Two or more races

It excludes "unknown" race which makes up 47.9% of members in this measure.

HealthPartners goal will be to reduce the disparity in childhood immunization rates between white and non-white members by 2.5% to 12.1% for those members for whom we have race data available.

Eligible Population for HEDIS Childhood Immunization Status Combo 10 (Per HEDIS 2020 Technical Specifications.)

Denominator: Children who turn two years of age during the measurement year.
Continuous Enrollment: Twelve months prior to the child's second birthday.
Numerator Requirement: Children who have received all of the following immunizations prior to their second birthday as indicated following the HEDIS 2020 technical specifications: four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenzae type B (HiB);

three hepatitis B (HepB); one chicken pox (VZV); four pneumococcal conjugates (PCV); one hepatitis A (HepA); two or three rotavirus (RV) and two influenza (flu) vaccines.

Table 5 *Baseline Rates Childhood Immunizations Status Baseline Disparities 2019 DOS*

Enrollment	White	Non-white	gap
Combo 2 rate	58.5%	43.9%	14.6

Initiatives/Interventions

HealthPartners has offered the Healthy Pregnancy program for Medicaid members for many years. This program offers individualized 1:1 nurse support to members at high risk for negative pregnancy outcomes. In 2021, we enhanced the Healthy Pregnancy program and added a robust online digital experience called My Pregnancy as a complement to offer a well-rounded education and support experience for our members that is tailored to meet the needs of each pregnant woman.

Healthy Pregnancy Redesign - The Healthy Pregnancy program is a HealthPartners condition management program for our members who are pregnant and at higher risk for negative pregnancy outcomes. Historically, Health Informatics has identified higher-risk women by utilizing an algorithm which includes current and historical claims when available. Healthy Pregnancy then sends an outreach letter to the member inviting them to participate in the program.

HealthPartners updated the Healthy Pregnancy program in important ways to increase the likelihood that the highest risk women will participate by better addressing health equity and social drivers of health as well as curate fully developed content for the My Pregnancy experience.

My Pregnancy Experience is an online education and support experience available to HealthPartners health plan members and HealthPartners care group patients on our authenticated website. This information supplements the support received from the Healthy Pregnancy program but is also available to all members and patients regardless of their participation in the more intensive Healthy Pregnancy Program.

1. We updated the algorithms we used to identify women for the Healthy Pregnancy program. We incorporate demographics, including payer-type, into our algorithms to identify members who are eligible for high-touch nurse support.

2. We offer a Healthy Pregnancy assessment where women can answer questions about their current health and questions related to their pregnancy, including support services they may benefit from. This self-reported information also helps inform their referral into the Healthy Pregnancy program and the content that is surfaced to them via My Pregnancy.

3. We updated the content for the emails/letters sent to members at each stage of their pregnancy. The content is personalized based on where in their pregnancy the member

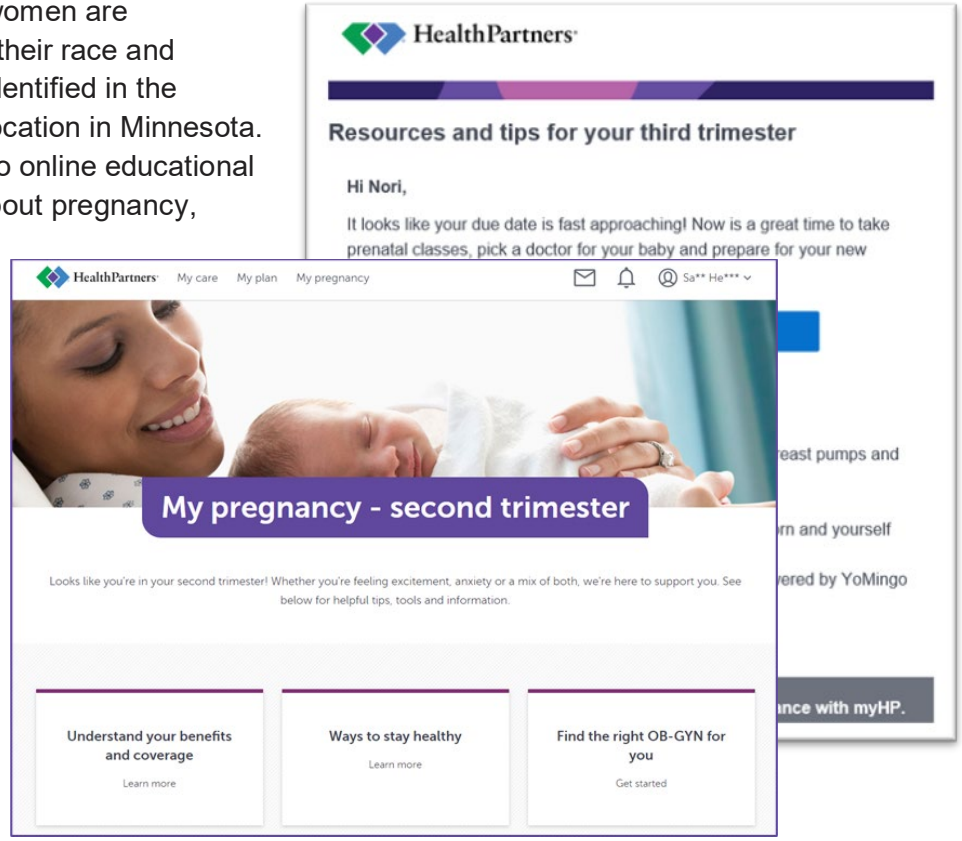
is at, if they completed the healthy pregnancy assessment, and if they are a member only, or if they are also a patient in our care group.

4. Our content for members with PMAP or MN Care includes topics that are important to low-income populations or those with Medicaid coverage. Examples include pregnancy- and post-partum related insurance benefits, such as doula and breastfeeding support, public insurance coverage for newborns, and post-partum birth control options; and content that addresses the health risks facing low-income pregnant women, such as pre-term birth and inadequate nutrition.

5. The platform allows members to access personalized information to support their pregnancy, including information about their health insurance benefits and coverage, patient friendly videos and blog content written by HealthPartners' pregnancy experts. To facilitate access to culturally humble resources, the My Pregnancy digital platform surfaces community resources for members based on their identified race, language, and residence. The platform includes search functions to help members identify the type of pregnancy care provider they prefer as well as a provider locator resource to connect with the provider.

6. Content on the My Pregnancy platform is personalized to members based on their due date, their residence, needs, and preferences identified via the pregnancy assessment and information obtained through claims.

Figure 2 Samples of Communication from My Pregnancy



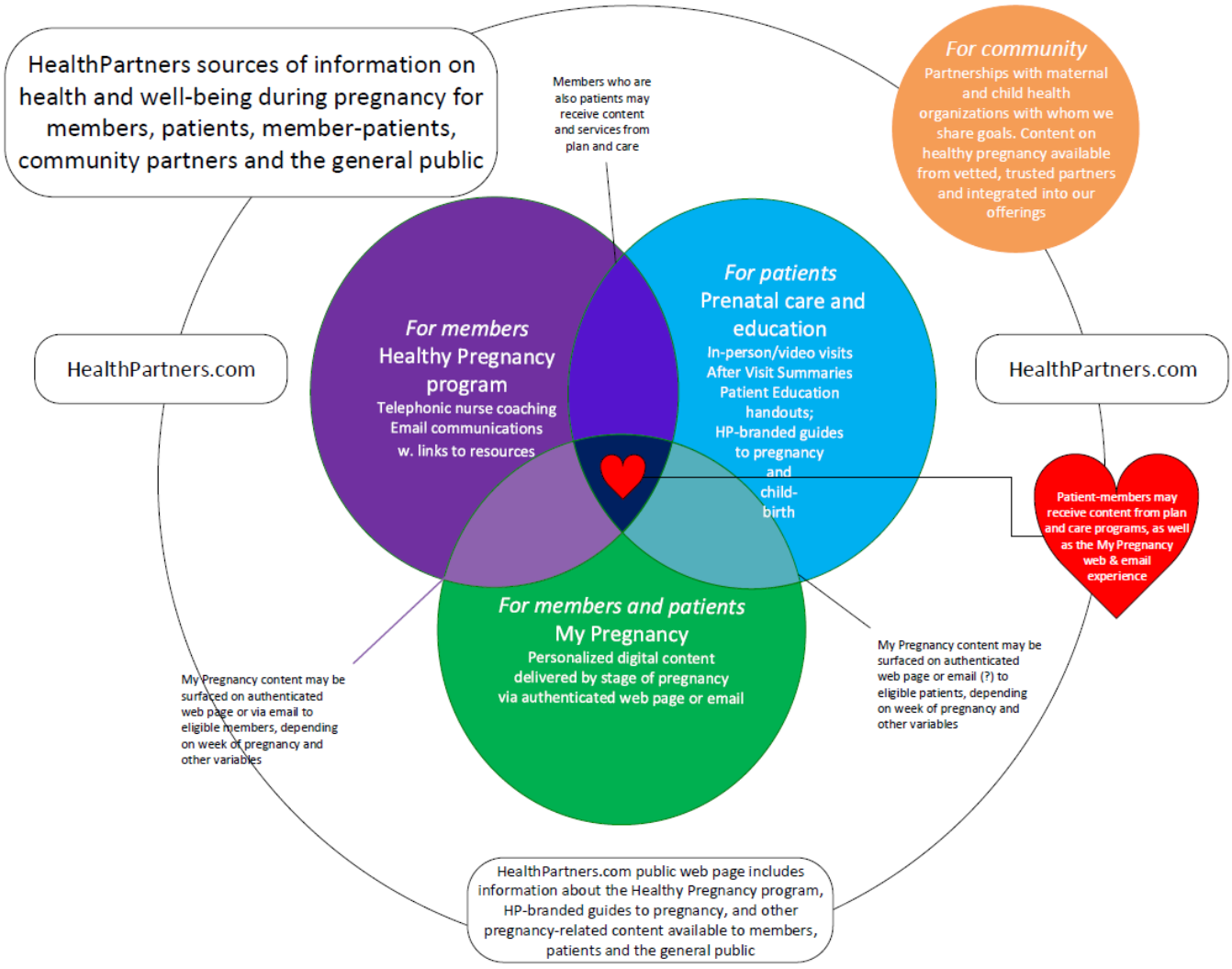
7. Resources for BIPOC women are personalized based on their race and ethnicity, preferences identified in the assessment and their location in Minnesota. We connect members to online educational materials and videos about pregnancy, including information about nutrition, chest feeding, caring for your newborn, mental health and well-being, and pregnancy complications like preeclampsia and gestational diabetes. Content includes topics like Medicaid coverage for doulas and other prenatal and childbirth supports; information

about WIC and SNAP; and information about our organization's Medicaid-serving partners in the community, such as Everyday Miracles, Hunger Solutions, and others.

8. Our Member Services staff and other member-facing teams can see what messages the member has received and can reinforce the referrals, answer questions about benefits or assist the member to the Healthy Pregnancy team for more information.

Together with the clinical care provided by their prenatal health care provider, these programs provide a robust suite of information and resources for our pregnant members.

Figure 3 *Graphic of Pregnancy Supports Provided*



Process Measures:

1. The number of PMAP/MNCare members who receive communications from the new system.
   a. In 2022, 7,414 members were sent information via email introducing them to the My Pregnancy platform. Of those, 4,836 opened the email, and 1,071 people clicked through from the email to view the content on the platform for a 14.5% click-through rate.

Race	Number Sent	Opened	Click Through Rate
Asian	945	71.4%	13.8%
Black/African American	2630	64.4%	16.6%
American Indian	77	61%	14.3%
Hispanic or Latino	602	68.6%	15.4%%
White	2554	62.1%	12.6%
Total	7414	65.2%	14.5%

   b. In 2022, a total of 13,720 Medicaid members visited the My Pregnancy web experience.
      i) The most common page visited was the benefits page, followed by the delivery preparation page.
      ii) The average time spent on the site per visit was 27.05 minutes.
      iii) Most members accessed the site from a mobile phone (77.7%) followed by another device such as a computer (21.55%) and a tablet (0.74%).
      iv) American Indian (42.75 minutes) Black (34.49 minutes) and Hispanic members (28.44 minutes) spent longer on the site than other groups.

2. Referrals into the Healthy Pregnancy Program. In 2022, there were 1,982 pregnant Medicaid members referred into the Healthy Pregnancy program. These referrals came from the high-risk registry which gets data from claims, the Pregnancy Risk Assessment, and live referrals from other areas of the plan or from clinicians.
   a. Of these members, 1,613 were identified as eligible for the program and 470 engaged with the program resulting in a 29% engagement rate for 2022. Members could be deemed not eligible for the program if they did not meet the risk criteria, were no longer pregnant, were inappropriately identified or other similar reasons.
   b. Incentive completion - 376 members completed the initial assessment and were eligible for the assessment incentive and 424 completed the program and received the second incentive as well.

Doula Support Expansion

As HealthPartners began to plan for the Healthy Start PIP, we evaluated the data that we had available to us about our members as well as research about birth outcomes and disparities. Doulas were clearly identified in the literature as a strategy to better support women of color. We looked at our own utilization of doulas by our Medicaid members and saw that only about 2% of our members who gave birth in a 12-month period had utilized a doula at any time.

HealthPartners consulted with many community partners during the development of the PIP proposal on the barriers to widespread doula utilization. We heard from the community that they would like to see more doulas who look like the communities they serve. People of color want BIPOC doulas who have been trained to provide culturally congruent support, but there is a lack of availability to doulas who can bill Medicaid. We heard from clinical partners that most clinicians are not aware that this is an eligible benefit for women with state coverage. And we heard from doulas that there are multiple structural barriers to the current administrative requirements for medical billable doula services.

At the time of proposal submission to DHS, HealthPartners had identified this as an internal strategy but because of the potential impact of improving access to doulas for the entire community, this has evolved into a collaborative intervention. HealthPartners has taken some steps to improve access to the service for our members in addition to the collaborative efforts outlined elsewhere. HealthPartners:

1. Agreed to increase the doula reimbursement rate to enhance the amount of reimbursement that the doula agencies can offer to their doulas. This is an important step to aid in recruitment and hopefully retention.

2. HealthPartners gave a grant to Everyday Miracles to train a cohort of doulas of color. Combined with grant dollars received from another Medicaid health plan in MN, this allowed training of additional BIPOC doulas to increase access to this service for women of color. These scholarships are for Black, Indigenous, and other women of color to become doulas. The first training took place in the Twin Cities metro and the second one took place in St Cloud for the central MN counties. They both included African, African American, and Indigenous women.

3. HealthPartners was invited to join the Birth Equity Community Council (BECC) during the planning stages of this PIP. We have become active with the group's efforts to impact the administrative barriers to doula certification and are working collaboratively to impact the training and supervision requirements for doula reimbursement. We were recognized as a BECC Community Partner at the December 2021 meeting.

4. In 2022, HealthPartners gave grants to both Everyday Miracles and the Ninde Doula program at Division of Indian Work (DIW) to support the continued development of their doula programs.

5. HealthPartners continues to work to educate internal staff about the value of doulas including establishing meetings between our Healthy Pregnancy staff and Everyday Miracles to share updates between the two organizations.

6. Collaborated with Everyday Miracles and DIW doula programs to create a video, Value of a Doula, which explains how a doula can support pregnant members to those who may not be familiar as well as explaining the Medicaid benefit. The video has been translated with subtitles into Spanish, Somali and Hmong.

7. We promoted the use of doulas in our provider newsletter, with information on how clinicians can assist their patients to access a doula. We also educated our Member Services staff on how to access doula services and included doula services in the My Pregnancy online platform.

Process Measure:

1. Number of PMAP and MNCare members who access doula services each year. The claims data through 2022 shows an increase of over 200% in usage of doula services overall. With 3,185 births in 2022, this reflects doula support provided for 4.5% of birthing members. We will continue to monitor this measure through the life of the project to evaluate trends.

	Baseline (12 months ending 10/8/19)				**Doula Usage 2021**				**Doula Usage 2022**			
	White	Non-white	Unknown	Total	White	Non-white	Unknown	Total	White	Non-white	Unknown	Total
L&D Session	16	21	0	37	15	32	8	55	18	63	1	82
Non L&D	19	25	0	44	32	48	5	85	42	93	1	136
Both L&D and Non					26	15	3	44	44	98	1	143
Unique Members				69	Unique Members			96	Unique Members			143

2. Number of contracted doulas/doula agencies available to our members.
   a. No new doula agencies were contracted during 2022, but we have been actively supporting Division of Indian Work to enable their doula program to become Medicaid eligible. With the addition of the Zaggi'idiwin Full Spectrum Indigenous Doula Training to the state register, DIW doulas who have been trained by this program are now eligible to be Medicaid doulas and we can finalize the contract.
   b. As a result of the enhanced focus on training doulas of color, Everyday Miracles roster of certified doulas is now 70% people of color compared to 40% at the start of 2020.

3. Impact of Doula Support. For 2022 births we wanted to quantify the benefits of doula support services for our members based on birth outcomes. An ongoing issue with Medicaid members is that it is not always possible for us to link the newborn baby with the mother who gave birth, and this impacted our ability to get accurate information for this metric. We were unable to link 23.5% of newborns to confirm if their mother used a doula. This data gap makes the outcomes data less than compelling.

Medicaid Doula Delivery Outcomes Summary
January 2022 – December 2022

Medicaid 2022						
	People of Color		White		Missing Race	
Outcome measure*	**With Doula**	**No Doula**	**With Doula**	**No Doula**	**With Doula**	**No Doula**
C-Section Rate	32.2% (29)	31.7% (785)	32.6% (14)	27.5% (346)	0% (0)	23.1% (31)
Multiple Birth Rate	5.9% (3)	1.4% (23)	6.5% (2)	0.9% (7)	0% (0)	0% (0)
Low Birth Weight	5.6% (3)	6.8% (111)	6.1% (2)	4.8% (37)	0% (0)	0% (0)
NICU Avg. Length of Stay	7.22 (9)	8.36 (276)	4.00 (5)	9.27 (131)	0 (0)	3.25 (4)
Number of Newborns	54	1,643	33	778	0	37

*C-section rate based on all moms. All other outcome measures based on successful mom-baby match.

Referrals to County Home Visiting

HealthPartners has provided counties who request it with monthly lists of our members who we identify as pregnant through claims or enrollment file. In 2021, we added elements to these member lists to add value and improve the county's ability to effectively engage members in family home visiting services. .

- We added demographic information where we have it, which includes race, ethnicity, and preferred language of the member.
- We added risk information when it is available from either prior pregnancies or current claims to enhance the knowledge of the county staff and inform their educational efforts.
- Counties have also requested due date information, but this is not something that is available in claims, so we have thus far been unable to identify a process for this element.

Process Measure: Number of members who receive Home Visiting Services. In 2022, 341 members received a nurse home visit following birth.

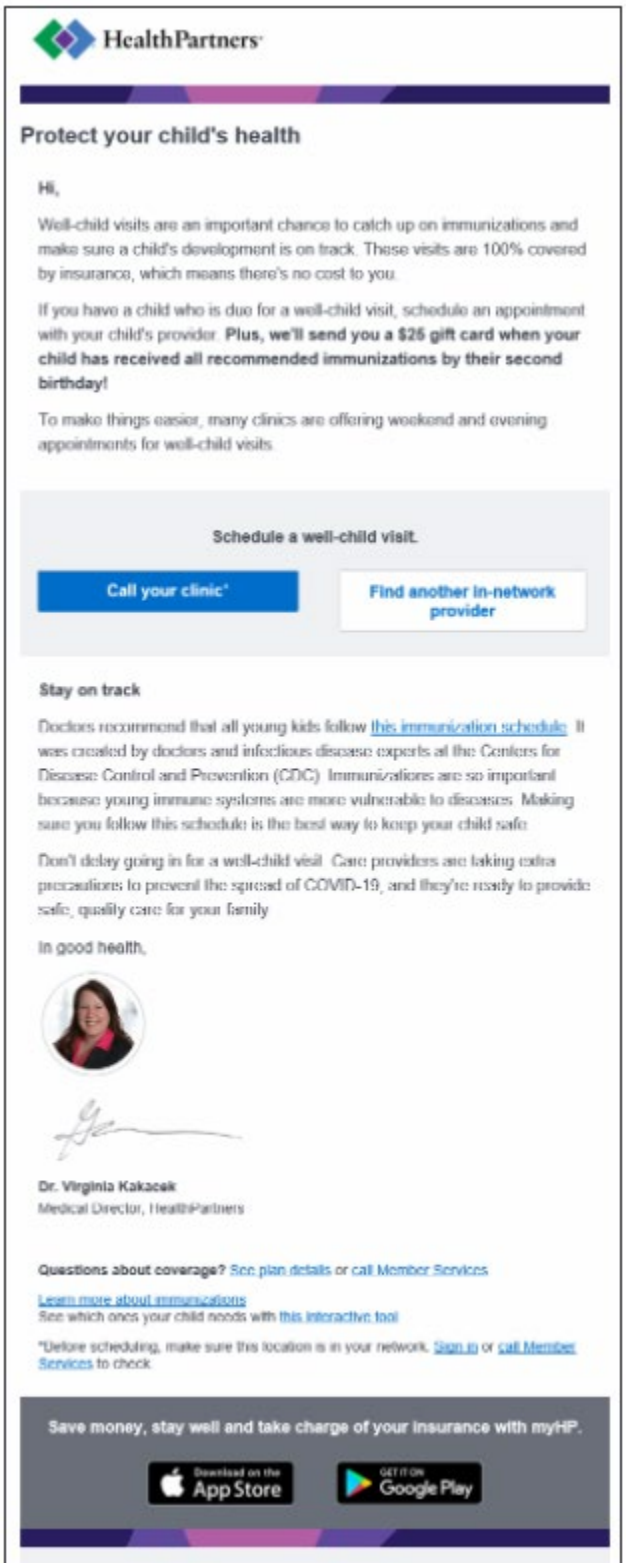
Childhood Immunization Outreach

During 2020, outreach about well child visits and immunizations were temporarily suspended due to the pandemic. When limited messaging resumed it was combined with messaging about the efforts clinics were taking to make it safe to visit. HealthPartners took the opportunity to create new messaging encouraging early childhood well visits and immunizations.

Utilizing personalization metrics for this outreach, two different messages were developed for the Medicaid campaign.

- Some members received a message that emphasized 'Authority'. A message was delivered by an expert who shared information about why it is important to bring your child in for well care and immunizations.
- Other members received a 'Reciprocity' message. Some parents don't know what shots their child needs, so a printable visual is included to help them.

Both messages also included information about the incentives available to members when they complete all recommended immunizations by their second birthday. If the member doesn't have their own clinic, there is a link to help them find care in the network. These messages are delivered through email, push notification, the landing page when someone logs into their on-line account, and through Riverview Member Services.


HealthPartners

Protect your child's health

Hi,

Well-child visits are an important chance to catch up on immunizations and make sure a child's development is on track. These visits are 100% covered by insurance, which means there's no cost to you.

If you have a child who is due for a well-child visit, schedule an appointment with your child's provider. **Plus, we'll send you a $25 gift card when your child has received all recommended immunizations by their second birthday!**

To make things easier, many clinics are offering weekend and evening appointments for well-child visits.

Schedule a well-child visit.

Call your clinic* | Find another in-network provider

Stay on track

Doctors recommend that all young kids follow this immunization schedule. It was created by doctors and infectious disease experts at the Centers for Disease Control and Prevention (CDC). Immunizations are so important because young immune systems are more vulnerable to diseases. Making sure you follow this schedule is the best way to keep your child safe.

Don't delay going in for a well-child visit. Care providers are taking extra precautions to prevent the spread of COVID-19, and they're ready to provide safe, quality care for your family.

In good health,

Dr. Virginia Kakacek
Medical Director, HealthPartners

Questions about coverage? See plan details or call Member Services.

Learn more about immunizations
See which ones your child needs with this interactive tool

*Before scheduling, make sure this location is in your network. Sign in or call Member Services to check.

Save money, stay well and take charge of your insurance with myHP.

Download on the App Store | GET IT ON Google Play

Process Measures for Well Child/Childhood Immunization Outreach

1. "Conversion rate" for PMAP/MNCare members who receive a well child and immunization reminder communication. A conversion is defined as a member taking action to complete the recommended care within three months of receiving the message.

a. Reminder messages were sent to 3,911 members in 2022. The overall open rate for the messages was 60.2% and 7.5% clicked though to further content.
b. The two message segments performed similarly but not exactly the same.
    i) The 'Expert" message had an open rate of 59.1% and a click through rate of 7.3%.
    ii) The 'Reciprocity' message had an open rate of 60.6% and a click through rate of only 7.6%.
    iii) Overall, 6.1% of members who received the message 'converted' within 30 days and completed the full set of care. This rate could be impacted by delays in access to clinic scheduling which were prevalent in 2022.

2. Number of members who achieve the incentive rewards available to them.
    a. Childhood immunization reward is sent to children who are fully immunized for the 10 childhood immunizations recommended by age 2 = 1,778
    b. Postpartum incentives are available to members who keep a postpartum appointment between 3 weeks and 8 weeks = 151
    c. Healthy Pregnancy Assessment = 376
    d. Healthy Pregnancy Completion = 424

Community Health Worker Outreach

In addition to our outreach campaigns, HealthPartners implemented a project with WellShare to have Community Health Workers (CHW) reach out to members in need of well visits and childhood immunizations. CHWs are trusted, knowledgeable front line health personnel who typically come from the communities they serve. CHWs bridge cultural and linguistic barriers, expand access to coverage and care, and improve health outcomes. As critical links between their communities and the health care system, CHWs reduce health disparities; boost health care quality, cultural competence, and affordability; and empower individuals and communities for better health.

1. HealthPartners created scripts for the CHWs who would be making the outreach phone calls.

2. We held an on-line training with the CHWs to coach them on the messages to be delivered and background information and resources to support them in their discussions with members.

3. We pulled lists of members in need of the services, sorted by race and language, and shared them with WellShare. Ten thousand children were included on the outreach lists.

4. Members who needed more services– either multiple well child visits or multiple immunizations to get caught up - were prioritized for the earliest outreach.

5. WellShare reported back on the success rates of the outreach.
    a. Of the total list, 3,159 members received education about the importance of immunizations and well child care. An additional 16 received the education and assistance from the CHWs to schedule the needed appointment.

b. We will analyze the success of this outreach based on claims submitted for the recommended services once full calendar year run-out is available.

Collaborative Interventions

HealthPartners participates in the health plan collaborative for this PIP along with Blue Plus, Hennepin Health, South Country Health Alliance (SCHA), and UCare. Stratis Health provides project development support and assistance to the collaborative. Together we have worked on interventions that address creating and strengthening community partnerships, and providing education to the healthcare community and those who work with birthing people and young children.

Increasing doula capacity – The health plan collaborative agreed that increasing doula utilization was an activity that could improve pregnancy and birth outcomes for members. We met with several community partners to explore the issue, join efforts that were already underway and encourage focus on specific efforts. These groups included the BECC Partnership, Healthy Black Pregnancies, Everyday Miracles, Division of Indian Work Ninde Doula Project, Minnesota Indian Women's Resource Center, and others. We met with Dr. Chomilo, DHS Medicaid Medical Director, and shared the concerns we have heard from the community and our partners and Dr Chomilo reported hearing many of these same concerns from his sources. Many of those barriers are outlined below in the barrier analysis. As a result of these conversations, the health plans have become more involved with the advocacy efforts of the community to impact the barriers to doula care.

We have been involved with the Birth Equity Community Council (BECC) which is focused on reducing disparities in maternal and infant birth outcomes for people of color. Over the course of the last three years, many of the doula issues have coalesced in importance to the community and this group is taking the lead on working with advocates and the state on several priorities including:

- Working to add culturally congruent doula trainings to the list of certifications that are accepted to be Medicaid eligible. We collaborated with community advocates and met with the Minnesota Department of Health to explain the issues. There are limited number of doula curriculum (8) that were approved by the state, many of them very traditional and not reflective of the diverse makeup of Minnesota's Medicaid membership. The legislature had revised statute to allow MDH to determine the appropriate curriculums to include as Medicaid eligible. The department established a process for application of curriculums to be added to the approved list. As of 3/22/23, six additional training programs have been added to the approved list, and one of the original ones has been inactivated.

- Community doulas believe that the need to bill under a clinician is a barrier to access. The Medicaid Medical Director advocated to include removal of this requirement in the Governor's 2023 proposed budget.

- The current reimbursement rate is not enough to provide a livable wage to doulas. The BECC collaborative, working with the Minnesota Coalition for Home Visiting, has

proposed legislation to increase the reimbursement for both the pre- and postnatal visits and the support for birth visit. This increase in the reimbursement rate would bring Medicaid reimbursement in-line with private pay doulas and encourage more doulas to provide this service to Medicaid members. The Minnesota Council of Health Plans and some individual health plans have signed the letter of support for this change.

This work will continue as needed and will expand to include promotion of doula services to clinical providers and community organizations that work with birthing people and their families.

Education

Webinars: The collaborative developed an educational webinar series to address topics that can impact birth outcomes and early childhood health with a focus on health equity and addressing racial bias. Webinars presented in 2022 were:

- Doulas 101: A Valuable Part of the Care Team. How Doulas Support a Healthy Pregnancy presented by Akhmiri Sekhr-Ra and Kaytee Crawford on March 23, 2022.

  Doulas can be a valuable part of a woman's health care team, and in Minnesota can be reimbursed by Medicaid, but they are underutilized for those at highest risk who could benefit the most. This webinar will introduce attendees to the value doulas can bring, what doulas do and do not do, and share strategies for integrating doulas into the prenatal care team to support women as well as hear examples of how doulas have positively impacted birth experiences. The webinar was attended by 144 people, primarily in public health. Eighty four percent of participants rated the webinar good or excellent and 93.3% felt it improved their understanding of the role of a doula in supporting birthing persons.

- Perinatal Substance Use ECHO – Legal Implications of Perinatal Substance Use presented by Dr Cresta Jones on December 13, 2022.

  Recent changes to Minnesota's mandated reporting laws were intended to reduce barriers to birthing people who may be using substances that have traditionally been included in mandatory reporting. For some clinicians and organizations, the changes have created confusion, resulting in inconsistent application of the standards. This webinar aims to clarify the requirements of the mandatory reporting law and give clinicians practical suggestions for having meaningful conversations with their patients at risk. Offered as part of the Hennepin Healthcare ECHO series, this session was co-sponsored by the health plan PIP collaborative.

A Reminder from your Healthcare Provider: Come back to get caught up. The Healthy Start PIP project, in collaboration with the Minnesota Council of Health Plans, created an educational blog about the importance of well child visits and immunizations. Directed at families with young children, the blog was posted on the MCHP site in December of 2022 in English with an accompanying voice recording to address concerns of health literacy. Additionally, the content has been translated into Spanish, Somali, and Hmong. The translated voice recordings will be

posted as they become available as well. This will be promoted to community partners once all pieces are finalized and posted on the website.

Barrier Analysis and Gaps in Care

The barriers to quality care for BIPOC people are numerous and complex and result in inequities in both birth outcomes and early childhood care. The specific interventions implemented in this project were initiated to begin to address some of those inequities in outcomes, but there are barriers to success inherent in these activities as well.

1. Early identification of pregnancy has been an ongoing issue for health plans. Many pregnant people are not financially eligible for coverage until they are pregnant, and this can delay prenatal care until they have this coverage in place. For those who already have coverage, delays or variation in claims submission can delay the notification of health plans to their pregnancy. It is not uncommon for clinics to schedule initial prenatal visits beyond the 12 week mark due to clinic capacity, missing the opportunity for early prenatal care as defined by HEDIS. Additionally, women who have a repeat pregnancy may not feel the urgency of early prenatal care or completing all recommended prenatal appointments.

2. Notifications of plan-related pregnancy resources can be hindered by lack of email addresses or incorrect mailing addresses. Engagement into the Healthy Pregnancy program relies on the availability of a phone and some members who have limited cellular minutes may be reluctant to use them communicating with a health plan nurse.

3. Immunization and well child visit reminders to parents of young children are also vulnerable to a lack of email and incorrect address. Additionally, some families may still be delaying care due to safety concerns related to visiting their clinic during a pandemic. Some clinics are experiencing severe staffing issues which makes access to appointments for care difficult.

4. Phone outreach to families proved to be challenging because of missing or incorrect phone numbers. Some caregivers expressed hesitancy to get recommended vaccines, including many who preferred a delayed schedule to what is recommended.

5. Doulas have been shown to improve birth outcomes, especially for women of color. In MN, it is a covered benefit for women on Medicaid. However, there remain barriers to women to access doulas of their choice, and barriers to become a doula who is able to submit reimbursement to Medicaid.
    a. The community wants to have more doulas that look like the community they serve. People of color want BIPOC doulas who have been trained to provide culturally congruent support.

    b. Clinicians including OB providers may not be aware that doulas are a covered benefit for women on Medicaid. And if they are aware, they may not fully understand the role of the doula or they may have misconceptions about doulas and may not

understand what a doula can do to enhance or reinforce the medical care they provide.

c. Individual doulas report that the requirement to work under a physician NPI number for Medicaid billing is difficult. Providers – especially in greater Minnesota – are reluctant to play that role.

d. Doula agencies who have developed a successful model to provide doula services to Medicaid members struggle to recruit and retain doulas of color due to many factors including:
   i) The Medicaid reimbursement rate is too low to provide a livable wage so many doulas choose to serve private pay clients where the fees are double or more.
   ii) The cost to obtain doula certification is significant and includes both the cost of the training itself as well as the cost for doulas to be listed on the DHS doula provider site, and the renewal every three years.
   iii) Once a doula is trained, there is a significant time lapse between beginning to provide care and when they can be paid, which is unsustainable for most people to support themselves.
   iv) Agencies make every effort to pair women of color with a doula from their own race or culture but if one is not available, they may be paired with a non-congruent doula or referred to a community partner who provides culturally congruent care but is not equipped to bill Medicaid.
   v) The structure of relying on grants to provide doula supports to their community is unsustainable, and the burden of becoming eligible for Medicaid billing is daunting.

Opportunities for Improvement: Results/Outcomes

The interventions discussed in this report were implemented throughout calendar year 2022 and are ongoing. Claims run out for establishing HEDIS rate achievement is not available for pre and post-partum care or childhood immunizations, but will be included in the update in next year's annual evaluation. Interim process measures are included above where relevant.

As this project is focused on reducing disparities, the following summary estimates PMAP volumes (prevalence) associated with key outcomes relating to maternity and deliveries.

Most current data available was used to determine race. People of Color includes - American Indian or Alaskan Native, Asian or Pacific Islander, Black or African American, Hispanic or Latino, Native Hawaiian or Other Pacific Islander, and other race.

PMAP Delivery Outcomes Summary
January 2021 – December 2022

	Medicaid 2021			Medicaid 2022		
Outcome	**People of Color**	**White**	**Missing Race**	**People of Color**	**White**	**Missing Race**
C-Section Rate	29.5% (673)	29.3% (419)	27.9% (38)	31.7% (814)	27.7% (360)	23.0% (31)
Multiple Birth Rate	2.6% (31)	2.5% (8)	2.3% (33)	1.7% (28)	3.4% (18)	1.8% (14)

Low Birth Weight	7.1% (145)	5.4% (54)	3.0% (6)	6.8% (118)	5.8% (39)	6.3% (50)
NICU Avg. Length of Stay	13.59	12.93	11.08	12.76	16.46	9.06
Number of Newborns	2,032	993	198	1,726	672	787

Disparities in these measures will be monitored over the three years of this project to help determine if there has been movement on these measures. As it is early in the project, we hesitate to assign causality at this early stage.

Prenatal and Postpartum Care rates

HEDIS data for Measurement Year 2022 will be available later in 2022 to monitor progress. Below are 2021 HEDIS rates, comparing white members to non-white members for the prenatal and postpartum measures. Rates of prenatal and postpartum care have decreased across the board for all populations during the pandemic and have not rebounded. The overall rate for non-white members continues to be higher than white members.

		Prenatal				**Postpartum**			
Product	White vs. Non-White	2019 Baseline rate	2019 GAP	MY 2021 Rate	2021 GAP	2019 Baseline rate	2019 GAP	MY 2021 Rate	2021 GAP
PMAP/MN CARE	White	81.8%	-1.8	72.4%	-2.9	62.8%	-4.5	57.6%	-2.8
PMAP/MN CARE	Non-White	83.6	-----	75.3%	----	67.3%	------	60.4%	------

Focus Study 2022
Improving Adolescent Immunization Rates

Accountable owner: *Patty Graham, QIC*

Member Populations Targeted

X	Commercial
	Medicare Freedom (Cost)
X	Medicaid
	MSHO
	SNBC
	HPUPH
	WI Marketplace

Description

This focus study aims to increase the number of Medicaid members who receive all recommended adolescent immunizations by their thirteenth birthday. Adolescent immunizations are an important way to prevent serious and deadly illnesses, and even prevent cancer later in life. However, adolescent immunization rates have remained stagnant, even decreasing during the height of the Covid-19 pandemic.

The immunizations recommended by age 13 include meningococcal, Tdap (Tetanus, diphtheria, pertussis) HPV (Human papillomavirus) and influenza. While influenza was included in the outreach education for this project, the measurement does not include that vaccine. Meningococcal and Tdap vaccines have been widely available and accepted for many years, and while the HPV vaccine has also been available for many years, it has been slow to gain widespread acceptance, resulting in much lower rates for that vaccine than the others. Additionally, recommendations have changed in recent years to include both males and females, so communication of this information is important to convey to parents so they can offer this protection to their children.

Reluctance of parents to approve all adolescent immunizations is primarily focused on the HPV vaccine. This vaccine is recommended for children at age 11-12, however can be given to the child as early as 9 years old. The reluctance of parents' centers around the fact that HPV is a sexually transmitted virus, and children are not typically sexually active at that age. Research has shown that children are not more likely to initiate sexual activity if they receive the HPV vaccine. However, research shows that the HPV vaccine is more effective over the long term when given at an earlier age (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4969174/). When the conversation of this vaccine is focused on sexual activity, it can make clinicians and parents uncomfortable. It is important to note that research shows that within 12 years of the HPV vaccine being introduced in the United States, the incidence of the four HPV types which the vaccine addresses, decreased 88% among 14–19-year-olds and 81% among 20-24 year old females in the US. (https://pubmed.ncbi.nlm.nih.gov/30998672/)

This project will focus on communication to parents about the importance of adolescent immunizations and providing clinician with tools to have these difficult conversations.

Goal

This project seeks to increase the HEDIS® measure, Immunizations for Adolescents (IMA) Combo 2, which includes Meningococcal, Tdap and both HPV vaccines recommended by age 13 years.

Medicaid Adolescent Immunization Rates Baseline

Year	HPV 1 dose	HPV 2 dose	Meningococcal	Tdap/TD	IMA Combo 2
2020	72	38	84	84	36
2021	67	35	72	73	31

Commercial Adolescent Immunization Rates Baseline

Year	HPV 1 dose	HPV 2 dose	Meningococcal	Tdap/TD	IMA Combo 2
2020	69	40	86	88	38
2021	70	41	79	81	37

Methods and Data Limitations

The IMA measure is typically a hybrid measure for publicly reported HEDIS, which means that a sample of the population is included, and information can be included that is extracted directly from the patient's medical record. In order to include the broadest population, we chose to utilize administrative data and include the full population. This data comes from claims, Minnesota Immunization Information Connection (MIIC) system and clinic electronic health records when available.

For this reason, more individuals are included in the data, but it may be incomplete if a claim was not submitted, or if the clinic did not submit the vaccine to the MIIC system. Additionally, it will not mirror the publicly reported HEDIS measure exactly.

Initiatives/Interventions

HealthPartners participated in the American Cancer Society Health Plan Adolescent Immunization (HPV Vax) Learning Collaborative in 2022. The overall project was on adolescent immunizations but was heavily focused on the HPV vaccine because that is the individual rate that brings the overall Combo 2 rate down.

Quality improvement staff participated in a bi-monthly learning opportunity with presentations by experts in the field who shared information on best practices, tools, and resources for improving HPV vaccination rates. Participating health plans shared their own experiences including successes and barriers to create a co-learning environment.

Research and best practice topics included a focus on data analytics as well as provider and members communication strategies. Topics included:

- On-time vaccination recommendations, including starting at age 9.
- Increasing vaccine confidence.
- Understanding data.
- Evidence based and informed interventions.
- Value based architecture.
- Effective provider communication.

Relevant information was shared with our provider network through articles in our provider newsletter, Fast Facts, as well as disseminating them to immunization-focused colleagues within our care group partners.

Immunization Communication

HealthPartners primary intervention for this project was to create an updated Adolescent Immunization campaign. In the past, we sent a communication out to parents of members in the target age group one time per year with basic information about the immunizations recommended for that age group. When the Covid-19 pandemic started, all communication about adolescent immunizations was halted. Once the Covid vaccine became available, the communications focused largely on that vaccine. We took the opportunity to enhance both the message and data analytics behind the message.

HealthPartners has multiple campaigns that deploy letters, emails and push messages that educate members about the importance of care or screenings and remind members when they are due for care.

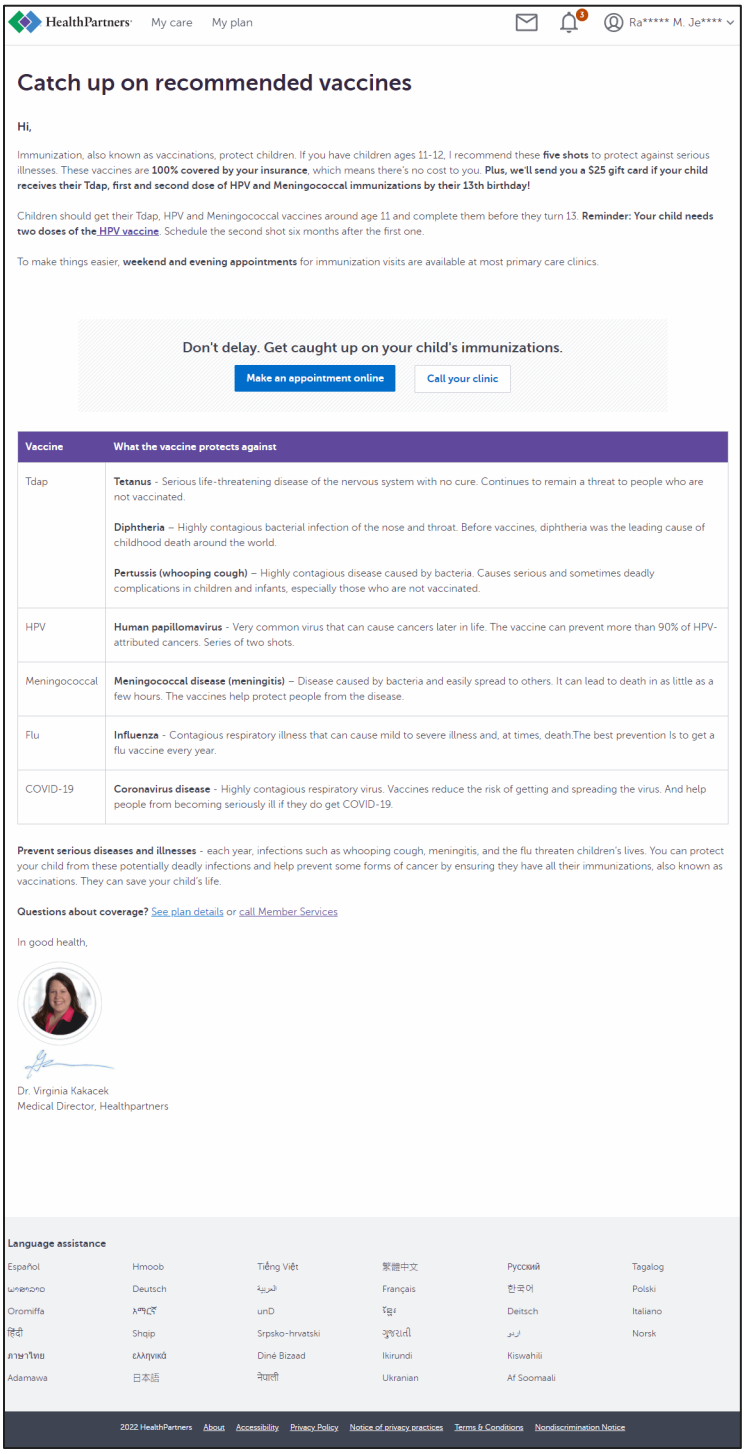
We created new messages for 11–12-year-olds focused on the immunizations recommended for that age group, and created a wrap-around Child and Teen Checkup campaign recommending well visits every year for all children.

Two differing messages (segments) were created for the adolescent immunizations campaign, and analytics determined which message we sent based on which message was deemed most likely to resonate with the parent based on analytics.

- Some members received a message that emphasized ‘Authority’ which emphasized the message from a trusted physician voice making the recommendation based on best practice. Basic factual information about what the immunization prevents backed up by a trusted voice would resonate with these caregivers.

- Other members received a ‘Fear’ message. This focused on the dangers of not providing the vaccines and some very basic information about how dangerous each of the preventable conditions could be. This is intended to evoke an emotional reaction which would resonate with other caregivers.

Both messages also included information about the incentives available to members when they complete all recommended immunizations by their thirteenth birthday. If the member doesn't have their own clinic, there is a link to help them find care in the network. These messages are delivered through email, push notification, the landing page when someone logs into their on-line account, and through Riverview Member Services. For members without an online account or email on file, we sent a letter via US mail.



HealthPartners My care My plan Ra***** M. Je*****

Catch up on recommended vaccines

Hi,

Immunization, also known as vaccinations, protect children. If you have children ages 11-12, I recommend these **five shots** to protect against serious illnesses. These vaccines are **100% covered by your insurance**, which means there's no cost to you. **Plus, we'll send you a $25 gift card if your child receives their Tdap, first and second dose of HPV and Meningococcal immunizations by their 13th birthday!**

Children should get their Tdap, HPV and Meningococcal vaccines around age 11 and complete them before they turn 13. **Reminder: Your child needs two doses of the HPV vaccine.** Schedule the second shot six months after the first one.

To make things easier, **weekend and evening appointments** for immunization visits are available at most primary care clinics.

Don't delay. Get caught up on your child's immunizations.

Make an appointment online | Call your clinic

Vaccine	What the vaccine protects against
Tdap	**Tetanus** - Serious life-threatening disease of the nervous system with no cure. Continues to remain a threat to people who are not vaccinated. **Diphtheria** – Highly contagious bacterial infection of the nose and throat. Before vaccines, diphtheria was the leading cause of childhood death around the world. **Pertussis (whooping cough)** – Highly contagious disease caused by bacteria. Causes serious and sometimes deadly complications in children and infants, especially those who are not vaccinated.
HPV	**Human papillomavirus** - Very common virus that can cause cancers later in life. The vaccine can prevent more than 90% of HPV-attributed cancers. Series of two shots.
Meningococcal	**Meningococcal disease (meningitis)** – Disease caused by bacteria and easily spread to others. It can lead to death in as little as a few hours. The vaccines help protect people from the disease.
Flu	**Influenza** - Contagious respiratory illness that can cause mild to severe illness and, at times, death.The best prevention is to get a flu vaccine every year.
COVID-19	**Coronavirus disease** - Highly contagious respiratory virus. Vaccines reduce the risk of getting and spreading the virus. And help people from becoming seriously ill if they do get COVID-19.

Prevent serious diseases and illnesses - each year, infections such as whooping cough, meningitis, and the flu threaten children's lives. You can protect your child from these potentially deadly infections and help prevent some forms of cancer by ensuring they have all their immunizations, also known as vaccinations. They can save your child's life.

Questions about coverage? See plan details or call Member Services

In good health,

Dr. Virginia Kakacek
Medical Director, Healthpartners

Language assistance

Español | Hmoob | Tiếng Việt | 繁體中文 | Русский | Tagalog
ພາສາລາວ | Deutsch | العربية | Français | 한국어 | Polski
Oromiffa | አማርኛ | unD | ਪੰਜਾਬੀ | Deitsch | Italiano
हिंदी | Shqip | Srpsko-hrvatski | ગુજરાતી | اردو | Norsk
ภาษาไทย | ελληνικά | Diné Bizaad | Ikirundi | Kiswahili
Adamawa | 日本語 | नेपाली | Ukranian | Af Soomaali

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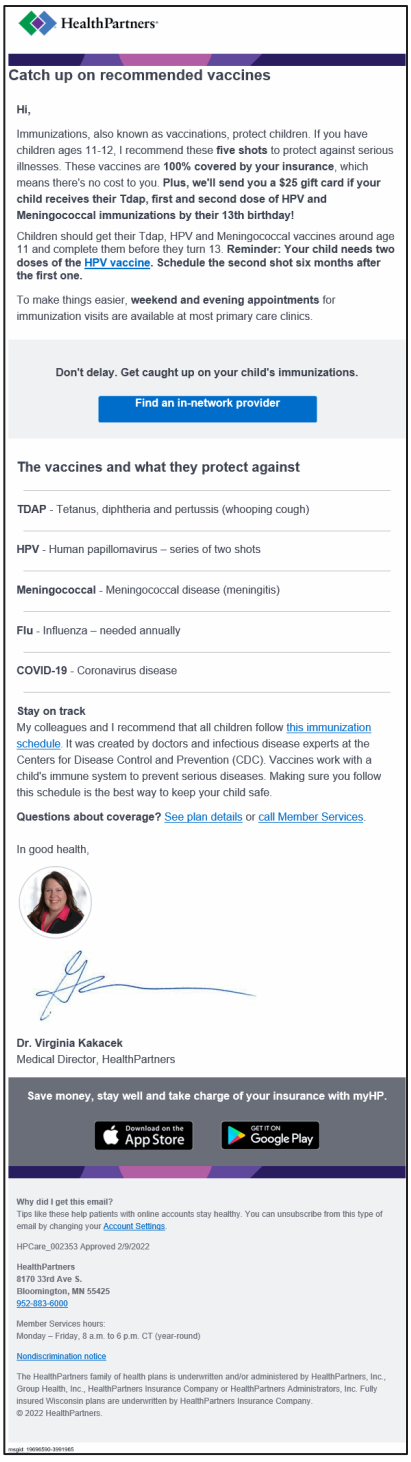

HealthPartners

Catch up on recommended vaccines

Hi,

Immunizations, also known as vaccinations, protect children. If you have children ages 11-12, I recommend these **five shots** to protect against serious illnesses. These vaccines are **100% covered by your insurance**, which means there's no cost to you. **Plus, we'll send you a $25 gift card if your child receives their Tdap, first and second dose of HPV and Meningococcal immunizations by their 13th birthday!**

Children should get their Tdap, HPV and Meningococcal vaccines around age 11 and complete them before they turn 13. **Reminder: Your child needs two doses of the HPV vaccine. Schedule the second shot six months after the first one.**

To make things easier, **weekend and evening appointments** for immunization visits are available at most primary care clinics.

Don't delay. Get caught up on your child's immunizations.

Find an in-network provider

The vaccines and what they protect against

TDAP - Tetanus, diphtheria and pertussis (whooping cough)

HPV - Human papillomavirus – series of two shots

Meningococcal - Meningococcal disease (meningitis)

Flu - Influenza – needed annually

COVID-19 - Coronavirus disease

Stay on track
My colleagues and I recommend that all children follow this immunization schedule. It was created by doctors and infectious disease experts at the Centers for Disease Control and Prevention (CDC). Vaccines work with a child's immune system to prevent serious diseases. Making sure you follow this schedule is the best way to keep your child safe.

Questions about coverage? See plan details or call Member Services.

In good health,

Dr. Virginia Kakacek
Medical Director, HealthPartners

Save money, stay well and take charge of your insurance with myHP.

Download on the App Store | GET IT ON Google Play

Why did I get this email?
Tips like these help patients with online accounts stay healthy. You can unsubscribe from this type of email by changing your Account Settings.

HPCare_002353 Approved 2/9/2022

HealthPartners
8170 33rd Ave S.
Bloomington, MN 55425
952-883-6000

Member Services hours:
Monday – Friday, 8 a.m. to 6 p.m. CT (year-round)

Nondiscrimination notice

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Immunization Campaign Results

Because of difficulties matching children to parents within the Medicaid population, email was not an effective delivery mechanism for this campaign. The members who received the message through their online account were most likely to respond to the message and get the needed care. However, the vast majority of members received the message through US Mail. The overall conversion rate for this campaign for Medicaid members was 11.1% compared to Commercial members with a 20.7% conversion rate.

Medicaid Results

Delivered by (Medicaid)	Number of members	Open rate	Click through rate**	Conversion rate***
Email	29	21 (72%)	0 (0%)	10.3%
Bell*	32	6 (19%)	4 (67%)	12.5%
US Mail	9,773	na	na	11.1%

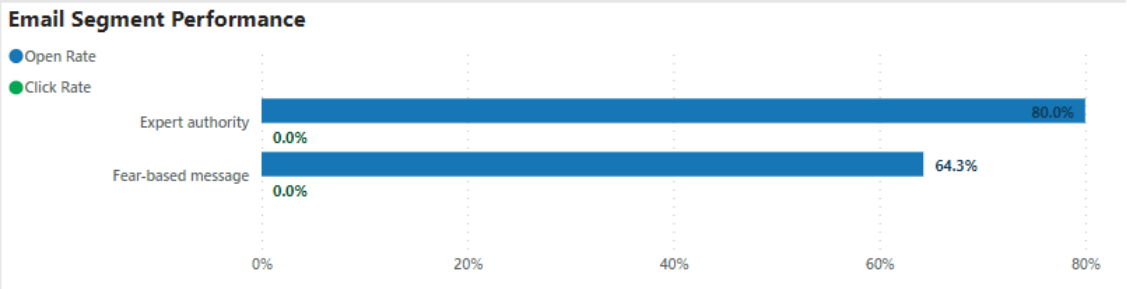
**Bell notifications are delivered when a member logs into their HealthPartners on-line account*

*** Click through rate means that the member's caregiver clicked into the message and went to the landing page where they could get more information.*

****Conversion rate shows that the member received the recommended care within 60 days of receiving the message.*

Message Results

While the numbers are quite small, those members who received the Authority message via email were almost 15 percentage points more likely to open the email and read it.



By contrast, those Medicaid members who received the *Fear* campaign were significantly more likely to act and have their child receive the immunizations.

Medicaid Message	Conversion rate
Expert	6.7%
Fear	27.3%

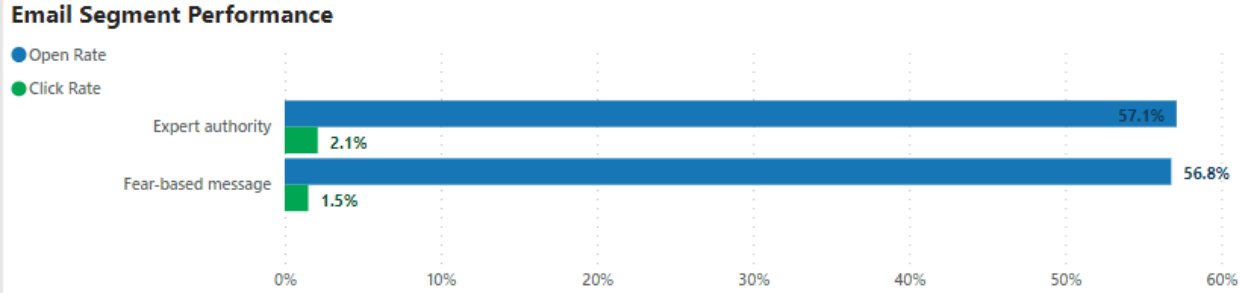
Commercial Results

By contrast, commercial insurance members responded to the two different messages slightly differently. Both the fear and authority messages were opened at almost the same rate, and the conversion rate for both segments were identical. This could be partly because commercial members have a larger trail of consumer data attached to them, so we were able to identify the

best message for them more accurately. By contrast, the Medicaid members were largely sent a letter “To the Parent or Caregiver of” the member. Going forward, our communications area will continue to attempt to refine who receives each message to achieve highest performance of this campaign.

Delivered by (Commercial)	Number of members	Open rate	Click through rate**	Conversion rate***
Email	26,267	14,970 (57%)	278 (2%)	21.2%
Bell*	26,868 (64%)	2,099 (8%)	189 (10%)	24.2%
US Mail	N/A	N/A	N/A	N/A

The open rate for both message segments was almost the same for commercial members, and the conversion rate was identical.



Commercial Message	Conversion rate
Expert	21.4%
Fear	21.4%

Member Incentive for Medicaid

HealthPartners provides a member incentive for our Medicaid members who are up to date on immunizations (meningococcal, TDAP and 2x HPV)) by their 13th birthday. This information is included in the reminder message they receive regardless of whether they receive the fear message or the authority message.

Of 3,608 members eligible for the incentive, 1,163 received it in 2022 (32%)

Care group MOC

HealthPartners and Park Nicollet care groups offer primary care providers Maintenance of Certification (MOC) opportunities. The MOC portfolio offers a streamlined process for physicians and physicians assistants to complete a QI project that is required to renew their specialty board certification.

In 2022, MOCs were offered for Improving Child and Adolescent Immunizations, and Addressing Health Disparities for Child and Adolescent Immunizations. Clinicians who chose to

participate received training on how SDOH impacts patients and explored their own implicit bias. Eighteen clinicians signed up for Addressing Health Disparities in Childhood Immunizations MOC. While none of them met their full disparity goals, other self-reported outcomes such as awareness of cultural humility, understanding the difference between health equity and equality and having the tools to support patients were greatly improved. The data below shows results for both the Child and adolescent immunizations cohort and the Addressing Health Disparities – Child and Adolescent Immunizations cohorts.

Immunizations MoC's Adolescent Immunizations cohort – 26 clinicians

Combo 10

- MoC cohort 3% higher than overall results (entire org)
- MoC cohort decreased Race Disparity Gap by over 5%
- MoC cohort decreased Payor Disparity Gap by over 1%

Combo 2

- MoC cohort 0.75% higher than overall results (entire org)
- MoC cohort decreased Race Disparity Gap by over 2%
- MoC cohort increased Payor Disparity Gap by over 4%

Addressing Health Disparities MoC – 3 clinicians

Combo 10

- MoC cohort finished 16% higher than overall results (entire org)
- MoC cohort increased Race Disparity Gap by ~3%
- MoC cohort decreased Payor disparity Gap by ~6.5%

Combo 2

- MoC cohort finished 15.7% higher than overall results (entire org)

Little to no change in the race and payor disparity gaps

Provider Education

We included an article in our Fast Facts Provider Newsletter about the importance of adolescent immunizations which included resources for effective conversations with parents and caregivers. We included links to trainings recommended during the ACS/Health Plan Learning Collaborative.

We also discussed this topic at our Quality Connections forum, where QI leaders from our network clinics share best practices on various QI topics. Two care groups presented their process for improving adolescent immunization rates including their outreach protocols, clinic processes and their provider training. 19 care groups attended this meeting.

Barrier Analysis and Gaps in Care

1. Adolescent HPV immunization rates continue to lag far behind other immunizations recommended for children in this age group. Attitudes and beliefs about the HPV vaccine and access to health care are significant barriers.

a. Providers who present the immunization as routine, and as a cancer prevention strategy have the most success in parent acceptance of the vaccine. Provider education efforts have focused on encouraging this approach. Some providers remain uncomfortable talking about the vaccine which reduces their ability to educate parents and caregivers.

2. Clinics in Minnesota were heavily impacted by staffing shortages which resulted in difficulty getting patients scheduled for routine care.

3. During the height of the Covid-19 pandemic, patients were reluctant to go to clinics for care. While this has largely rebounded for our commercial membership, our Medicaid membership has not retuned to routine care at the same level. This delay in care has impacted many quality metrics.

4. It has been widely reported by our clinic partners and health department colleagues that attitudes towards immunizations is changing. Negative attitudes toward the Covid vaccine have seeped into other preventive care, especially immunizations. Clinics report that families who have previously always accepted the vaccines are now pushing back on the advice of their clinician.

5. Medicaid members are far less likely to have active on-line accounts, have their email on file with us or to have current addresses in our system. All these barriers make a member communication campaign challenging.

Opportunities for Improvement: Results/Outcomes

Overall, progress was made to increase adolescent immunization rates in 2022, but these efforts were more impactful in the commercial membership. Medicaid rates increased over 2021 but did not return to pre-pandemic rates. While Commercial rates increased over both the previous year and surpassed pre-pandemic rates.

Medicaid Final

Year	HPV 1 dose	HPV 2 dose	Meningococcal	Tdap/TD	IMA Combo 2
2020	72	38	84	84	36
2021	67	35	72	73	31
2022	67	34	81	82	34

Commercial Final

Year	HPV 1 dose	HPV 2 dose	Meningococcal	Tdap/TD	IMA Combo 2
2020	69	40	86	88	38
2021	70	41	79	81	37
2022	68	41	86	88	40

For the first time in several years, the commercial IMA Combo 2 rate exceeds the Medicaid rate. We will continue to work with our providers to encourage improvement in IMA Combo 2 rates and will continue to explore strategies to improve this measure for all members.

Focus Study
2021 Performance Improvement Project: Reducing Disparities in Blood Pressure Control for Diabetes

Accountable owner: *Tammy Chambers, Patty Graham, QIC*

Member Populations Targeted

	Commercial
	Medicare Freedom (Cost)
	Medicaid
X	MSHO
X	SNBC
	HPUPH
	WI Marketplace

Description

This Performance Improvement Project (PIP) is intended to improve Comprehensive Diabetes Care and services for seniors and SNBC members with a focus on reducing disparities in blood pressure control for Black members compared to White members. To support improvement, HealthPartners is involved with joint collaborative interventions as well as plan specific strategies.

This PIP is a collaboration of Minnesota Managed Care Organizations (MCOs) ("the Collaborative"). MCOs participating in this collaboration for their SNBC, MSHO & MSC+ products include: BCBS (MHO and MSC+ only), HealthPartners, Hennepin Health (SNBC only), Medica, South Country Heath Alliance (SCHA) and UCare. Stratis Health provides project development support and assistance to the Collaborative.

According to the Minnesota Department of Health (MDH), since 2011, Minnesota adults have reported the lowest age-adjusted high blood pressure prevalence of any state in the country. MDH data showed very little change in the percentage of adults reporting they have been told they have high blood pressure, hovering around 1 in 4 adults from 2011 through 2017. An additional analysis of Minnesota adults with insurance coverage in 2014 showed similar rates of age-adjusted hypertension prevalence (25.4%).

Segments of data were identified by age group, ethnicity, and disability. More than half of adults aged 65 or older report being told they have high blood pressure at 52.7%. The break down by race/ethnicity was 30.4% for African American/African, 24% for White and 23% for Hispanic. It is difficult to assess whether there are significant differences in high blood pressure prevalence between people from different racial and ethnic groups because the available race or ethnicity-specific data is based on small numbers. There is evidence that age-adjusted high blood pressure prevalence is about 6 percentage points higher in African American/African Adults in

Minnesota compared to Whites. The small number of American Indian and Asian adults in the survey prevent the calculation of an age-adjusted prevalence estimate. Among individuals who are not disabled, 23.5% of adults reported having high blood pressure.

Compared to non-disabled individuals, Minnesota adults with a disability were more likely to report high blood pressure. Among those with a disability, those with a vision disability had the lowest prevalence of high blood pressure. Alternatively, adults with disabilities affecting mobility, independent living, and self-care were more likely to report high blood pressure than those with vision or cognitive disabilities.

This PIP focuses on decreasing the health disparity gap in HEDIS® and/or process measures chosen year-over-year from 2021 thru 2023 by improving member's self-management of their diabetes. To be able to reduce the disparities in diabetes, we will look to the already present evidence-based approaches to address the many factors that influence health, such as access to nutritious foods, options for physical activity through a collaborative approach between both health care and non-health care, and the social and environmental factors that affect vulnerable populations.

Goals

This project seeks to decrease the health disparity gap between Black/African American MSHO and SNBC members in the HEDIS® Comprehensive Diabetes Care, BP Control measure year-over-year from 2021 thru 2023.

Methods and Data Limitations

The MSHO project is focused on those members who receive care within the HealthPartners and Park Nicollet care systems with a focus on decreasing the disparity between Black/African American member-patients and white member-patients. In 2019, 70% of the members in the diabetes measure received their care through our own care group, making this project a collaboration between our plan and the member's caregiver.

Because the SNBC membership is not as concentrated within our own care group, the SNBC project will focus on all members regardless of attribution and will focus on clinician education and member outreach to improve blood pressure control.

Member identification will follow HEDIS specifications from the technical specifications for measurement year 2021 for Comprehensive Diabetes Care – BP Control. This measures the percentage of members 18 – 75 years of age with diabetes who have their blood pressure in control. Control is defined for this measure as <140/90 mm Hg).

Continuous enrollment and inclusion criteria – Members are continuously enrolled during the measurement year.

- Only MSHO members who are attributed to the HealthPartners and Park Nicollet family of care.
- All SNBC members who are included in the HEDIS sample AND all SNBC members who are attributed to the HealthPartners and Park Nicollet family of care.

The MSHO measure will utilize only administrative data utilizing claims and EPIC. We will produce yearly rates of blood pressure control for white members and Black/African American identified members with diabetes who are attributed to the HealthPartners and Park Nicollet care systems and determine the disparity for the MSHO product.

The SNBC Measure will utilize those members in the HEDIS sample as well as SNBC members who are attributed to the HealthPartners and Park Nicollet care systems. We will include more members than just the sample by using EPIC data to supplement the data we capture during chart review. The combination of data allows us to maximize the number of SNBC members included.

Baseline– Because the number of members in the measure can fluctuate from year to year, HealthPartners will use a three-year average (2017-2019) as our baseline rate upon which to improve. (Table 1)

Goal – HealthPartners will seek to decrease the disparity gap between Black or African American members and white members by 2.5% to 8.1 for MSHO and to 6.2 for SNBC.

Table 6 *Baseline Blood Pressure Control for People with Diabetes. Disparities 2017-2019*

Product	Race	2017	2018	2019	3 year num	3 year denom	3 year rate	Gap to white
MSHO	Black or African American	50/73 68.5%	55/86 64%	71/99 71.7%	176	258	68.2%	10.6
	White	89/108 82.4%	98/122 80.3%	118/157 75.2%	305	387	78.8%	-------
SNBC	Black or African American	29/38 76.3%	77/120 64.2%	109/148 73.6%	215	306	70.2%	8.7
	White	109/136 80.1%	173/215 80.5%	197/256 77%	479	607	78.9%	------

Data Barriers:

1. A known barrier with using the HEDIS Comprehensive Diabetes Care measure is that it is reported using a hybrid calculation. Hybrid measures are measures in which additional information in the medical chart may be sought to complement claims data in order to provide a full picture of the care/services provided. Thus, a sample of the population is drawn vs. abstracting medical record evidence for the entire measure denominator. Generally, the sample size is 411. Since the project has an emphasis on closing disparity gaps, using the hybrid methodology would produce a limited representation of the aimed reduction in disparity.

   Therefore, we will supplement SNBC sample data with members who receive their care in our care group. The primary intervention for MSHO members will be concentrated in our care group, so for MSHO we will be able to report the most robust administrative

data. Due to these adaptations to the traditional HEDIS measure, our reported data will not mirror HEDIS exactly.

2. HealthPartners does not have pharmacy data for our MSC+ members and we are unable to reliably identify members for this measure, so we will not include MSC+ members in the measurement. However, MSC+ members who can be identified will be included in all interventions and member outreach.

Initiatives/Interventions

Inexpensive blood pressure monitors are an effective way to monitor blood pressure at home. The USPSTF recommends out-of-office blood pressure measurement before making a new diagnosis of hypertension. Researchers at UT Southwestern Medical Center studied data from the Dallas Heart Study and learned that at-home measurements are more accurate, less expensive, and easier to obtain than blood pressure screenings done in medical settings. Patients' readings tend to be higher in the clinic due to stress or anxiety. According to guidelines from the American College of Cardiology and AHA, “people with high blood pressure should measure their blood pressure at home, keep a log of the results and show it to their doctor.

Provider Communication

There is limited awareness among members and clinicians that home blood pressure cuffs are a covered benefit for Medicaid members. We included an article in Fast Facts, our provider newsletter, reminding clinicians of the importance of blood pressure monitoring for comprehensive diabetes care, describing our commitment to reduce disparities in this measure, and informing them of the coverage for home blood pressure monitoring equipment for members who qualify.

We also shared this information with our care coordinators for both MSHO and SNBC as they can support members to access this equipment if needed.

Home Blood Pressure Monitor Project

During the height of the pandemic, the ability of clinicians to work with their patients to monitor their high blood pressure was impacted by the inability of patients to come to in-person visits. Clinics addressed this by utilizing home blood pressure monitors. We identified at that time that most members and many clinicians were not aware that blood pressure monitors are a covered benefit for Medicaid members who qualify. At the same time, while clinics are fully open for all care, staffing shortages make it difficult to devote time to outreach to patients who do not have an updated blood pressure reading on file.

1. HealthPartners collaborated with our care groups to identify our members who receive their healthcare in our care system, who have diabetes and whose blood pressure is not at goal.

2. For those members, we sent them a letter telling them they were eligible for a home blood pressure cuff, and we would provide one if desired.

3. We worked with the care group and the health care products team to identify and procure the preferred blood pressure cuff which has blue-tooth capability, allowing it to transmit the reading into the patient's medical record once the care group's technology allows for this.

4. We identified key educational pieces to help patients understand the importance of blood pressure control with diabetes and to help ensure they take their readings correctly. We had the following information translated into Spanish, Somali, Vietnamese, Cambodian/Khmer and Hmong:
    a. Understanding High Blood Pressure
    b. How to Take Your Blood Pressure at Home
    c. Dash Diet

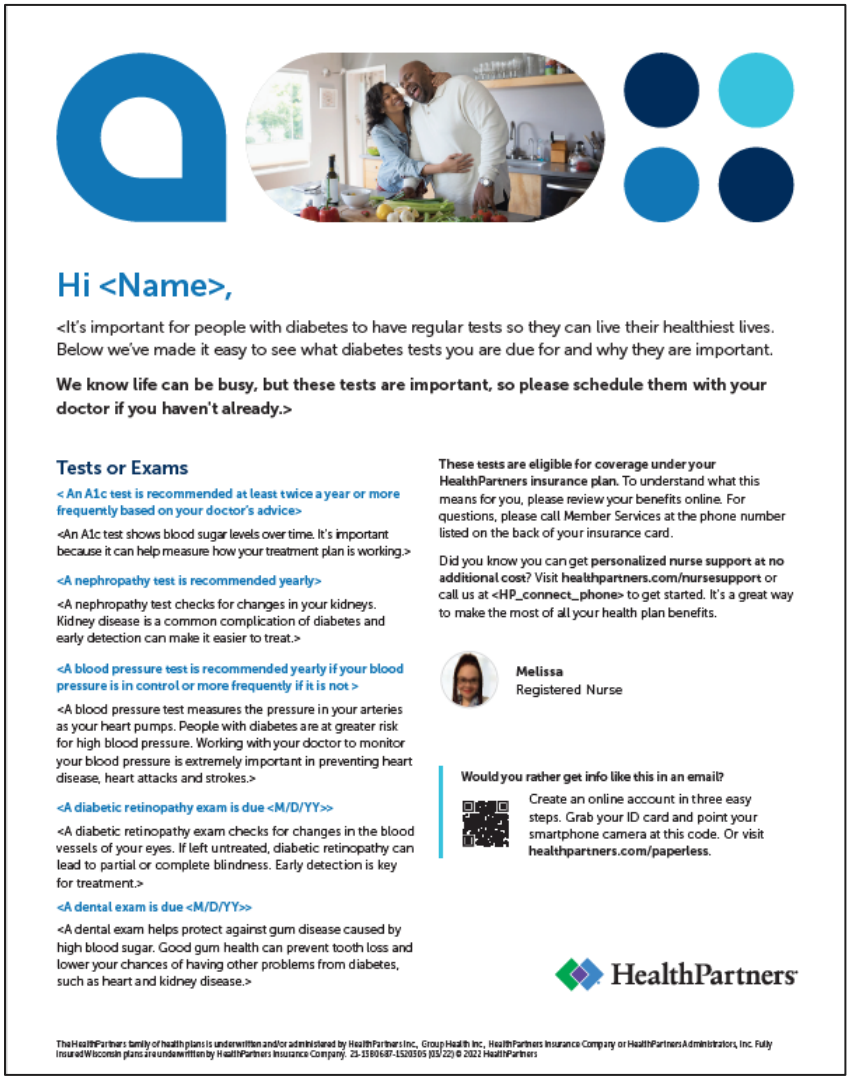
5. Blood pressure cuffs were sent in the mail to those members who accepted the benefit and were offered support from the clinic if they needed help to understand how to use the cuff or had other questions.

Ultimately, over 3200 Medicaid members with diabetes received a home blood pressure cuff to help monitor this important measure. Of these, 254 were MSHO members. We were unable to identify exactly how many MSC+ and SNBC members were included as the report did not distinguish between MSC+, SNBC and other Medicaid products (MNCare and PMAP). We will attempt to break this down and delineate the numbers in our year two interim report to DHS to show the impact this project had on member blood pressure control.

Member Education Communication

HealthPartners has an outreach campaign that encourages members with diabetes to get care from their clinician for many issues related to diabetes including A1C, nephropathy and eye exams. In 2021, we completed an update of this outreach to address BP control more effectively for diverse members.

1. We conducted a focus group of Black and African American colleagues to learn what people liked about our health plan outreach efforts and what could make the messaging stronger. Relevant input included the appearance of the envelope and letter itself to appear more friendly and more likely to be opened. We also adjusted who delivered the message. The group felt that if they weren't getting the information from their own clinician, that a nurse who looks like them would be more effective than a plan Medical Director.



Hi <Name>,

<It's important for people with diabetes to have regular tests so they can live their healthiest lives. Below we've made it easy to see what diabetes tests you are due for and why they are important.

We know life can be busy, but these tests are important, so please schedule them with your doctor if you haven't already.>

Tests or Exams

< An A1c test is recommended at least twice a year or more frequently based on your doctor's advice>

<An A1c test shows blood sugar levels over time. It's important because it can help measure how your treatment plan is working.>

<A nephropathy test is recommended yearly>

<A nephropathy test checks for changes in your kidneys. Kidney disease is a common complication of diabetes and early detection can make it easier to treat.>

<A blood pressure test is recommended yearly if your blood pressure is in control or more frequently if it is not >

<A blood pressure test measures the pressure in your arteries as your heart pumps. People with diabetes are at greater risk for high blood pressure. Working with your doctor to monitor your blood pressure is extremely important in preventing heart disease, heart attacks and strokes.>

<A diabetic retinopathy exam is due <M/D/YY>>

<A diabetic retinopathy exam checks for changes in the blood vessels of your eyes. If left untreated, diabetic retinopathy can lead to partial or complete blindness. Early detection is key for treatment.>

<A dental exam is due <M/D/YY>>

<A dental exam helps protect against gum disease caused by high blood sugar. Good gum health can prevent tooth loss and lower your chances of having other problems from diabetes, such as heart and kidney disease.>

These tests are eligible for coverage under your HealthPartners insurance plan. To understand what this means for you, please review your benefits online. For questions, please call Member Services at the phone number listed on the back of your insurance card.

Did you know you can get **personalized nurse support at no additional cost**? Visit **healthpartners.com/nursesupport** or call us at **<HP_connect_phone>** to get started. It's a great way to make the most of all your health plan benefits.

Melissa
Registered Nurse

Would you rather get info like this in an email?

Create an online account in three easy steps. Grab your ID card and point your smartphone camera at this code. Or visit **healthpartners.com/paperless.**

HealthPartners

2. Language was included about which diabetes management tests the member is due for and why it is important. Blood pressure monitoring was included for the first time.

3. A full color postal mailing was delivered to those members who don't have an on-line account.

4. We included resources for seniors and people with disabilities that are available from the plan including nurse support and on-line health coaching tools.

Process Measure: Of the members who received the communications, how many clicked through to learn more about the action they could take to improve their diabetes.

Below is information on the messages delivered to those members in 2022.

- Overall, 19.5% of MSHO, MSC+ and SNBC members who received information encouraging them to get their recommended diabetes screening tests, acted and got the screenings they were due for.
- In addition, 442 MSHO and 795 SNBC members received a postal mailing with this information, however conversion data on that is not available at this time.

Product	Email Msg sent	Opened	Clicked	Conversion
MSHO/MSC+	312	192 (62%)	70 (36%)	21.9%
SNBC	324	157 (48%)	45(29%)	18.5%

Care Coordination Tool

HealthPartners MSHO and SNBC Care Coordinators complete a health assessment with each member at least yearly. HealthPartners has many supplemental benefits which are relevant to MSHO members with diabetes, and it is important for care coordinators to know about them and to assist their members to access them when it would be beneficial to the member. To assist the Care Coordinators in connecting members to relevant resources, HealthPartners created a grid linking questions in the health assessment to the supplemental benefits that would address a vulnerability for the member. This easy reference tool has been shared with Care Coordinators and made available with direct links to the supplement benefits information that is applicable.

Process Measure: Annual utilization of supplemental benefits that support healthy diet and exercise.

Table 7 *Supplemental Benefits Usage*

Supplemental Benefit		2021 Usage	2022 Usage
Silver and Fit Fitness Membership	Silver & Fit health club membership and at-home fitness kits.	4,638	
SilverSneakers membership	Replaced Silver and Fit		2,091
Wearable activity tracker.	Electronic device to track steps and calculate calories burned.	292	1125
Wellness Classes	Juniper Classes, Diabetes Prevention Program, Living Well with Diabetes, and more.	29	254
Wellness support and education	A tablet with education and wellness tools for members with diabetes, heart disease, cognitive impairment or depression.	291	364
Nutrition Assistance	Home delivery of meals immediately following surgery or an inpatient hospital stay.	49	58

Supplemental Benefit		2021 Usage	2022 Usage
Nutrition Support	Weight Watchers (WW) Weight management program.	44	500
FarmboxRx	Fresh produce boxes filled with fruits and vegetables delivered to members with a qualifying Dx (NOTE: total includes all members and not just those with diabetes)		38,617 boxes
Transportation to health clubs	SilverSneakers		1895 total trips
Transportation to health education classes	Juniper classes, Weight Watchers		134 total trips

HealthPartners and Park Nicollet Partnership

With approximately 70% of our MSHO members, 60% of our MSC+ members and 24% of our SNBC members receiving care within our family of care, HealthPartners is in a unique position to take advantage of the close partnership between our care group and our health plan to impact the health of member-patients. In 2021, our care group initiated a pilot project: *Increase the Use of Home Blood Pressure Monitoring: A step in reducing the disparity gap for Medicaid patients with hypertension.* This project aims to:

- Provide standardized cardiovascular education utilizing Priority Wizard in a hypertension focused clinician visit.
- Increase use of home blood pressure monitors in hypertensive Medicaid patients on diabetes, hypertension, and vascular registries, who agree to program guidelines, by 25% from baseline in 6 months.
- Decrease proportion of hypertensive Medicaid patients with overdue blood pressure readings by 25% from baseline in 6 months.
- Improve blood pressure by 10 mmHg systolic, and/or 5 mmHg diastolic in 6 months.

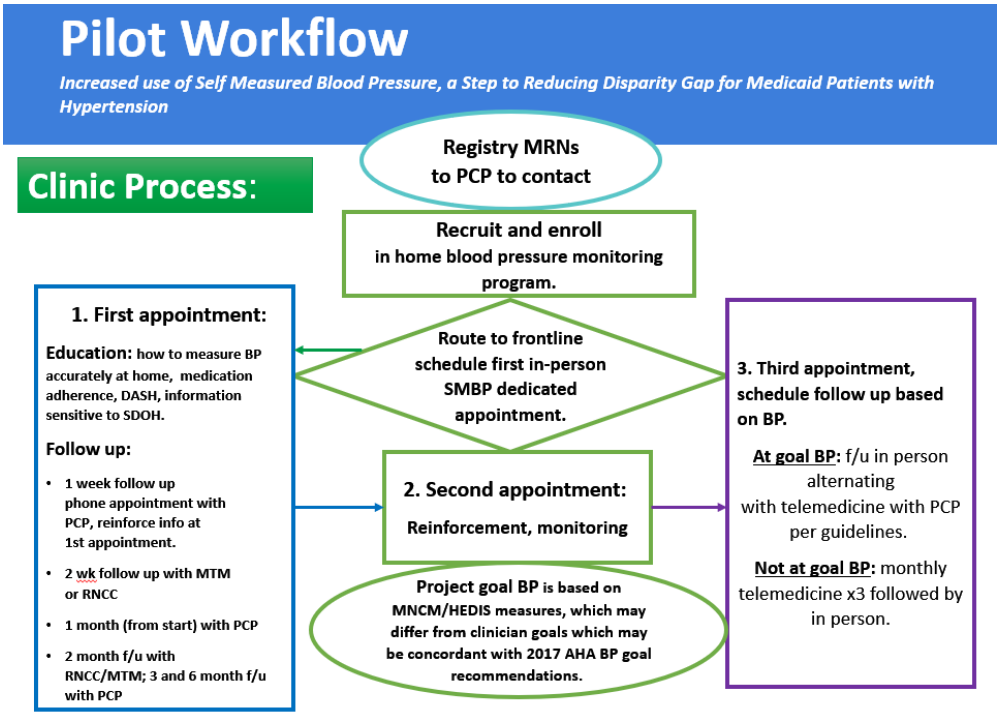
This pilot was planned to be implemented in 4 clinics with a large percentage of patients with Medicaid coverage, with a lead physician in each clinic. Patients included need to be open to scheduling an appointment to address hypertension and receive education for accurate home blood pressure monitoring. Training was provided to all clinical and relevant support staff.

The focus is on patients who have Medicaid as their health insurance because automated blood pressure monitors are covered under Medicaid insurance. However, the specific model preferred by the clinicians was not the ‘standard’ cuff in stock with our DME provider for Medicaid payment. Due to the ability to import data into the EMR, the project team felt it was important to utilize that equipment. A significant number of negotiations and approvals were needed to fully implement the project using the preferred technology.

We needed to define and establish the billing processes with the DME department of the care group and the health plan network management area. This resulted in a delay in kick-off of the project to March 2022.

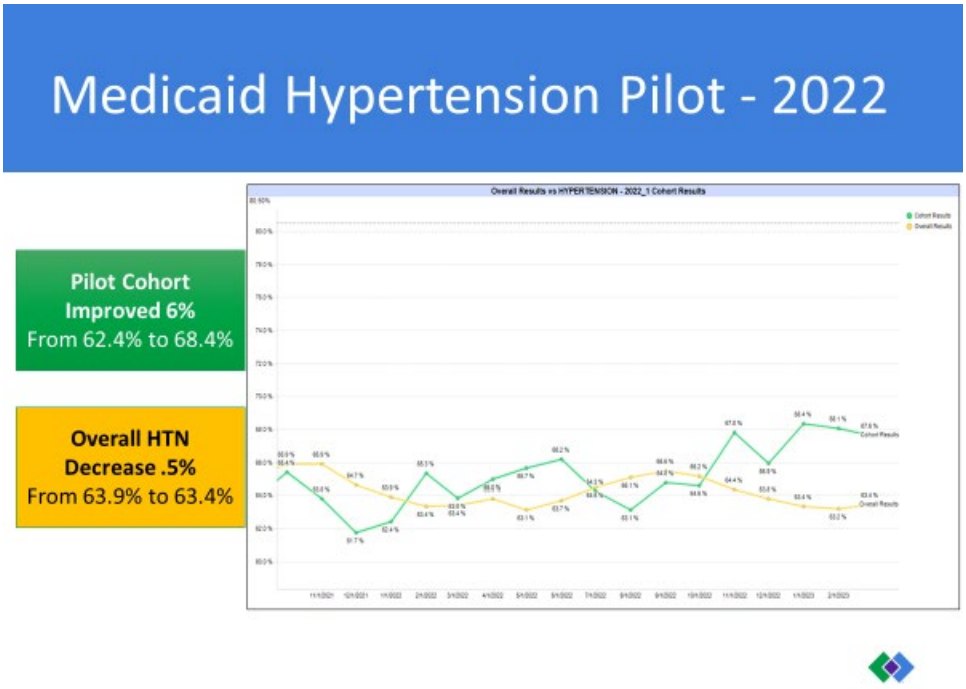
Training for the participating teams included delineation of responsibility based on the team members role, information on how to use the SDOH screening tools in EPIC, and the workflows that would be followed (see figure 1).

Figure 4 *Clinic Workflow for Hypertension Pilot*



It is important to note that while the focus of this project was all Medicaid members with hypertension, this did include members with diabetes who have hypertension. The project showed positive results in several areas, including a 6% increase in blood pressure control for those patients in the cohort, compared to a slight decrease in control for patients overall. (See graph 1)

Graph 1:



HealthPartners Care Group Health Disparities Maintenance of Certification

In addition to this pilot, HealthPartners care group is offering a Maintenance of Certification (MOC) on *Addressing Health Disparities MOC with a focus on Diabetes and Vascular Management*. In 2022, there were two cohorts of clinicians who participated in this project, with varying successes. This MOC will continue to be an option for clinicians to work on in 2023.

- Cohort 1 decreased the race disparity gap among their patients by over 6%.
    - Race data showed increase in patient of color outcomes by more than 5%.
    - Race data showed patients of color 67% at goal and more than 8% higher than white patients.
- Cohort 2 decreased the payor disparity gap by over 1%
    - Payor data showed increase for patients in Government Programs outcomes by more than 1%.
    - Payor data showed increase for patients in Government Programs at 57.1% at goal and 2% higher than Commercial patients.

Support for Social Drivers of Health

We know that social drivers of health (SDOH) such as food and housing resources directly impact a person's ability to meet health goals. In 2021, HealthPartners implemented a new approach to addressing SDOH for our members through a partnership with NowPow. This platform allows staff to make referrals for basic needs and other community resources that are local to the member.

- Needs are identified by members in a variety of ways including the Health Assessment, member-facing teams such as MTM Pharmacists, RideCare, Member Services, Disease and Case Management, Health Coaching as well as by clinicians within our care system.
- A customized list of resources is created for the member based on their location, hours the service is open, etc. and can be translated into many different languages. The list can be sent to the member via email.
- This resource is now available to anyone who logs onto the HealthPartners website regardless of participation with other HealthPartners services. Search local resources, assistance, and support | HealthPartners
- In 2022, four out of the top 10 types of services offered to members were food related. Because food insecurity is both such a prevalent issue, and so directly impacts health, HealthPartners is partnering with FarmboxRx to deliver boxes of fresh produce directly to members' homes for free. This is part of the organization's ongoing effort to address social and community factors that impact overall health, including food insecurity.
- Eligible seniors can receive up to two boxes of fresh fruits and vegetables each month. The boxes contain different seasonal options designed by a team of registered dietitian nutritionists and can be customized for specific health conditions. They also include nutrition and food education materials.

10 Most Common Service Types, based on Total Referrals Sent/Shared

	Total Referrals Sent/Shared	Average Distance to Service (mi)
Food pantry	158	3.81
Rent and mortgage payment assistance	145	4.65
Income-based housing	125	7.32
Housing search assistance	115	6.32
Fresh fruits and vegetables	104	4.68
Groceries	99	6.83
Utility payment assistance	90	4.72
Emergency-only financial assistance	80	4.65
Meal delivery	67	9.85
Coordinated Entry access point	67	12.38

Juniper Collaboration

Healthy Aging classes through Juniper are covered for MSHO members as part of our supplemental benefits package. Juniper classes include Living Well with Chronic Conditions, Living Well with Diabetes, and several classes to increase physical activity and strength. In 2022, HealthPartners and Juniper collaborated to reach out to eligible members and refer them for classes when the member is interested. HealthPartners supplied a list of 2,963 members with qualifying conditions for outreach.

Juniper sent out mailings and conducted outbound calls to 2,444 members and successfully had conversations with 48% of them. Ultimately, 254 MSHO members participated in Juniper classes in 2022.

Class	# of MSHO members
Living well with Diabetes	3
Living well with Chronic Conditions	6
Walk with Ease	115
Tai Ji Quan	88
Foundation Exercise program	15
Stay Active and Independent for Life	17

Juniper Live Well program participant feedback:

- 8/8 respondents reported that they:
  - Can manage their chronic condition
  - Can work with healthcare professionals
  - Feel better about managing their chronic conditions after the program

- Since participating in the program, participants reported making the following lifestyle changes:
  - Implementing exercise into their daily routine
  - Making changes to their eating habits

Collaborative Interventions

Community Outreach and Partnerships

2030 Minnesota Cardiovascular Health and Diabetes State Plan

In September 2018, CDC awarded funds to State and Local Health Departments to design, test, and evaluate innovative approaches to address the significant national health problems of diabetes and heart disease and stroke. MDH was one of the awardees. With CDC support, this grant will allow MDH to develop new approaches to increase the reach and effectiveness of evidence-based public health strategies in populations and communities with a high burden of diabetes, or heart disease and stroke. Recipients will conduct rigorous evaluations so that CDC and others can learn from this work.

The creation of the 2030 Minnesota Cardiovascular Health and Diabetes Plan is a collaborative effort of state and local partners; started in 2019 and lead by MDH. The plan will be a road map and call to action for individuals, communities, and organizations to collaborate and prevent, treat, and manage diabetes, heart disease, and stroke for the next ten years.

MDH shared multiple resources with the project team that each plan shared with our provider network and others working on diabetes care in our communities. These resources are also posted on the project page on the Stratis Health website.

In addition, we presented two joint webinars in collaboration with MDH in 2022 to fill knowledge and resource gaps for providers across Minnesota. These webinars are included in the webinar summary below.

Webinar series

The Collaborative offered a series of webinars in 2021 which will continue throughout the project to improve the comprehensive diabetes care and services for seniors and SNBC members, focusing on closing the gaps in health care disparities within our populations. Care Coordinators/Case Managers have an essential role in educating, supporting, and assisting members in setting and achieving health goals to improve their diabetes care. While some Care Coordinators/Case Managers are nurses, many are social workers who benefit from additional information on the role they can play to support their members with diabetes. All webinars are recorded and posted on the project page of the Stratis Health website for viewing anytime. The webinars offered in 2022 were:

Meeting the Challenges of Diabetes: Consequences of Disease Progression – 5/11/2022 Presented by Janet Ungs, Nurse Practitioner, Endocrinology, Park Nicollet Clinic

This webinar is the first in a series addressing knowledge gaps of care coordinators and others in diabetes progression. The goal of the presentation series is to provide Care Coordinators, Case Managers, and other professionals working with Minnesota Senior Health Options (MSHO) and Special Needs Basic Care (SNBC) members information to understand the impact of diabetes better and enhance their skillsets when working with members with diabetes. The webinar was attended by 401 people.

Food is Medicine – Integrating Effective Nutrition Interventions into the Healthcare System: A Concept Whose Time Has Come – 6/28/2022 Presented by Dr. Dariush Mozaffarian, Dean at the Tufts Friedman School of Nutrition Science/Policy

Presented in collaboration with the Minnesota Department of Health Diabetes section, this webinar focused on food insecurity as a social determinant of health and contributor to chronic disease prevention and management. Participants learned how health care clinicians and systems are finding new clinical and community interventions to improve patients access to quality nutrition and education. This webinar was attended by 607 individuals.

Implicit Bias & the Pursuit of Health Equity 8/10/2022 Presented by Dr. Talee Vang licensed health psychologist and Director of Health Equity Education & Welcome Services at Hennepin Healthcare

Implicit bias occurs on an unconscious level. Research suggests that implicit biases affect behaviors more than explicit biases. Research also points to the positive correlation between implicit bias and health disparities. Rooted in psychological theory, research, and practice, this webinar focused on developing a deeper understanding of implicit bias, how it is formed, and its impact on health disparities. In addition to increasing awareness of the relationship between implicit bias and health disparities, evidence-based approaches to decreasing implicit bias are presented. This webinar was attended by 471 people.

Transforming Food Shelves to Meet Clients Needs with SuperShelf 9/20/2022 Presented by a panel of collaborators with the MN SuperShelf partnership.

Minnesota's SuperShelf partnership is helping to increase access to healthy, appealing, and culturally connected foods across the state. Presented in collaboration with the Minnesota Department of Health Diabetes section, this webinar shared how food shelves are transforming to meet the food needs and improve the experience of people who are food insecure in Minnesota. This presentation will include an overview of the results of the SuperShelf Evaluation Study (NIH) including the Statewide Food Shelf survey, a unique data set with direct insight from people served by food shelves throughout the state. This webinar was attended by 479 individuals.

Meeting the Challenges of Diabetes: Working with Non-English Speakers with Diabetes
12/6/2022 Presented by Hilda Hererra, CHW with CHW Solutions and Marie Sherwood, Health Coach Disease Management, UCare Diabetes Health Journey program and Migraine Management Program

A diagnosis of diabetes can be overwhelming. When you don't speak the primary language of the health care system, it can be especially daunting to learn about your condition and understand all the recommended steps patients should take to stay healthy. This webinar reviewed the basics of working with interpreters; how language and cultural differences impact care, create misunderstandings, jeopardize appropriate follow-through, and common points where misunderstandings can happen. Community Health Workers and Care Coordinators can play a valuable role in reducing these barriers and the presenters will share tips from their years of experience working directly with people with diverse languages and cultures. This webinar was attended by 496 individuals.

Barrier Analysis and Gaps in Care

The initiatives implemented within the scope of this project are intended to improve seniors and SNBC enrollee members self-management of their diabetes. Additionally, this project will reduce the disparities by addressing factors such as nutrition and physical activity.

1. Members and clinicians may not be aware of supplemental benefits available to them, and members may not understand how those programs and services could benefit their chronic condition.
2. Clinics continue to be impacted by staffing shortages due to burn-out and leaving the profession, making access to appointments problematic. Some clinics are unable to fully support nurse-only blood pressure checks.
3. Clinics and members may not be aware that home blood pressure monitors are a covered benefit for Medicaid members.
4. Patients do not always schedule requested follow-up appointments for an elevated blood pressure.
5. In early 2022 there was continued hesitancy by members to return to clinics for preventive care services due to masking mandates and continued reluctance for in person visits even if vaccinated.
6. If blood pressure is elevated during a clinic visit, there is not always time for repeat auto average blood pressure measurement process as it takes an additional 8 minutes.

Opportunities for Improvement: Results/Outcomes

The core measurement for this project is the HEDIS® Comprehensive Diabetes Care, BP Control measure. Below is the baseline data and first-year data with claims run-out which reflects the 2021 measurement year. Additional outcomes data will be reported to DHS later in 2022 and will be included in next year's update for this project.

Table 8 *Baseline Blood Pressure Control for People with Diabetes. Disparities 2017-2019*

Product	Race	2017	2018	2019	3 year num	3 year denom	3 year rate	Gap to white
MSHO	Black or African American	50/73 68.5%	55/86 64%	71/99 71.7%	176	258	68.2%	10.6
	White	89/108 82.4%	98/122 80.3%	118/157 75.2%	305	387	78.8%	--------
SNBC	Black or African American	29/38 76.3%	77/120 64.2%	109/148 73.6%	215	306	70.2%	8.7
	White	109/136 80.1%	173/215 80.5%	197/256 77%	479	607	78.9%	--------

Table 9 *Year One (2021) Results*

Product	Race	Denominator	Numerator	2021MY Rate	Gap to White
MSHO	Black or African American	103	72	69.9%	0.9
	White	120	85	70.8%	---
SNBC	Black or African American	215	139	64.7%	11.2
	White	410	311	75.9%	

The health plan will continue our collaboration with the care group as we further develop interventions related to reducing disparities in diabetes care including patient and provider interventions. We will continue to partner with the other Medicaid health plans to develop supports, resources and education for Care Coordinators as they work to support members with diabetes.

MSHO Chronic Care Improvement Program

Summary of CCIP:

This chronic care improvement program (CCIP) will focus on identifying and diagnosing members with hypertension to engage members in clinical care for blood pressure management and improve health outcomes.

2022 CCIP Title:	H2422 Identifying Members with Hypertension to Improve Health Outcomes
MCO Name **Contact Person**:	HealthPartners, Inc. Tammy Chambers, Clinical Quality Consultant 952-883-5761 Tammy.j.chambers2@healthpartners.com
Implementation Date:	The hypertension CCIP will begin 1/1/2022 and conclude 12/31/2024.
Target Chronic Condition:	Hypertension

Description of CCIP

The chronic care improvement program (CCIP) will focus on identifying and diagnosing hypertension in the MSHO population. HealthPartners will utilize claims in capturing diagnosis of hypertension during clinic office visits and measure the prevalence year over year for the program. The progress will be measured based on the prevalence of members diagnosed with hypertension. The goal of the CCIP is to increase the identification and diagnosis of hypertension by 3% by the end of the three-year program.

Clinical Knowledge/Research

Screening for Hypertension in Adults: A Systematic Evidence Review for the U.S. Preventive Services Task Force (USPSTF) prepared for Agency for Healthcare Research and Quality U.S. Department of Health and Human Services identified that blood pressure screening at a single visit has a low sensitivity and adequate specificity for detection of hypertension, leading to a substantial number of potentially missed cases. Hypertension is one of the most important risk factors for cardiovascular disease (CVD).[1] Although hypertension is often discussed as though it is a disease entity, it is more appropriately categorized as a continuous risk factor that is a

[1]Aihara A, Imai Y, Sekino M, et al. Discrepancy between screening blood pressure and ambulatory blood pressure: a community-based study in Ohasama. Hypertension research : official journal of the Japanese Society of Hypertension. 1998;21(2):127-36. KQ2E4a, KQ3E5, KQ4E4.

strong predictor of poor health.[2][3] The USPSTF recommends screening for hypertension in adults aged 18 years or older with office blood pressure measurement (OBPM). The USPSTF recommends obtaining blood pressure measurements outside of the clinical setting for diagnostic confirmation before starting treatment. The USPSTF suggests annual screening for hypertension in adults aged 40 years or older and for adults at increased risk for hypertension (such as persons with high-normal blood pressure, who are overweight or obese, or who are African American). The USPSTF found convincing evidence that screening for hypertension with office blood pressure measurement and treatment of hypertension in adults substantially reduces the incidence of cardiovascular events.[4]

According to an article in The Joint Commission Journal on Quality and Patient Safety "hypertension increases risk for heart disease and stroke, and many persons are unaware that they have it. Blood pressure (BP) measurements are used to detect and diagnose hypertension and evaluate treatment. Controlling hypertension is a significant contributor to reducing risk for heart attack and stroke, which are leading causes of death in the United States. A 2010 article asserted that treating hypertension was the clinical preventive service that could avert the greatest number of deaths. Moreover, controlling hypertension may significantly reduce the more than $320 billion in health care costs and lost productivity caused by cardiovascular disease every year."[5]

Approximately 11 million U.S. adults with a usual source of health care have undiagnosed hypertension, placing them at increased risk for cardiovascular events (1–3). Using data from the National Health and Nutrition Examination Survey (NHANES), the Centers for Disease Control and Prevention (CDC) developed the Million Hearts Hypertension Prevalence Estimator Tool, which allows health care delivery organizations to predict their patient population's hypertension prevalence based on demographic and comorbidity characteristics (2). Organizations can use this tool to compare predicted prevalence with their observed prevalence to identify potential underdiagnosed hypertension. This study applied the tool using medical billing data alone and in combination with clinical data collected among 8.92 million patients from 25 organizations participating in American Medical Group Association (AMGA) national learning collaborative* to calculate and compare predicted and observed adult hypertension prevalence. Using billing data alone revealed that up to one in eight cases of hypertension might be undiagnosed. However, estimates varied when clinical data were included to identify comorbidities used to predict hypertension prevalence or describe observed hypertension

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[2] Akilli H, Kayrak M, Aribas A, et al. The relationship between exercise capacity and masked hypertension in sedentary patients with diabetes mellitus. Clin Exp Hypertens. 2013;36(1):9-16. https://doi.org/10.3109/10641963.2013.783047 KQ2E9, KQ3E9, KQ4E9.

[3] Al-Hashmi K, Al-Busaidi N, Amina B, et al. White coat hypertension and masked hypertension among omani patients attending a tertiary hospital for ambulatory blood pressure monitoring. Oman Med J. 2015;30(2):90-4. https://dx.doi.org/10.5001/omj.2015.20 KQ2E5b, KQ3E5b, KQ4E4.

[4] https://uspreventiveservicestaskforce.org/uspstf/draft-recommendation/hypertension-in-adults-screening-2020

[5] Improving Identification and Diagnosis of Hypertensive Patients Hiding in Plain Sight (HIPS) in Health Centers MargaretMeador,MPH,C-PHI;JeromeA.Osheroff,MD;BenjaminReisler,MPH The Joint Commission Journal on Quality and Patient Safety 2018; 44:117–129

prevalence. These findings demonstrate the tool's potential use in improving identification of hypertension and the likely importance of using both billing and clinical data to establish hypertension and comorbidity prevalence estimates and to support clinical quality improvement efforts."[6]

Target Population Total Enrollment:

In 2021, there were 2,138 HealthPartners MSHO members diagnosed with hypertension without complications. Of those 2,138 members, who in 2021 were enrolled for a minimum of 9 months in the H2422 MSHO contract that covers members in Minnesota, 92.2%, or 1,972, had hypertension without complications reconfirmed. This results in an opportunity to improve the hypertension reconfirmation rate by 7.8%, or 166 members. It is noted YTD for dates of service through December 2022 without the minimum numbers of months of continuous enrollment and without claims runout the prevalence was 37.3%. However, these results could be impacted by the membership growth and full runout of claims not included in the most recent data. Once the final runout is available, a review of the prevalence percentage will be performed. MSHO continues to have a high reconfirmation rate of those who have had a previous diagnosis.

2021Q4

Package Code	Product	2021Q4 Membership	# with Hypertension in Base Year (2020)	2021 Prevalence	2021 Reconfirmed	2021 Not Confirmed	Recon Rate	Opportunity
H2422	MSHO	4,214	2,138	50.7%	1,972	166	92.2%	7.8%

YTD 2022 through December (No claims runout)

Package Code	Product	Dec 2022 Membership	# with Hypertension in Base Year (2021)	2022 Prevalence	2022 Reconfirmed	2022 Not Confirmed	Recon Rate	Opportunity
H2422	MSHO	5,514	2,055	37.3%	1,896	159	92.3%	7.7%

Notes:

2021Q4 rates include Medicare members with at least 9 months of continuous enrollment in the evaluation year.

2022 YTD rates include members enrolled in December 2022 and do not require a minimum number of months of continuous enrollment. Also, the year-end rates have three months of claims runout, while the YTD rates do not.

Target Population Description:

The MSHO population is typically members greater than 65 years of age. According to the Minnesota Department of health, 52% of Minnesota adults aged 65 or older reported being told they have high blood pressure.[7] There is an opportunity to accurately identify and diagnose members with high blood pressure to appropriately manage the chronic condition of hypertension to prevent adverse health outcomes.

Again, using 2021Q4 baseline data, HealthPartners has identified approximately 2,138 MSHO Medicare members in the target population with a diagnosis of hypertension without

[6] https://www.cdc.gov/mmwr/volumes/67/wr/mm6729a2.htm

[7] https://www.health.state.mn.us/diseases/cardiovascular/cardio-dashboard/hbpprev.html

complications. This equates to a prevalence of 50.7% which differs slightly from the Minnesota statistic of 52%.

Target Goal

This chronic care improvement plan will seek to increase the diagnosis of hypertension in the MSHO population by (3%).

Baseline

The HealthPartners prevalence in the MSHO population for members with a diagnosis of hypertension without complications is 50.7% This will be utilized as the baseline. The goal is to increase the prevalence through better documentation and diagnosis of hypertension in the MSHO population by 3%.

National Standard

According to the U.S. Preventive Services Task Force, hypertension is a prevalent condition, effecting approximately 45% of the adult U.S. population. It is the most diagnosed condition at outpatient office visits. Hypertension is a major contributing risk factor to heart failure, heart attack, stroke, and chronic kidney disease.[8]

Data Source(s) Used to Measure Goal

The data source used to measure this goal will be claims data.

Planned Interventions

1. Multifactorial communication to reinforce identification and diagnosis of hypertension.
2. Enrollee outreach via authenticated accounts and once yearly direct mail sent to those members who do not have an authenticated account for those that have not completed an annual wellness visit.
3. Enrollee/Caregiver Engagement-utilize not only the annual wellness visits but all visits to address high blood pressure.
4. Enrollee/Caregiver Engagement-outreach members not at goal for blood pressure or overdue for monitoring.
5. Caregiver Engagement-patient education materials for high blood pressure in additional languages including Spanish, Somali, Vietnamese, Cambodian/Khmer, and Hmong.
6. Health Plan Care Management

[8] https://www.uspreventiveservicestaskforce.org/uspstf/draft-recommendation/hypertension-in-adults-screening-2020

Description of Intervention

1. The largest provider group which cares for approximately 75% of MSHO members utilizes a consistent robust multifactorial approach to raise visibility of evaluation and management of hypertension to deliver optimal care in blood pressure management.

2. Enrollee outreach via authenticated accounts if the member has signed up and once yearly direct mail sent to those members that do not have an authenticated account for those that have not completed an annual wellness visit. Approximately 50% of the MSHO population have authenticated accounts. Health plan diabetes outreach in 2022 included messaging for high blood pressure.

3. Utilize current outreach process to identify members who need annual wellness visits and encourage member to schedule those preventive visits and manage chronic conditions. Continue current process of addressing high blood pressure at every visit. These interventions will increase the rate of preventive visits completed and number of members identified with high blood pressure. The health plan is in conversations with the largest provider group that serves most of this population. This medical group is familiar with the Million Hearts Project that started in 2012 which was mentioned above. The implementation of standard blood pressure measurement in primary care with auto average measurement for elevated BP readings using Omron in one of the larger clinics in 2007 and for all patients and supported the expansion of this process across the whole organization in 2019. This medical group is currently using the Wizard tool developed by an internal research team to support hypertension management, treatment plan and shared decision making with the patient for all populations. They also have a new hypertension analysis with robust outcome data. Due to the continued impact of the COVID-19 pandemic they have seen a significant drop in optimal care. These barriers will be discussed further in the annual update.

4. Utilize the annual wellness visit to identify chronic conditions and schedule follow up screenings and identify risk of hypertension for members with high-normal blood pressure, who are overweight or obese, or who are African American. Ensure the screenings are completed by providing outreach to those members and establish an individualized care plan for those members. This intervention will increase the rate of members who are appropriately identified and diagnosed with hypertension.

5. The largest provider group follows the continuous improvement model and adjusts as necessary and currently has an initiative for those members not at goal or overdue for blood pressure monitoring where a letter is sent encouraging members to send readings back into my chart which will be manually updated as not automatic.

6. The largest provider group initiated 2022 Year End Chronic Condition Focus
    a. Focused List (Diabetes and Vascular)
    b. Action List (Hypertension)

7. Track my Health MyChart BP Outreach

8. There are patient education handouts that are provided to patients with 2022 year end initiatives:
    a. Blood Pressure Patient Education
        i. Understanding High Blood Pressure
        ii. How to Take Your Blood Pressure at Home
        iii. Dash Diet
    b. Additional languages include Spanish, Somali, Vietnamese, Cambodian/Khmer, and Hmong.

9. Health Plan Home BP Monitors Benefit and Distribution
    a. Eligible diabetes members not at goal
    b. Omron home BP monitor sent to patients at no cost.

10. Health Plan Care Management: follows process to identify and engage members with chronic conditions and provide support through care management if appropriate.

Measurement Methodology

How will progress be measured?

1. Identify MSHO Medicare Advantage members who have been diagnosed with hypertension in the previous year.

2. The number of members identified compared to the number of members that are diagnosed in the current year.

3. Member outreach:
    a. Identify MSHO Medicare Advantage members using internal metrics who need an annual wellness visit.
    b. The number of members identified for outreach compared to the number who scheduled preventive visits.

4. Utilize annual wellness visit (AWV):
    a. The annual wellness visit will be used to identify chronic conditions and ensure screenings that are clinically appropriate.
    b. MSHO members with the chronic condition of hypertension will be identified by the clinical team during the AWV and current process of addressing high blood pressure at every visit. The plan will conduct outreach to encourage them to complete an annual wellness visit and develop care plan to manage high blood pressure.
    c. Of those identified for outreach related to an annual wellness visit, how many have completed the AWV.

5. Member outreach for blood pressure monitoring:
    a. Identify members and send letter to members not at goal for blood pressure or overdue for blood pressure monitoring.
    b. The number of members identified for outreach compared to the number who are at goal for blood pressure or have been monitored.

6. Care Management Engagement:
    a. Identify member eligible for care management.
    b. The number of members engaged in care management compared to the number who are eligible.

Medicare Advantage Chronic Care Improvement Program

Summary of CCIP:

This chronic care improvement program (CCIP) will focus on identifying and diagnosing members with hypertension to engage members in clinical care for blood pressure management and improve health outcomes.

2022 CCIP Title:	H4882 Identifying Members with Hypertension to Improve Health Outcomes
MCO Name:	HealthPartners, Inc.
Contact Person:	Tammy Chambers, Clinical Quality Consultant 952-883-5761 Tammy.j.chambers2@healthpartners.com
Implementation Date:	The Hypertension CCIP will begin 1/1/2021 and conclude 12/31/2023.
Target Chronic Condition:	Hypertension

CCIP Annual Update

Barriers Encountered

1. Healthcare Team Issue(s) – The largest provider group which cares for approximately 80% of the HealthPartners Medicare Advantage population identified these barriers below:
    a. Limited access due to the continued impact from the pandemic; postponement of preventive visits and other routine care and pent-up demand
    b. Increase in staffing shortages across care groups due to health care burn out and declining enrollment in health care schooling programs.
        i. If blood pressure elevated, there is not always time for repeat auto average blood pressure measurement process as it takes an additional 8 minutes.
        ii. Inability to support nurse only blood pressure checks.
    c. Virtual visits:
        i. Inability to obtain a blood pressure reading if patient does not have an automated digital machine.
        ii. If patient has a machine and provides a reading that is elevated, no ability to follow auto average blood pressure measurement process.
    d. Patient engagement
        i. Patients do not always schedule requested follow-up for an elevated blood pressure.

2. HealthPartners has an incentive program with the largest provider group (new in 2022) and select network partners who manage much of the Medicare Advantage population. One of the incentives was in completing an annual wellness visit and a potential for earnings in reconfirming chronic conditions.
    a. These providers experienced staffing shortages, shift in ambulatory services to cover urgent care closings and pent-up delay in care continuing into 2022 due to the new COVID-19 variant surges.

3. Member issues:
    a. May not understand the importance of preventive care visits and getting their blood pressure checked.
    b. May not have ability to purchase a home blood pressure cuff to monitor blood pressure more closely.
    c. In early 2022 there was continued hesitancy by members to return to clinics for preventive care services due to masking mandates and continued reluctance for in person visits even if vaccinated.

Mitigation Strategies

1. The largest provider group clinicians use the “Priority Wizard” to assess a patient’s risk for cardiovascular disease, and this tool also makes recommendations for next steps in care.

2. For elevated blood pressures they have follow-up guidelines established that are followed.

3. 2022 Year End Chronic Condition Focus
    a. Focused List (Diabetes and Vascular)
    b. Action List (Hypertension)

4. Track my Health MyChart BP Outreach

5. There are patient education handouts that are provided to patients with 2022-year end initiatives:
    a. Blood Pressure Patient Education
        i. Understanding High Blood Pressure
        ii. How to Take Your Blood Pressure at Home
        iii. Dash Diet
    b. Additional languages include Spanish, Somali, Vietnamese, Cambodian/Khmer, and Hmong,

6. There are nutrition services available, and clinicians can consult with them or refer a patient who can schedule a visit with a dietician.

7. The Health Plan has an incentive program with the largest provider group and select network partners with potential earnings for both completion of an annual wellness visit and reconfirming chronic conditions.

8. The Health Plan provides outreach through authenticated accounts to members to encourage completing an annual wellness visit. Approximately 85% of the Medicare Advantage population have authenticated accounts. For those who do not have authenticated accounts they will receive direct mail outreach in Q4 2022 with a reminder to complete the annual wellness visit. Language was added to the diabetic outreach campaigns with a reminder for members to get their blood pressure checked, this will be distributed via authenticated accounts in 2022 communications.

9. The Health Plan Comprehensive Care Advocacy coordinators provide outreach to members who meet criteria for disease management and promote and coach members to complete the annual wellness visit.

Results and Findings

This project for 2020 dates of service identified a prevalence of 42.2%. The overall goal for this CCIP is to increase the prevalence by 3%. It was also noted the reconfirmation rate was 86.9% with an opportunity of 13.1%. Year to date through December 2022 without the minimum number of months requirement and without claims runout identified an increase of membership from 21,963 in 2020 to 37,433 in 2022 with a prevalence of 36.3% and opportunity of 11.6%. The 3% goal was not met in the annual update. However, these results could be impacted by the membership growth and full runout of claims not included in the most recent data. Once the final runout is available, a review of the prevalence percentage will be performed. HealthPartners Medicare Advantage (HP MA) continues to have a high reconfirmation rate of those who have had a previous diagnosis.

2020Q4

Package Code	Product	2020Q4 Membership	# with Hypertension in Base Year (2019)	2020 Prevalence	2020 Reconfirmed	2020 Not Confirmed	Recon Rate	Opportunity
H4882	HP MA	21,963	9,267	42.2%	8,056	1,211	86.9%	13.1%

2021Q4

Package Code	Product	2021Q4 Membership	# with Hypertension in Base Year (2020)	2021 Prevalence	2021 Reconfirmed	2021 Not Confirmed	Recon Rate	Opportunity
H4882	HP MA	34,003	14,889	43.8%	13,132	1,757	88.2%	11.8%

YTD 2022 through December (No claims runout)

Package Code	Product	Dec 2022 Membership	# with Hypertension in Base Year (2021)	2022 Prevalence	2022 Reconfirmed	2022 Not Confirmed	Recon Rate	Opportunity
H4882	HP MA	37,433	13,584	36.3%	12,010	1,574	88.4%	11.6%

Notes:

2020Q4, and 2021Q4 rates include Medicare members with at least 9 months of continuous enrollment in the evaluation year.

2022 YTD rates include members enrolled in December 2022 and do not require a minimum number of months of continuous enrollment. Also, the year-end rates have three months of claims runout, while the YTD rates do not.

Total Target Population

The total number of enrollees included members with at least 9 months of continuous enrollment in the evaluation year for the 2021Q4 dates of service was 34,003 with a reconfirmation rate of 88.2%. The opportunity for reconfirmation was 1,757 members or a rate of 11.8%.

Number of Enrollees Who Received Intervention(s)

The total number of enrollees who received reconfirmation of hypertension for the 2021Q4 dates of service was 13,132.

Results and/or Percentage

- The CCIP results and/or percentage data for each intervention; the overall 2021Q4 dates of service prevalence results were 43.8% which included all interventions combined.

- The numeric or percentage results comparing the target goal and baseline linked to each intervention; the prevalence percentage improved slightly from 42.4% to 43.8%. However, it was noted that the number of members increased with a slightly higher percentage completion rate.

- The data source(s) and data collection period.
  a. Claims and encounter data compile 2021Q4 rates include Medicare members with at least 9 months of continuous enrollment in the evaluation year.

Analysis of Results or Findings

There was a slight improvement in the prevalence percentage of 1.4% from 2020Q4 to 2021Q4 however YTD through December 2022 without 9 months of continuous enrollment was 36.3%, a decrease from the 2021Q4 43.8%.

Next Steps& Action Plan

1. A description of the actual or proposed changes: The largest provider group will continue to follow their processes for identifying and documenting hypertension. The health plan did establish a contractual incentive program with the largest provider group (new in 2022) and select network partners to complete a annual wellness visit and reconfirm chronic conditions. The Health Plan provides outreach for members to complete the annual wellness visit through authenticated accounts and direct mail for those who do not have authenticated accounts. The Health Plan offered an over-the-counter benefit in 2022 that may assist in providing partial coverage for a home blood pressure cuff if the member meets criteria.

2. The rationale for the changes and how the Action Plan will work towards achieving the project goal(s): The largest provider group follows the continuous improvement model and adjusts as necessary. They have developed a standard blood pressure (BP)measurement tip sheet; BP follow up guidelines tip sheet and other documents that support taking and managing blood pressure. They also provide education documents regarding blood pressure awareness and action plan to assist the members in recognizing blood pressure. Free blood pressure checks are offered at several clinics in the service area. The select incented network partners will continue to schedule annual wellness visits and address chronic conditions.

3. Whether or not these changes have already been implemented, or the plan for implementing these changes during the upcoming year. The largest provider group has

developed tools to assist in identifying and documenting hypertension in the Medicare Advantage population. The annual wellness visit is encouraged and year to date for the Medicare Advantage population there is a 68% completion rate through December 2022. The Health Plan will be adding an over-the-counter benefit in 2022 that could help defray the cost of a home blood pressure cuff if eligibility requirements are met. The Health Plan added language in the diabetic outreach campaigns with a reminder for members to get their blood pressure checked, this was distributed via authenticated accounts in 2022 communications. In which approximately 85% of the Medicare Advantage population has authenticated accounts.

Best Practices

1. How the MAO identified these best practices(s): The health plan meets regularly with the largest provider group and a annual wellness visit and reconfirmation rates are shared, and an incentive was implemented in 2022. The largest provider group has a very good clinical foundation to support identifying and documenting hypertension. Chronic conditions are identified and managed, the care model for hypertension includes standard guidelines and processes for diagnosis, treatment, follow-up care, measurement, and optimal care goals. The select incented providers also focus on completing the annual wellness visit and reconfirming chronic conditions.

2. How these best practices have or will impact the CCIP and expected results: It is expected that the clinical process workflows, annual wellness visits and reconfirming chronic conditions should increase the prevalence of the diagnosing and documenting hypertension.

3. How the MAO will share the details of these best practices with others: It is yet to be determined how the best practices will be shared more broadly and how they will be implemented.

4. How the MAO will or may implement these best practices going forward: The impact of the clinical processes for the largest provider group will be determined from the 2022 data. Also, the impact of the incentive program will be determined with 2022 data as well.

Lessons Learned

Lessons learned in 2022 were that provider's clinical processes continued to be impacted due to the pandemic. The providers will continue to follow their processes for identifying and documenting hypertension to ensure that all member/patients receive an annual visit and therefore reconfirm chronic conditions and complete preventive screenings. It is our hope that all the lessons learned with the largest provider group will then be able to be shared more broadly and increase the identification and diagnosis of hypertension.

Medical Record Documentation

Accountable Owner

Quality Improvement and Compliance: *Tammy Chambers*

Description

Medical record documentation standards should facilitate communication, coordination, and continuity of care. HealthPartners conducts an annual audit to measure the quality of documentation of select indicators. The Medical Record Standards Advance Care Planning measure is a requirement under our DHS contract for State Public Program members. The measure includes PMAP, MNCare, MSHO and MSC+ members 19 years and older seen at primary care clinics.

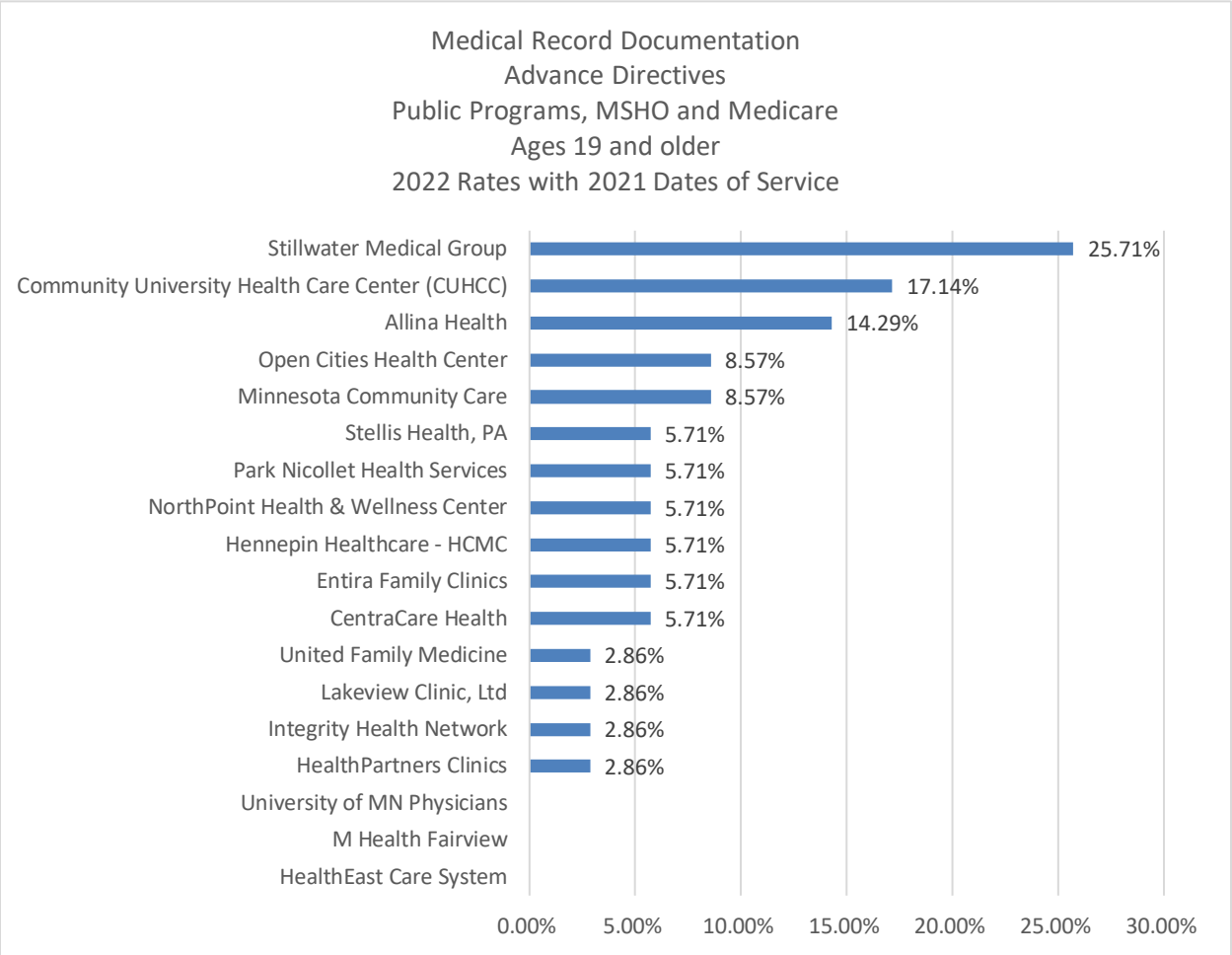
2022 Medical Record Documentation (DOS 2021) Indicators:

Indicator	Data Source	Purpose	Results	Action Plan
Advance Directives – documented in medical record that provider has discussed advance directive planning with member or member has a completed advanced directive on file. documented.	Data set pulled for HEDIS – Preventive Services Public Program Members Up to Date – Adult (19 years and older) – same data specifications as HEDIS® Advance Planning in Care of the Older Adult	Coordination of care and adequacy of medical record documentation.	Eighteen medical groups were included in the medical record documentation clinical indicator audit.	Continue to monitor and report clinic specific results.2022 result letters sent to medical groups, requesting they focus on a goal of20% or better advanced care planning documentation in 2023.

Goals

HealthPartners will continue to monitor and report medical record audit data. The 2022 result letters from HealthPartners Quality and Compliance team notified medical groups of their performance on this measure and requested groups work to meet a specific goal of at least 20% in 2022.

Opportunities for Improvement: Results/Outcomes



Performance ranged from a high of 25.71% percent to a low of 0.00% percent. This report is a snapshot in time and performance is based on a sample of medical records. The variability in performance may, in part, be due to sample size. However, the levels of documentation do indicate a continued need to focus on this measure as the aggregate percentage for 2021 DOS was 6.67% overall which was down from an average of 15.2% for 2020 DOS.

Interventions

1) In January of 2016 Medicare initiated payment to physicians to discuss end of life care planning with patients.

2) Communication regarding performance is shared with the selected provider groups with the recommended goal of 20% completion in the records reviewed.

3) Examples of some of the work done by one of the largest provider groups in our network are highlighted below:

a) In April 2022 a Huddle Article (a weekly recap of the most important information, news and events taking place across the organization) titled “Creating a Health Care Directive” was released for National Health Care Decisions Day.

b) Work continues around areas of opportunity identified in 2020:
   i) Clinicians trained in having advance directive conversations and provided tools/resources to do so such as a video example, clinician specific handbook and other pertinent resources.
   ii) Creation of two new forms for EPIC documentation.
   iii) Ability to track documentation by race, language, country of origin and payer.

c) In 2021 interpreter training was completed in advance care planning.

d) In 2021 EPIC advanced care planning projects were top priorities. The following work continues:
   i) *What Matters Most* offered an area within Epic where clinicians can document information gathered through interviews with patients about what is most important in their lives. Work is being done to add this information to the medical record.
   ii) An EPIC health care agent field is coming soon.
   iii) Communication has been shared with health plan regarding EPIC fields that identify advance care planning discussions.

e) New health care directive forms are now available and shared broadly
   i) In spring of 2022, the HealthPartners short & long form health care directives are now available in Spanish. In the fall of 2022 new Somali directives were created.

f) Reporting tools built in EPIC within the last year that answers the question, “does this patient have an advance directive on file.” Aggregated data for home and community services identified that 79.9% have an advance directive on file.

g) The wellness visit (AWV) structure supports the discussion about advance directives between the provider and member for those who are eligible.

Barriers

- The pandemic continued to impact preventive services in 2022.
  - There was pent up demand for delayed services.
  - Health systems experienced staffing shortages for front line, nursing and physician roles.
- Age can be a barrier to advance directive completion as young adults are less motivated to complete.
- Conversations and interpretations regarding having an advance directive may not translate in a culturally relevant way.

MSHO Model of Care Measurable Goals

Accountable Owner: Emi Bennett Vo, Government Programs

Member Populations Targeted

	Commercial
	Medicare Freedom (Cost)
	Medicaid
X	MSHO
	HPUPH
	WI Marketplace

Description

The MSHO Model of Care describes the management, procedures, and operational systems that HealthPartners has in place to provide access to services, coordination of care and the structure needed to best provide services and care for the MSHO population. The MSHO Model of Care was approved for years 2021-2022. We have not presented historical data because the Model of Care Measurable Goals can differ from previous approved versions.

The Centers for Medicare & Medicaid Services (CMS) requires plans to identify and define measurable goals and health outcomes for the Model of Care.

HealthPartners received a three-year approval for a new MSHO Model of Care, which is in effect for years 2023-2025. The new Model of Care includes updated measurable goals.

Goals, Results, Initiatives/Interventions

MSHO Model of Care Measurable Goals	Measurable Goals Description	Results 2021	Results 2022	Initiatives/Interventions
Initial Health Risk Assessment Rates	Achieve a 0.5% increase over the 2020 baseline rate at the end of a three-year period for initial health risk assessments completed within 90 days of each beneficiary's initial enrollment.	Not Met	Met	The MSHO care coordination team continued to address timeliness and engagement of members in initial HRA completion. The team exceeded its goal by the end of Q1 2022 and continued to exceed its goal at an increasing rate for Q2, Q3 and Q4. The interventions initiated in 2021 were successful in reaching and exceeding the goal. The Corrective Action Plan was formally closed in April 2022. The MSHO team

MSHO Model of Care Measurable Goals	Measurable Goals Description	Results 2021	Results 2022	Initiatives/Interventions
				continues to closely monitor its initial HRA completion rate.
Health Risk Assessment Reassessment Rates	Achieve a 0.5% increase over the 2020 baseline rate at the end of a three-year period for reassessments completed within 365 days of the previous health risk assessment.	Not Met	Not Met	The MSHO care coordination team continued to address timeliness and engagement of members in Reassessment HRA completion. The team did not reach its goal by the end of Q4 2022. The interventions initiated in 2021 were successful in maintaining but not improving the completion rate. The MSHO team experienced an increase in the number of members who declined an assessment or who were not reached over prior years. Although the Corrective Action Plan was formally closed in April 2022, the MSHO team continued to implement corrective action including care coordination staff retraining on tips to engage members who decline an RHRA, on member outreach to find members, and on documentation of member declines or unable to be reached. The MSHO care coordination team continues to evaluate, identify, and implement improvements.
Mammography – Breast Cancer Screening	Accomplish a relative 1.0% increase over the baseline of 69.4% from the 2019 HEDIS report reflecting 2018 dates of service at the end of a three-year period in the rate of breast cancer screenings.	Met	Not Met	We achieved a rate of 64%. In 2022, HealthPartners continued email notifications to members with authenticated accounts to complete breast cancer screening. We also engaged CHW Solutions to have community health workers outreach to non-HealthPartners care group members to encourage them to complete breast cancer screening (~19% completion). Care coordinators encouraged members to complete breast cancer screening.

MSHO Model of Care Measurable Goals	Measurable Goals Description	Results		Initiatives/Interventions
		2021	2022	
Annual Wellness Visit (AWV) Rates	Achieve a 1.0% increase over the 2018 dates of service baseline rate of 30.18% per year over the three-year period for annual wellness visits completed yearly for eligible enrollees.	Met	Met	We achieved a rate of 62.4%. In 2022, HealthPartners continued email notifications to members with authenticated accounts to complete the AWV. Also, there was a direct mail campaign sent to those members who did not have an authenticated account. Care coordinators encouraged members to complete the AWV.

HealthPartners performs an annual comprehensive review of the current measurable goals and health outcomes to determine if goals have met benchmarks and have been achieved. An evaluation of all measures is conducted to determine which measures will be continued, be reevaluated and redefined, or be removed and replaced with a new measure or outcome.

Barrier Analysis

Some barriers are discussed in the table above.

In addition, when the Model of Care was written, the goals were written over a three-year period in anticipation of a three-year approval. However, NCQA only approved the Model of Care for two years, so the goal period now extends beyond the timeframe of the Model of Care. The decision was made to not update the goals since it would require re-submission of the Model of Care for review.

2022 Over/Under Utilization Analysis: Inpatient Mental Health and Substance Use Disorder

Summary

The Over/Under Utilization Analysis of inpatient days per thousand for mental and chemical health is completed annually to monitor and evaluate inpatient mental health and chemical health rates over time.

Mental health and substance use disorder inpatient utilization for selected products is shown in tables A1-2, B1-2, and C1-2 following this report. Data in red exceeds either the upper and/or lower threshold.

When HealthPartners set thresholds, several years of historical data was included given year over year lowering of some days per 1000 outcomes. In 2015, HealthPartners rebased thresholds using more current experience data from 2011 – 2013.

In 2020, a large enough data set was available and upper and lower thresholds were established for lengths of stay (LOS) for SNBC members who HealthPartners has provided insurance coverage for since 2016. This population continues to be small and has a high number of members who have extended LOS for both mental health and substance use disorder conditions.

Background

HealthPartners has, through benefit design, network design, and medical management policies, structured a continuum of care which includes a variety of clinical services and options for members with varying acuity. Inpatient mental health and chemical health care are important components of the overall continuum of health services provided by HealthPartners.

The behavioral health inpatient admission rate is potentially sensitive to various impacts related to utilization of overall care, networks, benefits, and the population itself. For example, over-use of inpatient care can result from under-use of outpatient and intermediate levels of care. Conversely, under-use of inpatient care could result from over-dependence on outpatient and intermediate levels of care or avoidance of care despite increasing clinical complexity, inadequacy in the number of contracted facilities, or limited availability of contracted providers. Additionally, the prevalence of members who are diagnosed with behavioral health conditions and who may need or be seeking behavioral health care may fluctuate based on changes in required screenings, criteria for different levels of care or benefits for behavioral health care. Another substantial factor can be the size of a population. Small populations that have only a few thousand members, such as MSHO, can be subject to significant utilization volatility based on just a few outlier cases.

Relevance of the Analysis

The Over/Under Utilization Analysis of inpatient days per thousand for mental and chemical health is completed annually to monitor and evaluate inpatient mental health and chemical

health rates over time and to provide a global view of the effectiveness of behavioral health and utilization management programs (See Tables E and F), since the intent of these programs is to support improved continuity and coordination of outpatient care in efforts to decrease the likelihood of hospitalization. If it is found that inpatient rates exceed upper and lower thresholds, additional analysis and/or improvement actions, when required, are pursued with multidisciplinary input.

How Thresholds were Determined

Thresholds for over- and under- inpatient utilization are based on local and national HEDIS performance for mental health and chemical health utilization and developed using standard deviations and monthly averages that reflect a standardized approach to quantifying and projecting targets. Thresholds are set at the product and service levels to account for variance in benefits and health needs of members by product.

- For Medicaid, the upper threshold is the monthly average for the product/service type plus one standard deviation and the lower threshold is the monthly average minus one standard deviation. This applies to both mental health and chemical health separately.

- For MSHO and SNBC, the upper threshold is the monthly average for the product/service type plus 30% and the lower threshold is the monthly average minus 30%. Due to the comparatively small MSHO and SNBC populations, this creates high variability in monthly utilization rates. Using a standard deviation to set over and under thresholds would not yield meaningful results. It is for these reasons, that a plus or minus 30% was used instead of a standard deviation.

Findings

The following thresholds were either not met or exceeded in Medicaid and MSHO products for Mental Health and Substance Use Disorder:

- Medicaid – Mental Health lower threshold of 74.3 days per 1,000.
  - 2022 fell short of the lower threshold with a LOS of 66.3 days per 1,000.

- Medicaid – Substance Use Disorder lower threshold of 20.6 days per 1,000.
  - 2022 fell short of the lower threshold with a LOS of 20.3 days per 1,000.

- MSHO – Mental Health lower threshold of 127 days per 1,000.
  - 2022 fell short of the lower threshold with a LOS of 119.2 days per 1,000.

- MSHO – Substance Use Disorder upper threshold of 11.7 days per 1,000.
  - 2022 exceeded the upper threshold with a LOS of 13 days per 1,000.

SNBC inpatient LOS were within established thresholds for mental health and substance use disorder.

Quantitative Analysis

Analysis was completed for thresholds that were not met or exceeded, which can be found in Tables A1-2, B1-2, and C1-2. No analysis is required for results that were within established thresholds i.e. SNBC.

Facility Analysis

Data was gathered to analyze the five (5) highest volume psychiatric hospitals where members were admitted. Those facilities are Abbott Northwestern, University of Minnesota Medical Center, Regions, Mercy, and United hospitals. The analysis includes 1) average LOS for each hospital; 2) annual admission rates and 30-day readmission rates; 3) annual admission rates and 60-day readmission rates.

Average Length of Stay (*See* Table D1)
Overall, average LOS increased from 2021 to 2022. Three (3) hospitals had a higher average LOS than the previous year whereas, two (2) hospitals had a decline in average LOS over the previous year. Median LOS was essentially unchanged year over year. United had the highest average LOS while Regions had the lowest in 2022.

30 Day Readmission (*See* Table D2)
Overall, 30-day readmission rate decreased from 2021 to 2022, while total admissions remained essentially the same. All five (5) hospitals had a significant decrease in readmissions with the average rate dropping from 12.6% in 2021 to 8.6% in 2022. In 2022, Mercy had the highest 30-day readmission rate (10.08%) but was a 5.6% decrease from 2021. Abbott Northwestern had the lowest 30-day readmission rate as well as the largest decrease in 30-day readmission from 12.3% in 2021 to 7.2% in 2022.

60 Day Readmission (*See* Table D3)
Overall, 60-day readmission rates remained the same from 2021 to 2022, with total admission remaining essentially the same as well. Three (3) hospitals had an increase in 60-day admissions year over year. One (1) of those hospitals saw an increase of over 2% from 2021. Abbott Northwestern had the highest readmission rate of 14.1% in 2022. United had the lowest readmission rate of 7.7%.

Qualitative Analysis

Multiple factors outside the direct control of hospitals, care team and health plans affect health care outcomes. Health starts with our homes, neighborhoods, and families and is influenced by access to social and economic opportunities; the resources and supports available in our neighborhoods and communities; the quality and safety of schools and workplaces; the cleanliness of our water, food, and air; and the nature of our social interactions and relationships. Establishing and improving policies that positively affect social and economic conditions and those that support changes in individual behavior can, in turn, improve health for large numbers of people in ways that can be sustained over time.

Additionally, COVID 19 continues to have unique influences on individuals and families that have led to increases in anxiety, depression, and substance abuse. It's possible that COVID has

contributed to the underutilization of inpatient care as patients may have either avoided hospitals or have been discharged prematurely due to concern for potential infection.

While there has seemed to be underutilization of inpatient mental health care, there has been an increase in the need for inpatient substance use care as well as an increase in the need for step-down services for continuation of treatment. More severe and persistent substance use has required longer stays for acute treatment, and the need for step down services has placed pressure on the limited amount of SUD programs for members to be accepted upon discharge from an inpatient setting for the member to succeed in treatment.

Also influencing inpatient care, has been challenges related to the reduction of avoidable hospital readmissions. Examples include medication adherence, health literacy, family/caregiver support, access to and timely availability of outpatient and other lower levels of care, and social determinants of health.

While external factors are generally out of the control of HealthPartners, we have made efforts to mitigate the effect on members by continuously looking to improve processes, as necessary and as able, that more effectively and efficiently accommodate members' needs.

Actions Taken to Address Over or Under Utilization and Any Issues Identified in Data Analysis

1. Case Management services for all members admitted to inpatient care for psychiatric needs to support real time identification and engagement of high-risk members and to ensure care plans, including follow-up mental health appointments within 7 days and/or 30 days of discharge, are implemented before discharge. In addition, case management provides post-discharge counseling and support to all members.

2. Case manager collaboration with care team members including primary care providers, specialists, pharmacy resources, and community-based providers.

3. Case manager access to multiple electronic medical records with our regional partners to enhance our communication with providers and support the physician's plan of care.

4. Assessment and care planning between case managers and members with case managers tailoring interventions to address the member's unique needs, social determinants, barriers, and identified clinical gaps in care, including connections to culturally specific care.

5. Reinforcement by case managers to members of the benefits of virtual clinic/provider visits, the effectiveness of COVID-19 precautions for in-person clinical visits and the benefits of COVID-19 vaccinations in the prevention of disease transmission and severity.

6. Referrals by case managers to Medication Therapy Management (MTM) services for members with complex medication regimens or medication adherence concerns.

7. Referrals by case managers to a HealthPartners' reserved psychiatry appointment at a contracted mental health clinic in the community for members who are in urgent need of psychiatry care but not established with a provider.

8. Educational newsletters sent to members with designated behavioral health conditions who are prescribed designated types of psychotropic medications to support them in self-management of their condition and overall health.

9. Utilization management (UM) review of members admitted to psychiatric beds at in-network facilities by day 13 of the stay to help manage length of stays and costs. As part of this review process, UM and case management staff have the ability to seamlessly consult on members admitted to the hospital who may no longer require inpatient care.

10. Training for case managers to further enhance their expertise in working with members to reduce avoidable hospital readmissions, such as motivational interviewing, shared decision making, social determinants of health, cultural awareness, medical and behavioral health conditions, and post-discharge planning.

Monitoring of Effectiveness of Interventions

As demonstrated in the tables below, the initiatives noted above have effectively provided LOS and readmission rate year-over-year stability to the population. This has been supported by members participating in case management and disease management communications from 2021 to 2022. Therefore, this contributes to members receiving appropriate level or care as necessary for their mental health and substance use needs. We have continued to improve our process, including collaboration with network hospitals with significant mental health/substance use admissions, to focus more on clinically impactful interventions and engagement and less on administrative tasks and documentation. We hope to see further positive impacts over time.

Conclusion

- HealthPartners aims to support members throughout inpatient admissions and beyond by collaborating with care teams to understand the progression of members' care and ongoing needs and to create action plans regarding potentially avoidable readmissions and avoidable inpatient days. While best efforts are made to influence admissions positively, there will always remain factors outside the direct control of hospitals, care team, and health plans that affect length of stay and readmissions. However, health plan initiatives are continually reviewed for clinical effectiveness, efficiency, and opportunities for improvement.

- HealthPartners also monitors for changes in membership and unique characteristics and needs of each population by product. This will be of particular importance as members on Medicaid are more likely than members on other types of coverage to experience severe mental health needs that could lead to longer or more frequent inpatient care.

- COVID-19 has added an extra layer of complexity and uncertainty in not only providing case management to members with already complex health needs but also complicates

the use of health care as well as establishing and comparing data as regulations, variants, and vaccines provide a changing health landscape.

Quantitative Analysis of Utilization

Medicaid

Table A1: *Mental Health*

	Measures	Actual Performance	Thresholds	
			Upper	Lower
2021 DOS				
	Admits/1000	8.9		
	ALOS	8.7		
	Days/1000	77.1	114.8	74.3
2022 DOS				
	Admits/1000	7.2		
	ALOS	9.2		
	Days/1000	66.3	114.8	74.3

Table A2: *Substance Use Disorder*

	Measures	Actual Performance	Thresholds	
			Upper	Lower
2021 DOS				
	Admits/1000	4.8		
	ALOS	4.49		
	Days/1000	21.8	36.9	20.6
2022 DOS				
	Admits/1000	4.6		
	ALOS	4.38		
	Days/1000	20.3	36.9	20.6

MSHO

Table B1: *Mental Health*

	Measures	Actual Performance	Thresholds	
			Upper	Lower
2021 DOS				
	Admits/1000	10.4		
	ALOS	11.62		
	Days/1000	120.8	235.8	127
2022 DOS				
	Admits/1000	9.5		
	ALOS	12.59		
	Days/1000	119.2	235.8	127

Table B2: *Substance Use Disorder*

	Measures	Actual Performance	Thresholds	
			Upper	Lower
2021 DOS				
	Admits/1000	8.9		
	ALOS	3.51		
	Days/1000	31.2	11.7	6.3
2022 DOS				
	Admits/1000	2.9		
	ALOS	4.5		
	Days/1000	13	11.7	6.3

SNBC

Table C1: *Mental Health*

	Measures	Actual Performance	Thresholds	
			Upper	Lower
2021 DOS				
	Admits/1000	73.5		
	ALOS	10.96		
	Days/1000	805.5	1157.8	623.4
2022 DOS				
	Admits/1000	68.5		
	ALOS	12.31		
	Days/1000	843.1	1157.8	623.4

Table C2: *Substance Use Disorder*

	Measures	Actual Performance	Thresholds	
			Upper	Lower
2021 DOS				
	Admits/1000	17.9		
	ALOS	5.96		
	Days/1000	106.6	129.3	69.6
2022 DOS				
	Admits/1000	15.		
	ALOS	6.54		
	Days/1000	98.3	129.3	69.6

Average Length of Stay and Median Length of Stay

Table D1

	2021		2022	
	Avg. LOS	Median LOS	Avg. LOS	Median LOS
Abbott NW	9.16	6	841	5
Regions	6.43	3	6.57	3
Mercy	8.04	4	7.86	5
United	6.47	5	8.39	6
Univ. of MN	6.57	4	7.15	4
Total	**7.14**	**4**	**7.34**	**4**

30 Day Readmission to Any Acute Inpatient Psychiatric Facility

Table D2

	2021			2022		
	Total Admit	Readmits	Readmit Rate	Total Admit	Readmits	Readmit Rate
Abbott NW	309	26	8.41%	320	23	7.2%
Univ. of MN	628	47	7.48%	617	49	7.9%
Regions	630	52	8.25%	744	62	8.3%
Mercy	357	36	10.08%	358	41	11.5%
United	209	11	5.26%	143	13	9.1%
Total	**2133**	**172**	**8.06%**	**2182**	**188**	**8.6%**

60 Day Readmission to Any Acute Psychiatric Facility

Table D3

	2021			2022		
	Total Admit	Readmits	Readmit Rate	Total Admit	Readmits	Readmit Rate
Abbott NW	309	38	12.30%	320	45	14.1%
Univ. of MN	628	74	11.78%	617	85	13.8%
Regions	630	74	11.75%	744	93	12.5%
Mercy	357	61	17.09%	358	44	12.3%
United	209	22	10.53%	143	11	7.7%
Total	**2133**	**268**	**12.6%**	**2182**	**278**	**12.7%**

Behavioral Health Case Management

Table E1

Outpatient Complex Care Coordination:

	Full Year 2021				Full Year 2022			
	Identified	Participation Numerator	Participation Denominator	Total %	Identified	Participation Numerator	Participation Denominator	Total %
Medicaid	4573	1463	4142	35.3	3741	1535	3604	42.6
MSHO	19	17	17	100	12	10	11	90.9
SNBC	813	191	688	27.8	790	215	711	30.2

Table E2

Inpatient Complex Care Coordination:

	Full Year 2021				Full Year 2022			
	Identified	Participation Numerator	Participation Denominator	Total %	Identified	Participation Numerator	Participation Denominator	Total %
Medicaid	1448	1389	1406	98.8	1249	1235	1249	98.9
MSHO	36	36	36	100	30	28	30	93.3
SNBC	226	2013	214	94.9	199	193	199	97.0

Four Behavioral Health Disease Management Programs

Table F

	On Your Way			Moving Forward			Day by Day		
	MSHO	Medicaid	SNBC	MSHO	Medicaid	SNBC	MSHO	Medicaid	SNBC
CY2022	270	9276	646	552	8755	2768	161	3028	355
CY2021	NA	4805	189	NA	4466	1124	NA	1491	146

- *On Your WayTM*
  - *On Your Way* supports members newly starting antidepressant medication for depression through six monthly educational newsletters, refill reminders, and prescriber alerts for past due medications to support antidepressant adherence which is associated with better clinical and functional outcomes.
  - The first portion of table H demonstrates communications sent to members for *On Your Way.*
- *Moving ForwardTM*
  - Moving Forward supports members with bipolar disorder or schizophrenia through four quarterly newsletters, refill reminders, and prescriber alerts for past due medications to support mood stabilizer and antipsychotic medication adherence which is associated with better clinical and functional outcomes.
  - The second portion of table H demonstrates communications sent to members for *Moving Forward.*

- *Day by Day*
  - Day by Day supports members starting benzodiazepines for anxiety by providing education regarding appropriate use of anti-anxiety medication use and anxiety management.

  - The third portion of table H demonstrates communications sent to members for *Day by Day.*

Health – Care Management

Hospital Readmission Rates: Managed Comprehensive Care Advocacy Members

Accountable Owner: *Comprehensive Care Advocacy, Jill Davis, Mary Holland, Dana Baillet, and Matt Cline*

Member Populations Targeted

X	Commercial
X	Medicare Freedom (Cost)
X	Medicaid
	MSHO
	HPUPH
X	WI Marketplace

Description

HealthPartners' Comprehensive Care Advocacy department has an ongoing initiative to reduce avoidable hospital readmissions through care coordination initiatives.

Members identified for Comprehensive Care Advocacy programs have multifaceted medical and behavioral health conditions and are at high risk for future hospitalization. Reduction of hospital readmission rates continues to be a priority for care systems, health plans and the Centers for Medicare and Medicaid Services. According to quantitative studies, quality and patient safety are compromised during the vulnerable period when patients transition between different settings because of high rates of medication errors, incomplete or inaccurate information transfer, and lack of appropriate follow-up care. Communication interventions such as personalized transition care and post hospital telephone calls are associated with reducing hospital readmissions, improvements in treatment adherence and patient satisfaction (JAMA Network Open, 2021). Members hospitalized with COVID 19 may also benefit from personalized transition care planning. A 2021 retrospective cohort study found that interventions focusing on improvement in self-management planning reduced the risk of hospital readmission. Examples of self-management planning included shared decision making, patient education, medication management, and follow-up appointment reminders (The Joint Commission Journal on Quality and Patient Safety, 2021).

Multiple factors outside the direct control of hospitals, care team and health plans affect health care outcomes. Health starts with our homes, neighborhoods, and families. In addition to eating well, staying active and doing preventative care, our health is influenced by access to social and economic opportunities; the resources and supports available in our homes, neighborhoods, and communities; the quality of our schooling; the safety of our workplaces; the cleanliness of our water, food, and air; and the nature of our social interactions and

relationships. By working towards establishing and influencing policies that positively affect social and economic conditions and those that support changes in individual behavior, we can improve health for large numbers of people in ways that can be sustained over time. HealthyPeople2020 goals and initiatives towards establishing policies continue to be reflected into HealthyPeople2030.

The COVID 19 endemic continues to have unique influence on households related to employer and school vaccination policies and guidelines for quarantine, testing and treatment options.

Goals

The objective for this initiative is to reduce the percentage of actively managed comprehensive care advocacy members who had an inpatient readmission within 30 days of a previous hospital admission.

The population includes actively managed patients enrolled in comprehensive care advocacy's complex, disease, and behavioral health programs who had an inpatient admission with a length of stay > 0 within 30 days of a previous admission, a case actively managed in the reporting period and admission dates in the reporting period. Authorization/notification data was gathered from CCA's case management system to identify admission dates.

Numerator
Number of readmissions for the denominator population. An admission is considered a readmission when the admit date is within 30 days of the discharge date of the previous admission.

Denominator
Number of admissions for Medical Complex, Behavioral Health Complex, and Core Disease Management members who were actively managed in the reporting period and had at least one admission in the reporting period. Admission information is sourced from paid claims data.

Baseline and Goal
There is a universal definition for the reporting criteria for complex, disease, and behavioral health programs. Each program has a unique readmission rate and baseline.

Complex Case Management
Baseline: Reporting definitions to capture readmission rates were defined in 2019 combining claims based and CarePartner data. A new baseline was established in 2020 which was 23.6%.

2022 Goal: In 2021 our readmission rate was 22.5%. Our 2022 goal for complex case management was to maintain or reduce the readmission rate from the 2020 baseline of 23.6%.

Disease Case Management
Baseline: Reporting definitions to capture readmission rates were defined in 2019 combining claims based and CarePartner data. Baseline data was established in 2020 which was an 8.2% readmission rate.

2022 Goal: In 2021 our readmission rate was 4.7%. Our 2022 goal for disease management was to maintain or reduce the readmission rate from the 2020 baseline of 8.2%.

Behavioral Health Case Management
Baseline: Reporting definitions to capture readmission rates were defined in 2019 combining claims based and CarePartner data. Baseline data was established in 2020 which was a 16.1% readmission rate.

2022 Goal: In 2021 our readmission rate was 16.6%. Our 2022 goal for behavioral health case management was to maintain or reduce the readmission rate from the 2020 baseline of 16.1%.

Initiatives/Interventions

Case managers provide post-discharge support for members, participating in comprehensive care advocacy management programs, who experience a hospital admission. This support can include the following actions:

1. Enhanced engagement methods to meet the member needs, including adding digital notification regarding our services to high-risk members with HealthPartners web-based accounts.
2. *Complex Care Navigators* provide in person transition support to those at highest risk for readmission. Due to the COVID-19 endemic, the in-person transition support may be provided via a video visit, home visit, or visit while the member is in a facility.
3. Reinforce the benefits of virtual clinic/provider visits, the effectiveness of COVID-19 precautions for in-person clinical visits and the benefits of COVID-19 vaccinations in the prevention of disease transmission and severity.
4. Assessment and care planning with interventions tailored to address the member's unique needs, social determinants, barriers, and identified clinical gaps in care.
5. Close collaboration with care team members including PCPs, specialists, health care home nurses, home care providers, pharmacy resources, and community-based providers.
6. Case managers have access to multiple EMR's with our regional partners to enhance our communication with providers and support the physician's plan of care.
7. Connection to Medication Therapy Management (MTM) services for members with complex medication regimens or medication adherence concerns.
8. Facilitate maximization of available community resources.
9. Inpatient Case Management services to support real time identification and engagement of high-risk members to ensure milestones and care plans are implemented before discharge.
10. Support by Inpatient Case Navigators to provide in-person/video visit transitions of care and connection to resources to members in targeted geographic regions.

11. Coordination of behavioral health care upon discharge to support ongoing management of mental and chemical health needs.

12. Clinical case consultations with Medical Director or Psychiatrist involvement to provide case managers with condition-, treatment-, and member-specific interventions related to case management as well as the importance of primary care and new learnings.

13. Access to myStrength, a digital behavioral health application, that allow members to participate in individualized online cognitive behavioral therapy continues to be available to all members.

Additionally, case managers received the following trainings in 2022 to further enhance their expertise in working with members to reduce avoidable hospital readmissions:

1. Motivational Interviewing: Motivational interviewing is a style of communication designed to promote change and offer support through exploration of members motivations in consideration of how difficult it is to make behavioral changes. Case managers use this approach to improve member health by assisting members to identify internal motivation and encouraging them to make a commitment to positive change.

2. Call Quality Program: Case manager calls are evaluated by a call quality professional on a routine basis. Case managers are provided written and verbal feedback to continuously improved and enhance their interactions with members. The call quality program includes monthly motivational interviewing tips provided in a written format and discussed in team meetings.

3. Shared Decision Making: Shared decision making is a crucial component of patient-centered health care, wherein both the member and case manager contribute to the decision-making process. Case managers support member to make decisions that are consistent with the member's preferences and values.

4. Social Determinants of Health: Social determinants of health are non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age and the wider set of forces and systems shaping the conditions of daily life. Case managers are trained in assessing and mitigating these conditions using several internal and community resources.

5. Community supports and resources: Case managers receive training on community resources and access to NowPow, a digital application that acts as a clearing house for community resources.

6. Cultural Awareness: Case managers have access to Culture Vision, a web-based platform, that providers cultural information on multiple cultures, religions, and populations (LGBTQ+, veterans, homeless, etc.) Case managers are provided training that support DEI topics to support member engagement and understanding of influences that may affect readmission to the hospital.

7. EMR Capabilities: Case mangers receive ongoing updates and reinforcement on regional partners protocols for communication and workflows.
8. CORE (Asthma, Diabetes, COPD, Heart Failure, CAD) condition training: Case managers received training on all the CORE conditions to enhance their understanding of complications and risks for readmission.
9. Behavioral Health Lunch and Learns (PTSD, Borderline Personality Disorders, Depression, Anxiety, Bipolar disorder, Schizophrenia, Trauma Informed Care): Case managers received training on a series of behavioral health conditions to enhance their understanding of complications and risks for readmission.
10. Targeted Post Discharge Training: Behavioral health, inpatient, and restricted recipient program case managers received training with a focus on assessing for safe transitions of care and avoidance of risks related to readmission.
11. Medical Director Quarterly Updates (Gerontology, CKD, Stroke, Alcohol and Substance Abuse): These training topics are based on the results of our team member annual training needs assessments. The medical director provides condition specific education using case studies that relates to case management and readmission risk.
12. Well-Being Activities: Case managers participate in well-being activities and occasional webinars to support their own resilience and coping. Comprehensive care advocacy has a Be Well committee and team champions that facilitate group activities.

Barrier Analysis

The COVID-19 endemic continues to be an additional challenge in establishing and comparing accurate baseline data. The regulations, variants, and vaccines provide a changing health landscape. It may be beneficial to establish new baselines after the state of emergency has been rescinded and the health care landscape has settled in addition to the current endemic nature of COVID 19 (as opposed to the pandemic state in previous years.)

There are challenges related to the reduction of avoidable hospital readmissions. Examples include medication adherence, health literacy, family/caregiver support, access to outpatient and other lower levels of care, and social determinants of health. Seasonality impacts, such as influenza and related respiratory issues complicated by the COVID-19 variants during the winter months, also add to this challenge.

There are ongoing opportunities to reduce avoidable hospital readmissions. Case managers will continue to utilize shared decision making and motivational interviewing to help members and families identify their personal goals for their plan of care. Case managers will contact patients post discharge to support them through this transition and communicate with their primary care team regarding any identified concerns or barriers the member is experiencing. Additionally, care navigators will provide in person/video transition support to our highest risk members.

Gaps in Care

Case managers work closely with discharged members to close gaps in care encountered post discharge. These gaps often center around social determinants of health, diversity and equity, and health care system limitations that create challenges to members accessing care. When members experience issues such as obtaining reliable transportation to appointments, establishing care with a provider of their preferred language or ethnicity, or identifying a provider taking new patients, they may struggle to adhere to care recommendations, resort to using more urgent or emergent levels of care, or avoid care altogether until their needs require hospitalization.

To assist in closing gaps in care, case managers use the strong partnerships and ACO relationships that HealthPartners has developed with care delivery systems to facilitate collaborations with the care team. This allows for real time interactions to address and solve member needs.

Case managers have knowledge of and access to community supports and resources. Case managers enable member connections to resources related to specific needs and gaps in care.

Examples of these resources include but are not limited to:

1. NowPow; a personalized community referral platform
2. Culture Vision: a personalized platform for culturally appropriate care planning
3. National Alliance for Mental Illness (NAMI); educates, advocates, and leads to improve the lives of people with mental illness.
4. Make It OK; a campaign to reduce the stigma of mental illness.
5. Language Line; telephonic interpreter services
6. Maternal/Child resources – Doulas, Healthy Beginnings, Help Me Grow
7. County Connections
8. Senior Linkage Line, Disability HUB, Veterans Linkage Line, MinnesotaHelp

Opportunities for Improvement: Results/Outcomes

Complex Case Management

The 2022 goal for the complex case management readmission rate was 23.6%. The 2022 measurement period results were 26.4% for members engaged in complex case management. As we didn't achieve our goal, this continues to be an area of focus. All interventions for this initiative have been integrated into standard care coordination processes and this initiative will continue in 2023.

Disease Case Management

The 2022 goal for the disease case management readmission rate was 8.2%. The 2022 measurement period results were 10.3 % for members engaged in disease case management. As we didn't achieve our goal, this continues to be an area of focus. All interventions for this initiative have been integrated into standard care coordination processes and this initiative will continue in 2023.

Behavioral Health Case Management

The 2022 goal for the behavioral health case management readmission rate was 16.1%. The 2022 measurement period results were 16.7% for members engaged in behavioral health case management. As we didn't achieve our goal, this continues to be an area of focus. All interventions for this initiative have been integrated into standard care coordination processes and this initiative will continue in 2023.

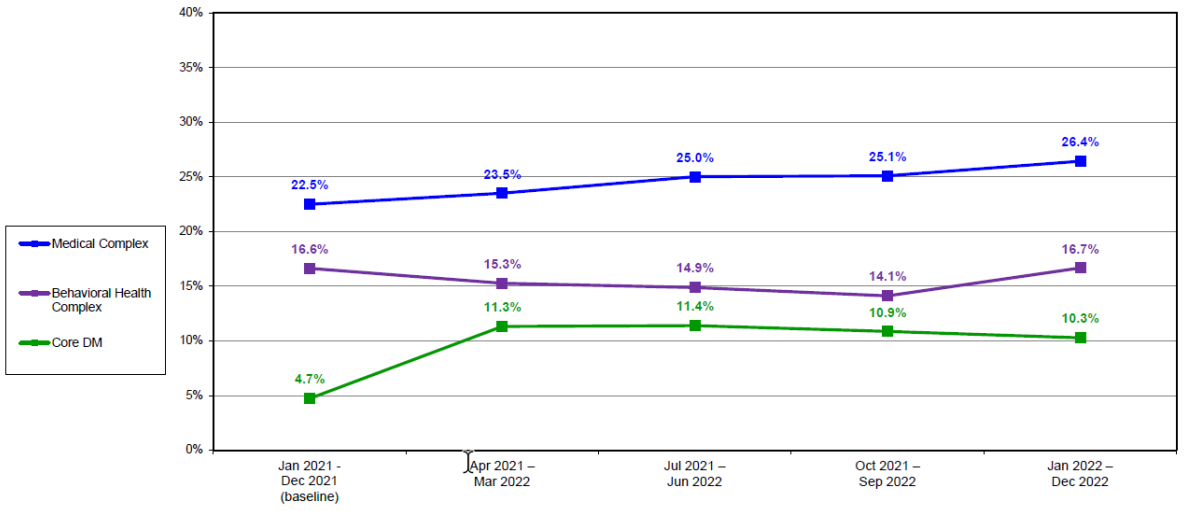
2022 CCA Readmission Rates

Denominator:

Number of admissions for Medical Complex, Behavioral Health Complex, and Core DM patients who were actively managed in the reporting period and had at least 1 admission in the reporting period. Admission information is sourced from paid claims data.

Numerator:

Number of readmissions for the denominator population. An admission is considered a readmission when the admit date is within 30 days of the discharge date of the previous admission.



		Jan 2021 - Dec 2021 (baseline)	Apr 2021 – Mar 2022	Jul 2021 – Jun 2022	Oct 2021 – Sep 2022	Jan 2022 – Dec 2022
Medical Complex	Numerator	378	373	375	341	393
	Denominator	1,681	1,587	1,499	1,359	1,487
	Rate	22.5%	23.5%	25.0%	25.1%	26.4%
Behavioral Health Complex	Numerator	71	56	50	47	59
	Denominator	427	367	336	333	354
	Rate	16.6%	15.3%	14.9%	14.1%	16.7%
Core DM	Numerator	16	37	36	34	33
	Denominator	339	327	316	313	321
	Rate	4.7%	11.3%	11.4%	10.9%	10.3%

Compliance Statement: Continuity and Coordination of Medical Care

HEDIS Data Tables – Column Titles

In 2021, NCQA changed how each year's HEDIS results are labeled. Up until 2020, HEDIS results were labeled in the year the data was collected. In 2021 and continuing into 2022, the labeling indicates the year being measured. At the time this report was written in April 2023, 2022 HEDIS Measurement Year(MY) data was not yet available. 2022 MY data will be reflected in the report written in April 2024.

Continuity and Coordination of Medical Care

Introduction

Improving coordination of care is one of HealthPartners' core strategies for delivering on our mission and the Triple Aim of improved health, experience, and affordability. Overall, continuity and coordination of care improvement initiatives promote efficient, effective, and safe care for members when they are transitioning between levels of care or receiving care from multiple providers. More specifically, continuity and coordination of medical care is the facilitation, across transitions and settings of care of:

- Patients getting the care or services they need, and
- Practitioners or providers getting the information they need to provide patient care.

HealthPartners monitors and takes action, as necessary, to improve continuity and coordination of care across the health care network. During 2022, HealthPartners continued to monitor the following aspects of continuity and coordination of medical care:

Monitor 1	All cause readmission rates	Movement across settings
Monitor 2	Low-intensity emergency room utilization	Movement across settings
Monitor 3	Provider satisfaction the timeliness and completeness of patient care information they receive from other types of providers	Movement between practitioners
Monitor 4	Postpartum visit rate	Movement across settings

This report describes the relevance of the measure, monitoring methodology, results, analysis, and actions for each monitor. Monitors are applicable to both the Commercial and Marketplace product lines.

Monitor 1: Readmission ratios (QI 3 A Factor 2)

Methodology

HealthPartners used the HEDIS inpatient readmission measure as our core metric. This measure is relevant to the HealthPartners population because inpatient readmissions are an indicator of potential gaps in care that surface after discharge. Reduction of hospital readmission rates continues to be a priority for care systems, health plans and the Centers for Medicare and Medicaid Services. According to quantitative studies, quality and patient safety are compromised during the vulnerable period when patients transition between different settings because of high rates of medication errors, incomplete or inaccurate information transfer, and lack of appropriate follow-up care. (JAMA Intern Med 2016 May 1).

Readmissions may result when patients do not receive needed follow-up care, don't understand self-care after discharge or because primary care providers do not have all the information they need to develop an effective treatment plan to manage the patient's condition. The commercial readmission goal was set based on improving HealthPartners performance to Band 3. Results

of this measure over multiple years are noted below in the Results section. Numerator and denominator are not included in the chart as this measure is calculated as a ratio instead of as a rate. We use the ratio measure, as it evaluates our performance considering the risk of the measured population. Results have been audited by an NCQA-accredited certification vendor.

Commercial Results

	HEDIS2016 (2015 DOS)	HEDIS2017 (2016 DOS)	HEDIS2018 (2017 DOS)	HEDIS2019 (2018 DOS)	HEDIS 2020 Old Measurement Specs (2019 DOS)	HEDIS 2020 New Measurement Specs (2019 DOS)	HEDIS MY 2020 (2020 DOS)	HEDIS MY 2021 (2021 DOS)
Indicator title	HEDIS All Cause Readmissions: Observed to expected ratio – Commercial							
Ratio	0.8815	.8734	.7582	0.6569	0.6060	0.5141	0.5447	0.5856
Statistical Significance Test & Results	There were major changes in the measure specifications for HEDIS 2020, however, we have calculated the rate with both the old and new methodology to allow for trending and significance testing. Due to the coronavirus pandemic, NCQA advises caution when using MY 2021 data.							
Performance goal	HealthPartners historical goal was to achieve band 3 performance and we met goal in 2018 and 2019. Due to the pandemic, benchmark performance was not publicly reported for the 2020 report period. However, 2020 performance as measured by the 2019 HEDIS methodology trended downward, and we would have met goal in 2020 if the benchmarks had remained constant. For 2021 we moved our goal to Band 2 because our performance at Band 3 was stable and we believed we could make further improvements. NCQA published benchmarks for HEDIS MY 2020 and we performed at Band 3 and did not meet our Band 2 goal. Our ratio for MY 2021 increased, but not statistically significantly. HealthPartners MY 2021 performance places us in Band 4. For 2022 we've chosen Band 2 as our goal. We recognize Band 2 is a stretch goal, but it is where we want to perform long-term.							

Wisconsin Marketplace Results

	HEDIS 2016 (2015 DOS)	HEDIS 2017 (2016 DOS)	HEDIS 2018 (2017 DOS)	HEDIS 2019 (2018 DOS)	HEDIS 2020 Old Measurement Specs (2019 DOS)	HEDIS 2020 New Measurement Specs (2019 DOS)	HEDIS MY 2020 (2020 DOS)	HEDIS MY 2021 (2021 DOS)
Indicator title	HEDIS All Cause Readmissions: Observed to expected ratio – WI Marketplace							
Ratio	NA	Product Launched	0	0.82	0.451	0.8143	0.388	0.5856
Statistical Significance Test & Results	Ratio has increased, but not statistically significant because there were only 2 readmissions out of 66 hospitalizations for 2020. There were major changes in the measure specifications for 2020, however, we calculated the rate using both the old and new methodology to allow for trending and significance testing. Due to the coronavirus pandemic, NCQA advises caution when using MY 2021 data.							
Performance goal	HealthPartners' historical goal is to attain commercial HEDIS measure band 3 for both the commercial and the marketplace products. Due to the pandemic, NCQA did not publicly report benchmark performance. 2020 performance as measured by the 2019 HEDIS methodology trended downward, and we would have met goal in 2020 if the benchmarks had remained constant. NCQA published benchmarks for HEDIS MY 2020 and we met goal, performing at Band 1. This measure is very volatile due to low membership in the population with just under 4500 members in 2021. Measurement year 2021 performance put us solidly in band 4. For 2022 we've chosen Band 2 as our goal. Since this product has low membership, we feel it's important to keep the goal similar to our Commercial Product lines.							

Quantitative Analysis (QI 3 A Factor 3)

HealthPartners uses HEDIS readmission rates to assess potential gaps in coordination of care. As a result of varied strategies deployed to reduce inappropriate readmissions, overall commercial results improved between 2016 and 2019 and we achieved our goal of Band 3 performance in both 2018 and 2019 and would have met goal in 2020 if benchmarks had remained constant. However, MY 2021 band performance places us solidly in Band 4, and HealthPartners appears to be declining on this measure. We have chosen to continue our focus on this measure, with the goal of achieving Band 3 for HEDIS MY 2022. We did not achieve Band 3 performance in 2021 as we did pre-pandemic and see the opportunity to improve our performance. This measure will continue to be monitored in subsequent years.

For 2022, we've chosen Band 2 as our goal. We recognize this is a stretch goal, but it's where we'd like to see long-term performance and we continue to see opportunities to improve our performance as we did not achieve Band 3 performance in 2022.

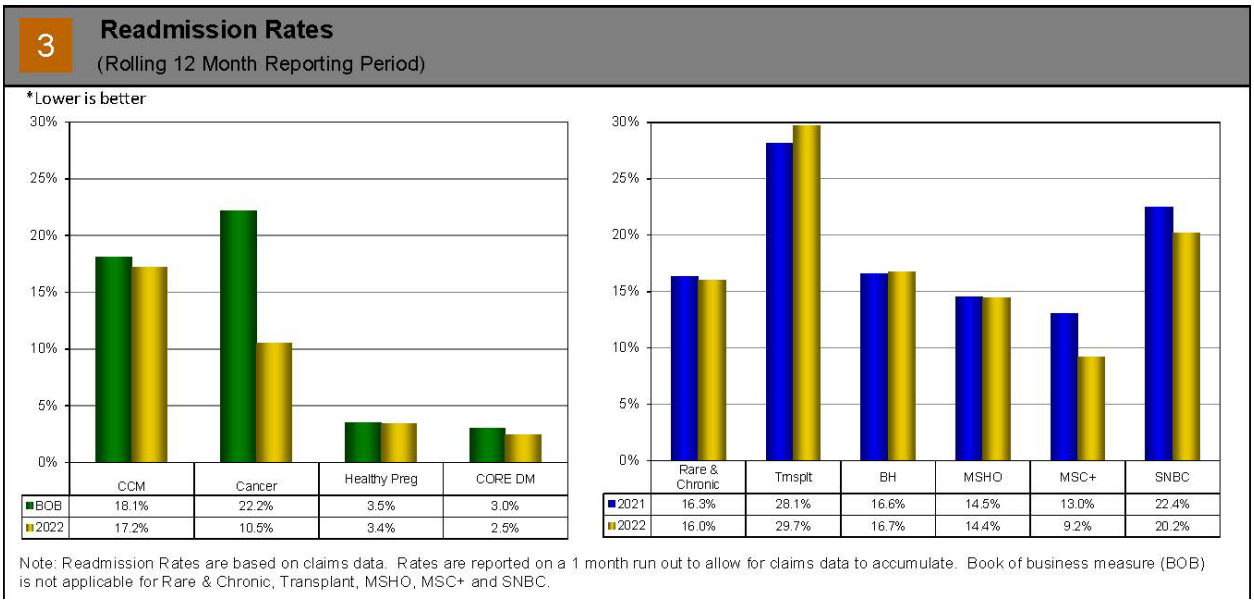
Qualitative Analysis (QI 3 A Factor 3)

As noted above, quantitative analysis shows that our HEDIS MY 2021 results did not meet goal of Band 3 performance. Reporting conducted by our Comprehensive Care Advocacy (CCA)

area helped identify member populations that had the highest readmission levels. These populations include members who participate in the following programs:

- Complex case management – top opportunity to reduce readmissions
- Cancer disease management
- Healthy Pregnancy

Transplant patients were also at higher risk of readmission. A subset of these patients also participate in complex case management.



Our Comprehensive Care Advocacy (CCA) senior leaders also note discharge planning is critical to optimize patient recovery. HealthPartners Complex Care Advocacy Case Managers support member transitions between facility and home during facility transfers.

There are challenges related to the reduction of avoidable hospital readmissions. Examples provided by our CCA leaders include medication adherence and lack of follow through with discharge instructions by patients, patients discharging from inpatient stay against medical advice, health literacy, family/caregiver support, and social determinants of health such as transportation, cultural barriers, access to proper nutrition and community resources. Additionally, discharge registries are not always consistently worked by care delivery due to clinic staffing and competing priorities.

Lack of connectivity with other EMRs for both specialists and primary care providers continues to be an issue as it pertains to coordination of care which was noted during our 2022 provider survey. Optimizing EMR's and predictive analytics through home grants will help providers fortify members are receiving appropriate discharge planning during facility transfers.

Barrier	Opportunity	Selected for Improvement?
Data analysis identifies complex patients as one of the populations at greatest risk for readmission. This population struggles with a variety of different challenges in managing their health.	There is significant opportunity with this population and remains a top barrier for our Complex Care Advocacy team. We can improve care coordination between settings by developing and implementing additional care coordination supports that are targeted toward this high-risk population especially when transitioning between a facility and home.	Yes – this remains a top barrier per discussion with the Director of Comprehensive Care Advocacy.
HealthPartners 2022 Provider survey identified barriers to coordination of care and lack of connectivity with other EMRs as the top barrier sited by 47% of primary care providers and 25% of specialists (see full report starting on page 19)	Improve coordination of care between settings and practitioners by integrating health plan care management resources with the provider care teams. Health plan has a comprehensive picture of all care received (via claims)	Yes – this continues to be a top barrier.

Actions (QI 3A factor 4)

Date Initiated	Action Implemented	Barriers Addressed
2015 and ongoing	HealthPartners awards annual Health Care Home (HCE) grants select primary care and multispecialty groups to support building capacity for addressing SDOH, improving health equity, providing member-centered support, and improving continuity and coordination of care to improve the health of our members, manage affordability and improve the member experience. For calendar year 2021, HealthPartners granted over $1.5 million to 30+ medical groups. HCH grants support providers in developing and implementing an HCH model that improves member care, increases member satisfaction and delivers DHS-certified HCH care management support services to members.	Grants help remove financial barriers to implementing systems, infrastructure and processes that improve continuity and coordination of care which streamline communications and standardize protocols and handoffs between providers to ensure that patients received needed care. Grants directly address provider concerns regarding lack of connectivity with other EMRs by providing dollars that can be used for EMR enhancements.
2020	Expanded community paramedic program to support patients post-discharge at three key network hospitals. The original diagnoses eligible for referral to the program included CHF, COPD, AMI, pneumonia, and stroke. In 2020, we expanded the program to include patients discharged post-covid hospitalization. During 2020, The Community Paramedic team cared for more than 150 patients with COVID-19 using an adapted care plan.	Support high-risk patients as they transition between a hospital setting to home-based care.

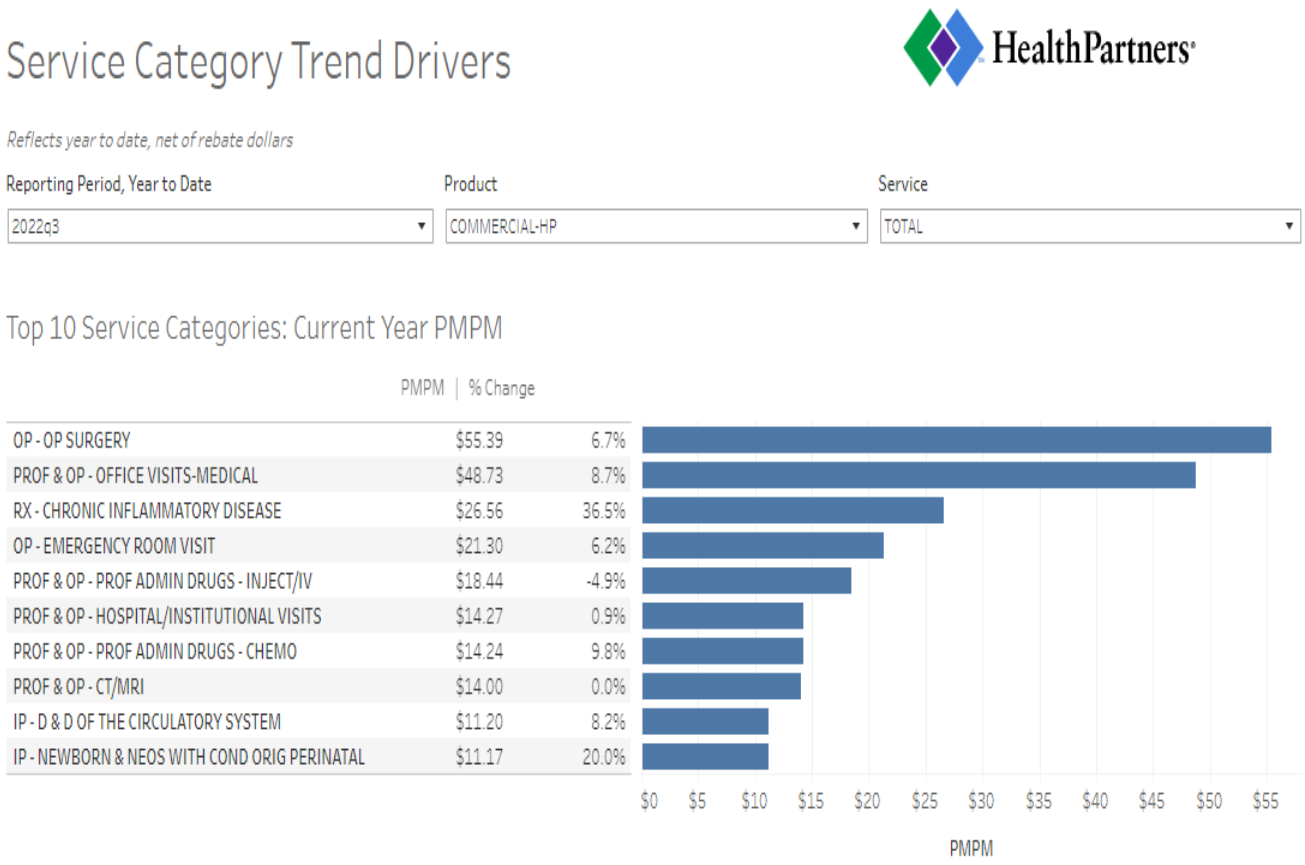
Date Initiated	Action Implemented	Barriers Addressed
2021-2022	The complex care pilot kicked off in 2021 and in 2022 the Transitional Care Management (TCM) billing code was implemented. The TCM billing code reimburses providers for treating patients with complex medical conditions during the 30-day post-discharge period but also enables us to identify and closely follow the members who need additional services. This enhances coordination between HealthPartners care coordinators and network clinic and clinicians for high-risk members.	This activity addresses two key issues identified in the barrier analysis. 1. The intervention provides tighter coordination of care between the health plan and the provider by optimizing patient after visit summaries to ensure valuable information is given to members who are at highest risk for readmission during discharge planning. We believe the implementation in the billing code helps address the barrier our CCA team identified when members transition between facility and home during facility transfers and will improve continuity and coordination of care. 2. Provides an opportunity to optimize EMR's and predictive analytics to help identify when a patient is on our health plan or a part of one our risk contracts and could benefit from care coordination.

Looking at prior interventions, which include community paramedics and health care home grants, both are still active and effective in addressing some aspects of the problem. The community paramedic intervention successfully prevents some readmissions, but the population that qualifies for the intervention is fairly small when compared to the overall HealthPartners population. This intervention is designed to support select, high-risk members with specific medical conditions. The 2022 Transitional Care Management (TCM) billing code system is an intervention which also targets high-risk members and helps enhance coordination between HealthPartners and network clinics and clinicians which ensures members are receiving enhanced coordination during facility transfers to their home. The Health Care Home grants are a long-standing intervention that providers find very helpful in making systemic investments to support continuity and coordination of care. Based on the provider survey results which will be detailed in Monitor 3, we believe the grants are impactful enabling providers to implement improved systems of care. Providers cited the barrier of "Lack of connectivity to other EMRS" 52% of the time in 2018 and continues to remain low at 38% in 2022.

Monitor 2: Low Intensity Emergency room utilization (QI 3 A Factor 2)

Methodology

The goal of this intervention is to reduce unnecessary or low intensity emergency department visits because they may cause fragmented care and gaps in continuity and coordination of care. In many cases, patients would be better served by receiving care from their primary care clinic which would have their complete medical history and be able to offer needed routine and preventive care services at the same time as taking care of an acute condition. This measure is relevant to our population because emergency room visits rank fourth among the top 10 service categories for 2022 which is consistent with its 2021 spot. This data reflects the combined utilization of both our commercial and marketplace members.



Outpatient ER Usage

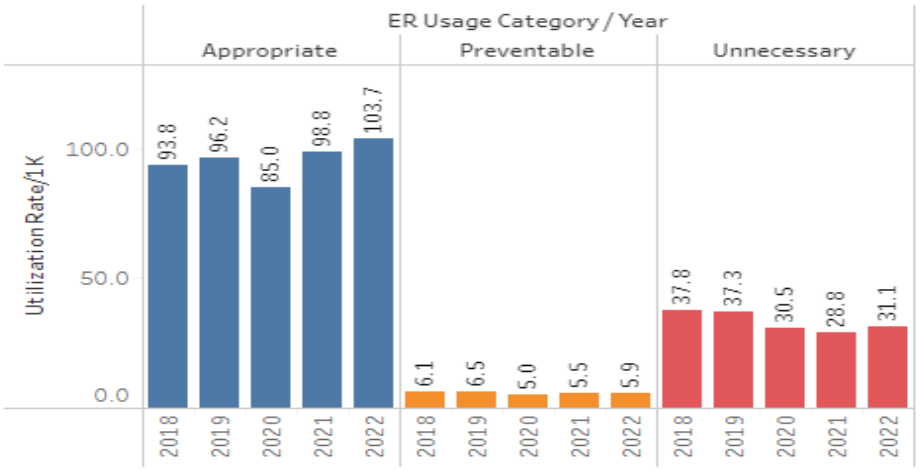
Reflects year to date, net of rebate, trendable dollars and services

Reporting Period, Year to Date: 2022q3

Product: COMMERCIAL-HP

This analysis uses an algorithm provided by a panel of emergency room physicians (via an NYU study) to identify diagnoses that constitute real emergencies.
Using this NYU algorithm definition, emergency room visits can be classified into three categories:
-**Appropriate ER Use**: diagnoses that constitute real emergencies
-**Preventable ER Use**: real emergencies that likely could have been prevented
-**Unnecessary ER Use**: conditions that are non-emergent / do not require immediate care

ER Utilization Rate, by Category



Additionally, unnecessary and preventable ED visits make up more than 31 percent of all emergency department utilization. This represents a significant opportunity to redirect care to the appropriate place of service so that the member's complete health care needs can be assessed and provided.

We believe this measure may be especially relevant for our marketplace population because the State of Minnesota has written language requiring plans meet emergency department utilization targets for our medical assistance and MinnesotaCare enrollees. Addressing this issue in the Marketplace population supports meeting our targets because Marketplace members may drop off commercial insurance and enroll in medical assistance if their income declines. This performance target has been mandated since January 1, 2012 (Minnesota Statute 256B.69) and has no end date.

HealthPartners obtained the New York University (NYU) algorithm that identifies potentially avoidable emergency room visits. As cited in an article by Rutgers University "According to the NYU algorithm, almost one half (47%) of all ED visits without admission are potentially avoidable with improved access to primary care (i.e., these visits are classified as non-

emergent, emergent but primary care treatable, or emergent/ED care needed/preventable avoidable). ED patients most likely to have their visits (without admission) classified as potentially avoidable include children ages 4 and under and traditionally underserved populations – i.e., charity care, self-pay, Medicaid, non-Hispanic blacks, and Hispanics.

Nevertheless, these patient groups do not account for the majority of potentially avoidable ED visits. Because they account for a larger share of hospital utilization overall, patients who are adults, privately insured, and non-Hispanic white account for the largest shares of potentially avoidable ED visits without admission."

This definition of an avoidable ED visit is broader than other definitions that may only account for services that could easily be treated in a primary care setting such as sore throats and ear infections. It encompasses urgent ED care that was needed yet could have been prevented through appropriate treatment in another setting. It also includes patients with complex, chronic conditions such as asthma, diabetes and COPD where timely care in other settings may have prevented an ED visit.

We calculated the rate of non-emergent emergency room visits for our Commercial and Marketplace members.

Commercial Results

	2018	2019	2020	2021	2022
Indicator title	Non-emergent Visits – Commercial				
Numerator	36,171	35,895	25,388	23,859	26,649
Denominator	131,103	131,363	105,571	110,047	114,627
Rate	27.60%	27.33%	24.05%	21.68%	23.25%
Statistical Significance Test & Results	HealthPartners used the Chi-square test to determine if rates change significantly from year to year. The 2016/2017 as well as the 2020 and 2021 changes were statistically significant, other changes are not. Our goal is to not exceed a rate of 25%. The rate change from 2021 to 2022 was statistically significant but still remains under the goal of not exceeding 25%.				

Marketplace Results

	2018	2019	2020	2021	2022
Indicator title	Non-emergent Visits – Commercial				
Numerator	65	65	65	65	65
Denominator	266	266	266	266	266
Rate	24.44%	24.75%	22.96%	24.75%	22.61%

Statistical Significance Test & Results	Data is not statistically significant due to the small population size. This measure is very volatile due to low membership with just over 3,000 members in 2020. Our goal is to not exceed a rate of 25%. We met goal in 2021. The change in rates between 2021 and 2022 were not statistically significant. Rate remains under the goal of not exceeding 25%.

HealthPartners discontinued monitoring the rate of emergency room utilization using the standard HEDIS measure because NCQA retired the measure in 2020. However, we have included historical performance below as we transition from the HEDIS measure to the non-emergent ED measure.

Commercial Results (historical)

	2014	2015	2016	2017	2018	2019
Indicator title	Emergency Department Visits – commercial					
Numerator	65,997	73,331	79,139	88,456	86,425	94,780
Denominator	5,759,743	6,459,016	6,896,476	7,467,786	7,414,060	8,110,793
Rate	137.50	136.24	137.70	142.14	139.88	140.23
Statistical Significance Test & Results	HealthPartners used the Chi-square test to determine if rates change significantly from year to year. The 2017/2018 changes were statistically significant.					
Performance goal	140.20 or less (we did not meet goal in 2019)					

Marketplace Results (historical)

	2017	2018	2019
Indicator title	Emergency Department Visits – marketplace		
Numerator	NA – product launched 1/1/17	16,272	33031
Denominator		239	378
Rate		176.25	137.33
Statistical Significance Test & Results	HealthPartners used the Chi-square test to determine if rates change significantly from year to year. The population is too small to reliably test and the rate is quite volatile.		
Performance goal	140.20 or less (goal met in 2019)		

Quantitative Analysis (QI 3 A Factor 3)

HealthPartners uses non-emergent Emergency Department Visit rates to assess for potential gaps and opportunities to improve continuity and coordination of care. From 2017 through 2021, commercial non-emergent emergency room visits trended downward; although the year over year changes were not statistically significant until 2020. Historical emergency room HEDIS rates for the commercial population have not shown consistent performance over time. The rate change from 2021 to 2022 for the commercial population was statistically significant, but we still met our goal. There is variability in our commercial performance and significant volatility in our Marketplace results. We met goal for the Marketplace population, but the rate change from 2021 to 2022 was not statistically significant. Preliminary 2023 data from January and February suggest the rate of non-emergent Emergency Department Visits is remaining stable with our current percentage, although it is too early to understand if this trend will continue into the rest of 2023.

Quantitative Analysis (QI 3 A Factor 3)

While our quantitative analysis shows we are meeting our goal of less than 25% non-emergent visits to the emergency room, over 30% of all emergency room utilization is unnecessary and increased from the previous year. Our Complex Care Advocacy (CCA) senior leaders indicated that lack knowledge for the member as well as lack of primary care/urgent care access are primary barriers to appropriate emergency room utilization.

To address this trend, our Marketing team created a campaign targeting the populations below to receive education about how to prevent unnecessary emergency room use:

- Newly enrolled and unattributed adult members
- Policyholders with at least one child on their contract
- Members who likely have a telemed-eligible need in the next two months and currently use urgent care.
- Members likely to have a non-emergent care need in the next two months and currently use the emergency room.
- Members with back or joint pain
- Members taking multiple medicines who have one or more risk factors.

Barrier	Opportunity	Selected for Improvement?
Our CCA senior leaders noted that lack of knowledge for the member on appropriate utilization	Provide education to members explaining what alternatives are available to receive care instead of the emergency room.	Yes
Lack of primary care or urgent care access is another barrier noted by our CCA senior leaders.	Help members select a primary care/pediatric care provider and provide education around why it's important.	Yes

Action (QI 3 A factor 5)

Date Initiated	Action Implemented	Barriers Addressed
2012 and ongoing	HealthPartners continues to administer total cost of care (TCOC) payment arrangements with contracted provider groups providing care for more than 85% of our membership. The TCOC payment strategy continues to evolve as we continually seek to better align incentives.	Traditional reimbursement models do not reward or incent providers to improve coordination of care and improve the flow of communication between providers. HealthPartners TCOC methodology supports important provider initiatives to streamline communications and enhance continuity and coordination of care.
2020	HealthPartners implemented a COVID-19 Advanced care process to help clinicians identify their high-risk patients, facilitate a discussion regarding an advanced directive and document the patient's wishes where it can easily be found	Improve continuity of care between primary care and hospitals by increasing the number of members who have an advance care plan and moving the ACP to the front page of the member's EPIC medical record for easy reference.
2021	Comprehensive care advocacy team is conducting intentional, targeted outreach to high-risk commercial and Marketplace members encouraging members to schedule COVID vaccines and offering education surrounding COVID. This includes care navigation to assist the member in finding a provider that is offering vaccinations. Health plan clinical staff routinely monitor complex cases to identify risks, communicates to the member's care team uses integrated EHR functions and connects the member with health plan and care delivery services designed to prevent exacerbations and prevent ED visits.	Prevent ED visits associated with COVID infections among the most vulnerable members. Improve connectivity and flow of key information between the member, the plan and the member's care team to ensure optimal plan of care.
2022	HealthPartners Marketing team deployed a communications campaign to educate members about the available	The appropriate site of care campaign addresses the appropriate utilization barrier as it sent out educational materials to the targeted members on what

Date Initiated	Action Implemented	Barriers Addressed
	alternatives to the emergency room when care is needed. “Appropriate Site of Care” campaign matched new members who haven’t used telemedicine and are predicted to have a have a care need in the next two months and who currently use urgent care, members likely to have a non-emergent care need in the next two months and currently use the emergency room, and members with back or joint pain with Telemedicine options and compare and cost options between the different sites of care. Educational materials were promoted via email, web, website push notifications and provided as Member Services talking points.	alternative care options are available and the cost comparisons between them. By educating members about additional care options for their conditions it will improve coordination of care by reducing unnecessary emergency room utilization and ensuring members get care at the appropriate site of care.
2022	A second campaign also coordinated by the HealthPartners Marketing team, with support from our CCA team educated members on the available alternatives to the emergency room when care is needed. “Visit The Doctor” campaign matched the following newly enrolled unattributed adult members and policyholders with at least on child on their contract to assist them in getting matched with a doctor for primary care/pediatric needs. Educational materials were sent out via email and web flyers.	This campaign addresses the lack of knowledge barrier by reaching out to unattributed members who don’t currently have a primary clinic by assisting them in matching with a primary care/pediatric care provider. Linking members to a primary care provider improves continuity and coordination of care by enabling members to get the care they need in the setting that helps them manage their care.

The 2020 and 2021 previous interventions were primarily related to the COVID-19 Pandemic. As the cases for COVID-19 are no longer spiking the concerns are no longer relevant to our current barriers, the data shows there is still a need for primary care access and education to prevent unnecessary emergency room utilization. HealthPartners feels our marketing campaigns to educate members on the importance of selecting a primary care provider and

appropriate site of care will improve continuity and coordination and reduce unnecessary emergency room utilization.

Monitor 3: Provider satisfaction with the quality of information they receive from other types of providers. (QI 3 A Factor 1)

Methodology

To support our goal of improving continuity and coordination of care, HealthPartners tracks provider satisfaction with the completeness and timeliness of information they receive regarding their patients from other practitioners. This information is relevant to our commercial and marketplace products because the direct provider feedback enables us to identify gaps and opportunities across all product types and between different types of facilities and practitioners so that we can implement targeted actions that improve providers getting timely and complete information to care for their patients. Although performance is improving, we have never met goal across all the survey measures which indicates the measure continues to be relevant to our plan and demonstrates an ongoing opportunity to improve the availability of timely and accurate information so that providers can provide optimal patient care.

The 2022 Provider Survey was mailed in May 2022 to a total of 1,086 providers and their office managers. To ensure all providers in the survey interacted with HealthPartners members we selected the survey pool from those providers who had requested two or more authorizations from the health plan during the last 15-month period.

Previous surveys showed a declining response rate. To address this issue, we increased the number of providers who were mailed the survey. We survey all psychiatrists who have submitted a PA in the past 15 months. Between 2019 and 2022, fewer psychiatrists met this criteria. Surveys were received through August 12th. HealthPartners received a total of 72 completed surveys; 53 surveys were returned unanswered due to bad addresses. The adjusted response rate was 7%; similar to 2021 but noticeably lower than 2019's 11% response. The 2022 aggregate results have a margin of error of +9 percentage points with a 90 percent confidence interval.

	2018 sample size	2019 sample size	2021 sample size	2022 sample size
Primary care	300	500	492	500
Specialty care	300	500	500	500
Psychiatrists	140	125	114	86

There is overlap in the providers who participate in our commercial network and our Exchange network. As such, we did not field separate surveys for each population.

2022 WI Atlas Network Providers

Type of provider	Total sample	WI Atlas providers	% of sample
Primary care providers	500	397	79.4%
Specialty care providers	500	390	78.0%
Psychiatry	86	75	87.2%

We have not attempted to segment the results by product due to the relatively low response rate and the high degree of overlap between our commercial and Exchange networks.

Results

The results of the survey are reported below. We did not report satisfaction levels of psychiatrists separately due to the small number respondents. There were only 3 respondents in 2022, too few to reliably conduct tests of statistical significance and to report some questions.

	Total			Primary Care			SCP Care			2021	2022
	2019	2021	2022	2019	2021	2022	2019	2021	2022	Goal	Goal
Timely Communication of Patient Care From:											
- Hospitals (% Excellent+ Average)	91%	96%	95%	96%	95%	97%	89%	94%	92%	85%	85%
- Emergency rooms (ERs) (% Excellent+ Average)	90%	94%	89%	96%	98%	97%	84%	94%	82%	85%	85%
- Behavioral health providers (% Excellent+ Average)	82%	85%	81%	85%	83%	81%	76%	88%	82%	85%	85%
- Primary care providers (% Excellent+ Average)	96%	97%	95%	98%	94%	100%	95%	100%	88%	85%	85%
- Specialty providers (% Excellent+ Average)	92%	96%	88%	92%	96%	89%	93%	95%	86%	85%	85%
- Skilled nursing facilities (% Excellent+ Average)	72%	72%	77%	77%	78%	88%	67%	64%	60%	85%	85%
- MTM pharmacist (% Excellent+ Average)	94%	93%	86%	93%	96%	92%	93%	92%	75%	85%	85%
- Urgent care centers (% Excellent+ Average)	81%	83%	80%	87%	86%	85%	76%	88%	74%	85%	85%
Complete Communication of Patient Care From:											
- Hospitals (% Excellent+ Average)	92%	98%	98%	93%	100%	100%	94%	93%	95%	85%	85%
- Emergency rooms (ERs) (% Excellent+ Average)	89%	100%	96%	93%	100%	100%	85%	100%	89%	85%	85%
- Behavioral health providers (% Excellent+ Average)	89%	92%	86%	88%	91%	86%	90%	100%	93%	85%	85%
- Primary care providers (% Excellent+ Average)	100%	98%	96%	100%	96%	100%	100%	100%	91%	85%	85%
- Specialty providers (% Excellent+ Average)	97%	100%	95%	94%	100%	97%	100%	100%	92%	85%	85%
- Skilled nursing facilities (% Excellent+ Average)	78%	69%	82%	83%	67%	91%	72%	80%	64%	85%	85%
- MTM pharmacist (% Excellent+ Average)	97%	100%	97%	97%	100%	100%	96%	100%	93%	85%	85%
- Urgent care centers (% Excellent+ Average)	87%	90%	83%	93%	88%	87%	77%	100%	82%	85%	85%
Top Barriers to Coordination of Care: (% Response marked, lower is better)*											
- Lack of standard process	18%	9%	12%	18%	8%*	9%*	18%	6%*	13%*	NA	NA
- Lack of connectivity with other EMRs	40%	36%	38%	36%	43%	47%	47%	35%	25%	NA	NA
- Don't know which primary care or specialty providers may have seen patient	16%	17%	12%	16%	15%	9%*	16%	18%*	17%*	NA	NA
- Lack of designated staff to coordinate care	15%	23%	22%	20%	25%	19%	7%	24%*	29%	NA	NA
- Some other reason	12%	15%	16%	16%	10%*	16%*	11%	18%*	17%*	NA	NA
NA = No goal is set because this data is collected to facilitate barrier analysis; not as a satisfaction measure.											
* = 5 or fewer responses to the question											

Analysis (QI 3 A Factor 3)

HealthPartners met goal on all but seven measures, timely communication from Emergency Rooms (ER), timely communication from behavioral health providers, timely communication from MTM pharmacist, timely and complete information from skilled nursing facilities and timely and complete information from urgent care centers. HealthPartners has initiatives that address continuity and coordination of care with behavioral health providers and these interventions are detailed in a separate report (QI 4 Continuity and Coordination between Medical and Behavioral Healthcare). The results do not suggest opportunities to improve timely or complete communication between specific types of medical practitioners. However, as in past years, practitioners continue to note that "Lack of connectivity with other EMRs" is the biggest barrier to continuity and coordination of care. The second most frequently cited barrier is "Lack of designated staff to coordinate care". Additionally, we received reports from multiple care delivery systems that low staffing remains an issue to providing continuity and coordination.

Since the survey measures related to movement between practitioners met goal, we analyzed member complaints to our Member Services department to identify those related to continuity of care issues to see if this data revealed different patterns. This global analysis was inclusive of all HealthPartners products and membership including commercial and marketplace. In 2021 and 2022 the level of complaints regarding continuity and coordination of care indicated similar levels. The report findings were reviewed at the Quality Review Committee which monitors member complaints against network providers and the committee found the coordination of care trend unremarkable.

Case Review Category Trends over the past 5 quarters

Category Description	Q4 21	Q4 21	Q1 22	Q1 22	Q2 22	Q2 22	Q3 22	Q3 22	Q4 22	Q4 22
Access	92	0.06	104	0.06	102	0.06	107	0.06	82	0.05
Communication/Behavior	94	0.06	110	0.07	107	0.06	88	0.05	85	0.05
Coordination of Care	39	0.02	35	0.02	28	0.02	39	0.02	31	0.02
Facilities/Environment	12	0.01	11	0.01	10	0.01	8	0.00	14	0.01
Technical Competence/Appropriaten	149	0.09	158	0.09	186	0.11	152	0.09	138	0.08
TOTAL	**386**	**0.23**	**418**	0.25	**433**	0.26	**394**	0.23	**350**	0.21
MEMBER COUNT	1632287		1656795		1665865		1668410		1677981	

3. **Quality Complaints Profile: Q4 2021 versus Q4 2022**
   - Access complaint rate decreased – not statistically significant.
   - Communication complaint rate decreased - statistically significant.
   - Coordination of care complaint rate remained the same – not statistically significant.
   - Facility complaint rate remained the same – not statistically significant.
   - Technical competence complaint rate decreased – not statistically significant.

Previous Primary Care Clinic Nursing Supervisor at Stillwater Medical Group (part of HealthPartners' care group), Courtney McElfresh, indicated a shortage of staffing in care delivery systems for nurses and medical assistants is a big concern for continuity and coordination of care. Clinics and Hospitals are having a hard time finding staffing to fill their open positions. This affects their ability to provide appropriate continuity of care between care settings. Specifically, when a practitioner doesn't have enough nurses or medical assistants to assist with pre-visit planning. This directly effects continuity of care for the patient because they are unable to obtain medical records from an outside facility, reach out to the patient for unknown visits to other practitioners, or complete specialty referrals in a timely manner.

Courtney also noted an additional barrier to coordination of care for urgent care facilities is also due to staffing. If members are unable to get in to see their primary care practitioner, they will be more willing to seek out an urgent care facility. An urgent care will likely only focus on the member's current issue and not the patient as a whole. This creates delays in the member's coordination of care, especially if the urgent care is not in the same care system as the member's primary.

Based on the barrier analysis previously described, HealthPartners identified the following:

Barrier	Opportunity	Selected for Improvement?
Reporting from multiple care groups indicates that lack of available staff is a barrier to providing appropriate continuity and coordination of care.	There is an overwhelming need for additional staffing in all areas of healthcare, but especially effects coordination of care when staffing for nurses and medical assistants is low.	No
Lack of designated staff to coordinate care and lack of standard processes (e.g. defined roles, methods, etc.) to ensure smooth transitions.	ACO models of care improve continuity and coordination of care. Under an ACO model, the care system implements standardized processes and programs to support their patients.	Yes
Poor coordination between primary care, including providers that are not affiliated with the same ACO.	Focus on collaboration and improving coordination of care between primary care providers inside and outside the ACO with emphasis on SNF or urgent care facilities since these providers had the lowest scores in the continuity and coordination of care survey.	Yes
Lack of connectivity to other EMRs	This is the top barrier that provider cite to strong continuity and coordination of care.	Yes

Action (QI 3 A factor 6)

Date Initiated	Action Implemented	Barriers Addressed
2020	HealthPartners developed an online Patient Management Application to support clinicians in managing high risk patients. The tool identifies high risk patients that could benefit from HealthPartners's disease & Case management programs; pre-visit, planning and visit summary support. The tool also creates transparency by identifying the clinics and physicians that are treating the patients identified in the tool so that the clinic has visibility into the patient's overall care plan, can conduct proactive patient outreach and enhance patient care.	Some patients seek care between practitioners and across various health care settings. The Patient Management Application improves continuity and coordination of care in two ways: 1. By giving clinicians information about where their patient is seeking care, clinicians can develop strategies to better manage patient care. 2. The tool includes a function to refer the patient into HealthPartners Disease and Case Management programs. These programs support the clinician's plan of care by coordinating member care across settings including skilled nursing facilities. In 2020, gaps in care registries were built into the PMA tool. This will assist clinicians in providing the care their patients need by moving the registry tool from its current secure site on HealthPartners.com to the tool. This will consolidate necessary information to successfully manage patient care into one tool with one sign on.
2015 and ongoing	In 2022, HealthPartners recognized 60 organizations that have been certified by the Minnesota Department of Health as a Health Care Home (300 clinics in total) with financial grants to support health care homes. Grant dollars may be used for: • Care Coordinator salaries • Data Systems including EMR enhancements • Redesign and deploy care processes that are aligned with their patient populations	Grants help remove financial barriers to implementing systems, infrastructure and processes that improve continuity and coordination of care which streamline communications and standardize protocols and handoffs between providers to ensure that patients received needed care. Grants directly address provider concerns regarding lack of connectivity with other EMRs by

Date Initiated	Action Implemented	Barriers Addressed
	across the care delivery system	providing dollars that can be used for EMR enhancements. Additionally, HealthPartners participates actively in the Minnesota Electronic Health Records Consortium, which is a collaborative effort among Minnesota health systems and other organizations to leverage clinical data to assist in care coordination which helps practitioners in getting the information they need to provide patient care and addresses the barrier for lack of connectivity to EMRs and will improve coordination of care between settings.
2022	In 2022, the HealthPartners Institute partnered with the Minnesota Department of Health and Minnesota Community measurement to initiate a research project that compares the effectiveness of different models of care coordination. Current evidence about care coordination in primary care suggests it can be effective in improving the quality of care. The first phase of the study is to gather data from 23,000 care coordination patients receiving care coordination in 322 clinics across 42 health care system in Minnesota. In 2023 they will be analyzing the data and providing recommendations on how the findings can be practically implemented.	The research will assist HealthPartners in determining which models of care coordination are most effective. This directly speaks to the poor coordination between primary care barrier as many different providers were included in this study. Additionally, the analyzed data that comes out of the study will be helpful in providing practical ideas on how to improve coordination of care for our members.

We believe our previous intervention, developing the online Patient Management Application (PMA) tool to support clinicians in managing his risk patients has continued to help improve continuity and coordination of care. We also will continue to provide grants to help remove

financial barriers and assist providers with funding for EMR enhancements and connecting with the Minnesota Electronic Health Records Consortium.

Monitor 4: Timeliness of Postpartum Care

Methodology

Timely postpartum care is critical to supporting the health of both women and their infants. According to the American College of Gynecology, all women should have a comprehensive postpartum visit no later than 12 weeks after birth. The comprehensive postpartum visit should include a full assessment of physical, social, and psychological well-being, including the following domains: mood and emotional well-being; infant care and feeding; sexuality, contraception, and birth spacing; sleep and fatigue; physical recovery from birth; chronic disease management; and health maintenance. The comprehensive nature of this assessment supports continuity and coordination of care by ensuring that any issues concerning the women's health are identified and appropriate follow-up care is coordinated.

Nationally, there have been gaps identified based on race/ethnicity and the delivery of comprehensive, high quality, patient-centered pre- and postpartum pregnancy care. The US has some of the highest maternal and infant mortality rates among comparable developed countries.[1] Racial disparities exist.

- Black infants in America are now more than twice as likely to die as white infants.[9]
- Black women are three to four times as likely to die from pregnancy-related causes as their white counterparts regardless of education and income.[10]

HealthPartners collected data for the patients who receive care in our care delivery system and identified statistically significant disparities in post-partum visit rates within our commercial population between white women and black women born in the US and black women born outside the US. HealthPartners Board of Directors reviewed the analysis, agreed that it was relevant to the HealthPartners population and provided feedback in setting improvement goals. The Board set the goal of eliminating the disparity. The HEDIS/CMS Stars Steering Committee also reviews health plan performance and has set an overall goal for HEDIS performance to achieve top decile results (Band 1). Reducing the disparity in post-partum visit rates will improve continuity and coordination of care because the visit supports transition of the woman's care from obstetrics/gynecology or midwifery to primary care by identifying health concerns like post-partum depression that are commonly treated in a primary care setting or behavioral health.

[9] Infant Mortality | Maternal and Infant Health | Reproductive Health | CDC
[10] Infant Mortality | Maternal and Infant Health | Reproductive Health | CDC

Commercial Results

	2018 (hybrid rate; 2017 DOS)	2019 (hybrid rate; 2018 DOS)	2019 (admin rate; 2018 DOS)	2020 Old Methodology (admin rate; 2019 DOS)	2020 New Methodology (hybrid rate; 2019 DOS)	HEDIS MY 2020 (2020 DOS)	HEDIS MY 2021 (2021 DOS)
Indicator title	HEDIS Postpartum Care						
Numerator	352	180	4,097	3,523	411	381	116
Denominator	411	219	7,574	6,692	372	411	134
Rate	85.6%	82.2%	54.1%	52.6%	90.5%	92.7%	86.60%
Statistical Significance Test & Results	There were major changes in the measure specifications for HEDIS 2020. Therefore, we have displayed the administrative rate for HEDIS 2019 and HEDIS 2020 using the HEDIS 2019 specs. This allows trending and significance testing. The increase between the 2020 New Methodology and HEDIS MY 2020 is not significant. MY 2021 was significantly lower than MY 2020.						
Performance goal	Historic performance: Goal is Band 1 performance, 91.73% based on HEDIS 2019 hybrid results. Due to the pandemic, national benchmarks were not published for HEDIS 2020. We did not meet goal in 2019 or in 2020 assuming that 2019 benchmarks remained constant in 2020. HealthPartners performance declined, and we landed in Band 3 for MY 2021. For 2022, HealthPartners Goal is Band 1 performance.						

WI Exchange Results

	2018 (hybrid rate; 2017 DOS)	2019 (hybrid rate; 2018 DOS)	2019 (admin rate; 2018 DOS)	2020 Old Methodology (admin rate; 2019 DOS)	2020 New Methodology (hybrid rate; 2019 DOS)	HEDIS MY 2020 (2020 DOS)	HEDIS MY 2021 (2021 DOS)
Indicator title	HEDIS Postpartum Care						
Numerator	0	6	5	3	10	8	20
Denominator	2	8	8	9	11	9	20
Rate	0%	75%	63%	33%*	91%	88.9%*	86.60%
Statistical Significance Test & Results	There were changes in the measure specifications for HEDIS 2020. Therefore, we have displayed the administrative rate for HEDIS 2019 and HEDIS 2020 using the HEDIS 2019 specs. This allows trending and significance testing.						
Performance goal	Historic Performance: Goal is Band 1 performance, 91.73% based on HEDIS 2019 hybrid results. Due to the pandemic, national benchmarks were not published for HEDIS 2020. We did not meet goal in 2019 and just barely missed goal in 2020 assuming that 2019 benchmarks remained constant in 2020. This measure is very volatile due to low membership. Benchmarks are available for MY 2021, and HealthPartners performed at Band 1 albeit with low numbers. Our goal for 2022 is to stay at Band 1						

Quantitative Analysis

Since 2017, HealthPartners commercial postpartum care rates have fluctuated significantly, although part of this is due to changes in the specification. We have consistently performed at Band 2 until 2019 when we dropped to Band 3. MY 2020 was the first year we met goal for the commercial population, and we did not meet goal for the Marketplace population. This year we achieved Band 3 for the Commercial population. Wisconsin Exchange achieved in Band 1 although the denominator was very small. We also stratify this HEDIS measure to identify subpopulations where performance lags. Based on this analysis and the relevancy to our commercial and marketplace populations, the Board has chosen to make pre- and post-partum visits a key measure for our organization-wide Partners for Better Health 2025 initiative.

The most recent Partners for Better Health Postpartum Care rates continue to show a disparity between our white population and patients of color.

Postpartum care measure	White Population	Persons of Color	Disparity	Target/Goal
2020 DOS	75.56%	71.74%	-3.82	Close gap
2021 DOS	94.98%	84.27%	-10.71	Close gap
2022 DOS	94.5%	84.2%	-10.30	Close Gap

We have not yet met our goal of entirely closing the gap between persons of color and the white population. This data indicates we continue to have an opportunity to improve our performance on this measure.

Multiple areas across the HealthPartners organization have the opportunity to impact performance on this measure. This includes our Complex Care Advocacy (CCA) which offers a pregnancy condition management program and our Health Equity Sponsor Group which provides strategic oversight to our work to improve disparities in maternal child health. These areas analyze performance and identify opportunities to improve.

Our CCA area noted that women who participate in our Healthy Pregnancy condition management program and the digital myPregnancy program, have higher post- partum visit rates than women who do not participate. They identified an opportunity to support a larger population of women. Work to implement a digital condition management program began in 2019 and was fully implemented in 2021. The Board of Directors also supported work to implement best practice bundles of care that promote evidence-based care to all our members and patients regardless of color or income status.

Additionally, leaders in CCA noted some of the biggest challenges for new moms is knowledge and access about post-partum care, mothers tend to focus primarily on their baby and neglect their own care, they have limited time and resources to access said care, the appointment times available might not work with their schedule.

Barrier	Opportunity	Selected for Improvement in 2022?
Our Complex Care Advocacy (CCA) team identified knowledge and access to be the primary barrier for not receiving care. Specifically, members tend to focus on the baby and deprioritize their own care. Access to their care is also challenging as they may be unable to go to the available appointment times due to limited time and resources, or additional children.	The opportunity to provide education and care coordination for post-partum mothers is still significant.	Yes
There remains a large disparity gap between white women and women of color for post-partum visits.	Women who engage in our myPregnancy condition management program have higher post-partum visit rates. Data shows we have an opportunity to improve program participation rate among members of color. Connecting with women of color and encouraging post-partum visits in a culturally sensitive way.	Yes

Actions

The HealthPartners Board of Directors has approved multiple interventions designed to improve pre-and post-partum visit rates and reduce the disparity between white patients and patients of color. Per the ACOG guideline, the post-partum visit facilitates continuity and coordination of care because the visit enables early diagnosis of health concerns and referral to appropriate ongoing care in a primary or specialty care setting.

Date Initiated	Action Implemented	Barriers Addressed
2019	Implementing standard work protocols and safety bundles. Simplify scheduling for prenatal and postnatal visits. We added an option for online scheduling. Interventions began in 2018 and continued into 2019.	Standardized care and safety protocols reduce disparities by ensuring that all patients are treated using best practice, evidence-based guidelines. Simplifying scheduling by adding an online option helps reduce barriers to scheduling postpartum care.
2020	Pilot program designed to support women with low/moderate risk during their pregnancy and in the post-partum period.	Promote post-partum visits through an updated, digital pregnancy condition management platform designed to address the factors that have the largest impact on outcomes including post- partum care. High-risk members are eligible for an interactive program with a nurse who will assist with appointment scheduling. Nurses use culturally-relevant resources and referral to community resources to support women of color. Timely postpartum care is also reinforced in the myPregnancy emails and communications.
2021	Incorporate culturally relevant resources and education designed to reduce the disparity in post-partum visit rates between patients of color and the white population.	During 2022 we will enhance the program to offer culturally relevant resources to people of color. Content will be surfaced based on the member's race, language, and ethnicity.

Date Initiated	Action Implemented	Barriers Addressed
2022	Health Pregnancy program is a condition management support program that was enhanced in 2022. All CCA nurses completed call quality training to help engage further with enrolled members and assist with making post-partum appointments that work with the members availability or ensuring they connected with the clinic and made an appointment.	This directly addresses the barrier and improves continuity and coordination of care as it helps to ensure members are connected directly with the clinic and have access to make an appointment for their post-partum visit. By also engaging with members, nurses can provide knowledge and resources around post-partum care.
2022	To better support our diverse membership, we tailored the algorithms used to identify members for our Health Pregnancy program. Members also receive support from the same nurse throughout their pregnancy and post-partum period. In addition, we provided outreach to high risk Indigenous pregnant women. The outreach happened pre-natal, but once members were connected and engaged in the program it included post-partum support. Our My Pregnancy digital experience delivers online education and support via our authenticated website. It supplements the Health Pregnancy program but is also available to all members regardless of their participation in the more intensive Healthy Pregnancy Program. Resources are personalized based on member's race and ethnicity, preference identified in the assessment and their location in Minnesota. Examples include information about nutrition, breastfeeding, newborn care, mental	Both actions implemented directly address the barrier that persons of color have a higher participation rate when they engage in our programs: • By enhancing our identification algorithm in 2022, it increases the likelihood of identifying the highest risk women, better address health equity and support members continuity of care by the same nurse supporting them throughout their pregnancy to help improve coordination of care with their practitioner.

Date Initiated	Action Implemented	Barriers Addressed
	health and well-being, and pregnancy complications like preeclampsia and gestational diabetes.	
2022	HealthPartners filmed a video in 2022 highlighting the support Doulas provide such as one-on-one physical, emotional and informational support before, during, and after the baby is born. In 2023, we are planning to launch a communications campaign promoting Doulas with a blog page and social media advertising.	This action addresses three of our barriers: 1. Members focusing primarily on their baby because a Doula provides whole family support for the entire process from pregnancy through post-partum. 2. Access to care because Doulas provide post-partum support for both the baby and mom and typically visit in-home and will encourage members to get their post-partum clinic visit and provide education on the importance of a timely post-partum visit which also improves continuity and coordination of care.

As a follow up to last year's intervention to offer culturally relevant resources to people of color for the myPregnancy program. The data collected shows the program successfully engages members from diverse backgrounds. Overall, members spend an average of 31.27 minutes per visit to the site; specifically, 42.75 minutes spent by Indigenous and 34.49 minutes for Black members. We believe our efforts to provide culturally relevant materials is driving this engagement and will hopefully drive higher post-partum rates.

HealthPartners met goal for Marketplace but not for Commercial. While we slightly reduced the disparity gap the difference is not statistically significant and we did not fully eliminate the disparity gap. Providing targeted outreach to the indigenous populations and having culturally appropriate digital resources for all has helped bring awareness to our different populations about the importance of post-partum care and worked towards our goal.

Another way we have worked to eliminate the disparity gap is through our Doula video. Doulas provide one-on-one physical, emotional and informational support before, during, and after the baby is born. Studies have shown that women of color in the United States, particularly, Black women, have higher risk of pregnancy complications than White women. Women of color are also less likely to receive all of the care they need from their care team and working with a Doula during and after pregnancy can help offset these factors as Doula's will provide education

on the importance of timely post-partum clinic visits and encourage members to make their appointment. We will enhance this campaign further in 2023.

HealthPartners implemented and received NCQA Health Equity Accreditation in March of 2023. We are using the post-partum HEDIS measure as a way to continue assess the quality of our programs and has increased focus on this monitor and our goal to completely eliminate the gap between white and persons of color post-partum visit rate.

Reporting

This QI activity was reported to the following HealthPartners enterprise committees:

Committee Name	Meeting Date	Committee Actions or Recommendations
Quality Council	May 2020	Report reviewed and approved
Quality Committee of the HealthPartners Board of Directors	June 2020	Report reviewed and approved
Quality Council	June 2021	Report reviewed and approved
Quality Committee of the HealthPartners Board of Directors	June 2021	Report reviewed and approved
Quality Council	May 2022	Report reviewed and approved
Quality Committee of the HealthPartners Board of Directors	June 2022	Report reviewed and approved
Quality Council	May 2023	Report reviewed and approved
Quality Committee of the HealthPartners Board of Directors	June 2023	Report reviewed and approved

The Quality Improvement and Compliance Department would like to thank the following colleagues who supported study design and ongoing analysis for this report. Their contributions supported overall report development, analysis and actions:

Subject Matter Expert	Department/Role
Rene' Fisher	Sr. Manager Health Informatics
Rachel Woods	Health Informatics Consultant
Kara Mencel	Health Informatics Consultant
Jill Davis,	Director, Disease and Case Mgmt
Melinda Hurley	Sr. Director, Disease and Case Management
Patty Graham	Sr. Quality Consultant
Courtney McElfresh	Clinical Quality Consultant

Continuity and Coordination between Medical Care and Behavioral Healthcare

Analysis Dates: *2021*
Report Date: *November 2022*
Member Populations included in Report Data: *Commercial and Marketplace*
Accountable Owner: *Mary Holland, Behavioral Health*

Introduction
HealthPartners collaborates between medical care providers and behavioral healthcare practitioners to monitor and improve coordination between medical care and behavioral healthcare as co-management of overall health, particularly co-existing behavioral health and medical conditions, is integral to effective treatment delivery, and positive clinical outcomes for patients and health plan members.

Data Collection

1. Exchange of Information
HealthPartners surveys primary care and specialty providers, including psychiatrists, through the QI/UM Provider Survey to understand their experience with continuity and coordination of care, particularly the timeliness and completeness of patient communication between providers.

The 2021 QI/UM Provider Survey was mailed to 1106 providers and their office managers who requested authorizations in the last 15-months. The majority of the 492 primary care physicians, 500 specialists and 114 psychiatrists surveyed had two or more authorizations.

HealthPartners received a total of 77 completed surveys; 25 surveys were returned unanswered due to bad addresses. The adjusted response rate was 7%; noticeably lower than 2019's 11% response rate. The 2021 aggregate results have a margin of error of +/- 9 percentage points with a 90 percent confidence interval. Due to the COVID-19 pandemic, the survey was not conducted in 2020.

The survey's care coordination section was modified in 2018 to measure both timeliness and completeness of patient communication. While the nature of the content for both topics is like past surveys, trending for the care coordination measures prior to 2018 is not recommended due to different response sets.

Measure	Goal	2018	2019	2021
Timely Communication of Patient Care From:				
Behavioral health providers (% Excellent+ Average)	80%	77%	82%	85%
Primary care providers (% Excellent+ Average)	80%	89%	96%	97%
Complete Communication of Patient Care From:				
Behavioral health providers (% Excellent+ Average)	80%	85%	89%	92%
Primary care providers (% Excellent+ Average)	80%	91%	100%	98%

Conclusion:

- **Timely Communication:** Goal Met

  Both behavioral health and primary care providers exceeded the goal satisfaction rate of 80% at 85% and 97% respectively and both satisfaction rates for 2021 increased from previous years.

- **Complete Communication:** Goal Met

  Both behavioral health and primary care providers exceeded the goal satisfaction rate of 80% at 92% and 98% respectively. The 2021 rate for behavioral health providers increased from previous years and the rate for primary care providers increased from 2018 and only decreased slightly from 2019.

2. Diagnoses, Treatment, and Referral of Behavioral Disorders Commonly Seen in Primary Care

Attention Deficit/Hyperactivity Disorder (ADHD) is often treated with medication. While medication for ADHD is often prescribed by behavioral health providers, it is not uncommon for it to be prescribed by a primary care provider. HealthPartners data in 2020 revealed that primary care for ADHD medication management is utilized at higher rates than specialty care (i.e., care provided by a behavioral health provider), which is assumed to be due to the accessibility of primary care as compared to behavioral health care. In efforts to support primary care providers' oversight and management of ADHD in patients, HealthPartners educates and encourages patients/caregivers to attend recommended follow-up appointments with providers, as measured by the HEDIS rate *Follow-Up Care for Children Prescribed ADHD Medication (ADD).*

Table*: Commercial HEDIS results for ADD*
Conclusion*: Goal not met*

	GOAL	2021	2020	2019
Commercial Initiation Phase	**48.7%**	37.2%	40.7%	43.6%
Commercial Continuation Phase	**59.3%**	43.0%	45%	49.1%

Table*: Marketplace Follow-up Care for Children Prescribed ADHD*
Conclusion*: Goal met*

	GOAL	2021	2020	2019
Marketplace Initiation Phase	**48.7%**	1/3 (33.3%)	0/1 (0.00%)	1/1 (100%)
Marketplace Continuation Phase	**59.3%**	0/1 (0.00%)	0/0 (0.00%)	0/0 (0.00%)

Based on HEDIS ADD measure. Denominator too small to be statistically significant to provide a rate.

HealthPartners ADD rate for the initiation phase, which measures the percentage of members 6-12 years old newly prescribed ADHD medication who had a follow-up care visit within 30 days of when the medication was dispensed, was 37.2%, which was below the goal rate of 48.7%. Additionally, the HealthPartners rate for the continuation phase, which measures the percentage of members who had two additional visits within 270 days/9 months after the initial phase, was 43.0%, which was also below the goal rate of 59.3%. These rates have remained below goal for 3 consecutive years and, therefore, remain an opportunity for improvement.

3. Appropriate Use of Psychotropic Medications

Antidepressant medication, while widely prescribed and often effective at treating depression, can take time, up to several weeks, to relieve depressive symptoms. For these reasons, it's important that patients adhere to antidepressant medications as they are prescribed and that physicians follow prescribing guidelines and provide oversight to patients for possible non-adherence and/or side effects, particularly in physically-vulnerable or high risk patients (NCBI, 2011). To monitor such adherence, HealthPartners measures Antidepressant Medication Management (HEDIS AMM) for both the Commercial and WI Marketplace populations.

Table*: HEDIS Antidepressant Medication Management (AMM)*

Effective Acute Phase	Goal	2021	2020	2019
Commercial	85%	84.6%	81.7%	80.4%
WI Marketplace	85%	88.2%	84%	79.2%

Conclusions:

Commercial: Goal Not Met

AMM rates for Commercial members have remained below the goal rate of 85% in recent years but have been steadily improving from 80.4% in 2019 to 81.7% in 2020 to 84.6% in 2021. Despite these rates falling below the goal rate, they are trending positively.

WI Marketplace: Goal Met

AMM rates for WI Marketplace members exceeded the goal of 85% in 2021 at 88.2%. This is the first rate in the past several years that this rate has met the goal. It should be noted that denominators for Marketplace rates have consistently been 50 or less in 2019 and 2020. In 2021, the denominator was 68.

4. Management of Treatment Access & Follow-Up for Members with Co-Existing Medical and Behavioral Disorders

HealthPartners measures treatment access and follow-up for members who have chronic medical conditions and a co-existing diagnosis of depression to determine the effectiveness of treatment across medical and behavioral health care, as well as to inform methods of identification, outreach, and engagement in HealthPartners Case and Disease Management programs to better support members' needs around coordination of care. This is accomplished by identifying through claims data members with chronic conditions of CAD, Diabetes and/or CHF and, of those members, those with depression. These members are then further examined

to see how many of them had a visit with a behavioral health provider and how many engaged in case management.

Table*: 2021 Chronic Medical Conditions with Co-morbid Depression Analysis for Commercial and Marketplace*

Conclusion*: 12 of the 14 goals were met. Less than 25% of the people with CHF & CAD had a behavioral health visit.*

Chronic condition(s)	# of Members with Condition(s)	Number and % of Members with Depression & chronic condition	% with dep. and medical dx having BH visit*	Goal % having BH visit	% members in CM/DM programs	Goal % members in CM / DM programs
CAD	9,221	1,094 (11.9%)	24.9%	≥25%	64.2%	>30%
Diabetes	36,120	5,060 (14.0%)	29.8%	≥25%	69.6%	>30%
CHF	1,513	269 (17.8%)	23.8%	≥25%	56.1%	>30%
Diabetes, CAD	3,229	552 (17.1%)	25.9%	≥25%	77.5%	>50%
Diabetes, CHF	704	139 (19.7%)	33.1%	≥25%	69.1%	>50%
CAD, CHF	644	108 (16.6%)	32.4%	≥25%	68.5%	>50%
Diabetes, CAD, CHF	438	83 (18.9%)	27.7%	≥25%	73.5%	>70%

**BH visit defined as at least one claim paid to a behavioral health provider for a behavioral health condition.*

One note: The CM/DM programs that are included are: telephonic, self-directed, active behavioral health cases, Moving Forward, On Your Way, and Step-by-Step; we are working to increase engagement in all of these.

Table*: 2020 Chronic Medical Conditions with Co-morbid Depression Analysis for Commercial and Marketplace*

Conclusion*: 11 of the 14 goals were met. Less than 25% of the people with diabetes & , diabetes, CHF, & CAD had a behavioral health visit. Only members with diabetes, CAD % CHF did not meet the goal % of members in a CM/DM program.*

Chronic condition(s)	# of Members with Condition(s)	Number and % of Members with Depression & chronic condition	% with dep. and medical dx having BH visit*	Goal % having BH visit	% members in CM/DM programs	Goal % members in CM / DM programs
CAD	8,065	1,809 (22.4%)	28.10%	>25%	75.20%	>30%
Diabetes	34,365	9,137 (26.6%)	30.50%	>25%	79.60%	>30%
CHF	1,555	475 (30.5%)	25.50%	>25%	50.50%	>30%
Diabetes, CAD	2,766	854 (30.9%)	27.80%	>25%	79.30%	>50%
Diabetes, CHF	721	268 (37.2%)	22.80%	>25%	60.80%	>50%
CAD, CHF	506	169 (33.4%)	34.30%	>25%	68.00%	>50%

Diabetes, CAD, CHF	410	176 (42.9%)	23.30%	>25%	63.10%	>70%

**BH visit defined as at least one claim paid to a behavioral health provider for a behavioral health condition.*

One note: The CM/DM programs that are included are: telephonic, self-directed, active behavioral health cases, Moving Forward, On Your Way, and Step-by-Step; we are working to increase engagement in all of these.

Table*: 2019 Chronic Medical Conditions with Co-morbid Depression Analysis for Commercial and Marketplace*

Conclusion*: 10 of the 14 goals were met. Less than 25% of the people with CHF, diabetes and CHF, and CAD and CHF had a behavioral health visit. Only members with diabetes, CAD and CHF did not meet the goal % of members in a CM/DM program.*

Chronic condition(s)	# of Members with Condition(s)	Number / percentage of Members with Depression & chronic condition	% with dep. and medical dx having BH visit*	Goal % having BH visit	% members in CM/DM programs	Goal % members in CM / DM programs
CAD	11,855	2380 (20.1%)	27.86%	>25%	69.83%	>30%
Diabetes	39,080	9532 (24.4%)	27.77%	>25%	74.48%	>30%
CHF	1,595	475 (29.8%)	24.84%	>25%	49.89%	>30%
Diabetes, CAD	3,845	1072 (27.9%)	27.33%	>25%	73.69%	>50%
Diabetes, CHF	833	287 (34.5%)	21.95%	>25%	53.31%	>50%
CAD, CHF	559	169 (30.2%)	23.67%	>25%	71.01%	>50%
Diabetes, CAD, CHF	495	176 (35.6%)	27.84%	>25%	68.18%	>70%

**BH visit defined as at least one claim paid to a behavioral health provider for a behavioral health condition.*

One note: The CM/DM programs that are included are: telephonic, self-directed, active behavioral health cases, Moving Forward, On Your Way, and Step-by-Step; we are working to increase engagement in all of these.

5. Preventative Behavioral Healthcare Program Implementation

Suicide prediction models predicting when a person may attempt suicide have, for many years, been elusive. In efforts to address the gap of predicting suicide attempts and completions, HealthPartners participated in a large, multi-site study in 2015 to develop a prediction model using health records and claims data. Influenced by these research efforts, HealthPartners health plan and care delivery leaders collaborated throughout 2018 to develop and implement consistent practices around assessing patients' risk of suicide, and in early 2019, the Columbia Suicide severity risk scale was identified to be used across the health plan and care delivery settings. Additionally, in August 2019, a suicide prediction model was incorporated into the health plan's Behavioral Health Case Management protocols that identified members at risk for suicide who would be outreached to by case managers and screened for suicide using the Columbia risk scale. Outcomes of these screenings could then be shared with care delivery providers to determine appropriate care and resources to address members' needs and risk.

Table: *Completed Columbia Suicide screenings*

Conclusion: *Goal met*

	Goal	2021	2020	2019
% of identified members who had Columbia screenings completed	**40%**	46%	49%	35%

Upon implementation in 2019, the goal was set to engage and complete Columbia screenings with 40% of members identified by the prediction model and outreached by case management. Data of Columbia screening completion rates revealed that 35% of members identified as at-risk for suicide by the prediction model completed the screening with Behavioral Health Case Management staff between August-December 2019. That rate improved to 49% throughout 2020 and, although decreased slightly, remained above goal at 46% throughout 2021. Additionally, this data includes both Commercial and Marketplace members.

6. Special Needs of Members with Severe and Persistent Mental Illness

Severe and persistent mental illness can be treated throughout a variety of interventions, a prominent one being medication. To ensure medication is effective as possible at treating the condition or symptoms, it is vital for the individual prescribed the medication to be adherent to it and to follow the recommendations of the prescriber. There are many reasons individuals may not be adherent to their medications, such as side effects, difficulty remembering when and what medication to take, or financial challenges that make affording medication difficult, among others. Nonadherence to medication and related recommendations for any of these reasons can lead to poor health outcomes, increased emergency department visits, hospitalizations, suicide rates, and mortality. For these reasons, HealthPartners monitors members' adherence to medication and related recommendations, as indicated through the following data.

Commercial

Adherence to medication management recommendations is important for anyone diagnosed with mental illness who is prescribed medication as part of their treatment, including children and adolescents. Because mental illness, even severe mental illness, can start early in a person's life, it is not uncommon for adolescents and young adults to be prescribed antipsychotic medication to help manage their symptoms. Antipsychotic medication, though, can lead to various side effects such as rapid weight gain, induction of diabetes, and increased cholesterol making individuals who take antipsychotics more susceptible to metabolic syndrome. Because of this, HealthPartners works to help children and adolescents prescribed antipsychotics follow-up with healthcare providers to complete metabolic monitoring – blood glucose and cholesterol testing, as measured by the HEDIS rate APM.

Table: *Commercial HEDIS Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)*

	Goal	2021	2020	2019
% of Members who completed Metabolic Monitoring	60%	42.2%	35.5%	40.6%

Conclusion: Goal not met
Commercial *APM* rates have fluctuated throughout the past several years but did show an increase from 35.4% in 2020 to 42.2% in 2021. Rates in recent years have fallen below the goal of 60%, implying opportunities remain to further support members in completing metabolic monitoring.

WI Marketplace

Enrollment or coverage changes in this population can be common and can create benefit-related confusion, which can impact adherence to treatment recommendations, including medication. When this occurs, medication adherence can be reduced.

Table*: WI Marketplace Adherence to Prescribed Medication*

	Goal	2021	2020	2019
% of Members who completed Metabolic Monitoring	80%	0/0 (0.00%)	0/0 (0.00%)	1/1 (100%)

Based on HEDIS APM measure. Denominator too small to be statistically significant to provide a rate.

Conclusion: Goal met
WI Marketplace medication adherence rates for individuals with severe and/or persistent mental illness have been nonexistent throughout recent years as no members have met criteria for such measure.

Collaborative Activities

1. Collaboration with Behavioral Health Care Practitioners

The following workgroups are facilitated by HealthPartners Behavioral Health to provide forums for primary care providers, behavioral health care providers, and health plan personnel to analyze clinical data, detect trends and barriers, and identify opportunities for improved continuity of care.

- The **HEDIS Behavioral Health Committee** involves actively practicing primary care physicians, psychiatrists, and behavioral health therapists, along with the health plan Behavioral Health Disease and Case Management programs and Health Informatics. This group meets regularly throughout the year to review data, conduct barrier analyses, and create work plans.

- The **Member-Focused Behavioral Health Workgroup** involves behavioral health professionals from HealthPartners Case Management and Utilization Management, HealthPartners Contracting, HealthPartners Government Programs, HealthPartners care delivery, and clinical leaders from high-volume contracted behavioral health care systems. This groups meets, at least, quarterly to review quality and performance data and to identify opportunities for improvement around health plan initiatives, policies, procedures, and expectations of providers.

2. Quantitative and Causal Analysis of Data to Identify Improvement Opportunities
Quantitative analysis of the data in Element E, Factors 1-6 reveals unmet goals in the areas of diagnosis, treatment, and referral of behavioral disorders commonly seen in primary care; use of psychotropic medication; and special needs of members with severe and persistent mental illness as evidenced by Commercial HEDIS rates that fell below goal for the ADD, AMM, and APM measures.

Causal analysis revealed the following potential contributors to these unmet rates and opportunities for improvement:

- **Social Determinants of Health**
  Each of the measures – ADD, AMM, and APM – require patients to attend appointments and/or adhere to medication. While for some patients these tasks may be simple or even routine, they may be challenging for other patients due to factors such as time and cost. To attend appointments, patients may need to find time outside of work or school, may need to commute to the clinic or arrange for telehealth access, and may have resulting insurance costs. Similar factors apply to medication – patients may need to plan for trips to the pharmacy and may be faced with copays.

- **Communication of treatment expectations**
  Throughout analysis of the ADD HEDIS measure by the HEDIS Behavioral Health Committee, it was identified that patients/caregivers are not inherently familiar with the standards of care for ADHD regarding the recommended frequency of or timing for follow-up appointments. In addition to this, it was also identified that verbiage used by clinicians regarding when patients should plan to attend follow-up appointments may not be clear enough for patients to attend their appointment within the timeframe required by HEDIS. For instance, providers may be using verbiage such as “follow-up in one month,” whereas “within 3 weeks” or “by {date}” could give patients/caregivers a clearer indication of when they should plan to attend their next appointment by and could help them complete the appointment within recommended timeframes. Because of this, it is beneficial to clearly educate and remind patients/caregivers about the recommended timeframes for scheduling and attending follow-up appointments to support their adherence to them.

- **Access to Care**
  The HEDIS Behavioral Health Committee and the Member-Focused Behavioral Health Workgroup have anecdotally reported that behavioral health care providers have experienced higher utilization of care and lower no-show rates by patients, particularly with the implementation of telehealth, likely due to individuals are experiencing higher stress or exacerbation of mental health symptoms since the onset of COVID. This higher utilization has, in turn, reduced the availability of providers and appointments, challenging patients to attend follow-up appointments within preferred or recommended timeframes, potentially impacting not only HEDIS rates but, more importantly, patients’ receipt of medication and other necessary care for their condition. This decrease in the availability of care impacts the ADD, AMM, and APM measures. For ADD, the measure

requires patients to attend multiple appointments within designated timeframes, some that providers may or may not be able to accommodate depending on their availability. For AMM, patients may need appointments with their prescriber to follow-up on the medication and receive refills that would allow them to meet the measure. And for APM, patients need to complete lab work, care that is required in-person, eliminating the option for telehealth that may be more viable for certain patients.

3. Opportunity #1 for Improvement from Element A

One opportunity identified from the barriers impacting the ADD, AMM, and APM HEDIS measures is to help members address issues or impacts that stem from social determinants of health. By lessening barriers patients may face when seeking recommended care, they may be more inclined to complete appointments timely and better adhere to treatment. However, providers likely have increasingly limited capacity to focus on and support members with such needs that stretch beyond the members' presenting condition or treatment plan. With this, there's benefit in Behavioral Health Case Management being available for providers to refer patients to and for those case managers to collaborate with providers to help address patients' social determinant of health needs that may be contributing to and/or impacted by behavioral health conditions or affecting patients' adherence to treatment. For this to be effective, providers need to remain informed of the Behavioral Health Case Management program, particularly its criteria and referral process to refer patients with HealthPartners insurance and severe mental health needs could benefit from additional support. By reminding providers of the case management support available to members/patients through the health plan and the referral process, it is the hope that more providers will refer eligible members to case management to address, more holistically, the needs of the member.

4. Opportunity #2 for Improvement from Element A

Another opportunity identified from the barriers impacting ADD, AMM, and APM was for the health plan to support patients/caregivers in their understanding of treatment recommendations and requirements by providing them with clear information around appointments and medication that indicates specific, individualized information, such as dates they should attend follow-up appointments by or instructions on how to follow-up with their provider/clinic as needed. In addition to providing such information to patients, it's also beneficial for providers to have knowledge of the messaging their patients are receiving so they can reinforce it. To do this, there is opportunity for the health plan to send digital or mailed communications to members to provide them with education on their condition and/or medication, instructions for attending follow-up appointments, and reminders for refilling medication and to include their provider in the communication to share information among everyone involved.

5. Collaborative Action #1 to Address Opportunities from Element A

To increase providers' knowledge of Behavioral Health Case Management as a resource for patients with mental health conditions who may have corresponding needs around social determinants of health, particularly those members who could potentially meet requirements for ADD, AMM or APM, HealthPartners Behavioral Health Case Management leaders and staff presented on the Behavioral Health Case Management program to various primary care network providers and clinics. Throughout these presentations, providers were educated on and

reminded of the nature of the HealthPartners Behavioral Health Case Management Program, including efforts Behavioral Health Case Managers make to collaborate with and facilitate communication between behavioral health and primary care providers of members engaged in the program, and how providers can refer members for Behavioral Health Case Management.

6. Collaborative Action #2 to Address Opportunities from Element A

To support patients in understanding and remembering treatment recommendations and requirements, such as appointments and medication refills, that support HEDIS measures, HealthPartners sends patients with designated mental health conditions who are prescribed certain psychotropic medications appointment and refill reminders. Members who are newly prescribed ADHD medication (who may qualify for ADD), members who are prescribed antidepressant medication (who may qualify for AMM), and children/adolescents who are prescribed antipsychotic medications (who may qualify for APM) are identified for mailed or digital communications reminding them of recommended appointments and refills.

Measuring Effectiveness

1. Effectiveness of Improvement Action #1 from Element B

Through presentations on HealthPartners Behavioral Health Case Management program to primary care providers, it was desired for providers to have an improved understanding of how the Behavioral Health Case Management program benefits patients who are also members of HealthPartners who have severe mental health conditions and other needs, how Behavioral Health Case Management works in collaboration with providers, and how to refer members into the program. Review of the referrals of members, including Commercial and WI Marketplace members who may have been eligible to meet the ADD, AMM, and APM measures, from providers into Behavioral Health Case Management revealed the following number of referrals over the past three years:

Table: *Provider referrals to HealthPartners Behavioral Health Case Management*

2021	2020	2019
36	23	45

Conclusion:

Referrals from providers into Behavioral Health Case Management improved from 2020 to 2021, potentially in response to education and reminders on the Behavioral Health Case Management program presented to providers, however the number of these referrals remains less than 50 per year for Commercial and WI Marketplace members which may have potential to increase with ongoing communication and collaboration with care delivery partners.

2. Effectiveness of Improvement Action #2 from Element B

HealthPartners mailed newsletters, appointment reminders, and/or medication refill reminders to Commercial and WI Marketplace members who were newly prescribed ADHD medication (who qualified for ADD), members who were prescribed antidepressant medication (who qualified for AMM), and children/adolescents who were prescribed antipsychotic medications (who qualified

for APM). Despite these communications, rates of ADD, AMM, and APM continued to fall below goal throughout 2021.

As a result of these rates remaining below goal for several years now, the HEDIS Behavioral Health Committee and additional care delivery primary and specialty providers have collaborated and will continue to collaborate to review the letters for improvements around factors such as verbiage, clarity of information, timing, and how they're being provided to members (digitally vs. standard mail). While some changes in these ways have occurred, others are still being prioritized, leaving opportunity to evaluate the changes in relation to future HEDIS rates.

Experience

Service Initiatives

Accountable Owner

Member Services – Michelle Anderson
Riverview Member Services – Alison Renneke, Kate Sahnow
Market Insights – Kody Donahue

Member Populations Targeted

x	Commercial
x	Medicare Advantage/Cost/PDP
x	Medicaid
x	MSHO
x	HPUPH
x	WI Marketplace

Description

HealthPartners deploys multiple initiatives designed to improve member satisfaction with the plan and deliver an exceptional experience that customers want and deserve at an affordable cost. Every year a subset of the service quality council uses identified key drivers to develop the annual plan.

Goal

The HealthPartners 2022 Experience Annual Plan focused on the following experience objectives:

- Coverage
- Cost
- Help
- Value

The overall objective of member service initiatives is to increase member engagement and satisfaction with the plan. We identify the key drivers, monitor, and evaluate our success through survey results (CAHPS, JD Power member survey and our member experience survey) and various member feedback methods (complaint reports, feedback from HealthPartners member/patient council and employers and myVoice surveys, HealthPartners online panel of members and patients).

Initiatives/Interventions

Coverage:

1. Provided a personalized web and mobile experience that is relevant and timely.

2. Enhanced My Pregnancy journey information to include information on benefits, planning for delivery, finding a pediatrician and other pertinent topics.
3. Onboarding campaigns expanded to Medicare and Medicaid members, as well as select plan members.
4. Completed discovery and early build for personalized My Dashboard for the authenticated experience, which will launch in 2023.
5. Added myStrength digital resilience solutions to all member plans.
6. Added Omada diabetes prevention and condition management programs.
7. To support members during COVID-19, continued refill too soon edit and increased the transition of care for Medicare from a 30-day to a 90-day supply.
8. Implemented automatic prescription prior authorization extensions for members with Medicare Advantage plans on 1/1/2022 and continued extensions for commercial members.
9. Implemented option for Part D members to request automatic refills for Part D medications ordered via WellDyne on September 1, 2022.
10. During the COVID-19 Public Health Emergency (PHE), we covered member hospitalizations at in-network benefit levels at out-of-network hospitals when diverted due to lack of availability.
11. Added a travel network to our employer group select ACO product for members needing to access care outside of the service area.
12. Increased Choice Card benefit for select Medicare plans services beyond what Medicare allows (chiropractic, eyewear, over-the-counter pharmacy items)
13. Offered NationsOTC over-the-counter benefit for select Medicare plans - either as a standalone benefit or as part of a Choice Card

Cost:

1. Created a financial hub that streamlines and brings better visibility to our cost tools for our members.
2. Launched Phase 2 of the transparency in coverage regulation, providing member plan and provider-specific out of pocket cost estimates for 500 services and procedures.
3. Promoted use of medical and pharmacy cost estimator tools to members through all member mailer
4. Implemented get connected campaigns for four commercial groups to encourage members to create an online account and go paperless.

5. Implemented quarterly get connected campaigns for Medicaid members without web accounts, using department of human services enrollment file, to create online account and go paperless.

6. Added go paperless soft alert in Living Well experience to encourage members logging in via Living Well to change their settings to paperless.

7. Specialty coupon optimizer program (Variable Copay) continues and expanded to include additional specialty medications.

8. Implemented a soft-steerage campaign related to place of service, moving members from high-cost infusion clinics to home infusion.

9. Implemented a soft-steerage campaign related to providers, moving members from higher cost to lower cost home infusion providers.

10. Expanded our medical injectable site of care program to include some oncology drugs.

11. Implemented dynamic refill too soon pharmacy processing. Refill too soon limitations are intended to limit stockpiling and waste. The intent is to ensure members are taking medications correctly and as intended by their prescribing physician. The refill too soon edits in our system control excess fills by members who continuously refill medications early. The system calculates at the member and medication level based on the member's history of accumulation for each medication. The pharmacy sees a point-of-sale (POS) message when a claim rejects for refill too soon. The message includes the date the medication can be refilled, which is based on the member's fill history.

12. Riverview implemented a process to avoid unnecessary Medicaid appeals when providers mistakenly bill members provider write-off amounts, providing members a better experience while reducing time-consuming appeals work for staff. These cases now appear in data as oral complaints instead of appeals. Provider billing complaints from Medicaid members in the first half of 2022 more than doubled from the same period in 2021.

13. Implemented enhanced oncology utilization management through a vendor partner, OncoHealth, improving affordability of oncology medications by ensuring appropriate utilization through expert oncologist prior authorization reviews.

Help:

1. Updated our Plan Directory to add ability to search for nursing facilities and surgical centers (instead of just filters), filters for race/ethnicity for doctors, information on language services and added in-network/cost level status plus link to benefits in results list.

2. Implemented mental health hub to promote our mental health resources and help members understand the resources available.

3. Added public facing page with information on how to submit claims.

4. Updated navigation and a new landing page to assist members in how to find different types of care.

5. Updated navigation and a new pharmacy landing page that explains what pharmacy features are available.

6. Added personalized resources within My Pregnancy experience based on member's race, ethnicity, language and/or insurance product.

7. Continued implementing new member engagement touch points: onboarding, personalized outreach, health and well-being engagement, blog, and digital content.

8. Continued improvement efforts with our mail order vendor including implementation of an auto-refill program for our Medicare Advantage members.

9. Implemented the Harper – Digital Chat Assistant experience when members initiate a chat with member services. This chat feature is available 24/7 to members when they are logged into their myHealthPartners account. Harper attempts to assist with various simple and complex questions depending on what the member sends as their chat message.

10. Phone line changes: improved access to specialized representatives who can assist members with premium questions.

11. Overall web experience improvements

12. Preventive coverage blogs/public site messaging improvements

13. Provider portal enhancements regarding dental coverage and provider appeals information.

14. Created online submission process for over the counter COVID-19 tests

15. WellDyne normally requires a credit card number even if there is no cost for the purchase. This is a barrier for some members, so we've asked them to turn off this requirement for MSHO members.

16. MNsure Pay Now service implemented - Pay Now redirects enrollees from MNsure to the health plan to immediately make their initial premium payment after enrolling. This involves less work tracking, canceling and reinstating coverage if the first premium payment is not made in time, and provides an improved applicant experience.

Value:

1. Created online COVID test reimbursement form for eligible members and regularly updated public facing web information with most current details on testing, vaccines, therapeutics, coverage and more.

2. Added information about Careline+ for members that have this benefit explaining what is available through this program.

3. Launched new personalized campaigns connecting members to NowPow and other social drivers of health resources for those who indicated a need via the health assessment.

4. Launched pilot with N1 targeting SNBC members to encourage them to complete a health risk assessment and enroll in care coordination, which increased rates of both.

5. To reduce administrative burden, over 6,000 prescription prior authorizations were grandfathered to allow continued fills.

6. Implemented an automated pharmacy prior authorization process, reducing processing time from 10-20 minutes to less than 20 seconds per case. This auto approval process currently accounts for about 5-10% of the prior authorization volume. Within the next year, roughly 50 additional drugs will be added to this initiative.

7. Created redirect from MNSure site to healthpartners.com that allows members to make first premium payment at time of enrollment with MNSure.

8. HealthPartners is the only full Medicare Advantage plan in Minnesota to earn a 5-star ranking from CMS this year.

9. Beginning in 2022, we used an external vendor (Bolger) to coordinate the order and issuance process for MSHO supplemental benefit items. Members received an order form early in 2022 that included the member's name and ID number. This process eliminated the need for members to call member services to order.

Barrier Analysis

Our causal analysis of barriers to improving member satisfaction and member experience shows the barriers remain relatively stable from one year to the next. Key barriers in 2022 were:

1. **COVID implications:** 2022 saw continued need for COVID vaccines, testing and treatment as waves of the virus came and went impacting availability of clinic and hospital resources.

2. **Staffing shortages:** The healthcare industry continued to be plagued by staffing shortages that began with the pandemic.

3. **Access to care:** The lingering impact of the COVID pandemic along with staffing shortages and clinic availability continued to impact consumers ability to receive primary and specialty care services as soon as needed.

4. **Cost**: Consumers continue to desire better access and more transparency when it comes to health care cost information, especially out-of-pocket costs before receiving care. This barrier is greatest for commercial members, especially those on high deductible plans, however Medicare and Medicaid members are also impacted.

5. **Member knowledge:** The complexity around healthcare and coverage is a barrier to member satisfaction. Members from all products desire information and tools to help them more fully understand their benefits, coverage, and in-network provider options. Members who do not fully understand their benefits and coverage often have trouble seeing the value of their plan.

Results and Outcomes

After two years of modified survey protocols and reporting due to the COVID-19 pandemic, CAHPS, JD Power and HealthPartners' own member experience survey were back to the standard administration schedules, protocols, and reporting.

For overall member satisfaction, HealthPartners had the highest member satisfaction among commercial health plans in MN and WI, outscoring other plans in our region for the CAHPS Health Plan Rating for the 15th year in a row. HealthPartners also continues to surpass the national average for customer service.

2022 showed incremental improvement across many measures in our member experience surveys that had experienced declines in the previous year. This includes improvement for key metrics like net promoter score where both commercial and Medicare Advantage surpassed their 2022 goals. This steady incremental improvement is attributed to an organization-wide focus on experience and service.

The areas of greatest opportunity based on key driver analysis across measurement tools continue to be access to out-of-pocket cost information before receiving care or filling a prescription and understanding your health plan and how to use it.

Access to cost information continues to be a priority for members and an area of focus internally. While progress was made with the healthpartners.com cost hub, phase 2 of the transparency in coverage regulation and member communications around cost to build awareness, we will continue to refine and evolve the cost information available to members while monitoring key metrics through JD Power and our member experience survey to evaluate our progress.

In order for members to see value in their health plan and feel they have coverage when they need it, they need to have a fuller understanding of their plan. Understanding how your plan works and how to use it are continual areas for improvement. We remain focused on providing members timely, relevant, personalized information via our member communications. These communications target key points in the member journey (i.e., onboarding, preventive care milestones, etc.) as well as create awareness for new services or resources that are available to members. Results from those campaigns in the past year continue to show promise:

- Engagement across member email communications was strong and increased from 2021. In 2022, we sent 3.8 million email outreaches and had a 55% open rate and 7% click through rate. Both are well above the industry average (22% open, 2-3% click through). Additionally, those who engaged with our outreach took the recommended action 25% more often than those who didn't open or click through the communication.

- New and enhanced targeted communications were launched to:
    - Remind members and patients to get important preventive care, such as mammograms and colorectal cancer screenings.
    - Encourage members to use valuable health plan programs and tools when needed, including their employee assistance plan, Iris digital cancer management program, and our cost transparency tools when they need care.
    - Support members in getting information about community and state services related to housing and food instability, transportation access, and other social drivers of health.
    - Educate and guide parents of young members and parents about COVID-19 vaccines and booster doses, important follow up after ADHD prescriptions, and well child and teen checkups.

MSHO supplemental benefits are provided free of charge to members to support good health and safety outside of their standard benefit set. Examples of 2023 MSHO supplemental benefits include:

1. Health and wellbeing benefits: coverage of one activity tracker per member per year (Electronic device to track steps and calculate calories burned), a Pedaler, access to the SilverSneakers Program and Weight Management Program

2. Dental: additional exam, fluoride, molar root canals & crowns up to $2,500, and a electric toothbrush.

3. Animatronic Support Pet – coverage of one animatronic support pet per member per year. Life-like pet provides companionship, reduces isolation, and can improve wellbeing and emotional function.

4. Family Caregiver Services – services provided to caregivers includes training, education, coaching, counseling, psychotherapy for caregivers, and family memory care (FMC) program for caregivers living with the member. FMC improves the caregiver's ability to manage the challenges of caregiving and provide social support.

5. Nutritional Services: home delivery meals immediately following surgery, or an inpatient hospital stay, fresh produce box through FarmboxRx, and PowerUp cooking classes.

6. In-home Bathroom Safety – up to $1000 coverage for assessment, devices and installation of permanent devices based on individual need.

7. Independent Living Skills – services to develop, maintain and improve a member's community living skills including communication, mobility, interpersonal skills, and self-care to keep the member living independently longer and in a safer environment.

8. Personal Emergency Response System – coverage for one in-home device used to notify appropriate personnel of an emergency and/or monthly device maintenance fee if the member received a device in a previous year.

9. Respite Care – short-term services to members with dementia when the primary care giver is absent or needs relief.

10. Virtuwell – unlimited virtual care visits through virtuwell.

Overall, CAHPS performance for state public programs is consistent with state averages. This includes Families & Children (F&C-MA), MNCare, MSC+ and SNBC. There were only two statistically significant differences compared to the state averages.

- The score for F&C-MA, Getting Care Quickly is significantly lower than the state average.
- The score for MNCare, Getting Needed Care is significantly lower than the state average.

Year-over-year comparison of scores show the following directional changes (change of +/- 5% or more) across plans:

- F&C-MA – declines in the rating of specialists seen most often, rating of the health plan and getting care quickly.
- MNCare – declines in the rating of all health care, getting needed care, getting care quickly, and coordination of care.
- MSC+ - increase in coordination of care and a decline in the rating of all health care.
- SNBC – declines in rating of all health care, getting needed care, getting care quickly, and coordination of care.

Complaints, Grievances and Appeals

Accountable Owner

Member Services – Michelle Anderson
Riverview Member Services – Kate Sahnow

Member Populations Targeted

x	Commercial
x	Medicare Advantage/Cost/PDP
x	Medicaid
x	MSHO
x	HPUPH
x	WI Marketplace

Description

Member Services works with members to answer their inquiries and resolve their complaints, grievances, and appeals. All member contacts are documented in our customer service system. From here, reports are created for the organization to identify opportunities and make improvements.

Individual departments receive system-generated reports with complaint detail pertaining to their areas on a daily, weekly, monthly, and quarterly basis. The data is reviewed for trends, follow-up, and service recovery opportunities. Year-end report summaries with trends and analysis are presented to the Health Plan Service Quality Council and the Experience Council. The data is used by these groups in the development of their annual plans. The following data is used to create specific member experience improvement initiatives and analysis. Results here are also used with other information in creation of the *Service Initiatives* report.

Results and Outcomes

Commercial Complaint and Appeal Results

	Calls Answered	per 1,000	Verbal Complaints	per 1,000	1st Level Appeals	per 1,000
2020	802,647	1,002	46,044	57.5	3,612	4.12
2021	720,982	621	39,748	34.2	4,150	5.46
2022*	738,909	641	37,436	32.4	4,233	5.71

***Note: Effective 1/1/2022, this now includes Behavioral Health Navigator and Nurse Navigator data.*

Trends and Analysis of Commercial Complaint and Appeal Data

1. Calls answered reflect an increase because as of 1/1/2022, data for Behavioral Health Navigator and Nurse Navigator calls is being included. The Commercial member complaints received per thousand decreased from 2021. Appeals received and appeals per thousand members saw just a slight increase from 2021.

2. The percent of first level appeals that become second level appeal requests increased from 9.7% in 2021 to 11.8% in 2022.

3. Non-clinical appeals increased in 2022 by 9%, due to an increase in network-related requests for members on a large employer group's focused network plan.

4. The volume of clinical appeal requests held steady, including for procedures and investigational services.

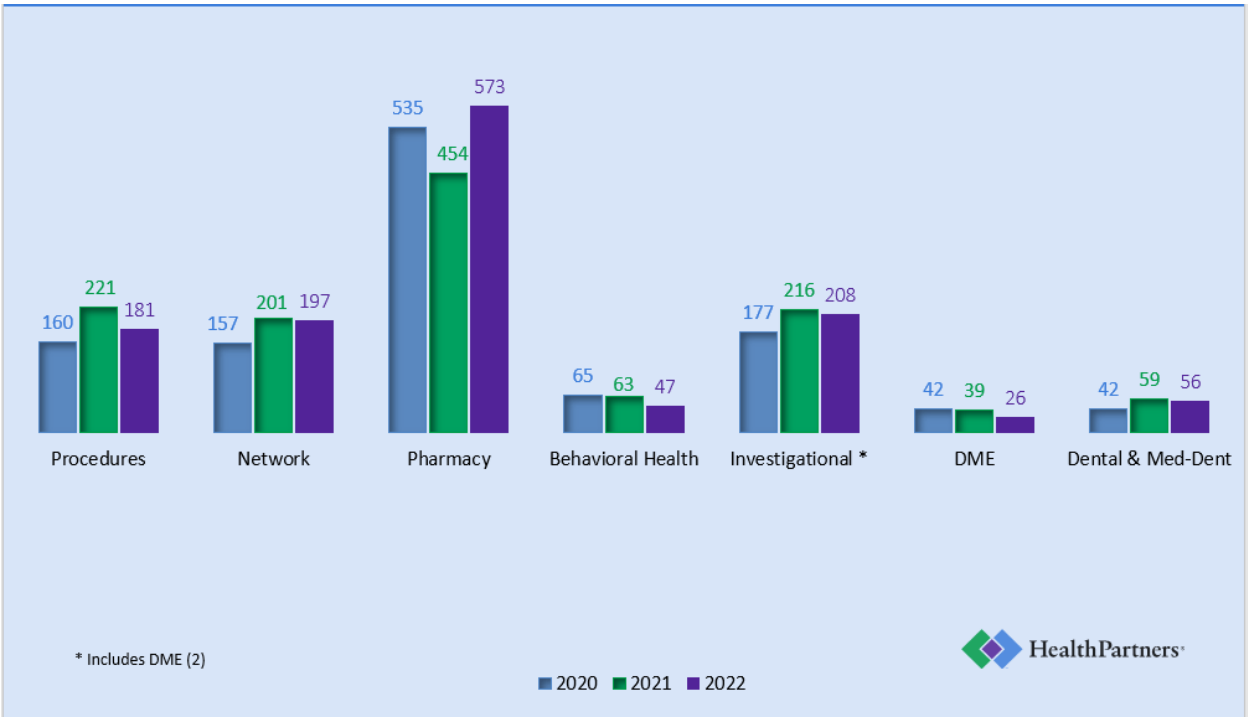
5. Pharmacy remained the highest volume of clinical appeals. More pharmacy requests are being resolved via the reconsideration process and don't require the full appeal process.
    a. Biologics for auto-immune disorders are 40% of Pharmacy appeals.
    b. 28% of Pharmacy appeals are expedited or 3-day.
    c. 60% of all expedited appeals are for clinical Pharmacy.

6. Ongoing appeal trends:
    a. The volume of appeals for behavioral health care remains very low.
    b. Genetic testing and pharmacogenetic testing appeals holding steady as a percent of all investigational appeals.
    c. More third-party appeals (drug manufacturers, specialty labs).
    d. Assumptions about what is covered as preventive.
    e. Cost and quality of care.

7. New appeal trends:
    a. Network-related appeals from members on our largest commercial employer group. We continue to work closely with the employer and have enhanced our communication to these members to help them stay within their plan network.
    b. More appeals for specialty medications, weight loss and migraine drugs. We continue to help members and providers know which medications are covered, and review requests for formulary exceptions.

Non-Clinical Appeals (N=1,296) No Medical Decision Required

Clinical Appeals (N=1,288) Medical Judgment Required



- Verbal complaint trends are similar to the above appeals trends with the addition of:
    - Network wrong clinic usage complaints were the highest complaint for 2022. With the trend of smaller narrow networks continuing, members struggle to understand how to use their network. The member education on these network changes varies by employer so some members understand the change while others do not and may use a clinic not in their plan network. The decision to remove our ability to make customer service adjustments by one of our largest plan sponsors when their members used a wrong clinic also contributed to a higher volume of complaints.

    - Other insurance information moved from the top complaint in 2021 to #2 in 2022. In September 2022, a new COB member campaign was launched, and after a few months of running the campaign, we are seeing results of a 26% increase in COB responses from September to December 2022 compared to the same period of 2021 (with comparable COB-eligible claims). Additional segments have been identified to potentially expand the reach of the COB campaign, so we are hopeful that as 2023 unfolds, we will see the complaint rate for this topic continue to decline.

    - Benefit complaints related to preventive and non-preventive services as well as copay/coinsurance disputes remain in our top five complaints. Members struggle to understand the difference between these services, and the movement to have our coverage more aligned with ACA has also brought member dissatisfaction. We continue to enhance our talking points for educating members related to preventive services definitions, guidelines, and recommendations. Blog posts on preventive coverage and cancer screenings launched in early February 2023, with planned links to this information as appropriate when the new My Dashboard launches on the www.healthpartners.com authenticated member website. This will also be the focus topic for the Winter 2023 all member mailer to be sent in April 2023.

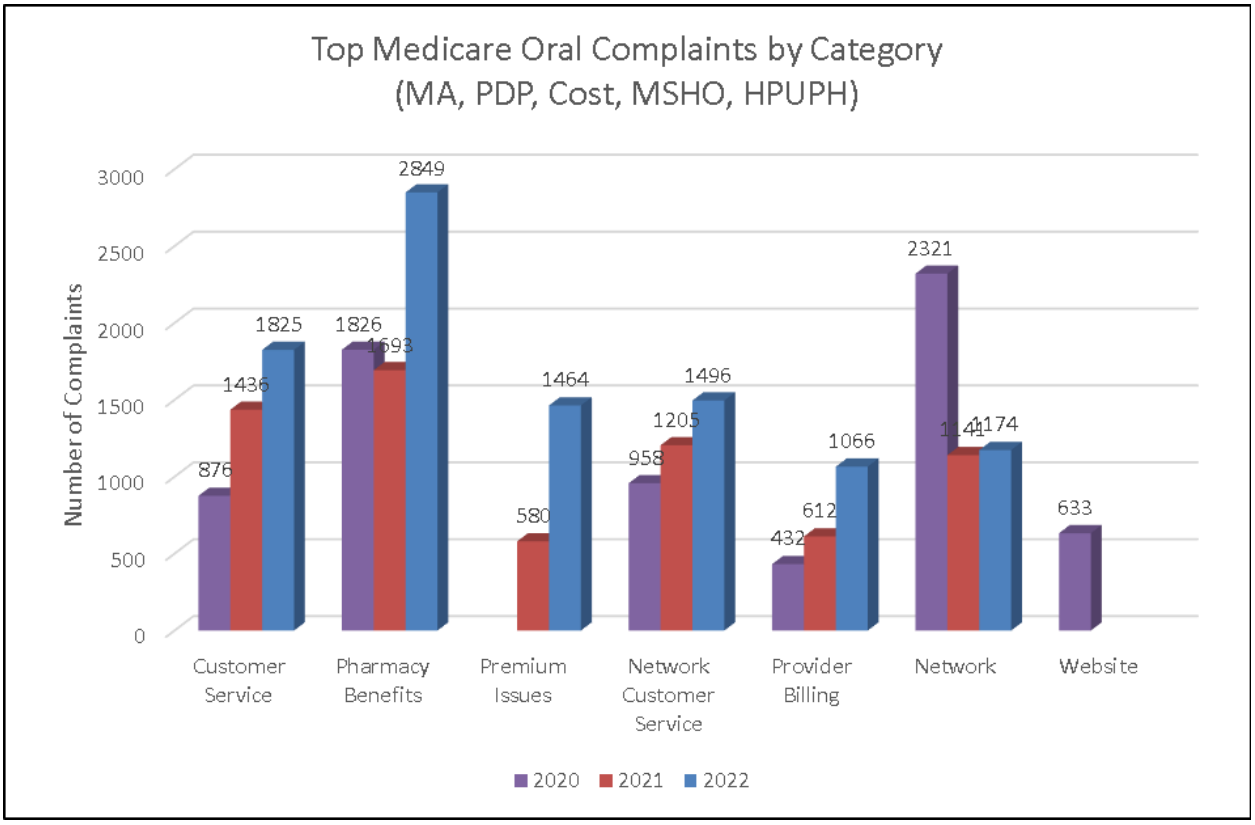
    - CDHP: Members' main frustration continued in 2022 to be FSA substantiation requests, and use of debit card in 2022 for 2021 expenses. Members are surprised we require substantiation/enforce deadlines after letting them use the debit card for an ineligible expense. We continue to look for ways to educate members. Substantiation request letters are sent when a debit card transaction needs to be verified as eligible. The first request is sent shortly after the transaction, with follow up 30 days later indicating that after an additional 30 days with no response, the card would be suspended. Additionally, a Year End statement is sent around October to let account holders know of the current election, balance, remaining amount in the account, as well as any grace period and/or runout date that applies.

Medicare, Medicaid, and WI Marketplace Complaint and Appeal Results

	Calls Answered	per 1,000	Oral Complaints	per 1,000	1st Level Appeal and Written Grievances	per 1,000
2020	242,233	1,103	16,612	80.5	1,273	6.2
2021	251,201	1,002	16,918	67.5	1,683	6.7
2022	281,641	996	23,418	82.8	1,813	6.4

Trends and Analysis of Government Plans Complaint and Appeal Data:

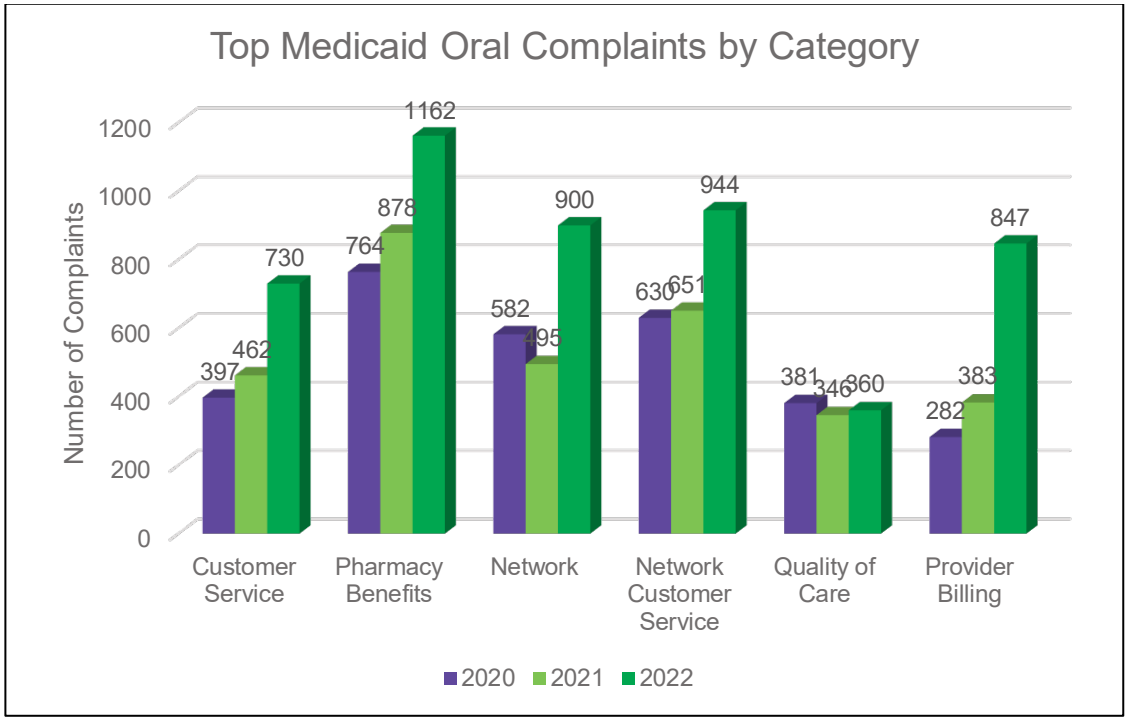
- Number of calls answered was higher than in 2021, and members expressed dissatisfaction verbally in 2022 at higher rates per 1,000 members.
    - Although the oral complaint rate increased, the rate of written appeals and grievances decreased in 2022. This indicates members were satisfied enough with oral resolutions to not pursue the issue further into an appeal or written grievance.



Trends in 2022 Medicare oral complaints:

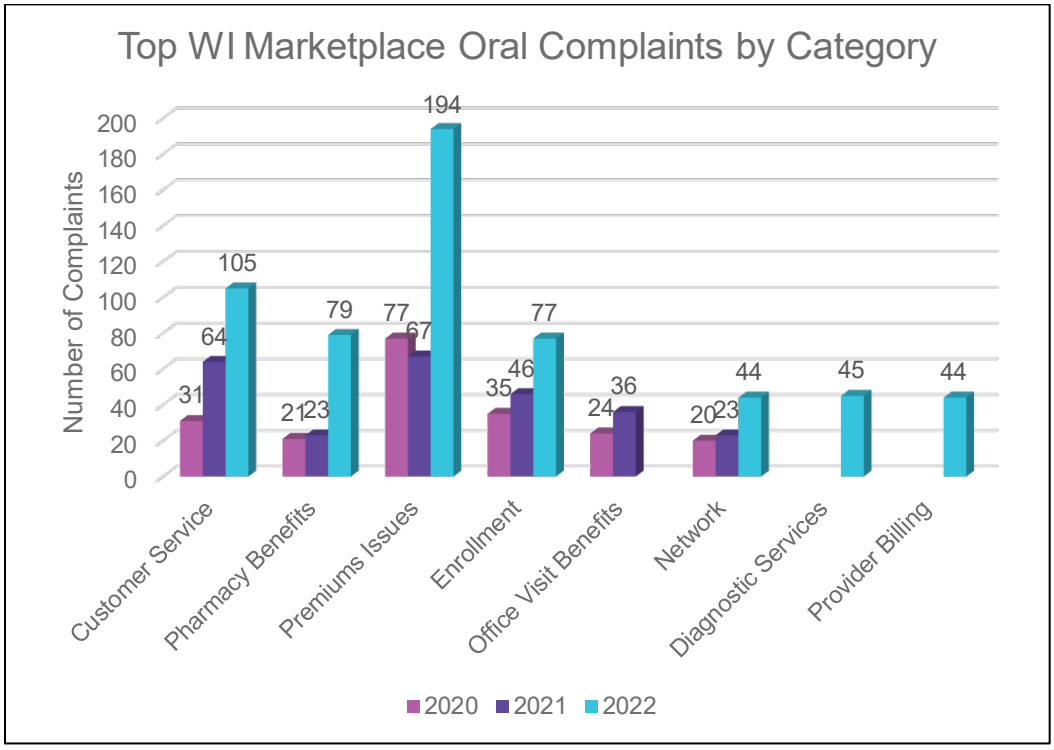
- Total grievances increased from 2021 to 2022 in all 6 top categories. The three largest increases were: Pharmacy Benefits, Premium Issues, and Provider Billing.
    - Pharmacy complaints continued to include dissatisfaction about plan cost sharing, Part D vaccine coverage, and WellDyne. In fall of 2022, WellDyne experienced delays and long hold times due to Hurricane Ian. WellDyne also experienced a cyber security event in May of 2022. Letters were mailed to members on June 20, 2022. In addition to recurring themes, we received increased complaints regarding Over-the-Counter pharmacy coverage, including our NationsOTC vendor.
    - Premium complaints related to incidents throughout the year. Members reported receiving Social Security Withhold letters in error, affecting 444 members. We transitioned to a different bank and banking platform which impacted our telephonic bill pay system as well as caused premium processing delays, and a courier issue resulted in late delivery of paper premium statements in August 2022.
    - Provider Billing complaints include situations such as providers asking members to submit their own claims to insurance, members receiving a bill for non-covered services, or providers billing members for the provider write-off amount in error.

- Total grievances decreased in some lower volume categories such as website, office visit benefits, and quality of care.
    - The total number of Website complaints from Medicare members in 2022 was 498; down from 560 in 2021 and 633 in 2020. Website related grievances remain out of the top six complaint categories.



Trends in 2022 Medicaid complaints:

- Total grievances increased from 2021 to 2022 in all six top categories. The three largest increases were: provider billing, network, and network customer service.
    - Provider billing complaints include situations such as members receiving a bill for non-covered services, or providers billing members for the provider write-off amount in error. This category also includes situations where an unnecessary appeal was prevented.
        - Riverview Member Services implemented a process to avoid unnecessary Medicaid appeals when providers mistakenly bill members provider write-off amounts, providing members a better experience while reducing time-consuming appeals work for staff. These cases now appear in data as oral complaints instead of appeals – Provider Billing complaints from Medicaid members in the first half of 2022 more than doubled from the same period in 2021. This shows the new process is working as designed.
    - The increase in Network Customer Service (provider) complaints may be related to continued staffing and access related pressures faced by providers throughout 2022.



Trends in 2022 Wisconsin Marketplace complaints:

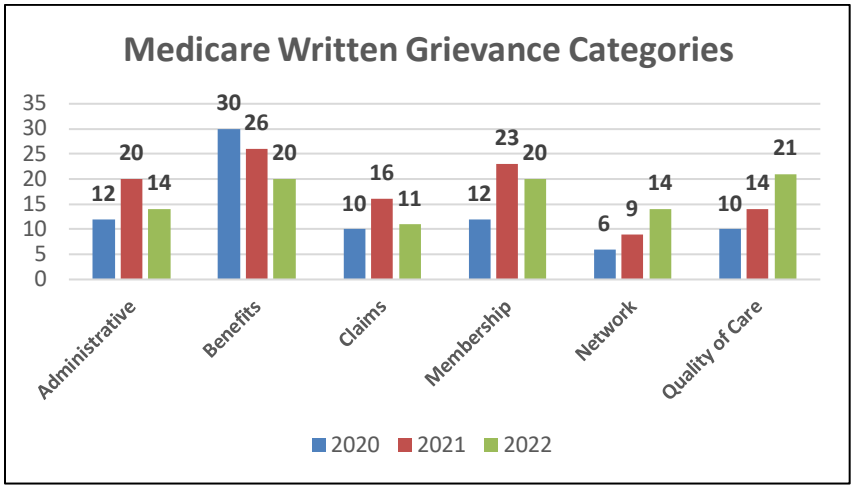
- Total grievances increased from 2021 to 2022 in all six top categories. The two largest increases were premiums issues and pharmacy benefits.

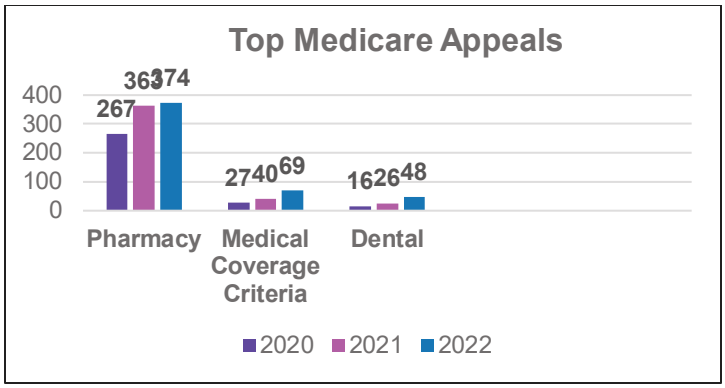
- Premium-related complaints included notable dissatisfaction about our transition to a new bank to manage plan premium payments. New bank implementation impacted elockbox payments, P.O. box changes, IVR phone systems, and couriers. In addition to transitioning to a new bank, a paper premium invoice delay occurred in 2022 due to a third-party vendor issue. Both events drove increased premium-related complaints in 2022.
- Pharmacy benefit complaints included dissatisfaction about cost-sharing, prior authorization requirements/process, and formulary options. As drug costs rise nationwide, members with deductibles and cost sharing may not understand what the experience will be until they have claims and may struggle to afford high-cost medications.

- A continued theme for WI Marketplace members' complaints is related to scenarios where HealthPartners does not manage the issue. In these cases (enrollments, disenrollments, demographic changes and tax credit determinations) we must divert the member to the Federally Facilitated Exchange for resolution. Members are dissatisfied when HealthPartners cannot resolve their complaint directly.
  - Implementation of the W3LL platform may encourage reduction of complaints for these reasons in 2023.

Top Medicare Written Grievance and Appeals by Category

***Data includes Cost, MSHO, MA, PDP, HPUPH**





Medicare Trends

1. In 2022, 65% of Medicare appeals had a resolution time frame of 14 calendar days or less. These include Part D appeals and expedited requests.

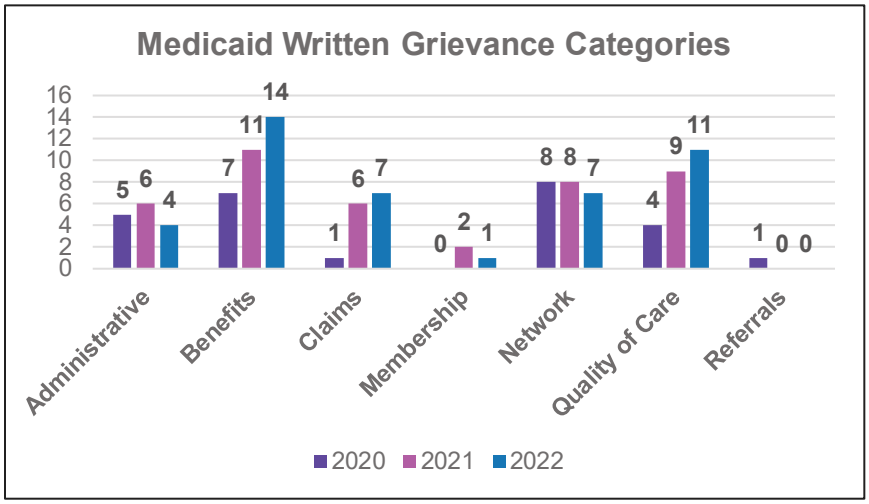
2. Pharmacy appeals continue to be our largest category of appeals. 62% of all Medicare appeals were related to drug requests.
    a. 30% of Part D appeals were approved. The most common approval reason is that information provided during the appeal demonstrates the member now meets criteria.
    b. 22% of the Part D requests were for CMS excluded drugs. Excluded drugs are classes of drugs not covered by Part D and are therefore ineligible for coverage.
    c. We had 12 requests for Part B drugs. We approved 7, in most cases we received additional information that the member now met criteria.
    d. We had 88 requests for tiering exceptions. These requests can only be approved if there is no other brand drug on a lower cost-sharing tier approved for treating the same condition.

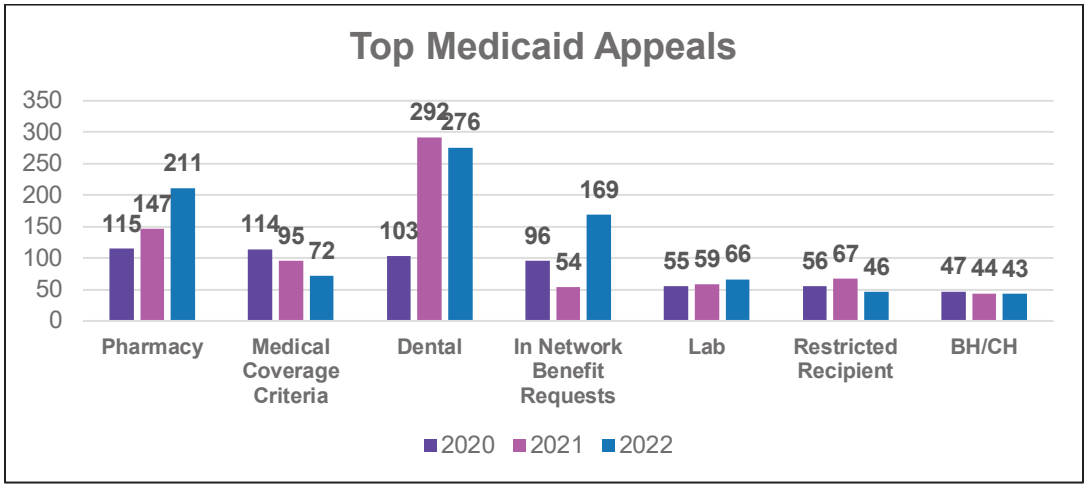
3. We continue to see an increase in requests for coverage of genetic testing across all our products, due to new technology on the market.

4. The highest number of dental appeals were related to preventive visits and TMJ/TMD.

5. Medicare grievance trends included grievances regarding general benefits, provider billing, premiums, and quality of care.

Top Medicaid Written Grievance and Appeal Categories





Medicaid Trends

1. Medicaid appeals and grievances numbers continue to be high due to the increase in membership.

2. Dental appeals have gone down from 2021 however, they are still our largest category. 45% of our dental appeals are for orthodontia.

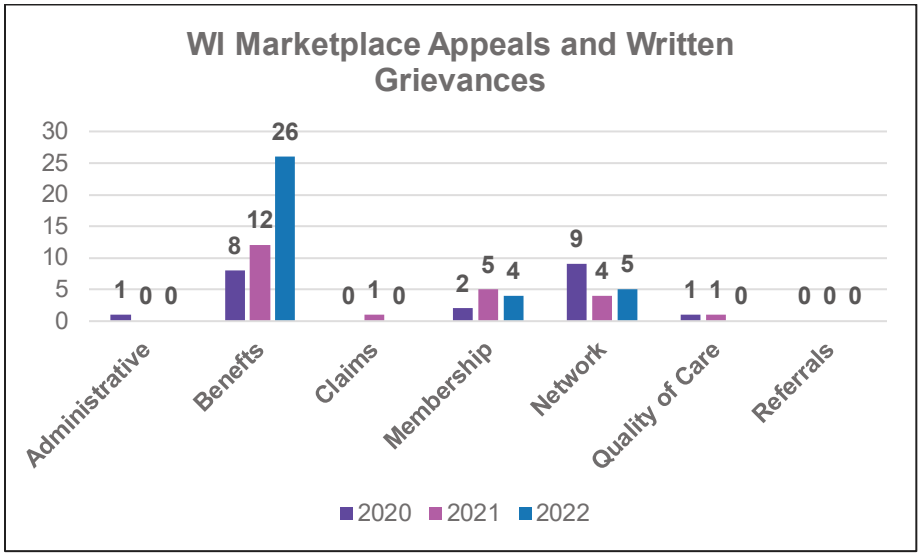
3. In 2022, we had 566 Medicaid pharmacy appeal requests. Of these, 355 were resolved through the pharmacy hand off process and 211 were resolved through the appeal process. We saw an increase in requests for certain drugs, including Botox, Nurtec ODT, Ozempic and Skyrizi. In most cases, these requests were denied because the member did not meet criteria.

a. The pharmacy handoff process is a pharmacist outreach and review process for our **Medicaid** members (except MSHO Part D). The pharmacist working on these requests reaches out to the provider to ensure we have all the necessary information. If additional information is received that changes the decision, the pharmacist can approve the request and the request is not considered an appeal. If the request cannot be approved, the request is sent back to Member Rights & Benefits to go through the appeal process. In most cases, the appeal is denied because if criteria had been met, it would have been approved during the handoff process. In 2022, 93% of pharmacy appeals were upheld.

4. In network benefit requests increased significantly. 88% of the requests were for services at Mayo.
5. Medicaid grievances for 2022 included members concerns with their experiences with Ridecare, clinic networks or experience with clinics, coordination with other insurance, provider billing, general benefit concerns and quality of care.

WI Marketplace First Level Appeals and Written Grievances

Total WI Marketplace Appeals and Written Grievance by Category



WI Marketplace trends:

- In 2022, we had 29 WI Marketplace appeals and 6 grievances.
  - The highest numbers of appeals (11) were requests for drug coverage.
  - The most common grievances (4) were related to enrollment and premiums.

- The numbers are low on this product and difficult to identify any trends. However, the types of complaints received are those that are commonly requested such as receiving in-network benefits from an out of network provider.

Monitoring the Utilization Management Program

Processes and Staffing

HealthPartners Utilization Management (UM) Program activities and initiatives encompass medical, pharmacy, and behavioral health services. Components fall within five major categories:

1. Improving systems of care (e.g. networks and approaches to delivery of care)
2. Providing decision-making support
3. Supporting utilization management at a member-specific or population-specific level
4. Measuring and analyzing performance
5. Implementing specific initiatives that are designed and developed to improve performance results

Licensed nurses, behavioral health professionals, and registered pharmacists work under the supervision of board-certified physicians for all case decisions involving medical necessity. Associate Medical Directors review coverage requests for medical necessity and make adverse determinations for lack of medical necessity, when appropriate. They consult with external specialty physicians as appropriate. When required, a physician with the same or similar specialty as a practitioner that typically treats or manages the condition for which the health care service is being requested, is used to make adverse medical necessity determinations, when the member does not appear to meet coverage criteria. The Medical Directors, Associate Medical Directors, the Directors of Comprehensive Care Advocacy, Pharmacy, and Utilization Management are collaboratively responsible for the development of new programs, initiatives, and the ongoing oversight of the day-to-day operations.

HealthPartners has implemented a formal process to ensure consistency of decision-making for coverage of medical and behavioral health treatments, procedures, and services, new and existing technologies, devices, and pharmaceuticals. Medical Coverage Criteria are used for prior authorization decisions, and disputed benefit interpretations and are also published on HealthPartners.com for transparency to members and providers. The processes include continuously updating the basis of decision-making with evidenced-based information regarding current best practices (e.g., practice guidelines, technology assessments) and cost-benefit considerations. This includes research of the reliable scientific literature, including articles in peer reviewed literature, recommendations and consensus statements from professional societies, technology assessments, and other available resources to determine safety, efficacy of the treatment/technology/device/drug, and effect on health care outcomes. The process for newly developed or revised criteria includes obtaining expert opinion from our network primary care physicians and/or specialists to ensure criteria input regarding community standards of practice. When appropriate, recommendations are made to modify contract language regarding benefit coverage determinations. Coverage criteria utilized as part of the UM program are reviewed, on an annual basis, updated as needed, and approved through the Medical Directors Committee or the Pharmacy and Therapeutics Committee. Newly developed or revised criteria are also reviewed by network primary care physicians and/or specialists to ensure criteria input regarding community standards of practice. All other coverage criteria are reviewed and

approved on a periodic review cycle. The Medical Coverage Policy staff, Medical Directors Committee, and Pharmacy and Therapeutics Committee are responsible for the medical coverage criteria development and implementation processes. The Coverage Criteria Policies are used for making medical necessity determinations for items and services on HealthPartners's Prior Authorization List.

State and federal laws, rules and regulatory requirements, criteria and coverage guidelines for the Centers for Medicare and Medicaid Services and for the Minnesota Department of Human Services are incorporated into the development of the HealthPartners Coverage Criteria.

Inter-rater Reliability Testing

We conduct inter-rater reliability evaluations annually for all Utilization Management review staff to ensure consistent application of coverage criteria and benefits. In 2022 we surveyed:

Staff type	Number of hypothetical cases
Non-physician medical & behavioral health reviewer (38)	10
Physician reviewers (3*) *2 physician reviewers were being on-boarded during the testing and did not participate.	6- Medical 10- Pharmacy
Non-physician pharmacy reviewer (27)	10

Area	Survey response rate	Consistency rate	Follow-up Actions
UM	97%	92%	Reviewed cases that had any variance in responses during team meetings to support staff alignment.
Pharmacy	92% (24/26) *One PCSA is in training and did not take the survey and another PCSA was out on leave an did not take the survey.	80%	Reviewed cases that had any variance in responses during team meetings to support staff alignment. Audit pharmacy reviewers monthly to ensure decisions are criteria based and that the review process follows all applicable policies and procedures.

Satisfaction with the Utilization Management Process

Annually, HealthPartners collects and evaluates data on member and provider experience with Utilization Management (UM) processes and acts when appropriate. Monitoring metrics include the annual Provider Satisfaction Survey, HEDIS/CAHPS 5.0H survey results, and member complaint and appeal data.

2022 Goals

- **Easy to understand denial letters:** Sustain a "Strongly Agree", "Agree", or "Neither Agree nor Disagree" response rate of 75% or greater by continuing to develop plain language resources as achieved in the 2019 Provider Survey.
- **Ability to find criteria online:** Increase 2022 response rate of "Strongly Agree", "Agree", or "Neither Agree nor Disagree" to 65% with expansion of new Verify Prior Auth tool and continuing to evaluate options to deliver easy to use online criteria.
- Continue to evaluate, update, and develop coverage criteria policies with input from providers and evidence-based medicine to support safe and effective care for our patients and members.
- Continue to monitor, evaluate, and institute appropriate actions to address member and practitioner experience with the UM process, as needed.

Assessment of Effectiveness

Provider Experience with the UM process

We mailed the Provider Survey in May 2022 to 1,086 providers and their office managers who had requested prior authorizations in the past 15-month period. The number of completed surveys was 72.

Progress Towards Goals

It is difficult to assess progress towards goals due to a historically low response rate. Compared to 2021, the 2022 results remain stable despite the challenges healthcare providers are facing, especially related to staffing.

Quantitative Analysis

Measure	2021	2022	Goal Met?
Pharmacy Prior Authorization Process: (% Strongly agree + Agree + Neither agree nor disagree)			
• I or my staff are able to find prior authorization criteria online	57%	63%	Not Met
• Coverage decision letter was stated in easily understandable language	88%	84%	Met
• Coverage decision letter gave directions for how to access a medical director or clinical pharmacist	81%	78%	N/A
Prior Authorization Process: (% Strongly agree + Agree + Neither agree nor disagree)			

Measure	2021	2022	Goal Met?
• I or my staff are able to find prior authorization criteria online	60%	67%	Met
• Coverage decision letter was stated in easily understandable language	84%	81%	Met
• Coverage decision letter gave directions for how to access a medical director	78%	81%	N/A

Qualitative Analysis

- Practitioners have a Verify PA tool available to them online to assist in determining whether a service or item requires prior authorization, and to point them to the appropriate medical coverage policy. In 2021, it was expanded to include pharmacy and behavioral health services. Tool expansion continued in 2022.
- The Utilization Management departments continue to improve use of plain language to ensure content is easily understandable for the member and balance that with clinical validity for the practitioner.

Member Experience with the UM process

HealthPartners conducts an annual assessment of member satisfaction to support continuous improvement in member experience with utilization review activities across medical, behavioral health, and pharmacy programs. Member experience measures used are those suggested by NCQA.

HealthPartners Market Insights and Medical Policy Departments compared key questions from the CAHPS and MA-PD CAPHS surveys. SPH Analytics conducted the Commercial CAHPS 2022 survey, which was administered between February and May 2022. SPH Analytics conducted the MA-PD CAPHS 2022 survey, which was administered between March and June 2022. In 2022, Minnesota DHS conducted the Medicaid CAHPS survey between January and March. These results are compared to the state's benchmark for each enrollee type.

- We do continue to see impacts of the COVID-19 pandemic in our CAHPS results across products.

Commercial Products: 2022 UM Member Satisfaction Results
Administered by HealthPartners

Questions that measure UM satisfaction levels for:		Group Commercial			
		HealthPartners			National Average
		2020	**2021**	**2022**	**2022**
How often get appointment to see a specialist as soon as needed? (CAHPS 5.0)	Q25	88%	81%	77%	82%
How often get needed care, tests or treatments. (CAHPS 5.0)	Q14	94%	91%	91%	87%

Medicare Products (Cost & Risk): 2022 UM Member Satisfaction Results
Administered by HealthPartners

Questions that measure UM satisfaction levels for:	Medicare Freedom® (Cost) Plan					Medicare Advantage				
		HealthPartners			Nat'l Ave		HealthPartners			Nat'l Ave
		2020	**2021**	**2022**	**2022**		**2020**	**2021**	**2022**	**2022**
Easy to get appointment with specialist (CAHPS 5.0)	Q29	92%	91%	87%	87%	Q29	90%	92%	88%	87%
How often get needed care, tests or treatments. (CAHPS 5.0)	Q10	95%	94%	95%	91%	Q10	93%	93%	92%	91%

Questions that measure UM satisfaction levels for:	HPUPH Medicare Advantage				
		HealthPartners			Nat'l Ave
		2020	**2021**	**2022**	**2022**
Easy to get appointment with specialist (CAHPS 5.0)	Q29	89%	92%	91%	87%
How often get needed care, tests or treatments. (CAHPS 5.0)	Q10	94%	96%	95%	91%

Medicaid: MNCare Adults and F&C: 2022 Utilization Management Member Satisfaction Results
Administered by Minnesota DHS

Questions that measure UM satisfaction levels for:	MNCare Adults					Families & Children (F&C)-MA				
		HealthPartners			MN State Ave		HealthPartners			MN State Ave
		2020	**2021**	**2022**	**2022**		**2020**	**2021**	**2022**	**2022**
Easy to get appointments with specialists. (CAHPS 5.0)	Q25	76%	83%	71%	77%	*Q25*	78%	80%	75%	78%
How often get needed care, tests or treatments. (CAHPS 5.0).	Q14	90%	90%	84%	88%	Q14	90%	85%	86%	87%

Medicaid: SNBC: 2022 Utilization Management Member Satisfaction Results
Administered by Minnesota DHS

Questions that measure UM satisfaction levels for:	SNBC				
		HealthPartners			MN State Ave
		2020	**2021**	**2022**	**2022**
Easy to get appointments with specialists. (CAHPS 5.0)	Q25	78%	87%	79%	81%
How often get needed care, tests or treatments. (CAHPS 5.0).	Q14	86%	87%	85%	86%

Medicaid: MSHO and MSC+ 2022 Utilization Management: Member Satisfaction Results
MSHO Administered by HealthPartners and MSC+ Administered by Minnesota DHS

Questions that measure UM satisfaction levels for:	MN Senior Health Options (MSHO)					MN Senior Care Plus (MSC+)				
		HealthPartners			Nat'l Ave		HealthPartners			MN State Ave
		2020	**2021**	**2022**	**2022**		**2020**	**2021**	**2022**	**2022**
Easy to get appointments with specialists. (CAHPS 5.0)	Q29	NR	NR	87%	87%	Q25	80%	74%	77%	83%
How often get needed care, tests or treatments. (CAHPS 5.0).	Q10	93%	89%	92%	91%	Q14	90%	87%	89%	88%

NR = Too few members responded to report results.

Product Trends for Ease of Getting Appointments/Required Care

- For Commercial group adult members, the 2022 CAHPS results for access to specialty appointments is below the National Average and down compared to 2021. Access to care, tests and treatment is above the National Average and consistent with 2021.
- HealthPartners Medicare plans consistently outscore the National Average for access to care, tests or treatment. 2022 scores for access to specialty appointments are consistent with the National Average or slightly above across HealthPartners Medicare plans.
- HealthPartners Medicaid plans 2022 scores come in below the State Average on access to specialty appointments. Except for MSC+, HealthPartners Medicaid plans scores are slightly below the state average on access to care, tests, and treatment.
    - Minnesota Care (MNCare) stands below the State Average on both measures, following decreases compared to last year.
    - F&C-MA stands below the state average on access to specialty appointments following a decrease compared to prior years. F&C-MA score on access to care, tests, and treatment is slightly below the State Average despite a slight increase over last year's score.
    - Scores for Special Needs Basic Care (SNBC) are slightly below the State Average for both measures. The Access to specialty appointments measure decreased substantially compared to last year, while access to care, tests, and treatments decreased slightly.
    - Minnesota Senior Care Plus (MSC+) is slightly above the State Average on access to care, tests, and treatments, but falls below the State Average on access to specialty appointments. The scores for both measures increased compared to 2021.

Analysis

Access to Care

There is little indication that HealthPartners members are experiencing specific plan-related barriers for getting care, although the erosion of commercial group members' score warrants monitoring and is likely related to health care affordability rather than specific HealthPartners utilization policy changes.

Specialty Access

HealthPartners recognizes that specialty appointment demand in Minnesota is robust, and our own care groups and contracted clinics have taken steps to improve specialty scheduling and patient flow through continued development and enhancement of online scheduling systems.

Referrals

Referrals to specialists are not required for most of our products. HealthPartners' comprehensive networks ensure that our members can receive the care they need within their designated network. On the few occasions when this is not possible, our utilization management and customer service teams work with the referring provider and member to find a specialty provider that meets the member's specific health care needs.

Focused Network Access Management

The In-Network Benefit Request coverage policy addresses requests for reimbursement of out-of-network care at in-network benefit levels. To be considered for this level of reimbursement, a clinician with knowledge of the member's current clinical condition and care needs will submit sufficient documentation for the plan to determine whether treatment for the member's current condition is available within the member's plan network.

Appeals

Pharmacy

There were 606 commercial Pharmacy Appeals in 2022. Top medications are reviewed each quarter, and coverage issues are reported back to the Pharmacy Review Committee. See Appendix 3 for detailed breakdown of pharmacy appeals. A large volume of pharmacy denials that are overturned are due to additional information. This has led to increased provider outreach for complete information with the initial request.

Investigational Services

See Appendix 3 for detailed breakdown of appeals for investigational services. Per analysis of data contained in Appendix 3, significant trends in appeals associated with investigational services are most likely due to a continued high volume of requests for genetic testing. In addition to aggressively pursuing direct-to-member marketing and directly initiating appeals, developer/manufacturers are also providing standardized appeal templates to service providers and encouraging them to submit appeals on the behalf of the member.

Genetic Testing

Given the rapidly expanding genetic testing market, growth in direct to consumer (DTC) marketing of genetic tests, and our organization's multiple efforts to ensure appropriate use, genetic testing continues to be a high-volume category of appeals. HealthPartners continues to address coverage of genetic testing by developing coverage criteria policies that support safe, effective, and evidence-based use of these tests. Increasingly, developers/manufacturers are aggressively pursuing direct–to-member marketing and are initiating a high volume of appeals on behalf of the member.

Online Access to Criteria

The low performance results specific to provider satisfaction with online access to criteria is likely because the criteria are not available within the Electronic Medical Record but instead are available on our website, and providers may not know where to find it. We believe our implementation and expansion of the verify PA tool with the addition of review-specific fillable PA forms linked in the criteria will help improve this satisfaction.

Barrier Analysis

Provider Survey:

In 2021, HealthPartners resumed fielding the annual Provider Satisfaction Survey. Shortly after the surveys were distributed, we experienced back-to-back COVID-19 surges. As a result, we saw a historically low response rate. As care delivery systems continue to struggle with staffing and patient volume, 2022's survey response rate remained low.

New Technology Direct to Member Marketing:

As new technologies are striving to increase market share, we see an impact on member requests for specific services, increased expectations of coverage, and third-party vendors appealing on the member's behalf. We expect this will always be a dynamic within the healthcare market, especially as we strive to ensure evidence-based coverage, as vendors are often marketing new technologies once they receive FDA approval, but before the quality evidence regarding effectiveness, safety, and effect on health outcomes is available.

Impact of Triple Aim strategies:
As we strive to improve health, experience, and affordability some of our initiatives can initially meet provider and member resistance as we are attempting to influence patterns of care and use of specific services. Effective utilization management spans the continuum of care and services, and we use it at selected leverage points to improve the safety, quality, value, and/or utilization of care. It may involve either or both consumer and provider engagement support services.

Systems and processes for both operational and administrative functions are designed and continuously improved to support effective and appropriate care delivery and utilization management initiatives.

Identified Opportunities for Improvement/Actions

In 2022, HealthPartners continued and enhanced our strategies and initiatives to support and improve member and provider experience.

- **Ease of use of online criteria:**
  In May of 2020, we introduced a new Prior Auth Verification Tool, which simplifies the process of determining when a prior auth is required. All the provider needs to determine if a PA is required are the service codes (CPT/Dx). It also directs the provider to the appropriate medical coverage policy. If the service/item does require a PA, a link to the resource to begin the PA request process is provided.

- **Electronic authorization function:**
  Utilization of the online prior authorization application for submission of medical PA continues to increase. This method ensures only minimally necessary information is collected to make a coverage decision and hopefully saves provider office time in collecting pertinent clinical information to submit a request.

  We have also enhanced our standard forms for those providers who prefer to submit via fax.

- **Pharmacy E-Prior Authorization:**
  HealthPartners continues to work with our vendors to support ePA. As of March 2019, we were receiving over 70% of prior authorization requests via ePA, and four years later, we have continued to receive 75% of pharmacy benefit requests via ePA. EMR vendors are continuing to make enhancements to their system functionality for providers to take advantage of this capability with seamless integration into provider workflows. In addition, HealthPartners has worked on creating question sets or decision trees that are specific to the drug being requested. For over 75% of ePA requests, providers will be sent a question

set that is specific to the drug being requested. The questions will ask for all the pertinent information necessary to make a decision, and it ensures that decisions are rendered similarly across different users. We are also expanding our work on auto-adjudication of requests (i.e., eliminate manual intervention). For certain medications, electronic submissions that meet defined criteria will be automatically processed, further reducing turnaround time. In March 2020, we piloted automatic adjudication for two drugs and have since expanded to over 140 drugs. As of March 2023, approximately 17% of prior authorization requests are automatically processed with approval decisions communicated to providers within approximately 10 seconds after submitting the request. In 2019, we also rolled out Real Time Pharmacy Benefit Check (also known as RTPB or RTBC), which provides more specific Formulary coverage information within the electronic medical record. The Real Time Pharmacy Benefit Check may also display alternative medications that do not require prior authorization for the provider to select if they wish to avoid the prior authorization process.

2023 Goals

- **Easy to understand denial letters**: Sustain a “Strongly Agree”, “Agree”, or “Neither Agree nor Disagree” response rate of 75% or greater by continuing to develop plain language resources.

- **Ability to find criteria online**: Increase 2022 response rate of “Strongly Agree”, “Agree”, or “Neither Agree nor Disagree” to 65% with continued expansion of the Verify Prior Auth tool and continuing to evaluate options to deliver easy to use online criteria.

- Continue to evaluate, update, and develop coverage criteria policies with input from providers and evidence-based medicine to support safe and effective care for our patients and members.

- Continue to monitor, evaluate, and institute appropriate actions to address member and practitioner experience with the UM process, as needed.

Health Equity

Health Disparities

Description

As an organization dedicated to the health and well-being of every person, we have the responsibility and opportunity to help build a stronger organization and community where racism and inequity have no place. HealthPartners has a long history of addressing structural racism and health equity; grounded in the mission, vision and values established by our consumer-elected board of directors. Our mission is to improve health and well-being in partnership with our members, patients, and the community. Our Partners for Better Health Goals 2025 reflects this mission. We seek to deliver outstanding care and service that is safe, timely, effective, equitable, efficient and patient/member/family centered.

We have been an industry leader in creating health and well-being programs aimed at reducing disparities in care, increasing diversity within our workplaces, and honoring the communities we serve. This focus is embedded in everything we do, and we partner meaningfully in our communities to address social determinants of health and act as an anchor tenant to improve health and economic development. Achieving health equity requires addressing disparate health outcomes and recognizing its relationship to structural racism and racial bias.

Goals

Our goal is to eliminate health disparities among our members and patients to improve their health and experience. We seek to develop community partnerships to support social, economic, and environmental health and well-being for our patients and members and to decrease the gaps in socioeconomic and physical environmental health determinants.

Initiatives/Interventions

HealthPartners has a longstanding commitment to improve the health of the diverse communities we serve. We've been recognized for outstanding care outcomes and performance, and we continue to partner with our communities to eliminate disparities. Our Equity, Inclusion and Anti-Racism Cabinet provides strategic leadership in planning and executing activities aimed at improving racial equity and health equity through reducing health care disparities, improving access, and supporting an inclusive culture.

Our strong leadership in this area is reflected in the awards and recognitions we've received for these efforts:

1. **Top 15 Health System** – IBM Watson Health named HealthPartners one of the Top 15 Health Systems in the nation five years in a row (2017-2021). Compared to other health systems, top performers had fewer patient deaths, fewer infections and complications, lower readmission rates, shorter lengths of stay, higher patient satisfaction and lower costs. It's a testament to our unique ability to partner across care, health plan and research to improve the health and well-being of our members, patients, and community.

2. **No. 1 in member satisfaction** – HealthPartners received the highest ranking in overall satisfaction among commercial health plans in the Minnesota-Wisconsin region four years in a row (2018-2021), according to the J.D. Power U.S. Commercial Member Health Plan Study. In addition, we received the highest rating in coverage and benefits, customer service, information and communication, and billing and payment.

3. **Top-rated health plan** – HealthPartners is one of the top-rated commercial health plans in Minnesota with a rating of 4.5 out of 5, according to the National Committee for Quality Assurance (NCQA) commercial Health Plan Ratings 2022. This is the 18th year in a row that NCQA recognized us as one of the highest performing plans in the nation.

4. **Medicare 5 Star Ratings** – HealthPartners has consistently been a highly rated Medicare plan by the Centers for Medicare and Medicaid Services (CMS). For the second year in a row, our Medicare Advantage plans in Minnesota and Wisconsin were awarded an overall 5 out of 5-Star Rating for 2023. For 2022, all five HealthPartners Medicare plans across our six-state service area were awarded an overall 5 out of 5-Star Rating. In addition, HealthPartners was the first and only MSHO plan in Minnesota to earn 5 stars for 2021 and one of only three such plans in the nation to earn the top rating.

5. **Consumer experience leader** – HealthPartners receives high scores from its health plan members in the annual CAHPS survey. Thirteen key areas are addressed in the survey, including doctor communication, customer service and getting care quickly where members rate their experience with each. Compared to all Minnesota health plans, HealthPartners has received the highest overall plan rating from members every year since 2007.

6. **Exceptional care – HEDIS®** – This year, 64% of our commercial HEDIS measures are in the top 25% in the nation, with 21% in the top 10%. This outscores our local competitors.

7. **CMS Health Equity Award** – In January 2019, HealthPartners was one of only two organizations in the nation to receive the Health Equity Award from CMS. The award recognizes areas where HealthPartners has implemented new models to increase access to care and reduce health disparities, including for behavioral health.

8. **AMGA Acclaim Award** – HealthPartners was named an Acclaim Award honoree by the American Medical Group Association (AMGA) for our Children's Health Initiative and its collaborative approach to improving child and family health. This effort included collecting data and eliminating gaps in care, supporting language access, partnering with communities, and building an understanding of equity, diversity, inclusion and bias.

9. **Colorectal Cancer Organization of the Year** – In 2018, HealthPartners was named the Colorectal Cancer Organization of the Year by the American Cancer Society for its work to improve colorectal cancer screening rates among patients of color.

10. **Improved Total Cost of Care** – HealthPartners continues to be a top performer in MN Community Measurement's Minnesota Health Care Quality Report. In 2021, our care system, including HealthPartners and Park Nicollet, performed better than average among medical groups in Minnesota. The findings underscore the importance of our integrated work across care delivery and health plan to improve total cost of care for patients and members.

11. **Best places to work** – For the second year in a row, HealthPartners was named one of the Top Workplaces in Minnesota by the Star Tribune. The award recognizes organizations dedicated to creating cultures of high engagement, inclusivity, and trust. HealthPartners has also been recognized as one of the best places to work by Forbes and the Minneapolis/St. Paul Business Journal.

12. **Top hospitals** – Our hospitals are consistently ranked among the best in nation. In 2022, Regions and Methodist hospitals were ranked among Newsweek's list of World's Best Hospitals and U.S. News and World Report's list of Best Regional Hospitals. In addition, Methodist Hospital was named among IBM Watson Health's list of 100 Top Hospitals in 2021 – the sixth time the hospital has earned this distinguished recognition. Regions Hospital was named one of HealthGrades' 50 Best Hospitals in America in 2020.

13. **Gold-level stroke treatment and care** – HealthPartners was recognized by the American Heart Association and American Stroke Association as a Gold-level practice for our commitment to high-quality stroke treatment and care.

14. **National leader in sustainability practices** – Health Care Without Harm named our organization a worldwide Climate Champion four years in a row (2019-2022). In 2022, HealthPartners also received 27 awards from Practice Greenhealth in recognition of our outstanding accomplishments in sustainability, including the System for Change award for the eighth consecutive year.

15. **Health care leadership** – HealthPartners President and CEO Andrea Walsh has been named to Modern Healthcare's list of 100 Most Influential People in Healthcare three years in a row (2020-2022). In addition, the Minneapolis/St. Paul Business Journal named Andrea their 2021 Executive of the Year. Andrea also received the 21st Century Pinnacle Leader Award from the Women's Health Leadership TRUST in 2020, which recognizes women who are trailblazers in leadership, transformation and innovation in health care. Minnesota Physician included Andrea among their list of 100 Most Influential Health Care Leaders in 2020.

Individual Awards

1. **2022** – DeLinda Washington, senior vice president and chief people officer, was recognized by Modern Healthcare as a Top Diversity Leader. She is one of the nation's

10 “Leaders to Watch,” recognized for their outstanding achievement in promoting diversity, equity and inclusion in their organizations and the health care industry.

2. **2022** – Toweya Brown-Ochs, director of diversity and inclusion, was recognized by Twin Cities Business as a Notable DEI Executive for creating and leading initiatives that foster inclusion within the organization and community.

3. **2021** – Methodist Hospital ICU nurse Jeanette Rupert received the inaugural Bernard J. Tyson Award for Excellence in Pursuit of Healthcare Equity from the Alliance of Community Health Plans (ACHP). She was recognized for her work to establish a local medical tent as a brick-and-mortar non-profit clinic in the community and for her collaboration with local nursing students to bring health care to underserved populations.

4. **2020** – Park Nicollet nurse Jenn Bourgoine received the Business of Pride – Ally Award from the Minneapolis/St. Paul Business Journal for her work supporting transgender patients.

5. **2019** – Dr. Deb Thorp, director of Park Nicollet gender services, received the Business of Pride award from the Minneapolis/St. Paul Business Journal for her work to improve access to compassionate care for LGBTQ patients and patients in immigrant and refugee communities.

Equity, Inclusion and Anti-Racism Cabinet

In 2020, HealthPartners established the Equity, Inclusion, and Anti-Racism Cabinet to aggressively accelerate our efforts to advance racial equity and health equity. The cabinet provides strategic leadership in planning and executing activities aimed at improving racial equity and health equity through reducing health care disparities, improving access, and supporting an inclusive culture. The cabinet aligns racial equity and health equity activities across the organization through inclusion in annual plans and supports tracking, monitoring, and measuring progress. The cabinet:

1. Provides an organization-wide approach to measure and reduce health care disparities.
2. Supports workforce development initiatives that reinforce cultural humility and respect.
3. Improves care for members with limited English proficiency and who are hearing impaired.
4. Involves members in planning and implementing racial equity and health equity approaches.
5. Engages with communities across the seven-county metropolitan area in partnerships to promote racial equity and health equity.
6. Provides direction for data collection, analysis, and reporting across the organization.
7. Communicates progress on initiatives across the organization, and externally as appropriate.

The Equity, Inclusion and Anti-Racism Cabinet provides leadership, direction, and oversight through four cornerstones to accelerate the pace of our work and cultivate alignment and partnership across the organization.

The image below illustrates the four cornerstones' approach of the Health Equity, Inclusion, and Anti-Racism Cabinet.

Community collaboration to gain insights and engage community

We have built a culture of health equity in our organization through partnerships with community organizations. In our 2021 Community Health Needs Assessments and Plans, conducted by each of our hospitals, priority needs were reviewed within the contextual factors of structural racism and COVID-19. During that process, we engaged community members, public health, and our own clinicians to more deeply understand how we might impact the health of our community.

Community partnership development is a core strategy in our work to promote and make change towards health equity. We invest in six general areas: healthy children, mental health, nutrition and fitness, health equity, wellness and prevention and research and education. We also have larger, multi-year partnerships and campaigns with community-based organizations to impact and improve community health including the MakeItOK campaign, PowerUp and Little Moments Count. Examples of partners include organizations such as the Keystone Community Services, Open Arms Minnesota, Reach Out and Read MN, American Red Cross Blood Services, Northside Achievement Zone (NAZ), the National Alliance on Mental Illness (NAMI), St. Paul Bookmobile, over 60 schools throughout the region, Hunger Solutions, and many others.

Healthy Children and Maternal Health

1. Little Moments Count: LMC is a growing social movement seeking to increase awareness of the importance and increase parent and caregiver behaviors of talking, playing, reading, singing and storytelling with children, in the first 1000 days of life (0-3 years old). LMC achieves this through collective impact partnership with over 70 cross-sector organizations, including early childhood, healthcare, non-profit community and cultural, faith community, media, governmental and other private sector organizations. LMC partners work together to magnify key family support resources and opportunities, as well as identify gaps to address through collective impact strategies.

   In 2022, LMC reached Minnesota and Wisconsin families and professionals through:

a. Over 14 million MN Public Radio (MPR) radio and digital public service announcements (PSAs).
b. Over 90,000 prints, 525,000 radio and 182,000 digital cultural community media impressions within Latinx, Hmong, Somali, African American and indigenous communities through strategic trusted community media and social media partnerships.
c. Reaching approximately 22,000 community event impressions through large events like the MN State Fair and smaller community outreach efforts, like the Ramsey County Mother's First Community Baby Shower.
d. Over 1000 views of the LMC Annual Conference featuring keynote speaker, Dr. Rosemarie Allen, MEd, "Racism and the Developing Brain."
e. 150,000 families receiving Reach Out & Read early brain development education and over 214,000 children's books at well child visits across 10 health care systems.
f. Over 1100 family LMC LEARN Survey responses from African American, Latinx, Hmong, Somali, Indigenous and Medicaid-insured communities – showing community-specific assets and needs to help guide LMC strategy in the future.
g. Over 5000 families reached through a new family birth center pilot introducing LMC resources to new parents delivering at 5 MN family birth centers.
h. In partnership with The Itasca Project, new and enhanced employer communication campaign and family support best practices and policy examples tools.

2. Children's Health Council: It's clear that there is a strong link between health and well-being early in life, and health and well-being later in life. HealthPartners is working to improve the health and well-being of children and their families by concentrating on areas of focus known as our Children's Health Council (previously known as Initiative). The four main guiding principles of the initiative are: promoting early brain development, providing family centered care, strengthening our communities and eliminate disparities in maternal, infant and pediatric health. In 2022, our areas of focus include: early brain development, adolescent health, pediatric, adolescent, and maternal mental health access and outcomes, healthy beginnings (maternal and newborn care), and lactation. Through this investment, we're helping lay a foundation that will benefit generations to come.

3. Reach Out and Read and early brain development messaging: Reach Out and Read reaches children from 6 months to age five. At the beginning of every visit, a child's healthcare provider will give the child an age and language appropriate book to share with their family. The provider uses this opportunity to gauge the child's early development and give the parents or caregivers guidance on how language-rich interactions, such as reading, singing, and playing together, help a child learn and grow healthily. In efforts to start this messaging early on, we added a black and white book to the 32-week prenatal visit and explain to families that there are benefits of talking, reading, and singing to their baby still in the womb. Each year, this program hands out

approximately 95,000 books between our well child checks and prenatal visits and offers books in over 12 different languages.

4. Well Child and Childhood Immunization Outreach: During the pandemic, we saw declines in many preventive care measures including well child visits and childhood immunizations. Delays in immunizations put children at increased risk for many preventable diseases, and lack of well care can delay identification of developmental delays or other health concerns. Our Medicaid membership had the lowest utilization of these health care services across our membership. HealthPartners utilized information from our care group and claims to identify 10,000 members up to 18 years old who needed immunizations, well-child care or both. We worked with WellShare International, a local Community Health Worker organization, to conduct outreach to these members to educate on the importance of preventive care, encourage visits to their clinician and help in scheduling these visits.

   WellShare has a roster of community health workers (CHW) from the community and were able to make calls in members' native languages when possible or utilize an interpreter when needed. Calls were made to members beginning in October and continue into 2023. As of the end of 2022, 5479 (55%) of the members on the list had been contacted at least once. CHWs were able to successfully engage 26% of the members they reached out to. Reasons for not reaching included disconnected or wrong phone numbers, messages left but not returned, and members who declined the intervention. CHWs were able to educate 1556 families on the importance of getting up to date on immunizations and well child exams and assisted 104 to schedule the appointment.

   In addition to this outreach, we worked with the other MN Medicaid plans and the Minnesota Council of Health Plans to create a blog post about the importance of getting caught back up on immunizations and well visits. The blog is available in written and audio form and is being translated to Spanish, Somali and Hmong for access to those communities.

5. Think Small Positive Parent Texting program: This easy, free program provides fun facts and easy tips each week with ideas on how parents/caregivers can promote their child's learning. Research shows when parents participate in this program their children are more prepared for kindergarten. In 2021, we included a Little Moments Count bookmark, which promotes Think Small, to our 32-week prenatal visit and 1 month well child check. This bookmark is offered in English, Spanish and Somali and we continue to use this bookmark throughout those respective visits.

6. PowerUp Teen Leadership Council: In 2020, the Children's Health Council (CHC) started to partner with PowerUp's Teen Council to provide feedback on care for teens. In the first year, they provided feedback on our adolescent questionnaire to ensure we are asking relevant questions, which we were then able to update. In 2021, CHC chairs were added to the advisory committee to help enhance their engagement through the program and into the community. Through 2022, the teen council provided feedback on relevant

topics to ensure clinicians covered important topics with teens. In 2023, HealthPartners is dedicated to a refresh training on adolescent health where the council will play an integral part in content developed to ensure relevancy during well child visits.

7. St. Paul Promise Neighborhood (SPPN): The Promise Neighborhood (Wilder Foundation, Ramsey County, and St. Paul Public Schools) is a community-wide initiative to provide academic, social and health support that children need to succeed in school and life. The focus is on families with children birth to age 5. HealthPartners is a partner on the advisory council.

8. Penumbra Theater: HealthPartners partners with Penumbra Theater, a local theater company that creates professional productions focused on the African American experience. Penumbra has evolved into a Center for Racial Healing that nurtures black artists, advances equity, and facilitates wellness for individuals and community. HealthPartners began a partnership with Penumbra to support the commissioning and development of a new play written by Harrison David Rivers as a response to the growing awareness of racial disparities in maternal health. While it could not be performed on the stage in 2021 due to COVID, Penumbra performed excerpts of *Weathering* in a virtual reading format for HealthPartners employees who serve on our pregnancy council, health equity and children's health initiative cabinet. The session was recorded and continues to be used for training across our organization.

   Weathering was brought to the stage in 2022 with rave reviews. Weathering puts a human face on those staggering statistics that black infants are more than twice as likely to die as white infants and lets us experience the tragedy of one family, as well as the healing that can happen within a community.

9. The Black Pregnancy and Post-Birth Journey: In 2021, with support from the Park Nicollet Foundation, HealthPartners & Park Nicollet partnered with a consulting agency, Heart of the Customer, to improve outcomes for Black expectant mothers by capturing their experiences during and after pregnancy to build empathy, undermine systemic racism, and improve outcomes for them and their babies. Black expectant and post-birth patients face far worse health and mortality outcomes that their white counterparts both in Minnesota and nationally. Studies show Black patients are less satisfied with their care and use fewer healthcare services. As a system, we want to build trust with our Black patients and their partners to provide timely and culturally competent care. As a result of our journey mapping inquiry with Heart of the Customer and our community consultants, a top identified program strategy was to offer a perinatal concierge that would stay connected to Black patients throughout their pregnancy care.

10. Healthy Black Pregnancies (formally known as ICHRP): To better serve our African American patient population, HealthPartners has partnered with Healthy Black Pregnancies. This group provides professional expertise; knowledge of prenatal African American maternal and child health issues; knowledge of the African American community; and connections to local, national, and international resources and colleagues. In 2021, our care group piloted referring our patients to their program. In

partnership with Healthy Black Pregnancies, we continue to work through some barriers with this referral process. Our Healthy Pregnancy care coordinators and staff from our clinics make referrals to their DIVA Moms program and other support services. In 2022, HP gifted Healthy Black Pregnancies a $50,000 grant to support the formalization of their structure as a 501c3 and to increase access to their support services.

11. Healthy Beginnings: This program helps women achieve a healthy pregnancy and birth by providing comprehensive screening and support to pregnant patients who are experiencing substance use issues, mental health struggles, homelessness, poverty, domestic violence, and/or other complex psychosocial issues. This evidence-based program reduces preterm births, and low birthweights. More than 10,000 pregnant patients per year receive screening and are eligible for support with these challenging life circumstances.

    Partnerships with the community:

    a. Cradle of Hope – Apply for portable cribs, provide safe sleep education, and distribute cribs to patients.
    b. Bundles of Love Charity – Distribution partner for the charity (bundles have handmade baby clothes, blankets, and baby care items)
    c. Everyday Miracles – Provide grant-funded scholarships for childbirth prep, breastfeeding, and newborn care classes; refer patients for doula services, car seat and breast pump distribution.
    d. Participation in Scott Co. Early Childhood Multidisciplinary Team (case consultation meetings with child protection and other community child welfare agencies)
    e. Ongoing referrals to WIC, MVNA and other county family home-visiting programs, Portico Healthnet, Hennepin County Project Child, HousingLink, Diaper Bank of Minnesota, Minnesota Day One Crisis Hotline, local food shelves and many other resources and supports.

12. Everyday Miracles: Through grant support, women seeking prenatal care through a HealthPartners clinic can seek support from Everyday Miracles and we will help fund the cost of the classes. Everyday Miracles is committed to improving maternal health, and specifically to reducing health disparities in communities at risk for poor outcomes. They strive to provide compassionate, culturally aware support and a nonjudgmental, welcoming community.

13. Lactation Café: With support from a grant, Park Nicollet was able to expand their Lactation Café at Methodist Hospital (previously Mom & Baby Café) to four ambulatory clinics. This free Café provides support, camaraderie, and lactation support for mothers postpartum. Lactation also partnered with the interpreter services department to provide interpreters at known, diverse clinics to assist patients who are English language learners. In 2023, there is a plan to expand partnership with Hennepin County WIC to

assist with the Cafes to help provide more culturally congruent care and help connect patients to community resources.

14. Doula Services: HealthPartners is pleased to note we are committed to expanding and funding doula services. Research shows that doulas can improve outcomes for both mother and baby. For example, studies show that doulas help reduce the rate of caesarean surgeries, which is higher among black women than other racial groups, and other costly interventions. Doulas also increase the rate of breastfeeding, which improves the health of new moms and babies and is less common among black or low-income women.

    Many people in the community are unfamiliar with doulas and how they can provide support to birthing people. HealthPartners created a video explaining what a doula is, the value they bring to the birth experience and how pregnant people can be connected with a doula. This video has been translated with sub-titles into Spanish, Somali and Hmong and will be shared widely to promote the use of doulas for families in the community.

    As voiced by the Ramsey County Birth Equity Community Council (BECC), the community has expressed a desire for more doula support that "looks like them." Through conversations with community doula programs and other community representatives, it has been identified that capacity is an issue, especially for women of color. HealthPartners has an ongoing relationship with Everyday Miracles as our primary doula provider for our Medicaid members. Everyday Miracles is committed to improving maternal health, and specifically to reducing health disparities in communities at risk for poor outcomes. They strive to provide compassionate, culturally aware support and a nonjudgmental, welcoming community. In 2021, along with another MN Medicaid health plan, HealthPartners funded the training and certification costs for additional doulas of color to serve Medicaid members. Since that time, Everyday Miracles roster of Doulas of color went from 40% of their doulas to 70% of their doulas identifying as people of color. We gifted Everyday Miracles a $50,000 grant in 2022 to further aid their work in providing support to the community.

    We are also engaged with a group of community members and organizations to encourage the state to update the allowable doula certifications to include culturally congruent trainings relevant for Black and Indigenous pregnant people. In 2022, the health department established a process for additional certifying agencies to become Medicaid eligible providers.

    We have been working with Division of Indian Work (DIW) to support their Ninde Doula program. Previously their program was funded by grants which couldn't fully fulfill the needs of the community for services. We have been working with them to become Medicaid billable to increase their funding capacity. In 2022, we provided a $50,000 grant to DIW to support the services and to formalize processes to be able to contract with them.

15. Referral partners: We continue to expand our collaboration with community partners to further support our most vulnerable patients and members. We work to identify and refer our eligible mothers who are patients or members to family home visiting and other county public health nurse home visiting programs and community-based programs to support diverse communities including doulas and other maternal health supports. We refer pregnant members on Medicaid to county home visiting for support and resources at the local level.

16. Perinatal Measurements: In November 2021, HealthPartners began participating in the U.S. Department of Health and Human Services (HHS) Perinatal Improvement Collaborative, a large-scale, data-driven collaborative of 200+ leading hospitals caring for diverse populations in all 50 states. The collaborative is overseen by the HHS Office on Women's Health (OWH), using relevant data, analytics, and performance improvement methodologies from Premier Inc. The HHS Perinatal Improvement Collaborative will be testing interventions and protocols to reduce preventable deaths and complications among mothers and their babies. Using Premier's comprehensive and standardized data collection system, the program will be able to quickly generate solutions for safer obstetric and neonatal care that can be implemented nationwide. The effort is guided by an external advisory panel comprising more than 20 expert clinicians, leaders, and patient partners from MoMMA's Voices, a coalition of advocacy organizations focused on leading causes of maternal mortality and morbidity.

17. Postpartum Hemorrhage and Hypertension in Pregnancy Safety Bundle: In June 2021, all 8 inpatient hospital birth center leaders, providers, nurse educators, quality improvement specialist, pharmacy, lab and Epic builders collaborated to roll out a robust program to improve maternal morbidity and mortality related to postpartum hemorrhage and hypertension in pregnancy. More than 1000 perinatal clinical providers completed education and training aimed at standardizing care of patients experiencing these obstetric emergencies. Standardization included policies, protocols, tools, order sets, medications, education, simulation, measurement, and monitoring. This work will impact over 9000 deliveries across the HealthPartners family of care hospital birth centers.

Mental Health

- Partnership with NAMI Minnesota: HealthPartners has had a mutually beneficial 16-year partnership with the Minnesota chapter of NAMI, a nonprofit organization dedicated to improving the lives of children and adults with mental illnesses and their families (namimn.org). HealthPartners has continuously been a sponsor of the NAMIWalks since 2007. HealthPartners continues to sponsor and participate in the NAMIWalks annually, on an organization-wide level, helping to raise funds and promote the walk. In 2022, our team was back in person at Minnehaha Park and raised over $18,000 for NAMI. We have collaborated with NAMI on the Make It OK anti-stigma campaign (described below), in which NAMI is a committed and expert organization that has pledged to help change hearts and minds about the misperceptions of mental illnesses by encouraging open conversations and education on mental illness.

- Make It Ok: Make It OK is a community campaign to reduce stigma by increasing understanding and creating caring conversations about mental illness.

  Make It OK is celebrating 10 years of progress in helping to stop the stigma of mental illnesses. Launched in collaboration with HealthPartners, Regions Hospital, the National Alliance on Mental Illness (NAMI), and other partners, the campaign works through community engagement, trained ambassadors, partners, online resources and more to mobilize and share Make It OK throughout communities. By creating open and caring conversations and helping to change attitudes about mental health and illnesses, Make It OK is increasing understanding and reducing the stigma so those living with a mental illness get the care and support they deserve. Read more in the 10-year report, linked here.

  2022 Make it Ok Highlights:

  - In 2022, Make It Ok continued to expand reach and engagement:
  - 209 Ambassadors trained through 17 virtual trainings.
  - 533 Reached through 32 virtual presentations.
  - 2,175 Engaged in Make It OK with a full return to community events.
  - Launched resources to promote mental well-being and resiliency, reduce stigma of substance use disorder, and equip adults to effectively support youth mental health.

- Science Museum of Minnesota: Since 2018, HealthPartners supported the Science Museum of Minnesota's development of the Mental Health: Mind Matters exhibit. This exhibit was originally developed in Finland but did not use culturally appropriate language or approaches for the United States, as well as did not provide culturally relevant resources. HealthPartners provided important financial support and subject matter expertise and content on resources, including creation of a dedicated resource area for adults and children. This resource area included culturally relevant resources in many languages and included dedicated pieces for perinatal psychiatric disorders as well as African American, recent refugee immigrant, Somali and Latin American communities. https://www.smm.org/toolkit/mindmatters

Nutrition and Fitness

- PowerUp: The PowerUp initiative makes it easy and fun for everyone to eat better, move more and live healthier lives. We do this important work in partnership with our members, patients, colleagues and communities through programs, tools and resources that support and inspire change.

  PowerUp has a special focus on kids and families because childhood overweight and obesity tripled in the past 30 years and remains a critical issue for the future of children's health. Research shows that today, kids are expected to live shorter, less healthy lives than their parents for the first time. Research also shows that it takes a multi-level approach, including schools, organizations and the entire community working together to change these trends.

In 2022, the PowerUp community health initiative continued to inspire and support kids and families to eat better, move more and feel good, while increasing focus and commitment to equity and the numerous factors that influence health and well-being in children. New resources were created to expand resources focused on ‘feeling good” with ways to relax and recharge, and resources were translated into three additional languages: Spanish, Hmong, and Somali. Community outreach was robust, both virtual and in person, and in 2022, PowerUp reached 64,686+ virtually, through classes, website, and e-newsletters, and 805 kids and families at 50 community events.

PowerUp School Challenge:
The School Challenge is an innovative program focused on encouraging elementary-aged students to get curious and excited to try fruits and veggies and move their bodies in fun, new ways. In 2022, schools told us it is a priority to help students feel good and recharge their bodies and brains. Therefore, “feel good” was added as a key focus alongside “eat better” and “move more,” helping kids explore the mind-body connection and ways to relax and recharge.

The School Challenge pivoted to increase flexibility and adaptability for any learning platform, whether inside a classroom or virtually from home. The challenge offers easy modules with digital tools, resources, and lesson plans, allowing teachers to choose when, where, and how to use them with their class. Teachers can now participate as an individual classroom or as part of an overall school program. This program is provided at no cost to schools or youth organizations.

By participating, teachers and youth leaders:

- Choose when, where and how to implement the challenge.
- Support and encourage students to eat better, move more and feel good.
- Earn classroom incentives to further promote student well-being.
- Receive fun and engaging PowerUp resources to share with students and families, available in multiple languages
- Are guided through the challenge with weekly program communications.
- Prioritize student wellness and do what's best for kids!

Now going into its tenth year, the classroom-based program includes more than 50 schools and on average, reaches more than 19,000 students throughout the region. As a result of participating in the challenge, 83% of staff and 74% of families reported positive changes in the eating habits, observing kids eating more fruits and vegetables.

Power Up School Challenge and Health Equity:
PowerUp is actively trying to reach and recruit more vulnerable communities to participate in the School Challenge. Using the Center for Disease Control’s Social Vulnerability Index, which uses census variables to identify communities that need extra support, we reassessed our recruitment strategy to target socially vulnerable districts and zips codes through partnerships, outreach, and social media ads.

With our increased focus on social needs and health equity, PowerUp convened the newly formed Community Health Education Advisory Council at HealthPartners to review and advise on the PowerUp Family Magazine, distributed to kids and families during the School Challenge. The group provided their perspectives and insights, keeping in mind inclusiveness, cultural relevance, health literacy, physical abilities, body sizes, and social needs.

- Hunger Solutions: Through our partnership with Hunger Solutions Minnesota (a nonprofit organization in Minnesota committed to ending hunger in MN), members/patients who screen positive for food insecurity are referred to the Minnesota Food Helpline. Hunger Solutions also helps screen for other needs the person may have such as housing or transportation. This partnership started as a pilot program with three HealthPartners clinics in 2017 and expanded to the health plan in early 2020. Electronic referral to Hunger Solutions continued to expand through 2022.

- SuperShelf: HealthPartners and Lakeview Hospital are founding partners of SuperShelf, an innovative project to transform food shelves by offering a positive, grocery store-like experience for members to access healthy and appealing foods. SuperShelf uses behavioral economics to make the healthiest choice the easiest choice while respecting individual preferences. There are now 40 SuperShelf sites across Minnesota who provide a welcoming and dignified experience for community members who are food insecure to access appealing, healthy food. https://www.supershelfmn.org/

- Unlockit: A program developed by Cycle Health and now integrated into the YMCA programming, is a map based outdoor scavenger hunt set at a variety of parks. HealthPartners is proud to be a sponsor in 2021 which tested the initial program. Programming expanded in 2022 including 16 parks. Participants may go anytime the park is open. Participants download the map, follow the clues, and unlock letters that, when unscrambled, form a keyword. They then submit that keyword to be entered to win fun prizes. https://www.ymcanorth.org/sites/default/files/Y-Adventure-Lab-UnLockIt-St-Croix.pdf?openyts=1675275840248

Health Equity

1. TPT: Racism Unveiled: HealthPartners is the sponsor of the new Twin Cities Public Television production, “Racism Unveiled.” The project is a collaboration with community members and leaders that examines the impact of systemic racism on Black, Indigenous and communities of color in Minnesota. https://www.tptoriginals.org/projects/racismunveiled/

2. Higher Ground Academy: A K-12 grade charter school located in Saint Paul, MN that serves primarily children of East African immigrants from Somalia and Ethiopia. Annually, Higher Ground Academy plans a career fair for their junior and senior high students. HealthPartners has recruited volunteers to participate since 2015. In 2022, six HealthPartners colleagues participated in reaching about 95 students.

3. Habitat for Humanity: Stable housing impacts educational achievement and a families' overall health. When HealthPartners and Park Nicollet combined in 2012, our organizations used volunteerism to learn about each other and share our values. According to *The Positive Impacts of Affordable Housing on Health A Research Summary*, when families pay excessive amounts of their income for housing, often they have insufficient funds remaining to meet other essential needs, including food, medical insurance, and health care. In 2022, HealthPartners sponsored 2 builds. 72 volunteers participated providing 576 volunteer hours.

4. Pride Festival: For 24 years, HealthPartners has participated in the Pride Festival and over 5 years in the parade. In honor of the 50th Year Anniversary of Pride in the Twin Cities, the HealthPartners booth at Pride hosted a polling question and distributed a charity gift of $5000 among three nonprofit charities based on participant's voting percentage.

   We asked, what *is your biggest barrier to care*? And we heard the following responses:

   - Cost of care/insurance (45%)
   - Finding an LGBTQ+ friendly clinician (17%)
   - Transportation/Location (9%)
   - I do not currently experience any barriers to care (29%)

   Our charity gift was then distributed to these local nonprofits who support the LGBTQ+ community: Reclaim; Twin Cities Pride; and Open Arms MN

5. Early Risers Podcast: HealthPartners is a proud ongoing sponsor of this impactful series and collaborates with Little Moments Count, Minnesota Public Radio and Think Small on this important anti-racism and anti-bias parenting and early childhood project. Each season of Early Risers features 6-episodes, released bi-weekly, in a podcast mini-series exploring talking with our youngest children about race and racism. Short, sweet, sometimes funny and always relatable, each episode runs between 20-30 minutes and helps parents, caretakers and educators tackle this big topic with their little ones. As of December 2022, the Early Risers podcast has been downloaded over 58,000 times, received nearly 175,000 impressions across social media pages, and was ranked 13th in the parenting category for Apple podcasts. Additionally, there have been almost 1,300 community downloads of episode discussion guides.
   https://www.littlemomentscount.org/earlyriserspodcast

6. Gender Services Navigator: Supported by the Park Nicollet Foundation, Park Nicollet Gender Services Department funds a gender services navigator role to build trust and help patients navigate often complicated care situations across our system. Examples include planning for gender affirmation surgery, connecting to transgender care, self-injection education, care coordination, and legal issues including name and gender marker changes. Since the start of the role in 2019, the Care Navigator has met with over 400 unique patients.

7. Saint Paul Public Library Bookmobile: Since 2014, HealthPartners has sponsored the Saint Paul Public Library Bookmobile, which is one of the last urban bookmobiles still in operation. The book mobile visits 45-50 sites on a regular basis in a two-week cycle reaching about 120,000 people per year. The Bookmobile ensures that the library is accessible to communities that face barriers in using the library's fixed facility due to transportation, cultural, language or other barriers. In addition to a financial contribution, HealthPartners also volunteers helping the bookmobile at local events. The bookmobile continued to operate in 2021 following COVID masking and distancing guidelines. And with additional grants, the bookmobile also expanded their wi-fi services for patrons. This was especially helpful when the fixed libraries were closed. In 2022, the bookmobile served over 1,500 children and families each week! https://sppl.org/bookmobile/

8. Twin Cities 32nd Annual MLK Holiday Breakfast: We sponsored the breakfast by purchasing steaming links to watch the virtual breakfast and distributed the links for colleagues to watch from their locations. we sponsored one in-person table at this annual event to celebrate Dr. King's legacy of service. In addition to sponsoring the breakfast, we encourage our colleagues to commit acts of service in the community and we provide community resources for colleagues to connect with in honor of Dr. King's legacy.

Wellness and Prevention

1. Diabetes and Hypertension outreach: In partnership with our care group, we identified Medicaid members who have diabetes and hypertension and created a program to get home blood pressure monitors out to these members. In total, we sent 3,143 monitors to members on our Medicaid products. The mailing included instructions on how to take a blood pressure reading at home and how to inform your care provider of the results. Our care group continues to work to engage with members whose blood pressure is outside of the recommended range.

2. Breast Cancer GAPS Project: HealthPartners care group participated in the Breast Cancer GAPS project which is focused on reducing disparities for Black breast cancer screening. This project heard from community members about why they are reluctant to get screened, then is using principles of community co-design to create solutions for these barriers. The project has created videos emphasizing that "We Matter" to encourage women of color to get screened. HealthPartners is working on how we will integrate those videos into our outreach on an ongoing basis.

3. Other targeted outreach: In partnership with CHW Solutions, HealthPartners implemented targeted outreach to our diverse MSHO membership to encourage them to receive breast cancer screening. As trusted members of the community, CHW Solutions staff were able to reach out to our members to remind them of important cancer screenings. They reached out to members in their native language when possible and utilized interpreters when needed. Languages included in the outreach list included English, Spanish, Hmong, Karen, Oromo, Russian, Romanian, Somali, Swahili, and Vietnamese. Of the 163 members identified, CHW Solutions was able to engage with 83

members, for a 51% engagement rate (61% if bad phone numbers are removed from the total). Members widely reported appreciating the outreach. Members who spoke English accepted help scheduling an appointment at a rate of 21% and those who spoke a language other than English accept assistance making an appointment with their clinic 17% of the time. Even for people who do not have a language barrier, engaging with the health care system can be intimidating. The support of a CHW helped to break down barriers to care for these members.

In addition to this outreach, our breast cancer screening reminder campaign was translated into Somali, Spanish, and Vietnamese to increase access to this information for more of our members.

4. Keystone Community Services: For over 80 years, Keystone Community Services has been serving Ramsey County with senior care, enrichment for children, basic needs, and crisis assistance. Keystone began as a small neighborhood community center. Today, Keystone reaches more than 40,000 people, and we share many patients and members. Keystone currently operates two food shelves Rice Street Food Shelf and Midway Food Shelf. And when HealthPartners was piloting our SuperShelf initiative, the Rice Street Food Shelf was a pilot! Our 3-year commitment made in 2022 has been used to support the expansion of their new warehouse and food mobile providing better access to neighborhoods with barriers. Keystone food shelves and food mobile provide quality, healthy food for the community, helping them be self-sufficient, stable, and successful.
    - Express Bike is a social enterprise of Keystone Community Services. Express Bike is a full-service bike shop specializing in refurbished bicycles and a nonprofit youth employment program - all rolled into one! In April of 2022, we hosted bicycle drives at four HealthPartners locations collecting 136 bicycles to support this program.

5. Open Arms: Since 1986, Open Arms of Minnesota prepares and delivers tasty, nourishing meals to critically ill Minnesotans and their families in need—100 percent free of charge. HealthPartners is proud to support the capital campaign to expand their services and opening a new kitchen in Saint Paul. https://www.openarmsmn.org/about-us/

Research and Education

1. Minnesota Health Literacy Partnership: This group shares information and engages in joint planning on health literacy issues from a statewide perspective. The group is committed to advancing health literacy, so all people in our community can understand and engage in their health and health care.

2. The Exchange: We participate in The Exchange, a collaborative of Minnesota health-related organizations. Members combine resources and collaborate to create and maintain an online library of health-related materials in languages most spoken in

Minnesota. The Exchange also disseminates information on issues of literacy, class, culture, race, and spirituality as they affect health disparities.

3. Make It. MSP: HealthPartners sponsors and is a key player in the Greater Minneapolis/St. Paul initiative called Make It. MSP, which is an initiative to help make the Minneapolis/St. Paul region a top performer in attracting and retaining people. As part of this initiative, we have representation on (1) the Make It. MSP People of Color Cohort, which is focusing on recruiting and retaining people of color to positions in the region and (2) the enterprise talent team, which focuses on recruitment into the region.

4. Shadow Program with Roosevelt High School: For the past 4 years, Park Nicollet has partnered with Minneapolis Roosevelt High School's Health Careers Program to offer mentorship opportunities for career exploration in the health care setting. Due to COVID-19, the structure had to change so there were no student shadowing opportunities, but Park Nicollet leaders still participated in the board and job fair. This will resume in 2023 with 15 students mentoring in February and March 2023.

5. Patient Care Assistant Apprenticeship: This program seeks to provide individuals with a place to begin a career in healthcare by providing them with the training needed to work in patient care. It also offers a career path for current employees in more entry level environmental services roles. With two pilot groups completed in 2021 and an additional cohort in 2022, we are assessing this program and hope to continue this program with modifications to enhance effectiveness.

6. Below are other 2022 school/student partnerships:
    - Washington Magnet School partnership: Regions partnered with this school to provide a diverse group of students with introductions to careers in health care. Each school year Regions engages with a student cohort of about 20 racially diverse students for four interactive learning events that introduce them to health care occupations and inspire them to consider their future careers.

    - HEIP/Scrubs Camp: Regions Hospital continues to support this important student experience that introduces young people to a variety of careers within healthcare. Regions Hospital supports this program in a variety of ways including advisory, facilitating learning sessions or tours, and at times through financial contributions to provide scholarships.

    - HOSA (Health Occupations Students of America): As a supporting member of HOSA, we help promote health care careers to high school students providing leadership on their board of directors, hosting student tours, and participating in numerous student experiences and competitions each year.

    - Enhanced Tuition Assistance Program: In 2022, we continued our enhanced tuition assistance program. This program exists through a partnership with Eastside Financial Center to increase economic growth and jobs for residents of St. Paul's

eastside community and help increase the diversity of healthcare workers at all levels of employment.

7. Career Fairs: HealthPartners actively seeks to hire a diverse staff and our recruitment team participated in several career fairs that focused on diversity. These events with local community organizations help promote their events and provide an opportunity for recruiters to meet with community members to increase diverse hiring. Examples of events we attended include:
    - Inver Hills Community College Allied Health Careers
    - CareerForce Veterans Employment Services and MDVA Career Fair
    - CLUES
    - Ramsey County Career Fair
    - Hmong Nurses Association Conference
    - Law Enforcement Opportunities Job Fair
    - St. Catherine's University Career Fair
    - MN Society of Radiologic Technologists Conference
    - Minneapolis College Career Services Event
    - Irondale High School Healthcare Career Fair
    - Mounds View High School Career Fair

Career growth and development

1. Accelerated Development program: In 2022 Regions resumed its Accelerated Development program which serves to inform, inspire, and prepare a diverse group of employees who have interest in advancing their career into future leadership roles.

2. Right Track and Right Track Plus programs: Regions hosted two interns from the St. Paul Right Track program in 2022.

3. Throughout 2022 we partnered with the International Institute of Minnesota who serves individuals new to the U.S. with job preparation and employment. Our partnership includes hosting their clients for tours of our hospital, informational sessions about health careers, mock interviews, and job placement.

4. In April of 2022 we supported Hospitality Career Pathway by conducting mock interviews with individuals with English as their second language to support their preparation for successful job interviews.

5. CompTIA Tech Career Academy: We partner with CompTIA Tech Career Academy's IT Ready program to host interns in our IS&T department. The IT Ready program specifically recruits women, people of color and veterans into their programs. In 2021, our IS&T department hosted 3 interns, and all were hired into permanent positions.

6. Prime Academy's "Prime Career Day": In January 2021 our IT hiring leaders participated in Prime Academy's "Prime Career Day" mock interviews. Prime Academy's focus is to humanize technology by bringing diverse and driven problem-solvers to the challenge of

creating a better tomorrow. They assist students in launching their tech careers through their Full Stack Engineering and User Experience Design programs.

7. Minneapolis Community & Technical College: In September 2021, the recruitment team participated in a panel discussion of local employers regarding the job market and healthcare careers with the Minneapolis Community & Technical College and their students. Minneapolis Community & Technical College students are 62% racially diverse.

8. AchieveMPLS: In November 2021, the recruitment team also participated in a panel discussion and mock interviews for college student interns via AchieveMPLS which is the Minneapolis Public Schools career and college readiness program.

Recruitment:

- Through HealthPartners/GHI's partnership with Minnesotadiversity.com, HealthPartners/GHI recruits diverse, local candidates through online advertisements on: JobsinMinneapolis.com, JobsinStPaul.com, MinneapolisDiversity.com, StPaulDiversity.com, and MinnesotaDiversity.com. These sites attract over 2 million monthly visitors and help us connect with local, diverse, quality applicants. This site promotes HealthPartners/GHI's open positions through 383 community and diversity outreach organizations within 50 miles of the city of Minneapolis. These organizations assist women, racially diverse individuals, individuals with disabilities and veterans with employment. Each of HealthPartners/GHI's open positions is emailed with a request for referrals to matched organizations. Some organizations include local workforce offices and their veteran employment representatives, Goodwill, YWCA, and the local vocational rehabilitation offices.

- In addition, the recruitment team also posts position in a variety of websites sites including MinorityNurse.com, NursingDiveristy.com, MABL (Minnesota Association of Black Lawyers), National Native American Bar, Clinical Lab Management Association (CLMA), Health Care Compliance Association (HCCA), MN Council of Non-Profits, and many college web sites.

Recruitment staff development:

1. Participation in several diversity, equity, and inclusion focused webinars and/or seminars including: Talent Flow - A workshop by The Diversity Institute in Honor of Black History Month, Reckoning with Women of Color, Money & The Workplace put on by the Center for Economic Inclusion, MN Dept of Labor & Industry webinar "Race + Gender Matter at Work- How to Truly Value Different Perspectives Across Identity", MN Talent & Recruiting Network seminar "Hiring Non Traditional Candidates in the Underserved population" which focused on hiring veterans, individuals with disabilities, etc.

2. Participated in mock interviews through Achieve College Internships. Achieve College Internships connects diverse college students with professional internships in the Twin Cities.

3. HealthPartners sponsored the 1st annual national Hmong Nurses Conference in May, 2022 and attended their conference career fair.

4. HealthPartners participated in the 30,000 feet Tech Geek intern program by hiring 3 diverse students as interns in our IT Department.

5. HealthPartners IS&T sponsored the Open-Source North conference and attended their conference career fair.

6. Several recruiters participated in a 4-part internal “Bias for HR Professionals” course including information on recognizing and mitigating bias in human resources.

7. We participated in the Ramsey County Healthcare Futures event including participating in a panel discussion about careers in healthcare for high school students.

8. We hosted several virtual career fairs through Indeed.

9. We participated in 2 virtual career fairs put on by Dakota County Department of Employment & Economic Development

Other Partnerships and Campaigns

1. School-Based Health Centers: in 4 high-need school district locations provided no-fee medical care, prescription support, dental services and insurance navigation to 4,272 children and youth from birth through high school graduation. This service also provided 740 no cost immunizations to children. Additional dental education and education/outreach was provided to 1,700 children and families. Services are provided in the Brooklyn Center, Burnsville, Richfield, and St. Louis Park school districts.
    - Interpreted visits: There were 242 no-cost interpreted visits in the four school clinics in 2022.
    - Naloxone (NARCAN): Park Nicollet partnered with Burnsville/Eagan/Savage District 191 health staff leaders to create a Naloxone policy and train staff and provide advisory and standing orders service.
    - Mantoux testing: Central Clinic clinicians and support staff partnered with St. Louis Park Public Schools and other partners, to provide a Certified Nursing Assistant program so that they have a career track upon graduating from high school. HealthPartners/Park Nicollet provided Mantoux testing services at the school that supported 48 participants to gain medical eligibility to participate.
    - Central and Diamondhead Clinics provided extra catch-up immunization and STI testing days to meet emerging needs identified by school health staff.
    - Brooklyn Center Health Resource Center Equity Assessment: Park Nicollet Foundation is partnering with Brooklyn Center Community Schools and the NW Hennepin Family Resource Collaborative to conduct a health equity assessment at our school clinic in Brooklyn Center High School

2. Growing Through Grief Program: Growing Through Grief (GTG) includes eight Park Nicollet counselors providing group and one-on-one grief counseling to students who

experienced the death of a family member or friend. Provided in 114 schools across 16 partnering school districts, the program supported more than 665 students per week. Assistance was also provided to support school districts in responding to 18 death-related crisis events supporting about 25,383 students, parents, and school staff with a total of10,281 contact hours of support for students and parents. In addition:

- GTG staff partnered with Minneapolis Public Schools to create an eight-week grief curriculum focused on community unrest, death, and related loss. This program was piloted with combined White and BIPOC staff from both organizations and will be rolled out to Brooklyn Center and Richfield school districts who have also experienced recent elevated levels of community violence and unrest.
- GTG staff partnered with New York Life Foundation to assist Westonka and Osseo school districts in presenting grief sensitive information and becoming Grief Sensitive School Districts
- Growing Through Grief Changemakers Cohort: GTG was chosen to be part of a national cohort of child bereavement service providers to develop and enhance their data collection, evaluation, and assessment capacity.

3. The NOW! (No Obstacles to Well-Being!) Tele mental Health Program: This program provides no cost school based mental health services in partnership with school districts via secure video technology and virtual platforms to children and adolescents in need. In 2022, mental health services were provided to 52 students with 744 hours of therapy in the Burnsville, Richfield and St. Louis Park school districts.

4. Mobile Mammo-a-Go-Go Community Outreach Program: Park Nicollet Foundation and Jane Brattain Breast Center partnered to support 66 events providing no-fee 3-D breast cancer screening, diagnostic services, and breast health education to 1,186 women-in need across our communities. 11% required follow up and 4 were diagnosed with cancer.

5. COVID-19 Vaccine Catch up Initiative: Park Nicollet Foundation provided support to enable two COVID-19 vaccine clinics in low income, vaccine hesitant communities. St. Louis Park firefighters and our Methodist Hospital MDA pharmacists partnered to provide COVID-19 vaccines to vulnerable community members in St. Louis Park.

6. Spiritual Care in Methodist Hospital. Park Nicollet Foundation provides funding to ensure patient services are available in all religious faiths.

7. The Grove: Park Nicollet Foundation and Methodist Hospital created an intentional outdoor space of healing with trees, paths and sitting places convenient to hospital patients, families and staff to meditate, reflect and promote mental health.

8. Hospice program for veterans: Park Nicollet Foundation provides funding to our hospice programs to provide care and special needs items and supports to veterans in hospice. In 2022, over 436 veterans have been served through this program.

9. Diabetes health literacy: Park Nicollet Foundation provided funding for our diabetes program to support the creation of a set of special illustrations for patients with low-vision and or low-literacy, related to diabetes care to use in education and care materials. A set of those tools focus on describing hyperglycemia and hypoglycemia to low-literacy audiences or those who speak English as a second language by using primarily quality illustrations that depict symptoms of both conditions.

10. Diabetes disparities: Park Nicollet Foundation has been providing funding for, and in partnership with the Internal Diabetes Center and the Park Nicollet Brookdale Clinic to conduct a series of targeted patient care programs with research to address/improve outcomes for diabetic patients of color.

11. George Floyd Global Memorial Art & Offerings Exhibit: Methodist Hospital, supported by Park Nicollet Foundation, began planning and partnering with the George Floyd Global Memorial Foundation to bring a 100-piece exhibit of community expressions to the hospital public spaces during January-March of 2023. Planning began in September 2022 and is expressly designed to promote healing, acceptance, and equity in care.

12. Itasca Project: We continue our work with the Itasca Project. This is an employer-led alliance to address regional issues that affect our future competitiveness and quality of life. A major focus of the Itasca Project is closing the gap on socioeconomic disparities in the region through collective action by businesses. The Itasca Project, a cross-sector alliance of employers, launched the First 1,000 Days initiative to help raise awareness among employers of the lifelong impact of early experiences prenatal to age 3. Our Little Moments Count collaborative helped to create the employee toolkit: https://www.littlemomentscount.org/employer-tool-kit

13. Rondo Neighborhood: HealthPartners is a proud sponsor of the Rondo Commemorative Plaza. In the 1930s, the Rondo neighborhood was a thriving and vibrant community. By the 1950s, about 85% of Saint Paul's African American population lived in the neighborhood. The community bond was strong, local businesses were thriving, and residents were gaining financial stability that comes with home ownership. In the 1960's, however, the neighborhood of Rondo was removed from the map for the construction of Interstate 94. 600 families lost their homes along with numerous businesses and institutions. The Rondo Commemorative Plaza was installed to capture the history of loss endured, lessons learned and the will to reconnect. In 2022, we participated in Rondo Juneteenth festival sharing health education and blood pressure checks.

14. One Campaign: The One Campaign is HealthPartners' biggest campaign for internal team member support of our hospitals' foundations and community nonprofits. The campaign was a success and $642,362 was raised supporting patient care and community programs and organizations.

Collection and Use of Data on Race, Ethnicity and Language Preferences

1. HealthPartners systematically collects data on race, ethnicity, language and country of origin directly from patients and members in a variety of ways, all of them voluntary. These data collection sources include healthpartners.com, online through our health assessment, and the electronic medical record in our care delivery system and in our dental group. We've found that collecting this information face-to-face from patients at the point of care or health plan contact is an effective data collection method. Across our care delivery system, we have collected race and language information for over 90% of our patients, with language and race collection rates at our hospitals exceeding 97% in 2022. In addition, we receive data from the Minnesota Department of Human Services, Minnesota Community Measurement, and Minnesota Immunization Information Connection (MIIC) for our members covered by Minnesota Health Care Programs. When we combine all these data sources, we have this information documented for over 97% of our Medicaid members under age 65.

2. We use this data to monitor the quality of care delivered and patient/member experience by race, ethnicity, and language. We also use the data to identify strategies to reduce health disparities in treatment, outcomes, and service.

3. We include race, ethnicity, and language data on the member registries we make available to network providers so they can identify and address disparities among their patients.

4. Where data is voluntarily available on provider race, ethnicity, language and/or country of origin, we use that data as a resource to respond to patient/member requests. Some of this data is available in the provider directories as well.

5. Hospital equity alignment: Using recently published hospital health equity standards from the Minnesota Hospital Association, Joint Commission, and CMS Hospital Inpatient Quality Reporting Program (HIQRP), we set out to document progress towards meeting the standards across all hospitals in our care system, identify gaps, and set clear goals to close these gaps.

    a. Cross-walked equity standards to understand requirements.
        i. Key elements across the standards include:
        ii. Health Equity as a strategic priority and an organizational culture & structure to advance the work.
        iii. Valid and reliable data collection and the ability to stratify key measures to identify disparities and address health-related social needs.
        iv. Documented work to address identified disparities and health-related social needs.
        v. Regular communication to and engagement of key stakeholders.

    b. Documented system level work being done to meet standards and shared with all hospitals.

c. Set 2023 hospital system equity goals to address identified gaps, building on work already in progress.
    i. Valid and reliable data collection:
        1. Standardize and train on data collection best practices across all hospitals.
    ii. Addressing patient's social needs:
    iii. Standardize collection of SDoH data and use of UniteUs to address social needs with a focus on transportation, food, and housing.

d. Quality improvement work to eliminate disparities:
    i. Continue work with Premier Perinatal Collaborative. Target improvements in emergency treatment of hypertension.
    ii. Bring disparity data to the Hospital Quality Steering Committee for prioritization to the appropriate committee.
    iii. Continue to build capacity and commitment at the local level.

e. Routine communication to stakeholders:
    i. Annual reporting (minimum of 1x per year):
        1. Hospital Board of Directors
        2. Patient Family Advisory Committee (PFAC)
        3. Medical Executive Committee
        4. Patient Care Committee
    ii. Additional quarterly reporting through:
        1. HP Health Equity & Eliminating Disparities Cornerstone
        2. Joint meetings of Methodist and Regions HEC

6. Health Equity Accreditation: Starting in 2022, HealthPartners implemented NCQA Health Equity accreditation standards for our Medicaid products. According to NCQA, this accreditation program focuses on the foundation of health equity work and supports health care organizations in evaluating and elevating the health of the populations they serve. Specific focus areas include building an internal culture that supports the organization's external health equity work; collecting data that helps the organization create and offer language services and provider networks that are mindful of individuals' cultural and linguistic needs; identifying opportunities to reduce health inequities and improve care. HealthPartners will formally apply for this accreditation in January 2023.

7. MN Community Measurement (MNCM): A collaborative HealthPartners is part of to improve health by publicly reporting health care information. The 2022 MNCM Health Care Disparities Report includes 8 publicly reported measures.

Language Assistance

1. We provide interpreter services in all key languages spoken by patients and have access to over 200 languages through telephone and the use of video remote interpretation. We consistently provide high quality face-to-face (including dedicated staff

in high-volume locations), telephone and video remote interpreter services to our patients in their preferred language for health care.

2. 100% of employed interpreters at HealthPartners have a minimum of 40 hours of professional training. 71% of HealthPartners employed interpreters hold national medical interpreting certification.

3. Updated annually, our Language Assistance Plan sets organizational best practices and expectations and is accompanied by the practical Your Guide to Interpreter Services. Your Guide provides answers to questions such as how to access an interpreter and how to talk with patients who wish to rely on family members to interpret. Training is conducted on these tools to support continued improvement in health and experience outcomes. Most recently, it has been further updated to reflect the most current federal government guidance on notification to members and patients on their right to language services (ACA 1557), updated data to reflect our membership, and updated organization structure information.

4. HealthPartners Interpreter Services leaders meet with all contracted agencies as needed to ensure they are meeting service standards and to engage them in improvement activities that support the Triple Aim.

5. Vocera units have been activated and dual handset phones are available at our largest hospital to support improved access to and use of telephonic language services. Several clinic sites also made improvements to their infrastructure and workflow to offer improved telephonic language services, and video remote services are available widely throughout our hospitals and clinics.

6. HealthPartners Interpreter Services facilitates the Interpreter Services Leadership Group, a Minnesota-based group of health care interpreter services leaders who meet to share best practices and work towards common goals related to service delivery, quality improvement, education, and affordability of language access services.

7. Interpreter awareness education continues to be offered in multiple new employee settings as a regular part of the agenda, including provider NEO at HealthPartners, HSC NEW, Regions NEO, and New Resident Orientation. HealthPartners member services, sales, case management and other representatives also are trained in how to use telephonic interpreter services. HealthPartners also sponsors several interpreter continuing education workshops each year for both employed and contracted interpreters. In 2022, workshops were offered on (1) building an LGBTQ+ inclusive environment and (2) best practices for health care remote interpreting.

8. HealthPartners interpreters were involved in several activities that benefit our patients, members and community. In 2022, these activities included:

   Participating in community benefit activities, including:

- Translating health and financial education materials into Hmong, Spanish, Oromo, Somali and Vietnamese.
- Providing training to interpreters through two continuing education events.
- Providing translation and voicemail interpretation services to Diamondhead Clinic, a free school-based program.
- Making outreach calls to select Somali-speaking patients who are overdue for a mammogram.
- Providing Spanish interpretation services to patients attending Lactation Cafés at several Park Nicollet clinics and Methodist Hospital.
- Three student interns from Century College were trained by our staff in 2022. Students were also invited to attend our continuing education events.

9. HealthPartners Government Programs provides an annual virtual interpreter training for contracted interpreters. The training topic for 2022 was "Hospital to Home: Safe Discharge Planning." The presenters for the training were Sue Oestreich, RN, BSN/PHN, CCM: Director - Care Coordination Programs, HealthPartners Comprehensive Care Advocacy; Florence Okoampa, LGSW, CCM: MSHO/MSC+ Program Manager, HealthPartners Comprehensive Care Advocacy; and Thomas von Sternberg, MD: HealthPartners Associate Medical Director. Participants for the training were eligible to receive 0.15 CEUs through the International Medical Interpreters Association. The training generated good discussions between the participants and presenters.

10. NCQA Health Equity Accreditation: As part of implementing NCQA Health Equity Accreditation standards, HealthPartners deployed surveys to gather information on member and staff experiences with language services. HealthPartners also surveyed network practitioners on providing culturally responsive care; this survey included questions about practitioner comfort and experience with providing language services to members.
    - Based on results from the staff survey, we developed a guide to assist health plan staff process requests for written translations, including decision support tips and a step-by-step guide on working with our written translation vendor. Member-facing departments also identified high-value member-facing documents and completed translation of approximately 38 member-facing documents in 2022.

    - Member experience with language surveys are sent only to Medicaid members, but results are shared with business areas that serve all members so insights can be applied broadly. These surveys assess experience during both health plan and health care encounters at our own care group and beyond.

    - Practitioner cultural responsiveness survey goes to network practitioners that may provide services to members with any form of HealthPartners coverage. In 2022, survey results provided insights into the need to provide more resources to practitioners on providing culturally responsive care, which led to HealthPartners issuing a Health Equity edition of Fast Facts (a newsletter available to all network

practitioners). We also collaborated with UCare and Stratis Health to create a website with resources to help providers advance culturally responsive care in their practices. https://culturecareconnection.org/cultural-responsiveness/.

- Staff and member survey results are shared with the enterprise Interpreter Services Workgroup who will continue to assess trends and implement changes around our language services on an as needed based on year-over-year data.

11. After-visit summary translation: Our static after-visit summary (AVS) content is now available in both Spanish and Vietnamese. We deployed this functionality in emergency centers across our system effective August 2021 and in the inpatient setting on February 22, 2023. We continue to collect user feedback as we move forward for deployment in other settings in 2023.

12. Patient instructions: Through our partnership with Healthwise, more than 3,600 Patient Instructions are now available in Epic in English and Spanish. These instructions can be added to the after-visit summary/discharge instructions and printed for patients.

13. Patient education: Park Nicollet Foundation funded the production of low-literacy versions of patient education content on recognition and management of high and low blood glucose. We received federal funding to translate a variety of preventive services and disease management patient education documents in multiple languages, including Spanish, Somali, Vietnamese and Hmong. In 2023, we plan to translate our colonoscopy prep content, heart failure and Ramadan-focused nutrition patient education content, among a host of others that we hope will advance health equity.

Member Materials & Communications

1. Member materials are created using a consumer-friendly checklist to ensure that communications are understandable, conversational, and consistent.
2. The MSHO summary of benefit is available in Spanish, Hmong and Somali, or other languages as needed, upon request. In addition to the summary of benefits, we can translate most materials upon request and in languages other than Spanish, Hmong, and Somali. We also translate some member outreach for preventive health services into Spanish, Hmong, Somali and Vietnamese.
3. Promotional materials, websites, and blog posts reflect the demographics that exist in the population, making photos racially, ethnically, ability, and age diverse.
4. Custom communications developed for some employer groups have been translated to better serve our Spanish and Somali speaking members.
5. Open enrollment materials for commercial products are available in Spanish and English.
6. HealthPartners Minnesota Health Care Programs and MSHO: The required DHS Language Block (LB) must be included with all member communications and materials. For small-sized materials, a condensed version of the language block is permissible. Additionally, materials that cover the following topics must include the DHS required Civil Rights Complaint Block (CB).

- Determine eligibility for programs.
- Require information needed for program eligibility.
- Inform members that their benefits have been increased, decreased terminated or denied.
- Include important information about the member's rights and responsibilities.

The DHS Civil Rights Complaint Block contains information about member civil rights and how a member can file a complaint if they believe they have been discriminated against.

7. The Minnesota Health Care Programs materials are translated upon request, including the Medicaid/MSHO/SNBC and welcome letter.

8. The MSHO sales cover letter is translated in Spanish, Hmong, Korean, Vietnamese, Russian, and other languages upon request.

9. The Multi-Language Insert (MLI) is a standalone document that must be included with all CMS required materials for Medicare individual and group plans. The MLI is a standardized notification that informs the reader that interpreter services are available in 15 of the most common non-English languages in the United States.

10. The Affordable Care Act Section 1557 Non-Discrimination Notice and Taglines are provided to all members. This occurs in our annually mandated information mailing in June.

11. Created advertising on local radio stations and/or in diverse community publications for Somali, Hmong, Native American, African American, and Hispanic populations.

12. Development and promotion of unique supplemental benefits for MSHO members address social determinants of health and support members with chronic conditions, including benefits such as FarmboxRx fresh produce delivery, animatronic support pets, caregiver support, and tablets with education and wellness tools.

13. Pregnant members in the Healthy Pregnancy program have access to personalized digital support through the My Pregnancy experience when they log into healthpartners.com. This includes personalized resources based on the pregnant person's race, ethnicity, language and insurance product. For example, D.I.V.A. Moms is surfaced as a resource for Black pregnant members. It is an African American led program designed for pregnant and postpartum Black women. Similarly, members on a Medicaid product receive personalized information about unique benefits such as covered Doula support.

Building an Effective Workforce to Support Health Equity, Diversity, and Inclusion

1. Twin Cities Pride Festival and March: 115 colleagues volunteered at the festival and walked in the Pride march that was held in-person for the first time since 2019. HealthPartners donated $5,000 to three LGBTQ+ organizations in the community.

2. Continuous updating of the internal Diversity, Equity and Inclusion (DE&I) website: As a part of the organization-wide effort to migrate two different internal platforms into one, the DE&I internal website is continuously updated with relevant and timely DEI related information.

3. Diversity, Equity and Inclusion Dashboard: Created and shared first ever colleague diversity dashboard that shared the racial experiences of colleagues within the organization and specific organizations. Met with all senior leaders and direct reports to share their dashboard with them. Trained HR colleagues on usage of, creation of, and understanding of data behind demographic data. Leaders utilize the findings in the dashboard to create annual plans and DEI goals.

4. Inclusive Leader Workshop: a 4-part module offered to leaders builds tools to create an inclusive workplace for their teams and the community we serve. Leaders develop skills to have coaching conversations with their teams, learn how to use the equity lens toolkit to bring equity to policies, practices and procedures, and build a DEI strategy for their respective teams. In 2023, we had 14 cohorts complete the training (130 leaders), 50 different applications of the equity framework, and 15 DEI plans created.

5. Unconscious Bias Training: A training offered to all colleagues. This 4-part module deepens our understanding of how unconscious bias can impact others and the work that we do. Colleagues learn to identify bias, mitigate bias and how to move beyond bias to actionable anti-racist results. In 2022, there were 38 facilitated sessions (926 colleagues completed 1 session and 113 completed all 4 sessions). Post surveys show significant increase in understanding and confidence explaining bias to others.

6. LGBTQ+ Training: Revised available training for colleagues on LGBTQ+ using updated language and more inclusive examples in collaboration with the Diversity, Equity and Inclusion department and the LGBTQ+ colleague resource group.

7. Colleague Resource Groups: are voluntary, employee-led groups organized around shared underrepresented identities throughout HealthPartners, such as race, gender, age, sexuality, veteran status, and disabilities. Additionally, groups may be organized around shared interests that affirm diversity and inclusion throughout the organization. They help us serve the diverse and individual needs of patients, members and customers, as well as strengthen respect and inclusion in our workplace. In 2022, we had three active groups: Black and African American, LGBTQ+ and leaders of color resource group.

8. Clinician Affinity Groups: similar in nature to colleague resource groups, clinician affinity groups are voluntary, clinician lead groups organized around areas of identities and areas of collective interests.

9. DEI Simulations: In efforts to create an anti-racism workplace, HealthPartners pulled together colleagues from Clinical Simulation, Diversity & Inclusion and Nursing Education to create scenarios rooted in bias, many created off actual colleague experiences, to help others understand how to respond and what to do next in bias situations.

10. Listening Sessions: HealthPartners offered quarterly listening sessions to our staff with a panel discussion around areas of diversity. In 2022 we held four listening sessions that reflected different dimensions of diversity, including ageism, disability, LGBTQ+ and being a racial ally.

11. Gender Care Coordination: The Gender Services team has been leading efforts to coordinate patient access and consistent, quality care and experience across the organization, which has included collaborating with clinicians and teams across multiple departments and locations who provide gender care to patients. This collaboration has focused on multiple areas of gender care and created standards of care, patient education materials, and clinician trainings and resources to support quality care.

12. Culture Roots: We have extensive internal communications to build staff understanding and capabilities in cultural humility. The bimonthly “Culture Roots” newsletter continues to be an organization-wide educational tool. The Culture Roots subscriber list is currently at 841. Topics for 2022 included addressing breastfeeding disparities, partnering to advance health literacy, eliminating disparities in childhood immunizations, ageism in health care, and improving accessibility to advance health equity.

13. Health Equity Champions: The HealthPartners Health Equity Champions program continued in 2022. The champions are staff members and providers who receive expert training so they can become advocates and serve as local resources for their colleagues in caring for patients from diverse cultures and those with limited English proficiency.
    a. Nearly 338 Champions were participating by end of 2022; we had 52 new Champions join us this year.
    b. In addition to producing Culture Roots, the Health Equity Champions team distributed announcements to help increase Champions’ awareness of and participation of various health-equity-related events and activities.
    c. We continue to use our Teams channel to communicate in real time to share insights, news and announcements. Champions opt-in to this dedicated Teams space. Currently, 113 members stay connected through this channel.
    d. Our 2022 annual event was held virtually in October. The topic was on ageism. Our presenter was Dr. Rajean Moone, Associate Director of Education at the Center for Healthy Aging & Innovation at the University of Minnesota. Dr. Moone’s presentation included an age-friendly organization assessment tool that

we can use to address ageism in our organization's culture, practices and policies.

e. The Health Equity Champions program held several additional virtual events in 2022. The presentations were well-attended and generated positive feedback.
    i. We held four quarterly Teams presentations in 2022 to help Champions stay updated on health equity activities, programs and initiatives happening across our system. Each presentation focused on initiatives cascading up to the "eliminating disparities" cornerstone of our organization's equity, inclusion, and anti-racism work. Topics included health equity research updates, the HealthPartners Children's Health Council, using our organization's framework for designing for equity, and our Addressing Health Disparities Maintenance of Certification (MOC) project.
    ii. We held two "community organization spotlights," designed to highlight organizations that had volunteer opportunities and whose mission aligned with our vision to advance equity and inclusion and eliminate racism.
f. Champions continued to have opportunities this year to participate in small-group feedback sessions or pilot trainings to lend a diversity lens to various projects we have happening across the organization.
    i. Early in 2022, we sent out a survey to Champions asking them about the organizations they volunteer with. This was in partnership with Community Relations. We evaluated the responses to inform how we might proceed with our Volunteer Spotlight presentations done throughout 2022.
    ii. We sent out an invitation in October for Champions to participate in focus groups to discuss member communication for Indigenous populations.

Equity, Diversity and Anti-racism website: This is a landing page for our Cabinet and links to our Cornerstone work. The site helps provide structure to our work, easily shares information about that work, resources, and calls out ways colleagues can get engaged.

Assessment of Effectiveness

We routinely review and analyze race and ethnicity data to identify, test and implement strategies to reduce disparities in treatment outcomes and service. We have found that developing consistent workflows that help caregivers identify and offer needed services to all patients—and then customizing those services based on cultural, linguistic, socioeconomic, or other differences, helps reduce health disparities. Our approach is to continually improve our performance. The following are examples of disparity-reduction initiatives that we continued to refine and improve in 2022.

Example #1: Mammography Screening Improvement

Accountable owner

Paula Indehar – Improvement Specialist

Member Populations Targeted

x	Commercial
x	Medicare Freedom (Cost)
x	Medicaid
x	MSHO
x	HPUPH
x	WI Marketplace

Description

In 2007, we identified disparities in mammography screening rates between patients of color and white patients and between government programs patients and other patients. Since then, we have conducted many interventions to continually improve our performance. Interventions included culturally humble scripting on preventive services, same-day mammograms, and telephone outreach to patients of color and government program populations of women ages 50 to 75 who were not up-to-date on a mammogram. We implement focused interventions with consultant support at clinics with the greatest opportunities.

For 2020, we continued to work across all families of care with an additional focus of delivering screening mammograms safely within a pandemic. We have 27 locations with onsite mammography and almost all sites offer 3D technology. We have extended hours at our locations to include weekends and some evenings to accommodate patient needs. Mammo- a Go-Go truck has added two additional HealthPartners sites to their list of locations they travel to. We had to adjust some of our processes for same day mammography to allow for a safer environment for our patients for screenings. Same day mammograms started back up in September of 2020. Breast cancer screening registry outreach was put on hold for a few months but was resumed in October of 2020 and revised the communication we provided sharing the steps we have taken to make it safe to come in for screenings. In 2021 we began our focus around access, innovation and communication. We partnered with the Health Equity Saint Paul Anchor strategy cornerstone on building trust with our patients and communities. All this to

increase screenings and decrease our disparity rates for patients of color and government program patients.

We continue to learn about how we can best reach our patients and get them in for the screening tests they need. The goals for mammography screening rates are to increase rates for all women and to decrease the disparity in rates between patients of color and white patients (as well as between government program patients and other-insured patients).

For 2023 our focus continues to be on our disparity gaps between patients of color and white patients as well as our disparity gaps in our commercial payors and government plans. We currently are having staffing challenges which is contributing to our access and availability on weekends and evenings. Our radiology groups have been actively recruiting and working with schools seeking candidates. We are continuing to offer same day and walk in availability at our sites and working towards a 10% increase from the 2022 totals. We are seeing success in our current outreach to our patients when using the channels of a direct email, text, or letter.

Goals

Our main objective is to close the disparity gaps we are seeing in our women of color vs white women. We will see the impact of this work by seeing a decrease in the gap over the year.

We are focusing on women who are 52-74 years and who have had a mammogram in the last twenty-seven months. We exclude women who have a bilateral mastectomy, are deceased, are frail, are a permanent nursing home resident, orthose that are currently enrolled in hospice.

As of January 2023, in our care group we have 117,878 eligible women and 81.59% of those women have been screened for breast cancer. Patients of color account for 14.1% of the eligible population at a screening rate of 72.08%. White women account for 84.1% with a screening rate of 83.66%. The remaining 1.7% have an unknown race and are screening at a rate of 58.49%. For our disparity gap between commercial payors and government payors, our care group is at a rate of 65.43%. Our commercial payor patients are 91.3% of the eligible population and our government programs patients are 8.7% of the eligible population.

Initiatives/Interventions

This year our initiatives will be focused on recruitment for staffing, offering of the Addressing Health Disparities MOC using breast cancer screening for a measure clinicians can make improvements on. We worked with the Breast Gap project to produce videos for patients of color on why they matter and what to expect when having a mammogram. We hope to add these into our clinical reminders campaign.

We continue to monitor the clinical reminders campaign and look for ways we can optimize the success of the campaign. At the end of 2022 we had an overall conversion rate of 28.6%, our email conversion rate was 31.5%, text conversion rate was 12.7% and the U.S. mail conversion rate was 17.8%

We are in the process of translating materials and investigating the opportunity to add QR codes to some of our patient education material for breast cancer screening.

Barrier Analysis

Member/patient barriers include cultural perceptions about health and medical care, role of the individual in health and decision making, socioeconomic factors, language, access to care, lack of understanding of the health care system, and limited health literacy.

Staff and provider barriers include not understanding cultural beliefs and approaches of patients and members, comfort with using interpreters and translated information, sufficiency of translated information in needed languages, and time to spend on increasing knowledge and using equitable care resources.

Organization and system barriers include the many competing priorities that are part of a changing health care system, keeping up with best practices, and keeping care and service affordable.

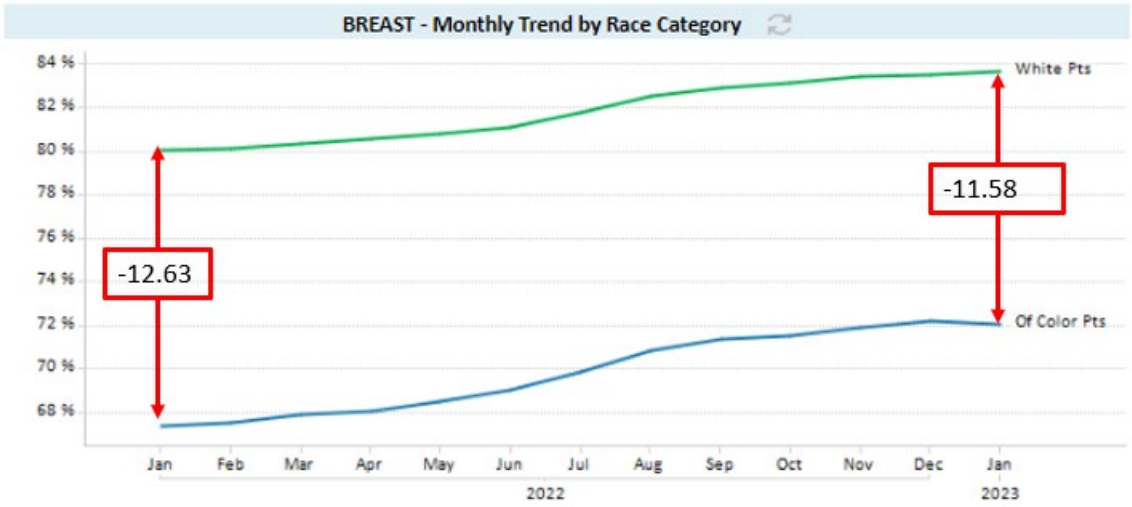
We continue to have residual pandemic barriers which include delay in care due to patient fear of being exposed to COVID/illnesses when in the clinic for mammogram. We also have staffing challenges causing a decrease in access and availability of appointments during the week, especially during evenings and weekends.

Gaps in Care

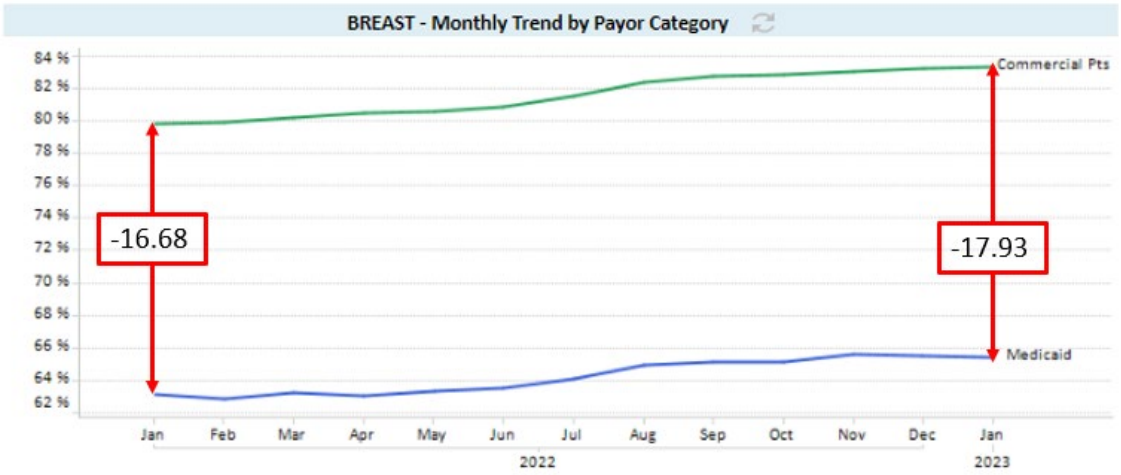
- Staffing issues have caused us to not be able to offer mammograms in the evening and weekends and contributes to the decrease in capacity of the Mammo A Go Go truck to 65%. Staffing constraints have also limited the number of community events that we can participate in.

Opportunities for Improvement: Results/Outcomes

Breast Cancer Screening by Race



Breast Cancer Screening by Payor



Example #2: Colorectal Cancer Screening Improvement

Accountable owner

Greg Fedio, Clinical Project manager

Member Populations Targeted

X	Commercial
X	Medicare Freedom (Cost)
X	Medicaid
X	MSHO
X	HPUPH
X	WI Marketplace

Description

Our goal is to increase colorectal cancer screening rates in patients to at least 80 percent, while also bringing race and payer rates into alignment with the overall population. To achieve this goal, we have developed a care model process that allows us to initiate the process easily and effectively, while also taking into account disparities in colorectal screenings and making proactive strides to reduce this gap.

Goals

- Decrease disparity gaps in colorectal cancer screening between patients of color and white patients.
- Decrease disparity gaps in colorectal cancer screening between patients with government insurance and patients with commercial insurance.
- Increase understanding of community needs for colorectal cancer screening.
- Expand projects that focus on closing disparity gaps.
- Improve colorectal cancer screening outreach and access.
- Improve processes related to the electronic medical record.

Initiatives/Interventions

1. Increasing visibility and stressing the importance of colorectal cancer screenings in patients. A health maintenance modifier is added to a patient's record once they reach the age in which they should begin regular screenings. In 2021, this modifier was updated to reflect the changes in colorectal cancer screening recommendations from the United States Preventive Services Task Force (USPSTF). It is now active for all patients between the ages of 45 and 75.

2. While completing pre-visit planning in the electronic medical record, nursing staff are automatically prompted when a patient is due for a colorectal cancer screening.

3. During the rooming process, our staff use pre-approved scripting to inquire as to whether the patient has had screenings, and to offer education on the importance of colorectal screenings as well as how the process works.

4. Other tactics we utilize to increase awareness and education for patients include social media postings and advertising on our waiting room monitors in March for Colon Cancer Awareness Month; letter reminders sent to patients that are due for screenings; and by developing education materials in six different languages to reach a broader patient base.

5. Approximately 8,500 Fecal Immunochemical Tests (FIT) were sent to patients that have never been screened for colorectal cancer, along with information about the importance of screening. This is a useful tactic in helping increase screening rates while offering patients a non-invasive screening option.

6. Twenty-nine clinicians took part in a 6-month long Maintenance of Certification (MOC) project that focused on closing disparity gaps in colorectal cancer screening rates between white patients and patients of color. The project showed success as all screening rates increased and the cohort of participating clinicians were able to increase their screening rates of patients of color at a higher rate than their screening rates of white patients.

7. While these systems have proven effective, we have an expert panel of senior leaders, doctors and researchers that meets twice a year to review evidence and set goals related to colorectal cancer screening. Additionally, we have a multi-disciplinary team that meets monthly to review data and discuss strategies, to continue our progress without stagnation.

Barrier Analysis

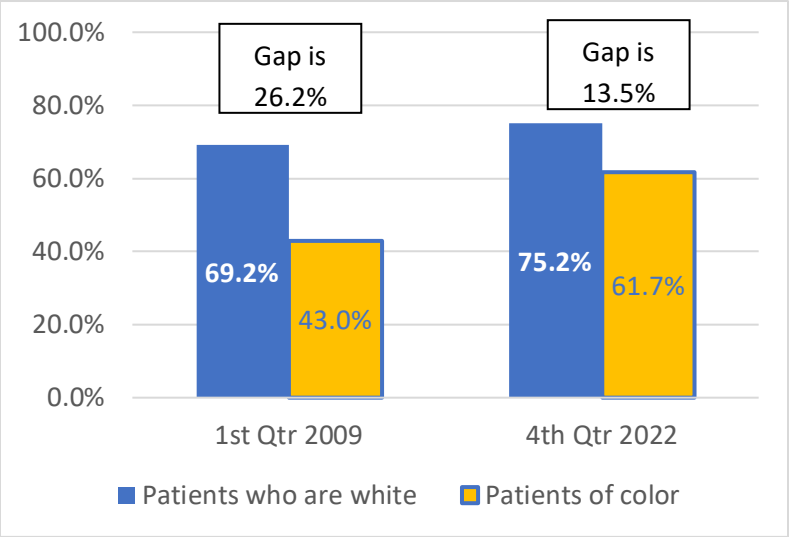
Often there are misconceptions about the screening process, and we work to make patients feel comfortable. We demonstrate at-home screening kits, known as FIT (fecal immunochemical test) kits, provide in-room educational materials, and answer questions about colonoscopy and FIT screening options. When the patient agrees to the services, our staff orders the screening. If they do not agree to the screening, the clinician will re-affirm the importance of colorectal screenings. If the FIT test is the screening method chosen, and a patient completes the test, the patient will be automatically mailed a follow up kit in a year. In addition, a letter will be sent to the patient after the kit has been mailed, if they have not returned the kit within 2 weeks.

Gaps in Care

As a result of the efforts mentioned, colorectal screening percentage for patients of color at HealthPartners Medical Group has gone from 43% in 2009, to 61.7% percent by end of 2022. These rates increased from 2020 to 2021, despite the continued pandemic. This data speaks to the fact that our systems are making an impact on improving the number of screenings.

Opportunities for Improvement–Results/Outcomes

Colorectal Cancer Screening by Race



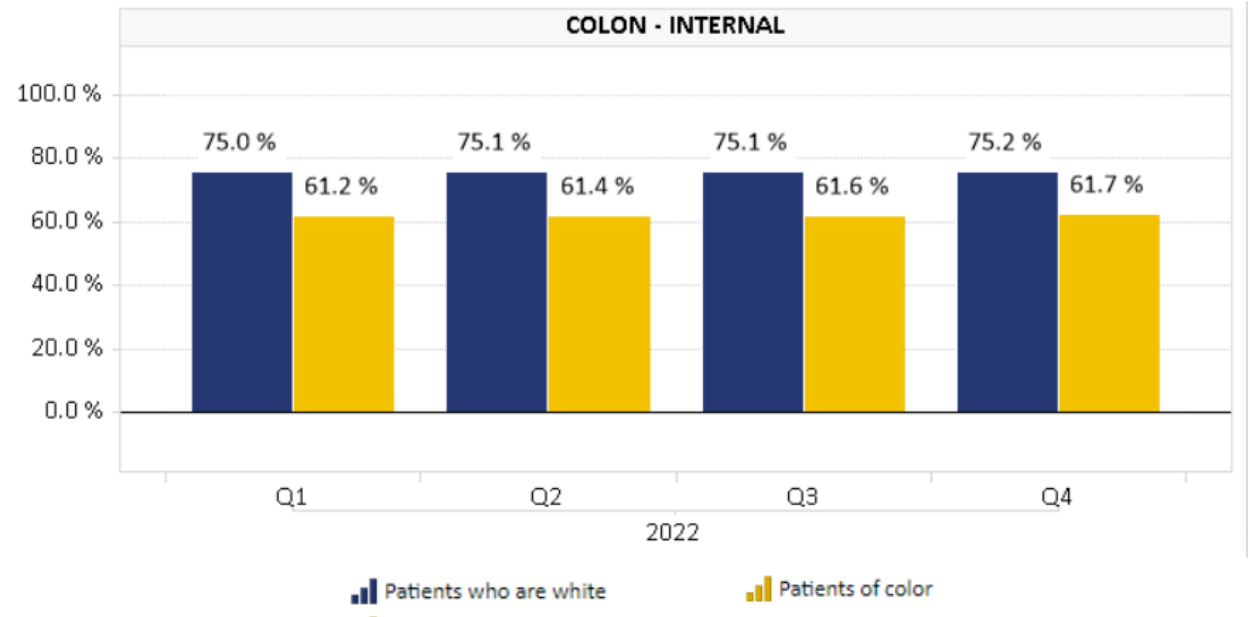
Interventions

- Shared decision making (FIT/colonoscopy)
- Addressing clinician unconscious bias (FIT/colonoscopy)
- Patient outreach
- Addressing health disparities MOC

Definition:

All patients: *Percent patients who have been screened for colorectal cancer by Colonoscopy in the last 10 years, Flexible Sigmoidoscopy in the last 5 years, and/or Fecal Occult Blood Test (FOBT) or Fecal Colorectal Screening (FIT) in the last 12 months.*

Patients of color: *Eligible patients of color, African Americans and Native Americans age 46-75, who have been screened for colorectal cancer by Colonoscopy in the last 10 years, Flex Sig in the last 5 years, or FOBT/FIT in the last 12 months.*



Example #3: Addressing Health Disparities Maintenance of Certification (MOC) Project

Accountable owner
Greg Fedio, Clinical Project manager

Member Populations Targeted

X	Commercial
X	Medicare Freedom (Cost)
X	Medicaid
X	MSHO
X	HPUPH
X	WI Marketplace

Description

Maintenance of Certification (MOC) projects have proven to be effective tools to help improve quality metrics while enabling clinicians to meet their ongoing specialty board requirements. In 2021, HealthPartners launched a new MOC project focused on closing health disparity gaps between patients of color and white patients.

Goals

- Define the role bias management, cultural humility, and social determinants of health play in reducing health disparities in personal practice.
- Analyze and identify health disparities that exist within personal practice.
- Adopt strategies, tools and resources to close health equity gaps in selected focus areas of practice.
- Report an increase in health equity by reducing health disparities in selected focus areas. (Asthma, Breast cancer screening, Colorectal cancer screening or Child Immunizations)

Initiatives/Interventions

- Participating clinicians were provided with educational videos to enhance their knowledge and enhance their ability to close health disparity gaps. Video subject matter included:
    - Information on health disparities and health disparity work at HealthPartners
    - Social Determinants of HealthPartners
    - Three modules on bias
    - Specific information related to their measure of choice (asthma, breast cancer screening, colorectal cancer screening or child immunizations)
- Participants were provided with lists of eligible patients of color and monthly updates on their metric(s).
- Based upon the curricula and the patient lists, providers had the freedom to implement interventions of their choice to help close disparity gaps.

Barrier Analysis

There continues to be substantial barriers to the work to close health disparity gaps. Clinicians brought up well-known existing barriers such as time, resources, and insurance. Clinicians also were able to utilize their learnings from the project to identify other barriers such as systemic racism, language proficiency, their own biases, and social determinants of health.

Gaps in Care

Clinician feedback suggested that without improvements to social determinants of health, gap closure was difficult to obtain. Through this pilot other opportunities that have been identified are:

- The importance of learning the patient's story
- Involving the whole team (rooming staff, care coordinator, medication therapy management) is vital to make progress.
- Clinician confidence in overcoming barriers to close disparity gaps fluctuates and varies.

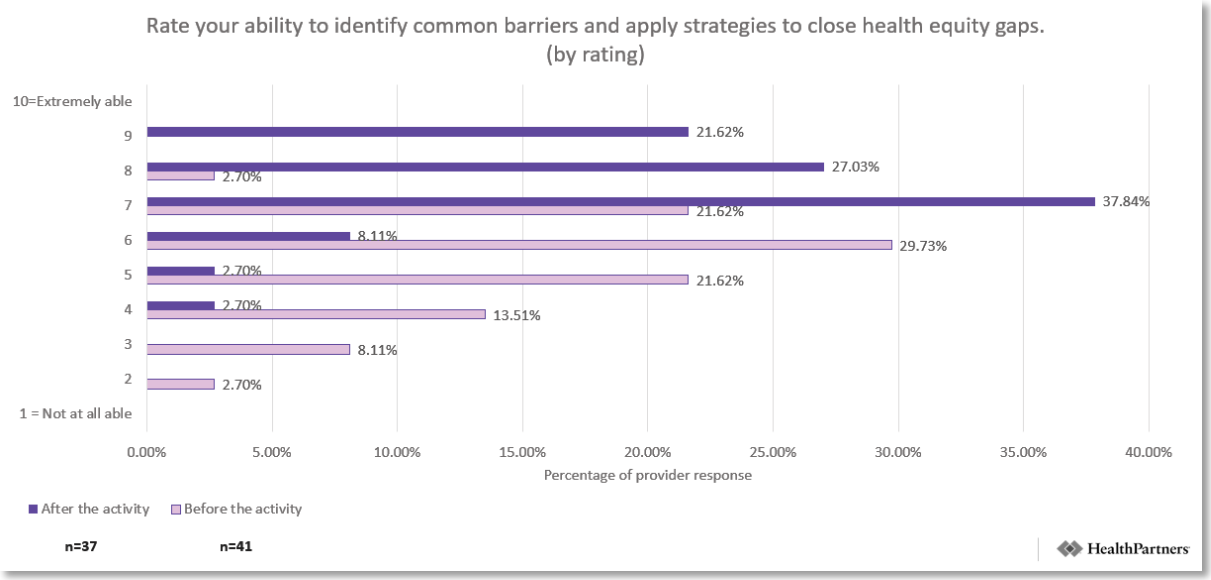
Opportunities for Improvement–Results/Outcomes

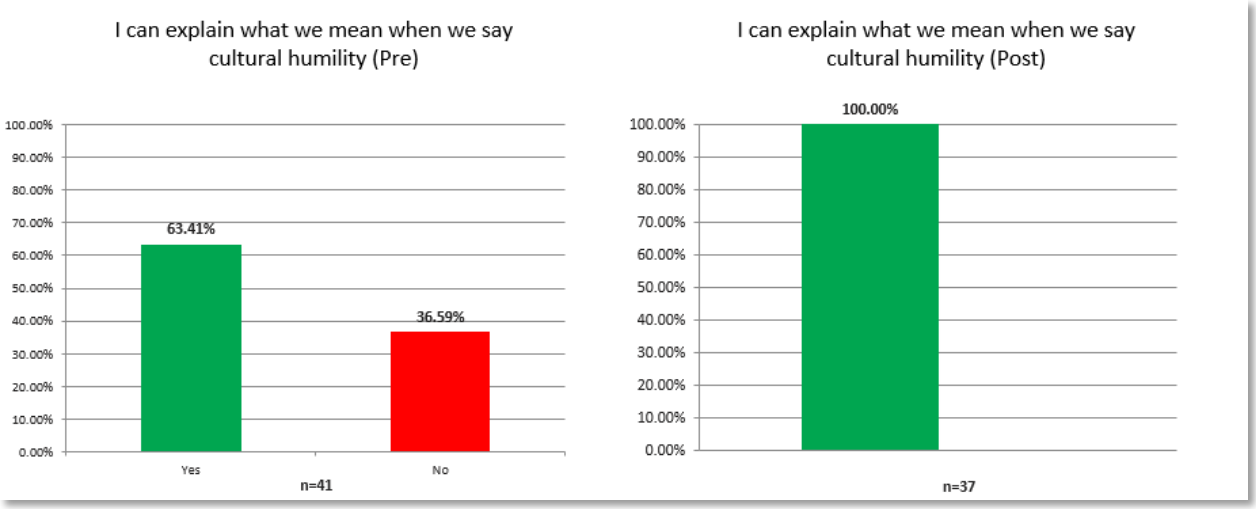
Overall, the MOC is a tangible way to connect the dots between equity work and quality. This is evidenced by:

- Disparity gap closure in breast cancer screening and colorectal cancer screening metrics
- Clinicians improved their ability to identify barriers and apply resources.
- Clinicians improved their knowledge of equity and bias related topics.
- Most clinicians reported making changes to their practice because of the project.
- Most clinicians feel they can sustain progress.

Cohort Summary - Race

	COLON - 2021 _1								
Report Date	# Eligible	% Met ALL	% Rate Change	# Eligible Pts Of Color	% Met - Pts Of Color	# Eligible - White	% Met - White	Race - Disparity Gap	
3/1/2021	11,156	75.55 %		1,514	60.11 %	9,493	78.19 %	-18.09 %	Before MOC
4/1/2021	11,428	75.71 %	0.21 %	1,551	60.67 %	9,716	78.33 %	-17.66 %	
5/1/2021	11,605	76.12 %	0.54 %	1,610	61.06 %	9,828	78.82 %	-17.76 %	
6/1/2021	11,740	76.12 %	0.00 %	1,635	61.83 %	9,936	78.69 %	-16.86 %	
7/1/2021	11,860	76.18 %	0.07 %	1,675	62.99 %	10,016	78.55 %	-15.57 %	
8/1/2021	11,823	76.11 %	-0.10 %	1,680	63.33 %	9,977	78.40 %	-15.07 %	
9/1/2021	11,905	76.16 %	0.07 %	1,702	62.87 %	10,039	78.55 %	-15.69 %	After MOC


Rate your ability to identify common barriers and apply strategies to close health equity gaps.
(by rating)
10=Extremely able
9
8
7
6
5
4
3
2
1 = Not at all able
21.62%
27.03%
2.70%
37.84%
21.62%
8.11%
29.73%
2.70%
21.62%
2.70%
13.51%
8.11%
2.70%
0.00%
5.00%
10.00%
15.00%
20.00%
25.00%
30.00%
35.00%
40.00%
Percentage of provider response
After the activity
Before the activity
n=37
n=41
HealthPartners


I can explain what we mean when we say cultural humility (Pre)
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
63.41%
36.59%
Yes
No
n=41
I can explain what we mean when we say cultural humility (Post)
100.00%
n=37

Example #4: Immunization Disparities Improvement

Accountable owner
Alison Salita, Quality and Measurement

Member Populations Targeted

x	Commercial
	Medicare Freedom (Cost)
x	Medicaid
	MSHO
	HPUPH
	WI Marketplace

Description

The primary functions of the Immunization Disparities Workgroup are to (1) increase and maintain vaccination completion rates of childhood immunizations and adolescent immunizations, and (2) reduce disparities in our vaccination completion rates, for race and payor, across all families of care including the HP Health Plan, which include HPMG, Hutchinson, Olivia, Park Nicollet, and the Valley/Western Wisconsin.

Goals

Goals are still being determined for 2023. We believe there will be an overall goal for the total population, in addition to a gap closure goal.

Interventions for reducing disparities with immunizations include:

- Coordination of existing work across the organization that is focused on improving vaccination rates.
    - Continued education on best practice check list for immunizations and well child visits.
    - Make clinician and staff education available around vaccine hesitancy.
    - Participation in the MDH Childhood Immunization Workgroup specifically focusing on health disparities in childhood immunizations.
    - Participation in No Shots No School campaign for the 25th year.
    - Partnering with the Health Plan on immunization campaigns including Medicaid outreach for overdue well child checks and immunizations.
    - Translation of immunization materials into top 4 languages.
    - Partnership with obstetrics on educating mom prenatally about the importance of immunizing infants.

- Immunization and Well Child Outreach Registries
    - Continue to produce overdue immunization and well child lists for sites to review and do additional outreach.

    - Clinical reminders team outreach for all ages for overdue well child visits started in September 2022 (email, text). Translations and a 3rd option for outreach happening in 2023.
    - Clinical reminders for immunizations will happen in 2023.
    - Participating in the MDH overdue immunization texting program.

- Maintenance of Certification/CME opportunities:
    - Offered Addressing Health Disparities MoC – Childhood Immunization Track – did not see the results we had hoped for with regards to closing the disparity gaps in this cohort.
    - Offered MoC for improvement of overall rates for Combo 10 and Combo 2 vaccines, although there was a slight decline in overall rates during the project, the decreases happened at a much smaller rate than overall clinician population and we saw decreases in 3 out of 4 disparity gaps with the MoC cohort.

Barrier Analysis

Member and patient barriers may include:

- Cultural perceptions or misconceptions around vaccines. There can be cultural differences that make it more challenging to complete the course of certain vaccines, such as MMR and HPV.
- Anti-vaccine movements exist in pockets. In these cases, families are choosing not to vaccinate their children at all.
- Confusion and myths related to COVID vaccine in children have increased vaccine hesitancy with all childhood immunizations.
- Anticipation of COVID vaccines for children has led to delaying other routine vaccinations.
- Access to care.

Staff and provider barriers include:

- Standard rooming is not standard within families of care or across the organization. Consequently, standard rooming audits have revealed that health maintenance alerts are not always being reviewed and/or offered at the appropriate times.
- Variation can occur in the way providers or staff introduce vaccines to the patient and the family, allowing the family to think certain vaccines are considered “optional”. For instance, some clinicians may simply be omitting the non-school required vaccines in the discussion.

Opportunities for Improvement: Results/Outcomes

While we saw a decrease in rates for both childhood and adolescent immunizations in the first half of 2022 (national and statewide trend), because of these efforts we saw our rates start to rebound in August of 2022, and we have continued to increase and maintain those rates throughout the remainder of 2022. We believe this rebound is multifactorial. This is probably the result of children under 2 years catching up on well child visits and immunizations. We

continue to have access issues due to staffing which could be contributing to slow rebound. Prevalent and early influenza season in 2022 could explain the higher rate of influenza vaccination in our younger population.

We decreased both race and payor gaps over the course of 2022. We surpassed our goal for race in childhood immunizations and made progress in our payor gap to goal as well.

Community needs and community partnerships:

- Minnesota school project, review, learn, expand – work with school districts on vaccine clinics – like Moundsview did for COVID vaccine, expand to other vaccines as well.
- "Catch Up" clinic opportunities – can we focus on areas where we see the most disparities in outcomes and create pop up clinics to provide vaccine services – resource dependent, may need to partner with the State of County to achieve.
- Pediatric social work partnership – understanding from those doing the work where the biggest gaps with the community are.
- Dental partnership around HPV to reduce oropharyngeal cancers.
- IHI project with Somali community coming in 2023.

Improving Immunization outreach

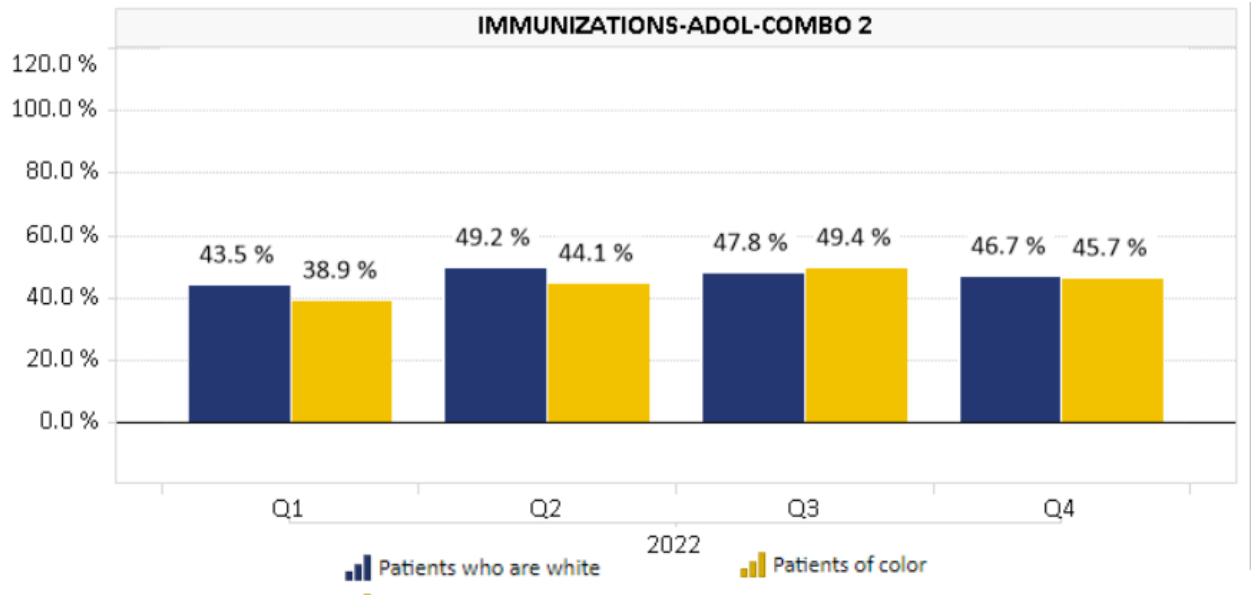
- Work with the digital products team to shift and expand outreach to clinical reminders team. Immunizations coming in 2023.
- Encourage sites to utilize the overdue immunization site lists for phone outreach when other methods have not worked.
- Continue MDH partnership for overdue immunization texting.

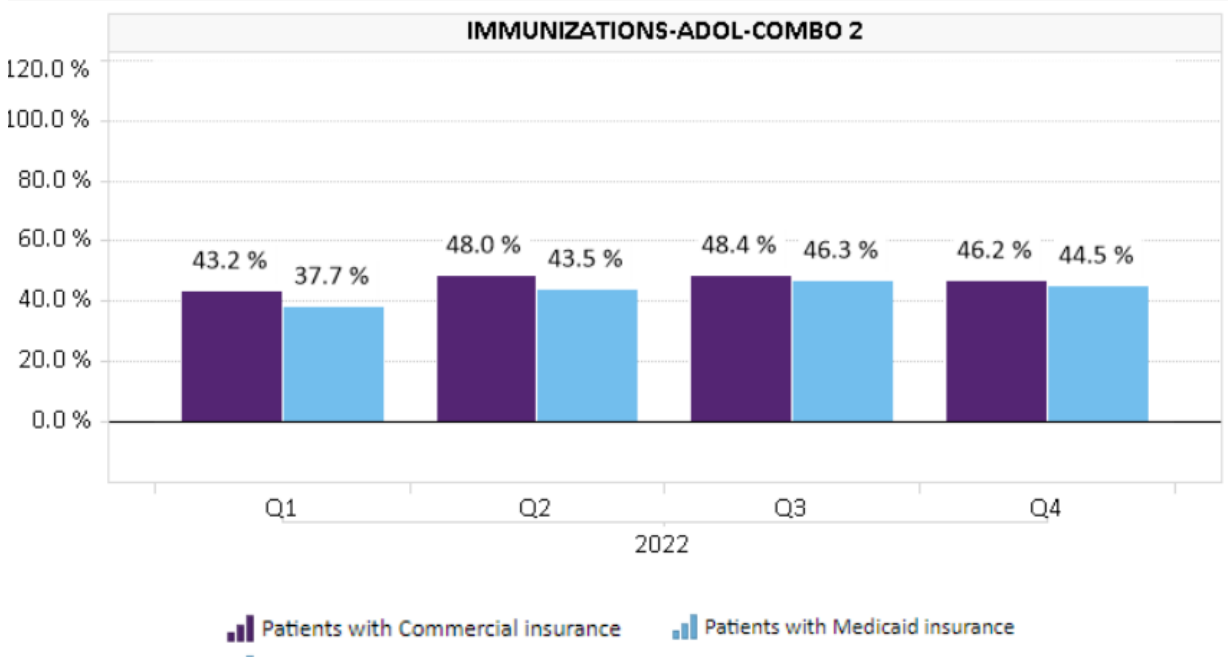
Projects focused on increasing overall rates and decreasing disparity gaps

- Work to improve and expand "Addressing Health Disparities" MOC project for childhood immunizations will be available in 2023.
- Combo 2 and Combo 10 MoC projects will be available in 2023.
- Vaccinate children at every opportunity (well child checks, acute visits, urgent care).
- Continued work with dental partners on HPV vaccination.
- Leverage best practice check list to increase provider measures.
- Starting work on Rise to Immunize – adult vaccinations.

Improving data and Epic related processes

- Simplification of HMA with new ACIP recommendations.
- Simplification of contraindications screening questionnaire in EPIC.
- Leverage Quick Schedule for efficient and accurate follow-up for delayed or series-based vaccinations.
- New immunizations analysis will transition to PowerBI in 2023 – will enable us to analyze data in different ways, much more robust than the current HBI highlight.


IMMUNIZATIONS-ADOL-COMBO 2
120.0 %
100.0 %
80.0 %
60.0 %
40.0 %
20.0 %
0.0 %
43.5 %
38.9 %
49.2 %
44.1 %
47.8 %
49.4 %
46.7 %
45.7 %
Q1
Q2
Q3
Q4
2022
Patients who are white
Patients of color


IMMUNIZATIONS-ADOL-COMBO 2
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Q1
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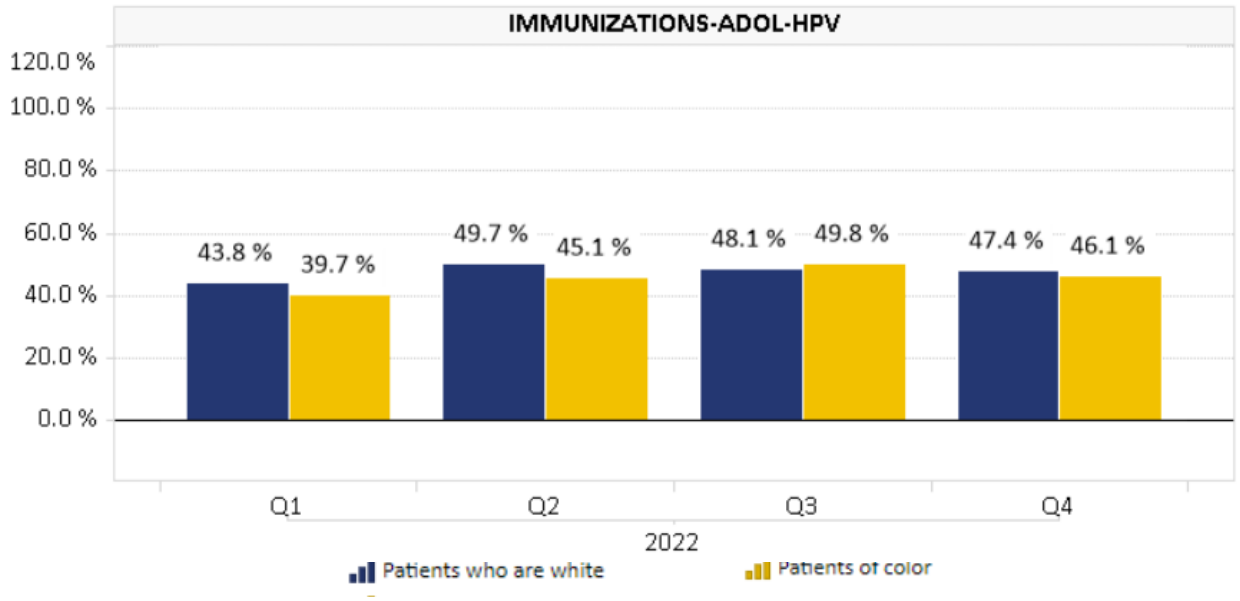
Q3
Q4
2022
Patients with Commercial insurance
Patients with Medicaid insurance


IMMUNIZATIONS-ADOL-HPV
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60.0 %
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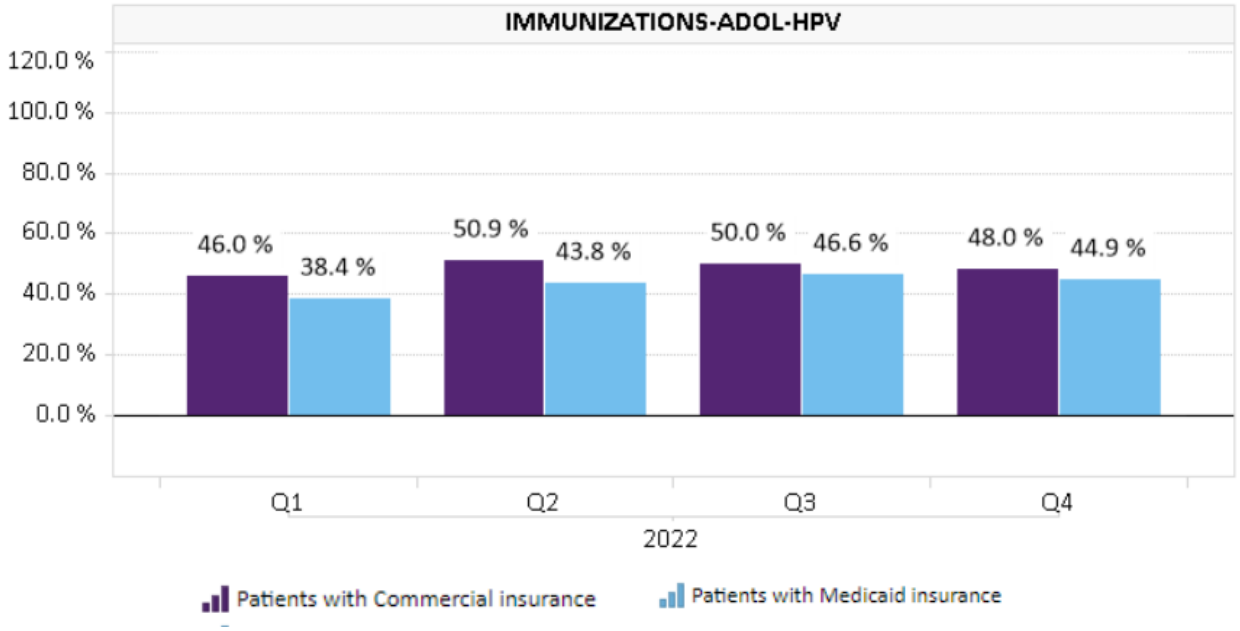
Q1
Q2
Q3
Q4
2022
Patients who are white
Patients of color


IMMUNIZATIONS-ADOL-HPV
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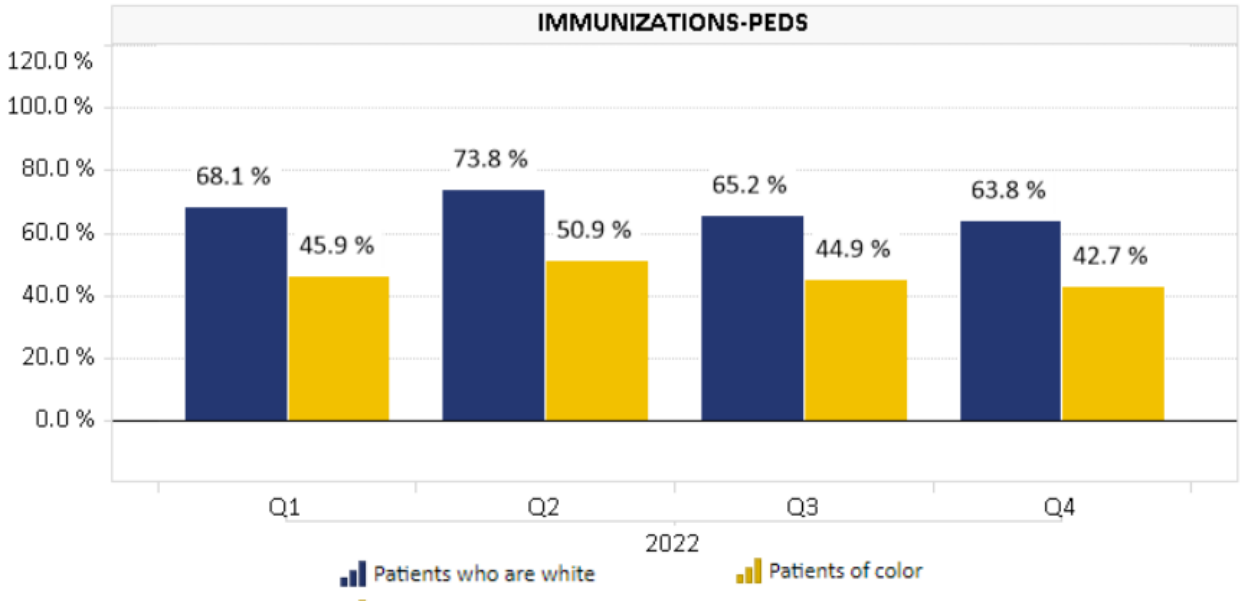
Q1
Q2
Q3
Q4
2022
Patients with Commercial insurance
Patients with Medicaid insurance


IMMUNIZATIONS-PEDS
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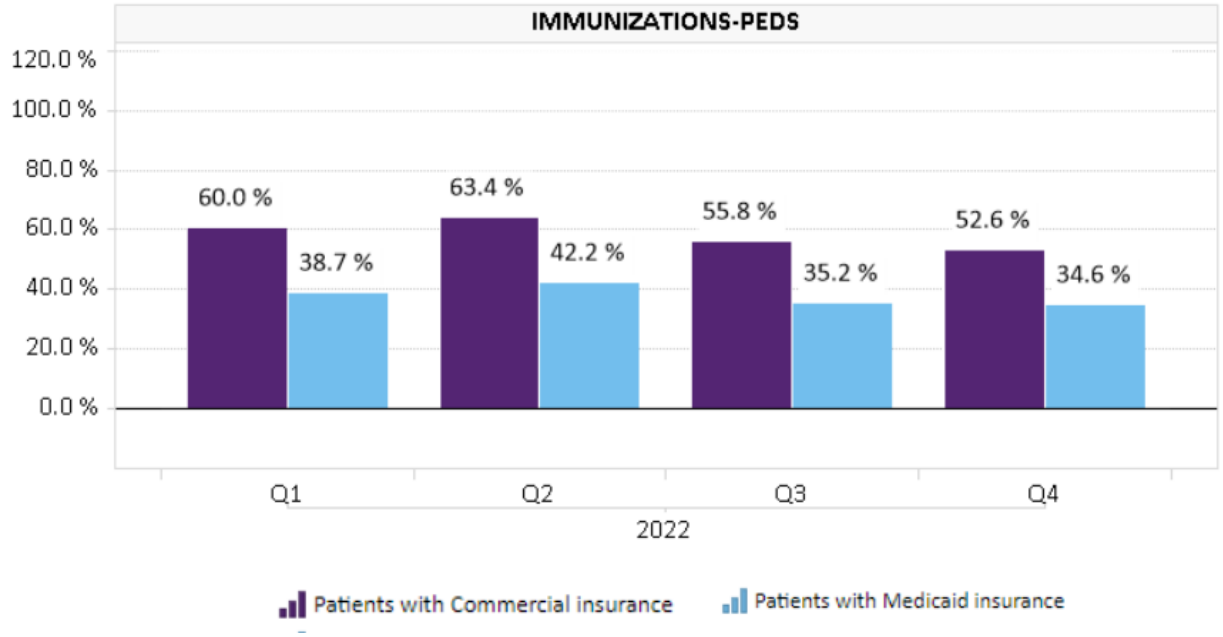
63.8 %
42.7 %
Q1
Q2
Q3
Q4
2022
Patients who are white
Patients of color


IMMUNIZATIONS-PEDS
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40.0 %
20.0 %
0.0 %
60.0 %
38.7 %
63.4 %
42.2 %
55.8 %
35.2 %
52.6 %
34.6 %
Q1
Q2
Q3
Q4
2022
Patients with Commercial insurance
Patients with Medicaid insurance

Enhancing Network Responsiveness

HealthPartners 2022

Provider/Member Race, Language and Country Survey

Health Plan Membership and Physicians by Race
Medicaid Product
July 2022 membership as of August 15th, 2022
If Department of Human Services data exists for a member, HealthPartners gold standard method of data is used.
***Midlands providers excluded.**

RACE	Medicaid Members 2022		PHYSICIANS 2022*	
	N	%	N	%
American Indian or Alaskan Native	3,891	1.75%	62	0.4%
Asian or Pacific Islander	25,600	11.48%	415	1.92%
Black or African American	62,768	28.15%	253	1.17%
Choose not to Answer	0	0	2696	12.52%
Hispanic or Latino	12,840	5.75%	0	0.0%
Native Hawaiian or Other Pacific Islander	586	0.26%	6	0.02%
Other Race	6,195	2.77%	288	1.33%
White	105,305	47.22%	6,321	29.35%
Data Collected	**217,185**	**97.4%**	**10,041**	**46.6%**
Data Not Collected	**5,780**	**2.6%**	**11,491**	**53.4%**
Total	**222,965**	**100.0%**	**21,532**	**100.0%**

Health Plan Membership and Physicians by Language Spoken*
Medicaid Products
July 2022 membership as of August, 15, 2022
If Department of Human Services data exists for a member, HealthPartners gold standard method of data is used. *All physicians speak English as their first language, any languages listed are a second language spoken.
****Midlands providers are excluded.**

Language	Medicaid Members	Medicaid Providers
Afar	9	.
Afrikaans	1	21
Akan	.	5
Akkan	12	.
Albanian	11	6
American Sign Language	119	54
Amharic	1,287	205
Anuak	34	.
Arabic	552	1,130
Armenian	1	8
Assamese	.	5
Azerbaijani	.	4
Bassa	7	.
Belarusian	.	25
Bemba	.	1
Bengali	45	133
Bosnian	25	30
Bulgarian	2	38
Burmese	178	24
Cambodian	102	1
Cantonese	210	.
Catalan	.	3
Cebuano	.	3
Chinese	16	374
Chinese-Cantonese	.	171
Chinese-Fuzhounese	.	2
Chinese-Mandarin	.	340
Choose not to answer	1	.
Creole	12	.
Croatian	.	56
Czech	.	86
Danish	.	21
Dari	3	.
Dinka	1	.

Language	Medicaid Members	Medicaid Providers
Dutch	3	76
Dzongkha	.	2
East Indian	5	2
Efik	.	2
Egyptian	.	1
English	185,406	.
Estonian	1	.
Ethiopian	1	7
Ewe	8	10
Fante	.	9
Farsi	13	201
Filipino	4	203
Finnish	2	11
French	312	1,346
Fulani	4	.
Ga	1	4
Georgian	3	.
German	3	912
Gikuyu	.	14
Greek	.	161
Guarani	.	1
Gujarati	14	362
Haitian Creole	1	15
Hausa	1	7
Hebrew	2	187
Hindi	56	2,775
Hindko	.	1
Hmong	1,582	175
Hungarian	1	75
ILocano	2	.
Ibibio	.	7
Icelandic	.	22
Igbo	4	70
Ilocano	.	18
Indonesian	7	29
Iranian	.	4
Irish	.	22
Italian	2	257
Japanese	5	149
Kannada	.	256
Karen	1,208	.
Kashmiri	.	10

Language	Medicaid Members	Medicaid Providers
Khmer	104	1
Kinyarwanda	.	2
Kissi	2	4
Konkani	.	6
Korean	87	127
Kpelleh	5	.
Krahn	1	.
Krio	3	.
Kru	3	.
Kurdish	5	9
Labo	.	17
Lao	.	13
Latin	.	12
Latvian	.	1
Lebanese-Syrian Arabic	.	6
Liberian English	1	.
Lingala	11	.
Lithuanian	1	46
Loatian	177	.
Lorma	4	.
Luganda	.	7
Macedonian	.	7
Madi	1	.
Malagasy	.	1
Malayalam	.	155
Malaysian	3	34
Maltese	.	11
Mandarin Chinese	659	.
Marathi	1	171
Mina	.	10
Moldavian	.	8
Mongolian	4	1
Navajo	1	.
Nepali	706	123
Norwegian	.	118
Nuer	5	.
Nyanja	.	1
Ojibwe	.	2
Oriya	.	6
Oromo	1,766	29
Other Language	135	.
Pashto	194	4

Language	Medicaid Members	Medicaid Providers
Persian	72	157
Pidgin English	10	.
Polish	5	174
Portuguese	19	. 236
Punjabi	10	545
Pushto	1	14
Romanian	21	198
Russian	387	744
Sanskrit	.	1
Sarpo	1	.
Serbian	1	41
Serbo Croatian	4	28
Shona	.	28
Sindhi	.	44
Sinhalese	.	4
Slovak	.	76
Somali	3,985	240
Spanish	5,802	4,664
Sudanese Arabic	1	.
Swahili	198	155
Swedish	1	85
Tagalog	46	237
Taiwanese	2	28
Tamil	11	385
Telegu/Telugu	5	.
Telugu	.	421
Thai	35	73
Tibetan	87	9
Tigre	.	4
Tigrigna	247	24
Tswana	.	1
Turkish	12	156
Twi	7	18
Ukrainian	25	96
Urdu	37	1,306
Vai	.	1
Vietnamese	2,292	232
Wolof	2	7
Yoruba	41	176
Zulu	.	7

Language	Medicaid Members	Medicaid Providers
Data Collected	208,525	15,541
Data Not Collected	14,412	5,991
Total	222,937	21,532
Capture Rate	93.5%	72.2%

Health Plan Membership and Physicians by Country of Origin
Medicaid Products
July 2022 membership as of August 15th, 2022
If Department of Human Services data exists for a member, HealthPartners gold standard method of data is used.
***Midlands providers are excluded.**

Country	Medicaid Members	Medicaid Providers
Afghanistan	269	4
Albania	7	5
Algeria	26	.
American Samoa	2	.
Angola	2	.
Antigua and Barbuda	2	.
Argentina	3	3
Armenia	3	.
Australia	19	50
Azerbaijan	4	.
Bahamas, The	3	.
Bahrain	1	8
Bangladesh	43	8
Belarus	22	6
Belize	1	.
Benin	14	.
Bermuda	4	.
Bhutan	205	2
Bolivia	5	6
Bosnia	.	1
Bosnia and Herzegovina	32	.
Botswana	1	2
Brazil	41	4
Bulgaria	7	1
Burkina Faso	4	.
Burma	668	.
Burundi	30	.
Cambodia	341	.
Cameroon	232	5
Canada	83	205
Central African Republic	1	.

Country	Medicaid Members	Medicaid Providers
Chad	1	.
Chile	18	7
China	574	65
Colombia	56	36
Congo, Democratic Republic of the	120	.
Congo, Republic of the	7	.
Coral Sea Islands	1	.
Costa Rica	5	2
Cote d'Ivoire	23	.
Croatia	2	.
Cuba	16	4
Cyprus	1	.
Czech Republic	5	.
Czechoslovakia	.	3
Denmark	2	4
Djibouti	19	2
Dominica	1	.
Dominican Republic	57	9
Ecuador	137	.
Egypt	155	37
El Salvador	179	1
Eritrea	206	37
Estonia	3	.
Ethiopia	3,248	23
Fiji	1	.
Finland	3	2
France	27	2
Gabon	1	.
Gambia, The	30	.
Georgia	4	.
Germany	51	70
Ghana	119	2
Greece	4	5
Grenada	2	.
Guadeloupe	1	.
Guam	8	.
Guatemala	81	5
Guinea	64	.
Guinea-Bissau	1	.
Guyana	88	1
Haiti	30	1
Honduras	65	.

Country	Medicaid Members	Medicaid Providers
Hong Kong	17	6
Hungary	3	7
Iceland	1	.
India	251	305
Indonesia	12	15
Iran	65	58
Iraq	63	3
Ireland	11	.
Israel	47	17
Italy	11	9
Jamaica	39	3
Japan	26	15
Jordan	59	3
Kazakhstan	7	1
Kenya	817	8
Korea	14	.
Korea, North	3	.
Korea, South	178	84
Kuwait	19	.
Kyrgyzstan	3	.
Laos	777	5
Latvia	5	.
Lebanon	47	93
Liberia	1,002	1
Libya	11	.
Lithuania	4	.
Luxembourg	1	.
Macau	1	.
Macedonia	3	.
Madagascar	5	.
Malawi	2	.
Malaysia	24	.
Maldives	2	.
Mali	3	.
Malta	5	.
Mexico	988	28
Moldova	22	8
Mongolia	4	.
Montenegro	1	.
Morocco	45	.
Myanmar	64	7
Namibia	4	.

Country	Medicaid Members	Medicaid Providers
Nauru	1	.
Nepal	385	12
Netherlands	5	.
New Caledonia	1	.
New Zealand	1	.
Nicaragua	12	6
Niger	1	.
Nigeria	522	76
Norway	4	5
Occupied Palestinian Territory	1	.
Pakistan	115	128
Panama	9	.
Papua New Guinea	2	.
Paraguay	4	.
Peru	46	8
Philippines	229	59
Poland	13	14
Portugal	2	.
Puerto Rico	187	11
Qatar	2	.
Romania	19	8
Russia	160	23
Rwanda	18	.
Saint Kitts and Nevis	1	.
Saint Lucia	1	.
Saint Vincent	.	2
Saint Vincent and the Grenadines	1	.
Saudi Arabia	48	4
Scotland	.	1
Senegal	8	.
Serbia	9	.
Sierra Leone	62	.
Singapore	3	.
Slovakia	3	10
Slovenia	1	.
Solomon Islands	1	.
Somalia	3,157	26
South Africa	92	10
Spain	7	9
Sri Lanka	7	1
Sudan	117	16
Suriname	2	.

Country	Medicaid Members	Medicaid Providers
Sweden	9	.
Switzerland	4	13
Syria	32	32
Taiwan	20	29
Tajikistan	4	.
Tanzania	28	18
Thailand	693	21
Togo	100	1
Trinidad and Tobago	6	.
Tunisia	6	.
Turkey	18	17
Turkmenistan	3	.
Tuvalu	1	.
Uganda	61	1
Ukraine	92	27
United Arab Emirates	46	1
United Kingdom	66	48
United States	101,643	5,628
Uruguay	8	1
Uzbekistan	5	2
Vanuatu	1	.
Venezuela	51	.
Vietnam	1,634	54
Virgin Islands	5	.
West Bank	3	.
Western Sahara	1	.
Yemen	30	1
Zambia	9	.
Zimbabwe	2	.
Data Collected	121,997	7,627
Data Not Collected	100,968	13,905
Total	222,965	21,532
Capture Rate	54.7%	35.4%

HE 4B, Factor 1: Analysis of Practitioner Availability to Meet Member Language Needs

Health Plan Members and Network Physicians by Language Spoken – Top 10 responses Medicaid Products
July 2022 membership as of August 15th, 2022

LANGUAGE	MEMBER COUNT	%	LANGUAGE (2ND LANGUAGE)	PHYSICIAN COUNT	%
English	185,406	83.15%	English		100.00%
Spanish	5,802	2.60%	Spanish	4,664	21.66%
Somali	3,985	1.78 %	Hindi	2,775	12.88%
Vietnamese	2,292	1.02%	French	1,346	6.2%
Oromo	1,766	0.79%	Urdu	1,306	6.06%
Hmong	1,582	0.70%	Arabic	1,130	5.24%
Amharic	1,287	0.57%	German	912	4.23%
Karen	1,208	0.54%	Russian	744	3.45%
Nepali	706	0.31%	Punjabi	545	2.53%
Mandarin	659	0.11%	Telugu	421	1.19%
Other languages	3,860	1.93	Other languages	1,698	8.76%
Data Collected	**208,553**	**93.5%**	**Data Collected**	**15,541**	**72.2%**
Data Not Collected	**14,412**	**6.5%**	**Data Not Collected**	**5,991**	**27.8%**

In the third quarter of 2022, we made improvements to our provider database by updating our provider information form for our contracted groups to be able to provide information regarding bilingual staff. This information will also appear in directories. Because this is a recent update, there is not any data to report currently.

Language Analysis:

- HealthPartners uses a variety of methods to collect language data from members and providers.
- Because providers and members provide language information on a voluntary basis, the tables above do not represent 100% of the populations.
- In general, members are much more likely to provide language information than providers, which is done through their DHS Medicaid enrollment application.
- Based on the data collected, there is strong alignment between the language needs of our members and the provider's ability to speak the language. The table above lists the top ten languages spoken for both members and providers.
    - 83.15% of members and 100% of providers speak English.2.60% of members and 21.66% of providers speak Spanish.

HE 4B, Factor 2: Analysis of Practitioner Availability to Meet Member Needs for Culturally Appropriate Care

Health Plan Members and Network Physicians by Country of Origin – Top 10 responses
Medicaid Products
July 2022 membership as of August 15th, 2022

COUNTRY	MEMBER COUNT	%	COUNTRY	PHYSICIAN COUNT	%
USA	101,643	45.59%	USA	5,628	26.13784
Ethiopia	3,248	1.46%	India	305	1.416496
Somalia	3,157	1.42%	Canada	205	0.952071
Vietnam	1,634	0.73	Pakistan	128	0.594464
Liberia	1,002	0.45	Lebanon	93	0.431915
Mexico	988	0.44	Korea, South	84	0.390117
Kenya	817	0.37	Nigeria	76	0.352963
Laos	777	0.35	Germany	70	0.325098
Thailand	693	0.31	China	65	0.301876
Burma	668	0.30	Philippines	59	0.274011
Data Collected	**121,997**	**54.7%**	**Data Collected**	**7,615**	**35.4%**
Data Not Collected	**100,968**	**45.3%**	**Data Not Collected**	**13,905**	**64.6%**

Country of Origin Analysis:

- Country of origin data is collected in the same manner as language data and is subject to the same limitations.
- As noted above, members are much more likely to provide this information than providers.
- Based on the data collected, there is strong alignment between the country of origin noted by our members and provider's country of origin.
- 45.59% of members and 26.13% of providers reported the United States as their country of origin,

Race

Health Plan Members and Network Physicians by Race – Top 10 responses
Medicaid Products
July 2022 membership as of August 15th, 2022

RACE	MEMBER COUNT	%	RACE	PHYSICIAN COUNT	%
White	105,305	47.22%	White	6,321	29.35%
Black or African American	62,768	28.15%	Choose not to answer	2,696	12.52%
Asian or Pacific Islander	25,600	11.48%	Asian or Pacific Islander	415	1.92%
Hispanic or Latino	12,840	5.75%	Other Race	288	1.33%
Other Race	6,195	2.77%	Black or African American	253	1.174%
American Indian or Alaskan Native	3,891	1.74%	Hispanic or Latino	0	0.00%
Native Hawaiian or Other Pacific Islander	586	0.26%	American Indian or Alaskan Native	62	0.28%
Choose not to answer	0	0.00%	Native Hawaiian or Other Pacific Islander	6	0.02%
Data Collected	**217,185**	**97.4%**	**Data Collected**	**10,041**	**46.6%**
Data Not Collected	**5,780**	**2.6%**	**Data Not Collected**	**11,491**	**53.4%**

ANALYSIS

- Data is collected in the same manner as language and country of origin data and is subject to the same limitations.
- As noted above, members are much more likely to provide this information compared to providers. Overall, there is a strong correlation between the race reported by members and providers. 47.22% of members and 29.35% of providers reported their race as white.

HE 4B, Factors 1 and 2: Practitioner Cultural Responsiveness Survey

HealthPartners conducted a survey of network practitioners to analyze the capacity of our practitioner network to meet the needs of members for culturally appropriate care. The survey was deployed in July 2022. The survey was administered electronically with a link sent to administrative clinic contacts requesting that they distribute it to their providers. Information

about the survey, along with a link, was also published in a July 2022 provider newsletter. 78 practitioners responded from the following types of care:

Type of Care	Percent of Respondents
Primary Care	31%
Specialty Care	42%
Mental health care	15%
Other	13%

The following questions were answered on a 7-point scale, with 1 being not at all confident/comfortable and 7 being extremely confident/comfortable. The mean score for each question is displayed in the chart below. Because this is the first year that we deployed this survey, the results will be used as our baseline for future year analysis with a goal to meet or exceed the rates from this initial survey.

Question	Mean Score
How confident are you in your ability to identify opportunities to provide culturally responsive care to your patients?	5.17
How comfortable are you tailoring your communications and recommendations to support patients who come from different cultures?	5.18
How confident are you in your ability to identify barriers to health equity among patients?	5.27
How comfortable are you taking action to address barriers to health equity among patients?	4.94

An additional question was asked regarding familiarity and access to resources.

Question	I'm aware of resources and have access to them	I'm aware of resources but don't have good access to them	I'm not aware of any resources
Which of the following best describe your familiarity and access to resources to help provide culturally informed care or address barriers to health equity among patients?	38%	40%	22%

62% of providers said they either did not have good access to or were not aware of resources to provide culturally informed care/address barriers to health equity among patients. This response indicates an opportunity to increase provider awareness of and access to these resources. Based on this opportunity, we have identified a goal to increase the percentage of providers who are aware of and have access to resources by 5% in the 2023 survey.

The survey also assessed provider experience with language services. 94% of respondents reported having worked with an interpreter before and over 90% reported being aware of interpreter services.

The following questions were answered on a 7-point scale, with 1 being not at all confident/comfortable and 7 being extremely confident/comfortable. The mean score for each question is displayed in the charts below.

Question	Mean Score
Thinking specifically about language assistance services. How confident are you in your ability to identify when a patient could benefit from an interpreter or other language assistance services?	6.10
How comfortable are you using interpreter services with patients?	5.94

ANALYSIS

- Overall, respondents reported high rates of confidence in identifying opportunities to provide culturally responsive care and comfort tailoring their own communications to support patients.
- Respondents also indicated high confidence in identifying when patients could benefit from interpreter services.
- Respondents indicated more confidence in their ability to identify barriers to health equity for patients than their comfort with taking action to address these barriers.
- Most respondents reported having worked with an interpreter before and reported high comfort with doing so.
- While the majority (78%) of providers are aware of resources to help provide culturally responsive care or address barriers to health equity, 40% report not having good access to them. 22% of respondents reported not having awareness of these resources at all.
    - Based on these results, the main opportunity identified by the survey is the need to increase provider awareness of and access to resources to support their work with patients.

CONCLUSION

Availability of Providers Related to Language, Country of Origin and Race:

HealthPartners anticipates and meets the linguistic and ethnic needs of our members by gathering language, country of origin and race data from both members and providers. To continually ensure our members have access to the care they need, including providers of a certain race or country of origin or providers who speak a certain language, many steps are taken. HealthPartners conducts member satisfaction surveys, reviews member complaints to

evaluate patterns and trends regarding access and availability of care and invites members to participate in focus groups to gain insight into what they are looking for when choosing health care.

Specifically, we continually monitor language line usage and member complaints regarding access to care or barriers to providers who share a member's language, country of origin or race. There have been no complaints regarding network access based on language, country of origin or race.

We believe the strategies HealthPartners has implemented to meet members' needs for a diverse clinician care experience contribute to the low level of complaints.

- HealthPartners has a robust network. We hold contracts with nearly 100% of the providers in Minnesota and contract with new providers as we become aware of them.
- The state of Minnesota mandates health care practitioners offer interpreter services upon patient request across all settings of care.
- We participate in The Exchange, a collaborative of Minnesota health-related organizations, whose members share their translated health materials. The Exchange also disseminates information on issues of literacy, class, culture, race, and spirituality as they affect health disparities.
- We provide services for members to help them with language assistance including:
    - FindCare, a searchable online tool where members can search for providers by specialty, gender, and language spoken (other than English) in addition to other search options. Members without online access can receive the same information by calling member services.
    - Several member services staff are bilingual and available to assist members in navigating care. If we do not have staff who speak the requested language, we use the Language Line service which translates more than 200 languages.
    - We have a diverse work force throughout the organization who come from a range of countries and races who speak a variety of languages.
    - We hold contracts with interpreter services agencies who support all key languages spoken by our members.

HealthPartners also works to build a culture that supports the needs of a diverse member population. For example:

- HealthPartners Equitable Care Champions program is one of multiple strategies in the equitable care initiative to reduce health disparities and improve satisfaction of diverse communities. The champions are staff members and providers who receive expert training to become advocates and serve as local resources for their colleagues in caring for patients from diverse cultures and those with limited English proficiency.
- HealthPartners sponsors and is a key partner in Make It. MSP., an initiative to make our region a top performer in attracting and retaining talented professionals. Part of this

initiative focuses on recruiting and retaining people of color and connecting professionals of color as they grow and thrive in our community. By supporting a more diverse professional community, HealthPartners strives to meet the needs of our increasingly diverse member population.

HE 4B, Factors 3 and 4 – Opportunities and Actions

- HealthPartners provider's language, race, and country of origin strongly correlate to our members. There were no complaints from members related to lack of access to providers due to language, race, or country of origin. No new opportunities were identified to improve access to providers based on language, race, and country of origin. Therefore, no action was taken to improve our networks.

- We found that providers are overall less likely to report information about their race, ethnicity, and language than members. An opportunity was identified to increase the volume of providers who share this information with HealthPartners. Action taken:
    - To encourage contracted groups to give us information about their providers regarding race, ethnicity, and language, in September 2022 we began an incentive program. The program pays a set amount for each provider who provides us with race, ethnicity and language information. We are hopeful this will help us in obtaining more information about our providers.

- Survey results indicate an opportunity to improve provider awareness of and access to resources to support culturally informed care and/or address barriers to health equity for patients. Actions taken:
    - Issued a provider newsletter focusing on health equity topics and resources in July 2022.
    - In collaboration with UCare, a local health plan, we developed a webpage (https://culturecareconnection.org/cultural-responsiveness/) that offers cultural and linguistic resources for providers. This was launched September 2022 and providers were notified of this resource via our provider newsletter.

HE 6: Reducing Healthcare Disparities

Introduction

Inequities in the quality of health, health care, and health outcomes experienced by groups based on social, racial, ethnic, economic, and environmental characteristics persist across the United States[11]. The American Hospital Association (AHA) identified that data collection, stratification, and use is essential to developing initiatives to eliminate disparities in health outcomes[12]. Unless measured, healthcare systems lack awareness of specific disparities in health and healthcare impacting the populations they serve. A 2020 report by Advancing Health Equity notes that to reduce disparities across groups, healthcare organizations must first understand where disparities exist and why[13].

HealthPartners takes multiple approaches to identify and address health disparities and ensure we are providing culturally and linguistically appropriate services (CLAS) to members. This report provides a comprehensive review of HealthPartners efforts to identify and reduce healthcare disparities in 2022. It includes quantitative results for data to assess disparities and CLAS (sources listed below), comparison of results to a benchmark or goal, and an interpretation of the results.

Data to assess disparities:

1. HEDIS measures of clinical performance
2. CAHPS results

Data to monitor and assess culturally and linguistically appropriate services:

3. Utilization of language services for organization functions
4. Survey of individual experience with language services for organization functions and during healthcare encounters
5. Survey of staff experience with language services for organization functions

Based on the results of our analysis, HealthPartners has identified opportunities for improvement and selected opportunities to reduce healthcare disparities and improve CLAS.

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[11] https://www.ncsl.org/research/health/health-disparities-overview.aspx#:~:text=Even%20when%20income%2C%20health%20insurance,ethnicity%20independent%20of%20other%20factors.
[12] https://www.aha.org/system/files/media/file/2021/03/Market_Insights_Disparities_Data.pdf
[13] https://www.solvingdisparities.org/sites/default/files/Using%20Data%20Strategy%20Overview%20Oct.%202020.pdf

HE 6B, Factors 1-3

Monitor 1: Use of HEDIS Data to Assess Disparities by race, ethnicity, language, and gender

Methodology

During 2021, HealthPartners analyzed the HEDIS measure initiation and engagement of alcohol and other drug abuse or dependence treatment (IET) by race, ethnicity, preferred language, and gender for all Medicaid members.

The IET measures assess adults and adolescents 13 years of age and older with a new episode of alcohol or other drug (AOD) dependence who received the following:

- Initiation of AOD treatment: adolescents and adults who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication-assisted treatment (MAT) within 14 days of diagnosis.
- Engagement of AOD treatment: adolescents and adults who initiated treatment and had two or more additional AOD services or MAT within 34 days of the initiation visit.

In the charts below, the overall numerator/denominator totals for race/ethnicity vary from those for gender as not all subgroups are included in our data when stratified by race due to small denominators (<10).

HealthPartners used this measure due to several factors. Nationally, nearly 12 percent of Medicaid members have a substance use diagnosis[14]. Research has found racial disparities in rates of receiving substance use treatment[15] and NCQA notes that less than 20% of individuals with substance use disorders receive treatment.

Further, a 2020 report[16] on drug and alcohol abuse in Minnesota identified multiple data points that highlight the relevance of this clinical measure for our Minnesota Medicaid population:

- 5.5% of adults in Minnesota met the criteria for having an alcohol use disorder.
- Men are more likely than women to meet the criteria for an alcohol use disorder as are American Indians compared to other racial/ethnic groups.
- Those without health insurance were substantially more likely to have an alcohol use disorder (12.9%) than those with health insurance (5.1%).
- About 5.7% of Minnesota adults needed treatment for alcohol use disorders and about 2.1% needed treatment for drug use disorders.

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[14] https://www.medicaid.gov/medicaid/benefits/behavioral-health-services/substance-use-disorders/index.html
[15] https://healthpolicy.usc.edu/evidence-base/racial-disparities-in-accessing-treatment-for-substance-use-highlights-work-to-be-done/
[16] https://www.lrl.mn.gov/docs/2020/mandated/200125.pdf

Overall, only 7.4% of those with substance use disorders received treatment. While about twice as many of those with drug use disorders received treatment (13.7%) than did those with alcohol use disorders (6.8%), still more than 9 out of 10 adults with a substance use disorder did not receive any treatment.

To analyze data for each subgroup, we used the following benchmark goals:

- IET Initiation (total) – 41.1%
- IET Engagement (total) - 16.17%

These goals represent the average IET rates for Medicaid products across multiple Minnesota health plans.

Results are reviewed in the Medicaid QUI group and brought to the Government Programs Quality and Utilization Committee (GPQUI) on an annual basis. The HealthPartners Quality Council reviews GPQUI meeting minutes quarterly.

IET - Race/Ethnicity

	2021			
	IET Initiation Goal: 41.1%	**Goal met?**	**IET Engagement Goal: 16.17%**	**Goal met?**
American Indian/Alaskan Native	36.75% (104/283)	N	13.07% (37/283)	N
Asian/Pacific Islander	36.59% (60/164)	N	15.76% (26/165)	N
Black/African American	35.65% (528/1481)	N	12.88% (191/1483)	N
Hispanic/Latino	32.68% (84/257)	N	14.79% (38/257)	N
Other Race	40.35% (23/57)	N	10.53% (6/57)	N
Unknown	43.94% (29/66)	Y	12.12% (8/66)	N
White	36.11% (1600/4430)	N	13.54% (600/4431)	N

Analysis

All racial/ethnic groups fell below goal on IET initiation except for “unknown, which exceeded the regional benchmark by nearly 3 percentage points. The “other race” group nearly met goal with a rate of 40.35. The Hispanic/Latino group had the lowest rate at 32.68%. All other groups had similar rates, ranging from 35.65% (Black/African American) to 36.75% (American Indian/Alaskan Native).

No groups met goal for IET engagement. The lowest-scoring groups were “unknown” (12.12%), “other race” (10.53%) and Black/African American (12.88%). Asian/Pacific Islanders scored the highest (15.76%), followed by Hispanic/Latino (14.79%).

IET - Preferred Language[17]

	2021			
	IET Initiation Goal: 41.1%	**Goal met?**	**IET Engagement Goal: 16.17%**	**Goal met?**
English	36.15% (2392/6617)	N	13.44% (890/6620)	N
Oromo	20.00% (1/5)	N	N/A	N/A
Somali	57.14% (4/7)	Y	42.86% (3/7)	Y
Spanish	28.13% (9/32)	N	12.50% (4/32)	N
Unknown	34.04% (16/47)	N	14.89% (7/47)	N
Vietnamese	7.69% (1/13)	N	N/A	N/A

Analysis

Most groups did not meet goal for IET Initiation. All non-English groups had relatively low denominators which can cause considerable variation in rates. Vietnamese was the lowest scoring group (7.69%), while Somali was the highest (57.14%) and the only group to meet goal. However, both groups had low denominators (Vietnamese had a total pool of 13 and Somali had a total pool of 7). English had the second-highest rate of 36.15%.

Somali also met goal on IET engagement with a score of 42.86%. All other groups fell below goal, with the lowest being Spanish at12.5%.

[17] There were no eligible members on these measures for the following languages: Amharic, Arabic, Hmong, Khmer, Mandarin, Nepali.

IET - Gender

	2021			
	IET Initiation Goal: 41.1%	**Goal Met?**	**IET Engagement Goal: 16.17%**	**Goal Met?**
Male	38.17% (1388/3636)	N	14.24% (518/3638)	N
Female	33.48% (1044/3118)	N	12.47% (389/3120)	N

Analysis

Neither group met goal on IET initiation or engagement. Males had higher rates than females on both measures and had a higher denominator. Males fell below goal on IET initiation by nearly 3 percentage points, while females fell nearly 8 percentage points below goal.

On IET engagement, males only fell about two percentage points below goal while females fell about four percentage points below goal.

HE 6B, Factor 4

Monitor 2: Use of CAHPS data to assess disparities

Methodology

HealthPartners decided to analyze member experience around access to interpreters by race and or ethnicity to assess for any disparities. In 2021, 9.5% of Medicaid members spoke a language other than English. A 2015 report from the Minnesota Department of Health also reported that nearly eleven percent of Minnesotans aged 5 and older speak a language other than English at home. Research shows that high-quality health care interpreter services improve health outcomes for limited English proficiency (LEP) patients[18].

HealthPartners analyzed the following CAHPS measure in 2021:

- *"An interpreter is someone who repeats or signs what one person says in a language used by another person. In the last 6 months, when you needed an interpreter to help you speak with doctors or other health providers, how often did you get one?"*

As this is the first year HealthPartners is analyzing this CAHPS measure, we will use the 2021 rates below as benchmark goals for future years.

[18] https://www.leg.mn.gov/docs/2015/mandated/150235.pdf

Results are reviewed with the Government Programs Quality and Utilization Committee (GPQUI) on an annual basis. The HealthPartners Quality Council reviews GPQUI meeting minutes quarterly.

Results

	2021	
Race/ Ethnicity	% Responding Always & Usually (N)	% Responding "I have never needed to use an interpreter" (N)
Multi-racial	21% (3/14)	79% (54/68)
White	8% (16/190)	80% (738/928)
Black	27% (26/95)	60% (144/239)
Hispanic	43% (15/35)	46% (32/69)
Other	53% (67/127)	35% (67/194)

Analysis

Most respondents indicated they have never needed to use an interpreter. White and multi-racial respondents had the highest rates for this response, with 80% and 79% never needing an interpreter, respectively. Hispanic and "other" respondents had lower rates for this response with only 46% and 35% never needing an interpreter, respectively.

Of those who did need an interpreter, 43% of Hispanic respondents and 53% of "other" respondents said they always or usually get one when needed. Only 8% of White respondents said they always or usually get an interpreter, followed by multi-racial respondents (21%) and Black respondents (27%).

There was a significant gap (45 percentage points) between always or usually ratings of the highest ("other") and lowest (White) groups. There was a 16-percentage point gap between always or usually ratings of Black respondents and "other" respondents.

All groups had relatively low ratings of being always or usually able to get an interpreter when needed, with none except "other" exceeding 50%.

HE 6C, Factor 1

Monitor 3: Utilization of language services for organization functions

Methodology

Annually, HealthPartners reviews Medicaid member utilization of oral interpreter services through our vendor LanguageLine and internal bilingual Spanish line as well as utilization of written translation services through our vendor TransPerfect. The internal Spanish line is only

available for calls to our Member Services department, while Language Line and TransPerfect are available to all member-facing departments. Utilization data is analyzed against Medicaid member language data to help with identification of gaps and/or trends.

The utilization data below is based on unique calls. We do not track utilization by individual members. As such, the total calls could include multiple calls from the same member over the year. The NCQA quality team identified a future opportunity to enhance the data by completing system enhancements that would allow staff to note in the member record whenever a language service was utilized.

Case Management utilization data is only available as an aggregate for all members across all products. We applied the average percentage of Medicaid members engaged in case management programs (Disease Management – 20%, Case Management – 24%, Behavioral Health – 47%) to estimate the total Medicaid member calls using a language service in 2021.

Our utilization management (UM) and claims departments do not have any member-facing staff and as a result they are not included in the utilization data below.

Results

2021 Medicaid Member Language Data		
Language	**Count**	**% of Total Medicaid Membership**
English	170,172	84%
Non-English	19,195	9.5%
Unknown	12,803	6.3%
Choose Not to Answer	1	0%
Total	**202,171**	**100%**

2021 Top 5 Non-English Languages Spoken by Medicaid members	% of Members	2021 Top 5 Languages on LanguageLine Report	% of Total Calls
Spanish	2.6%	Spanish	34.57%
Somali	1.5%	Somali	17.34%
Vietnamese	1.3%	Vietnamese	8.77%
Hmong	.8%	Hmong	6.15%
Oromo	.7%	Karen	4.27%

Language Service Type	Total 2021 Calls with Medicaid Members	% of 2021 Calls Using Language Service (N)
Bilingual Staff – Member Services	126,235 calls	>1% (64)
LanguageLine – Case Management	29,348 calls	10% (2988) See note above regarding data limitations
LanguageLine – Member Services	126,235 calls	1.1% (1379)
LanguageLine – RideCare	12,000 calls	5.7% (683)
All Services	167,583 calls	3% (5114)

2021 TransPerfect Written Translation Utilization	
Translation Language	**Count**
English > Spanish	6
English > Hmong	4
English > Somali	3
English > Korean	1
English > Russian	1
English > Vietnamese	1
Total	**16**

Analysis

In 2021, 9.5% of Medicaid members spoke a language other than English. There were 5114 Medicaid member calls using language services in member services, case management, and Ridecare, which represents about 3% of total calls across these departments.

Just over one percent of all Riverview Member Services calls used LanguageLine and less than one percent used bilingual staff. Nearly six percent of Ridecare calls and ten percent of case management calls used LanguageLine.

There were only 16 written translations completed across all member-facing health plan departments in 2021.

The percentage of total calls utilizing language services in 2021 (3%) is below the total percentage of Medicaid members who speak a language other than English (9.5%). The top 4 languages utilized via LanguageLine and the bilingual staff line align with the top 4 languages spoken by our Medicaid membership. Karen was the fifth-highest language utilized, while Oromo is the fifth-highest language spoken by Medicaid members in 2021. In 2021, 0.1% of

HealthPartners Medicaid members spoke Karen. It is important to note that language was unknown for 6.2% of Medicaid members in 2021, which can impact top language ratings.

All in all, we have adequate capacity to support members who do not speak English and our language service utilization aligns with languages spoken by our members. The proportion of calls using language services are generally in line with the rate of members who speak a language other than English. Case management does appear to have a higher language service utilization than other departments (10%), but as noted above, the number of calls had to be estimated due to system limitations and thus it is difficult to draw conclusions about trends.

The relatively low rate of language service utilization (ranging from 1% to 10%) compared to the number of Medicaid members who speak a language other than English (9.5% or 19,195 total members) does raise questions about whether non-English speaking members are aware of available telephonic language services and whether additional communication/education is needed to encourage all members to contact HealthPartners as needed.

HE 6C, Factors 2 & 4

Monitor 4: Individual experience with language services for organization functions and during health care encounters (2 surveys)

Methodology

Annually, HealthPartners conducts two member surveys to evaluate members' experience with language services at both the health plan and care delivery levels. The HealthPartners Center for Evaluation and Survey Research uses member lists provided by health informatics (described below), sends written surveys and performs follow up phone calls (using either a bilingual staff or a LanguageLine interpreter) to orally offer the survey to identified members.

Both surveys are deployed at the same time. This year, surveys were mailed to members on August 3, 2022. Mailed materials included an English and translated version of the survey. Phone follow-ups began on August 18, 2022, and the survey closed on September 3, 2022.

Members are identified by health informatics based on the following details:

Survey 1, Health Plan: Medicaid members who have been in contact with a member-facing staff within the past month and speak one of our top three languages of Spanish, Somali, and Vietnamese. These members were surveyed regarding our plan language services.

Survey 2, Health Care Encounter: Medicaid members who have had a health care encounter with any provider within the past month and speak one of our top three languages of Spanish, Somali, and Vietnamese. These members were surveyed about their experience during their health care encounter.

The health plan experience survey results are broken down by language assistance used, member language and language of survey completion. The health care encounter experience

survey is broken down by language assistance used, in-person vs. virtual, patient language, and language of survey completion.

Survey results are shared with the project work group and NCQA Health Equity Accreditation Steering Committee for review and discussion.

Results

Survey 1 – Individual experience with language services for organization functions (health plan)

Table 1: Total Respondents

Total Respondents	Response Rate
57	31%

Table 2: Member Language

Member Language	Percentage (n)
Spanish	44% (25)
Somali	28% (16)
Vietnamese	28% (16)

Table 3: Survey Completion Language

Survey Language	Percentage (n)
English	26% (15)
Non-English	74% (42)

Table 4: Utilization

Question: During the most recent call with your health plan, which language assistance did you receive? (n=57)			
	%	**Goal**	**Goal Met?**
Bilingual Staff (n)	7% (4)	NA	NA
Interpreter (n)	68% (39)		
Family or Friend (n)	N/A (0)		
I did not receive any language assistance (n)	25% (14)		
Total percent of members receiving any type of language assistance (n)	75% (43)	90%	N

Table 5: Ease of Use and Helpfulness

Question	**Very Easy (n)**	**Goal**	**Goal Met?**
How easy was it to use the language assistance provided? (42)	76% (32)	75%	Yes

Question	**Very Helpful (n)**	**Goal**	**Goal Met?**
How helpful was the language assistance? (41)	90% (37)	90%	Yes

Table 6: Language Assistance Availability

Question	**Always (n)**	**Goal**	**Goal Met?**	**Never (n)**	**Goal**	**Goal Met?**
How often are you offered language assistance when you need it? (n=55)	55% (30)	60%	No	9% (5)	5% or less	No

Table 7: Satisfaction with Translated Materials

Question	Very Satisfied (n)	Goal	Goal Met?	I have not received translated materials (n)	Goal	Goal Met?
If you have ever received translated materials from your clinic or hospital, how satisfied were you with those written materials? (n=52)	48% (25)	50%	No	38% (20)	35% or less	No

Analysis - Individual experience with language services for organization functions (health plan)

The majority (74%) of health plan survey respondents completed the survey in a non-English language. More respondents spoke Spanish (44%) than Somali or Vietnamese (28% each). A large majority of respondents used some type of language service (75%); none of the respondents used a family or friend to translate. 25% of respondents did not receive any language assistance during their call.

Overall, respondents indicated that the language assistance provided was easy to use, with 76% indicating assistance was very easy to use. Respondents also indicated that language assistance was overall very helpful (90%). Just over half of health plan survey respondents said they always receive language assistance when they need it, while 9% said never. Neither response met goal which indicates an opportunity to explore barriers to health plan members being offered language assistance services during their calls with the health plan.

Another opportunity indicated by health plan survey responses, is regarding translated materials. 38% of respondents said they have not received translated materials (goal is not to exceed 35%). Of those that have received written translations, most (48%) report being very satisfied with them. Increasing staff awareness of how to access and request written translations of member materials was selected as an intervention to improve culturally and linguistically appropriate services and is described later in this report.

Survey 2 – Individual experience with language services during a health care encounter

Table 1: Total Respondents

Total Respondents	Response Rate
62	32%

Table 2: Patient Language

Patient Language	Percentage (n)
Spanish	32% (20)
Somali	34% (21)
Vietnamese	34% (21)

Table 3: Survey Completion Language

Survey Language	Percentage (n)
English	31% (19)
Non-English	69% (43)

Table 4: Utilization

During your most recent visit to a clinic or hospital for your own care, which language assistance did you receive? (n=62)			
	%	Goal	Goal Met?
Bilingual Staff (n)	5% (3)	NA	NA
Interpreter (n)	82% (51)		
Family or Friend (n)	5% (3)		
I did not receive any language assistance (n)	8% (5)		

Total percent of members receiving any type of language assistance (n)	92% (57)	90%	Y

Table 5: Patient language assistance method

Question	In-Person (n)	By video/phone (n)
Which of the following best describes how you received the language assistance? (n=50)	60% (30)	40% (20)

Table 6: Ease of Use and Helpfulness

Question	Very Easy (n)	Goal	Goal Met?
How easy was it to use the language assistance provided? (53)	85% (45)	75%	Yes

Question	Very Helpful (n)	Goal	Goal Met?
How helpful was the language assistance? (55)	95% (52)	90%	Yes

Table 7: Language Assistance Availability

Question	Always (n)	Goal	Goal Met?	Never (n)	Goal	Goal Met?
How often are you offered language assistance when you need it? (n=62)	66% (41)	60%	Yes	3% (2)	5% or less	Yes

Table 8: Satisfaction with Translated Materials

Question	Very Satisfied (n)	Goal	Goal Met?	I have not received translated materials (n)	Goal	Goal Met?
If you have ever received translated materials from your clinic or hospital, how	57% (30)	50%	Yes	23% (12)	35% or less	Yes

satisfied were you with those written materials? (n=53)

Analysis - Individual experience with language services during a health care encounter

The majority (69%) of patient survey respondents completed the survey in a non-English language. Respondent languages were evenly distributed across Spanish (32%), Somali (34%), and Vietnamese (34%). A large majority of respondents used interpreter services (82%);5% used a family or friend to translate and 8% of respondents did not receive any language assistance on their recent call.

Overall, respondents indicated that the language assistance provided was very easy to use (85%), which exceeds goal by 10 percent. Respondents also indicated that language assistance was overall very helpful (95%) which exceeds goal by 5 percent. Two-thirds of patient respondents say they always receive language assistance when they need it and only 3% say never; both responses met goal. 60% of patients received language assistance in person, while 40% received assistance via video or phone.

Patient respondents report higher rates of receiving written translations than health plan respondents and higher satisfaction with materials (57% very satisfied vs. 48% very satisfied for health plan respondents).

Overall ratings of language assistance ease, helpfulness and availability were higher for patient respondents than for health plan respondents, reinforcing the opportunities identified in the analysis of the health plan survey.

HE 6C, Factor 3

Monitor 5: Staff experience with language services for organization functions

Annually, HealthPartners conducts a survey of member-facing staff to evaluate the following: (1) staff understanding of how to access language services, (2) staff ability to access language services when needed, and (3) when staff can access relevant language services, how satisfied they are with them.

Methodology

The electronic survey link is distributed to managers of member-facing departments[19] (see table below); managers are asked to distribute to staff and send a reminder one week before the survey closes.

CareLine
Commercial Member Services
Dispute Resolution Team
Comprehensive Care Advocacy & Disease and Case Management
Pharmacy Navigators
Nurse Navigators
RideCare
Riverview Member Services
Riverview Member Rights & Benefits
Worksite Health and Population Wellbeing

Survey results are shared with the project work group and NCQA Health Equity Accreditation Steering Committee. The survey results are also brought to the Interpreter Services Workgroup and to the Health Equity Cornerstone Co-Chairs for additional review and discussion. Any action items identified by these reviewers are brought to the appropriate contractor (LanguageLine, TransPerfect, etc.).

[19] Utilization Management and Claims not included in survey as they do not have any direct member contact.

Results

Table 1: Utilization

Question: Which of the following language assistance services have you used to assist members? [Mark all that apply] (n=300)			
	%	**Goal**	**Goal Met?**
An interpreter through the LanguageLine (n)	73% (219)	70%	Y
Written translation through TransPerfect (n)	3% (9)	4.5%	Y
Assistance from a bilingual staff member (self or other) (n)	15% (45)	15%	Y

Table 2: Access

Question	**Always (n)**	**Goal**	**Goal Met?**	**Never (n)**	**Goal**	**Goal Met?**
How often are you able to access an interpreter through the Language Line when you need one? (n=218)	61% (133)	75%	N	1% (2)	5% or fewer	Y
How often are you able to have written materials translated through TransPerfect when you need them? (n=9)	78% (7)	75%	Y	N/A (0)	5% or fewer	N/A
How often are you able to access assistance from a bilingual staff member when needed? (n=29)	18% (5)	25%	N	7% (2)	10% or fewer	Y

Table 3: Ease of Use

Question	**Very Easy (n)**	**Goal**	**Goal Met?**
You mentioned you've used LanguageLine to assist members, how easy was it to access an interpreter through the LanguageLine? (n=218)	71% (155)	75%	N
You mentioned you've used written translation through TransPerfect to assist members, how easy was it to get access to translated materials through TransPerfect? (n=9)	78% (7)	75%	Y
How easy was it to access assistance from a bilingual staff member? (n=29)	38% (11)	40%	N

Table 4: Satisfaction

Question	Extremely Satisfied (n)	Goal	Goal Met?
Overall, how satisfied are you with the language assistance services offered through the LanguageLine? (n=217)	38% (82)	40%	N
Overall, how satisfied are you with the language assistance services offered through TransPerfect? (n=9)	33% (3)	40%	N
Overall, how satisfied are you with the language assistance services received from bilingual staff members? (n=28)	32% (9)	40%	N

Table 5: Areas of Work

Q: Which best describes the area in which you work? (n=246)

Department	Percentage (n)
Comprehensive Care Advocacy	27% (66)
Riverview Member Services	25% (62)
Disease & Case Management	15% (37)
CareLine	15% (37)
Dispute Resolution Team	7% (17)
Worksite Health & Population Wellbeing	4% (10)
Nurse Navigators	3% (7)
Pharmacy Navigators	2% (5)
Riverview Member Rights & Benefits	2% (5)
Ridecare	N/A (0)

Analysis

The most frequently accessed language assistance service is interpretation through LanguageLine. Staff overall report high rates of ease of use with only 3 percent indicating it is not easy. 38 percent of respondents said they were extremely satisfied with LanguageLine, which fell below goal of 40%. Some staff reported difficulty getting an interpreter for some languages, including Oromo, Somali, Karen, and Tigrinya.

The least frequently accessed language service is written translation through TransPerfect. Only 3 percent of respondents used this service. Of those who had used TransPerfect, the majority (78 percent) say they are always able to access translated materials when needed, which exceeds the goal of 75%. Satisfaction rates are similar to the LanguageLine, with 33 percent of respondents being extremely satisfied.

15 percent of respondents had experience with assistance from a bilingual staff member. Of these respondents, two-thirds received help from a staff member other than themselves. Spanish is the most common language spoken by bilingual staff members, followed by Somali and Hmong. Access rates for this service were lower than for LanguageLine and TransPerfect, with only 18% of respondents saying they could always access a bilingual staff member. Satisfaction rates for this service were similar, with 32 percent of respondents being extremely satisfied. No language service met the “extremely satisfied” goal of 40%.

A key finding of this survey is the low utilization rate of our written translation vendor TransPerfect. Only 3 percent of respondents had used TransPerfect. Of these respondents, ease and satisfaction rates were high. This is a positive finding and indicates that this service is useful, but the low utilization rate indicates staff are unaware of how to access it. Increasing staff awareness and use of how to work with TransPerfect was identified as an intervention to improve culturally and linguistically appropriate services and is described later in this report. We have identified a goal to increase staff utilization of TransPerfect by 50% at next survey (4.5%).

Another key finding is in accessing bilingual staff; only 18% of staff say they are always able to access assistance from a bilingual staff member. These results indicate there may be opportunities to further explore the process for accessing bilingual staff and their availability.

HE 6D, Factors 1-2

Opportunities

HealthPartners utilized the data described in the monitors above, as well as collaboration with departments across the enterprise, to identify opportunities to reduce healthcare disparities and improve culturally and linguistically appropriate services (CLAS).

The HealthPartners quality team deployed a staff survey to identify opportunities to reduce healthcare disparities and improve culturally and linguistically appropriate services. This survey was sent to the following departments in October 2021. We received 8 responses which are reflected in the opportunities table below.

Department
Government Programs

Health Informatics
Marketing
E-Commerce
Provider Relations Network Management
Riverview Member Services
Quality Improvement and Compliance
Worksite Health and Population Wellbeing
Improvement & Integration
Comprehensive Care Advocacy
Pharmacy Administration
Medical Director

In 2022, we instituted a health equity policy evaluation to our annual policy review process which generated additional opportunities.

As described in the methodologies above, all data results are reviewed and analyzed by groups of key stakeholders. These groups participate in barrier analysis and opportunity identification.

The HealthPartners quality team compiled and assessed all identified opportunities. We used the factors below to prioritize and make recommendations for interventions to reduce health care disparities and improve CLAS:

1. Evidence of disparities and/or CLAS service gaps observed in data (i.e., HEDIS, CAHPS, surveys)
2. Lack of strong interventions designed to improve performance.
3. Resources available to implement needed improvements.
4. Strong alignment with key organizational priorities to support our members.

The opportunities selected for intervention were then presented to the NCQA Health Equity Implementation Steering Committee for endorsement. Any opportunities not selected for intervention this year are being tracked and monitored for possible intervention in the future.

Topic	Barrier	Opportunity	Selected for Intervention?	Priority
Language services	The staff survey revealed that only 9 out of 375 member facing staff responded to the question; “How often are you able to have written materials translated through TransPerfect when you need them?” Response rates were low because staff had not utilized written translation services.	Increase staff awareness of written translation services	Yes. This intervention was selected to improve CLAS (HE 6D, Factor 4).	High

Topic	Barrier	Opportunity	Selected for Intervention?	Priority
Healthcare disparities	Native American population has the greatest rate of disparity on HEDIS prenatal and postpartum care measure.	Increase the rate of post-partum appointments for the Medicaid Native American population.	Yes. This intervention was selected to reduce a healthcare disparity (HE 6D, Factor 3).	High
Member Communications	Many existing member communications across departments (i.e., CCA, CEM) are only available in English.	Translate high-priority member communications into languages spoken by HealthPartners member population.	Yes	High
Healthcare Access	HealthPartners data shows increased percentages of members in rural areas have highest inpatient utilization and readmissions. There is a known lack of providers in rural areas (i.e., 2-3% of oncologists practice in rural areas while 20% of oncology care patients live in rural areas).	Mobile healthcare options in rural or urban areas where healthcare is not easily accessible.	No	Low
Health Risk Assessment (HRA) completion	Hispanic/Latino members have lower HRA completion rate than overall completion rate for MSHO/MSC+ members.	Identify drivers for lower completion rate and accordant strategies to address this.	No	Low
Interpreter Services	Comprehensive care advocacy case managers report difficulty using video visits for members who don't speak English.	Implement ability to change HealthPartners website to a different language so members can understand material and access support.	No	Low
Healthcare Access	Many members unaware of services available to them, have difficulty accessing care due to location, lack of language services, and/or distrust of providers.	Partner with religious organizations and grassroots community organizations to connect with underserved communities to	No	Low

Topic	Barrier	Opportunity	Selected for Intervention?	Priority
		improve healthcare access.		
Plan administration	The plan is beginning to evaluate their polices through an equity lens, however a significant majority of policy owners and reviewers are white women. With a gap in diverse experiences and perspectives reviewing the policies there is a higher likelihood of missing an improvement opportunity.	Increase the participation of diverse staff within the healthcare and medical management annual policy reviews.	TBD	Medium
Culturally responsive training for staff	Member-facing areas across the plan do not have a consistent training resource for working with members who are LGBTQ+ and/or gender diverse. Not all areas provide training to staff on working with these members. This can lead to members having different experiences with different areas. Staff may also not be aware of best practices on supporting these members.	Create a centralized health plan resource guide for supporting members who are LGBTQ+ and/or gender diverse.	No	Medium
Practitioner R/E/L/SO/GI data	We rely on practitioner and clinic self-reporting for data about practitioner demographic data. As such, our data is limited.	Create plan to expand on collecting R/E/L data from practitioners.	Yes	Medium
Member R/E/L/SO/GI	We rely primarily on third party sources for data about member R/E/L/SO/GI information. As such, our data is limited.	Add choice to update demographic data in the plan side of the website to enable member self-report of demographic info.	No	Medium
Language services/plan administration	The health plan lacks a single set of standards/funding streams for written translations across departments which can impact utilization of this language service.	Formalize and fund written translation standards across the plan. Centralize language assistance	No	Medium

Topic	Barrier	Opportunity	Selected for Intervention?	Priority
		(interpreters, written trans) costs across the plan.		
Language services/plan administration	Some departments employ bi-lingual staff who are expected to use language skills on calls with members. There are not currently any employment incentives for these staff who use additional skills in their everyday work.	Explore further incentivizing bi-lingual or multi-lingual staff to utilize their language skills.	No	Medium
Organizational readiness	The plan's DEI scorecard shows higher turnover rates for Black, Indigenous, and colleagues of color compared to all colleagues and colleagues who are White.	Identify opportunities to improve retention rates among Black, Indigenous, and staff of color.	No	Medium
Language services	The main system for documenting member encounters in member services (HCSS) does not have any option to identify when language services were used or requested during an encounter.	Enhance HCSS functionality to include the option to select when language services are used during an encounter with members and what type of language service was used (i.e. LanguageLine or other oral interpreter, bilingual staff, written translation requested)	No	Medium
Language services	Comprehensive care advocacy case managers report difficulty using video visits for members who don't speak English.	Incorporate remote-in options for interpreters during video visits.	Yes	High
Education	White male boys have highest Autism diagnosis rate by high degree compared to other populations	Implement provider and community education on recognizing autism spectrum disorders (ASD), resources for diagnosing and	No	Low

Topic	Barrier	Opportunity	Selected for Intervention?	Priority
		treating and reducing the stigma.		
Healthcare access	Complicated and ongoing treatment plans for Autism leads to difficulties in communication to caregivers who are non-English speaking, or otherwise have barriers in understanding medical language; and difficulties in accessing ongoing treatment for populations with low socioeconomic status.	RideCare opportunities to help with access to ASD diagnosis/treatment. Compile a report of all children with an ASD diagnosis and offer case management to this population and/or the entire population with ASD including adults. Review and analysis of contracting providers to ensure all members have access to providers for ASD near their home and that are culturally/linguisticall y/racially diverse.	No	Low
Healthcare access	Denials from chronic pain management programs can be cause by many factors not controlled by the patient including a lack of relationship with a PCP, lack of access (money, time, etc.) to get to appointments needed for approval of this treatment plan.	UM teams to connect members who are denied from these programs a CCA referral to help with finding other sources of care or to help coordinate care to meet requirements for program	No	Low
Health Plan Policy Equity Review	Policy QA 01 Practitioner Office Site Quality -Ensuring office sites are accessible to those who do not have a car or regular form of transportation	Office/clinic settings accessible via public transportation to be considered. Potentially provide transportation from public transit routes to the clinics - will help members who	Yes	High

Topic	Barrier	Opportunity	Selected for Intervention?	Priority
		do not have their own mode of transportation access clinics that are not near/on a public transportation route.		
Health Plan Policy Equity Review	Policy QA 01 Practitioner Office Site Quality - Ensuring office sites are accommodating to people with physical, mental, and sensory disabilities	Explore if criteria account for enough aspects of space that could impact members mentally as well as physically - noise, light, colors and if verbiage and images are inclusive.	No	Low
Health Plan Policy Equity Review	Policy QA 02 Access to Care and Service Equity Review	Ask a survey question as to whether members' location was a factor in appointment availability as well as the decision to have a telehealth visit vs. face to face.	No	Low
Health Plan Policy Equity Review	Policy QA 02 Access to Care and Service Equity Review	Add/document language line, utilize interpreter services, TTY services.	No	Low
Health Plan Policy Equity Review	Policy QA 02 Access to Care and Service Equity Review	Funding for more prepaid/urgent appointments for behavioral health such as therapy, BH/CD assessments, etc. in addition to the existing prepaid psychiatry appointments.	No	Low
Health Plan Policy Equity Review	Policy QA 05 Case Review Process for Quality of Care Equity Review	Propose to MD Directors that a health equity report be created and reviewed every	No	Low

Topic	Barrier	Opportunity	Selected for Intervention?	Priority
		quarter that encompasses all complaints for that quarter and yearly. When a clinic/provider is identified, it will be presented to QRS committee to determine next steps.		
Health Plan Policy Equity Review	Policy QA 17 Clinical Practice Guidelines Equity Review	Add language that we can use Fast Facts to disseminate resources on effectively communicating with patients with language needs.	No	Low
Health Plan Policy Equity Review	Policy QA 17 Clinical Practice Guidelines Equity Review	Familiarize collaboration with UCARE/Stratis for language resources which will be available to clinicians.	Yes	Low
Health Plan Policy Equity Review	Policy QUM 02 Data Request for Medical Management Review Processes Equity Review	Create a new field within HCSS/CP or EXL to align with SOGI. This creates options for when members wish to identify as a gender besides male/female.	No	Medium
Health Plan Policy Equity Review	Policy QUM 05: Continuity and Coordination of Care Improvement Projects Equity Review	The policy could require at least one of these issues to be related to closing gaps in care experienced by at-risk and underserved populations and include equity in the barrier analysis.	Yes	High

Topic	Barrier	Opportunity	Selected for Intervention?	Priority
Health Plan Policy Equity Review	Policy QUM 08 Quality Improvement and Utilization Management Program Administration Equity Review	Always ensure BIPOC voices are represented in our governing bodies.	Yes	High

HE 6D, Factor 3

Intervention 1: Address a Disparity

Overview

HealthPartners NCQA Health Equity Core Team staff completed an S-B-A-R process to identify and select an initiative to address a disparity. This process identified that Indigenous populations had the largest gaps across multiple HEDIS measures compared to Whites and other groups, particularly prenatal and postpartum care. Additionally, HealthPartners saw a decrease in prenatal and postpartum care rates across all racial and ethnic groups. HealthPartners chose to align our selected intervention with the broader health plan and care group equity initiative around child and maternal health, which also supports the disparities seen in our HEDIS data.

Given the significant disparity in prenatal and postpartum care rates for the Medicaid Indigenous population, we identified a goal to increase the rate of post-partum appointments for this group and to close the gap by at least 5%. For this intervention, we have chosen to compare HEDIS PPC performance for Indigenous women against the aggregate rate because the White population does not have the highest level of performance on this measure.

The following actions are being taken to achieve this goal:

1. Partner with Division of Indian Work (DIW) to obtain certification of doula curriculum specific to the Native American population and obtain Medicaid reimbursement. DIW offers the Ninde (My Heart) Doula program to Indigenous women in the Twin Cities community. Some of the doulas are certified by a mainstream doula program, but DIW would like to utilize a traditional Native curriculum called Zaagi'idiwin. This curriculum is not currently approved by the state for doulas who can bill Medicaid. HealthPartners is working with DIW and other community groups to expand the roster of doula curriculums to include additional culturally specific doula training, including Zaagi'idiwin.

2. Offer culturally relevant resources as part of the My Pregnancy platform. When HealthPartners has race and language information on members who access the My Pregnancy online prenatal education platform, relevant culturally specific information is presented to them as additional resources.

3. Develop a video highlighting the support that doulas provide. In Minnesota, doulas are a covered benefit for Medicaid members. Most people are not familiar with doulas and how support from a doula could benefit them. HealthPartners is creating a video in 2022 explaining what a doula is, the types of support they provide, the benefits seen and how to access a doula, if desired. This will be member-focused but will also be shared with our network providers to educate them as well.

4. Update healthy pregnancy outreach algorithms to target Native American members who are pregnant regardless of risk profile. When HealthPartners identifies a member as pregnant, we send a letter inviting them to access our pregnancy program and online resources. If a member is identified as high risk, an outreach specialist reaches out to

the member by phone to do a screening and determine if they are eligible for one-on-one nurse support. For Indigenous women, rather than having that outreach done by a paraprofessional, an RN reaches out directly to better engage the member and provide more streamlined access to our programs.

HE 6D, Factor 5

Plan for Evaluation

The Quality Improvement and Compliance department takes responsibility for monitoring progress against goals. Reports will be reviewed and monitored at least yearly at the Medicaid Quality and Utilization Improvement Work Group which reports into the Government Programs Quality and Utilization Committee (GPQUI). GPQUI will review and approve progress reports. The HealthPartners Quality Council reviews GPQUI meeting minutes quarterly. Additional details about our evaluation plan are described in the table below.

Evaluation Steps	Description	Due Date	Outcome
Implement actions	Actions to reduce healthcare disparities described above were implemented over the course of 2022.	Q4 2022	All actions have been implemented.
Community Advisory Council presentation – 2022 goals	Present 2022 goals to reduce healthcare disparities to Community Advisory Council for input.	September 2022	Completed
Presentation to Medicaid QUI – interim 2022 evaluation	Present initial HEDIS rates and interventions implemented to date to reduce healthcare disparities to Medicaid Quality and Utilization Improvement Work group for interim evaluation of effectiveness and barrier analysis.	November 2022	Completed
Evaluation session with Community Advisory Council members – interim 2022 evaluation	Meet with subset of Community Advisory Council members to review initial HEDIS rates and interventions to date to reduce healthcare disparities for interim evaluation of effectiveness, barrier analysis and further opportunity identification.	December 2022	Forthcoming
2023 Measurement Plan Development	As part of annual Quality Improvement/Culturally and Linguistically Appropriate Services Program Description process, identify goals to reduce healthcare disparities for 2023. We will evaluate effectiveness of 2022 interventions to	Q1 2023	Forthcoming

Evaluation Steps	Description	Due Date	Outcome
	date to support identification of 2023 goals.		
Community Advisory Council Presentation – 2023 Goals	As part of annual Quality Improvement/Culturally and Linguistically Appropriate Services Program Description process, bring opportunities to Community Advisory Council for review and feedback on 2023 goals to reduce healthcare disparities.	Q1 2023	Forthcoming
Community Advisory Council presentation – 2022 evaluation	When updated data sources (2022 HEDIS rates) are available for analysis and trending, present results to Community Advisory Council for final evaluation of 2022 interventions.	End of Q2/beginning of Q3 2023	Forthcoming
Completion of 2023 Reducing Healthcare Disparities report	Gather 2022 HEDIS rates to analyze trending of measures. Compare these data sources to previous year's report to support evaluation and outcome of interventions to reduce healthcare disparities and improve CLAS. Complete report with year over year analysis of data.	Q3 2023	Forthcoming
Presentation to Medicaid QUI – 2022 evaluation	When updated data sources (2022 HEDIS rates) are available for analysis and trending, present results to Medicaid QUI for final evaluation of effectiveness and barrier analysis on 2022 interventions.	Q3 2023	Forthcoming

HE 6D, Factor 4

Intervention 2: Improve CLAS

Overview

HealthPartners NCQA core team interviewed member-facing departments on their current practices for obtaining written translations of materials for members. The results of these interviews, combined with feedback on the staff language survey (monitor 5), and the written translation utilization report (monitor 3), showed that HealthPartners is inconsistently and underutilizing this service. Additionally, many member-facing departments and staff are not aware of our vendor TransPerfect or how to obtain written translations.

We identified an opportunity to increase staff awareness of the process for requesting written translations as this is an important aspect of delivering culturally and linguistically appropriate services for our members. Our goal is to increase the number and percentage of staff who request written translation services by 50% as evidenced by data from the annual staff experience with language services survey.

The following actions are being taken to achieve this goal:

1. Interview departmental leaders for awareness of HealthPartners designated translation vendor
2. Develop a work aid that describes how to access written translation services and distribute to staff; this work aid was developed with input from departmental leaders as well as our interpreter services team.
3. Re-survey staff to assess the impact of work aid on awareness.
4. Annually evaluate TransPerfect utilization for the health plan

Additionally, we are collaborating with member-facing departments to identify documents that offer high value for members to translate into some of our top languages so that more member materials are already available as written translations.

HE 6D, Factor 6

Plan for Evaluation

The Quality Improvement and Compliance department takes responsibility for monitoring progress against goals. Reports will be reviewed and monitored at least yearly at the Medicaid Quality and Utilization Improvement Work Group which reports into the Government Programs Quality and Utilization Committee (GPQUI). GPQUI will review and approve progress reports. The HealthPartners Quality Council reviews GPQUI meeting minutes quarterly. Reports will also be brought to the Interpreter Services Workgroup on an annual basis. Additional details about our evaluation plan are described in the table below.

Evaluation Steps	Description	Due Date	Outcome
Implement actions	Actions to improve CLAS described above were implemented over the course of 2022.	Q4 2022	All actions have been implemented.
Written Translation Workgroup Presentation	Present staff language survey groups to workgroup for input.	June 2022	Completed
Community Advisory Council Presentation – 2022 Goals	Present interventions implemented to date to improve CLAS to Community Advisory Council for input.	September 2022	Completed
Presentation to Medicaid QUI –	Present 2022 survey data and interventions implemented to date to improve CLAS to Medicaid Quality and	November 2022	Completed

Evaluation Steps	Description	Due Date	Outcome
Interim 2022 Evaluation	Utilization Improvement Work group for interim evaluation of effectiveness and barrier analysis.		
Interpreter Services Workgroup Presentation	Present member language survey results to workgroup for input.	November 2022	Completed
Evaluation session with Community Advisory Council members – interim 2022 evaluation	Meet with subset of Community Advisory Council members to review 2022 survey and language service utilization data and interventions to date to improve CLAS for interim evaluation of effectiveness, barrier analysis and opportunity identification.	December 2022	Forthcoming
2023 Measurement Plan Development	As part of annual Quality Improvement/Culturally and Linguistically Appropriate Services Program Description process, identify goals to improve CLAS for 2023. As part of this process, will evaluate effectiveness of 2022 interventions to support identification of 2023 goals.	Q1 2023	Forthcoming
Community Advisory Council presentation – 2023 goals	As part of annual Quality Improvement/Culturally and Linguistically Appropriate Services Program Description process, bring opportunities to Community Advisory Council for review and feedback on 2023 goals to improve CLAS.	Q1	Forthcoming
Community Advisory Council Presentation – 2022 Evaluation	When updated data sources are available for analysis and trending (2023 surveys), present results to Community Advisory Council for final evaluation of 2022 interventions.	End of Q2/beginning of Q3 2023	Forthcoming
Completion of 2023 Reducing Healthcare Disparities report	Re-deploy surveys and gather 2022 language services utilization data to analyze trending of measures. Compare these data sources to previous year's report to support evaluation and outcome of interventions to improve CLAS. Complete report with year over year analysis of data.	Q3 2023	Forthcoming

Evaluation Steps	Description	Due Date	Outcome
Presentation to Medicaid QUI – 2022 evaluation	When updated data sources (2023 surveys) are available for analysis and trending present results to Medicaid QUI for final evaluation of effectiveness and barrier analysis on 2022 interventions.	Q3 2023	Forthcoming

Affordability

Affordability Initiatives

Description

HealthPartners Triple Aim affordability approach is built on a strong foundation of activities designed to reduce overuse and misuse of resources and to improve the value of services provided to our members. We systematically identify new opportunities and enhance our programs to capture cost savings. In 2022, we identified 37 different affordability strategies encompassing administration, health and care engagement, products and benefits, pharmacy and provider relations. At the end of the year, 25 of these strategies were on track to meet their affordability targets and progress was made on an additional 8 strategies.

Goal

In 2022, we established an affordability target based upon a projection of the upcoming year's claims to reduce the expected Total Cost of Care (TCOC) by 1 - 2 percent and we were able to achieve a projecting savings of 2.21%.

Initiatives/Interventions

The Affordability Council meets bi-monthly to accelerate activities to achieve our affordability goals using the framework below:

1. Establish organization-wide affordability goals and measures
2. Generate potential affordability ideas and concepts in partnership with other functions in the organization
3. Ensure the number and scope of affordability initiatives are sufficiently broad to inform decisions on resource allocations to support affordability
4. Evaluate and select affordability drivers with the highest potential cost reduction impacts
5. Lead priority setting and allocate resources to support success
6. Track progress on affordability initiatives across the enterprise
7. Leverage enterprise collaboration in achieving these affordability goals
8. Link the work of this council to other affordability initiatives and work streams across the organization

Affordability Initiative Identification Process

HealthPartners has developed a multi-disciplinary affordability council and trend management team to systematically identify short and long-term opportunities and implement strategies for claims cost savings. Each year, this team develops an annual plan that outlines new claims trend management focus areas. Concurrently, they continually identify and evaluate new opportunities. The team has implemented a "Phase Gate" approach, which incorporates SBARs (scope and situation, potential claims cost savings opportunity, and potential strategy options) to assure an efficient process to support execution of ideas to generate intended results. Initiatives are closely monitored, including ongoing barrier analysis. Initiative leads create an overall timeline for each phase through feasibility and monitor progress to the timeline.

Examples of key affordability focus areas include:

- Health plan administration – through the implementation of claims system enhancements including out-of-network claims management
- Pharmacy program – through improvements in pharmacy rebates, supporting appropriate site of care for injectable medications and targeting to better manage specialty pharmaceuticals.
- Health and Care Engagement initiatives – focus on supporting provider collaboration, member activation, improving systems of quality, effectiveness, and safety
- Products and benefits – implement value-based network design, infertility benefit redesign, implement ”paperless” products and digital condition management solutions.

Gaps in Care

The Health and Care Engagement division, which administers many of our population management programs, has developed a systematic process for affordability ideation. Quarterly updates are provided based on competitor analysis, purchasers, and consultants, contracted vendors, trend management, leader insights from conferences and CMS webinars. We also monitor, review, and compile national best practices work to ensure a shared understanding of innovative work that is occurring across the country.

Results/Outcomes

HealthPartners successfully identified and implemented new affordability strategies in 2022. We exceeded the 2022 savings goal by realizing nearly $84 million in saving. Examples of achieved results reflect a strong focus on population health management and include the following:

- Understanding and addressing social determinants of health at the individual level and addressing home and workplace environmental factors. Ongoing initiatives include:
    - Contracting with *CHW Solutions* to provide community health worker services to our members at a sustainable rate
    - Implementing, Now Pow a third party managed and updated community resource directory that will enable member facing teams to make referrals with higher likelihood of member follow-through, replacing less robust in-house maintained directory
    - Reducing clinical quality disparities – key measures include Antidepressant Medication Continuation and Follow-up after MI admission
- Member engagement and activation
- These initiatives create value for both purchasers and members by:
- Reducing readmission rates result in lower total costs and a faster return to work for employees.
- Gap in care closure translates to better employee/dependent outcomes potentially preventing future complications and resulting in higher rates of productivity.
- Increased health and well-being engagement results in improved productivity and lower costs for employers.

- Providing alternative channels and/or access to best-in-class solutions to support employee health goals contributes to a competitive and appealing benefit set and employee retention.

Initiatives to reduce readmission rates include:

- Comprehensive Care Advocacy provides members with holistic support and supports care transitions through integrated access to the care group's EMR system
- Implementing targeted outreach to high-risk members
- Reimplementing in-person complex care navigation support for high risk member transitions

Initiatives to improve member health and well-being Living Well programs include:

- App enhancements including engagement reminders and program completion reminders
- Proactive communication to Medicaid members with triggering behaviors (i.e. no PCP, ER visit,)
- MyStrength Implementation to support members dealing with behavioral health concerns
- Support digital channels for engagement in comprehensive care advocacy services: Better engage members in condition support by connecting members to available online resources for condition management and network navigation, and to close targeted gaps in care (aligned with HEDIS) in Core DM programs.
- Launch Omada condition management program
- Redesign the Healthy Pregnancy program to enhance member engagement and support.
- Improve management of high cost cases by enhancing our ability to support members in their cancer journey through the OncoHealth pilot partnership (Iris Oncology) and through our evolving partnership with our internal pharmacy admin team

Medical Coverage Policy Development

Description

Medical Coverage Policy develops written coverage criteria to provide consistent information, clinical criteria, and interpretation of coverage. These criteria serve as the basis for authorization decisions to determine the medical necessity and clinical appropriateness of certain medical procedures, behavioral health services, pharmaceuticals, devices, and other benefits, including items on the prior authorization list. New and emerging technologies are also evaluated for appropriateness and effectiveness.

Goal

- Promote best care, affordability and experience while reducing overuse and misuse of health care services.
- Ensure members have equitable access to care that is safe, effective and has been proven to have a positive effect on health outcomes.
- Ensure coverage policies support integrity of coverage and authorization program decisions, including aligning with the most current reliable scientific evidence and consideration of scientific advances, expert opinion, or changes in current standards of medical practice.

Initiatives/Interventions

Implement strategies to support best care, affordability, and experience:

1. Routine monitoring of literature and horizon scanning is performed to identify new or updated evidence on key topics.

2. The New Technology Committee assesses new technologies to determine if they are investigational/experimental and forwards their consensus recommendation to the Medical Director Committee or its policy development subgroup for coverage consideration and to applicable business units (e.g., Provider Relations and Network Management or prior authorization program) for strategy development.

3. New or revised policies are approved by the Medical Director Committee and brought to the coding committee for implementation and alignment of claims edits. This includes incorporating analysis of new technology and new applications of existing technologies.

4. Implementation of coverage policies in collaboration with medical directors, quality and utilization improvement, contracting, claims, member services, product, and benefits with a specific focus on alignment with coding and claims payment.

5. Focus on strategic topics such as orthopedic (spine, hips, knees), site of service, genetic testing/genetic therapies, mental health parity and investigational services.

6. Collaboration with a contracted vendor to provide us with market analytics consultation for genetic testing. Routinely conduct comprehensive analyses of claims data to provide

us with current actionable opportunities in medical coverage policy, reimbursement, payment integrity, and laboratory contracting.

7. Collaboration with the Provider Relations and Network Management department related to genetic testing laboratory contracts to ensure cost-effective and consistent pricing for covered tests. We work to identify opportunities for enhancement of our contracted network through developing new relationships with select high-value laboratory partners. This contracted network allows us greater control over our resources, while providing access to the genetic tests our members and patients need.

8. Annual or periodic review is performed on all coverage policies.

Barrier Analysis

1. Rapidly emerging new technologies and FDA approvals.

2. Genetic testing rapid pace of new tests, growth of large scale/panel tests, limited clinical evidence, coding and payment challenges.

3. Absence of sufficient evidence on some topics to make an adequate determination.

4. Absence of sound and/or varying understanding of codes and inconsistent and variable coding practices among providers (e.g., genetic testing).

5. Managing the interaction and interpretation of coverage for multiple product lines concurrently.

6. Multiple competing priorities of policy development to meet requirements for new technologies, Medicare and Medicaid policies, revision of policies, affordability topics and changes to policies to better support prior authorization programs.

7. Complexity of managing multiple communication channels to ensure consistent messaging regarding complex coverage policies and criteria.

8. Payment liability for non-covered claims (provider versus member). Typically, unless the coverage policy requires prior authorization or is investigational/experimental, the claim is denied to member liability, resulting in a dissatisfying member experience.

Opportunities for improvement:

1. Routinely assess for and implement policy development process redesign to be maximally efficient, credible, and scalable.

2. Facilitate improvement of the claims edit implementation process to ensure accurate edits that support current coverage policy determinations and align with policy effective dates.

3. Ensure accurate and consistent billing practices for genetic and molecular testing services.

4. Identifying opportunities to enter into contract agreements with additional specialized genetics laboratories to ensure alignment with market rates and a diverse and comprehensive portfolio of laboratory partners to serve our patients and members.

5. Continuously maintaining medical coverage policies and developing medical management strategies to ensure we are covering evidence-based applications.

6. Ongoing assessment of system needs for accurate and efficient coverage policy implementation.

7. Identify opportunities to address complexity of verbiage within key medical coverage policies.

8. Continuous focus on new and emerging technologies and changes in medical practice to ensure accurate coverage policy positions and attention to affordability opportunities.

Results/Outcomes

New Technology Committee:

1. The committee continues to improve the timing of topics moving through the committee so that they can be appropriately addressed via policy and/or the claims process, thus ensuring correct medical management and claims payment/non-payment. This is evidenced by the number of topics which have been added to either the Investigational Services-List of Non-Covered Services policy, another existing policy, or closed for review.

2. In 2022, the New Technology Committee reviewed topics originating from a wide scope of sources including horizon scanning, local providers, and HP internal departments. A total of 79 topics were reviewed: This included three new topics, two watch list items and 74 items on the Investigational Services-List of Non-Covered Services policy. Of these, three topics were added to the Investigative List of Non-Covered Services policy. The horizon scanning process has allowed the committee to be more proactive in terms of identifying and evaluating new technology. No topics were moved forward to the Medical Director's Committee this year for policy development.

3. The committee maintained its process efficiencies via use of the Fast Track evaluation and voting process to reach consensus without the need for a formal meeting when indicated. This helps support stewardship and green initiatives by conducting paperless or electronic meetings.

4. The committee continues to prioritize topics for which there remains current, evolving literature.

5. New Technology Committee utilizes a dedicated email address to help streamline communication with the New Technology Committee. Both internal and external customers can use this address to submit questions regarding a specific new technology topic.

Coverage Policy:

1. A total of 21 new clinical coverage criteria policies were developed including two new genetic testing policies, surgical treatments for lipedema and lymphedema, hip and knee surgeries and several policies that support differences in Medicaid and Medicare coverage.

2. Ongoing evaluation of policies to determine the relevance to current standard of care, evidence, cost, and claims history, resulted in three policies being retired. Content found in other policies was transitioned to benefit coverage documents to provide clearer connections in member materials.

3. Annual review was performed on 393 coverage policies resulting in revising coverage criteria for 85 policies.

4. Continued partnership with sales to develop coverage specific needs of employer groups such as gender confirmation surgery and infertility and fertility services.

5. Implemented claims strategies to ensure accurate claims processing and payment to align with coverage criteria, maintaining clinical appropriateness and cost effectiveness.

6. Continued partnerships with behavioral health, pharmacy, and utilization management to ensure we align workflows for coverage criteria that intersects multiple areas.

7. Addressed complexity of verbiage within all coverage policies by adding clear language in common terms within the list of definitions.

8. Partnered with Contracts and Benefits to deliver content within benefit contracts that aligns with coverage policy.

9. Continued partnership with Provider and Network management to optimize the contracted network of genetic testing laboratories and continued contract relationship with a claims data analysis vendor to identify trends in claims data and opportunities for strengthening coverage criteria and payment strategies.

Provider Support

Practitioner Credentialing

Description

HealthPartners reviews and evaluates the qualifications of licensed independent practitioners to help assure that care and services are provided to enrollees by competent professional staff.

	2019	2020	2021	2022	Goal
Network Size	80,633	86,831	93,574	96,793	NA
Non-delegated	26,897	25,705	26,333	27,058	NA
Delegated (regional network only)	53,736	61,126	67,241	69,735	NA
Initial Applications (all practitioner types)					
Number processed	3126	2825	3233	3618*	
Percent of clean applications completed in 45 days**	38%	29%	32%	99.8%	100%
Percent of issue applications completed within 75 days**	N/A	N/A	N/A	98.7%	100%
Average turn-around time in days	39	39	32	34	N/A
Recredentialing Applications (all practitioner types)					
Number processed	6527	8916*	6898	6981	
Percent completed within 36 months	100%	99.96%	100%	100%	100%

*Record number of applications

** New goals as of 2022 because of timely credentialing law

- Previous goal was 30 days from receipt of a clean application.
- New goal is 45 days from receipt of a complete/clean application or 75 days from receipt of a complete/issue application.

Network Initiatives

Provider Engagement

Description

HealthPartners mission is to improve health and well-being in partnership with our members, patients, and community. We work to promote team-based care to achieve best patient outcomes, build systematic links to providers and support best practices within our contracted network partners.

Goals

- Our goal is to engage, empower and partner with providers to achieve the best health for our members and to transform care delivery to achieve best care. experience outcomes, and affordable value to our members. Our objectives:
    - To drive improvement in healthcare quality within care delivery systems and maximize participation of all providers over time.
    - To take a strategic approach working with network clinics to improve quality measures mutually beneficial for both HealthPartners and our provider partners.
    - To give priority to topics that, because of their prevalence or severity, have potential for significant impact on our population and are amenable to improvement through focused action.
    - To assess provider satisfaction with the health plan through periodic satisfaction surveys and feedback from health plan providers.

Initiatives/Interventions

1. HealthPartners Network & Quality Contracted Provider Workgroup collaborates on strategies for outreach to contracted clinics. They are also working to establish a communication strategy inclusive of all departments currently doing outreach to contracted clinics.

2. HealthPartners plan Medical Directors, Provider Relations, Integration and Improvement (Quality Improvement and Compliance-QIC) and Health Informatics staff met with Medicare Advantage (MA) Network Partner Provider groups in the incentive program on focused initiatives throughout the year.

3. The Patient Management Application (PMA) is an excel-based tool that was shared with MA incented network provider partners. This tool includes the attributed membership for all lines of business if appropriate for the network partners. The PMA identifies areas of opportunity in cost, utilization, reconfirmation of chronic conditions, annual wellness visit completion and incented HEDIS® measures. The details of the QMA (quality results at the patient level) are included in the PMA.

4. The Quality Management Application (QMA) is a monitoring report including performance results for the annual wellness visit and incented HEDIS® measures to

identify gaps in preventive care. HealthPartners provides the QMA report in a PDF format to the MA incented network provider partners monthly through our secure FTP transfer process.

5. The Chronic Condition Reconfirmation Rate (CCRR) monitoring report includes providers' performance on closing/documenting chronic condition gaps in the current year and which conditions have an opportunity to be documented, supporting risk and diagnosis accuracy. The CCRR report is shared in a PDF format with the MA incented network provider partners monthly through our secure FTP transfer process.

6. HealthPartners is interested to learn more from providers on how best to share quality and condition gap information in such a way that it can be easily ingested into existing workflows for review, reducing administrative burden on providers.

7. The QMA report is tracked, trended, and shared with MA incented providers at least three times per year and reviewed during scheduled meetings.

8. HealthPartners continued the Medicare Advantage incentive program, the annual wellness visit, reconfirmation rate completion, and select HEDIS® measures in 2022 for twelve providers. Telemedicine continued to be an option for Medicare annual wellness visits in 2022.

9. The MA incented network provider partners continued to feel the impact of the pandemic due to pent up demand, members wanting in-person visits, staffing shortages, and staff burnout. The network partners continued to focus on social determinants of health (SDOH) by identifying food insecurities and transportation barriers for vulnerable populations and strengthening community partnerships to address the needs of the population.

10. HealthPartners offered an 'opt in' Colorectal FIT kit campaign through Virtuwell. This program included attributed Medicare, Medicare Advantage and MSHO members for our network partners.

11. The quality improvement and compliance team sends a monthly list of women with history of a fracture for the osteoporosis management star measure to the MA incented network provider partners to provide outreach to those members to close the gap in care as appropriate.

Barrier Analysis

HealthPartners encounters the following challenges as we evaluate and promote the provider engagement:

1. Identifying ways to involve and engage doctors/clinicians and minimize interruptions and demands that impact patient care.

2. Distribution of QMA reports to appropriate clinic staff to improve quality outcomes including MNCM and HEDIS® measures.

3. Identifying that clinic systems have their “standardized processes” and understanding how we can promote collaboration to meet better member/patient quality outcomes.

4. Identifying the network partners individual initiatives at a clinic level and individual provider level to engage all providers within the group to achieve best care practices.

5. Difficulty scheduling meetings on a regular cadence with incented providers due to competing priorities.

6. Resource constraints noted for gap closure and recommended flat file transfer to reduce administrative burden to MA incented network provider partners.

7. Variance in reports received from payers creating difficulty for incented provider to ingest all the data to close the gaps as each payer has a different file format.
    a. HealthPartners was able to ingest different formats to meet the incented provider group’s individual needs.

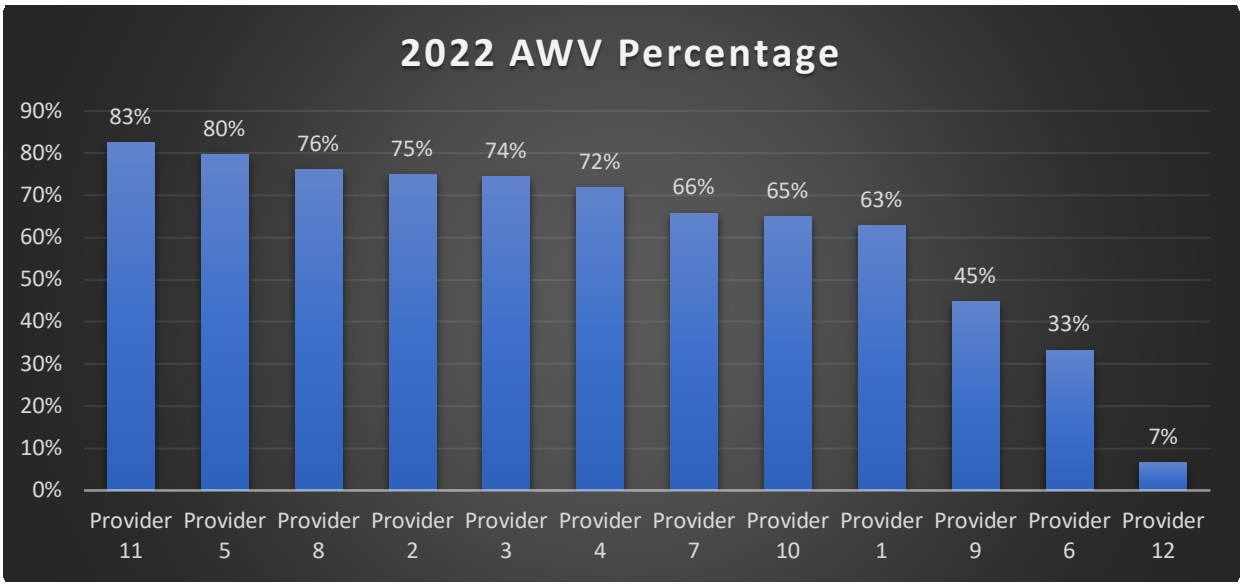
8. Reluctance by some providers regarding messaging to the members to complete preventive services as the member may have received more than one type of messaging.

9. Member preventive care campaigns continued including the promotion of annual wellness visit completion.

Opportunities for Improvement: Results/Outcomes

- Increase utilization of the PMA tool used by providers and QMA within the tool to review quality results at the patient level as an opportunity to address preventive screenings.
- Create a comprehensive document encompassing HealthPartners reporting capabilities.
- Partnering with MA incented network provider partners to create flat file transfer in similar formats they already use and streamline the process to ingest provider groups information into the HealthPartners system.
- Opportunity for future growth in MA incented network provider partners. There were twelve incented network partners in 2022.

2022 Annual Wellness Visit Completion Rate Results for Medicare Advantage Incented Providers:



Current activities will continue in the next program year with expanded collaboration with provider network and Quality Improvement and Compliance to support and improve provider engagement.

Provider Consultations

Description

Activities or processes within a health care organization consist of what is done and how it is done. The biggest impact for quality improvement is when both these areas are addressed together. HealthPartners supports quality improvement through partnerships with care delivery systems, national and local group, to improve healthcare quality.

HealthPartners collaborates with health care systems through the Partners in Excellence (PIE) Program which recognizes excellence, innovation, and persistent and sustainable change to impact preventive care for the population they serve.

Along with the quality awards program, HealthPartners offers consultative services through the Quality Improvement and Compliance (QIC) department to clinic groups to support their quality improvement initiatives. Clinics may choose technical assistance on clinic processes, or they may benefit from analysis of data specific to their clinic. HealthPartners continued the network partner provider incentive program that included consultation with HealthPartners teams which included, Health Informatics, Provider Relations, Risk Operations, Medical Directors, and Clinical Quality Consultants on selected HEDIS® measures, annual wellness visit, and reconfirmation rate completion to reduce gaps in care.

Goals

Our goal is to motivate better performance of quality measures through continued and enhanced partnering with care delivery systems. Our objectives:

- Identify opportunities to work with clinic systems to help improve their quality outcomes as defined in HEDIS® and MNCM through process improvement.
- Drive improvements in healthcare quality within care delivery systems to maximize participation of all providers over time. Provider engagement is one of the most important factors affecting the success of a quality improvement program.
- Publicly recognize and award care groups for achieving high levels of performance in the Triple Aim – exceptional clinical quality, patient experience, and affordable care.
- Reinforce principles of prevention, population-based care, and evidence–based decision making and continuous process improvement.

Initiatives/Interventions

1. QIC staff is available to consult with network partners about their quality improvement processes. Further analysis of data provided by HealthPartners is also available through the QIC department.

2. Provider Incentive Program (PIP) and Partners in Excellence (PIE) goals are aligned with plan goals and HEDIS®.

3. HealthPartners collaborates with health care systems through the Partners in Excellence (PIE) Program which recognizes excellence, innovation, and persistent and sustainable change to impact preventive care for the population they serve. As well as recognition for medical, specialty or pharmacy groups achieving high levels of performance on:
    a. Triple Aim Performance
        i. Clinical Quality
        ii. Patient Experience
        iii. Affordability
    b. Financial rewards are based on medical, specialty or pharmacy group performance as measured by Minnesota Community Measurement (MNCM). For those measures that do not have corresponding MNCM measures, we utilize HealthPartners Clinical Indicator measurement set, and HealthPartners Consumer Choice Satisfaction survey.
    c. For 2022, we had 22 provider groups who were awarded for silver level performance, and 1 provider group who was awarded for gold level performance.

4. Health Informatics monitors provider performance and creates in-depth, actionable quality and total cost of care reporting that enables providers to improve their performance. Providers receive reports on a quarterly basis.

5. HealthPartners currently provides the Patient Management Application (PMA) Tool in which the Quality Management Application (QMA) report is included for the MA incented network provider partners on a quarterly basis. These reports are available to be viewed

online through a secure login to the Provider Portal. The report includes data on preventive services and chronic disease. The QMA also has quality results at a patient level which aligns with measures as defined by HEDIS® codes. The reports provide aggregated claims information to primary care and specialty providers to support and assist improvement process efforts in care delivery and care coordination with patients.

6. Plan medical directors and quality improvement staff meet with network providers during consultations, round tables, and Quality Connections Forums

7. Quality Connections Forums are held three times per year to engage HealthPartners provider groups in quality initiatives to improve publicly reported measures. This group has grown from 5 provider groups in 2012 to 17 in 2022. The meetings offer clinics a forum to share successes, challenges, and results of QI initiatives. Sharing tested strategies provides opportunities for the provider groups to use tested interventions for quality improvement. The virtual forum continued to have strong attendance.

8. HealthPartners continually shares educational opportunities such as webinars and conferences with quality improvement staff who are affiliated with network partners to enhance their knowledge of evidence-based activities and support their QI efforts.

Barrier Analysis

1. Clinic systems may feel they “don’t have time” to participate in awards programs and consultative meetings that they see as non-clinical activities. Common reasons for this reluctance include:
    a. Payment system for volume rather than quality of outcomes
    b. Insufficient resources to support adoption of recommended initiatives or staff training.
    c. Competing priorities may not align with health plan priorities.
    d. Clinic systems and practitioners may be unaware of consultant services offered through HealthPartners.
    e. Tools provided such as the Patient Management Application Tool seems duplicative and not value added to reports clinic systems already have in place.
    f. Variation in reports received from payers creates difficulty for provider groups to ingest all the data to close the gaps as each payer has a different file format.

Opportunities for Improvement: Results/Outcomes

1. QIC Quality Consultants are actively partnering with HealthPartners Provider Relations and Network Management to educate network clinics on Quality Consultant services.
2. Continue promotion of the Partners in Excellence Programs to clinics.
3. Continue to expand Quality Connections Forums to encourage continuous quality improvement with our network partners.
4. Identify provider groups that would benefit from the Quality Connections meeting who are not currently attending and/or invited.
5. Incorporate the Patient Management Application into a broader support tool to enhance current tools used by provider partners.

6. We still want to recognize the ways in which organizations are working to change the way they deliver health care or the ways in which organizations are implementing a novel quality improvement process for patient preventive care screenings that is leading to greater performance.

HealthPartners is committed to continuing these efforts to educate clinical systems and providers on the services offered by HealthPartners to promote improving quality outcomes. We will continue to support and engage clinical systems in the Partners in Quality Program to promote innovation, excellence, and sustainable change to impact preventive care for the populations they serve.

Centers of Excellence

Member Populations Targeted

X	Commercial
X	Medicare Freedom (Cost)
X	Medicaid
X	MSHO
	HPUPH
	WI Marketplace

Description

HealthPartners operates Centers of Excellence (COE's) on the premise of identifying providers for a specific service who provide exceptionally high-quality care through outcome measurement, demonstration of cost-efficient care, and provide members an exceptional experience.

Goals

Definition includes:

1. Triple Aim focus: high quality care, cost efficiencies for the procedure and exceptional patient experience.
2. Current COE's: Transplant & Weight Loss Surgery
3. Consistent review of outcomes by all COE participants
4. Medical policies developed to ensure criteria by procedure is met
5. Measurement:
    a. Weight Loss Surgery: Data compiled from Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP)
    b. Transplant: Scientific Registry of Transplant Recipients (SRTR)
6. All Minnesota products included

Initiatives/Interventions

Transplant: In 2023, we will continue to update our outcome measure summary, sourced from the scientific registry of transplant recipient database, and discuss these results in meetings with our transplant COEs.

Weight Loss Surgery: 2023 will have a continued focus on measuring post-operative psychosocial well-being of patients; with results reviewed in our annual roundtable.

Barrier Analysis

- Benefit coverage –Benefit coverage for Weight Loss Surgery continues to be a significant issue facing both members and providers wanting to provide the service when benefit offering is not an option.

- Systems issues in the organization – Many changes over the last couple years in UM management (prior notification process) for transplant.
- Co-pay restrictions
- Problems with provider access – providers requesting to participate as a COE provider when they are not meeting accreditation requirements, volume requirements, and outcome requirements.
- Opportunities identified for improvement and recommended interventions to overcome the barriers and issues.
    - Annual review of COE criteria
    - Benefits committee to review contract language and benefit coverage options
    - Continual feedback from providers with operational process

Gaps in Care

Ongoing analysis of additions to the COE network based on volume, outcomes, and accreditation based on employer and provider requests.

Opportunities for Improvement: Results/Outcomes

NA

High Value Networks

Member Populations Targeted

X	Commercial
X	Medicare Freedom (Cost)
X	Medicaid
X	MSHO
	HPUPH
	WI Marketplace

Description

The goal of high value procedure designations is to help ensure members receive the best value for their health care dollars. Specific high volume and/or high-cost surgical procedures are analyzed to identify variation in cost and quality, to designate facilities that are high quality and cost effective at a procedure level.

Goals

- Ensuring members have access to high quality and cost-efficient healthcare.
- Annual measurement results compiled and shared.
- The following procedures are evaluated on quality and cost for high value designations:

  Orthopedic Care
  - Arthroscopic knee surgery
  - Arthroscopic shoulder surgery
  - Back surgery
  - Carpal tunnel surgery
  - Hip replacement surgery & revision
  - Knee replacement & revision
  - Rotator cuff surgery

  Otolaryngology
  - Tonsil and/or adenoid surgery
  - Tympanostomy surgery

  Other
  - Cataract removal
  - Cholecystectomy
  - Hernia repair, inguinal

Measurement:

Cost:

Cost performance is measured in terms of an index, or costs compared to the 13-county metro average, for each procedure. To achieve high value designation for a procedure, facilities must

demonstrate cost-effective performance that is better than the 13-county metro average for the procedure. An index greater than 1.0 reflects cost performance that is worse (or more expensive) than the metro average, where an index less than 1.0 reflects cost performance that is better (or less expensive) than the metro average. The facility, provider, and any associated ancillary costs during the procedure episode can impact the procedure-specific total cost index (TCI).

Quality:
To be designated as high value, hospitals with an overall quality rating must have achieved either a 3- or 4-star overall quality rating in the quality assessment. Please refer to https://www.healthpartners.com/provider-public/ for more information regarding this assessment.

Initiatives/Interventions

Procedure Specific Total Cost Index (must be less than 1.00)	+	High Quality Hospital (hospitals only – must have received a 3 or 4 star overall quality rating – does not apply to surgery centers)	+	Procedure Specific Complications Measures (Must meet or exceed quality thresholds)	=	High Value Designation (for the measured procedure)
0.988	+	√	+	Meets or Exceeds	=	✓ Designated
0.988	+	n/a (surgery center)	+	Meets or Exceeds	=	✓ Designated
1.012	+	√	+	Meets or Exceeds	=	Not Designated (high cost)
0.988	+	√	+	Below	=	Not Designated (below on complications quality)
0.988	+	No check	+	Meets or Exceeds	=	Not Designated (hospital with less than 3 star overall quality rating
N/A	+	√	+	Meets or Exceeds	=	Not Designated (no cost assessment)
0.950	+	√	+	Not Available	=	Not Designated (no quality assessment)

Barrier Analysis
NA

Gaps in Care
NA

Opportunities for Improvement: Results/Outcomes

See high value network designations on www.HealthPartners.com/provider

Partners in Excellence (PIE)

Member Populations Targeted

X	Commercial
X	Medicare Freedom (Cost)
X	Medicaid
X	MSHO
	HPUPH
	WI Marketplace

Description

The Partners in Excellence program forms the basis for HealthPartners' financial and public recognition for medical, specialty or pharmacy groups achieving high levels of performance on the Triple Aim of exceptional clinical quality, patient experience, and affordable care.

Goals

1. Our goal is to recognize and reward groups who deliver on the Triple Aim.
2. Annual measurement results are compiled and shared.
3. The measurements are grouped in the following clusters: Staying Healthy and Care for Illness, Care for Chronic Conditions, Getting Care and Information, Quality of Communication, and Quality of Care & Service.
4. The following measurement sources are used to determine achievement of the PIE goals:
    a. Minnesota Community Measurement (MNCM)
    b. Minnesota Community Measurement Survey
    c. HPI Specialty Survey Information
    d. HPI Evidence Based Connect
    e. HPI Clinical Indicators
5. All Minnesota products are included in each care groups' measurement.

Initiatives/Interventions

1. The following principals are used in the PIE program:
2. Use measures that are relevant and clear to providers and consumers.
3. Use measures that are accurate, valid, reliable, and obtainable.
4. Use established measures, those endorsed nationally or generally accepted national or regional standards.
5. Draw on a range of measures from a variety of sources, where possible, for a robust overall rating methodology.

6. Apply consistent measurement approaches and use scoring that avoids or minimizes subjectivity.
7. Disclose the methodology so it is transparent to providers, consumers, and employers.
8. Silver performance recognizes high quality care delivered in the Health or Patient Experience dimension.
9. Gold performance recognizes high quality care delivered in the Health or Patient Experience dimension and at an affordable total cost.

Barrier Analysis

Since MNCM discontinued their patient satisfaction survey, HealthPartners has developed and implemented our own patient experience survey for primary and specialty care.

This survey will be used to measure patient experience across our network.

Gaps in Care

None

Opportunities for Improvement: Results/Outcomes

In 2023, we will continue to refine our measure while making sure to inventory meaningful measures that are in each of our domains. We will use MNCM as our primary source for measurements results.

Total Cost of Care (TCOC)

Member Populations Targeted

X	Commercial
	Medicare Freedom (Cost)
	Medicaid
	MSHO
X	HPUPH
X	WI Marketplace

Description

The total cost of care report supports the Triple Aim goals by creating a more complete picture of the drivers of health care costs, which can be used to identify opportunities within individual practices. TCOC is a comprehensive reflection of a provider's resource use, intensity, appropriateness, and efficiency built around the services a provider group's patients receive and the clinics, specialists, and hospitals in which they receive the services.

Goals

- To simultaneously deliver improved health, optimal patient experience, and affordable care and coverage
- Consider the goals and measures of success from the annual work plan.
- Individual providers will set a contractual trend target to meet in a calendar year. If that trend target is met the provider will earn shared savings dollars.
- Total Cost of Care equation:

- ✓ The product of prices paid and resources used
- ✓ Volume of health care services and resources used
- ✓ Fee schedule
- ✓ Referral patterns
- ✓ Place of service

- Currently TCOC is only available and measured for commercial populations.

Initiatives/Interventions

HealthPartners schedules annual / biannual meetings with TCOC providers to identify potential opportunities where costs and utilization could be reduced. The opportunities are provider specific based on overall population served, cost of services and practice patterns.

Barrier Analysis

- Examples of categories that may create qualitative and/or quantitative barriers.
    - Organization staffing – Current staffing of organizations may not allow for telehealth and other technological support services.
    - Systems issues in the organization – TCOC has only been built for commercial populations as it stands today. There is increased interest in getting the data for other patient populations and being able to see different cuts of data based on clinic locations.

Opportunities for Improvement: Results/Outcomes

- 2023 – Finalizing Tableau 2.0 rollout. One platform that will include data for all product types and the provider will get better visual data looks for different cuts. It will also house our other already established tools to help with care coordination and pharmacy costs.
- 2023 – Adding site of care data at the procedure level will provide information to care systems on what site of care (inpatient, outpatient, clinic, home) a procedure is performed, along with a benchmark that identifies site of care best practice.

Monitoring Activities

Delegation

Description

HealthPartners gives other entities the authority to perform certain functions on its behalf. Oversight of the contracted entity is performed to ensure the delegated functions are performed according to HealthPartners expectations.

Delegated Entity	Delegated Functions	Initial Delegation Date	Last Audit Date	Status	Comments
Allina Health System	Practitioner Credentialing	March 2020	8/02/2022 NCQA accredited Policy and Procedure and CMS File Review	On-going monitoring	Reviewed and approved at Quality Review Committee. CAP reported to DHS
AllMed	Utilization Management	June 14, 2021	5/26/2021 pre-delegation assessment	Delegate termed 10/20/2022	Reviewed and Approved at Quality Review Committee
Altru Health System	Practitioner Credentialing	January 1998	06/17/2022	On-going monitoring	Reviewed and approved at Quality Review Committee. CAP reported to DHS
Aspirus Network	Practitioner Credentialing	November 2006	7/14/2022	On-going monitoring	Reviewed and approved at Quality Review Committee. CAP reported to DHS
Aurora Health Care	Practitioner Credentialing	October 2017	8/29/2022	On-going monitoring	Reviewed and approved at Quality Review Committee.
Avera Health	Practitioner Credentialing	September 2002	9/7/2022 NCQA accredited health plan – Policy and Procedure and CMS File Review	On-going Monitoring	Reviewed and approved at Quality Review Committee. CAP reported to DHS
BayCare Health System	Practitioner Credentialing	October 2017	8/2/2022	On-going Monitoring	Reviewed and approved at Quality Review Committee

Delegated Entity	Delegated Functions	Initial Delegation Date	Last Audit Date	Status	Comments
Becker County	SNBC Care Coordination	July 1, 2016	4/29/2021 High performer, no audit in 2022	Delegate Termed 12/31/2022	Information submitted to Gov Programs Sr Manager of Monitoring and Compliance and to VP of Internal Audit & Compliance
Bellin Health	Practitioner Credentialing	September 2017	6/1/2022	On-going Monitoring	Reviewed and approved at Quality Review Committee
Blue Sky, Inc.	SNBC Care Coordination	July 1, 2016	5/17/2022	Delegate Termed 12/31/2022	Information submitted to Gov Programs Sr Manager of Monitoring and Compliance and to VP of Internal Audit & Compliance
Bluestone Physician Services	SNBC and MSHO/MSC+ Care Coordination	July 1, 2016 for SNBC and October 1, 2017 for MSHO/MSC+	5/24/2021 for SNBC and 6/25/2021 for MSHO/MSC+ High performer status, no audit in 2022	On-going Monitoring	Information submitted to Gov Programs Sr Manager of Monitoring and Compliance and to VP of Internal Audit & Compliance
Bolger	Marketing/Fulfillment	April 2012	8/2022	Annual Packet & Onsite Audit are reviewed and approved by Marketing	Shared with Marketing Leadership and Government Programs Sr Manager of Monitoring and Compliance
Carlton County PHHS	SNBC Care Coordination	July 1, 2016	5/25/2021 High performer, no audit in 2022	Delegate termed 12/31/2022	Information submitted to Gov Programs Sr Manager of Monitoring and Compliance and to VP of Internal Audit & Compliance
Children's Minnesota	Practitioner Credentialing	June 2021	2/19/2022 NCQA accredited Policy and Procedure	On-going monitoring	Reviewed and approved at Quality Review Committee. CAP reported to DHS

Delegated Entity	Delegated Functions	Initial Delegation Date	Last Audit Date	Status	Comments
			and CMS File Review		
Children's Hospital and Health System (Wisconsin)	Practitioner Credentialing	January 2021	12/12/2022	On-going monitoring	Reviewed and approved at Quality Review Committee
CIGNA	Practitioner Credentialing	January 2007	3/15/2022 NCQA accredited health plan – Policy and Procedure Review	On-going monitoring	Reviewed and approved at Quality Review Committee
CIGNA Behavioral Health	Practitioner Credentialing	January 2007	4/28/2022 NCQA accredited health plan – Policy and Procedure Review	On-going monitoring	Reviewed and approved at Quality Review Committee
CIGNA Dental	Practitioner Credentialing	June 2019	3/28/2022	On-going monitoring	Reviewed and approved at Quality Review Committee
Doctor on Demand	Practitioner Credentialing	April 2016	5/9/2022 NCQA accredited in credentialing – Policy and Procedure and CMS File Review	On-going monitoring	Reviewed and approved at Quality Review Committee. CAP reported to DHS
Essentia Health	Practitioner Credentialing	January 2000	7/29/2022	On-going monitoring	Reviewed and approved at Quality Review Committee. CAP reported to DHS.
EyeMed Vision Care	Practitioner Credentialing (optometrists only)	April 2008	11/28/2022 NCQA certified CVO	On-going monitoring	Reviewed and approved at Quality Review Committee
Exela, formerly known as SourceHOV	Data entry of paper claims	1991	2/28/2022	On-going monitoring	Annual SOC-1 results reviewed with management.

Delegated Entity	Delegated Functions	Initial Delegation Date	Last Audit Date	Status	Comments
Fairview Health Services	Practitioner Credentialing	January 1999	9/07/2022 NCQA certified CVO	On-going monitoring	Reviewed and approved at Quality Review Committee. CAP reported to DHS
Froedtert Health Inc.	Practitioner Credentialing	September 2020	9/28/2022	On-going monitoring	Reviewed and approved at Quality Review Committee
Fulcrum Health	Practitioner Credentialing	July 2018	5/26/2022 NCQA accredited in credentialing – Policy and Procedure and CMS File Review	On-going monitoring	Reviewed and approved at Quality Review Committee
Fulcrum	Network	May 1995	12/20/2022	On-going monitoring	Reviewed and approved by Director and Manager in Provider Relations & Network Management
Guild Inc.	SNBC Care Coordination	July 1, 2016	05/20/2022	On-going Monitoring	Information submitted to Gov Programs Sr Manager of Monitoring and Compliance and to VP of Internal Audit & Compliance
Gundersen Health System	Practitioner Credentialing	January 2017	5/25/2022	On-going Monitoring	Reviewed and approved at Quality Review Committee. CAP reported to DHS
Health Plus	Practitioner Credentialing	November 2015	10/25/2022	On-going monitoring	Reviewed and approved at Quality Review Committee
Independent Lifestyles Inc	SNBC Care Coordination	July 1, 2016	5/19/2021 High performer no audit in 2022	On-going Monitoring	Information submitted to Gov Programs Sr Manager of Monitoring and Compliance and to VP of Internal Audit & Compliance
Koochiching County PHHS	SNBC Care Coordination	July 1, 2016	5/16/2022	Delegate termed 12/31/2022	Information submitted to Gov Programs Sr Manager of Monitoring and Compliance and to VP of Internal Audit & Compliance
Lutheran Social Service of MN	SNBC Care Coordination	July 1, 2016	5/21/2021	On-going Monitoring	Information submitted to Gov Programs Sr Manager of Monitoring and Compliance and to

Delegated Entity	Delegated Functions	Initial Delegation Date	Last Audit Date	Status	Comments
			High performer, no audit in 2022		VP of Internal Audit & Compliance
Mahnomen County	SNBC Care Coordination	July 1, 2016	05/02/2022	Delegate Termed 12/31/2022	Information submitted to Gov Programs Sr Manager of Monitoring and Compliance and to VP of Internal Audit & Compliance
Marshall County Social Services	SNBC Care Coordination	July 1, 2016	5/27/2021 High performer, no audit in 2022	Delegate termed 12/31/2022	Information submitted to Gov Programs Sr Manager of Monitoring and Compliance and to VP of Internal Audit & Compliance
Mayo Clinic Rochester	Practitioner Credentialing	February 1996	8/2/2022	On-going monitoring	Reviewed and approved at Quality Review Committee
Mayo Clinic Health System	Practitioner Credentialing	November 2007 (original MCHS) January 2020 (MCHS Franciscan and Eau Claire merged into one MCHS agreement)	6/7/2022 NCQA accredited in credentialing – Policy and Procedure and CMS File Review	On-going monitoring	Reviewed and approved at Quality Review Committee. CAP reported to DHS
Marshfield Clinic	Facility Credentialing	September 2006	11/15/2021 NCQA accredited in credentialing – Policy and Procedure Review	On-going monitoring	Reviewed and approved at Quality Review Committee.
Marshfield Clinic/Security Health Plan	Practitioner Credentialing	September 2006	11/15/2022 NCQA accredited health plan– Policy and Procedure Review	On-going monitoring	Reviewed and approved at Quality Review Committee
MD Live	Practitioner Credentialing	January 2016	7/22/22	Delegation agreement	Reviewed and approved at Quality Review Committee

Delegated Entity	Delegated Functions	Initial Delegation Date	Last Audit Date	Status	Comments
			NCQA accredited in credentialing – Policy and Procedure Review	termed 2/1/2023	
Medical Review Institute of America (MRIoA)	Utilization Management	January 1, 2021	3/24/2021 NCQA accredited in UM	On-going monitoring	Reviewed and approved by QRC
MedImpact	Network and Claims Processing	January 2008	6/2022	On-going monitoring	Reviewed and approved at Pharmacy Quality Committee
Medimore	Practitioner Credentialing	September 2015	8/24/2022	On-going monitoring	Reviewed and approved at Quality Review Committee
Mercy of Iowa City PHO	Practitioner Credentialing	March 2017	4/14/2022	Delegation agreement termed 11/30/2022	Reviewed and approved at Quality Review Committee
Meriter Hospital	Practitioner Credentialing	February 2019	12/5/2022	On-going monitoring	Reviewed and approved at Quality Review Committee
Midlands Choice	Practitioner Credentialing	January 2017	5/31/2022	On-going monitoring	Reviewed and approved at Quality Review Committee
Midlands Choice	Organizational Facility Assessments	4/1/2018	9/22/2021	On-going monitoring	Reviewed and approved at Quality Review Committee
Minnesota Stroke Association	SNBC Care Coordination	July 1, 2016	4/30/2021	Delegate Termed 10/31/2022	Information submitted to Gov Programs Sr Manager of Monitoring and Compliance and to VP of Internal Audit & Compliance
Monument Health	Practitioner Credentialing	5/1/2021	3/22/2022	NCQA accredited in credentialing – Policy and Procedure Review	Reviewed and approved at Quality Review Committee.
MultiPlan (aka PHCS)	Practitioner Credentialing (optometrists only)	January 2007	10/27/2022 NCQA accredited in credentialing - Policy and Procedure Review	On-going monitoring	Reviewed and approved at Quality Review Committee.

Delegated Entity	Delegated Functions	Initial Delegation Date	Last Audit Date	Status	Comments
Norman County PH	SNBC Care Coordination	July 1, 2016	4/29/2021 High performer, no audit in 2022	Delegate termed 12/31/2022	Information submitted to Gov Programs Sr Manager of Monitoring and Compliance and to VP of Internal Audit & Compliance
Oakleaf Medical Network	Practitioner Credentialing	March 2006	4/26/2022	On-going monitoring	Reviewed and approved at Quality Review Committee. CAP reported to DHS
Olmsted Medical Center	Practitioner Credentialing	January 1997	8/01/2022 NCQA certified CVO	On-going monitoring	Reviewed and approved at Quality Review Committee. CAP reported to DHS
OncoHealth	Oncology Utilization Review	1/1/2021	11/11/2022	On-going monitoring	Reviewed and approved at Pharmacy Quality Committee
Paramount	Practitioner Credentialing	September 2015	7/29/2022 NCQA certified CVO	On-going monitoring	Reviewed and approved at Quality Review Committee
Polk County PHHS	SNBC Care Coordination	July 1, 2016	5/16/2022	Delegate Termed 12/31/2022	Information submitted to Gov Programs Sr Manager of Monitoring and Compliance and to VP of Internal Audit & Compliance
Roseau County Social Services	SNBC Care Coordination	July 1, 2016	5/5/2021 High performer, no audit in 2022	Delegate termed 12/31/2022	Information submitted to Gov Programs Sr Manager of Monitoring and Compliance and to VP of Internal Audit & Compliance
Sanford Health	Practitioner Credentialing	January 2000	8/11/2022 NCQA accredited health plan - Policy and Procedure and CMS File Review	On-going Monitoring	Reviewed and approved at Quality Review Committee. CAP reported to DHS
Security Health Plan (for Ministry Healthcare)	Practitioner Credentialing	June 2007	NCQA accredited health plan– Policy and Procedure Review	Delegation termed 11/1/2021	

Delegated Entity	Delegated Functions	Initial Delegation Date	Last Audit Date	Status	Comments
			10/28/2020		
StaffCorp	Practitioner Credentialing	May 2019	10/11/2022	On-going Monitoring	Reviewed and approved at Quality Review Committee
St Luke's Hospital of Duluth	Practitioner Credentialing	June 2017	3/21/2022 NCQA accredited in credentialing – Policy and Procedure and CMS File Review	On-going Monitoring	Reviewed and approved at Quality Review Committee. CAP reported to DHS.
Teladoc Physicians	Practitioner Credentialing	January 2013	4/21/2022 NCQA accredited in credentialing – Policy and Procedure	On-going Monitoring	Reviewed and approved at Quality Review Committee
ThedaCare	Practitioner Credentialing	September 2017	9/30/2022 NCQA certified CVO	On-going monitoring	Reviewed and approved at Quality Review Committee
The Medical College of Wisconsin	Practitioner Credentialing	September 2020	11/10/2022	On-going monitoring	Reviewed and approved at Quality Review Committee
University of Iowa Hospitals and Clinics	Practitioner Credentialing	June 2015	7/29/2022 NCQA certified CVO	On-going monitoring	Reviewed and approved at Quality Review Committee
Nebraska Medicine (University of Nebraska Physicians)	Practitioner Credentialing	January 2021	9/26/2022	On-going monitoring	Reviewed and approved at Quality Review Committee
University of Wisconsin Hospital & Clinics	Practitioner Credentialing	January 2019	5/27/2022	On-going monitoring	Reviewed and approved at Quality Review Committee
VGM, Inc. (Homelink)	Network	January 2014	5/13/2022	On-going monitoring	Reviewed and approved by Director and Manager in Provider Relations & Network Management
Winona Health Services	Practitioner Credentialing	February 2019	10/01/2022 NCQA accredited in credentialing	On-going monitoring	Reviewed and approved at Quality Review Committee.

Delegated Entity	Delegated Functions	Initial Delegation Date	Last Audit Date	Status	Comments
			– Policy and Procedure and CMS File Review		
LifeStance Health	Practitioner Credentialing	1/24/23	12/14/2022	On-going monitoring	Reviewed and approved at Quality Review Committee
SSM Dean Health	Practitioner Credentialing	8/1/2022	4/15/2022 NCQA accredited Policy and Procedure	On-going monitoring	Reviewed and approved at Quality

HealthPartners®

Quality Improvement Evaluation Appendices 2022

June 2023

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Appendix 1:
HEDIS CAHPS Results

HEDIS / CAHPS Results for HEDIS Measurement Year 2021

The National Committee for Quality Assurance (NCQA) developed HEDIS® (Healthcare Effectiveness Data and Information Set) to measure health plan performance. HEDIS is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. The combined results of NCQA Accreditation and HEDIS® provide the most complete view of health plan quality available.

The scope of the NCQA HEDIS Compliance Audit includes the following domains: Effectiveness of Care; Access/Availability of Care; Satisfaction with the Experience of Care; Health Plan Stability; Use of Services; Cost of Care; and Health Plan Descriptive Information. HealthPartners has undergone a full audit. The included HEDIS measures were deemed reportable according to the NCQA HEDIS Compliance Audit Standards.

Measurement Year 2021 was the 28th year of HEDIS® reporting by HealthPartners. It includes information across our commercial, Medicare, Medicaid and Exchange product lines. HealthPartners presents results for HEDIS® measures in the prescribed performance areas below:

- effectiveness of care
- access/availability of care
- health plan stability
- use of services
- satisfaction with the experience of care

This report does not contain our complete set of HEDIS® scores. However, it does contain some key measures that demonstrate our level of success in quality improvement. For complete commercial results, see NCQA Quality Compass.

Assessment of Effectiveness

For measurement year 2021 HealthPartners successfully underwent a Full NCQA HEDIS® Compliance Audit™. All measures that were reviewed during this audit were deemed reportable according to the NCQA HEDIS® Compliance Standards.

The HEDIS® compliance audit evaluates the ability of health plans to process and report information for HEDIS®. The audit ensures that health plans' HEDIS® results are comparable.

HEDIS/CAHPS Results HEDIS MY2021

HEDIS® Rates for HealthPartners: Commercial

HEDIS Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	HEDIS 2018	HEDIS 2019	HEDIS 2020	HEDIS MY2020	HEDIS MY2021
Childhood Immunizations Status – Combo 10	62.0%	61.1%	67.1%	64.0%	71.4%	71.4%	73.4%	73.2%
Immunizations for Adolescents								
Combo 1	74.9%	88.5%	92.0%	86.6%	88.8%	88.8%	85.4%	88.3%
Combo 2			17.3%	27.1%	30.4%	36.5%	38.4%	40.2%
Appropriate Treatment of Children with URI	90.7%	91.7%	90.4%	90.2%	92.3%	87.8%	89.9%	96.0%
Appropriate Treatment of Children with Pharyngitis	93.7%	94.4%	94.5%	96.2%	95.5%	91.5%	95.4%	79.8%
Colorectal Cancer Screening	74.9%	69.2%	69.2%	69.3%	78.0%	78%	74.3%	68.5%
Breast Cancer Screening	78.7%	81.1%	79.4%	79.1%	78.5%	78.9%	77.1%	76.5%
Chlamydia Screening in Women	52.9%	53.9%	53.2%	55.5%	55.1%	55.3%	45.8%	48.5%
Controlling High Blood Pressure	75.6%	78.6%	74.3%	71.8%	72.5%	72.5%	65.2%	60.9%
Comprehensive Diabetes Care								
HbA1c Testing	95.6%	95.6%	94.3%	96.0%	94.7%	94.7%	91.8%	retired
BP Control <140/90							68.6%	70.8%
A1C < 8	67.5%	67.5%	63.9%	65.0%	65.3%	65.3%	65.5%	61.2%
Eye Exam	59.9%	56.9%	63.0%	59.9%	62.6%	62.6%	63.9%	62.2%
Asthma Medication Ratio	82.5%	83.8%	84.5%	82.0%	81.3%	81.3%	84.0%	81.3%
Follow-up After Hospitalization For Selected Mental Illness								
7 Day Follow-Up	65.4%	67.0%	60.6%	53.8%	51.3%	54.8%	55.7%	56.9%
Antidepressant Medication Management – Effective Continuation Phase	59.9%	59.3%	59.8%	60.9%	62.0%	62.2%	64.4%	69.1%
Well Child Visits in the First 15 Months	81.9%	81.1%	82.3%	83.9%	84.5%	84.1%	78.9%	82.9%
Use of Opioids at High Dosage (lower is better)					2.46	4.90	5.35	3.8
Use of Opioids from Multiple Providers - Multiple Prescribers and Multiple Pharmacies (lower is better)					3.17	2.53	1.94	1.5

HEDIS® Rates for HealthPartners: Minnesota Health Care Programs: PMAP

HEDIS Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	HEDIS 2018	HEDIS 2019	HEDIS 2020	HEDIS MY2020	HEDIS MY2021
Childhood Immunizations Status – Combo 10	48.7%	61.1%	50.9%	50.9%	52.1%	52.1%	49.9%	38.9%
Immunizations for Adolescents – Combo 2				33.1%	35.3%	36.2%	36.7%	34.1%
Cervical Cancer Screening	73.5%	73.5%	66.4%	67.6%	70.6%	70.6%	65.9%	70.8%
Chlamydia Screening in Women	68.4%	68.4%	67.5%	69.1%	70.1%	69.7%	61.0%	63.1%
Comprehensive Diabetes Care								
HbA1c Testing	93.3%	93.3%	94.5%	93.1%	92.0%	92.0%	85.2%	retired
BP Control <140/90							66.7%	68.4%
A1C < 8	61.7%	63.0%	63.1%	57.9%	67.0%	67.0%	53.3%	54.0%
Eye Exam	63.1%	62.8%	65.0%	68.8%	70.3%	70.3%	61.8%	62.3%
Asthma Medication Ratio	62.5%	62.5%	63.4%	61.9%	58.7%	58.7%	59.0%	61.7%
Antidepressant Medication Management – Effective Continuation Phase	34.6%	34.6%	35.8%	36.6%	36.0%	34.8%	34.1%	39.9%
Well Child Visits in the First 15 Months	64.2%	64.2%	76.4%	74.0%	71.5%	71.5%	55.0%	58.3%
Child and Adolescent Well-Care Visits							42.1%	51.1%
Use of Opioids at High Dosage (lower is better)					3.7	7.6	8.05	6.5
Use of Opioids from Multiple Providers - Multiple Prescribers and Multiple Pharmacies (lower is better)					6.5	5.8	4.2	4.1

HEDIS® Rates for HealthPartners: Minnesota Health Care Programs: MnCare

HEDIS Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	HEDIS 2018	HEDIS 2019	HEDIS 2020	HEDIS MY2020	HEDIS MY2021
Childhood Immunizations Status – Combo 10	NA[2]	NA[2]	NA[2]	NA[2]	NA[2]	NA[2]	NA[2]	NA[2]
Immunizations for Adolescents – Combo 2	NA[2]	NA[2]	NA[2]	NA[2]	NA[2]	NA[2]	NA[2]	NA[2]
Cervical Cancer Screening	73.0%	66.4%	65.0%	65.2%	68.6%	68.6%	64.7%	70.1%
Chlamydia Screening in Women	65.8%	70.3%	64.1%	62.6%	69.3%	68.9%	53.2%	59.7%
Comprehensive Diabetes Care								
HbA1c Testing	98.6%	97.5%	96.7%	95.3%	94.9%	94.9%	88.1%	retired
BP Control <140/90							65.5%	73.7%
A1C < 8	67.1%	70.9%	66.4%	66.6%	67.0%	67.0%	60.8%	59.4%
Eye Exam	73.1%	71.6%	67.0%	69.0%	70.3%	70.3%	66.9%	64.5%
Asthma Medication Ratio	62.9%	70.0%	75.9%	71.7%	71.7%	69.9%	63.9%	72.6%
Antidepressant Medication Management – Effective Continuation Phase	47.9%	46.1%	44.8%	43.5%	42.9%	50.9%	47.5%	51.7%
Well Child Visits in the First 15 Months	NA[2]	NA[2]	NA[2]	NA[2]	NA[2]	NA[2]	NA[2]	NA[2]
Child and Adolescent Well-Care Visits							21.5%	31.8%
Use of Opioids at High Dosage (lower is better)					1.8	5.9	5.42	3.4
Use of Opioids from Multiple Providers - Multiple Prescribers and Multiple Pharmacies (lower is better)					4.8	3.6	3.15	2.1

[2] = Denominator<30; rate is not reportable.

HEDIS® Rates for HealthPartners: Medicare Cost Population

HEDIS Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	HEDIS 2018	HEDIS 2019	HEDIS 2020	HEDIS MY2020	HEDIS MY2021
Colorectal Cancer Screening	81.7%	82.3%	82.8%	82.2%	86.4%	86.4%	83.1%	76.7%
Breast Cancer Screening	81.1%	83.4%	82.5%	82.8%	83.3%	81.0%	77.6%	76.4%
Controlling High Blood Pressure	87.1%	86.2%	87.4%	79.8%	78.6%	78.6%	64.7%	66.3%
Comprehensive Diabetes Care								
HbA1c Testing	96.8%	97.0%	97.0%	95.1%	97.8%	97.8%	96.1%	retired
BP Control <140/90							75.3%	73.2%
A1C < 8	84.0%	81.1%	82.6%	79.8%	79.6%	79.6%	74.6%	69.8%
Eye Exam	80.8%	80.4%	82.2%	81.3%	82.1%	82.1%	74.2%	68.2%
Antidepressant Medication Management – Effective Continuation Phase	69.6%	69.7%	65.1%	70.5%	65.2%	75.2%	NA[2]	NA[2]
Managing Osteoporosis after Fracture in Women	23.2%	22.3%	24.2%	26.1%	26.5%	29.5%	NA[2]	NA[2]
Use of Opioids at High Dosage (lower is better)					2.5	6.0	4.62	NA[2]
Use of Opioids from Multiple Providers - Multiple Prescribers and Multiple Pharmacies (lower is better)					2.3	2.6	1.35	NA[2]

[2] = Denominator<30; rate is not reportable.

HEDIS® Rates for HealthPartners: MSHO Population

HEDIS Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	HEDIS 2018	HEDIS 2019	HEDIS 2020	HEDIS MY2020	HEDIS MY2021
Colorectal Cancer Screening	62.5%	61.9%	66.6%	72.3%	76.4%	76.4%	65.3%	65.4%
Breast Cancer Screening	69.6%	70.8%	66.4%	67.8%	69.4%	72.4%	71.0%	62.3%
Controlling High Blood Pressure	82.4%	87.6%	89.3%	87.1%	78.8%	78.8%	67.9%	68.0%
Comprehensive Diabetes Care								
HbA1c Testing	96.0%	97.1%	95.5%	95.4%	96.2%	97.6%	91.1%	retired
BP Control <140/90							66.5%	68.5%
A1C < 8	75.1%	75.7%	76.4%	71.8%	71.6%	75.7%	67.7%	70.1%
Eye Exam	76.0%	79.6%	79.2%	80.5%	83.9%	84.8%	73.8%	79.8%
Antidepressant Medication Management – Effective Continuation Phase	65.7%	64.1%	64.4%	64.3%	74.7%	59.3%	73.5%	73.6%
Managing Osteoporosis after Fracture in Women	16.1%	NA[2]	21.4%	20.0%	NA[2]	NA[2]	NA[2]	NA[2]
Use of Opioids at High Dosage (lower is better)					3.1	4.7	7.96	5.9
Use of Opioids from Multiple Providers - Multiple Prescribers and Multiple Pharmacies (lower is better)					3.1	2.7	1.32	1.4

[2] = Denominator<30; rate is not reportable.

HEDIS® Rates for HealthPartners: Medicare Advantage

HEDIS Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	HEDIS 2018	HEDIS 2019	HEDIS 2020	HEDIS MY2020	HEDIS MY2021
Colorectal Cancer Screening					83.0%	83.0%	82.0%	79.6%
Breast Cancer Screening					84.5%	82.5%	82.7%	81.7%
Controlling High Blood Pressure					80.2%	80.2%	69.1%	72.3%
Comprehensive Diabetes Care								
HbA1c Testing					99.3%	99.3%	95.0%	retired
BP Control <140/90							70.8%	76.7%
A1C < 8					82.2%	82.2%	76.5%	75.3%
Eye Exam					81.5%	81.5%	75.0%	78.5%
Antidepressant Medication Management – Effective Continuation Phase					NA[2]	71.1%	74.6%	76.1%
Managing Osteoporosis after Fracture in Women					NA[2]	NA[2]	19.4%	30.0%
Use of Opioids at High Dosage (lower is better)					2.8	4.7	4.57	4.2
Use of Opioids from Multiple Providers - Multiple Prescribers and Multiple Pharmacies (lower is better)					0.0	0.4	1.85	.9

[2] = Denominator<30; rate is not reportable.

HEDIS® Rates for HealthPartners: Wisconsin Exchange

HEDIS Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	HEDIS 2018	HEDIS 2019	HEDIS 2020	HEDIS MY2020	HEDIS MY2021
Childhood Immunizations Status – Combo 3							NA[2]	NA[2]
Immunizations for Adolescents – Combo 2							NA[2]	NA[2]
Cervical Cancer Screening							44.7%	44.6%
Chlamydia Screening in Women							28.9%	30%
Comprehensive Diabetes Care								
A1C < 8							56.8%	60.8%
Eye Exam							49.6%	47.5%
Asthma Medication Ratio							89.3%	81.8%
Antidepressant Medication Management – Effective Continuation Phase							64%	64.7%
Well Child Visits in the First 15 Months							NA[2]	NA[2]
Child and Adolescent Well-Care Visits							36.8%	47.2%

[2] = Denominator<30; rate is not reportable.

CAHPS® – Commercial Adult Trended Results					
Overall Ratings	Response	2021 HP Percentile	2022 HP Percentile	2022 HealthPartners	2022 National Average
Health Plan Rating	% 8, 9, 10	50	66	69%	67%
Health Care Rating	% 8, 9, 10	50	66	80%	77%
Personal Doctor Rating	% 8, 9, 10	66	75	89%	86%
Specialist Rating	% 8, 9, 10	90	75	89%	85%
Composite: Getting Needed Care	% Always + Usually	25	50	84%	84%
Composite Components					
How often was it:					
Easy to get appointments with specialists	% Always + Usually	10	25	77%	82%
Easy to get care, tests or treatments you believed necessary	% Always + Usually	50	75	91%	87%
Composite: Getting Care Quickly	% Always + Usually	25	66	87%	84%
Composite Components					
How often did you:					
Get care when care was needed right way	% Always + Usually	NR	NR	NR	85%
Get non-urgent care as soon as you wanted	% Always + Usually	25	75	85%	81%
Composite: How Well Doctors Communicate	% Always + Usually	33	33	95%	95%
Composite Components					
How often did doctors or other health providers					
Explain things in a way you could understand	% Always + Usually	50	33	96%	96%
Listen carefully to you	% Always + Usually	33	50	95%	95%
Show respect for what you had to say	% Always + Usually	25	25	95%	97%
Spend enough time with you	% Always + Usually	50	50	94%	94%
Composite: Coordination of Care How often doctors or other health providers seemed informed or up-to-date about care received from other doctors	% Always + Usually	25	33	83%	84%

CAHPS® – Commercial Adult Trended Results, continued					
	Response	2021 HP Percentile	2022 HP Percentile	2022 HealthPartners	2022 National Average
Composite: Customer Service	% Always + Usually	90	NR	NR	90%
Composite Components					
How often did:					
Plan's customer service gave needed information/help	% Always + Usually	90	NR	NR	84%
Customer service treated you with courtesy and respect	% Always + Usually	75	NR	NR	96%
Plan's forms were easy to fill out	% Always + Usually	25	75	98%	97%
Composite: Claims Processing	% Always + Usually	75	90	94%	90%
Composite Components					
How often did your health plan:					
Handle your claims quickly	% Always + Usually	75	90	94%	89%
Handle your claims accurately	% Always + Usually	90	75	95%	92%

NR = not reported due to insufficient data.

CAHPS® – Medicare Freedom (Cost) Trended Results					
Overall Ratings	Response	2021 Stars	2022 Stars	2022 HealthPartners	2022 National Average
Health Plan Rating	% 9 & 10	4	4	88%	88%
Health Care Rating	% 9 & 10	4	4	87%	87%
Personal Doctor Rating	% 9 & 10			96%	92%
Specialist Rating	% 9 & 10			92%	90%
Overall Prescription Drug Plan Rating	% 9 & 10	NR	NR	NR	87%
Composite: Getting Needed Care	% Always + Usually	5	5	85%	81%
Composite Components					
How often was it:					
Easy to get appointments with specialists	% Always + Usually			87%	87%
Easy to get care, tests or treatments you believed necessary	% Always + Usually			95%	91%
Composite: Getting Care Quickly	% Always + Usually	5	5	83%	77%
Composite Components					
How often did you:					
Get care when care was needed right away	% Always + Usually			NR	90%
Get non-urgent care as soon as you wanted	% Always + Usually			91%	87%
Composite: How Well Doctors Communicate	% Always + Usually			NR	96%
Composite Components					
How often did doctors or other health providers					
Explain things in a way you could understand	% Always + Usually			NR	95%
Listen carefully to you	% Always + Usually			NR	96%
Show respect for what you had to say	% Always + Usually			NR	97%
Spend enough time with you	% Always + Usually			95%	95%
Composite: Care Coordination	% Always + Usually	5	5	89%	86%
Composite Components					
How often did your doctor or health provider:					
Doctor had medical records/other information during visit	% Always + Usually			NR	97%
Doctor communicate about tests (combined items)	% Always + Usually			95%	88%
Doctor's office follow-up on test results	% Always + Usually			94%	87%

CAHPS® – Medicare Freedom (Cost) Trended Results, continued					
	Response	2021 Stars	2022 Stars	2022 HealthPartners	2022 National Average
Got test results as soon as needed	% Always + Usually			95%	90%
Doctor talked with you about all Rx you are taking	% Always + Usually			90%	86%
Got help from doctor's office to manage your care among different providers/services	% Yes			NR	96%
Doctor informed/up-to-date about care from specialists	% Always + Usually			89%	85%
Composite: Customer Service	% Always + Usually	5	5	94%	90%
Composite Components					
How often did:					
Plan's customer service gave needed information/help	% Always + Usually			91%	87%
Customer service treated you with courtesy & respect	% Always + Usually			NR	97%
Plan's forms were easy to fill out	% Always + Usually			NR	NR
Composite: Getting Needed Prescription Drugs	% Always + Usually	NR	NR	NR	90%
Composite Components					
How often was it easy to:					
Use your plan to get medicines your doctor prescribed	% Always + Usually			NR	95%
Fill your prescriptions (combined retail & mail order)	% Always + Usually			NR	95%
Fill your prescriptions at local pharmacy	% Always + Usually			NR	96%
Fill your prescriptions by mail	% Always + Usually			NR	93%

NR = Too few members responded to report results.

CAHPS® – Medicare Advantage Trended Results					
Overall Ratings	Response	2021 Stars	2022 Stars	2022 HealthPartners	2022 National Average
Health Plan Rating	% 9 & 10	4	5	90%	88%
Health Care Rating	% 9 & 10	5	5	88%	87%
Personal Doctor Rating	% 9 & 10			92%	92%
Specialist Rating	% 9 & 10			90%	90%
Overall Prescription Drug Plan Rating	% 9 & 10	2	4	87%	87%
Composite: Getting Needed Care	% Always + Usually	5	4	83%	81%
Composite Components					
How often was it:					
Easy to get appointments with specialists	% Always + Usually			88%	87%
Easy to get care, tests or treatments you believed necessary	% Always + Usually			92%	91%
Composite: Getting Care Quickly	% Always + Usually	5	5	82%	77%
Composite Components					
How often did you:					
Get care when care was needed right away	% Always + Usually			NR	90%
Get non-urgent care as soon as you wanted	% Always + Usually			88%	87%
Composite: How Well Doctors Communicate	% Always + Usually			NR	96%
Composite Components					
How often did doctors or other health providers					
Explain things in a way you could understand	% Always + Usually			NR	95%
Listen carefully to you	% Always + Usually			NR	96%
Show respect for what you had to say	% Always + Usually			NR	97%
Spend enough time with you	% Always + Usually			97%	95%
Composite: Care Coordination	% Always + Usually	5	5	88%	86%
Composite Components					
How often did your doctor or health provider:					
Doctor had medical records/other information during visit	% Always + Usually			NR	97%
Doctor communicate about tests (combined items)	% Always + Usually			92%	88%
Doctor's office follow-up on test results	% Always + Usually			91%	87%

CAHPS® – Medicare Advantage Trended Results, continued					
	Response	2021 HP Stars	2022 HP Stars	2022 HealthPartners	2022 National Average
Got test results as soon as needed	% Always + Usually			93%	90%
Doctor talked with you about all Rx you are taking	% Always + Usually			84%	86%
Got help from doctor's office to manage your care among different providers/services	% Yes			NR	96%
Doctor informed/up to date about care from specialists	% Always + Usually			89%	85%
Composite: Customer Service	% Always + Usually	5	5	93%	90%
Composite Components					
How often did:					
Plan's customer service gave needed information/help	% Always + Usually			95%	87%
Customer service treated you with courtesy & respect	% Always + Usually			NR	97%
Plan's forms were easy to fill out	% Always + Usually			NR	NR
Composite: Getting Needed Prescription Drugs	% Always + Usually	4	5	92%	90%
Composite Components					
How often was it easy to:					
Use your plan to get medicines your doctor prescribed	% Always + Usually			96%	95%
Fill your prescriptions (combined retail & mail order)	% Always + Usually			96%	95%
Fill your prescriptions at local pharmacy	% Always + Usually			95%	96%
Fill your prescriptions by mail	% Always + Usually			NR	93%

NR = Too few members responded to report results.

CAHPS® – HPUPH Medicare Advantage Trended Results					
Overall Ratings	Response	2021 Stars	2022 Stars	2022 HealthPartners	2022 National Average
Health Plan Rating	% 9 & 10	5	5	92%	88%
Health Care Rating	% 9 & 10	5	5	91%	87%
Personal Doctor Rating	% 9 & 10			95%	92%
Specialist Rating	% 9 & 10			92%	90%
Overall Prescription Drug Plan Rating	% 9 & 10	3	5	90%	87%
Composite: Getting Needed Care	% Always + Usually	5	5	87%	81%
Composite Components					
How often was it:					
Easy to get appointments with specialists	% Always + Usually			91%	87%
Easy to get care, tests or treatments you believed necessary	% Always + Usually			95%	91%
Composite: Getting Care Quickly	% Always + Usually	5	5	91%	77%
Composite Components					
How often did you:					
Get care when care was needed right away	% Always + Usually			NR	90%
Get non-urgent care as soon as you wanted	% Always + Usually			94%	87%
Composite: How Well Doctors Communicate	% Always + Usually			NR	96%
Composite Components					
How often did doctors or other health providers					
Explain things in a way you could understand	% Always + Usually			NR	95%
Listen carefully to you	% Always + Usually			NR	96%
Show respect for what you had to say	% Always + Usually			NR	97%
Spend enough time with you	% Always + Usually			NR	95%
Composite: Care Coordination	% Always + Usually	5	5	89%	86%
Composite Components					
How often did your doctor or health provider:					
Doctor had medical records/other information during visit	% Always + Usually			NR	97%
Doctor communicate about tests (combined items)	% Always + Usually			95%	88%
Doctor's office follow-up on test results	% Always + Usually			NR	87%

CAHPS® – HPUPH Medicare Advantage Trended Results, continued					
	Response	2021 Stars	2022 Stars	2022 HealthPartners	2022 National Average
Got test results as soon as needed	% Always + Usually			96%	90%
Doctor talked with you about all Rx you are taking	% Always + Usually			92%	86%
Got help from doctor's office to manage your care among different providers/services	% Yes			NR	96%
Doctor informed/up-to-date about care from specialists	% Always + Usually			88%	85%
Composite: Customer Service	% Always + Usually	5	5	95%	90%
Composite Components					
How often did:					
Plan's customer service gave needed information/help	% Always + Usually			NR	87%
Customer service treated you with courtesy & respect	% Always + Usually			NR	97%
Plan's forms were easy to fill out	% Always + Usually			NR	NR
Composite: Getting Needed Prescription Drugs	% Always + Usually	4	5	93%	90%
Composite Components					
How often was it easy to:					
Use your plan to get medicines your doctor prescribed	% Always + Usually			98%	95%
Fill your prescriptions (combined retail & mail order)	% Always + Usually			97%	95%
Fill your prescriptions at local pharmacy	% Always + Usually			NR	96%
Fill your prescriptions by mail	% Always + Usually			NR	93%

NR = Too few members responded to report results.

CAHPS® – Medicare Senior Health Options (MSHO) Trended Results					
Overall Ratings	Response	2021 Stars	2022 Stars	2022 HealthPartners	2022 National Average
Health Plan Rating	% 9 & 10	4	4	88%	88%
Health Care Rating	% 9 & 10	4	3	86%	87%
Personal Doctor Rating	% 9 & 10			NR	92%
Specialist Rating	% 9 & 10			NR	90%
Overall Prescription Drug Plan Rating	% 9 & 10	3		87%	87%
Composite: Getting Needed Care	% Always + Usually	3	3	81%	81%
Composite Components					
How often was it:					
Easy to get appointments with specialists	% Always + Usually			87%	87%
Easy to get care, tests or treatments you believed necessary	% Always + Usually			92%	91%
Composite: Getting Care Quickly	% Always + Usually	4	4	79%	77%
Composite Components					
How often did you:					
Get care when care was needed right away	% Always + Usually			NR	90%
Get non-urgent care as soon as you wanted	% Always + Usually			85%	87%
Composite: How Well Doctors Communicate	% Always + Usually			NR	96%
Composite Components					
How often did doctors or other health providers					
Explain things in a way you could understand	% Always + Usually			NR	95%
Listen carefully to you	% Always + Usually			NR	96%
Show respect for what you had to say	% Always + Usually			NR	97%
Spend enough time with you	% Always + Usually			NR	95%
Composite: Care Coordination	% Always + Usually	4	4	87%	86%
Composite Components					
How often did your doctor or health provider:					
Doctor had medical records/other information during visit	% Always + Usually			NR	97%
Doctor communicate about tests (combined items)	% Always + Usually			93%	88%
Doctor's office follow-up on test results	% Always + Usually			91%	87%

CAHPS® – Medicare Senior Health Options (MSHO) Trended Results, continued					
	Response	2021 HP Stars	2022 HP Stars	2022 HealthPartners	2022 National Average
Got test results as soon as needed	% Always + Usually			94%	90%
Doctor talked with you about all Rx you are taking	% Always + Usually			NR	86%
Got help from doctor's office to manage your care among different providers/services	% Yes			NR	96%
Doctor informed/up-to-date about care from specialists	% Always + Usually			NR	85%
Composite: Customer Service	% Always + Usually	4	4	91%	90%
Composite Components					
How often did:					
Plan's customer service gave needed information/help	% Always + Usually			88%	87%
Customer service treated you with courtesy & respect	% Always + Usually			NR	97%
Plan's forms were easy to fill out	% Always + Usually			99%	NR
Composite: Getting Needed Prescription Drugs	% Always + Usually	2	2	88%	90%
Composite Components					
How often was it easy to:					
Use your plan to get medicines your doctor prescribed	% Always + Usually			84%	95%
Fill your prescriptions (combined retail & mail order)	% Always + Usually			95%	95%
Fill your prescriptions at local pharmacy	% Always + Usually			NR	96%
Fill your prescriptions by mail	% Always + Usually			NR	93%

NR = Too few members responded to report results.

CAHPS® – Medicaid Families & Children Medical Assistance (F&C-MA) Trended Results				
Overall Ratings	Response	2021 HealthPartners	2022 HealthPartners	2022 State F&C-MA Average
Health Plan Rating	% 8, 9, 10	79%	76%	79%
Health Care Rating	% 8, 9, 10	77%	80%	73%
Personal Doctor Rating	% 8, 9, 10	88%	85%	85%
Specialist Rating	% 8, 9, 10	85%	77%	80%
Composite: Getting Needed Care	% Always + Usually	83%	81%	83%
Composite Components				
How often was it:				
Easy to get appointments with specialists	% Always + Usually	80%	75%	78%
Easy to get care, tests or treatments you believed necessary	% Always + Usually	85%	86%	87%
East to get after-hours care needed	% Always + Usually	54%	47%	50%
Composite: Getting Care Quickly	% Always + Usually	83%	77%	84%
Composite Components				
How often did you:				
Get care when care was needed right away	% Always + Usually	89%	81%	88%
Get non-urgent care as soon as you wanted	% Always + Usually	78%	72%	80%
Composite: How Well Doctors Communicate	% Always + Usually	95%	95%	96%
Composite Components				
How often did doctors or other health providers				
Explain things in a way you could understand	% Always + Usually	97%	97%	97%
Listen carefully to you	% Always + Usually	95%	97%	95%
Show respect for what you had to say	% Always + Usually	96%	96%	97%
Spend enough time with you	% Always + Usually	93%	91%	94%
Personal doctor informed about care from other doctors	% Always + Usually	88%	86%	84%

CAHPS® – Medicaid Families & Children Medical Assistance (F&C-MA) Trended Results, continued				
	Response	2021 HealthPartners	2022 HealthPartners	2022 State F&C-MA Average
Composite: Customer Service	% Always + Usually	92%	91%	92%
Composite Components				
How often did:				
Plan's customer service give needed information/help	% Always + Usually	88%	87%	87%
Customer service treat you with courtesy and respect	% Always + Usually	96%	94%	96%
Plan's forms were easy to fill out	% Always + Usually	84%	81%	82%

CAHPS® – Medicaid MinnesotaCare (MNCare) Trended Results				
Overall Ratings	Response	2021 HealthPartners	2022 HealthPartners	2022 State MNCare Average
Health Plan Rating	% 8, 9, 10	81%	77%	81%
Health Care Rating	% 8, 9, 10	82%	75%	79%
Personal Doctor Rating	% 8, 9, 10	88%	85%	86%
Specialist Rating	% 8, 9, 10	84%	80%	85%
Composite: Getting Needed Care	% Always + Usually	86%	78%	82%
Composite Components				
How often was it:				
Easy to get appointments with specialists	% Always + Usually	83%	71%	77%
Easy to get care, tests or treatments you believed necessary	% Always + Usually	90%	84%	88%
Easy to get after-hours care needed	% Always + Usually	37%	34%	38%
Composite: Getting Care Quickly	% Always + Usually	82%	77%	82%
Composite Components				
How often did you:				
Get care when care was needed right away	% Always + Usually	86%	82%	86%
Get non-urgent care as soon as you wanted	% Always + Usually	79%	73%	78%
Composite: How Well Doctors Communicate	% Always + Usually	97%	94%	96%
Composite Components				
How often did doctors or other health providers				
Explain things in a way you could understand	% Always + Usually	97%	93%	95%
Listen carefully to you	% Always + Usually	96%	94%	96%
Show respect for what you had to say	% Always + Usually	98%	95%	97%
Spend enough time with you	% Always + Usually	96%	93%	95%
Personal doctor informed about care from other doctors	% Always + Usually	91%	80%	85%

CAHPS® – Medicaid Minnesota (MNCare) Trended Results, continued				
	Response	2021 HealthPartners	2022 HealthPartners	2022 State MNCare Average
Composite: Customer Service	% Always + Usually	93%	93%	88%
Composite Components				
How often did:				
Plan's customer service give needed information/help	% Always + Usually	93%	90%	85%
Customer service treat you with courtesy and respect	% Always + Usually	94%	97%	95%
Plan's forms were easy to fill out	% Always + Usually	84%	86%	85%

CAHPS® – Special Needs Based Care (SNBC) Trended Results				
Overall Ratings	Response	2021 HealthPartners	2022 HealthPartners	2022 State MN Care Average
Health Plan Rating	% 8, 9, 10	79%	78%	77%
Health Care Rating	% 8, 9, 10	78%	73%	74%
Personal Doctor Rating	% 8, 9, 10	85%	86%	86%
Specialist Rating	% 8, 9, 10	85%	81%	82%
Composite: Getting Needed Care	% Always + Usually	87%	82%	83%
Composite Components				
How often was it:				
Easy to get appointments with specialists	% Always + Usually	87%	79%	81%
Easy to get care, tests or treatments you believed necessary	% Always + Usually	87%	85%	86%
Easy to get after-hours care needed	% Always + Usually	46%	43%	40%
Composite: Getting Care Quickly	% Always + Usually	88%	81%	81%
Composite Components				
How often did you:				
Get care when care was needed right away	% Always + Usually	90%	83%	83%
Get non-urgent care as soon as you wanted	% Always + Usually	86%	79%	81%
Composite: How Well Doctors Communicate	% Always + Usually	95%	94%	93%
Composite Components				
How often did doctors or other health providers				
Explain things in a way you could understand	% Always + Usually	94%	94%	94%
Listen carefully to you	% Always + Usually	95%	94%	94%
Show respect for what you had to say	% Always + Usually	96%	97%	95%
Spend enough time with you	% Always + Usually	95%	93%	93%
Personal doctor informed about care from other doctors	% Always + Usually	94%	86%	86%

CAHPS® – Special Needs Based Care (SNBC) Trended Results, continued				
	Response	2021 HealthPartners	2022 HealthPartners	2022 State MN Care Average
Composite: Customer Service	% Always + Usually	89%	86%	89%
How often did:				
Plan's customer service gave needed information/help	% Always + Usually	85%	80%	84%
Customer service treated you with courtesy & respect	% Always + Usually	94%	92%	93%
Plan's forms were easy to fill out	% Always + Usually	81%	72%	77%

CAHPS® – Medicaid Minnesota Senior Care Plus Trended Results				
Overall Ratings	Response	2021 HealthPartners	2022 HealthPartners	2022 State Senior Care Plus Average
Health Plan Rating	% 8, 9, 10	80%	80%	82%
Health Care Rating	% 8, 9, 10	79%	79%	81%
Personal Doctor Rating	% 8, 9, 10	87%	85%	89%
Specialist Rating	% 8, 9, 10	88%	86%	85%
Composite: Getting Needed Care	% Always + Usually	81%	83%	84%
Composite Components				
How often was it:				
Easy to get appointments with specialists	% Always + Usually	74%	77%	83%
Easy to get care, tests or treatments you believed necessary	% Always + Usually	87%	89%	88%
Easy to get after-hours care needed	% Always + Usually	34%	32%	39%
Composite: Getting Care Quickly	% Always + Usually	83%	83%	86%
Composite Components				
How often did you:				
Get care when care was needed right away	% Always + Usually	90%	86%	89%
Get non-urgent care as soon as you wanted	% Always + Usually	76%	79%	83%
Composite: How Well Doctors Communicate	% Always + Usually	94%	95%	95%
Composite Components				
How often did doctors or other health providers				
Explain things in a way you could understand	% Always + Usually	94%	96%	96%
Listen carefully to you	% Always + Usually	96%	96%	96%
Show respect for what you had to say	% Always + Usually	94%	94%	96%
Spend enough time with you	% Always + Usually	92%	94%	94%
Personal doctor informed about care from other doctors	% Always + Usually	86%	89%	90%

CAHPS® – Medicaid Minnesota Senior Care Plus Trended Results, continued				
	Response	2021 HealthPartners	2022 HealthPartners	2022 State Senior Care Plus Average
Composite: Customer Service	% Always + Usually	87%	89%	91%
Composite Components				
How often did:				
Plan's customer service give needed information/help	% Always + Usually	80%	81%	87%
Customer service treat you with courtesy and respect	% Always + Usually	94%	96%	95%
Plan's forms were easy to fill out	% Always + Usually	77%	74%	77%

Appendix 2:
Utilization Review Report

HealthPartners 2022 Utilization Management Program Commercial Appeals

*Includes total number of UM decisions for HP and HPUPH commercial products appealed for all categories of appeals and a breakdown of specific high volume appeals within each category

Category	Q1	Q2	Q3	Q4
Pharmacy	**171**	**166**	**124**	**145**
Rebif	34	0	0	0
Taltz	24	17	11	17
Tremfya	13	13	11	5
Otezla	13	14	10	15
Skyrizi	8	10	16	12

Appendix 3:
Denial Rates

HealthPartners 2022 Pharmacy Denial Rates

Pharmacy	**1Q2022**	**2Q2022**	**3Q2022**	**4Q2022**
Pharmacy Members	887,546	892,264	892,154	898,325
Total Reviews	21,494	19,300	18,373	19,794
Total Denials	4,674	4,375	4,245	4,882
Denial Rate / 1k Mbrs	5.27	4.90	4.76	5.43
% of Reviews Denied	21.7%	22.7%	23.1%	24.7%
% of Denials Appealed	6.7%	6.4%	6.2%	5.4%
Total Appeals Received	314	279	265	263
Commercial	195	138	135	138
ACA/ per Pharmacy	0	1	1	1
Riverview	119	140	129	124
Appeal Rate / 1k Mbrs	0.35	0.31	0.30	0.29
Appeals Overturned	55	53	34	57
Commercial	31	19	13	29
ACA/ per Pharmacy	0	0	0	1
Riverview	24	34	21	27
Overturn Rate / 1k Mbrs	0.06	0.06	0.04	0.06
% of Appeals Overturn	17.5%	19.0%	12.8%	21.7%

Appendix 4:
Availability Assessment

Practitioner Availability Report

2022

Published March, 2023

Practitioner Availability
HealthPartners Population – Year 2022

Introduction

HealthPartners annually evaluates the adequacy of its provider network. The policy, definitions and procedures are outlined below in the "Annual Assessment of Practitioner Availability Policy". An analysis and action plan follows this policy.

HealthPartners®

Subject Network Assessment of Practitioner Availability And Network Responsiveness	**Attachments:** ☐ Yes ☒ No
Key Words Network Assessment, Practitioner Availability, Access	**Number** CC 002
Category Business Practice(BP)	**Effective Date** January 1999
Manual Contracted Care Internal Policy	**Last Review Date** April 1, 2022
Issued By Provider Relations and Network Management	**Next Review Date** June 1, 2023
Applicable Professional Services Network Management Hospital & Regional Network Management	**Origination Date** January 1999
	Retired Date
Review Responsibility Bev Vacinek, Judy Haataja, Donny Bechtle, Rita Murtada, Marty Michael, Shawn Mason	**Contact Bev Vacinek**

Products:
☒ Fully Insured ☒ Self-Insured ☒ Medicare Advantage ☒ Medicare Cost ☒ Medicaid ☒ MSHO ☒ SNBC ☒ WI Marketplace

I. PURPOSE

HealthPartners maintains and monitors a network of healthcare providers that is sufficient to provide adequate access to covered services and to meet the needs of our population.

In addition to monitoring our networks to ensure they meet time and distance standards, we also analyze the capacity of our network to meet the language needs of our members and its capacity to provide culturally appropriate care.

II. POLICY

HealthPartners ensures that all healthcare services are supported by written arrangement and are available to our members for all services, including preventive and specialty services. We also ensure that we have employed or contracted with appropriately qualified institutional and individual providers, that these providers have sufficient capacity to make services available to our members, and that their focus is on affordable, quality care. It is very important to provide our members with adequate numbers and types of providers with access to continuous care across the life cycle. It is also important to make sure that these providers are conveniently located for our membership and that care is cost effective. We want to ensure that HealthPartners makes available the types of providers that can meet the racial, ethnic, cultural, and linguistic needs and preferences of the people who represent our membership as well as meet their special medical needs, special risks, or other special circumstances, including the frail or disabled and those near the end of life.

III.

PROCEDURE(S)

Race/Ethnicity and Language(s) Spoken

HealthPartners collects information from providers about their race, ethnicity, culture and language spoken to ensure our networks have practitioners that can meet the cultural and linguistic needs of members.

The following information is collected:

1. Languages in which a practitioner is fluent when communicating about medical care
2. Language services available through the practice
3. Practitioner race/ethnicity

The following information is published:

1. Practitioner languages in physician directories
2. Language services available through practices in physician directories

Practitioner race/ethnicity is provided by Member Services when requested by members who call in for assistance finding a practitioner.

At least every three years, HealthPartners will:

1. Analyze the capacity of our network to meet the language needs of members. We assess and report on practitioner and bilingual staff language capabilities and determines whether its language services are sufficient to meet the needs of members. Assessment includes:
    - Languages spoken by practitioners.
    - Presence of bilingual staff in practitioners' offices.
    - Whether practitioners have worked with an interpreter.

2. Analyze the capacity of our network to meet the needs of members for culturally appropriate care. We use information about the demographic profile of our membership and practitioner network to identify potential unmet needs and assess the network's ability to deliver culturally appropriate care to our members. Our assessment may include practitioners':
   • Attitude about working with people from different cultures.
   • Awareness of health beliefs and health-related behaviors among people from prevalent cultures in the service area.
   • Ability to determine language or cultural barriers interfering with communication.
   • Skills in assessing patient understanding.
   • Participation in CME cultural humility training.

   Our report describes practitioner demographics and assessments of identified member needs.

3. Develop a plan to address gaps identified because of the analysis.

4. Address gaps based on our plan.

Time and Distance Standards

Network analysis of time and distance standards is done using various methodologies. Using GeoAccess® software, a zip code mapping analysis and a physician/member ratio analysis are performed annually for all products except our Minnesota Senior Health Options (MSHO) products, which is performed twice annually.

HealthPartners complies with the requirements of the Centers for Medicare and Medicaid Services (CMS), the Minnesota Departments of Health (MDH) and Human Services (DHS), and the National Committee for Quality Assurance (NCQA) in analyzing access through time and distance standards.

A variety of concurrent monitoring activities are performed. The Provider Relations and Network Management staff review the results to determine whether there are adequate providers in the service area to meet our standards for availability. If the standards are not met, the staff designs an action plan that includes attempting to contract with additional practitioners in the specified deficient areas.

More frequent assessments are done if there are deficiencies noted or if changes to either the provider network or membership numbers are noted through established concurrent monitoring activities. The Provider Relations and Network Management staff has overall accountability for performing the assessment.

The standards of measurement are as follows:

Geographic Standards for Commercial and Marketplace Exchange Members

- One Primary Care Provider within 30 miles of a member
  - Family Practice/General Practice – one provider within 30 miles of a member
  - Internal Medicine – one provider within 30 miles of a member
  - Pediatrics – one provider within 30 miles of a pediatric member (age 0-18)
- One High Volume Specialty Care Provider within 60 miles of a member
  - Cardiology – one provider within 60 miles of a member
  - Obstetrics and Gynecology – one provider within 60 miles of a member
  - Orthopedics – one provider within 60 miles of a member
  - Otolaryngology – one provider within 60 miles of a member
- One High Impact Provider within 60 miles of a member
  - Oncology – one provider within 60 miles of a member
- One Behavioral Health Provider within 30 miles of a member in each category below:
  - Licensed Marriage & Family Therapist – one provider within 30 miles of a member
  - Licensed Psychologist – one provider within 30 miles of a member
  - Licensed Social Worker – one provider within 30 miles of a member
  - Psychiatrist – one provider within 30 miles of a member
- Hospital – one hospital within 30 miles of a member

Quantity/ Ratio Standards for number of practitioners and provider: Commercial and Marketplace Exchange Members

Quantity

- One Primary Care Provider per 1,500 members
  - Family Medicine/General Practice – one provider per 1,500 members
  - Internal Medicine – one provider per 1,500 members
  - Pediatrics - one provider per 1,500 pediatric members (age 0-18)
- One High Volume Specialty Care Provider per 10,000 members
  - Cardiology – one provider per 10,000 members
  - Obstetrics & Gynecology – one provider per 10,000 members
  - Orthopedics – one provider per 10,000 members
  - Otolaryngology – one provider per 10,000 members
- One High Impact Provider per 10,000 members
  - Oncology – one provider per 10,000 members
- One Behavioral Health Provider per 10,000 members in each category below
  - Licensed Marriage & Family Therapist - one provider per 10,000 members
  - Licensed Psychologist – one provider per 10,000 members
  - Licensed Social Worker – one provider per 10,000 members
  - Psychiatrist – one provider per 10,000 members

Ratio

- Primary Care Providers – 95% of members will have access to primary care providers based on the total population versus total number of providers
  - Family Medicine/General Practice

    - Internal Medicine
    - Pediatrics (members age 0-18)
- High Volume Specialty Care Providers – 95% of members will have access to high volume specialty care providers based on the total population versus total number of providers in each category below
    - Cardiology
    - Obstetrics & Gynecology
    - Orthopedics
    - Otolaryngology
- High Impact Specialty Care - 95% of members will have access to high volume specialty care providers based on the total population versus total number of providers in the category below
    - Oncology
- Behavioral Health Providers – 95% of members will have access to behavioral health providers based on the total population versus total number of providers in each category below
    - Licensed Marriage & Family Therapist
    - Licensed Psychologist
    - Licensed Social Worker
    - Psychiatrist
- Hospitals - 95% of members will have access to a hospital based on the total population versus total number of facilities

<u>Geographic Standards for Medicare Cost, Medicare Advantage, HealthPartners Care, Special Needs Basic Care (SNBC) and Minnesota Senior Health Options (MSHO) Members</u>

- One Primary Care Provider within 30 miles of a member
    - Family Practice/General Medicine – one provider within 30 miles of a member
    - Internal Medicine – one provider within 30 miles of a member
    - Pediatrics – one provider within 30 miles of a pediatric member (age 0-18)
- One High Volume Specialty Care Provider within 60 miles of a member
    - Cardiology – one provider within 60 miles of a member
    - Obstetrics and Gynecology – one provider within 30 miles of a member
    - Orthopedics – one provider within 60 miles of a member
    - Otolaryngology Provider – one provider within 60 miles of a member
- One High Impact Provider within 60 miles of a member
    - Oncology – one provider within 60 miles of a member
- One Behavioral Health Provider within 30 miles of a member
    - Licensed Marriage & Family Therapist – one provider within 30 miles of a member
    - Licensed Psychologist – one provider within 30 miles of a member
    - Licensed Social Worker – one provider within 30 miles of a member
    - Psychiatrist – one provider within 30 miles of a member
- One Hospital within 30 miles of a member

Quantity/ Ratio Standards for number of practitioners and provider: HealthPartners Freedom (Medicare Cost), HealthPartners Care, Special Needs Basic Care (SNBC) and Minnesota Senior Health Options (MSHO) Members

Quantity

- One Primary Care Provider per 1,500 members
  - Family Medicine/General Practice – one provider per 1,500 members
  - Internal Medicine – one provider per 1,500 members
  - Pediatrics - one provider per 1,500 pediatric members (age 0-18)
- One High Volume Specialty Care Provider per 10,000 members
  - Cardiology – one provider per 10,000 members
  - Obstetrics & Gynecology – one provider per 10,000 members
  - Orthopedics – one provider per 10,000 members
  - Otolaryngology – one provider per 10,000 members
- One High Impact Specialty Care Provider per 10,000 members
  - Oncology – one provider per 10,000 members
- One Behavioral Health Provider per 10,000 members
  - Licensed Marriage & Family Therapist – one provider per 10,000 members
  - Licensed Psychologist – one provider per 10,000 members
  - Licensed Social Worker – one provider per 10,000 members
  - Psychiatrist – one provider per 10,000 members

Ratio

- Primary Care Providers – 95% of members will have access to primary care providers based on the total population versus total number of providers in each category below
  - Family Medicine/General Practice
  - Internal Medicine
  - Pediatrics (members age 0-18)
- High Volume Specialty Care Providers – 95% of members will have access to high volume specialty care providers based on the total population versus total number of providers in each category below
  - Cardiology
  - Obstetrics & Gynecology
  - Orthopedics
  - Otolaryngology
- High Impact Specialty Care - 95% of members will have access to high volume specialty care providers based on the total population versus total number of providers in the category below
  - Oncology
- Behavioral Health Providers – 95% of members will have access to behavioral health providers based on the total population versus total number of providers in each category below

- Licensed Marriage & Family Therapist
- Licensed Psychologist
- Licensed Social Worker
- Psychiatrist

- Hospitals - 95% of members will have access to a hospital based on the total population versus total number of facilities

Marketing staff use membership and practitioner files to create a GeoAccess® mapping and assessment of availability. The Provider Relations and Network Management staff leads the analysis of the finished GeoAccess products and the HSD tables to assess performance against the standards listed above. The focus is an "exception analysis," looking at where and why the standards were not met (if applicable). Opportunities to improve availability are noted in the analysis and action plans are developed to address opportunities for improvement.

The results of the completed GeoAccess® analysis are shared with the appropriate Government Programs staff and committees on an annual basis.

IV. DEFINITIONS

The principal categories of practitioners assessed for availability are defined as follows:

Primary Care Providers

Primary Care Providers are defined as MDs, DOs, (Doctor of Osteopathy), MBBSs and MBBCH (Bachelor of Medicine and Bachelor of Surgery), NPs (nurse practitioner), PAs (physician assistant) and CNSs (clinical nurse specialist) who provide care in the following practice areas: Family Practice, General Practice, Internal Medicine, and Pediatrics. There are providers in other practice areas that members may use for routine and preventive health care services (i.e. Obstetrics and Gynecology physicians,) but for this analysis only the listed practice areas were used.

Specialty Care Providers

Specialty Care Providers are defined as MDs, DOs, (Doctor of Osteopathy), MBBSs and MBBCH (Bachelor of Medicine and Bachelor of Surgery), NPs (nurse practitioner), PAs (physician assistant) , CNSs (clinical nurse specialist), DPM (Doctor of Podiatric medicine) DC (Doctor of Chiropractic) who are not defined as primary care providers.

High Volume Specialty Care Providers

High Volume Specialty Care providers are specialty care providers not defined as primary care providers but whose specialties provide high volumes of services to our members relative to other specialties.

The specialty types that provide high volumes of services are determined by the analysis of the number of units of procedures performed times the RVU for each procedure. This is done by analyzing the "Units/RVU" data obtained from reports generated by the Health Informatics Department. We then perform GeoAccess® studies for the specialties that stand out as being higher volume than the others. The high volume specialties identified are Cardiology, Obstetrics & Gynecology, Orthopedics, and Otolaryngology (ENT).

(Note: Regardless of the outcome of the analysis, HealthPartners includes Obstetrics and Gynecology and Behavioral Health as high volume specialists.)

High Impact Specialty Care Providers

High Impact Specialty Care Providers are specialty care providers not identified as primary care providers but whose specialties provide high impact services to our members relative to other specialties. Oncology is defined as a high impact specialty care provider.

Behavioral Health Providers

Behavioral Health Providers are defined by HealthPartners as Specialty Care Providers, but for the purposes of this assessment, are evaluated for availability as a unique category. For this assessment, Behavioral Health Practitioners are defined as Psychiatrists (professional suffix of MD or DO), Licensed Psychologists (professional suffix of LP), Licensed Social Workers (professional suffix of LICSW) and Licensed Marriage and Family Therapists (professional suffix of LMFT.)

Chiropractic Providers

Chiropractors are defined by HealthPartners as Specialty Care Providers, but for the purposes of this assessment, are evaluated for availability as a unique category. For this assessment, Chiropractors are defined as Doctor of Chiropractic (DC).

Hospitals

The Hospital category includes HealthPartners contracted hospitals that provide inpatient medical or surgical care and treatment.

V. COMPLIANCE

Failure to comply with this policy or the procedures may result in disciplinary action, up to and including termination.

VI. ATTACHMENTS:

None

VII. OTHER RESOURCES :

Minnesota Statutes 62D.124
CMS: Medicare Managed Care Manual, Chapter 4
2022 Families and Children DHS Contract
2022 MSHO/MSC DHS Contract
2022 SNBC DHS contract
2022 NCQA Health Plan Standards
2022 NCQA Health Equity Standards HE 4 A & B

VIII.

APPROVAL(S)

Electronically signed by
Sr. Director
Provider Relations and Network
Management

IX.

ENDORSEMENT

Methodology

Practitioner availability was assessed using geographic standards, provider/member ratio standards, and concurrent monitoring.

Geographic Standards

Availability was assessed using Quest Analytics Suite™ software. This process plotted the addresses of our members to the designated sets of HealthPartners network provider types as defined and measured in the "Network Assessment of Practitioner Availability" policy- primary care, specialty care, high volume specialty care providers (Cardiology, Obstetrics & Gynecology, Orthopedics, and Otolaryngology (ENT), behavioral health, and hospitals, and chiropractors. In addition, for informational purposes, data is collected on dermatology, gastroenterology and ophthalmology.

Due to differences in the distance requirements, service areas, and provider networks, separate analyses were performed for members in Commercial, HealthPartners Care, MSHO, SNBC, HealthPartners UnityPoint Medicare Advantage, Wisconsin Medicare Advantage, Minnesota Medicare Advantage, Medicare Cost products, Wisconsin Exchange and Minnesota Exchange. The analysis points out the overall compliance with standards and produces an exception report that identifies opportunities for improvement.

Ratio Standards

Availability was assessed by taking the membership count and applying it to the following designated sets of HealthPartners network provider types as defined and measured in the "Network Assessment of Practitioner Availability" policy- primary care, specialty care, high volume specialty care providers (cardiology, ENT, orthopedics, surgeons), obstetrics and gynecology, behavioral health, chiropractors and hospitals. In addition, for informational purposes, data is collected on Dermatology, Gastroenterology, Ophthalmology and Surgeons.

Concurrent Monitoring

Since the HealthPartners network is configured to meet defined standards, monitoring performance is accomplished throughout the year by concurrent monitoring of changes in both the provider network and enrollment.

If practitioners are withdrawn (i.e., clinic closure, contract termination), Provider Relations and Network Management staff evaluates the impact of the change against the above noted access standards. Similarly, the network is evaluated prior to a significant increase in membership due to factors such as the addition of a large client. The number and location of primary care clinics that are not accepting new patients are also monitored. Clinics that report they are not accepting new patients are contacted annually to check if there is a change in their status. For 2022, there were three primary care clinics that were not accepting new patients.

To determine where improvements are indicated and to ensure that availability standards continue to be met, HealthPartners maintains a Service Quality Council and a Quality Council. The Quality Council maintains a dashboard of items that represents a combination of satisfaction indicators as well as process and outcome measures for the Service Quality Council. The two councils monitor the organization's service and the success of improvement initiatives. The goal is to include measurements on the dashboard that are short-term

indicators of process measures that are direct drivers of overall member and patient satisfaction. Short-term indicators are needed in order to make adjustments throughout the year if necessary. The following are some of the items that are presented, reviewed, and acted upon:

- Member Services Complaint and Appeal Summary specific to “Availability”
- Annual Practitioner Availability Report/Quest Analytics Suite™ Reports
- Medicare CAHPS (Consumer Assessment of Health Plans Survey) and Medicare Disenrollment Reasons Survey (This is a survey of seniors who have voluntarily left their health plan. The survey is conducted quarterly. Specific results of the Disenrollment and surveys are published annually.)
- CAHPS Commercial (Consumer Assessment of Health Plans Survey) Survey, including the 2022 HEDIS CAHPS adult commercial results for question # 4: “When you needed care right away for an illness, injury or condition, how often did you get care as soon as you thought you needed?
- Medicare HSD tables for senior products
- HealthPartners also uses Census Bureau data on race/ethnicity to create and maintain its practitioner network.
- As part of HealthPartners annual provider data audit, we will continue to actively ask our contracted providers for any changes in their medical group. This information is reviewed by contracting staff who determines whether any reported change would warrant new contracts to be extended to enhance our members’ access to services.
- We will continue to ask our primary care providers to routinely notify us of new providers in rural communities.
- We will evaluate the network to assess whether there are opportunities to enhance our network by including these new providers in our HealthPartners network.
- We will continue to monitor member complaints regarding access to care and services from enrollees and follow-up as appropriate.
- We continue to encourage high volume specialty clinics and physicians to provide outreach services in rural communities.
- Members continue to have the option of going outside of the HealthPartners network and using their traditional Medicare coverage if they prefer to go to a provider closer to them.

HealthPartners Service Area Analysis – Provider Type	Access Standard	Total Pop.	Provider Counts	% Pop. Meeting Standard	Average Distance to a Provider	Member Count- Pop. Meeting Standard	Member Count- Pop. not Meeting standard	Additional information when % Pop. Meeting Standard is not 100%
Primary Care Providers	1 provider within 30 miles	*331,778	51,685	99.9%	2.4 miles	331,750	28	Yes. See Section II
Family/General Medicine	1 provider within 30 miles	*331,778	37,434	99.9%	2.5 miles	331,750	28	Yes. See Section II
Internal Medicine – 18 and over	1 provider within 30 miles	*287,046	10,549	99.9%	3.4 miles	286,736	310	Yes. See Section II
Pediatrics – 18 and under	1 provider within 30 miles	*44,732	4,971	99.0%	3.9 miles	44,266	466	Yes. See Section II
Behavioral Health								
Behavioral Health	1 provider within 30 miles	*331,778	47,031	99.8%	2.0 miles	331,185	593	Yes. See Section II
Licensed Marriage and Family Therapists	1 provider within 30 miles	*331,778	4,646	98.5%	2.9 miles	326,671	5,107	Yes. See Section II
Licensed Psychologists	1 provider within 30 miles	*331,778	6,736	99.5%	3.0 miles	330,214	1,564	Yes. See Section II
Licensed Social Workers	1 provider within 30 miles	*331,778	10,462	99.7%	2.6 miles	330,857	921	Yes. See Section II
Psychiatrists	1 provider within 30 miles	*331,778	4,100	99.0%	4.2 miles	328,539	3,239	Yes. See Section II
Specialty Providers	1 provider within 60 miles	*331,778	329,399	100%	1.6 miles	331,778	0	None
High Volume Specialists								
Cardiology	1 provider within 60 miles	*331,778	12,313	99.9%	4.1 miles	331,751	27	Yes. See Section II
Obstetrics & Gynecology	1 provider within 60 miles	*331,778	10,711	99.8%	3.2 miles	331,185	593	Yes. See Section II
Orthopedics	1 provider within 60 miles	*331,778	12,385	99.9%	3.2 miles	331,759	19	Yes. See Section II
Otolaryngology (ENT)	1 provider within 60 miles	*331,778	2,465	99.9%	4.6 miles	331,402	376	Yes. See Section II
High Impact Specialists								
Oncology	1 provider within 60 miles	*331,778	7,835	99.9%	5.2 miles	331,508	270	Yes. See Section II
Additional Specialties Analyzed for Informational Purposes Only								
Dermatology	1 provider within 60 miles	*331,778	3,106	99.8%	5.3 miles	331,038	740	Yes. See Section II
Gastroenterology	1 provider within 60 miles	*331,778	4,465	99.6%	6.7 miles	330,343	1,435	Yes. See Section II
Ophthalmology	1 provider within 60 miles	*331,778	2,982	99.9%	4.7 miles	331,561	217	Yes. See Section II
Surgery	1 provider within 60 miles	*331,778	10,790	99.9%	3.3 miles	331,769	9	Yes. See Section II
Chiropractic	1 provider within 60 miles	*331,778	5,822	99.9%	2.2 miles	331,553	225	Yes. See Section II

Hospitals	1 hospital within 30 miles	*331,778	670	99.9%	5.3 miles	331,634	144	Yes. See Section II

*331,778 members live in the service area; those who do not live in the service area are not included in this table.

HealthPartners Commercial Membership Summary

HealthPartners practitioner availability standards have been met for over 99.9% of the membership for the provider types defined in the "Network Assessment of Practitioner Availability" policy. We investigated how we could meet the standard for all members.

Primary Care – Requirement is 30 miles

99.9% of our membership met the requirement for a Primary Care provider within 30 miles. There are 28 members who live more than 30 miles from a Primary Care provider at an average of 35.3 miles. No further action will be taken at this time as HealthPartners already holds contracts with these area primary care providers.

Members Without Access								
State Name	County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
				#	#	#	%	1
Minnesota	Beltrami	Grygla	56727	2	0	2	100.0	33.9
	Cook	Grand Marais	55604	11	9	1	9.1	37.7
	Lake of the Woods	Angle Inlet	56711	4	0	4	100.0	33.1
North Dakota	Benson	Esmond	58332	1	0	1	100.0	40.6
		Maddock	58348	4	0	4	100.0	32.9
	Bottineau	Bottineau	58318	1	0	1	100.0	38.1
	Divide	Crosby	58730	7	0	7	100.0	38.7
	Kidder	Tappen	58487	11	0	5	45.5	31.5
	Pierce	Esmond	58332	1	0	1	100.0	44.3
		Rugby	58368	1	0	1	100.0	38.3
South Dakota	Dewey	Eagle Butte	57625	1	0	1	100.0	30.6
Grand Totals				44	9	28	63.6	35.3

Each category of primary care was also analyzed independently.

Primary Care – Family & General Medicine – Requirement is 30 miles

99.9% of our membership met the requirement for a Primary Care-Family & General Medicine provider within 30 miles. There are 28 members who live more than 30 miles from a Primary Care provider at an average of 35.3 miles. No further action will be taken at this time as HealthPartners already holds contracts with these area primary care providers.

Members Without Access								
State Name	County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
				#	#	#	%	1
Minnesota	Beltrami	Grygla	56727	2	0	2	100.0	33.9
	Cook	Grand Marais	55604	11	9	1	9.1	37.7
	Lake of the Woods	Angle Inlet	56711	4	0	4	100.0	33.1
North Dakota	Benson	Esmond	58332	1	0	1	100.0	40.6
		Maddock	58348	4	0	4	100.0	32.9
	Bottineau	Bottineau	58318	1	0	1	100.0	38.1
	Divide	Crosby	58730	7	0	7	100.0	38.7
	Kidder	Tappen	58487	11	0	5	45.5	31.5
	Pierce	Esmond	58332	1	0	1	100.0	44.3
		Rugby	58368	1	0	1	100.0	38.3
South Dakota	Dewey	Eagle Butte	57625	1	0	1	100.0	30.6
Grand Totals				44	9	28	63.6	35.3

Primary Care – Internal Medicine – Requirement is 30 miles

99.9% of our membership met the requirement for a Primary Care-Internal Medicine provider within 30 miles. There are 310 members who live more than 30 miles from a Primary Care provider at an average of 37.6 miles. No further action will be taken at this time as HealthPartners already holds contracts with these area primary care providers.

Members Without Access

State Name	County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
				#	#	#	%	1
Iowa	Cedar	Clarence	52216	1	0	1	100.0	31.2
	Clinton	Lost Nation	52254	4	0	4	100.0	30.8
	Delaware	Greeley	52050	2	0	2	100.0	31.2
		Manchester	52057	2	0	2	100.0	34.1
	Fayette	Arlington	50606	2	0	2	100.0	33.5
	Iowa	Williamsburg	52361	15	0	1	6.7	30.5
	Jones	Wyoming	52362	2	0	2	100.0	33.2
	Woodbury	Correctionville	51016	4	0	4	100.0	32.0
		Cushing	51018	2	0	2	100.0	33.8
Minnesota	Beltrami	Grygla	56727	2	0	2	100.0	35.1
		Northome	56661	1	0	1	100.0	35.3
	Cook	Grand Marais	55604	9	0	9	100.0	57.7
		Hovland	55606	1	0	1	100.0	73.2
		Lutsen	55612	3	0	3	100.0	40.5
		Tofte	55615	1	0	1	100.0	31.0
	Koochiching	Big Falls	56627	2	0	2	100.0	31.5
		International Falls	56649	15	0	15	100.0	35.9
	Lake	Isabella	55607	4	0	1	25.0	32.5
	Lake of the Woods	Angle Inlet	56711	2	0	2	100.0	33.1
		Baudette	56623	4	0	3	75.0	36.3
Nebraska	Cherry	Valentine	69201	5	0	5	100.0	42.4
	Custer	Anselmo	68813	1	0	1	100.0	53.8
	Dawes	Crawford	69339	4	0	4	100.0	45.6
	Holt	Oneill	68763	1	0	1	100.0	44.9
		Stuart	68780	2	0	2	100.0	36.5
	Hooker	Mullen	69152	1	0	1	100.0	60.9
	Keith	Ogallala	69153	3	0	3	100.0	31.0
	Morrill	Bridgeport	69336	2	0	2	100.0	31.2
	Sheridan	Gordon	69343	1	0	1	100.0	59.0
	Valley	Ord	68862	2	0	2	100.0	32.5
North Dakota	Benson	Esmond	58332	1	0	1	100.0	42.5
		Maddock	58348	2	0	2	100.0	32.9
	Bottineau	Bottineau	58318	1	0	1	100.0	55.7
	Divide	Crosby	58730	6	0	6	100.0	54.1
	Eddy	New Rockford	58356	1	0	1	100.0	32.9
	Emmons	Hazelton	58544	1	0	1	100.0	32.5
	Foster	Carrington	58421	7	0	7	100.0	42.4
	Kidder	Dawson	58428	4	0	4	100.0	47.4
		Steele	58482	9	0	9	100.0	40.2
		Tappen	58487	10	0	10	100.0	39.9

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Internal Medicine Continued:

Members Without Access								
State Name	County	City	Zip Code	Member Counts		Without Access[1]		Average Distance
				#	#	#	%	1
North Dakota	Logan	Napoleon	58561	3	0	3	100.0	52.2
	McHenry	Anamoose	58710	2	0	2	100.0	54.0
		Balfour	58712	1	0	1	100.0	37.9
		Drake	58736	3	0	3	100.0	48.1
	McIntosh	Zeeland	58581	4	0	4	100.0	46.4
	McLean	Coleharbor	58531	1	0	1	100.0	39.0
		Garrison	58540	1	0	1	100.0	30.4
		Turtle Lake	58575	2	0	2	100.0	43.6
		Underwood	58576	10	0	8	80.0	32.6
		Washburn	58577	27	0	27	100.0	33.6
	Mountrail	Ross	58776	1	0	1	100.0	40.1
		Stanley	58784	20	0	3	15.0	32.4
		Tioga	58852	1	0	1	100.0	37.5
		White Earth	58794	4	0	4	100.0	37.6
	Pierce	Esmond	58332	1	0	1	100.0	50.1
		Rugby	58368	1	0	1	100.0	55.5
	Rolette	Dunseith	58329	1	0	1	100.0	72.3
	Stutsman	Medina	58467	1	0	1	100.0	30.4
		Streeter	58483	4	0	4	100.0	33.5
		Woodworth	58496	3	0	3	100.0	33.6
	Towner	Cando	58324	5	0	5	100.0	31.6
		Egeland	58331	3	0	3	100.0	34.8
	Ward	Ryder	58779	1	0	1	100.0	30.7
	Wells	Fessenden	58438	3	0	3	100.0	48.6
		Harvey	58341	1	0	1	100.0	39.4
	Williams	McGregor	58755	2	0	2	100.0	41.2
		Tioga	58852	15	0	15	100.0	35.7
South Dakota	Aurora	White Lake	57383	2	0	2	100.0	32.1
	Bon Homme	Avon	57315	1	0	1	100.0	34.3
	Charles Mix	Lake Andes	57356	2	0	2	100.0	44.9
		Platte	57369	1	0	1	100.0	36.7
	Day	Waubay	57273	5	0	3	60.0	32.2
	Dewey	Eagle Butte	57625	1	0	1	100.0	30.6
	Douglas	Armour	57313	2	0	2	100.0	30.7
	Edmunds	Bowdle	57428	7	0	5	71.4	30.7
	Gregory	Burke	57523	1	0	1	100.0	41.4
		Gregory	57533	3	0	3	100.0	38.3
	Haakon	Philip	57567	1	0	1	100.0	49.0
	Hutchinson	Freeman	57029	11	0	10	90.9	32.8
		Marion	57043	2	0	2	100.0	32.7

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Internal Medicine Continued:

Members Without Access								
State Name	County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
				#	#	#	%	1
South Dakota	Hutchinson	Olivet	57052	1	0	1	100.0	31.6
		Tripp	57376	2	0	2	100.0	31.9
	Pennington	Wall	57790	4	0	4	100.0	49.3
	Roberts	Peever	57257	1	0	1	100.0	30.4
	Tripp	Winner	57580	1	0	1	100.0	36.5
	Walworth	Bowdle	57428	2	0	2	100.0	30.5
Wisconsin	Burnett	Danbury	54830	102	0	9	8.8	31.7
		Spooner	54801	18	0	12	66.7	31.1
	Douglas	Danbury	54830	4	0	4	100.0	32.6
	Juneau	Mauston	53948	4	0	4	100.0	31.5
		Wonewoc	53968	3	0	3	100.0	32.6
	Marinette	Niagara	54151	6	0	6	100.0	34.2
	Sauk	La Valle	53941	2	0	1	50.0	30.4
Grand Totals				**452**	**0**	**310**	**68.6**	**37.6**

Primary Care – Pediatrics – Requirement is 30 miles

99.0% of our membership met the requirement for a Primary Care-Pediatrics provider within 30 miles. There are 466 members who live more than 30 miles from a Primary Care provider at an average of 40.8 miles. No further action will be taken at this time as HealthPartners already holds contracts with these area primary care providers.

Members Without Access

State Name	County	City	Zip Code	Member Counts		Without Access[1]		Average Distance
				#	#	#	%	1
Iowa	Cerro Gordo	Clear Lake	50428	9	0	9	100.0	34.5
		Mason City	50401	8	0	8	100.0	35.1
		Rockwell	50469	1	0	1	100.0	35.0
	Cherokee	Marcus	51035	1	0	1	100.0	37.0
	Clay	Dickens	51333	2	0	2	100.0	37.7
		Spencer	51301	10	0	10	100.0	40.1
	Delaware	Greeley	52050	1	0	1	100.0	31.2
	Dickinson	Milford	51351	3	0	3	100.0	30.8
	Fayette	West Union	52175	1	0	1	100.0	34.3
	Franklin	Hampton	50441	3	0	3	100.0	32.5
		Latimer	50452	2	0	2	100.0	32.5
	Hancock	Britt	50423	2	0	2	100.0	43.5
		Crystal Lake	50432	2	0	2	100.0	36.1
		Forest City	50436	3	0	3	100.0	31.6
		Garner	50438	34	0	34	100.0	40.0
		Klemme	50449	1	0	1	100.0	41.0
	Jones	Wyoming	52362	1	0	1	100.0	33.2
	Kossuth	Algona	50511	4	0	4	100.0	39.9
		Titonka	50480	1	0	1	100.0	34.4
	Palo Alto	Ayrshire	50515	1	0	1	100.0	45.7
		Cylinder	50528	1	0	1	100.0	38.1
		Emmetsburg	50536	4	0	4	100.0	38.3
		Graettinger	51342	22	0	22	100.0	31.5
		Ruthven	51358	2	0	2	100.0	41.6
	Sioux	Ireton	51027	1	0	1	100.0	31.4
	Winnebago	Forest City	50436	9	0	5	55.6	30.7
	Winneshiek	Calmar	52132	2	0	2	100.0	35.8
		Decorah	52101	1	0	1	100.0	32.2
Minnesota	Aitkin	Finlayson	55735	1	0	1	100.0	44.7
		Isle	56342	9	0	6	66.7	33.9
		McGregor	55760	3	0	3	100.0	36.0
	Big Stone	Ortonville	56278	2	0	2	100.0	43.4
	Cook	Grand Marais	55604	2	0	2	100.0	66.3
	Itasca	Bigfork	56628	10	0	10	100.0	33.4
		Effie	56639	2	0	2	100.0	38.0
		Max	56659	1	0	1	100.0	38.1
		Northome	56661	1	0	1	100.0	42.3
		Talmoon	56637	2	0	2	100.0	30.4
		Wirt	56688	2	0	2	100.0	42.5
	Kanabec	Isle	56342	4	0	4	100.0	33.5

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Pediatrics Continued:

Members Without Access								
State Name	County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
				#	#	#	%	1
Minnesota	Kanabec	Mora	55051	49	0	3	6.1	32.2
	Kittson	Halma	56729	3	0	3	100.0	41.2
	Koochiching	Big Falls	56627	1	0	1	100.0	51.4
		International Falls	56649	1	0	1	100.0	55.8
	Lac qui Parle	Canby	56220	1	0	1	100.0	37.0
		Madison	56256	2	0	2	100.0	35.3
	Lake	Ely	55731	5	0	5	100.0	44.2
		Silver Bay	55614	4	0	4	100.0	36.9
	Lake of the Woods	Angle Inlet	56711	2	0	2	100.0	47.3
	Marshall	Stephen	56757	2	0	2	100.0	36.0
	Mille Lacs	Isle	56342	8	0	7	87.5	31.5
		Wahkon	56386	1	0	1	100.0	31.8
	Pine	Askov	55704	4	0	4	100.0	35.3
		Finlayson	55735	7	0	7	100.0	40.4
		Hinckley	55037	17	0	16	94.1	35.7
		Sandstone	55072	3	0	3	100.0	40.1
		Willow River	55795	8	0	8	100.0	34.2
	Pope	Clontarf	56226	1	0	1	100.0	32.5
	St. Louis	Babbitt	55706	4	0	4	100.0	31.3
		Ely	55731	11	0	11	100.0	41.0
	Stevens	Chokio	56221	2	0	2	100.0	41.3
		Hancock	56244	5	0	5	100.0	32.8
		Morris	56267	16	0	13	81.2	32.8
	Swift	Benson	56215	23	0	20	87.0	30.7
		Clontarf	56226	3	0	3	100.0	34.7
	Traverse	Wheaton	56296	3	0	3	100.0	31.9
	Yellow Medicine	Canby	56220	7	0	7	100.0	32.1
Nebraska	Cheyenne	Potter	69156	1	0	1	100.0	45.4
	Dawes	Crawford	69339	1	0	1	100.0	45.6
	Dawson	Lexington	68850	2	0	2	100.0	32.2
	Morrill	Bridgeport	69336	2	0	2	100.0	31.2
	York	York	68467	2	0	2	100.0	40.8
North Dakota	Benson	Maddock	58348	2	0	2	100.0	32.9
	Burke	Flaxton	58737	1	0	1	100.0	66.0
	Cavalier	Langdon	58249	2	0	2	100.0	49.8
		Munich	58352	1	0	1	100.0	39.7
		Walhalla	58282	1	0	1	100.0	67.2
	Dickey	Ellendale	58436	3	0	3	100.0	37.7
	Divide	Crosby	58730	1	0	1	100.0	54.2
	Foster	Carrington	58421	3	0	3	100.0	41.5

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Pediatrics Continued:

Members Without Access								
State Name	County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
				#	#	#	%	1
North Dakota	Kidder	Dawson	58428	2	0	2	100.0	48.0
		Steele	58482	6	0	6	100.0	40.7
		Tappen	58487	1	0	1	100.0	39.3
	LaMoure	Dickey	58431	1	0	1	100.0	33.8
		Edgeley	58433	1	0	1	100.0	36.5
		Lamoure	58458	5	0	5	100.0	41.2
	Logan	Napoleon	58561	1	0	1	100.0	52.7
	McHenry	Anamoose	58710	1	0	1	100.0	54.0
		Drake	58736	1	0	1	100.0	48.1
	McIntosh	Zeeland	58581	1	0	1	100.0	66.9
	McLean	Turtle Lake	58575	2	0	2	100.0	48.3
		Underwood	58576	2	0	2	100.0	46.1
		Washburn	58577	7	0	7	100.0	33.6
	Mountrail	Stanley	58784	5	0	5	100.0	50.7
		White Earth	58794	1	0	1	100.0	43.0
	Nelson	Michigan	58259	1	0	1	100.0	34.4
	Pembina	Bathgate	58216	2	0	2	100.0	68.1
	Ransom	Lisbon	58054	1	0	1	100.0	36.8
	Renville	Mohall	58761	1	0	1	100.0	35.8
	Sargent	Forman	58032	1	0	1	100.0	51.7
		Milnor	58060	1	0	1	100.0	30.8
	Steele	Finley	58230	1	0	1	100.0	41.3
		Hope	58046	1	0	1	100.0	30.3
	Stutsman	Streeter	58483	1	0	1	100.0	33.1
	Towner	Cando	58324	4	0	4	100.0	32.0
	Walsh	Grafton	58237	1	0	1	100.0	37.7
	Wells	Fessenden	58438	1	0	1	100.0	48.7
	Williams	Tioga	58852	4	0	4	100.0	36.4
South Dakota	Beadle	Cavour	57324	3	0	3	100.0	39.5
		Huron	57350	2	0	2	100.0	44.3
	Buffalo	Gann Valley	57341	3	0	3	100.0	50.9
	Campbell	Herreid	57632	1	0	1	100.0	75.6
		Java	57452	2	0	2	100.0	69.2
	Corson	Trail City	57657	1	0	1	100.0	74.1
	Dewey	Glencross	57630	1	0	1	100.0	71.0
	Edmunds	Bowdle	57428	1	0	1	100.0	57.2
	Hutchinson	Freeman	57029	3	0	3	100.0	32.7
		Marion	57043	1	0	1	100.0	30.7
		Olivet	57052	2	0	2	100.0	31.6
	Marshall	Britton	57430	5	0	5	100.0	40.5

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Pediatrics Continued:

Members Without Access								
State Name	County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
				#	#	#	%	1
South Dakota	McCook	Salem	57058	3	0	3	100.0	30.9
	Roberts	Rosholt	57260	1	0	1	100.0	32.0
		Sisseton	57262	1	0	1	100.0	46.0
	Walworth	Bowdle	57428	1	0	1	100.0	61.8
		Mobridge	57601	26	0	26	100.0	81.4
		Selby	57472	9	0	9	100.0	76.4
Wisconsin	Burnett	Danbury	54830	12	0	12	100.0	33.2
		Webster	54893	43	0	5	11.6	31.3
	Marinette	Niagara	54151	1	0	1	100.0	33.9
Grand Totals				**565**	**0**	**466**	**82.5**	**40.8**

Behavioral Health – Requirement is 30 miles

99.8% of our members met the 30 mile requirement for Behavioral Health. There are 593 members who live more than 30 miles from a Behavioral Health provider at an average of 51.1 miles. No further action will be taken at this time as HealthPartners already holds contracts with these area behavioral health providers.

Members Without Access

State Name	County	City	Zip Code	Member #	Counts #	Without Access[1] #	Without Access[1] %	Average Distance 1
Minnesota	Beltrami	Grygla	56727	2	0	2	100.0	38.4
	Cook	Grand Marais	55604	11	7	1	9.1	37.4
	Kittson	Karlstad	56732	3	0	2	66.7	31.4
	Lake of the Woods	Angle Inlet	56711	4	0	4	100.0	47.4
Nebraska	Hooker	Mullen	69152	1	0	1	100.0	62.2
North Dakota	Bottineau	Bottineau	58318	1	0	1	100.0	37.6
	Burke	Flaxton	58737	4	0	4	100.0	42.1
	Dickey	Fullerton	58441	7	0	4	57.1	32.2
		Oakes	58474	27	0	27	100.0	42.7
	Divide	Crosby	58730	7	0	7	100.0	38.7
	Eddy	New Rockford	58356	1	0	1	100.0	31.9
	Foster	Carrington	58421	10	0	10	100.0	39.8
	Golden Valley	Beach	58621	1	0	1	100.0	57.1
	Kidder	Tappen	58487	11	0	5	45.5	31.5
	LaMoure	Dickey	58431	4	0	4	100.0	30.1
		Lamoure	58458	19	0	19	100.0	31.6
		Verona	58490	3	0	3	100.0	39.2
	McHenry	Balfour	58712	1	0	1	100.0	32.5
	McKenzie	Watford City	58854	42	0	20	47.6	31.3
	McLean	Coleharbor	58531	1	0	1	100.0	38.6
		Garrison	58540	1	0	1	100.0	30.4
		Turtle Lake	58575	4	0	4	100.0	43.6
		Underwood	58576	12	0	10	83.3	32.6
		Washburn	58577	34	0	34	100.0	32.0
	Mountrail	Palermo	58769	1	0	1	100.0	32.7
	Ransom	Lisbon	58054	15	0	15	100.0	36.9
		McLeod	58057	1	0	1	100.0	33.7
	Renville	Mohall	58761	3	0	3	100.0	35.0
	Rolette	Dunseith	58329	1	0	1	100.0	39.0
	Sargent	Cogswell	58017	2	0	2	100.0	55.5
		Forman	58032	3	0	3	100.0	51.7
		Gwinner	58040	2	0	2	100.0	50.2
		Milnor	58060	3	0	3	100.0	30.8
		Stirum	58069	1	0	1	100.0	47.7
	Stutsman	Woodworth	58496	3	0	3	100.0	33.6
South Dakota	Aurora	White Lake	57383	2	0	2	100.0	31.1
	Brown	Hecla	57446	1	0	1	100.0	32.8
	Buffalo	Gann Valley	57341	5	0	5	100.0	36.2
	Campbell	Herreid	57632	12	0	12	100.0	40.6
		Java	57452	4	0	4	100.0	44.7

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Behavioral Health Continued:

Members Without Access								
State Name	County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
				#	#	#	%	1
South Dakota	Campbell	Mound City	57646	5	0	5	100.0	51.2
		Pollock	57648	2	0	2	100.0	43.1
	Clark	Clark	57225	3	0	3	100.0	30.6
	Corson	Mc Laughlin	57642	3	0	3	100.0	64.5
		Trail City	57657	6	0	6	100.0	79.3
		Wakpala	57658	2	0	2	100.0	63.1
	Day	Pierpont	57468	1	0	1	100.0	32.0
		Waubay	57273	5	0	3	60.0	32.9
	Dewey	Eagle Butte	57625	1	0	1	100.0	61.3
		Glencross	57630	3	0	3	100.0	78.5
		Isabel	57633	2	0	2	100.0	72.0
		Timber Lake	57656	3	0	3	100.0	77.2
	Edmunds	Bowdle	57428	8	0	8	100.0	56.1
	Faulk	Faulkton	57438	1	0	1	100.0	43.3
		Onaka	57466	1	0	1	100.0	52.0
	Gregory	Burke	57523	1	0	1	100.0	38.2
		Gregory	57533	3	0	3	100.0	45.9
	Haakon	Philip	57567	1	0	1	100.0	67.5
	Hand	Miller	57362	1	0	1	100.0	50.4
	Lyman	Presho	57568	3	0	3	100.0	39.9
	Marshall	Britton	57430	26	0	26	100.0	41.5
		Eden	57232	1	0	1	100.0	46.5
		Langford	57454	2	0	2	100.0	39.6
	Pennington	Wall	57790	4	0	4	100.0	49.2
	Potter	Hoven	57450	1	0	1	100.0	64.7
	Roberts	Peever	57257	1	0	1	100.0	30.5
	Spink	Doland	57436	3	0	3	100.0	35.9
		Redfield	57469	6	0	6	100.0	39.0
	Tripp	Winner	57580	1	0	1	100.0	45.5
	Walworth	Akaska	57420	1	0	1	100.0	67.6
		Bowdle	57428	3	0	3	100.0	57.6
		Glenham	57631	5	0	5	100.0	60.5
		Java	57452	2	0	2	100.0	51.6
		Mobridge	57601	206	0	206	100.0	65.2
		Selby	57472	52	0	52	100.0	58.3
Grand Totals				**639**	**7**	**593**	**92.8**	**51.1**

Each category of behavioral health was also analyzed independently.

Behavioral Health – Licensed Marriage & Family Therapy – Requirement is 30 miles

98.5% met the standard for Marriage and Family Therapists. There are 5,107 members who live more than 30 miles from a Licensed Marriage and Family Therapy provider at an average of 67.8 miles. HealthPartners has contracts with known behavioral health providers in these rural areas and continues to pursue contracts with behavioral health providers as they become known.

Members Without Access								
State Name	County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
				#	#	#	%	1
Iowa	Adair	Adair	50002	3	0	3	100.0	31.4
	Allamakee	Harpers Ferry	52146	1	0	1	100.0	32.2
	Floyd	Charles City	50616	31	0	1	3.2	30.9
	Franklin	Ackley	50601	5	0	5	100.0	30.2
	Fremont	Hamburg	51640	2	0	2	100.0	35.1
	Guthrie	Adair	50002	1	0	1	100.0	33.8
	Hardin	Ackley	50601	3	0	3	100.0	30.8
	Howard	Chester	52134	5	0	5	100.0	31.4
		Riceville	50466	9	0	1	11.1	32.8
	Lee	Keokuk	52632	1	0	1	100.0	32.1
	Mitchell	Osage	50461	46	0	4	8.7	30.4
	Ringgold	Mount Ayr	50854	12	0	1	8.3	30.5
		Redding	50860	7	0	7	100.0	31.7
	Taylor	Bedford	50833	1	0	1	100.0	32.7
		Blockton	50836	14	0	14	100.0	33.0
	Wayne	Lineville	50147	7	0	7	100.0	32.9
Minnesota	Becker	Park Rapids	56470	11	0	11	100.0	31.8
	Beltrami	Grygla	56727	2	0	2	100.0	53.0
		Northome	56661	1	0	1	100.0	35.0
	Clearwater	Gonvick	56644	14	0	12	85.7	31.7
	Cook	Grand Marais	55604	11	0	11	100.0	84.8
		Hovland	55606	1	0	1	100.0	94.1
		Lutsen	55612	3	0	3	100.0	71.8
		Schroeder	55613	4	0	4	100.0	58.3
		Tofte	55615	1	0	1	100.0	64.6
	Fillmore	Le Roy	55951	2	0	2	100.0	31.7
		Preston	55965	22	0	1	4.5	30.9
	Hubbard	Park Rapids	56470	147	0	69	46.9	30.9
	Itasca	Bigfork	56628	76	0	42	55.3	32.8
		Effie	56639	22	0	22	100.0	37.7
		Max	56659	5	0	5	100.0	33.5
		Northome	56661	4	0	4	100.0	38.1
		Spring Lake	56680	2	0	2	100.0	30.7
		Squaw Lake	56681	7	0	3	42.9	33.8
		Wirt	56688	10	0	10	100.0	36.5
	Kittson	Hallock	56728	5	0	5	100.0	62.4
		Halma	56729	6	0	6	100.0	55.8
		Karlstad	56732	3	0	3	100.0	52.2
		Kennedy	56733	2	0	2	100.0	51.5
		Lancaster	56735	1	0	1	100.0	66.9

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Marriage & Family Therapists Continued:

Members Without Access								
State Name	County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
				#	#	#	%	1
Minnesota	Koochiching	Big Falls	56627	3	0	3	100.0	32.7
	Lake	Ely	55731	12	0	12	100.0	43.9
		Finland	55603	1	0	1	100.0	62.8
		Isabella	55607	4	0	4	100.0	47.6
		Silver Bay	55614	12	0	12	100.0	46.5
		Two Harbors	55616	47	0	6	12.8	31.9
	Lake of the Woods	Angle Inlet	56711	4	0	4	100.0	88.0
		Baudette	56623	4	0	4	100.0	56.0
		Williams	56686	3	0	3	100.0	70.5
	Mahnomen	Bejou	56516	1	0	1	100.0	35.5
		Lengby	56651	4	0	4	100.0	34.3
		Mahnomen	56557	25	0	23	92.0	34.1
		Naytahwaush	56566	3	0	3	100.0	30.9
	Marshall	Argyle	56713	2	0	2	100.0	33.3
		Gatzke	56724	2	0	2	100.0	58.2
		Goodridge	56725	6	0	6	100.0	46.6
		Grygla	56727	3	0	3	100.0	59.6
		Newfolden	56738	15	0	15	100.0	39.6
		Stephen	56757	15	0	15	100.0	39.9
		Strandquist	56758	1	0	1	100.0	48.9
		Thief River Falls	56701	9	0	9	100.0	35.2
		Viking	56760	2	0	2	100.0	32.7
		Warren	56762	53	0	1	1.9	32.8
	Norman	Ada	56510	36	0	32	88.9	31.3
		Fertile	56540	1	0	1	100.0	30.4
		Gary	56545	3	0	3	100.0	34.9
		Halstad	56548	3	0	3	100.0	30.5
		Mahnomen	56557	4	0	4	100.0	30.7
		Twin Valley	56584	21	0	19	90.5	34.5
	Pennington	Goodridge	56725	6	0	6	100.0	44.1
		Thief River Falls	56701	126	0	112	88.9	31.9
	Polk	Bagley	56621	1	0	1	100.0	31.2
		Erskine	56535	8	0	1	12.5	31.5
		Fosston	56542	18	0	18	100.0	38.3
		Gully	56646	8	0	8	100.0	40.0
		Lengby	56651	3	0	3	100.0	34.0
		McIntosh	56556	1	0	1	100.0	35.7
	Red Lake	Brooks	56715	2	0	1	50.0	30.9
	Roseau	Greenbush	56726	4	0	4	100.0	65.2
		Roseau	56751	24	0	24	100.0	82.8

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Marriage & Family Therapists Continued:

Members Without Access								
State Name	County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
				#	#	#	%	1
Minnesota	Roseau	Salol	56756	1	0	1	100.0	91.1
		Wannaska	56761	1	0	1	100.0	73.6
		Warroad	56763	8	0	8	100.0	88.9
	St. Louis	Babbitt	55706	53	0	42	79.2	30.6
		Ely	55731	99	0	96	97.0	40.8
		Orr	55771	3	0	3	100.0	36.4
		Winton	55796	2	0	2	100.0	44.0
	Traverse	Wheaton	56296	18	0	18	100.0	32.0
Nebraska	Antelope	Royal	68773	1	0	1	100.0	76.5
		Tilden	68781	1	0	1	100.0	48.6
	Cedar	Coleridge	68727	5	0	5	100.0	39.8
		Crofton	68730	5	0	5	100.0	44.2
		Fordyce	68736	1	0	1	100.0	41.4
		Hartington	68739	6	0	6	100.0	38.9
		Wynot	68792	1	0	1	100.0	31.9
	Cherry	Valentine	69201	5	0	5	100.0	142.3
	Cheyenne	Potter	69156	2	0	2	100.0	48.0
		Sidney	69162	1	0	1	100.0	61.2
	Clay	Edgar	68935	2	0	2	100.0	40.6
	Custer	Anselmo	68813	1	0	1	100.0	56.1
	Dawes	Crawford	69339	5	0	5	100.0	55.4
	Gage	Beatrice	68310	1	0	1	100.0	32.8
	Greeley	Wolbach	68882	1	0	1	100.0	34.2
	Holt	Oneill	68763	1	0	1	100.0	96.9
		Stuart	68780	2	0	2	100.0	121.2
	Hooker	Mullen	69152	1	0	1	100.0	98.2
	Keith	Ogallala	69153	3	0	3	100.0	92.8
	Lincoln	Hershey	69143	4	0	4	100.0	57.1
		North Platte	69101	9	0	9	100.0	46.3
		Sutherland	69165	4	0	4	100.0	63.4
	Madison	Meadow Grove	68752	2	0	2	100.0	44.8
		Norfolk	68701	36	0	36	100.0	40.0
	Morrill	Bridgeport	69336	4	0	4	100.0	32.3
	Nance	Fullerton	68638	1	0	1	100.0	33.1
	Pierce	Pierce	68767	19	0	19	100.0	53.2
	Sheridan	Gordon	69343	1	0	1	100.0	99.0
	Stanton	Norfolk	68701	7	0	7	100.0	40.3
	Valley	Ord	68862	2	0	2	100.0	51.4
	Wayne	Hoskins	68740	4	0	4	100.0	46.0
		Wayne	68787	2	0	2	100.0	36.2

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Marriage & Family Therapists Continued:

Members Without Access								
State Name	County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
				#	#	#	%	1
Nebraska	York	York	68467	5	0	5	100.0	41.7
North Dakota	Barnes	Dazey	58429	6	0	6	100.0	62.5
		Luverne	58056	2	0	2	100.0	55.1
		Marion	58466	2	0	2	100.0	74.6
		Oriska	58063	3	0	3	100.0	47.1
		Pillsbury	58065	1	0	1	100.0	50.3
		Rogers	58479	8	0	8	100.0	65.4
		Sanborn	58480	4	0	4	100.0	65.6
		Valley City	58072	221	0	221	100.0	54.7
		Wimbledon	58492	1	0	1	100.0	78.5
	Benson	Esmond	58332	1	0	1	100.0	72.3
		Fort Totten	58335	2	0	2	100.0	90.9
		Leeds	58346	6	0	6	100.0	85.6
		Maddock	58348	4	0	4	100.0	84.3
		Minnewaukan	58351	1	0	1	100.0	94.0
		Saint Michael	58370	3	0	3	100.0	81.7
		Warwick	58381	8	0	8	100.0	77.6
	Billings	Belfield	58622	2	0	2	100.0	121.5
	Bottineau	Bottineau	58318	1	0	1	100.0	55.7
	Burke	Flaxton	58737	4	0	4	100.0	67.8
	Burleigh	Baldwin	58521	6	0	6	100.0	93.0
		Bismarck	58501	105	0	105	100.0	100.9
			58503	217	0	217	100.0	97.9
			58504	125	0	125	100.0	104.1
			58507	1	0	1	100.0	101.5
		Driscoll	58532	1	0	1	100.0	109.9
		Menoken	58558	9	0	9	100.0	105.4
		Regan	58477	1	0	1	100.0	82.7
		Sterling	58572	6	0	6	100.0	104.3
		Wilton	58579	6	0	6	100.0	80.6
	Cass	Buffalo	58011	2	0	2	100.0	33.2
		Erie	58029	4	0	3	75.0	32.2
		Fingal	58031	4	0	4	100.0	35.8
		Page	58064	11	0	11	100.0	39.5
	Cavalier	Langdon	58249	23	0	23	100.0	85.5
		Munich	58352	7	0	7	100.0	95.7
		Walhalla	58282	3	0	3	100.0	83.2
	Dickey	Ellendale	58436	17	0	17	100.0	38.8
		Forbes	58439	1	0	1	100.0	42.2
		Fullerton	58441	7	0	7	100.0	48.4

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Marriage & Family Therapists Continued:

Members Without Access								
State Name	County	City	Zip Code	Member Counts		Without Access[1]		Average Distance
				#	#	#	%	1
North Dakota	Dickey	Oakes	58474	27	0	27	100.0	50.7
	Divide	Crosby	58730	7	0	7	100.0	102.4
	Eddy	New Rockford	58356	1	0	1	100.0	98.6
		Sheyenne	58374	1	0	1	100.0	96.5
	Emmons	Hazelton	58544	1	0	1	100.0	110.7
	Foster	Carrington	58421	10	0	10	100.0	98.4
	Golden Valley	Beach	58621	1	0	1	100.0	157.2
	Grant	Flasher	58535	1	0	1	100.0	123.0
	Griggs	Hannaford	58448	5	0	5	100.0	69.2
	Hettinger	New England	58647	3	0	3	100.0	139.1
		Regent	58650	1	0	1	100.0	139.0
	Kidder	Dawson	58428	6	0	6	100.0	113.7
		Steele	58482	15	0	15	100.0	115.2
		Tappen	58487	11	0	11	100.0	110.9
	LaMoure	Dickey	58431	4	0	4	100.0	70.0
		Edgeley	58433	2	0	2	100.0	62.8
		Lamoure	58458	19	0	19	100.0	63.3
		Marion	58466	3	0	3	100.0	72.5
		Montpelier	58472	3	0	3	100.0	75.9
		Verona	58490	3	0	3	100.0	65.2
	Logan	Napoleon	58561	4	0	4	100.0	94.7
	McHenry	Anamoose	58710	3	0	3	100.0	54.4
		Balfour	58712	1	0	1	100.0	38.3
		Drake	58736	4	0	4	100.0	48.4
	McIntosh	Zeeland	58581	5	0	5	100.0	77.8
	McKenzie	Alexander	58831	6	0	6	100.0	112.0
		Watford City	58854	42	0	42	100.0	96.2
	McLean	Coleharbor	58531	1	0	1	100.0	40.2
		Garrison	58540	1	0	1	100.0	41.2
		Riverdale	58565	1	0	1	100.0	51.1
		Turtle Lake	58575	4	0	4	100.0	51.8
		Underwood	58576	12	0	12	100.0	54.3
		Washburn	58577	34	0	34	100.0	66.5
		Wilton	58579	9	0	9	100.0	77.9
	Mercer	Beulah	58523	1	0	1	100.0	55.9
		Golden Valley	58541	1	0	1	100.0	72.7
	Morton	Mandan	58554	145	0	145	100.0	99.6
		New Salem	58563	4	0	4	100.0	98.0
		Saint Anthony	58566	1	0	1	100.0	111.7
	Mountrail	Palermo	58769	1	0	1	100.0	43.8

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Marriage & Family Therapists Continued:

Members Without Access								
State Name	County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
				#	#	#	%	1
North Dakota	Mountrail	Ross	58776	1	0	1	100.0	60.8
		Stanley	58784	25	0	25	100.0	51.7
		Tioga	58852	1	0	1	100.0	73.6
		White Earth	58794	5	0	5	100.0	68.8
	Nelson	Lakota	58344	1	0	1	100.0	60.9
		Michigan	58259	2	0	2	100.0	50.7
		Niagara	58266	1	0	1	100.0	41.6
	Oliver	Center	58530	5	0	5	100.0	81.1
		New Salem	58563	1	0	1	100.0	86.3
	Pembina	Bathgate	58216	5	0	5	100.0	70.2
		Cavalier	58220	7	0	7	100.0	66.9
		Walhalla	58282	12	0	12	100.0	80.7
	Pierce	Esmond	58332	1	0	1	100.0	65.2
		Rugby	58368	1	0	1	100.0	59.6
	Ramsey	Brocket	58321	3	0	3	100.0	64.1
		Crary	58327	2	0	2	100.0	73.5
		Devils Lake	58301	227	0	227	100.0	85.3
		Edmore	58330	4	0	4	100.0	70.5
		Webster	58382	4	0	4	100.0	88.3
	Ransom	Enderlin	58027	4	0	4	100.0	40.6
		Lisbon	58054	15	0	15	100.0	48.4
		McLeod	58057	1	0	1	100.0	36.4
	Renville	Mohall	58761	3	0	3	100.0	37.5
	Richland	Hankinson	58041	2	0	2	100.0	40.8
		Lidgerwood	58053	1	0	1	100.0	52.4
		McLeod	58057	1	0	1	100.0	31.1
		Mooreton	58061	10	0	10	100.0	36.9
		Wahpeton	58075	112	0	5	4.5	31.1
		Wyndmere	58081	1	0	1	100.0	40.9
	Rolette	Dunseith	58329	1	0	1	100.0	72.3
	Sargent	Cogswell	58017	2	0	2	100.0	55.8
		Forman	58032	3	0	3	100.0	60.0
		Gwinner	58040	2	0	2	100.0	56.9
		Milnor	58060	3	0	3	100.0	44.1
		Stirum	58069	1	0	1	100.0	57.0
	Stark	Belfield	58622	18	0	18	100.0	132.3
		Dickinson	58601	92	0	92	100.0	117.4
			58602	1	0	1	100.0	117.3
		Gladstone	58630	2	0	2	100.0	112.8
		Richardton	58652	5	0	5	100.0	105.4

Continued on next page...

Marriage & Family Therapists Continued:

Members Without Access								
State Name	County	City	Zip Code	Member Counts		Without Access[1]		Average Distance
				#	#	#	%	1
North Dakota	Stark	South Heart	58655	4	0	4	100.0	126.1
	Steele	Finley	58230	2	0	2	100.0	45.9
		Hope	58046	5	0	5	100.0	50.5
		Luverne	58056	3	0	3	100.0	57.7
	Stutsman	Cleveland	58424	8	0	8	100.0	103.1
		Courtenay	58426	1	0	1	100.0	88.2
		Jamestown	58401	210	0	210	100.0	87.8
			58402	2	0	2	100.0	87.9
		Kensal	58455	4	0	4	100.0	89.5
		Medina	58467	1	0	1	100.0	102.9
		Streeter	58483	5	0	5	100.0	92.5
		Woodworth	58496	3	0	3	100.0	116.7
	Towner	Cando	58324	9	0	9	100.0	94.1
		Egeland	58331	3	0	3	100.0	104.0
	Traill	Blanchard	58009	1	0	1	100.0	39.3
		Galesburg	58035	1	0	1	100.0	39.5
		Hillsboro	58045	24	0	24	100.0	31.8
		Mayville	58257	13	0	13	100.0	31.0
		Portland	58274	1	0	1	100.0	31.8
	Walsh	Edinburg	58227	1	0	1	100.0	55.4
		Fordville	58231	5	0	5	100.0	40.7
		Grafton	58237	14	0	14	100.0	39.1
		Hoople	58243	2	0	2	100.0	49.8
		Minto	58261	11	0	5	45.5	31.0
		Park River	58270	3	0	3	100.0	46.5
	Ward	Makoti	58756	1	0	1	100.0	30.3
		Ryder	58779	1	0	1	100.0	31.1
	Wells	Fessenden	58438	4	0	4	100.0	87.6
		Harvey	58341	1	0	1	100.0	89.0
	Williams	Epping	58843	5	0	5	100.0	95.7
		McGregor	58755	2	0	2	100.0	81.6
		Ray	58849	1	0	1	100.0	86.6
		Tioga	58852	19	0	19	100.0	76.6
		Williston	58801	101	0	101	100.0	108.2
			58802	1	0	1	100.0	107.6
			58803	5	0	5	100.0	108.2
South Dakota	Aurora	Plankinton	57368	7	0	7	100.0	84.4
		White Lake	57383	2	0	2	100.0	96.0
	Beadle	Cavour	57324	12	0	12	100.0	63.3
		Huron	57350	41	0	41	100.0	66.6

Continued on next page...

Marriage & Family Therapists Continued:

Members Without Access								
State Name	County	City	Zip Code	Member Counts #		Without Access¹ #	Without Access¹ %	Average Distance 1
South Dakota	Beadle	Iroquois	57353	2	0	2	100.0	64.8
	Bon Homme	Avon	57315	1	0	1	100.0	73.1
	Brookings	Brookings	57006	32	0	27	84.4	31.8
		Volga	57071	9	0	9	100.0	37.4
		White	57276	7	0	7	100.0	31.6
	Brown	Hecla	57446	1	0	1	100.0	33.2
	Buffalo	Gann Valley	57341	5	0	5	100.0	106.4
	Butte	Belle Fourche	57717	6	0	6	100.0	193.2
	Campbell	Herreid	57632	12	0	12	100.0	82.1
		Java	57452	4	0	4	100.0	68.7
		Mound City	57646	5	0	5	100.0	82.6
		Pollock	57648	2	0	2	100.0	91.7
	Charles Mix	Lake Andes	57356	2	0	2	100.0	90.3
		Platte	57369	1	0	1	100.0	102.7
	Clark	Clark	57225	3	0	3	100.0	31.4
	Corson	Mc Laughlin	57642	3	0	3	100.0	115.4
		Trail City	57657	6	0	6	100.0	112.5
		Wakpala	57658	2	0	2	100.0	100.1
	Custer	Custer	57730	3	0	3	100.0	130.2
		Hermosa	57744	3	0	3	100.0	137.3
	Davison	Ethan	57334	1	0	1	100.0	66.6
		Mitchell	57301	94	0	94	100.0	62.1
		Mount Vernon	57363	16	0	16	100.0	72.8
	Day	Pierpont	57468	1	0	1	100.0	32.5
		Waubay	57273	5	0	3	60.0	34.3
	Dewey	Eagle Butte	57625	1	0	1	100.0	138.3
		Glencross	57630	3	0	3	100.0	116.4
		Isabel	57633	2	0	2	100.0	143.0
		Timber Lake	57656	3	0	3	100.0	125.8
	Douglas	Armour	57313	2	0	2	100.0	78.9
		Delmont	57330	1	0	1	100.0	70.0
	Edmunds	Bowdle	57428	8	0	8	100.0	56.8
	Fall River	Hot Springs	57747	1	0	1	100.0	108.2
	Faulk	Faulkton	57438	1	0	1	100.0	43.4
		Onaka	57466	1	0	1	100.0	52.1
	Gregory	Burke	57523	1	0	1	100.0	127.5
		Gregory	57533	3	0	3	100.0	134.6
	Haakon	Philip	57567	1	0	1	100.0	183.0
	Hand	Miller	57362	1	0	1	100.0	58.2
		Wessington	57381	1	0	1	100.0	75.1

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Marriage & Family Therapists Continued:

Members Without Access								
State Name	County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
				#	#	#	%	1
South Dakota	Hanson	Alexandria	57311	13	0	13	100.0	49.2
		Canova	57321	6	0	6	100.0	48.7
		Ethan	57334	3	0	3	100.0	58.0
		Fulton	57340	4	0	4	100.0	53.2
		Spencer	57374	5	0	5	100.0	43.2
	Hughes	Blunt	57522	3	0	3	100.0	96.4
		Pierre	57501	21	0	21	100.0	118.0
	Hutchinson	Dimock	57331	5	0	5	100.0	59.6
		Freeman	57029	12	0	12	100.0	33.9
		Marion	57043	3	0	3	100.0	31.7
		Menno	57045	3	0	3	100.0	43.6
		Olivet	57052	3	0	3	100.0	48.8
		Parkston	57366	14	0	14	100.0	61.1
		Tripp	57376	2	0	2	100.0	61.9
	Jerauld	Woonsocket	57385	1	0	1	100.0	85.5
	Kingsbury	Arlington	57212	5	0	1	20.0	33.8
		Iroquois	57353	1	0	1	100.0	44.1
	Lake	Madison	57042	50	0	50	100.0	36.0
	Lawrence	Deadwood	57732	4	0	4	100.0	171.6
		Lead	57754	3	0	3	100.0	174.1
		Nemo	57759	3	0	3	100.0	166.0
		Spearfish	57783	17	0	17	100.0	181.5
	Lyman	Presho	57568	3	0	3	100.0	137.2
	Marshall	Britton	57430	26	0	26	100.0	41.9
		Eden	57232	1	0	1	100.0	51.6
		Langford	57454	2	0	2	100.0	40.1
	McCook	Bridgewater	57319	3	0	3	100.0	34.5
		Salem	57058	23	0	19	82.6	31.9
		Spencer	57374	2	0	2	100.0	40.9
	Meade	Black Hawk	57718	3	0	3	100.0	160.5
		Box Elder	57719	4	0	4	100.0	161.0
		Piedmont	57769	3	0	3	100.0	163.8
		Rapid City	57701	1	0	1	100.0	160.4
		Sturgis	57785	11	0	11	100.0	175.2
	Miner	Canova	57321	1	0	1	100.0	42.1
		Howard	57349	1	0	1	100.0	54.1
	Pennington	Box Elder	57719	23	0	23	100.0	158.2
		Hill City	57745	3	0	3	100.0	145.3
		Rapid City	57701	37	0	37	100.0	154.1
			57702	32	0	32	100.0	152.3

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Marriage & Family Therapists Continued:

Members Without Access								
State Name	County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
				#	#	#	%	1
South Dakota	Pennington	Rapid City	57703	18	0	18	100.0	153.9
			57709	2	0	2	100.0	154.5
		Wall	57790	4	0	4	100.0	163.1
	Potter	Hoven	57450	1	0	1	100.0	64.8
	Roberts	Peever	57257	1	0	1	100.0	30.5
		Rosholt	57260	7	0	7	100.0	37.6
		Sisseton	57262	8	0	8	100.0	38.8
	Sanborn	Artesian	57314	2	0	2	100.0	58.0
		Letcher	57359	2	0	2	100.0	68.6
	Spink	Doland	57436	3	0	3	100.0	45.6
		Redfield	57469	6	0	6	100.0	40.0
	Stanley	Fort Pierre	57532	6	0	6	100.0	121.5
	Tripp	Winner	57580	1	0	1	100.0	159.4
	Turner	Freeman	57029	5	0	5	100.0	34.4
	Walworth	Akaska	57420	1	0	1	100.0	80.0
		Bowdle	57428	3	0	3	100.0	61.4
		Glenham	57631	5	0	5	100.0	85.2
		Java	57452	2	0	2	100.0	67.4
		Mobridge	57601	206	0	206	100.0	94.7
		Selby	57472	52	0	52	100.0	76.1
	Yankton	Gayville	57031	4	0	4	100.0	31.5
		Mission Hill	57046	1	0	1	100.0	37.1
		Yankton	57078	46	0	46	100.0	43.1
Wisconsin	Ashland	Butternut	54514	56	0	56	100.0	42.2
		Glidden	54527	61	0	59	96.7	33.0
	Bayfield	Cable	54821	32	0	19	59.4	32.3
		Gordon	54838	1	0	1	100.0	36.7
		Solon Springs	54873	56	0	56	100.0	33.5
	Clark	Neillsville	54456	15	0	1	6.7	30.7
		Thorp	54771	9	0	1	11.1	31.3
	Crawford	Prairie du Chien	53821	5	0	5	100.0	37.4
		Soldiers Grove	54655	4	0	4	100.0	38.5
	Douglas	Gordon	54838	52	0	41	78.8	32.0
		Solon Springs	54873	163	0	1	0.6	31.4
	Forest	Armstrong Creek	54103	4	0	4	100.0	42.9
		Crandon	54520	127	0	4	3.1	30.8
		Laona	54541	7	0	7	100.0	34.2
	Grant	Bagley	53801	1	0	1	100.0	30.6
		Blue River	53518	1	0	1	100.0	37.6
		Boscobel	53805	1	0	1	100.0	43.4

Continued on next page...

Marriage & Family Therapists Continued:

Members Without Access								
State Name	County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
				#	#	#	%	1
Wisconsin	Grant	Mount Hope	53816	1	0	1	100.0	30.6
	Iowa	Dodgeville	53533	9	0	9	100.0	31.3
		Highland	53543	3	0	3	100.0	37.1
		Mineral Point	53565	3	0	3	100.0	32.9
	Iron	Butternut	54514	2	0	2	100.0	45.9
		Gile	54525	3	0	3	100.0	33.1
		Hurley	54534	83	0	83	100.0	34.0
		Mercer	54547	7	0	7	100.0	43.0
		Montreal	54550	46	0	46	100.0	31.9
	Jackson	Alma Center	54611	1	0	1	100.0	31.5
		Merrillan	54754	1	0	1	100.0	32.3
	Marinette	Niagara	54151	7	0	7	100.0	46.1
	Oneida	Tomahawk	54487	8	0	5	62.5	32.4
	Price	Brantwood	54513	8	0	4	50.0	35.2
		Butternut	54514	17	0	17	100.0	44.7
		Catawba	54515	8	0	6	75.0	30.5
		Fifield	54524	9	0	9	100.0	42.7
		Ogema	54459	24	0	23	95.8	33.9
		Park Falls	54552	138	0	138	100.0	45.3
		Phillips	54555	48	0	48	100.0	36.0
		Prentice	54556	47	0	47	100.0	38.1
	Sawyer	Hayward	54843	553	0	127	23.0	33.8
		Winter	54896	50	0	11	22.0	31.1
	Taylor	Lublin	54447	1	0	1	100.0	32.2
		Medford	54451	25	0	24	96.0	33.8
	Vernon	Viola	54664	1	0	1	100.0	33.2
	Vilas	Presque Isle	54557	7	0	5	71.4	32.9
Grand Totals				**6,414**	**0**	**5,107**	**79.6**	**67.8**

Behavioral Health – Licensed Psychologists – Requirement is 30 miles

99.5% met the standard for Psychologists. There are 1,564 members who live more than 30 miles from a Psychologist provider at an average of 54.4 miles. HealthPartners has contracts with known behavioral health providers in these rural areas and continues to pursue contracts with behavioral health providers as they become known.

Members Without Access								
State Name	County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
				#	#	#	%	1
Iowa	Adair	Creston	50801	11	0	11	100.0	31.8
		Orient	50858	24	0	19	79.2	33.2
	Adams	Creston	50801	13	0	5	38.5	31.4
		Prescott	50859	22	0	1	4.5	30.6
	Howard	Chester	52134	5	0	5	100.0	31.7
	Madison	Lorimor	50149	10	0	5	50.0	31.4
	Union	Lorimor	50149	17	0	2	11.8	31.1
	Wayne	Seymour	52590	25	0	6	24.0	30.7
Minnesota	Beltrami	Grygla	56727	2	0	2	100.0	39.2
		Northome	56661	1	0	1	100.0	35.0
	Cook	Grand Marais	55604	11	2	1	9.1	37.9
	Fillmore	Preston	55965	22	0	1	4.5	31.2
	Kittson	Hallock	56728	5	0	5	100.0	58.7
		Halma	56729	6	0	6	100.0	42.4
		Karlstad	56732	3	0	3	100.0	35.7
		Kennedy	56733	2	0	2	100.0	48.9
		Lancaster	56735	1	0	1	100.0	58.7
	Koochiching	Big Falls	56627	3	0	3	100.0	31.5
	Lake of the Woods	Angle Inlet	56711	4	0	4	100.0	88.0
		Baudette	56623	4	0	4	100.0	56.0
		Williams	56686	3	0	3	100.0	70.2
	Marshall	Stephen	56757	15	0	15	100.0	36.3
	Norman	Halstad	56548	3	0	3	100.0	30.5
	Roseau	Greenbush	56726	4	0	4	100.0	38.0
		Roseau	56751	24	0	24	100.0	52.6
		Salol	56756	1	0	1	100.0	60.1
		Wannaska	56761	1	0	1	100.0	42.6
		Warroad	56763	8	0	8	100.0	66.7
	St. Louis	Orr	55771	3	0	2	66.7	37.8
	Traverse	Beardsley	56211	2	0	2	100.0	30.5
		Wheaton	56296	18	0	16	88.9	31.9
Nebraska	Antelope	Royal	68773	1	0	1	100.0	31.7
	Custer	Anselmo	68813	1	0	1	100.0	63.8
	Holt	Oneill	68763	1	0	1	100.0	48.1
		Stuart	68780	2	0	2	100.0	67.5
	Hooker	Mullen	69152	1	0	1	100.0	63.1
	Keith	Ogallala	69153	3	0	3	100.0	49.7
	Valley	Ord	68862	2	0	2	100.0	32.5
North Dakota	Benson	Esmond	58332	1	0	1	100.0	41.6
		Maddock	58348	4	0	4	100.0	31.9

Continued on next page...

Psychologists Continued:

Members Without Access								
State Name	County	City	Zip Code	Member Counts		Without Access[1]		Average Distance
				#	#	#	%	1
North Dakota	Billings	Belfield	58622	2	0	2	100.0	75.1
	Bottineau	Bottineau	58318	1	0	1	100.0	55.2
	Burke	Flaxton	58737	4	0	4	100.0	64.1
	Cass	Erie	58029	4	0	1	25.0	31.3
	Cavalier	Langdon	58249	23	0	23	100.0	50.1
		Munich	58352	7	0	7	100.0	39.0
		Walhalla	58282	3	0	3	100.0	67.1
	Dickey	Ellendale	58436	17	0	17	100.0	38.2
		Forbes	58439	1	0	1	100.0	41.5
		Fullerton	58441	7	0	7	100.0	47.6
		Oakes	58474	27	0	27	100.0	50.3
	Divide	Crosby	58730	7	0	7	100.0	54.4
	Eddy	New Rockford	58356	1	0	1	100.0	31.9
	Emmons	Hazelton	58544	1	0	1	100.0	31.8
	Foster	Carrington	58421	10	0	10	100.0	41.3
	Golden Valley	Beach	58621	1	0	1	100.0	87.3
	Grant	Flasher	58535	1	0	1	100.0	39.8
	Hettinger	New England	58647	3	0	3	100.0	100.8
		Regent	58650	1	0	1	100.0	88.4
	Kidder	Dawson	58428	6	0	6	100.0	46.2
		Steele	58482	15	0	15	100.0	38.8
		Tappen	58487	11	0	11	100.0	39.8
	LaMoure	Dickey	58431	4	0	4	100.0	33.2
		Edgeley	58433	2	0	2	100.0	36.5
		Lamoure	58458	19	0	19	100.0	41.1
		Verona	58490	3	0	3	100.0	39.2
	Logan	Napoleon	58561	4	0	4	100.0	51.2
	McHenry	Anamoose	58710	3	0	3	100.0	53.0
		Balfour	58712	1	0	1	100.0	36.9
		Drake	58736	4	0	4	100.0	47.0
	McIntosh	Zeeland	58581	5	0	5	100.0	66.7
	McKenzie	Watford City	58854	42	0	35	83.3	31.8
	McLean	Coleharbor	58531	1	0	1	100.0	39.5
		Garrison	58540	1	0	1	100.0	40.9
		Riverdale	58565	1	0	1	100.0	50.8
		Turtle Lake	58575	4	0	4	100.0	46.9
		Underwood	58576	12	0	12	100.0	45.2
		Washburn	58577	34	0	34	100.0	32.0
	Mercer	Beulah	58523	1	0	1	100.0	55.6
		Golden Valley	58541	1	0	1	100.0	64.5

Continued on next page...

Psychologists Continued:

Members Without Access								
State Name	County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
				#	#	#	%	1
North Dakota	Mountrail	Palermo	58769	1	0	1	100.0	39.6
		Ross	58776	1	0	1	100.0	48.2
		Stanley	58784	25	0	25	100.0	47.6
		Tioga	58852	1	0	1	100.0	43.3
		White Earth	58794	5	0	5	100.0	43.4
	Nelson	Michigan	58259	2	0	2	100.0	34.0
		Niagara	58266	1	0	1	100.0	40.2
	Oliver	New Salem	58563	1	0	1	100.0	35.1
	Pembina	Bathgate	58216	5	0	5	100.0	68.1
		Cavalier	58220	7	0	7	100.0	65.1
		Walhalla	58282	12	0	12	100.0	69.9
	Pierce	Esmond	58332	1	0	1	100.0	49.2
		Rugby	58368	1	0	1	100.0	54.9
	Ransom	Lisbon	58054	15	0	15	100.0	36.9
		McLeod	58057	1	0	1	100.0	33.7
	Renville	Mohall	58761	3	0	3	100.0	35.5
	Rolette	Dunseith	58329	1	0	1	100.0	71.7
	Sargent	Cogswell	58017	2	0	2	100.0	55.5
		Forman	58032	3	0	3	100.0	51.7
		Gwinner	58040	2	0	2	100.0	50.2
		Milnor	58060	3	0	3	100.0	30.8
		Stirum	58069	1	0	1	100.0	47.7
	Stark	Belfield	58622	18	0	18	100.0	94.9
		Dickinson	58601	92	0	92	100.0	94.6
			58602	1	0	1	100.0	94.2
		Gladstone	58630	2	0	2	100.0	83.9
		Richardton	58652	5	0	5	100.0	70.5
		South Heart	58655	4	0	4	100.0	98.0
	Steele	Finley	58230	2	0	2	100.0	40.9
		Hope	58046	5	0	1	20.0	34.3
	Stutsman	Medina	58467	1	0	1	100.0	30.4
		Streeter	58483	5	0	5	100.0	33.4
		Woodworth	58496	3	0	3	100.0	33.6
	Towner	Cando	58324	9	0	9	100.0	31.9
		Egeland	58331	3	0	3	100.0	37.5
	Traill	Blanchard	58009	1	0	1	100.0	38.4
		Galesburg	58035	1	0	1	100.0	38.6
		Hillsboro	58045	24	0	24	100.0	31.7
		Mayville	58257	13	0	3	23.1	30.8
		Portland	58274	1	0	1	100.0	30.1

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Psychologists Continued:

Members Without Access								
State Name	County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
				#	#	#	%	1
North Dakota	Walsh	Edinburg	58227	1	0	1	100.0	52.1
		Fordville	58231	5	0	5	100.0	39.8
		Grafton	58237	14	0	14	100.0	37.5
		Hoople	58243	2	0	2	100.0	48.5
		Park River	58270	3	0	3	100.0	45.5
	Ward	Ryder	58779	1	0	1	100.0	30.1
	Wells	Fessenden	58438	4	0	4	100.0	47.5
		Harvey	58341	1	0	1	100.0	38.3
	Williams	McGregor	58755	2	0	2	100.0	44.4
		Tioga	58852	19	0	19	100.0	36.2
South Dakota	Aurora	White Lake	57383	2	0	2	100.0	36.3
	Brookings	Brookings	57006	32	0	23	71.9	30.7
		Volga	57071	9	0	9	100.0	36.3
	Brown	Hecla	57446	1	0	1	100.0	32.8
	Buffalo	Gann Valley	57341	5	0	5	100.0	46.7
	Campbell	Herreid	57632	12	0	12	100.0	75.5
		Java	57452	4	0	4	100.0	68.3
		Mound City	57646	5	0	5	100.0	80.7
		Pollock	57648	2	0	2	100.0	67.0
	Charles Mix	Lake Andes	57356	2	0	2	100.0	40.6
		Platte	57369	1	0	1	100.0	48.4
	Clark	Clark	57225	3	0	3	100.0	30.6
	Corson	Mc Laughlin	57642	3	0	3	100.0	69.5
		Trail City	57657	6	0	6	100.0	92.1
		Wakpala	57658	2	0	2	100.0	80.3
	Day	Pierpont	57468	1	0	1	100.0	32.7
		Waubay	57273	5	0	3	60.0	32.9
	Dewey	Eagle Butte	57625	1	0	1	100.0	117.2
		Glencross	57630	3	0	3	100.0	94.4
		Isabel	57633	2	0	2	100.0	102.4
		Timber Lake	57656	3	0	3	100.0	96.3
	Douglas	Armour	57313	2	0	2	100.0	33.0
	Edmunds	Bowdle	57428	8	0	8	100.0	56.5
	Faulk	Faulkton	57438	1	0	1	100.0	43.6
		Onaka	57466	1	0	1	100.0	52.0
	Gregory	Burke	57523	1	0	1	100.0	67.2
		Gregory	57533	3	0	3	100.0	61.0
	Haakon	Philip	57567	1	0	1	100.0	78.3
	Hand	Miller	57362	1	0	1	100.0	50.4
	Hughes	Blunt	57522	3	0	3	100.0	86.5

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Psychologists Continued:

Members Without Access								
State Name	County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
				#	#	#	%	1
South Dakota	Hughes	Pierre	57501	21	0	21	100.0	103.7
	Hutchinson	Freeman	57029	12	0	11	91.7	33.5
		Marion	57043	3	0	3	100.0	32.7
		Olivet	57052	3	0	3	100.0	31.6
	Kingsbury	Arlington	57212	5	0	1	20.0	33.8
	Lake	Madison	57042	50	0	50	100.0	35.5
	Lyman	Presho	57568	3	0	3	100.0	70.4
	Marshall	Britton	57430	26	0	26	100.0	41.8
		Eden	57232	1	0	1	100.0	51.1
		Langford	57454	2	0	2	100.0	40.3
	McCook	Salem	57058	23	0	23	100.0	30.7
	Pennington	Wall	57790	4	0	4	100.0	49.4
	Potter	Hoven	57450	1	0	1	100.0	64.7
	Roberts	Peever	57257	1	0	1	100.0	30.8
		Rosholt	57260	7	0	5	71.4	31.7
		Sisseton	57262	8	0	8	100.0	38.1
	Spink	Doland	57436	3	0	3	100.0	35.9
		Redfield	57469	6	0	6	100.0	39.5
	Stanley	Fort Pierre	57532	6	0	6	100.0	101.7
	Tripp	Winner	57580	1	0	1	100.0	45.4
	Walworth	Akaska	57420	1	0	1	100.0	79.8
		Bowdle	57428	3	0	3	100.0	61.1
		Glenham	57631	5	0	5	100.0	84.8
		Java	57452	2	0	2	100.0	67.1
		Mobridge	57601	206	0	206	100.0	88.7
		Selby	57472	52	0	52	100.0	75.8
Wisconsin	Iron	Gile	54525	3	0	3	100.0	33.1
		Hurley	54534	83	0	83	100.0	33.9
		Montreal	54550	46	0	46	100.0	31.9
	Marinette	Niagara	54151	7	0	7	100.0	44.5
	Monroe	Camp Douglas	54618	1	0	1	100.0	31.9
		Tomah	54660	5	0	1	20.0	31.4
	Price	Catawba	54515	8	0	2	25.0	33.7
		Ogema	54459	24	0	24	100.0	33.3
		Prentice	54556	47	0	3	6.4	31.2
	Rusk	Glen Flora	54526	4	0	4	100.0	33.0
		Hawkins	54530	6	0	5	83.3	31.9
		Ladysmith	54848	7	0	5	71.4	32.6
		Tony	54563	4	0	4	100.0	37.1
	Taylor	Lublin	54447	1	0	1	100.0	33.8

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Psychologists Continued:

Members Without Access								
State Name	County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
				#	#	#	%	1
Wisconsin	Taylor	Medford	54451	25	0	24	96.0	33.7
Grand Totals				**1,771**	**2**	**1,564**	**88.3**	**54.4**

Behavioral Health – Licensed Social Workers – Requirement is 30 miles

99.7% met the standard for Social Workers. There are 921 members who live more than 30 miles from a Social Work provider at an average of 47.3 miles. HealthPartners has contracts with known behavioral health providers in these rural areas and continues to pursue contracts with behavioral health providers as they become known.

Members Without Access								
State Name	County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
				#	#	#	%	1
Minnesota	Beltrami	Grygla	56727	2	0	2	100.0	38.4
	Clearwater	Gonvick	56644	14	0	12	85.7	31.7
	Cook	Grand Marais	55604	11	3	1	9.1	37.7
	Kittson	Hallock	56728	5	0	5	100.0	30.9
		Halma	56729	6	0	6	100.0	40.0
		Karlstad	56732	3	0	3	100.0	35.7
		Lancaster	56735	1	0	1	100.0	37.2
	Lake of the Woods	Angle Inlet	56711	4	0	4	100.0	88.0
		Baudette	56623	4	0	4	100.0	52.7
		Williams	56686	3	0	3	100.0	65.4
	Mahnomen	Bejou	56516	1	0	1	100.0	35.1
		Lengby	56651	4	0	4	100.0	34.3
		Mahnomen	56557	25	0	23	92.0	32.6
	Marshall	Stephen	56757	15	0	4	26.7	31.0
	Norman	Ada	56510	36	0	7	19.4	32.1
		Fertile	56540	1	0	1	100.0	30.1
		Gary	56545	3	0	3	100.0	34.6
		Halstad	56548	3	0	3	100.0	30.3
		Twin Valley	56584	21	0	19	90.5	34.4
	Polk	Bagley	56621	1	0	1	100.0	31.2
		Erskine	56535	8	0	1	12.5	30.9
		Fosston	56542	18	0	18	100.0	38.3
		Gully	56646	8	0	8	100.0	32.4
		Lengby	56651	3	0	3	100.0	34.0
		McIntosh	56556	1	0	1	100.0	34.1
	Roseau	Greenbush	56726	4	0	4	100.0	37.8
		Roseau	56751	24	0	24	100.0	52.2
		Salol	56756	1	0	1	100.0	59.7
		Wannaska	56761	1	0	1	100.0	42.1
		Warroad	56763	8	0	8	100.0	66.2
Nebraska	Cherry	Valentine	69201	5	0	5	100.0	55.4
	Cheyenne	Potter	69156	2	0	2	100.0	47.9
		Sidney	69162	1	0	1	100.0	60.9
	Hooker	Mullen	69152	1	0	1	100.0	62.5
	Morrill	Bridgeport	69336	4	0	4	100.0	31.5
North Dakota	Bottineau	Bottineau	58318	1	0	1	100.0	37.6
	Burke	Flaxton	58737	4	0	4	100.0	64.1
	Cass	Erie	58029	4	0	3	75.0	30.6
	Dickey	Fullerton	58441	7	0	4	57.1	32.2
		Oakes	58474	27	0	27	100.0	42.7

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Social Workers Continued:

Members Without Access								
State Name	County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
				#	#	#	%	1
North Dakota	Divide	Crosby	58730	7	0	7	100.0	53.4
	Eddy	New Rockford	58356	1	0	1	100.0	31.9
	Foster	Carrington	58421	10	0	10	100.0	41.6
	Golden Valley	Beach	58621	1	0	1	100.0	57.1
	Hettinger	Regent	58650	1	0	1	100.0	34.1
	Kidder	Tappen	58487	11	0	5	45.5	31.5
	LaMoure	Dickey	58431	4	0	4	100.0	30.1
		Lamoure	58458	19	0	19	100.0	31.6
		Verona	58490	3	0	3	100.0	39.2
	McHenry	Balfour	58712	1	0	1	100.0	32.5
	McKenzie	Watford City	58854	42	0	29	69.0	31.8
	McLean	Coleharbor	58531	1	0	1	100.0	39.0
		Garrison	58540	1	0	1	100.0	30.4
		Turtle Lake	58575	4	0	4	100.0	43.6
		Underwood	58576	12	0	10	83.3	32.6
		Washburn	58577	34	0	34	100.0	32.0
	Mountrail	Palermo	58769	1	0	1	100.0	39.6
		Ross	58776	1	0	1	100.0	46.8
		Stanley	58784	25	0	25	100.0	47.6
		Tioga	58852	1	0	1	100.0	41.8
		White Earth	58794	5	0	5	100.0	41.9
	Nelson	Michigan	58259	2	0	2	100.0	35.0
		Niagara	58266	1	0	1	100.0	39.5
	Ransom	Lisbon	58054	15	0	15	100.0	36.9
		McLeod	58057	1	0	1	100.0	33.7
	Renville	Mohall	58761	3	0	3	100.0	35.5
	Rolette	Dunseith	58329	1	0	1	100.0	39.0
	Sargent	Cogswell	58017	2	0	2	100.0	55.8
		Forman	58032	3	0	3	100.0	51.7
		Gwinner	58040	2	0	2	100.0	50.2
		Milnor	58060	3	0	3	100.0	30.8
		Stirum	58069	1	0	1	100.0	47.7
	Steele	Finley	58230	2	0	2	100.0	40.9
		Hope	58046	5	0	1	20.0	34.3
	Stutsman	Woodworth	58496	3	0	3	100.0	33.6
	Traill	Blanchard	58009	1	0	1	100.0	37.9
		Galesburg	58035	1	0	1	100.0	38.7
		Hillsboro	58045	24	0	20	83.3	31.9
		Mayville	58257	13	0	3	23.1	30.5
	Ward	Ryder	58779	1	0	1	100.0	30.1

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Social Workers Continued:

Members Without Access								
State Name	County	City	Zip Code	Member #	Counts #	Without Access[1] #	Without Access[1] %	Average Distance 1
North Dakota	Williams	McGregor	58755	2	0	2	100.0	43.0
		Tioga	58852	19	0	19	100.0	34.7
South Dakota	Aurora	White Lake	57383	2	0	2	100.0	36.3
	Bon Homme	Avon	57315	1	0	1	100.0	35.1
	Brown	Hecla	57446	1	0	1	100.0	33.2
	Buffalo	Gann Valley	57341	5	0	5	100.0	46.7
	Butte	Belle Fourche	57717	6	0	6	100.0	49.7
	Campbell	Herreid	57632	12	0	12	100.0	40.6
		Java	57452	4	0	4	100.0	44.7
		Mound City	57646	5	0	5	100.0	51.2
		Pollock	57648	2	0	2	100.0	43.1
	Charles Mix	Lake Andes	57356	2	0	2	100.0	47.2
		Platte	57369	1	0	1	100.0	48.4
	Clark	Clark	57225	3	0	3	100.0	30.8
	Corson	Mc Laughlin	57642	3	0	3	100.0	64.5
		Trail City	57657	6	0	6	100.0	79.3
		Wakpala	57658	2	0	2	100.0	63.1
	Day	Pierpont	57468	1	0	1	100.0	32.5
		Waubay	57273	5	0	3	60.0	32.9
	Dewey	Eagle Butte	57625	1	0	1	100.0	61.3
		Glencross	57630	3	0	3	100.0	78.5
		Isabel	57633	2	0	2	100.0	72.9
		Timber Lake	57656	3	0	3	100.0	77.2
	Douglas	Armour	57313	2	0	2	100.0	33.0
	Edmunds	Bowdle	57428	8	0	8	100.0	56.2
	Faulk	Faulkton	57438	1	0	1	100.0	43.4
		Onaka	57466	1	0	1	100.0	52.1
	Gregory	Burke	57523	1	0	1	100.0	43.7
		Gregory	57533	3	0	3	100.0	45.7
	Haakon	Philip	57567	1	0	1	100.0	67.5
	Hand	Miller	57362	1	0	1	100.0	50.4
	Hutchinson	Freeman	57029	12	0	11	91.7	33.4
		Marion	57043	3	0	3	100.0	32.7
		Olivet	57052	3	0	3	100.0	32.8
		Tripp	57376	2	0	2	100.0	34.5
	Lawrence	Lead	57754	3	0	3	100.0	32.7
		Spearfish	57783	17	0	17	100.0	39.7
	Lyman	Presho	57568	3	0	3	100.0	40.5
	Marshall	Britton	57430	26	0	26	100.0	41.9
		Eden	57232	1	0	1	100.0	46.5

Continued on next page...

Social Workers Continued:

Members Without Access								
State Name	County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
				#	#	#	%	1
South Dakota	Marshall	Langford	57454	2	0	2	100.0	40.1
	Pennington	Wall	57790	4	0	4	100.0	49.2
	Potter	Hoven	57450	1	0	1	100.0	64.8
	Roberts	Peever	57257	1	0	1	100.0	30.7
	Spink	Doland	57436	3	0	3	100.0	35.9
		Redfield	57469	6	0	6	100.0	39.1
	Tripp	Winner	57580	1	0	1	100.0	59.4
	Walworth	Akaska	57420	1	0	1	100.0	67.6
		Bowdle	57428	3	0	3	100.0	57.6
		Glenham	57631	5	0	5	100.0	60.5
		Java	57452	2	0	2	100.0	51.6
		Mobridge	57601	206	0	206	100.0	65.2
		Selby	57472	52	0	52	100.0	58.3
Grand Totals				1,030	3	921	89.4	47.3

<u>Behavioral Health – Psychiatry – Requirement is 30 miles</u>

99.0% met the standard for Psychiatrists. There are 3,239 members who live more than 30 miles from a Psychiatry provider at an average of 45.6 miles. HealthPartners has contracts with known behavioral health providers in these rural areas and continues to pursue contracts with behavioral health providers as they become known.

Members Without Access								
State Name	County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
				#	#	#	%	1
Iowa	Buena Vista	Alta	51002	1	0	1	100.0	33.4
		Newell	50568	6	0	6	100.0	37.1
		Storm Lake	50588	18	0	18	100.0	35.2
	Cerro Gordo	Clear Lake	50428	50	0	50	100.0	32.8
		Dougherty	50433	2	0	2	100.0	33.4
		Mason City	50401	73	0	73	100.0	35.5
		Nora Springs	50458	1	0	1	100.0	33.6
		Plymouth	50464	2	0	2	100.0	30.4
		Rockford	50468	9	0	9	100.0	35.0
		Rockwell	50469	6	0	6	100.0	31.8
		Ventura	50482	3	0	1	33.3	30.4
	Cherokee	Aurelia	51005	5	0	5	100.0	33.0
		Cherokee	51012	5	0	5	100.0	30.9
	Clayton	Farmersburg	52047	2	0	1	50.0	30.3
	Clinton	Lost Nation	52254	5	0	5	100.0	31.2
	Floyd	Charles City	50616	31	0	1	3.2	31.2
		Floyd	50435	4	0	4	100.0	30.6
		Rockford	50468	9	0	9	100.0	34.4
		Rudd	50471	5	0	5	100.0	35.2
	Franklin	Ackley	50601	5	0	5	100.0	30.1
	Hancock	Forest City	50436	22	0	22	100.0	31.6
		Garner	50438	135	0	2	1.5	30.7
	Hardin	Ackley	50601	3	0	1	33.3	32.6
		Iowa Falls	50126	61	0	8	13.1	32.5
	Howard	Chester	52134	5	0	5	100.0	33.2
		Riceville	50466	9	0	8	88.9	30.8
	Jones	Wyoming	52362	3	0	3	100.0	32.9
	Mitchell	Orchard	50460	1	0	1	100.0	34.2
		Osage	50461	46	0	12	26.1	31.8
	Winnebago	Forest City	50436	59	0	26	44.1	30.5
Minnesota	Beltrami	Grygla	56727	2	0	2	100.0	39.2
		Northome	56661	1	0	1	100.0	35.0
	Big Stone	Appleton	56208	2	0	2	100.0	40.2
		Ortonville	56278	23	0	20	87.0	34.4
	Cass	Federal Dam	56641	2	0	2	100.0	30.5
	Chippewa	Milan	56262	6	0	6	100.0	34.8
		Montevideo	56265	69	0	1	1.4	30.6
	Cook	Grand Marais	55604	11	0	11	100.0	58.1
		Hovland	55606	1	0	1	100.0	74.2
		Lutsen	55612	3	0	3	100.0	41.4

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Psychiatrists Continued:

Members Without Access								
State Name	County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
				#	#	#	%	1
Minnesota	Cook	Tofte	55615	1	0	1	100.0	32.0
	Fillmore	Le Roy	55951	2	0	2	100.0	32.1
		Preston	55965	22	0	1	4.5	31.2
	Itasca	Bigfork	56628	76	0	46	60.5	34.0
		Effie	56639	22	0	22	100.0	37.7
		Max	56659	5	0	5	100.0	36.7
		Northome	56661	4	0	4	100.0	41.1
		Spring Lake	56680	2	0	2	100.0	33.8
		Squaw Lake	56681	7	0	3	42.9	36.2
		Wirt	56688	10	0	10	100.0	39.4
	Kittson	Karlstad	56732	3	0	2	66.7	31.4
	Koochiching	Big Falls	56627	3	0	3	100.0	63.7
		International Falls	56649	16	0	16	100.0	82.6
		Littlefork	56653	2	0	2	100.0	71.3
	Lake	Ely	55731	12	0	12	100.0	44.6
		Isabella	55607	4	0	1	25.0	32.4
	Lake of the Woods	Angle Inlet	56711	4	0	4	100.0	48.8
		Baudette	56623	4	0	4	100.0	52.8
		Williams	56686	3	0	3	100.0	38.5
	Mahnomen	Mahnomen	56557	25	0	9	36.0	30.6
	Norman	Ada	56510	36	0	32	88.9	31.5
		Fertile	56540	1	0	1	100.0	30.4
		Gary	56545	3	0	3	100.0	34.4
		Mahnomen	56557	4	0	4	100.0	30.8
		Twin Valley	56584	21	0	19	90.5	35.3
	St. Louis	Babbitt	55706	53	0	51	96.2	31.2
		Ely	55731	99	0	96	97.0	41.6
		Kabetogama	56669	2	0	2	100.0	70.4
		Orr	55771	3	0	3	100.0	37.0
		Winton	55796	2	0	2	100.0	44.8
	Stevens	Alberta	56207	3	0	2	66.7	31.6
	Swift	Appleton	56208	5	0	5	100.0	36.4
		Benson	56215	173	0	5	2.9	30.9
		Danvers	56231	8	0	8	100.0	33.5
		Holloway	56249	1	0	1	100.0	36.8
Nebraska	Antelope	Royal	68773	1	0	1	100.0	41.7
	Cherry	Valentine	69201	5	0	5	100.0	121.9
	Cheyenne	Potter	69156	2	0	2	100.0	46.7
		Sidney	69162	1	0	1	100.0	60.0
	Custer	Anselmo	68813	1	0	1	100.0	63.2

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Psychiatrists Continued:

Members Without Access								
State Name	County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
				#	#	#	%	1
Nebraska	Dawes	Crawford	69339	5	0	5	100.0	53.7
	Dawson	Lexington	68850	4	0	4	100.0	30.3
	Holt	Oneill	68763	1	0	1	100.0	63.7
		Stuart	68780	2	0	2	100.0	79.0
	Hooker	Mullen	69152	1	0	1	100.0	65.0
	Keith	Ogallala	69153	3	0	3	100.0	49.5
	Morrill	Bridgeport	69336	4	0	4	100.0	31.5
	Sheridan	Gordon	69343	1	0	1	100.0	97.8
North Dakota	Barnes	Dazey	58429	6	0	6	100.0	34.7
		Luverne	58056	2	0	2	100.0	35.6
		Oriska	58063	3	0	3	100.0	41.0
		Pillsbury	58065	1	0	1	100.0	30.2
		Rogers	58479	8	0	2	25.0	30.1
		Valley City	58072	221	0	217	98.2	33.1
	Benson	Maddock	58348	4	0	4	100.0	32.9
	Bottineau	Bottineau	58318	1	0	1	100.0	37.6
	Burke	Flaxton	58737	4	0	4	100.0	64.1
	Cass	Buffalo	58011	2	0	2	100.0	32.1
		Fingal	58031	4	0	4	100.0	34.6
	Dickey	Fullerton	58441	7	0	4	57.1	32.2
		Oakes	58474	27	0	27	100.0	42.7
	Divide	Crosby	58730	7	0	7	100.0	98.3
	Eddy	New Rockford	58356	1	0	1	100.0	32.9
	Foster	Carrington	58421	10	0	10	100.0	41.3
	Golden Valley	Beach	58621	1	0	1	100.0	57.2
	Griggs	Hannaford	58448	5	0	5	100.0	34.1
	Kidder	Tappen	58487	11	0	5	45.5	31.5
	LaMoure	Dickey	58431	4	0	4	100.0	30.1
		Lamoure	58458	19	0	19	100.0	31.6
		Verona	58490	3	0	3	100.0	42.1
	McHenry	Anamoose	58710	3	0	3	100.0	35.1
		Balfour	58712	1	0	1	100.0	36.9
	McKenzie	Alexander	58831	6	0	6	100.0	73.9
		Watford City	58854	42	0	42	100.0	65.0
	McLean	Coleharbor	58531	1	0	1	100.0	39.0
		Garrison	58540	1	0	1	100.0	30.4
		Turtle Lake	58575	4	0	4	100.0	43.6
		Underwood	58576	12	0	10	83.3	32.6
		Washburn	58577	34	0	34	100.0	32.0
	Mountrail	Palermo	58769	1	0	1	100.0	39.6

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Psychiatrists Continued:

Members Without Access								
State Name	County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
				#	#	#	%	1
North Dakota	Mountrail	Ross	58776	1	0	1	100.0	56.9
		Stanley	58784	25	0	25	100.0	47.6
		Tioga	58852	1	0	1	100.0	69.5
		White Earth	58794	5	0	5	100.0	64.7
	Nelson	Michigan	58259	2	0	2	100.0	30.8
		Niagara	58266	1	0	1	100.0	32.5
	Ransom	Enderlin	58027	4	0	4	100.0	39.5
		Lisbon	58054	15	0	15	100.0	47.6
		McLeod	58057	1	0	1	100.0	34.4
	Renville	Mohall	58761	3	0	3	100.0	35.5
	Richland	Lidgerwood	58053	1	0	1	100.0	31.0
		McLeod	58057	1	0	1	100.0	30.3
	Rolette	Dunseith	58329	1	0	1	100.0	39.0
	Sargent	Cogswell	58017	2	0	2	100.0	55.5
		Forman	58032	3	0	3	100.0	53.3
		Gwinner	58040	2	0	2	100.0	51.5
		Milnor	58060	3	0	3	100.0	32.1
		Stirum	58069	1	0	1	100.0	53.9
	Steele	Luverne	58056	3	0	3	100.0	33.6
	Stutsman	Woodworth	58496	3	0	3	100.0	34.4
	Ward	Ryder	58779	1	0	1	100.0	30.1
	Wells	Fessenden	58438	4	0	4	100.0	48.6
		Harvey	58341	1	0	1	100.0	39.4
	Williams	Epping	58843	5	0	5	100.0	91.6
		McGregor	58755	2	0	2	100.0	77.4
		Ray	58849	1	0	1	100.0	82.5
		Tioga	58852	19	0	19	100.0	72.5
		Williston	58801	101	0	101	100.0	95.6
			58802	1	0	1	100.0	93.9
			58803	5	0	5	100.0	96.6
South Dakota	Aurora	Plankinton	57368	7	0	7	100.0	79.3
		White Lake	57383	2	0	2	100.0	85.6
	Beadle	Cavour	57324	12	0	12	100.0	81.5
		Huron	57350	41	0	41	100.0	77.6
		Iroquois	57353	2	0	2	100.0	76.1
	Bon Homme	Avon	57315	1	0	1	100.0	34.6
	Brookings	Volga	57071	9	0	2	22.2	31.5
	Brown	Hecla	57446	1	0	1	100.0	33.0
	Buffalo	Gann Valley	57341	5	0	5	100.0	106.4
	Butte	Belle Fourche	57717	6	0	6	100.0	50.7

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Psychiatrists Continued:

Members Without Access								
State Name	County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
				#	#	#	%	1
South Dakota	Campbell	Herreid	57632	12	0	12	100.0	40.6
		Java	57452	4	0	4	100.0	44.7
		Mound City	57646	5	0	5	100.0	51.2
		Pollock	57648	2	0	2	100.0	43.1
	Charles Mix	Lake Andes	57356	2	0	2	100.0	60.1
		Platte	57369	1	0	1	100.0	80.6
	Clark	Clark	57225	3	0	3	100.0	54.0
		Garden City	57236	1	0	1	100.0	56.0
	Codington	Florence	57235	2	0	2	100.0	52.1
		Henry	57243	4	0	4	100.0	57.5
		Watertown	57201	83	0	83	100.0	43.5
	Corson	Mc Laughlin	57642	3	0	3	100.0	64.5
		Trail City	57657	6	0	6	100.0	80.9
		Wakpala	57658	2	0	2	100.0	63.1
	Davison	Ethan	57334	1	0	1	100.0	57.6
		Mitchell	57301	94	0	94	100.0	63.0
		Mount Vernon	57363	16	0	16	100.0	68.6
	Day	Pierpont	57468	1	0	1	100.0	32.0
		Waubay	57273	5	0	5	100.0	50.0
	Dewey	Eagle Butte	57625	1	0	1	100.0	97.1
		Glencross	57630	3	0	3	100.0	81.4
		Isabel	57633	2	0	2	100.0	72.0
		Timber Lake	57656	3	0	3	100.0	77.2
	Douglas	Armour	57313	2	0	2	100.0	56.9
		Delmont	57330	1	0	1	100.0	49.8
	Edmunds	Bowdle	57428	8	0	8	100.0	56.2
	Fall River	Hot Springs	57747	1	0	1	100.0	46.0
	Faulk	Faulkton	57438	1	0	1	100.0	43.4
		Onaka	57466	1	0	1	100.0	52.1
	Grant	Big Stone City	57216	1	0	1	100.0	34.8
		Marvin	57251	1	0	1	100.0	42.8
		Milbank	57252	27	0	27	100.0	38.1
		Strandburg	57265	2	0	2	100.0	37.3
		Summit	57266	6	0	6	100.0	45.8
	Gregory	Burke	57523	1	0	1	100.0	97.7
		Gregory	57533	3	0	3	100.0	106.1
	Haakon	Philip	57567	1	0	1	100.0	78.3
	Hamlin	Castlewood	57223	11	0	10	90.9	33.4
		Hazel	57242	1	0	1	100.0	50.2
		Lake Norden	57248	1	0	1	100.0	39.0

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Psychiatrists Continued:

Members Without Access								
State Name	County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
				#	#	#	%	1
South Dakota	Hand	Miller	57362	1	0	1	100.0	58.2
		Wessington	57381	1	0	1	100.0	75.1
	Hanson	Alexandria	57311	13	0	13	100.0	50.3
		Canova	57321	6	0	6	100.0	49.7
		Ethan	57334	3	0	3	100.0	54.3
		Fulton	57340	4	0	4	100.0	54.3
		Spencer	57374	5	0	5	100.0	44.2
	Hughes	Blunt	57522	3	0	3	100.0	96.4
		Pierre	57501	21	0	21	100.0	118.0
	Hutchinson	Dimock	57331	5	0	5	100.0	49.2
		Freeman	57029	12	0	11	91.7	33.5
		Marion	57043	3	0	3	100.0	32.7
		Olivet	57052	3	0	3	100.0	32.5
		Parkston	57366	14	0	14	100.0	45.6
		Tripp	57376	2	0	2	100.0	37.5
	Jerauld	Woonsocket	57385	1	0	1	100.0	86.5
	Kingsbury	Arlington	57212	5	0	5	100.0	35.6
		Iroquois	57353	1	0	1	100.0	69.4
	Lake	Madison	57042	50	0	50	100.0	34.8
	Lawrence	Deadwood	57732	4	0	3	75.0	31.1
		Lead	57754	3	0	3	100.0	33.8
		Spearfish	57783	17	0	17	100.0	40.8
	Lyman	Presho	57568	3	0	3	100.0	137.2
	Marshall	Britton	57430	26	0	26	100.0	41.5
		Eden	57232	1	0	1	100.0	46.5
		Langford	57454	2	0	2	100.0	39.6
	McCook	Bridgewater	57319	3	0	3	100.0	35.5
		Salem	57058	23	0	23	100.0	32.5
		Spencer	57374	2	0	2	100.0	41.9
	Miner	Canova	57321	1	0	1	100.0	43.1
		Howard	57349	1	0	1	100.0	55.0
	Pennington	Wall	57790	4	0	4	100.0	49.5
	Potter	Hoven	57450	1	0	1	100.0	64.8
	Roberts	Big Stone City	57216	1	0	1	100.0	31.2
		Peever	57257	1	0	1	100.0	31.3
		Summit	57266	3	0	3	100.0	43.5
		Wilmot	57279	2	0	1	50.0	32.7
	Sanborn	Artesian	57314	2	0	2	100.0	59.0
		Letcher	57359	2	0	2	100.0	69.6
	Spink	Doland	57436	3	0	3	100.0	45.3

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Psychiatrists Continued:

Members Without Access								
State Name	County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
				#	#	#	%	1
South Dakota	Spink	Redfield	57469	6	0	6	100.0	40.0
	Stanley	Fort Pierre	57532	6	0	6	100.0	121.5
	Tripp	Winner	57580	1	0	1	100.0	133.8
	Walworth	Akaska	57420	1	0	1	100.0	69.6
		Bowdle	57428	3	0	3	100.0	57.6
		Glenham	57631	5	0	5	100.0	60.5
		Java	57452	2	0	2	100.0	51.6
		Mobridge	57601	206	0	206	100.0	65.2
		Selby	57472	52	0	52	100.0	58.3
Wisconsin	Bayfield	Cable	54821	32	0	19	59.4	32.3
		Gordon	54838	1	0	1	100.0	36.7
		Solon Springs	54873	56	0	56	100.0	33.7
	Crawford	Prairie du Chien	53821	5	0	1	20.0	30.2
	Douglas	Gordon	54838	52	0	45	86.5	34.9
		Minong	54859	3	0	3	100.0	31.0
		Solon Springs	54873	163	0	1	0.6	32.5
	Iron	Gile	54525	3	0	3	100.0	33.1
		Hurley	54534	83	0	83	100.0	33.9
		Montreal	54550	46	0	46	100.0	31.9
	Marinette	Niagara	54151	7	0	7	100.0	40.2
	Sauk	Lone Rock	53556	1	0	1	100.0	32.5
	Sawyer	Hayward	54843	553	0	549	99.3	37.0
	Washburn	Hayward	54843	35	0	35	100.0	32.7
		Minong	54859	58	0	20	34.5	31.9
		Springbrook	54875	23	0	13	56.5	31.3
Grand Totals				**4,124**	**0**	**3,239**	**78.5**	**45.6**

Cardiology – Requirement is 60 miles

99.9% of our membership met the requirement for a Cardiology provider within 60 miles. There are 27 members who live more than 60 miles from a Cardiology provider at an average of 70.6 miles. No further action will be taken at this time as HealthPartners already holds contracts with these area cardiology providers.

Members Without Access								
State Name	County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
				#	#	#	%	1
Minnesota	Cook	Grand Marais	55604	11	0	10	90.9	70.3
		Hovland	55606	1	0	1	100.0	76.3
		Lutsen	55612	3	0	1	33.3	61.7
Nebraska	Custer	Anselmo	68813	1	0	1	100.0	61.7
	Hooker	Mullen	69152	1	0	1	100.0	64.9
North Dakota	Burke	Flaxton	58737	4	0	4	100.0	66.0
	Divide	Crosby	58730	7	0	7	100.0	76.3
	Rolette	Dunseith	58329	1	0	1	100.0	72.2
South Dakota	Haakon	Philip	57567	1	0	1	100.0	68.0
Grand Totals				**30**	**0**	**27**	**90.0**	**70.6**

Obstetrics & Gynecology (OB-GYN) – Requirement is 30 miles

99.8% of our membership met the requirement for an Ob-Gyn provider within 30 miles. There are 593 members who live more than 30 miles from an Ob-Gyn provider at an average of 38.7 miles however there are primary care providers within the standard 30 miles that also provide obstetrics and gynecology services. No further action will be taken at this time as HealthPartners already holds contracts with these area Ob-Gyn providers.

Members Without Access

State Name	County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
				#	#	#	%	1
Iowa	Ringgold	Mount Ayr	50854	12	0	1	8.3	30.6
		Redding	50860	7	0	7	100.0	31.9
Minnesota	Beltrami	Grygla	56727	2	0	2	100.0	37.9
	Cook	Grand Marais	55604	11	0	11	100.0	68.3
		Hovland	55606	1	0	1	100.0	76.3
		Lutsen	55612	3	0	3	100.0	59.5
		Schroeder	55613	4	0	4	100.0	49.4
		Tofte	55615	1	0	1	100.0	54.8
	Itasca	Bigfork	56628	76	0	3	3.9	31.4
		Effie	56639	22	0	22	100.0	36.2
		Wirt	56688	10	0	6	60.0	30.3
	Kittson	Hallock	56728	5	0	5	100.0	31.0
		Halma	56729	6	0	6	100.0	41.2
		Karlstad	56732	3	0	3	100.0	36.9
		Kennedy	56733	2	0	2	100.0	34.1
		Lancaster	56735	1	0	1	100.0	37.2
	Koochiching	Big Falls	56627	3	0	3	100.0	32.2
	Lake	Finland	55603	1	0	1	100.0	43.0
		Silver Bay	55614	12	0	12	100.0	46.6
		Two Harbors	55616	47	0	1	2.1	36.1
	Lake of the Woods	Angle Inlet	56711	4	0	4	100.0	48.8
		Baudette	56623	4	0	4	100.0	49.7
		Williams	56686	3	0	3	100.0	38.5
	Marshall	Stephen	56757	15	0	15	100.0	36.5
Nebraska	Cherry	Valentine	69201	5	0	5	100.0	83.2
	Dawes	Crawford	69339	5	0	5	100.0	53.7
	Hooker	Mullen	69152	1	0	1	100.0	64.1
	Morrill	Bridgeport	69336	4	0	4	100.0	33.0
	Sheridan	Gordon	69343	1	0	1	100.0	97.8
North Dakota	Benson	Esmond	58332	1	0	1	100.0	42.5
		Maddock	58348	4	0	4	100.0	32.9
	Bottineau	Bottineau	58318	1	0	1	100.0	55.4
	Burke	Flaxton	58737	4	0	4	100.0	66.0
	Cavalier	Langdon	58249	23	0	23	100.0	34.9
		Munich	58352	7	0	7	100.0	38.9
	Divide	Crosby	58730	7	0	7	100.0	54.4
	Eddy	New Rockford	58356	1	0	1	100.0	32.9
	Emmons	Hazelton	58544	1	0	1	100.0	32.5
	Foster	Carrington	58421	10	0	10	100.0	41.3
	Golden Valley	Beach	58621	1	0	1	100.0	55.7

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OB-GYN Continued:

Members Without Access								
State Name	County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
				#	#	#	%	1
North Dakota	Grant	Flasher	58535	1	0	1	100.0	40.2
	Kidder	Dawson	58428	6	0	6	100.0	47.5
		Steele	58482	15	0	15	100.0	40.2
		Tappen	58487	11	0	11	100.0	39.8
	LaMoure	Edgeley	58433	2	0	2	100.0	33.6
	Logan	Napoleon	58561	4	0	4	100.0	38.4
	McHenry	Anamoose	58710	3	0	3	100.0	52.2
		Balfour	58712	1	0	1	100.0	36.0
		Drake	58736	4	0	4	100.0	46.3
	McLean	Coleharbor	58531	1	0	1	100.0	38.3
		Garrison	58540	1	0	1	100.0	30.4
		Turtle Lake	58575	4	0	4	100.0	43.6
		Underwood	58576	12	0	10	83.3	32.6
		Washburn	58577	34	0	34	100.0	33.3
	Mountrail	Palermo	58769	1	0	1	100.0	42.5
		Ross	58776	1	0	1	100.0	41.5
		Stanley	58784	25	0	25	100.0	50.0
		Tioga	58852	1	0	1	100.0	43.1
		White Earth	58794	5	0	5	100.0	43.1
	Pierce	Esmond	58332	1	0	1	100.0	50.1
		Rugby	58368	1	0	1	100.0	55.5
	Renville	Mohall	58761	3	0	3	100.0	35.8
	Rolette	Dunseith	58329	1	0	1	100.0	72.2
	Stutsman	Medina	58467	1	0	1	100.0	30.4
		Streeter	58483	5	0	5	100.0	33.4
		Woodworth	58496	3	0	3	100.0	33.6
	Towner	Cando	58324	9	0	9	100.0	31.8
		Egeland	58331	3	0	3	100.0	37.3
	Ward	Ryder	58779	1	0	1	100.0	30.7
	Wells	Fessenden	58438	4	0	4	100.0	48.6
		Harvey	58341	1	0	1	100.0	39.4
	Williams	McGregor	58755	2	0	2	100.0	44.2
		Tioga	58852	19	0	19	100.0	36.0
South Dakota	Charles Mix	Lake Andes	57356	2	0	2	100.0	40.3
	Dewey	Eagle Butte	57625	1	0	1	100.0	53.8
		Isabel	57633	2	0	2	100.0	41.7
	Douglas	Armour	57313	2	0	2	100.0	30.7
	Edmunds	Bowdle	57428	8	0	5	62.5	33.4
	Fall River	Hot Springs	57747	1	0	1	100.0	42.4
	Faulk	Faulkton	57438	1	0	1	100.0	40.4

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OB-GYN Continued:

Members Without Access								
State Name	County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
				#	#	#	%	1
South Dakota	Gregory	Burke	57523	1	0	1	100.0	41.4
		Gregory	57533	3	0	3	100.0	38.3
	Haakon	Philip	57567	1	0	1	100.0	66.8
	Hand	Miller	57362	1	0	1	100.0	46.3
	Lyman	Presho	57568	3	0	3	100.0	34.5
	Pennington	Wall	57790	4	0	4	100.0	48.2
	Spink	Redfield	57469	6	0	6	100.0	39.0
	Tripp	Winner	57580	1	0	1	100.0	42.8
	Walworth	Bowdle	57428	3	0	3	100.0	30.5
Wisconsin	Bayfield	Cable	54821	32	0	19	59.4	32.1
		Gordon	54838	1	0	1	100.0	34.3
		Solon Springs	54873	56	0	56	100.0	33.4
	Douglas	Gordon	54838	52	0	10	19.2	31.3
		Solon Springs	54873	163	0	1	0.6	32.0
	Sawyer	Hayward	54843	553	0	88	15.9	31.8
Grand Totals				**1,414**	**0**	**593**	**41.9**	**38.7**

Orthopedics – Requirement is 60 miles

99.9% of our membership met the requirement for an orthopedic provider within 60 miles. There are 19 members who live more than 60 miles from an Orthopedist at an average of 67.0 miles. No further action will be taken at this time as HealthPartners already holds contracts with these area orthopedic providers.

Members Without Access								
State Name	County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
				#	#	#	%	1
Minnesota	Cook	Grand Marais	55604	11	0	10	90.9	66.9
		Hovland	55606	1	0	1	100.0	76.3
		Lutsen	55612	3	0	1	33.3	61.7
Nebraska	Hooker	Mullen	69152	1	0	1	100.0	63.5
North Dakota	Burke	Flaxton	58737	4	0	4	100.0	66.0
	Rolette	Dunseith	58329	1	0	1	100.0	72.2
South Dakota	Haakon	Philip	57567	1	0	1	100.0	66.8
Grand Totals				22	0	19	86.4	67.0

Otolaryngology (ENT) – Requirement is 60 miles

99.9 % of our membership met the requirement for an ENT provider within 60 miles. There are 376 members who live more than 60 miles from an ENT provider at an average of 79.4 miles. No further action will be taken at this time as HealthPartners already holds contracts with these area ENT providers.

Members Without Access								
State Name	County	City	Zip Code	Member Counts		Without Access[1]		Average Distance
				#	#	#	%	1
Minnesota	Cook	Grand Marais	55604	11	0	11	100.0	90.4
		Hovland	55606	1	0	1	100.0	100.6
		Lutsen	55612	3	0	3	100.0	79.0
		Schroeder	55613	4	0	4	100.0	65.6
		Tofte	55615	1	0	1	100.0	71.9
	Koochiching	Big Falls	56627	3	0	3	100.0	67.4
		International Falls	56649	16	0	16	100.0	82.7
		Littlefork	56653	2	0	2	100.0	72.5
	Lake	Finland	55603	1	0	1	100.0	68.1
	St. Louis	Kabetogama	56669	2	0	2	100.0	70.2
Nebraska	Hooker	Mullen	69152	1	0	1	100.0	63.5
North Dakota	Burke	Flaxton	58737	4	0	4	100.0	68.0
	Divide	Crosby	58730	7	0	7	100.0	76.1
	McIntosh	Zeeland	58581	5	0	5	100.0	67.5
	Rolette	Dunseith	58329	1	0	1	100.0	72.5
South Dakota	Campbell	Herreid	57632	12	0	12	100.0	75.7
		Java	57452	4	0	4	100.0	69.4
		Mound City	57646	5	0	5	100.0	81.2
		Pollock	57648	2	0	2	100.0	67.1
	Corson	Mc Laughlin	57642	3	0	3	100.0	69.5
		Trail City	57657	6	0	6	100.0	79.9
		Wakpala	57658	2	0	2	100.0	80.3
	Dewey	Eagle Butte	57625	1	0	1	100.0	62.2
		Glencross	57630	3	0	3	100.0	79.1
		Isabel	57633	2	0	2	100.0	88.7
		Timber Lake	57656	3	0	3	100.0	81.8
	Haakon	Philip	57567	1	0	1	100.0	68.2
	Potter	Hoven	57450	1	0	1	100.0	65.4
	Walworth	Akaska	57420	1	0	1	100.0	67.9
		Bowdle	57428	3	0	3	100.0	62.0
		Glenham	57631	5	0	5	100.0	80.5
		Java	57452	2	0	2	100.0	68.0
		Mobridge	57601	206	0	206	100.0	81.8
		Selby	57472	52	0	52	100.0	75.9
Grand Totals				**376**	**0**	**376**	**100.0**	**79.4**

Oncology – Requirement is 60 miles

99.9 % of our membership met the requirement for an oncology provider within 60 miles. There are 270 members who live more than 60 miles from an oncology provider at an average of 70.0 miles. No further action will be taken at this time as HealthPartners already holds contracts with these area Oncology providers.

Members Without Access								
State Name	County	City	Zip Code	Member Counts		Without Access[1]		Average Distance
				#	#	#	%	1
Minnesota	Cook	Grand Marais	55604	11	0	11	100.0	84.2
		Hovland	55606	1	0	1	100.0	76.3
		Lutsen	55612	3	0	3	100.0	79.0
		Schroeder	55613	4	0	4	100.0	65.6
		Tofte	55615	1	0	1	100.0	71.9
	Lake	Finland	55603	1	0	1	100.0	68.3
Nebraska	Holt	Oneill	68763	1	0	1	100.0	67.9
		Stuart	68780	2	0	2	100.0	73.9
	Hooker	Mullen	69152	1	0	1	100.0	63.5
	Sheridan	Gordon	69343	1	0	1	100.0	84.5
North Dakota	Burke	Flaxton	58737	4	0	4	100.0	68.2
	Rolette	Dunseith	58329	1	0	1	100.0	72.8
South Dakota	Campbell	Herreid	57632	12	0	3	25.0	62.5
		Pollock	57648	2	0	2	100.0	67.0
	Corson	Mc Laughlin	57642	3	0	3	100.0	69.5
		Trail City	57657	6	0	6	100.0	79.7
		Wakpala	57658	2	0	2	100.0	74.6
	Dewey	Eagle Butte	57625	1	0	1	100.0	61.9
		Glencross	57630	3	0	3	100.0	78.9
		Isabel	57633	2	0	2	100.0	88.3
		Timber Lake	57656	3	0	3	100.0	81.5
	Gregory	Burke	57523	1	0	1	100.0	66.5
		Gregory	57533	3	0	3	100.0	60.4
	Haakon	Philip	57567	1	0	1	100.0	68.0
	Walworth	Glenham	57631	5	0	3	60.0	60.5
		Mobridge	57601	206	0	206	100.0	68.8
Grand Totals				**281**	**0**	**270**	**96.1**	**70.0**

Dermatology – Requirement is 60 miles

99.8% of our membership met the 60 mile requirement. There are 740 members who live more than 60 miles from a dermatologist at an average of 84.0 miles. No further action will be taken at this time as HealthPartners already holds contracts with these area orthopedic providers.

Members Without Access

State Name	County	City	Zip Code	Member #	Counts #	Without Access[1] #	Without Access[1] %	Average Distance 1
Minnesota	Cook	Grand Marais	55604	11	0	11	100.0	84.2
		Hovland	55606	1	0	1	100.0	76.3
		Lutsen	55612	3	0	3	100.0	76.2
		Schroeder	55613	4	0	4	100.0	63.1
		Tofte	55615	1	0	1	100.0	69.2
	Lake	Finland	55603	1	0	1	100.0	67.7
Nebraska	Banner	Harrisburg	69345	2	0	2	100.0	105.8
	Cherry	Valentine	69201	5	0	5	100.0	102.9
	Cheyenne	Potter	69156	2	0	2	100.0	83.2
		Sidney	69162	1	0	1	100.0	65.6
	Custer	Anselmo	68813	1	0	1	100.0	63.5
	Holt	Oneill	68763	1	0	1	100.0	69.2
		Stuart	68780	2	0	2	100.0	90.3
	Hooker	Mullen	69152	1	0	1	100.0	64.6
	Morrill	Bridgeport	69336	4	0	4	100.0	79.7
	Scotts Bluff	Gering	69341	17	0	17	100.0	110.5
		Minatare	69356	1	0	1	100.0	102.8
		Mitchell	69357	5	0	5	100.0	105.3
		Scottsbluff	69361	54	0	54	100.0	108.1
			69363	1	0	1	100.0	108.5
	Sheridan	Gordon	69343	1	0	1	100.0	78.5
North Dakota	Billings	Belfield	58622	2	0	2	100.0	74.8
	Dickey	Ellendale	58436	17	0	15	88.2	61.9
		Oakes	58474	27	0	13	48.1	60.4
	Golden Valley	Beach	58621	1	0	1	100.0	87.2
	Hettinger	New England	58647	3	0	3	100.0	101.1
		Regent	58650	1	0	1	100.0	88.9
	McIntosh	Zeeland	58581	5	0	5	100.0	66.5
	Mercer	Golden Valley	58541	1	0	1	100.0	64.5
	Stark	Belfield	58622	18	0	18	100.0	94.7
		Dickinson	58601	92	0	92	100.0	94.5
			58602	1	0	1	100.0	94.2
		Gladstone	58630	2	0	2	100.0	83.9
		Richardton	58652	5	0	5	100.0	70.5
		South Heart	58655	4	0	4	100.0	97.7
South Dakota	Brown	Aberdeen	57401	72	0	72	100.0	76.7
		Columbia	57433	2	0	2	100.0	76.2
		Groton	57445	2	0	1	50.0	65.4
		Hecla	57446	1	0	1	100.0	74.8
		Houghton	57449	4	0	4	100.0	79.8

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Dermatology Continued:

Members Without Access								
State Name	County	City	Zip Code	Member Counts		Without Access[1]		Average Distance
				#	#	#	%	1
South Dakota	Brown	Westport	57481	1	0	1	100.0	83.5
	Campbell	Herreid	57632	12	0	12	100.0	75.1
		Java	57452	4	0	4	100.0	90.2
		Mound City	57646	5	0	5	100.0	83.0
		Pollock	57648	2	0	2	100.0	66.5
	Corson	Mc Laughlin	57642	3	0	3	100.0	69.5
		Trail City	57657	6	0	6	100.0	79.9
		Wakpala	57658	2	0	2	100.0	80.1
	Dewey	Eagle Butte	57625	1	0	1	100.0	62.2
		Glencross	57630	3	0	3	100.0	79.1
		Isabel	57633	2	0	2	100.0	88.7
		Timber Lake	57656	3	0	3	100.0	81.8
	Edmunds	Bowdle	57428	8	0	8	100.0	80.6
		Ipswich	57451	10	0	10	100.0	91.8
	Faulk	Faulkton	57438	1	0	1	100.0	75.3
		Onaka	57466	1	0	1	100.0	71.6
	Gregory	Burke	57523	1	0	1	100.0	75.1
		Gregory	57533	3	0	3	100.0	80.4
	Haakon	Philip	57567	1	0	1	100.0	68.2
	Hand	Miller	57362	1	0	1	100.0	67.0
	Marshall	Britton	57430	26	0	26	100.0	63.9
	McPherson	Leola	57456	3	0	3	100.0	81.1
	Potter	Hoven	57450	1	0	1	100.0	66.5
	Spink	Mellette	57461	2	0	2	100.0	67.7
		Redfield	57469	6	0	6	100.0	73.0
	Tripp	Winner	57580	1	0	1	100.0	70.3
	Walworth	Akaska	57420	1	0	1	100.0	67.9
		Bowdle	57428	3	0	3	100.0	79.4
		Glenham	57631	5	0	5	100.0	80.5
		Java	57452	2	0	2	100.0	84.7
		Mobridge	57601	206	0	206	100.0	81.8
		Selby	57472	52	0	52	100.0	79.3
Grand Totals				**757**	**0**	**740**	**97.8**	**84.0**

Gastroenterology – Requirement is 60 miles

99.6% of our membership met the 60 mile requirement. There are 1,435 members who live more than 60 miles from a gastroenterologist at an average of 88.0 miles. No further action will be taken at this time as HealthPartners already holds contracts with these area gastroenterology providers.

Members Without Access								
State Name	County	City	Zip Code	Member Counts		Without Access[1]		Average Distance
				#	#	#	%	1
Iowa	Wayne	Allerton	50008	25	0	5	20.0	60.6
		Lineville	50147	7	0	7	100.0	66.8
Minnesota	Cook	Grand Marais	55604	11	0	11	100.0	88.4
		Hovland	55606	1	0	1	100.0	97.6
		Lutsen	55612	3	0	3	100.0	76.2
		Schroeder	55613	4	0	4	100.0	63.1
		Tofte	55615	1	0	1	100.0	69.2
	Koochiching	Big Falls	56627	3	0	3	100.0	67.4
		International Falls	56649	16	0	16	100.0	82.7
		Littlefork	56653	2	0	2	100.0	72.5
	Lake	Finland	55603	1	0	1	100.0	67.7
	St. Louis	Kabetogama	56669	2	0	2	100.0	70.2
Nebraska	Cheyenne	Potter	69156	2	0	2	100.0	66.1
		Sidney	69162	1	0	1	100.0	67.4
	Custer	Anselmo	68813	1	0	1	100.0	64.6
	Holt	Stuart	68780	2	0	2	100.0	73.9
	Hooker	Mullen	69152	1	0	1	100.0	63.5
North Dakota	Barnes	Dazey	58429	6	0	4	66.7	63.1
		Marion	58466	2	0	2	100.0	73.2
		Rogers	58479	8	0	8	100.0	64.6
		Sanborn	58480	4	0	4	100.0	64.7
		Wimbledon	58492	1	0	1	100.0	67.9
	Billings	Belfield	58622	2	0	2	100.0	117.7
	Burke	Flaxton	58737	4	0	4	100.0	68.3
	Dickey	Ellendale	58436	17	0	17	100.0	93.5
		Forbes	58439	1	0	1	100.0	105.3
		Fullerton	58441	7	0	7	100.0	83.8
		Oakes	58474	27	0	27	100.0	71.1
	Divide	Crosby	58730	7	0	7	100.0	102.8
	Golden Valley	Beach	58621	1	0	1	100.0	151.8
	Griggs	Hannaford	58448	5	0	5	100.0	66.0
	Hettinger	New England	58647	3	0	3	100.0	101.3
		Regent	58650	1	0	1	100.0	88.9
	Kidder	Tappen	58487	11	0	2	18.2	60.9
	LaMoure	Dickey	58431	4	0	4	100.0	74.9
		Edgeley	58433	2	0	2	100.0	93.2
		Lamoure	58458	19	0	19	100.0	74.4
		Marion	58466	3	0	3	100.0	70.7
		Montpelier	58472	3	0	3	100.0	86.4
		Verona	58490	3	0	3	100.0	65.1

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Gastroenterology Continued:

Members Without Access								
State Name	County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
				#	#	#	%	1
North Dakota	McIntosh	Zeeland	58581	5	0	5	100.0	67.4
	McKenzie	Alexander	58831	6	0	6	100.0	112.2
		Watford City	58854	42	0	42	100.0	96.5
	Mercer	Golden Valley	58541	1	0	1	100.0	64.5
	Mountrail	Ross	58776	1	0	1	100.0	61.2
		Tioga	58852	1	0	1	100.0	74.0
		White Earth	58794	5	0	5	100.0	69.1
	Rolette	Dunseith	58329	1	0	1	100.0	72.3
	Stark	Belfield	58622	18	0	18	100.0	112.9
		Dickinson	58601	92	0	92	100.0	94.6
			58602	1	0	1	100.0	94.2
		Gladstone	58630	2	0	2	100.0	83.9
		Richardton	58652	5	0	5	100.0	70.5
		South Heart	58655	4	0	4	100.0	103.1
	Stutsman	Cleveland	58424	8	0	8	100.0	78.6
		Courtenay	58426	1	0	1	100.0	68.0
		Jamestown	58401	210	0	210	100.0	83.3
			58402	2	0	2	100.0	83.7
		Medina	58467	1	0	1	100.0	66.0
		Streeter	58483	5	0	5	100.0	67.7
		Woodworth	58496	3	0	3	100.0	67.3
	Williams	Epping	58843	5	0	5	100.0	96.0
		McGregor	58755	2	0	2	100.0	82.0
		Ray	58849	1	0	1	100.0	87.0
		Tioga	58852	19	0	19	100.0	77.0
		Williston	58801	101	0	101	100.0	108.5
			58802	1	0	1	100.0	108.0
			58803	5	0	5	100.0	108.6
South Dakota	Aurora	Plankinton	57368	7	0	7	100.0	78.9
		White Lake	57383	2	0	2	100.0	85.1
	Beadle	Cavour	57324	12	0	12	100.0	84.3
		Huron	57350	41	0	41	100.0	92.3
		Iroquois	57353	2	0	2	100.0	77.6
	Brown	Aberdeen	57401	72	0	72	100.0	105.9
		Columbia	57433	2	0	2	100.0	95.3
		Groton	57445	2	0	2	100.0	89.1
		Hecla	57446	1	0	1	100.0	78.6
		Houghton	57449	4	0	4	100.0	85.5
		Westport	57481	1	0	1	100.0	100.8
	Buffalo	Gann Valley	57341	5	0	5	100.0	108.0

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Gastroenterology Continued:

Members Without Access								
State Name	County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
				#	#	#	%	1
South Dakota	Campbell	Herreid	57632	12	0	12	100.0	75.6
		Java	57452	4	0	4	100.0	90.8
		Mound City	57646	5	0	5	100.0	84.8
		Pollock	57648	2	0	2	100.0	67.0
	Charles Mix	Platte	57369	1	0	1	100.0	80.3
	Clark	Clark	57225	3	0	3	100.0	72.5
		Garden City	57236	1	0	1	100.0	66.2
	Corson	Mc Laughlin	57642	3	0	3	100.0	69.5
		Trail City	57657	6	0	6	100.0	92.1
		Wakpala	57658	2	0	2	100.0	80.3
	Davison	Mitchell	57301	94	0	94	100.0	64.6
		Mount Vernon	57363	16	0	16	100.0	68.2
	Day	Pierpont	57468	1	0	1	100.0	78.7
		Waubay	57273	5	0	5	100.0	65.1
	Dewey	Eagle Butte	57625	1	0	1	100.0	117.3
		Glencross	57630	3	0	3	100.0	94.4
		Isabel	57633	2	0	2	100.0	102.5
		Timber Lake	57656	3	0	3	100.0	96.3
	Edmunds	Bowdle	57428	8	0	8	100.0	110.1
		Ipswich	57451	10	0	10	100.0	121.7
	Faulk	Faulkton	57438	1	0	1	100.0	141.1
		Onaka	57466	1	0	1	100.0	127.1
	Gregory	Burke	57523	1	0	1	100.0	66.5
		Gregory	57533	3	0	3	100.0	60.4
	Haakon	Philip	57567	1	0	1	100.0	78.2
	Hand	Miller	57362	1	0	1	100.0	138.4
		Wessington	57381	1	0	1	100.0	115.3
	Hughes	Blunt	57522	3	0	3	100.0	118.2
		Pierre	57501	21	0	21	100.0	104.4
	Jerauld	Woonsocket	57385	1	0	1	100.0	88.4
	Kingsbury	Iroquois	57353	1	0	1	100.0	77.6
	Lyman	Presho	57568	3	0	3	100.0	70.1
	Marshall	Britton	57430	26	0	26	100.0	64.1
		Langford	57454	2	0	2	100.0	68.5
	McPherson	Leola	57456	3	0	3	100.0	116.3
	Potter	Hoven	57450	1	0	1	100.0	118.8
	Sanborn	Artesian	57314	2	0	2	100.0	60.9
		Letcher	57359	2	0	2	100.0	71.7
	Spink	Conde	57434	1	0	1	100.0	94.4
		Doland	57436	3	0	3	100.0	88.9

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Gastroenterology Continued:

Members Without Access								
State Name	County	City	Zip Code	Member Counts		Without Access[1]		Average Distance
				#	#	#	%	1
South Dakota	Spink	Mellette	57461	2	0	2	100.0	111.2
		Redfield	57469	6	0	6	100.0	115.1
	Stanley	Fort Pierre	57532	6	0	6	100.0	101.6
	Walworth	Akaska	57420	1	0	1	100.0	106.8
		Bowdle	57428	3	0	3	100.0	107.2
		Glenham	57631	5	0	5	100.0	92.2
		Java	57452	2	0	2	100.0	97.7
		Mobridge	57601	206	0	206	100.0	88.7
		Selby	57472	52	0	52	100.0	97.5
Grand Totals				**1,466**	**0**	**1,435**	**97.9**	**88.0**

Ophthalmology – Requirement is 60 miles

99.9 % of our membership met the requirement for an Ophthalmology provider within 60 miles. There are 217 members who live more than 60 miles from an Ophthalmology provider at an average of 86.9 miles. No further action will be taken at this time as HealthPartners already holds contracts with these area ophthalmology providers.

Members Without Access

State Name	County	City	Zip Code	Member #	Counts #	Without Access[1] #	Without Access[1] %	Average Distance 1
Minnesota	Cook	Grand Marais	55604	11	0	11	100.0	90.3
		Hovland	55606	1	0	1	100.0	82.9
		Lutsen	55612	3	0	3	100.0	78.9
		Schroeder	55613	4	0	4	100.0	65.5
		Tofte	55615	1	0	1	100.0	71.8
	Lake	Finland	55603	1	0	1	100.0	67.9
Nebraska	Hooker	Mullen	69152	1	0	1	100.0	63.5
North Dakota	Billings	Belfield	58622	2	0	2	100.0	74.8
	Burke	Flaxton	58737	4	0	4	100.0	69.2
	Golden Valley	Beach	58621	1	0	1	100.0	87.2
	Hettinger	New England	58647	3	0	3	100.0	96.2
		Regent	58650	1	0	1	100.0	84.2
	Mercer	Golden Valley	58541	1	0	1	100.0	61.5
	Stark	Belfield	58622	18	0	18	100.0	94.7
		Dickinson	58601	92	0	92	100.0	90.0
			58602	1	0	1	100.0	89.6
		Gladstone	58630	2	0	2	100.0	79.3
		Richardton	58652	5	0	5	100.0	65.9
		South Heart	58655	4	0	4	100.0	97.7
South Dakota	Corson	Trail City	57657	6	0	6	100.0	61.5
	Dewey	Eagle Butte	57625	1	0	1	100.0	100.2
		Glencross	57630	3	0	3	100.0	65.1
		Isabel	57633	2	0	2	100.0	83.7
		Timber Lake	57656	3	0	3	100.0	71.0
	Haakon	Philip	57567	1	0	1	100.0	78.3
	Hughes	Blunt	57522	3	0	3	100.0	96.7
		Pierre	57501	21	0	21	100.0	104.4
	Lyman	Presho	57568	3	0	3	100.0	70.1
	Potter	Hoven	57450	1	0	1	100.0	64.8
	Stanley	Fort Pierre	57532	6	0	6	100.0	101.6
	Walworth	Akaska	57420	1	0	1	100.0	64.9
		Bowdle	57428	3	0	3	100.0	61.2
		Selby	57472	52	0	7	13.5	61.7
Grand Totals				**262**	**0**	**217**	**82.8**	**86.9**

Surgery – Requirement is 60 miles

99.9 % of our membership met the requirement for Surgeons within 60 miles. There are 9 members who live more than 60 miles from a Surgeon at an average of 66.0 miles. No further action will be taken at this time as HealthPartners already holds contracts with these area surgeons.

Members Without Access

State Name	County	City	Zip Code	Member #	Counts #	Without Access[1] #	Without Access[1] %	Average Distance 1
Minnesota	Cook	Grand Marais	55604	11	0	2	18.2	62.7
		Hovland	55606	1	0	1	100.0	73.2
Nebraska	Hooker	Mullen	69152	1	0	1	100.0	63.5
North Dakota	Burke	Flaxton	58737	4	0	4	100.0	66.0
South Dakota	Haakon	Philip	57567	1	0	1	100.0	68.2
Grand Totals				**18**	**0**	**9**	**50.0**	**66.0**

Chiropractic – Requirement is 60 miles

99.9% of our membership met the requirement for Chiropractors within 60 miles. There are 225 members who live more than 60 miles from a Chiropractor at an average of 83.4 miles. No further action will be taken at this time as HealthPartners already holds contracts with these area Chiropractors.

Members Without Access								
State Name	County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
				#	#	#	%	1
Nebraska	Hooker	Mullen	69152	1	0	1	100.0	60.9
North Dakota	Burke	Flaxton	58737	4	0	4	100.0	66.0
	Divide	Crosby	58730	7	0	7	100.0	100.7
	McKenzie	Alexander	58831	6	0	6	100.0	75.1
		Watford City	58854	42	0	42	100.0	66.5
	Mountrail	Tioga	58852	1	0	1	100.0	72.2
		White Earth	58794	5	0	5	100.0	67.5
	Williams	Epping	58843	5	0	5	100.0	94.5
		McGregor	58755	2	0	2	100.0	80.1
		Ray	58849	1	0	1	100.0	85.4
		Tioga	58852	19	0	19	100.0	75.3
		Williston	58801	101	0	101	100.0	96.9
			58802	1	0	1	100.0	95.2
			58803	5	0	5	100.0	97.9
South Dakota	Haakon	Philip	57567	1	0	1	100.0	66.9
	Hughes	Pierre	57501	21	0	18	85.7	62.6
	Stanley	Fort Pierre	57532	6	0	6	100.0	62.1
Grand Totals				**228**	**0**	**225**	**98.7**	**83.4**

Hospitals – Requirement is 30 miles

99.9% of our membership met the 30 mile requirement. There are 144 members who live more than 30 miles from a hospital at an average of 35.4 miles. No further action will be taken at this time as HealthPartners already hold contracts with these area hospitals.

Members Without Access

State Name	County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
				#	#	#	%	1
Minnesota	Beltrami	Grygla	56727	2	0	2	100.0	40.3
		Northome	56661	1	0	1	100.0	35.3
	Cass	Backus	56435	14	0	2	14.3	30.6
		Hackensack	56452	15	0	10	66.7	32.2
		Longville	56655	37	0	24	64.9	32.7
		Pine River	56474	47	0	3	6.4	31.1
		Walker	56484	59	0	15	25.4	31.6
	Cook	Grand Marais	55604	11	1	1	9.1	37.7
		Schroeder	55613	4	0	4	100.0	34.5
	Koochiching	Big Falls	56627	3	0	3	100.0	31.5
	Lake	Finland	55603	1	0	1	100.0	37.4
	Lake of the Woods	Angle Inlet	56711	4	0	4	100.0	47.3
	Marshall	Grygla	56727	3	0	3	100.0	30.8
Nebraska	Hooker	Mullen	69152	1	0	1	100.0	63.5
North Dakota	Benson	Maddock	58348	4	0	4	100.0	33.0
	Bottineau	Bottineau	58318	1	0	1	100.0	37.6
	Golden Valley	Beach	58621	1	0	1	100.0	55.8
	Kidder	Dawson	58428	6	0	6	100.0	44.1
		Steele	58482	15	0	15	100.0	40.7
		Tappen	58487	11	0	11	100.0	37.3
	LaMoure	Edgeley	58433	2	0	2	100.0	33.1
	McHenry	Anamoose	58710	3	0	3	100.0	35.1
		Balfour	58712	1	0	1	100.0	35.2
	Stutsman	Medina	58467	1	0	1	100.0	30.5
South Dakota	Clark	Clark	57225	3	0	3	100.0	30.1
	Dewey	Eagle Butte	57625	1	0	1	100.0	53.8
		Isabel	57633	2	0	2	100.0	48.7
		Timber Lake	57656	3	0	3	100.0	31.6
	Lyman	Presho	57568	3	0	3	100.0	34.9
Wisconsin	Douglas	Danbury	54830	4	0	1	25.0	31.1
	Price	Ogema	54459	24	0	1	4.2	30.1
	Taylor	Medford	54451	25	0	11	44.0	31.4
Grand Totals				**312**	**1**	**144**	**46.2**	**35.4**

HealthPartners 2022 Service Area Analysis – Ratio Standards*

HealthPartners Commercial Products

HealthPartners Service Area Analysis – Provider Type	Ratio Access Standard	Total Pop.	Provider Counts	Actual Ratio (Provider to Member)	% Pop. Meeting Standard	Member Count-Pop. Meeting Standard	Member Count-Pop.-Not Meeting ratio standard	Action Needed
Primary Care Providers	1 per 1,500 members	*331,778	51,685	1 per 6 members	100%	331,778	0	No
Family Medicine/ General Medicine	1 per 1,500 members	*331,778	37,434	1 per 9 members	100%	331,778	0	No
Internal Medicine – 18 and over	1 per 1,500 members	*287,046	10,549	1 per 27 members	100%	287,046	0	No
Pediatrics – 18 and under	1 per 1,500 members	*44,732	4,971	1 per 9 members	100%	44,732	0	No
Behavioral Health								
Behavioral Health	1 per 10,000 members	*331,778	47,031	1 per 7 members	100%	331,778	0	No
Licensed Marriage and Family Therapists	1 per 10,000 members	*331,778	4,646	1 per 71 members	100%	331,778	0	No
Licensed Psychologists	1 per 10,000 members	*331,778	6,736	1 per 49 members	100%	331,778	0	No
Licensed Social Workers	1 per 10,000 members	*331,778	10,462	1 per 32 members	100%	331,778	0	No
Psychiatrists	1 per 10,000 members	*331,778	4,100	1 per 81 members	100%	331,778	0	No
Specialty Care	1 per 10,000 members	*331,778	329,399	1 per 1 member	100%	331,778	0	No
High Volume Specialists								
Cardiology	1 per 10,000 members	*331,778	12,313	1 per 27 members	100%	331,778	0	No
Ob-Gyn	1 per 10,000 members	*331,778	**10,711**	1 per 31 members	100%	331,778	0	No
Orthopedics	1 per 10,000 members	*331,778	12,385	1 per 27 members	100%	331,778	0	No
Otolaryngology (ENT)	1 per 10,000 members	*331,778	2,465	1 per 135 members	100%	331,778	0	No
High Impact Specialists								
Oncology	1 per 10,000 members	*331,778	7,835	1 per 42 members	100%	331,778	0	No
Additional Specialties Analyzed for Informational Purposes Only								
Dermatology	1 per 10,000 members	*331,778	3,106	1 per 107 members	100%	331,778	0	No
Gastroenterology	1 per 10,000 members	*331,778	4,465	1 per 74 members	100%	331,778	0	No
Ophthalmology	1 per 10,000 members	*331,778	2,982	1 per 111 members	100%	331,778	0	No
Surgery	1 per 10,000 members	*331,778	10,790	1 per 31 members	100%	331,778	0	No
Chiropractic	1 per 10,000 members	*331,778	5,822	1 per 57 members	100%	331,778	0	No

*Ratio standards are in accordance with community standards based on a survey of HMOs in HealthPartners Service Area.

HealthPartners ratio standards have been met for the provider types defined in the “Network Assessment of Practitioner Availability” policy.

HealthPartners Service Area Analysis – Provider Type	Access Standard	Total Pop.	Provider Counts	% Pop. Meeting Standard	Average Distance to a Provider	Member Count- Pop. Meeting Standard	Member Count- Pop. not Meeting standard	Additional information when % Pop. Meeting Standard is not 100%
Primary Care Providers	1 provider within 30 miles	*29,973	6,419	100%	2.4 miles	29,973	0	None
Family/General Medicine	1 provider within 30 miles	*29,973	4,449	100%	2.5 miles	29,973	0	None
Internal Medicine – 18 and over	1 provider within 30 miles	*27,068	687	100%	3.3 miles	27,068	0	None
Pediatrics – 18 and under	1 provider within 30 miles	*2,905	1,306	99.6%	3.3 miles	2,893	12	Yes. See Section II
Behavioral Health								
Behavioral Health	1 provider within 30 miles	*29,973	25,849	100%	1.5 miles	29,973	0	None
Licensed Marriage and Family Therapists	1 provider within 30 miles	*29,973	3,838	100%	1.9 miles	29,973	0	None
Licensed Psychologists	1 provider within 30 miles	*29,973	3,738	100%	2.2 miles	29,973	0	None
Licensed Social Workers	1 provider within 30 miles	*29,973	5,975	100%	2.1 miles	29,973	0	None
Psychiatrists	1 provider within 30 miles	*29,973	1,505	99.9%	3.6 miles	29,968	5	Yes. See Section II
Specialty Care	1 provider within 60 miles	*29,973	58,307	100%	1.3 miles	29,973	0	None
High Volume Specialists								
Cardiology	1 provider within 60 miles	*29,973	1,237	100%	4.1 miles	29,973	0	None
Obstetrics & Gynecology	1 provider within 30 miles	*29,973	2,675	100%	3.0 miles	29,973	0	None
Orthopedics	1 provider within 60 miles	*29,973	2,814	100%	3.0 miles	29,973	0	None
Otolaryngology (ENT)	1 provider within 60 miles	*29,973	264	100%	4.2 miles	29,973	0	None
High Impact Specialists								
Oncology	1 provider within 60 miles	*29,973	1,494	100%	4.8 miles	29,973	0	None
Additional Specialties Analyzed for Informational Purposes Only								
Dermatology	1 provider within 60 miles	*29,973	530	100%	4.4 miles	29,973	0	None
Gastroenterology	1 provider within 60 miles	*29,973	1,166	100%	4.6 miles	29,973	0	None
Ophthalmology	1 provider within 60 miles	*29,973	622	100%	3.9 miles	29,973	0	None
Surgery	1 provider within 60 miles	*29,973	1,573	100%	3.0 miles	29,973	0	None
Chiropractic	1 provider within 60 miles	*29,973	3,392	100%	1.6 miles	29,973	0	None

Hospitals	1 hospital within 30 miles	*29,973	40	100%	5.2 miles	29,973	0	None

**29,973 members live in the service area; those who do not live in the service area are not included in this table.

HealthPartners Minnesota Marketplace Exchange (Peak) Membership Summary

HealthPartners practitioner availability standards have been met for over 99% of the membership for the provider types defined in the "Network Assessment of Practitioner Availability" policy. We investigated how we could meet the standard for all members.

Primary Care – Pediatrics – Requirement is 30 miles

99.6% of our membership met the requirement for a Primary Care provider within 30 miles for Pediatrics. There are 12 members who live more than 30 miles from a Pediatric provider at an average of 33.8 miles. No further action will be taken at this time as HealthPartners already holds contracts with these area primary care providers.

Members Without Access							
County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
			#	#	#	%	1
Stearns, MN	Brooten	56316	2	0	1	50.0	32.4
	Sauk Centre	56378	16	0	11	68.8	34.0
Grand Totals			**18**	**0**	**12**	**66.7**	**33.8**

Behavioral Health – Psychiatry – Requirement is 30 miles

99.9% met the standard for Psychiatrists. There are 2,683 members who live more than 30 miles from a Psychiatry provider at an average of 45.3 miles. HealthPartners has contracts with known behavioral health providers in these rural areas and continues to pursue contracts with behavioral health providers as they become known.

Members Without Access							
County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
			#	#	#	%	1
Stearns, MN	Belgrade	56312	60	0	3	5.0	30.3
	Paynesville	56362	136	0	2	1.5	30.3
Grand Totals			**196**	**0**	**5**	**2.6**	**30.3**

HealthPartners 2022 Service Area Analysis – Ratio Standards*

HealthPartners Minnesota Marketplace Exchange (Peak) Products

HealthPartners Service Area Analysis – Provider Type	Ratio Access Standard	Total Pop.	Provider Counts	Actual Ratio (Provider to Member)	% Pop. Meeting Standard	Member Count-Pop. Meeting Standard	Member Count-Pop.-Not Meeting ratio standard	Action Needed
Primary Care Providers	1 per 1,500 members	*29,973	6,419	1 per 5 members	100%	29,973	0	No
Family Medicine/ General Medicine	1 per 1,500 members	*29,973	4,449	1 per 7 members	100%	29,973	0	No
Internal Medicine – 18 and over	1 per 1,500 members	*27,068	687	1 per 39 members	100%	27,068	0	No
Pediatrics – 18 and under	1 per 1,500 members	*2,905	1,306	1 per 2 members	100%	2,905	0	No
Behavioral Health								
Behavioral Health	1 per 10,000 members	*29,973	25,849	1 per 1 member	100%	29,973	0	No
Licensed Marriage and Family Therapists	1 per 10,000 members	*29,973	3,838	1 per 8 members	100%	29,973	0	No
Licensed Psychologists	1 per 10,000 members	*29,973	3,738	1 per members	100%	29,973	0	No
Licensed Social Workers	1 per 10,000 members	*29,973	5,975	1 per 5 members	100%	29,973	0	No
Psychiatrists	1 per 10,000 members	*29,973	1,505	1 per 20 members	100%	29,973	0	No
Specialty Care	1 per 10,000 members	*29,973	58,307	2 per 1 member	100%	29,973	0	No
High Volume Specialists								
Cardiology	1 per 10,000 members	*29,973	1,237	1 per 24 members	100%	29,973	0	No
Ob-Gyn	1 per 10,000 members	*29,973	2,675	1 per 11 members	100%	29,973	0	No
Orthopedics	1 per 10,000 members	*29,973	2,814	1 per 11 members	100%	29,973	0	No
Otolaryngology (ENT)	1 per 10,000 members	*29,973	264	1 per 114 members	100%	29,973	0	No
High Impact Specialists								
Oncology	1 per 10,000 members	*29,973	1,494	1 per 20 members	100%	29,973	0	No
Additional Specialties Analyzed for Informational Purposes Only								
Dermatology	1 per 10,000 members	*29,973	530	1 per 57 members	100%	29,973	0	No
Gastroenterology	1 per 10,000 members	*29,973	1,166	1 per 26 members	100%	29,973	0	No
Ophthalmology	1 per 10,000 members	*29,973	622	1 per 48 members	100%	29,973	0	No
Surgery	1 per 10,000 members	*29,973	1,573	1 per 19 members	100%	29,973	0	No
Chiropractic	1 per 10,000 members	*29,973	3,392	1 per 9 members	100%	29,973	0	No

*Ratio standards are in accordance with community standards based on a survey of HMOs in HealthPartners Service Area.

HealthPartners ratio standards have been met for the provider types defined in the “Network Assessment of Practitioner Availability” policy.

HealthPartners Service Area Analysis – Provider Type	Access Standard	Total Pop.	Provider Counts	% Pop. Meeting Standard	Average Distance to a Provider	Member Count- Pop. Meeting Standard	Member Count- Pop. not Meeting standard	Additional information when % Pop. Meeting Standard is not 100%
Primary Care Providers	1 provider within 30 miles	*7,829	19,328	100%	2.7 miles	7,829	0	None
Family/General Medicine	1 provider within 30 miles	*7,829	14,592	100%	2.7 miles	7,829	0	None
Internal Medicine – 18 and over	1 provider within 30 miles	*7,057	2,447	100%	3.4 miles	7,057	0	None
Pediatrics – 18 and under	1 provider within 30 miles	*772	2,314	99.4%	4.1 miles	767	5	Yes. See Section II
Behavioral Health								
Behavioral Health	1 provider within 30 miles	*7,829	34,023	100%	2.3 miles	7,829	0	None
Licensed Marriage and Family Therapists	1 provider within 30 miles	*7,829	3,843	99.9%	3.5 miles	7,819	10	Yes. See Section II
Licensed Psychologists	1 provider within 30 miles	*7,829	4,400	100%	3.1 miles	7,829	0	None
Licensed Social Workers	1 provider within 30 miles	*7,829	6,333	100%	2.9 miles	7,829	0	None
Psychiatrists	1 provider within 30 miles	*7,829	2,175	99.9%	4.2 miles	7,827	2	Yes. See Section II
Specialty Care	1 provider within 60 miles	*7,829	133,879	100%	2.0 miles	7,829	0	None
High Volume Specialists								
Cardiology	1 provider within 60 miles	*7,829	4,293	100%	5.0 miles	7,829	0	None
Obstetrics & Gynecology	1 provider within 30 miles	*7,829	5,132	99.9%	3.4 miles	7,826	3	Yes. See Section II
Orthopedics	1 provider within 60 miles	*7,829	5,138	100%	3.5 miles	7,829	0	None
Otolaryngology (ENT)	1 provider within 60 miles	*7,829	843	100%	5.2 miles	7,829	0	None
High Impact Specialists								
Oncology	1 provider within 60 miles	*7,829	3,762	100%	5.5 miles	7,829	0	None
Additional Specialties Analyzed for Informational Purposes Only								
Dermatology	1 provider within 60 miles	*7,829	1,385	100%	6.6 miles	7,829	0	None
Gastroenterology	1 provider within 60 miles	*7,829	1,653	100%	9.8 miles	7,829	0	None
Ophthalmology	1 provider within 60 miles	*7,829	1,096	100%	5.0 miles	7,829	0	None
Surgery	1 provider within 60 miles	*7,829	4,305	100%	3.5 miles	7,829	0	None
Chiropractic	1 provider within 60 miles	*7,829	3,369	100%	2.6 miles	7,829	0	None

Hospitals	1 hospital within 30 miles	*7,829	172	100%	5.6 miles	7,829	0	None

*7,829 members live in the service area; those who do not live in the service area are not included in this table.

HealthPartners Minnesota Marketplace Exchange (Apex) Membership Summary

HealthPartners practitioner availability standards have been met for over 99% of the membership for the provider types defined in the "Network Assessment of Practitioner Availability" policy. We investigated how we could meet the standard for all members.

Primary Care – Pediatrics – Requirement is 30 miles

99.4% of our membership met the requirement for a Primary Care-Pediatrics provider within 30 miles. There are 5 members who live more than 30 miles from a Primary Care provider at an average of 33.7 miles. No further action will be taken at this time as HealthPartners already holds contracts with these area primary care providers.

Members Without Access

County	City	Zip Code	Member #	Counts #	Without Access[1] #	Without Access[1] %	Average Distance 1	Average Distance 2
Stevens, MN	Chokio	56221	1	0	1	100.0	40.8	40.8
	Hancock	56244	3	0	3	100.0	32.0	32.0
	Morris	56267	1	0	1	100.0	31.8	31.8
Grand Totals			**5**	**0**	**5**	**100.0**	**33.7**	**33.7**

Behavioral Health – Licensed Marriage & Family Therapy – Requirement is 30 miles

99.9% met the standard for Marriage and Family Therapists. There are 10 members who live more than 30 miles from a Licensed Marriage and Family Therapy provider at an average of 34.8 miles. HealthPartners has contracts with known behavioral health providers in these rural areas and continues to pursue contracts with behavioral health providers as they become known.

Members Without Access

County	City	Zip Code	Member #	Counts #	Without Access[1] #	Without Access[1] %	Average Distance 1	Average Distance 2
Lincoln, MN	Hendricks	56136	2	0	2	100.0	31.6	34.6
St. Louis, MN	Ely	55731	2	0	2	100.0	40.8	40.8
Traverse, MN	Wheaton	56296	6	0	6	100.0	32.4	32.9
Grand Totals			**10**	**0**	**10**	**100.0**	**33.9**	**34.8**

Behavioral Health – Psychiatry – Requirement is 30 miles

99.9% met the standard for Psychiatrists. There are 2 members who live more than 30 miles from a Psychiatry provider at an average of 41.1 miles. HealthPartners has contracts with known behavioral health providers in these rural areas and continues to pursue contracts with behavioral health providers as they become known.

Members Without Access

County	City	Zip Code	Member #	Counts #	Without Access[1] #	Without Access[1] %	Average Distance 1	Average Distance 2
St. Louis, MN	Ely	55731	2	0	2	100.0	41.1	41.6
Grand Totals			**2**	**0**	**2**	**100.0**	**41.1**	**41.6**

Obstetrics & Gynecology (OB-GYN) – Requirement is 30 miles

99.9% of our membership met the 30 mile requirement. There are 3 members who live more than 30 miles from an obstetrician and gynecologist at an average of 34.2 miles; however there are primary care providers within the standard 30 miles that also provide obstetrics and gynecology services.

Members Without Access								
County	City	Zip Code	Member Counts		Without Access[1]		Average Distance	
			#	#	#	%	1	2
Jackson, MN	Alpha	56111	2	0	2	100.0	36.2	36.2
	Jackson	56143	1	0	1	100.0	30.1	30.1
Grand Totals			3	0	3	100.0	34.2	34.2

HealthPartners 2022 Service Area Analysis – Ratio Standards*

HealthPartners Minnesota Marketplace Exchange (Apex) Products

HealthPartners Service Area Analysis – Provider Type	Ratio Access Standard	Total Pop.	Provider Counts	Actual Ratio (Provider to Member)	% Pop. Meeting Standard	Member Count-Pop. Meeting Standard	Member Count-Pop.-Not Meeting ratio standard	Action Needed
Primary Care Providers	1 per 1,500 members	*7,829	19,328	3 per 1 member	100%	7,829	0	No
Family Medicine/ General Medicine	1 per 1,500 members	*7,829	14,592	2 per 1 member	100%	7,829	0	No
Internal Medicine – 18 and over	1 per 1,500 members	*7,057	2,447	1 per 3 members	100%	7,057	0	No
Pediatrics – 18 and under	1 per 1,500 members	*772	2,314	3 per 1 member	100%	772	0	No
Behavioral Health								
Behavioral Health	1 per 10,000 members	*7,829	34,023	4 per 1 member	100%	7,829	0	No
Licensed Marriage and Family Therapists	1 per 10,000 members	*7,829	3,843	1 per 2 members	100%	7,829	0	No
Licensed Psychologists	1 per 10,000 members	*7,829	4,400	1 per 2 members	100%	7,829	0	No
Licensed Social Workers	1 per 10,000 members	*7,829	6,333	1 per 1 member	100%	7,829	0	No
Psychiatrists	1 per 10,000 members	*7,829	2,175	1 per 4 members	100%	7,829	0	No
Specialty Care	1 per 10,000 members	*7,829	133,879	17 per 1 member	100%	7,829	0	No
High Volume Specialists								
Cardiology	1 per 10,000 members	*7,829	4,293	1 per 2 members	100%	7,829	0	No
Ob-Gyn	1 per 10,000 members	*7,829	5,132	1 per 1 member	100%	7,829	0	No
Orthopedics	1 per 10,000 members	*7,829	5,138	1 per 1 member	100%	7,829	0	No
Otolaryngology (ENT)	1 per 10,000 members	*7,829	843	1 per 9 members	100%	7,829	0	No
High Impact Specialists								
Oncology	1 per 10,000 members	*7,829	3,762	1 per 2 members	100%	7,829	0	No
Additional Specialties Analyzed for Informational Purposes Only								
Dermatology	1 per 10,000 members	*7,829	1,385	1 per 6 members	100%	7,829	0	No
Gastroenterology	1 per 10,000 members	*7,829	1,653	1 per 5 members	100%	7,829	0	No
Ophthalmology	1 per 10,000 members	*7,829	1,096	1 per 7 members	100%	7,829	0	No
Surgery	1 per 10,000 members	*7,829	4,305	1 per 2 members	100%	7,829	0	No
Chiropractic	1 per 10,000 members	*7,829	1,385	1 per 6 members	100%	7,829	0	No

*Ratio standards are in accordance with community standards based on a survey of HMOs in HealthPartners Service Area.

HealthPartners ratio standards have been met for the provider types defined in the "Network Assessment of Practitioner Availability" policy.

Summary of Analysis and Interventions **Geographic Standards - Results**

HealthPartners Wisconsin Marketplace Exchange (Atlas) Products **2022 Service Area analysis – Geographic Standards**

HealthPartners Service Area Analysis – Provider Type	Access Standard	Total Pop.	Provider Counts	% Pop. Meeting Standard	Average Distance to a Provider	Member Count- Pop. Meeting Standard	Member Count- Pop. not Meeting standard	Additional information when % Pop. Meeting Standard is not 100%
Primary Care Providers	1 provider within 30 miles	*5,512	8,960	100%	4.2 miles	5,512	0	None
Family/General Medicine	1 provider within 30 miles	*5,512	6,266	100%	4.2 miles	5,512	0	None
Internal Medicine – 18 and over	1 provider within 30 miles	*5,188	1,240	99.6%	5.1 miles	5,167	21	Yes. See Section II
Pediatrics – 18 and under	1 provider within 30 miles	*324	1,478	98.1%	5.3 miles	318	6	Yes. See Section II
Behavioral Health								
Behavioral Health	1 provider within 30 miles	*5,512	25,994	100%	3.5 miles	5,512	0	None
Licensed Marriage and Family Therapists	1 provider within 30 miles	*5,512	3,826	99.8%	4.7 miles	5,501	11	Yes. See Section II
Licensed Psychologists	1 provider within 30 miles	*5,512	3,807	100%	4.6 miles	5,512	0	None
Licensed Social Workers	1 provider within 30 miles	*5,512	6,018	99.8%	4.3 miles	5,501	11	Yes. See Section II
Psychiatrists	1 provider within 30 miles	*5,512	1,615	99.7%	5.5 miles	5,493	19	Yes. See Section II
Specialty Care	1 provider within 60 miles	*5,512	81,411	100%	2.8 miles	5,512	0	None
High Volume Specialists								
Cardiology	1 provider within 60 miles	*5,512	1,716	100%	7.3 miles	5,512	0	None
Obstetrics & Gynecology	1 provider within 30 miles	*5,512	3,265	99.9%	4.6 miles	5,504	8	Yes. See Section II
Orthopedics	1 provider within 60 miles	*5,512	3,200	100%	4.6 miles	5,512	0	None
Otolaryngology (ENT)	1 provider within 60 miles	*5,512	354	100%	7.3 miles	5,512	0	None
High Impact Specialists								
Oncology	1 provider within 60 miles	*5,512	1,679	100%	5.7 miles	5,512	0	None
Additional Specialties Analyzed for Informational Purposes Only								
Dermatology	1 provider within 60 miles	*5,512	869	100%	11.0 miles	5,512	0	None
Gastroenterology	1 provider within 60 miles	*5,512	1,259	100%	7.2 miles	5,512	0	None
Ophthalmology	1 provider within 60 miles	*5,512	683	100%	7.7 miles	5,512	0	None
Surgery	1 provider within 60 miles	*5,512	2,173	100%	5.7 miles	5,512	0	None
Chiropractic	1 provider within 60 miles	*5,512	3,122	100%	3.6 miles	5,512	0	None
Hospitals	1 hospital within 30 miles	*5,512	59	99.2%	5.9 miles	5,467	45	Yes. See Section II

*5,512 members live in the service area; those who do not live in the service area are not included in this table.

HealthPartners Wisconsin Marketplace Exchange (Atlas) Membership Summary

HealthPartners practitioner availability standards have been met for the membership for the provider types defined in the "Network Assessment of Practitioner Availability" policy.

Primary Care – Internal Medicine – Requirement is 30 miles

99.6% of our membership met the requirement for a Primary Care-Internal Medicine provider within 30 miles. There are 21 members who live more than 30 miles from a Primary Care provider at an average of 31.5 miles. No further action will be taken at this time as HealthPartners already holds contracts with these area primary care providers.

Members Without Access							
County	City	Zip Code	Member #	Counts #	Without Access[1] #	Without Access[1] %	Average Distance 1
Burnett, WI	Danbury	54830	68	0	18	26.5	31.4
	Spooner	54801	5	0	2	40.0	30.8
Douglas, WI	Danbury	54830	1	0	1	100.0	35.7
Grand Totals			**74**	**0**	**21**	**28.4**	**31.5**

Primary Care – Pediatrics – Requirement is 30 miles

98.1% of our membership met the requirement for a Primary Care provider within 30 miles for Pediatrics. There are 6 members who live more than 30 miles from a Pediatric provider at an average of 39.8 miles. No further action will be taken at this time as HealthPartners already holds contracts with these area primary care providers.

Members Without Access							
County	City	Zip Code	Member #	Counts #	Without Access[1] #	Without Access[1] %	Average Distance 1
Burnett, WI	Danbury	54830	4	0	4	100.0	42.1
	Webster	54893	2	0	2	100.0	35.4
Grand Totals			**6**	**0**	**6**	**100.0**	**39.8**

Behavioral Health – Licensed Marriage & Family Therapy – Requirement is 30 miles

99.8% met the standard for Marriage and Family Therapists. There are 11 members who live more than 30 miles from a Licensed Marriage and Family Therapy provider at an average of 32.2 miles. HealthPartners has contracts with known behavioral health providers in these rural areas and continues to pursue contracts with behavioral health providers as they become known.

Members Without Access							
County	City	Zip Code	Member #	Counts #	Without Access[1] #	Without Access[1] %	Average Distance 1
Douglas, WI	Gordon	54838	16	0	7	43.8	31.5
	Solon Springs	54873	19	0	4	21.1	33.3
Grand Totals			**35**	**0**	**11**	**31.4**	**32.2**

Behavioral Health – Licensed Social Workers – Requirement is 30 miles

99.8% met the standard for Social Workers. There are 11 members who live more than 30 miles from a Social Work provider at an average of 32.2 miles. HealthPartners has contracts with known behavioral health providers in these rural areas and continues to pursue contracts with behavioral health providers as they become known.

Members Without Access							
County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
			#	#	#	%	1
Douglas, WI	Gordon	54838	16	0	7	43.8	31.5
	Solon Springs	54873	19	0	4	21.1	33.3
Grand Totals			35	0	11	31.4	32.2

Behavioral Health – Psychiatry – Requirement is 30 miles

99.7% met the standard for Psychiatrists. There are 19 members who live more than 30 miles from a Psychiatry provider at an average of 33.2 miles. HealthPartners has contracts with known behavioral health providers in these rural areas and continues to pursue contracts with behavioral health providers as they become known.

Members Without Access							
County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
			#	#	#	%	1
Douglas, WI	Gordon	54838	16	0	14	87.5	32.9
	Solon Springs	54873	19	0	4	21.1	34.7
	Wascott	54890	1	0	1	100.0	30.5
Grand Totals			36	0	19	52.8	33.2

Obstetrics & Gynecology (OB-GYN) – Requirement is 30 miles

99.9% of our membership met the requirement for an Ob-Gyn provider within 30 miles. There are 8 members who live more than 30 miles from an Ob-Gyn provider at an average of 32.7 miles; however there are primary care providers within the standard 30 miles that also provide obstetrics and gynecology services.

Members Without Access							
County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
			#	#	#	%	1
Douglas, WI	Gordon	54838	16	0	4	25.0	31.3
	Solon Springs	54873	19	0	4	21.1	34.0
Grand Totals			35	0	8	22.9	32.7

Hospitals – Requirement is 30 miles

99.2% of our membership met the 30 mile requirement. There are 45 members who live more than 30 miles from a Hospital at an average of 33.5 miles. No further action will be taken at this time as HealthPartners already hold contracts with these area hospitals.

Members Without Access							
County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
			#	#	#	%	1
Burnett, WI	Danbury	54830	72	0	19	26.4	31.5
	Spooner	54801	5	0	4	80.0	31.6
Douglas, WI	Danbury	54830	1	0	1	100.0	32.3
	Gordon	54838	16	0	16	100.0	35.8
	Solon Springs	54873	19	0	4	21.1	34.8
	Wascott	54890	1	0	1	100.0	37.1
Grand Totals			114	0	45	39.5	33.5

HealthPartners 2022 Service Area Analysis – Ratio Standards*

HealthPartners Wisconsin Marketplace Exchange (Atlas) Products

HealthPartners Service Area Analysis – Provider Type	Ratio Access Standard	Total Pop.	Provider Counts	Actual Ratio (Provider to Member)	% Pop. Meeting Standard	Member Count-Pop. Meeting Standard	Member Count-Pop.-Not Meeting ratio standard	Action Needed
Primary Care Providers	1 per 1,500 members	*5,512	8,960	2 per 1 member	100%	5,512	0	No
Family Medicine/ General Medicine	1 per 1,500 members	*5,512	6,266	1 per 1 member	100%	5,512	0	No
Internal Medicine – 18 and over	1 per 1,500 members	*5,188	1,240	1 per 4 members	100%	5,188	0	No
Pediatrics – 18 and under	1 per 1,500 members	*324	1,478	5 per 1 member	100%	324	0	No
Behavioral Health								
Behavioral Health	1 per 10,000 members	*5,512	25,994	5 per 5 members	100%	5,512	0	No
Licensed Marriage and Family Therapists	1 per 10,000 members	*5,512	3,826	1 per 1 member	100%	5,512	0	No
Licensed Psychologists	1 per 10,000 members	*5,512	3,807	1 per 1 member	100%	5,512	0	No
Licensed Social Workers	1 per 10,000 members	*5,512	6,018	1 per 1 member	100%	5,512	0	No
Psychiatrists	1 per 10,000 members	*5,512	1,615	1 per 3 members	100%	5,512	0	No
Specialty Care	1 per 10,000 members	*5,512	81,411	15 per 1 member	100%	5,512	0	No
High Volume Specialists								
Cardiology	1 per 10,000 members	*5,512	1,716	1 per 3 members	100%	5,512	0	No
Ob-Gyn	1 per 10,000 members	*5,512	3,265	1 per 2 members	100%	5,512	0	No
Orthopedics	1 per 10,000 members	*5,512	3,200	1 per 2 members	100%	5,512	0	No
Otolaryngology (ENT)	1 per 10,000 members	*5,512	354	1 per 16 members	100%	5,512	0	No
High Impact Specialists								
Oncology	1 per 10,000 members	*5,512	1,679	1 per 3 members	100%	5,512	0	No
Additional Specialties Analyzed for Informational Purposes Only								
Dermatology	1 per 10,000 members	*5,512	869	1 per 6 members	100%	5,512	0	No
Gastroenterology	1 per 10,000 members	*5,512	1,259	1 per 4 members	100%	5,512	0	No
Ophthalmology	1 per 10,000 members	*5,512	683	1 per 8 members	100%	5,512	0	No
Surgery	1 per 10,000 members	*5,512	2,173	1 per 3 members	100%	5,512	0	No
Chiropractic	1 per 10,000 members	*5,512	3,122	1 per 2 members	100%	5,512	0	No

*Ratio standards are in accordance with community standards based on a survey of HMOs in HealthPartners Service Area.

HealthPartners ratio standards have been met for the provider types defined in the "Network Assessment of Practitioner Availability" policy.

HealthPartners Service Area Analysis – Provider Type	Access Standard	Total Pop.	Provider Counts	% Pop. Meeting Standard	Average Distance to a Provider	Member Count- Pop. Meeting Standard	Member Count- Pop. not Meeting standard	Additional information when % Pop. Meeting Standard is not 100%
Primary Care Providers	1 provider within 30 miles	*722	27,118	99.3%	3.6 miles	717	5	Yes. See Section II
Family/General Medicine	1 provider within 30 miles	*722	20,963	99.3%	3.6 miles	717	5	Yes. See Section II
Internal Medicine – 18 and over	1 provider within 30 miles	*690	3,293	99.3%	6.3 miles	685	5	Yes. See Section II
Pediatrics – 18 and under	1 provider within 30 miles	*32	2,889	100.0%	5.1 miles	32	0	None
Behavioral Health								
Behavioral Health	1 provider within 30 miles	*722	42,408	100.0%	3.7 miles	722	0	None
Licensed Marriage and Family Therapists	1 provider within 30 miles	*722	4,226	87.5%	9.8 miles	632	90	Yes. See Section II
Licensed Psychologists	1 provider within 30 miles	*722	5,762	98.6%	8.6 miles	712	10	Yes. See Section II
Licensed Social Workers	1 provider within 30 miles	*722	8,515	100.0%	6.2 miles	722	0	None
Psychiatrists	1 provider within 30 miles	*722	3,315	95.7%	7.2 miles	691	31	Yes. See Section II
Specialty Care	1 provider within 60 miles	*722	227,158	100.0%	2.2 miles	722	0	None
High Volume Specialists								
Cardiology	1 provider within 60 miles	*722	8,118	100.0%	5.7 miles	722	0	None
Obstetrics & Gynecology	1 provider within 30 miles	*722	7,600	99.9%	6.1 miles	721	1	Yes. See Section II
Orthopedics	1 provider within 60 miles	*722	8,600	100.0%	5.5 miles	722	0	None
Otolaryngology (ENT)	1 provider within 60 miles	*722	1,593	100.0%	7.6 miles	722	0	None
High Impact Specialists								
Oncology	1 provider within 60 miles	*722	6,399	100.0%	8.1 miles	722	0	None
Additional Specialties Analyzed for Informational Purposes Only								
Dermatology	1 provider within 60 miles	*722	2,319	100.0%	7.0 miles	722	0	None
Gastroenterology	1 provider within 60 miles	*722	2,529	100.0%	11.7 miles	722	0	None
Ophthalmology	1 provider within 60 miles	*722	2,014	100.0%	10.0 miles	722	0	None
Surgery	1 provider within 60 miles	*722	7,943	100.0%	6.4 miles	722	0	None
Chiropractic	1 provider within 60 miles	*722	3,135	100.0%	4.2 miles	722	0	None
Hospitals	1 hospital within 30 miles	*722	406	97.5%	7.6 miles	704	18	Yes. See Section II

*722 members live in the service area; those who do not live in the service area are not included in this table.

HealthPartners Wisconsin Marketplace Exchange (Robin Oak) Membership Summary

HealthPartners practitioner availability standards have been met for over 99% of the membership for the provider types defined in the "Network Assessment of Practitioner Availability" policy. We investigated how we could meet the standard for all members.

Primary Care – Requirement is 30 miles

99.3% of our membership met the requirement for a Primary Care provider within 30 miles. There are 5 members who live more than 30 miles from a Primary Care provider at an average of 38.2 miles. No further action will be taken at this time as HealthPartners already holds contracts with these area primary care providers.

Members Without Access								
County	City	Zip Code	Member Counts		Without Access[1]		Average Distance	
			#	#	#	%	1	2
Florence, WI	Florence	54121	4	0	4	100.0	38.2	38.2
	Niagara	54151	1	0	1	100.0	38.1	38.1
Grand Totals			**5**	**0**	**5**	**100.0**	**38.2**	**38.2**

Each category of primary care was also analyzed independently.

Primary Care-Family & General Medicine – Requirement is 30 miles

99.3% of our membership met the requirement for a Primary Care-Family & General Medicine provider within 30 miles. There are 5 members who live more than 30 miles from a Primary Care provider at an average of 38.2 miles. No further action will be taken at this time as HealthPartners already holds contracts with these area primary care providers.

Members Without Access								
County	City	Zip Code	Member Counts		Without Access[1]		Average Distance	
			#	#	#	%	1	2
Florence, WI	Florence	54121	4	0	4	100.0	38.2	38.2
	Niagara	54151	1	0	1	100.0	38.1	38.1
Grand Totals			**5**	**0**	**5**	**100.0**	**38.2**	**38.2**

Primary Care – Internal Medicine – Requirement is 30 miles

99.3% of our membership met the requirement for a Primary Care-Internal Medicine provider within 30 miles. There are 5 members who live more than 30 miles from a Primary Care provider at an average of 40.5 miles. No further action will be taken at this time as HealthPartners already holds contracts with these area primary care providers.

Members Without Access								
County	City	Zip Code	Member Counts		Without Access[1]		Average Distance	
			#	#	#	%	1	2
Florence, WI	Florence	54121	4	0	4	100.0	40.6	40.6
	Niagara	54151	1	0	1	100.0	39.9	41.1
Grand Totals			**5**	**0**	**5**	**100.0**	**40.5**	**40.7**

Behavioral Health – Licensed Marriage & Family Therapy – Requirement is 30 miles

87.5% met the standard for Marriage and Family Therapists. There are 90 members who live more than 30 miles from a Licensed Marriage and Family Therapy provider at an average of 38.4 miles. HealthPartners has contracts with known behavioral health providers in these rural areas and continues to pursue contracts with behavioral health providers as they become known.

Members Without Access								
County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance	
			#	#	#	%	1	2
Florence, WI	Florence	54121	4	0	4	100.0	49.1	68.6
	Niagara	54151	1	0	1	100.0	54.8	66.2
Kewaunee, WI	Algoma	54201	2	0	2	100.0	30.3	33.8
Marinette, WI	Athelstane	54104	4	0	4	100.0	49.2	61.0
	Crivitz	54114	7	0	7	100.0	51.7	53.3
	Dunbar	54119	2	0	2	100.0	58.9	60.2
	Marinette	54143	2	0	2	100.0	45.0	47.2
	Pembine	54156	2	0	2	100.0	65.8	67.6
	Peshtigo	54157	2	0	2	100.0	43.8	45.6
	Wausaukee	54177	1	0	1	100.0	62.3	62.5
Menominee, WI	Gillett	54124	3	0	3	100.0	35.8	35.8
	Keshena	54135	33	0	33	100.0	32.3	36.5
Oconto, WI	Crivitz	54114	2	0	2	100.0	38.7	55.8
	Gillett	54124	4	0	2	50.0	32.4	32.4
	Lakewood	54138	2	0	2	100.0	31.3	53.4
	Mountain	54149	6	0	6	100.0	33.5	53.3
	Oconto	54153	3	0	1	33.3	33.9	35.7
	Suring	54174	5	0	5	100.0	38.5	40.6
Shawano, WI	Shawano	54166	23	0	9	39.1	32.0	32.9
Grand Totals			**108**	**0**	**90**	**83.3**	**38.4**	**44.2**

Behavioral Health – Licensed Psychologists – Requirement is 30 miles

98.6% met the standard for Psychologists. There are 10 members who live more than 30 miles from a Psychologist provider at an average of 36.9 miles. HealthPartners has contracts with known behavioral health providers in these rural areas and continues to pursue contracts with behavioral health providers as they become known.

Members Without Access								
County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance	
			#	#	#	%	1	2
Florence, WI	Florence	54121	4	0	4	100.0	38.2	38.2
	Niagara	54151	1	0	1	100.0	38.1	38.1
Marinette, WI	Athelstane	54104	4	0	1	25.0	30.1	30.9
	Dunbar	54119	2	0	2	100.0	36.4	36.4
	Pembine	54156	2	0	2	100.0	37.7	37.7
Grand Totals			**13**	**0**	**10**	**76.9**	**36.9**	**37.0**

Behavioral Health – Psychiatry – Requirement is 30 miles

95.7% met the standard for Psychiatrists. There are 31 members who live more than 30 miles from a Psychiatry provider at an average of 36.9 miles. HealthPartners has contracts with known behavioral health providers in these rural areas and continues to pursue contracts with behavioral health providers as they become known.

Members Without Access								
County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance	
			#	#	#	%	1	2
Marinette, WI	Athelstane	54104	4	0	4	100.0	35.0	38.6
	Crivitz	54114	7	0	7	100.0	42.3	42.3
	Dunbar	54119	2	0	2	100.0	36.4	37.6
	Marinette	54143	2	0	2	100.0	42.4	42.4
	Pembine	54156	2	0	2	100.0	40.4	42.3
	Peshtigo	54157	2	0	2	100.0	41.2	41.2
	Wausaukee	54177	1	0	1	100.0	47.2	48.2
Marquette, WI	Montello	53949	3	0	1	33.3	31.5	32.0
	Westfield	53964	7	0	4	57.1	30.7	37.4
Oconto, WI	Crivitz	54114	2	0	2	100.0	32.7	34.1
	Mountain	54149	6	0	3	50.0	30.3	30.4
	Oconto	54153	3	0	1	33.3	31.3	31.3
Grand Totals			**41**	**0**	**31**	**75.6**	**36.9**	**38.6**

Obstetrics & Gynecology (OB-GYN) – Requirement is 30 miles

99.9% of our membership met the requirement for an Ob-Gyn provider within 30 miles. There is 1 member who lives more than 30 miles from an Ob-Gyn provider at an average of 31.6 miles; however there are primary care providers within the standard 30 miles that also provide obstetrics and gynecology services. No further action will be taken at this time as HealthPartners already holds contracts with these area Ob-Gyn providers.

Members Without Access								
County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance	
			#	#	#	%	1	2
Florence, WI	Niagara	54151	1	0	1	100.0	31.6	31.6
Grand Totals			**1**	**0**	**1**	**100.0**	**31.6**	**31.6**

Hospitals – Requirement is 30 miles

97.5% of our membership met the 30 mile requirement. There are 18 members who live more than 30 miles from a hospital at an average of 34.2 miles. No further action will be taken at this time as HealthPartners already hold contracts with these area hospitals.

Members Without Access								
County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance	
			#	#	#	%	1	2
Florence, WI	Niagara	54151	1	0	1	100.0	32.2	55.1
Marinette, WI	Athelstane	54104	4	0	4	100.0	34.0	34.4
	Dunbar	54119	2	0	2	100.0	41.9	42.2
	Pembine	54156	2	0	2	100.0	38.4	38.6
Marquette, WI	Montello	53949	3	0	1	33.3	31.1	31.5
Oconto, WI	Crivitz	54114	2	0	2	100.0	33.8	35.6
	Lakewood	54138	2	0	2	100.0	31.7	31.7
	Mountain	54149	6	0	4	66.7	31.2	32.2
Grand Totals			**22**	**0**	**18**	**81.8**	**34.2**	**36.1**

HealthPartners 2022 Service Area Analysis – Ratio Standards*

Robin Oak Products

HealthPartners Service Area Analysis – Provider Type	Ratio Access Standard	Total Pop.	Provider Counts	Actual Ratio (Provider to Member)	% Pop. Meeting Standard	Member Count-Pop. Meeting Standard	Member Count-Pop.-Not Meeting ratio standard	Action Needed
Primary Care Providers	1 per 1,500 members	*722	27,118	38 per 1 member	100.0%	722	0	No
Family Medicine/ General Medicine	1 per 1,500 members	*722	20,963	29 per 1 member	100.0%	722	0	No
Internal Medicine – 18 and over	1 per 1,500 members	*690	3,293	5 per 1 member	100.0%	722	0	No
Pediatrics – 18 and under	1 per 1,500 members	*32	2,889	90 per 1 member	100.0%	722	0	No
Behavioral Health								
Behavioral Health	1 per 10,000 members	*722	42,408	59 per 1 member	100.0%	722	0	No
Licensed Marriage and Family Therapists	1 per 10,000 members	*722	4,226	6 per 1 member	100.0%	722	0	No
Licensed Psychologists	1 per 10,000 members	*722	5,762	8 per 1 member	100.0%	722	0	No
Licensed Social Workers	1 per 10,000 members	*722	8,515	12 per 1 member	100.0%	722	0	No
Psychiatrists	1 per 10,000 members	*722	3,315	5 per 1 member	100.0%	722	0	No
Specialty Care	1 per 10,000 members	*722	227,158	315 per 1 member	100.0%	722	0	No
High Volume Specialists								
Cardiology	1 per 10,000 members	*722	8,118	12 per 1 member	100.0%	722	0	No
Ob-Gyn	1 per 10,000 members	*722	7,600	11 per 1 member	100.0%	722	0	No
Orthopedics	1 per 10,000 members	*722	8,600	12 per 1 member	100.0%	722	0	No
Otolaryngology (ENT)	1 per 10,000 members	*722	1,593	2 per 1 member	100.0%	722	0	No
High Impact Specialists								
Oncology	1 per 10,000 members	*722	6,399	9 per 1 member	100.0%	722	0	No
Additional Specialties Analyzed for Informational Purposes Only								
Dermatology	1 per 10,000 members	*722	2,319	3 per 1 member	100.0%	722	0	No
Gastroenterology	1 per 10,000 members	*722	2,529	4 per 1 member	100.0%	722	0	No
Ophthalmology	1 per 10,000 members	*722	2,014	3 per 1 member	100.0%	722	0	No
Surgery	1 per 10,000 members	*722	7,943	11 per 1 member	100.0%	722	0	No
Chiropractic	1 per 10,000 members	*722	3,135	4 per 1 member	100.0%	722	0	No

*Ratio standards are in accordance with community standards based on a survey of HMOs in HealthPartners Service Area.

HealthPartners ratio standards have been met for the provider types defined in the "Network Assessment of Practitioner Availability" policy.

HealthPartners Service Area Analysis – Provider Type	Access Standard	Total Pop.	Provider Counts	% Pop. Meeting Standard	Average Distance to a Provider	Member Count- Pop. Meeting Standard	Member Count- Pop. not Meeting standard	Additional information when % Pop. Meeting Standard is not 100%
Primary Care Providers	1 provider within 30 miles	*7,742	5,330	99.8%	3.8 miles	7,723	19	Yes. See Section II
Family/General Medicine	1 provider within 30 miles	*7,742	4,445	99.8%	3.8 miles	7,723	19	Yes. See Section II
Internal Medicine – 18 and over	1 provider within 30 miles	*7,742	530	92.2%	7.3 miles	7,138	604	Yes. See Section II
Pediatrics – 18 and under	1 provider within 30 miles	*0	355	0%	n/a	0	0	None
Behavioral Health								
Behavioral Health	1 provider within 30 miles	*7,742	3,982	99.9%	3.8 miles	7,737	5	Yes. See Section II
Licensed Marriage and Family Therapists	1 provider within 30 miles	*7,742	98	84.4%	7.8 miles	6,537	1,205	Yes. See Section II
Licensed Psychologists	1 provider within 30 miles	*7,742	883	94.9%	7.3 miles	7,349	393	Yes. See Section II
Licensed Social Workers	1 provider within 30 miles	*7,742	978	99.2%	5.0 miles	7,678	64	Yes. See Section II
Psychiatrists	1 provider within 30 miles	*7,742	800	94.6%	6.9 miles	7,323	419	Yes. See Section II
Specialty Care	1 provider within 60 miles	*7,742	40,697	100%	2.1 miles	7,742	0	None
High Volume Specialists								
Cardiology	1 provider within 60 miles	*7,742	1,810	100%	4.8 miles	7,742	0	None
Obstetrics & Gynecology	1 provider within 30 miles	*7,742	1,537	97.1%	5.8 miles	7,518	224	Yes. See Section II
Orthopedics	1 provider within 60 miles	*7,742	2,037	100%	4.1 miles	7,742	0	None
Otolaryngology (ENT)	1 provider within 60 miles	*7,742	342	100%	8.1 miles	7,742	0	None
High Impact Specialists								
Oncology	1 provider within 60 miles	*7,742	1,264	100%	6.5 miles	7,742	0	None
Additional Specialties Analyzed for Informational Purposes Only								
Dermatology	1 provider within 60 miles	*7,742	598	100%	6.1 miles	7,742	0	None
Gastroenterology	1 provider within 60 miles	*7,742	500	100%	9.1 miles	7,742	0	None
Ophthalmology	1 provider within 60 miles	*7,742	569	100%	6.8 miles	7,742	0	None
Surgery	1 provider within 60 miles	*7,742	1,868	100%	4.7 miles	7,742	0	None
Chiropractic	1 provider within 60 miles	*7,742	247	100%	5.4 miles	7,742	0	None
Hospitals	1 hospital within 30 miles	*7,742	125	99.8%	5.9 miles	7,726	16	Yes. See Section II

*7,742 members live in the service area; those who do not live in the service area are not included in this table.

HealthPartners UnityPoint Medicare Advantage Membership Summary

HealthPartners practitioner availability standards have been met for over 98% of the membership for the provider types defined in the "Network Assessment of Practitioner Availability" policy. We investigated how we could meet the standard for all members.

Primary Care – Requirement is 30 miles

99.8% of our membership met the requirement for a Primary Care provider within 30 miles. There are 19 members who live more than 30 miles from a Primary Care provider at an average of 33.2 miles. No further action will be taken at this time as HealthPartners already holds contracts with these area primary care providers.

Members Without Access								
State Abbr	County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
				#	#	#	%	1
IA	Washington	Brighton	52540	1	0	1	100.0	38.3
		Washington	52353	15	0	15	100.0	33.1
		Wayland	52654	1	0	1	100.0	34.1
IL	Fulton	Astoria	61501	2	0	2	100.0	30.5
Grand Tot...				**19**	**0**	**19**	**100.0**	**33.2**

Each category of primary care was also analyzed independently.

Primary Care-Family & General Medicine – Requirement is 30 miles

99.8% of our membership met the requirement for a Primary Care-Family & General Medicine provider within 30 miles. There are 19 members who live more than 30 miles from a Primary Care provider at an average of 33.2 miles. No further action will be taken at this time as HealthPartners already holds contracts with these area primary care providers.

Members Without Access								
State Name	County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
				#	#	#	%	1
Illinois	Fulton	Astoria	61501	2	0	2	100.0	30.5
Iowa	Washington	Brighton	52540	1	0	1	100.0	38.3
		Washington	52353	15	0	15	100.0	33.1
		Wayland	52654	1	0	1	100.0	34.1
Grand Totals				**19**	**0**	**19**	**100.0**	**33.2**

Primary Care – Internal Medicine – Requirement is 30 miles

92.2% of our membership met the 30 mile requirement. There are 604 members who live more than 30 miles from an Internal Medicine provider at an average of 35.6 miles. We investigated how we could meet the standard for all members.

Members Without Access

State Name	County	City	Zip Code	Member Counts	Without Access[1]		Average Distance
				#	#	%	1
Illinois	Fulton	Astoria	61501	2	0	2	100.0	44.8
		Lewistown	61542	6	0	1	16.7	30.1
		London Mills	61544	4	0	2	50.0	30.8
		Vermont	61484	2	0	2	100.0	45.8
	Jo Daviess	Stockton	61085	6	0	6	100.0	37.9
		Warren	61087	2	0	2	100.0	35.6
Iowa	Buchanan	Lamont	50650	3	0	3	100.0	35.7
	Cedar	Clarence	52216	10	0	6	60.0	30.8
	Cherokee	Cherokee	51012	5	0	5	100.0	33.5
		Holstein	51025	2	0	2	100.0	43.5
		Quimby	51049	3	0	3	100.0	41.9
		Washta	51061	3	0	3	100.0	39.7
	Clarke	Osceola	50213	143	0	113	79.0	32.0
		Weldon	50264	3	0	3	100.0	36.5
		Woodburn	50275	10	0	7	70.0	32.4
	Clayton	Elkader	52043	5	0	5	100.0	43.7
		Farmersburg	52047	2	0	2	100.0	46.1
		Garber	52048	1	0	1	100.0	33.9
		Greeley	52050	1	0	1	100.0	32.9
		Guttenberg	52052	7	0	3	42.9	31.1
		Mc Gregor	52157	2	0	2	100.0	44.8
		Monona	52159	1	0	1	100.0	51.9
		Strawberry Point	52076	7	0	7	100.0	43.3
		Volga	52077	2	0	2	100.0	44.9
	Delaware	Delaware	52036	2	0	2	100.0	33.8
		Delhi	52223	2	0	1	50.0	30.5
		Dundee	52038	2	0	2	100.0	37.4
		Earlville	52041	3	0	2	66.7	30.4
		Edgewood	52042	1	0	1	100.0	37.6
		Hopkinton	52237	1	0	1	100.0	30.3
		Manchester	52057	14	0	14	100.0	32.6
		Masonville	50654	1	0	1	100.0	30.3
	Fayette	Arlington	50606	2	0	2	100.0	37.3
		Fayette	52142	4	0	4	100.0	35.3
		Wadena	52169	2	0	2	100.0	42.3
		West Union	52175	5	0	5	100.0	38.3
	Greene	Bagley	50026	1	0	1	100.0	40.1
		Churdan	50050	6	0	1	16.7	32.3
		Jefferson	50129	20	0	20	100.0	35.7
		Scranton	51462	1	0	1	100.0	36.4

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Internal Medicine Continued:

Members Without Access								
State Name	County	City	Zip Code	Member #	Counts #	Without Access[1] #	Without Access[1] %	Average Distance 1
Iowa	Ida	Holstein	51025	4	0	4	100.0	51.1
		Ida Grove	51445	2	0	2	100.0	58.7
	Iowa	North English	52316	1	0	1	100.0	33.7
		Parnell	52325	2	0	2	100.0	31.4
		Wellman	52356	1	0	1	100.0	33.4
		Williamsburg	52361	8	0	2	25.0	30.5
	Jackson	Baldwin	52207	1	0	1	100.0	32.6
		Maquoketa	52060	7	0	3	42.9	30.8
	Johnson	Kalona	52247	9	0	2	22.2	30.1
	Jones	Center Junction	52212	3	0	2	66.7	31.4
		Monticello	52310	65	0	3	4.6	30.4
		Onslow	52321	2	0	1	50.0	31.9
		Wyoming	52362	4	0	4	100.0	32.1
	Plymouth	Hinton	51024	9	0	6	66.7	32.8
		Kingsley	51028	3	0	3	100.0	34.4
		Sioux City	51108	1	0	1	100.0	30.7
	Washington	Brighton	52540	1	0	1	100.0	43.0
		Kalona	52247	10	0	10	100.0	33.9
		Riverside	52327	12	0	2	16.7	30.7
		Washington	52353	15	0	15	100.0	34.5
		Wayland	52654	1	0	1	100.0	35.4
		Wellman	52356	2	0	2	100.0	37.1
	Woodbury	Anthon	51004	5	0	5	100.0	50.5
		Climbing Hill	51015	2	0	2	100.0	50.4
		Correctionville	51016	6	0	6	100.0	45.5
		Hornick	51026	5	0	5	100.0	50.0
		Lawton	51030	12	0	12	100.0	39.7
		Moville	51039	7	0	7	100.0	43.7
		Oto	51044	2	0	2	100.0	53.0
		Salix	51052	6	0	6	100.0	46.1
		Sergeant Bluff	51054	17	0	17	100.0	39.4
		Sioux City	51103	22	0	21	95.5	31.0
			51104	70	0	70	100.0	31.7
			51105	13	0	13	100.0	33.2
			51106	110	0	110	100.0	36.6
			51108	11	0	9	81.8	33.3
		Sloan	51055	4	0	4	100.0	51.8
		Smithland	51056	2	0	2	100.0	59.0
Grand Totals				756	0	604	79.9	35.6

Behavioral Health – Requirement is 30 miles

99.9% of our members met the 30 mile requirement for Behavioral Health. There are 5 members who live more than 30 miles from a Behavioral Health provider at an average of 34.6 miles. No further action will be taken at this time as HealthPartners already holds contracts with these area behavioral health providers.

Members Without Access								
State Name	County	City	Zip Code	Member #	Counts #	Without Access[1] #	Without Access[1] %	Average Distance 1
Illinois	Jo Daviess	Stockton	61085	6	0	3	50.0	33.9
		Warren	61087	2	0	2	100.0	35.7
Grand Totals				8	0	5	62.5	34.6

Each category of behavioral health was also analyzed independently.

Behavioral Health – Licensed Marriage & Family Therapy – Requirement is 30 miles

84.4% of our membership met the 30 mile requirement. There are 1,205 members who live more than 30 miles from a behavioral health provider at an average of 39.4 miles. HealthPartners has contracts with known behavioral health providers in these rural areas and continues to pursue contracts with behavioral health providers as they become known.

Members Without Access

State Name	County	City	Zip Code	Member Counts		Without Access[1]		Average Distance
				#	#	#	%	1
Illinois	Fulton	Astoria	61501	2	0	2	100.0	45.7
		Fairview	61432	2	0	2	100.0	31.9
		Lewistown	61542	6	0	5	83.3	30.9
		London Mills	61544	4	0	4	100.0	33.7
		Vermont	61484	2	0	2	100.0	46.8
	Jo Daviess	Apple River	61001	1	0	1	100.0	54.9
		East Dubuque	61025	13	0	13	100.0	59.8
		Galena	61036	12	0	12	100.0	59.2
		Hanover	61041	1	0	1	100.0	56.2
		Stockton	61085	6	0	6	100.0	55.6
		Warren	61087	2	0	2	100.0	46.4
Iowa	Black Hawk	Cedar Falls	50613	149	0	149	100.0	37.7
		Dewar	50623	1	0	1	100.0	41.9
		Dunkerton	50626	14	0	14	100.0	43.8
		Evansdale	50707	37	0	37	100.0	37.4
		Gilbertville	50634	7	0	7	100.0	35.5
		Hudson	50643	8	0	1	12.5	30.7
		Janesville	50647	5	0	5	100.0	44.9
		Jesup	50648	3	0	3	100.0	36.8
		La Porte City	50651	8	0	8	100.0	31.9
		Raymond	50667	5	0	5	100.0	38.3
		Waterloo	50701	102	0	97	95.1	36.2
			50702	53	0	53	100.0	36.1
			50703	55	0	55	100.0	39.3
			50704	1	0	1	100.0	37.9
	Boone	Ogden	50212	7	0	4	57.1	30.5
		Stratford	50249	1	0	1	100.0	36.9
	Bremer	Denver	50622	10	0	10	100.0	49.5
		Frederika	50631	2	0	2	100.0	63.9
		Janesville	50647	5	0	5	100.0	46.3
		Plainfield	50666	3	0	3	100.0	60.0
		Readlyn	50668	2	0	2	100.0	51.9
		Sumner	50674	4	0	4	100.0	58.2
		Tripoli	50676	4	0	4	100.0	59.2
		Waverly	50677	43	0	43	100.0	52.3
	Buchanan	Fairbank	50629	3	0	3	100.0	42.1
		Hazleton	50641	2	0	2	100.0	40.9
		Independence	50644	17	0	15	88.2	31.9
		Jesup	50648	17	0	17	100.0	35.5
		Lamont	50650	3	0	3	100.0	37.8

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Marriage & Family Therapists Continued:

Members Without Access								
State Name	County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
				#	#	#	%	1
Iowa	Butler	Allison	50602	3	0	3	100.0	54.1
		Aplington	50604	3	0	3	100.0	46.4
		Austinville	50608	1	0	1	100.0	46.1
		Cedar Falls	50613	3	0	3	100.0	42.8
		Clarksville	50619	10	0	10	100.0	55.7
		Greene	50636	3	0	3	100.0	64.4
		Kesley	50649	2	0	2	100.0	50.1
		New Hartford	50660	4	0	4	100.0	42.9
		Parkersburg	50665	5	0	5	100.0	42.3
		Shell Rock	50670	4	0	4	100.0	50.1
	Clarke	Grand River	50108	2	0	2	100.0	37.6
		Murray	50174	9	0	5	55.6	34.5
		Osceola	50213	143	0	1	0.7	30.7
		Weldon	50264	3	0	1	33.3	32.6
	Clayton	Elkader	52043	5	0	5	100.0	55.9
		Farmersburg	52047	2	0	2	100.0	64.2
		Garber	52048	1	0	1	100.0	51.9
		Greeley	52050	1	0	1	100.0	46.5
		Guttenberg	52052	7	0	7	100.0	58.7
		Mc Gregor	52157	2	0	2	100.0	70.9
		Monona	52159	1	0	1	100.0	70.4
		Strawberry Point	52076	7	0	7	100.0	46.0
		Volga	52077	2	0	2	100.0	52.7
	Delaware	Delaware	52036	2	0	2	100.0	33.1
		Dundee	52038	2	0	2	100.0	37.3
		Earlville	52041	3	0	3	100.0	39.1
		Edgewood	52042	1	0	1	100.0	43.3
		Manchester	52057	14	0	13	92.9	32.5
		Masonville	50654	1	0	1	100.0	30.2
		Worthington	52078	1	0	1	100.0	32.9
	Fayette	Arlington	50606	2	0	2	100.0	48.2
		Fairbank	50629	4	0	4	100.0	46.4
		Fayette	52142	4	0	4	100.0	54.1
		Maynard	50655	1	0	1	100.0	51.0
		Oelwein	50662	13	0	13	100.0	45.0
		Sumner	50674	1	0	1	100.0	57.6
		Wadena	52169	2	0	2	100.0	54.8
		West Union	52175	5	0	5	100.0	64.0
	Greene	Grand Junction	50107	2	0	2	100.0	31.0
	Grundy	Aplington	50604	2	0	2	100.0	40.6

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Marriage & Family Therapists Continued:

Members Without Access								
State Name	County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
				#	#	#	%	1
Iowa	Grundy	Cedar Falls	50613	1	0	1	100.0	37.8
		Dike	50624	12	0	12	100.0	33.8
		Grundy Center	50638	29	0	1	3.4	31.4
		Holland	50642	7	0	7	100.0	31.7
		Wellsburg	50680	6	0	6	100.0	36.3
	Hamilton	Jewell	50130	5	0	5	100.0	38.5
		Stanhope	50246	2	0	2	100.0	39.0
		Stratford	50249	3	0	3	100.0	39.0
		Webster City	50595	10	0	10	100.0	48.8
		Williams	50271	1	0	1	100.0	52.0
	Hardin	Alden	50006	4	0	4	100.0	53.3
		Eldora	50627	18	0	18	100.0	37.4
		Hubbard	50122	2	0	2	100.0	43.0
		Iowa Falls	50126	4	0	4	100.0	46.8
		Steamboat Rock	50672	3	0	3	100.0	38.6
		Union	50258	6	0	6	100.0	31.8
	Humboldt	Dakota City	50529	10	0	10	100.0	36.6
		Eagle Grove	50533	1	0	1	100.0	45.7
		Goldfield	50542	1	0	1	100.0	41.7
		Humboldt	50548	43	0	43	100.0	35.9
		Livermore	50558	1	0	1	100.0	31.0
		Renwick	50577	3	0	3	100.0	41.4
		Rutland	50582	1	0	1	100.0	31.4
		Thor	50591	4	0	4	100.0	43.8
	Iowa	North English	52316	1	0	1	100.0	31.0
		Williamsburg	52361	8	0	2	25.0	31.2
	Jackson	Andrew	52030	1	0	1	100.0	41.2
		Baldwin	52207	1	0	1	100.0	35.4
		Bellevue	52031	5	0	5	100.0	49.3
		Bernard	52032	2	0	2	100.0	44.1
		La Motte	52054	1	0	1	100.0	52.0
		Maquoketa	52060	7	0	7	100.0	35.9
	Jones	Cascade	52033	2	0	2	100.0	34.4
		Onslow	52321	2	0	2	100.0	32.1
		Wyoming	52362	4	0	1	25.0	35.2
	Madison	Macksburg	50155	1	0	1	100.0	34.4
	Marshall	Clemons	50051	1	0	1	100.0	31.3
		State Center	50247	15	0	3	20.0	31.4
	Story	Roland	50236	4	0	3	75.0	30.4
		Story City	50248	7	0	6	85.7	31.3

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Marriage & Family Therapists Continued:

Members Without Access								
State Name	County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
				#	#	#	%	1
Iowa	Washington	Brighton	52540	1	0	1	100.0	32.2
		Crawfordsville	52621	1	0	1	100.0	33.0
		Wayland	52654	1	0	1	100.0	32.8
	Webster	Badger	50516	1	0	1	100.0	39.2
		Clare	50524	4	0	4	100.0	32.3
		Dayton	50530	5	0	5	100.0	36.1
		Fort Dodge	50501	229	0	227	99.1	33.7
		Humboldt	50548	4	0	4	100.0	34.1
		Lehigh	50557	6	0	6	100.0	36.7
		Otho	50569	7	0	7	100.0	32.5
		Vincent	50594	3	0	3	100.0	42.7
	Wright	Dows	50071	1	0	1	100.0	63.9
		Eagle Grove	50533	15	0	15	100.0	50.6
		Goldfield	50542	3	0	3	100.0	44.2
Grand Totals				**1,425**	**0**	**1,205**	**84.6**	**39.4**

Behavioral Health – Licensed Psychologists – Requirement is 30 miles

94.9% met the standard for Psychologists. There are 393 members who live more than 30 miles from a Psychologist provider at an average of 40.3 miles. HealthPartners has contracts with known behavioral health providers in these rural areas and continues to pursue contracts with behavioral health providers as they become known.

Members Without Access

State Name	County	City	Zip Code	Member Counts	Without Access[1]		Average Distance
				#	#	%	1
Illinois	Jo Daviess	Apple River	61001	1	0	1	100.0	51.8
		East Dubuque	61025	13	0	13	100.0	61.5
		Galena	61036	12	0	12	100.0	58.8
		Hanover	61041	1	0	1	100.0	56.2
		Stockton	61085	6	0	6	100.0	54.0
		Warren	61087	2	0	2	100.0	43.2
Iowa	Boone	Ogden	50212	7	0	6	85.7	30.6
	Buchanan	Lamont	50650	3	0	3	100.0	36.9
	Clarke	Grand River	50108	2	0	2	100.0	47.6
		Murray	50174	9	0	9	100.0	41.8
		New Virginia	50210	6	0	6	100.0	32.0
		Osceola	50213	143	0	143	100.0	38.4
		Peru	50222	1	0	1	100.0	31.9
		Truro	50257	1	0	1	100.0	30.4
		Weldon	50264	3	0	3	100.0	45.8
		Woodburn	50275	10	0	10	100.0	38.2
	Clayton	Elkader	52043	5	0	5	100.0	53.8
		Farmersburg	52047	2	0	2	100.0	60.2
		Garber	52048	1	0	1	100.0	52.5
		Greeley	52050	1	0	1	100.0	47.0
		Guttenberg	52052	7	0	7	100.0	59.5
		Mc Gregor	52157	2	0	2	100.0	68.9
		Monona	52159	1	0	1	100.0	62.9
		Strawberry Point	52076	7	0	7	100.0	44.9
		Volga	52077	2	0	2	100.0	47.1
	Delaware	Delaware	52036	2	0	2	100.0	33.8
		Delhi	52223	2	0	1	50.0	30.2
		Dundee	52038	2	0	2	100.0	37.7
		Earlville	52041	3	0	3	100.0	39.8
		Edgewood	52042	1	0	1	100.0	43.6
		Manchester	52057	14	0	14	100.0	32.6
		Masonville	50654	1	0	1	100.0	30.6
		Worthington	52078	1	0	1	100.0	34.5
	Fayette	Arlington	50606	2	0	2	100.0	39.5
		Fayette	52142	4	0	4	100.0	38.1
		Maynard	50655	1	0	1	100.0	31.6
		Sumner	50674	1	0	1	100.0	34.0
		Wadena	52169	2	0	2	100.0	44.9
		West Union	52175	5	0	5	100.0	44.4
	Greene	Grand Junction	50107	2	0	2	100.0	31.0

Continued on next page...

Psychologists Continued:

Members Without Access								
State Name	County	City	Zip Code	Member Counts #		Without Access[1] #	%	Average Distance 1
Iowa	Hardin	Union	50258	6	0	6	100.0	31.8
	Iowa	North English	52316	1	0	1	100.0	31.0
		Williamsburg	52361	8	0	2	25.0	31.2
	Jackson	Andrew	52030	1	0	1	100.0	41.2
		Baldwin	52207	1	0	1	100.0	35.4
		Bellevue	52031	5	0	5	100.0	49.3
		Bernard	52032	2	0	2	100.0	46.4
		La Motte	52054	1	0	1	100.0	52.0
		Maquoketa	52060	7	0	7	100.0	35.9
	Jasper	Reasnor	50232	1	0	1	100.0	36.1
		Sully	50251	3	0	3	100.0	31.2
	Jones	Cascade	52033	2	0	2	100.0	36.6
		Center Junction	52212	3	0	1	33.3	30.5
		Monticello	52310	65	0	4	6.2	30.7
		Onslow	52321	2	0	2	100.0	34.5
		Wyoming	52362	4	0	4	100.0	33.0
	Madison	Macksburg	50155	1	0	1	100.0	34.4
	Marion	Knoxville	50138	10	0	10	100.0	33.6
		Melcher Dallas	50062	4	0	4	100.0	33.8
			50163	1	0	1	100.0	32.6
		Pella	50219	29	0	29	100.0	38.9
	Marshall	Clemons	50051	1	0	1	100.0	31.3
		State Center	50247	15	0	10	66.7	30.9
	Poweshiek	Montezuma	50171	8	0	2	25.0	30.1
	Washington	Brighton	52540	1	0	1	100.0	32.1
		Crawfordsville	52621	1	0	1	100.0	32.8
		Wayland	52654	1	0	1	100.0	32.6
Grand Totals				**475**	**0**	**393**	**82.7**	**40.3**

Behavioral Health – Licensed Social Workers – Requirement is 30 miles

99.2% met the standard for Social Workers. There are 64 members who live more than 30 miles from a Social Work provider at an average of 34.6 miles. HealthPartners has contracts with known behavioral health providers in these rural areas and continues to pursue contracts with behavioral health providers as they become known.

Members Without Access								
State Name	County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
				#	#	#	%	1
Illinois	Fulton	Astoria	61501	2	0	2	100.0	44.9
		London Mills	61544	4	0	4	100.0	31.4
		Vermont	61484	2	0	2	100.0	45.7
	Jo Daviess	Stockton	61085	6	0	6	100.0	37.4
		Warren	61087	2	0	2	100.0	37.4
Iowa	Clarke	Grand River	50108	2	0	2	100.0	37.6
		Murray	50174	9	0	5	55.6	34.5
		Osceola	50213	143	0	1	0.7	30.7
		Weldon	50264	3	0	1	33.3	32.6
	Hamilton	Williams	50271	1	0	1	100.0	31.4
	Hardin	Alden	50006	4	0	3	75.0	35.4
		Iowa Falls	50126	4	0	2	50.0	34.1
	Jasper	Reasnor	50232	1	0	1	100.0	33.7
		Sully	50251	3	0	3	100.0	30.5
	Madison	Macksburg	50155	1	0	1	100.0	32.7
	Marion	Pella	50219	29	0	27	93.1	33.2
	Wright	Dows	50071	1	0	1	100.0	35.8
Grand Totals				**217**	**0**	**64**	**29.5**	**34.6**

Behavioral Health – Psychiatry – Requirement is 30 miles

94.6% of our membership met the 30 mile requirement. There are 419 members who live more than 30 miles from a behavioral health provider at an average of 34.3 miles. HealthPartners has contracts with known behavioral health providers in these rural areas and continues to pursue contracts with behavioral health providers as they become known.

Members Without Access								
State Name	County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
				#	#	#	%	1
Iowa	Marion	Knoxville	50138	10	0	10	100.0	32.8
		Melcher Dallas	50062	4	0	4	100.0	33.5
			50163	1	0	1	100.0	32.3
		Pella	50219	29	0	29	100.0	37.8
	Marshall	Clemons	50051	1	0	1	100.0	31.3
		State Center	50247	15	0	13	86.7	31.4
	Plymouth	Remsen	51050	7	0	4	57.1	30.4
	Poweshiek	Montezuma	50171	8	0	2	25.0	30.1
	Sioux	Alton	51003	6	0	6	100.0	38.0
		Boyden	51234	3	0	3	100.0	38.5
		Granville	51022	1	0	1	100.0	38.7
		Hospers	51238	3	0	3	100.0	38.1
		Hull	51239	5	0	5	100.0	36.5
		Orange City	51041	19	0	19	100.0	38.2
		Rock Valley	51247	17	0	1	5.9	30.2
		Sioux Center	51250	4	0	4	100.0	39.5
	Story	Colo	50056	7	0	4	57.1	33.3
		Gilbert	50105	1	0	1	100.0	32.2
		Nevada	50201	23	0	8	34.8	32.1
		Roland	50236	4	0	4	100.0	36.3
		Story City	50248	7	0	7	100.0	36.2
	Woodbury	Correctionville	51016	6	0	5	83.3	32.1
		Smithland	51056	2	0	2	100.0	31.4
Grand Totals				**527**	**0**	**419**	**79.5**	**34.3**

Obstetrics & Gynecology (OB-GYN) – Requirement is 30 miles

97.1% of our membership met the 30 mile requirement. There are 224 members who live more than 30 miles from an obstetrician and gynecologist at an average of 33.2 miles; however there are primary care providers within the standard 30 miles that also provide obstetrics and gynecology services. No further action will be taken at this time as HealthPartners already holds contracts with these area Ob-Gyn providers.

Members Without Access								
State Name	County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
				#	#	#	%	1
Illinois	Fulton	Astoria	61501	2	0	2	100.0	45.6
		Fairview	61432	2	0	2	100.0	30.5
		Lewistown	61542	6	0	5	83.3	30.9
		London Mills	61544	4	0	4	100.0	32.1
		Vermont	61484	2	0	2	100.0	46.8
	Jo Daviess	Stockton	61085	6	0	5	83.3	33.7
		Warren	61087	2	0	2	100.0	35.6
Iowa	Cherokee	Marcus	51035	4	0	4	100.0	32.2
	Clarke	Osceola	50213	143	0	126	88.1	32.7
		Weldon	50264	3	0	3	100.0	37.6
		Woodburn	50275	10	0	10	100.0	33.7
	Clayton	Farmersburg	52047	2	0	2	100.0	32.5
		Mc Gregor	52157	2	0	2	100.0	38.0
		Monona	52159	1	0	1	100.0	39.0
	Fayette	West Union	52175	5	0	5	100.0	34.9
	Greene	Bagley	50026	1	0	1	100.0	36.1
		Churdan	50050	6	0	1	16.7	30.9
		Grand Junction	50107	2	0	1	50.0	30.4
		Jefferson	50129	20	0	20	100.0	34.3
		Scranton	51462	1	0	1	100.0	35.0
	Hamilton	Williams	50271	1	0	1	100.0	31.5
	Hardin	Alden	50006	4	0	3	75.0	35.3
		Iowa Falls	50126	4	0	1	25.0	37.2
	Plymouth	Remsen	51050	7	0	3	42.9	30.2
	Sioux	Alton	51003	6	0	6	100.0	31.7
		Granville	51022	1	0	1	100.0	34.6
		Orange City	51041	19	0	8	42.1	30.6
	Woodbury	Correctionville	51016	6	0	1	16.7	30.2
	Wright	Dows	50071	1	0	1	100.0	36.8
Grand Totals				**273**	**0**	**224**	**82.1**	**33.2**

Hospitals – Requirement is 30 miles

99.8% of our membership met the 30 mile requirement. There are 16 members who live more than 30 miles from a hospital at an average of 35.8 miles. No further action will be taken at this time as HealthPartners already holds contracts with these area hospitals.

Members Without Access								
State Name	County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
				#	#	#	%	1
Illinois	Fulton	Astoria	61501	2	0	2	100.0	44.8
		Fairview	61432	2	0	2	100.0	31.2
		Lewistown	61542	6	0	1	16.7	30.1
		London Mills	61544	4	0	4	100.0	33.0
		Vermont	61484	2	0	2	100.0	45.8
Iowa	Hamilton	Williams	50271	1	0	1	100.0	31.5
	Hardin	Alden	50006	4	0	3	75.0	33.0
	Wright	Dows	50071	1	0	1	100.0	36.8
Grand Totals				**22**	**0**	**16**	**72.7**	**35.8**

HealthPartners 2022 Service Area Analysis – Ratio Standards*

HealthPartners UnityPoint Medicare Advantage Product

HealthPartners Service Area Analysis – Provider Type	Ratio Access Standard	Total Pop.	Provider Counts	Actual Ratio (Provider to Member)	% Pop. Meeting Standard	Member Count-Pop. Meeting Standard	Member Count-Pop.-Not Meeting ratio standard	Action Needed
Primary Care Providers	1 per 1,500 members	*7,742	5,330	1 per 1 member	100%	7,742	0	No
Family Medicine/ General Medicine	1 per 1,500 members	*7,742	4,445	1 per 2 members	100%	7,742	0	No
Internal Medicine – 18 and over	1 per 1,500 members	*7,742	530	1 per 15 members	100%	7,742	0	No
Pediatrics – 18 and under	1 per 1,500 members	*0	355	n/a	n/a	0	0	No
Behavioral Health								
Behavioral Health	1 per 10,000 members	*7,742	3,982	1 per 2 members	100%	7,742	0	No
Licensed Marriage and Family Therapists	1 per 10,000 members	*7,742	98	1 per 79 members	100%	7,742	0	No
Licensed Psychologists	1 per 10,000 members	*7,742	883	1 per 9 members	100%	7,742	0	No
Licensed Social Workers	1 per 10,000 members	*7,742	978	1 per 8 members	100%	7,742	0	No
Psychiatrists	1 per 10,000 members	*7,742	800	1 per 10 members	100%	7,742	0	No
Specialty Care	1 per 10,000 members	*7,742	40,697	5 per 1 member	100%	7,742	0	No
High Volume Specialists								
Cardiology	1 per 10,000 members	*7,742	1,810	1 per 4 members	100%	7,742	0	No
Ob-Gyn	1 per 10,000 members	*7,742	1,537	1 per 5 members	100%	7,742	0	No
Orthopedics	1 per 10,000 members	*7,742	2,037	1 per 4 members	100%	7,742	0	No
Otolaryngology (ENT)	1 per 10,000 members	*7,742	342	1 per 23 members	100%	7,742	0	No
High Impact Specialists								
Oncology	1 per 10,000 members	*7,742	1,264	1 per 6 members	100%	7,742	0	No
Additional Specialties Analyzed for Informational Purposes Only								
Dermatology	1 per 10,000 members	*7,742	598	1 per 13 members	100%	7,742	0	No
Gastroenterology	1 per 10,000 members	*7,742	500	1 per 15 members	100%	7,742	0	No
Ophthalmology	1 per 10,000 members	*7,742	569	1 per 14 members	100%	7,742	0	No
Surgery	1 per 10,000 members	*7,742	1,868	1 per 4 members	100%	7,742	0	No
Chiropractic	1 per 10,000 members	*7,742	247	1 per 31 members	100%	7,742	0	No

*Ratio standards are in accordance with community standards based on a survey of HMOs in HealthPartners Service Area.

HealthPartners ratio standards have been met for the provider types defined in the "Network Assessment of Practitioner Availability" policy.

HealthPartners Service Area Analysis – Provider Type	Access Standard	Total Pop.	Provider Counts	% Pop. Meeting Standard	Average Distance to a Provider	Member Count- Pop. Meeting Standard	Member Count- Pop. not Meeting standard	Additional information when % Pop. Meeting Standard is not 100%
Primary Care Providers	1 provider within 30 miles	*34,996	19,351	99.9%	1.5 miles	34,995	1	Yes. See Section II
Family/General Medicine	1 provider within 30 miles	*34,996	14,608	99.9%	1.6 miles	34,995	1	Yes. See Section II
Internal Medicine – 18 and over	1 provider within 30 miles	*34,996	2,446	99.9%	1.9 miles	34,993	3	Yes. See Section II
Pediatrics – 18 and under	1 provider within 30 miles	*0	2,324	0%	n/a	0	0	None
Behavioral Health								
Behavioral Health	1 provider within 30 miles	*34,996	23,355	99.9%	1.2 miles	34,995	1	Yes. See Section II
Licensed Marriage and Family Therapists	1 provider within 30 miles	*34,996	2,743	99.8%	1.6 miles	34,941	55	Yes. See Section II
Licensed Psychologists	1 provider within 30 miles	*34,996	3,824	99.9%	1.5 miles	34,966	30	Yes. See Section II
Licensed Social Workers	1 provider within 30 miles	*34,996	5,150	99.9%	1.4 miles	34,988	8	Yes. See Section II
Psychiatrists	1 provider within 30 miles	*34,996	2,107	99.9%	2.2 miles	34,977	19	Yes. See Section II
Specialty Care	1 provider within 60 miles	*34,996	136,119	100%	0.9 mile	34,996	0	None
High Volume Specialists								
Cardiology	1 provider within 60 miles	*34,996	4,566	100%	2.6 miles	34,996	0	None
Obstetrics & Gynecology	1 provider within 30 miles	*34,996	5,039	99.9%	1.9 miles	34,991	5	Yes. See Section II
Orthopedics	1 provider within 60 miles	*34,996	5,226	100%	2.0 miles	34,996	0	None
Otolaryngology (ENT)	1 provider within 60 miles	*34,996	893	99.9%	2.9 miles	34,995	1	Yes. See Section II
High Impact Specialists								
Oncology	1 provider within 60 miles	*34,996	3,937	100%	3.4 miles	34,996	0	None
Additional Specialties Analyzed for Informational Purposes Only								
Dermatology	1 provider within 60 miles	*34,996	1,380	100%	2.9 miles	34,996	0	None
Gastroenterology	1 provider within 60 miles	*34,996	1,723	100%	3.6 miles	34,996	0	None
Ophthalmology	1 provider within 60 miles	*34,996	1,138	100%	2.7 miles	34,996	0	None
Surgery	1 provider within 60 miles	*34,996	4,505	100%	2.0 miles	34,996	0	None
Chiropractic	1 provider within 60 miles	*34,996	3,102	100%	1.2 miles	34,996	0	None
Hospitals	1 hospital within 30 miles	*34,996	171	99.7%	4.1 miles	34,908	88	Yes. See Section II

*34,996 members live in the service area; those who do not live in the service area are not included in this table.

HealthPartners Minnesota Medicare Advantage (Journey) Membership Summary

HealthPartners practitioner availability standards have been met for over 99% of the membership for the provider types defined in the "Network Assessment of Practitioner Availability" policy. We investigated how we could meet the standard for all members.

Primary Care – Requirement is 30 miles

99.9% of our membership met the requirement for a Primary Care provider within 30 miles. There is 1 member who lives more than 30 miles from a Primary Care provider at an average of 40.8 miles. No further action will be taken at this time as HealthPartners already holds contracts with these area primary care providers.

Members Without Access							
County	City	Zip Code	Member #	Counts #	Without Access[1] #	Without Access[1] %	Average Distance 1
Lake of the Woods, MN	Baudette	56623	4	0	1	25.0	40.8
Grand Totals			4	0	1	25.0	40.8

Each category of primary care was also analyzed independently.

Primary Care-Family & General Medicine – Requirement is 30 miles

99.9% of our membership met the requirement for a Primary Care-Family & General Medicine provider within 30 miles. There is 1 member who lives more than 30 miles from a Primary Care provider at an average of 40.8 miles. No further action will be taken at this time as HealthPartners already holds contracts with these area primary care providers.

Members Without Access							
County	City	Zip Code	Member #	Counts #	Without Access[1] #	Without Access[1] %	Average Distance 1
Lake of the Woods, MN	Baudette	56623	4	0	1	25.0	40.8
Grand Totals			4	0	1	25.0	40.8

Primary Care – Internal Medicine – Requirement is 30 miles

99.9% of our membership met the 30 mile requirement. There are 3 members who live more than 30 miles from an Internal Medicine provider at an average of 40.8 miles. No further action will be taken at this time as HealthPartners already holds contracts with these area primary care providers.

Members Without Access							
County	City	Zip Code	Member #	Counts #	Without Access[1] #	Without Access[1] %	Average Distance 1
Beltrami, MN	Kelliher	56650	2	0	2	100.0	40.8
Lake of the Woods, MN	Baudette	56623	4	0	1	25.0	40.8
Grand Totals			6	0	3	50.0	40.8

Behavioral Health – Requirement is 30 miles

99.9% of our members met the 30 mile requirement for Behavioral Health. There is 1 member who lives more than 30 miles from a Behavioral Health provider at an average of 40.8 miles. No further action will be taken at this time as HealthPartners already holds contracts with these area behavioral health providers.

Members Without Access							
County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
			#	#	#	%	1
Lake of the Woods, MN	Baudette	56623	4	0	1	25.0	40.8
Grand Totals			**4**	**0**	**1**	**25.0**	**40.8**

Each category of behavioral health was also analyzed independently.

Behavioral Health – Licensed Marriage & Family Therapy – Requirement is 30 miles

99.8% met the standard for Marriage and Family Therapists. There are 55 members who live more than 30 miles from a Licensed Marriage and Family Therapy provider at an average of 46.5 miles. HealthPartners has contracts with known behavioral health providers in these rural areas and continues to pursue contracts with behavioral health providers as they become known.

Members Without Access							
County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
			#	#	#	%	1
Beltrami, MN	Kelliher	56650	2	0	2	100.0	40.9
Clearwater, MN	Bagley	56621	2	0	2	100.0	31.9
Hubbard, MN	Park Rapids	56470	8	0	8	100.0	32.6
Kittson, MN	Humboldt	56731	1	0	1	100.0	70.5
Lake of the Woods, MN	Baudette	56623	4	0	4	100.0	89.2
	Roosevelt	56673	1	0	1	100.0	90.8
Lyon, MN	Marshall	56258	8	0	8	100.0	31.7
Mahnomen, MN	Fosston	56542	1	0	1	100.0	38.3
Marshall, MN	Grygla	56727	1	0	1	100.0	67.5
	Viking	56760	1	0	1	100.0	36.7
Norman, MN	Ada	56510	1	0	1	100.0	31.2
	Halstad	56548	2	0	2	100.0	33.2
	Twin Valley	56584	1	0	1	100.0	34.9
Pennington, MN	Thief River Falls	56701	3	0	3	100.0	43.1
Polk, MN	Lengby	56651	1	0	1	100.0	34.3
Redwood, MN	Milroy	56263	2	0	2	100.0	31.3
	Redwood Falls	56283	5	0	5	100.0	35.0
	Vesta	56292	1	0	1	100.0	39.0
	Wabasso	56293	1	0	1	100.0	38.0
Roseau, MN	Greenbush	56726	4	0	4	100.0	66.6
	Roseau	56751	1	0	1	100.0	87.1
	Salol	56756	2	0	2	100.0	98.2
Traverse, MN	Browns Valley	56219	1	0	1	100.0	44.7
	Wheaton	56296	1	0	1	100.0	32.7
Grand Totals			**55**	**0**	**55**	**100.0**	**46.5**

Behavioral Health – Licensed Psychologists – Requirement is 30 miles

99.9% met the standard for Psychologists. There are 30 members who live more than 30 miles from a Psychologist provider at an average of 50.9 miles. HealthPartners has contracts with known behavioral health providers in these rural areas and continues to pursue contracts with behavioral health providers as they become known.

Members Without Access

County	City	Zip Code	Member Counts		Without Access[1]		Average Distance
			#	#	#	%	1
Beltrami, MN	Kelliher	56650	2	0	2	100.0	40.8
Kittson, MN	Humboldt	56731	1	0	1	100.0	68.4
Lake of the Woods, MN	Baudette	56623	4	0	4	100.0	82.2
	Roosevelt	56673	1	0	1	100.0	69.4
Murray, MN	Fulda	56131	3	0	3	100.0	36.3
	Iona	56141	1	0	1	100.0	34.5
Nobles, MN	Ellsworth	56129	1	0	1	100.0	34.8
	Magnolia	56158	2	0	2	100.0	35.0
	Round Lake	56167	1	0	1	100.0	52.0
	Worthington	56187	6	0	6	100.0	52.3
Rock, MN	Luverne	56156	4	0	1	25.0	31.0
Roseau, MN	Greenbush	56726	4	0	4	100.0	39.3
	Roseau	56751	1	0	1	100.0	53.3
	Salol	56756	2	0	2	100.0	61.9
Grand Totals			**33**	**0**	**30**	**90.9**	**50.9**

Behavioral Health – Licensed Social Workers – Requirement is 30 miles

99.9% met the standard for Social Workers. There are 8 members who live more than 30 miles from a Social Work provider at an average of 36.2 miles. HealthPartners has contracts with known behavioral health providers in these rural areas and continues to pursue contracts with behavioral health providers as they become known.

Members Without Access

County	City	Zip Code	Member Counts		Without Access[1]		Average Distance
			#	#	#	%	1
Lake of the Woods, MN	Baudette	56623	4	0	1	25.0	40.8
Norman, MN	Halstad	56548	2	0	2	100.0	30.5
	Twin Valley	56584	1	0	1	100.0	30.5
Roseau, MN	Greenbush	56726	4	0	4	100.0	39.3
Grand Totals			**11**	**0**	**8**	**72.7**	**36.2**

Behavioral Health – Psychiatry – Requirement is 30 miles

99.9% met the standard for Psychiatrists. There are 19 members who live more than 30 miles from a Psychiatry provider at an average of 33.9 miles. HealthPartners has contracts with known behavioral health providers in these rural areas and continues to pursue contracts with behavioral health providers as they become known.

Members Without Access

County	City	Zip Code	Member #	Counts #	Without Access[1] #	Without Access[1] %	Average Distance 1
Beltrami, MN	Kelliher	56650	2	0	2	100.0	40.7
Lake of the Woods, MN	Baudette	56623	4	0	1	25.0	40.8
Nobles, MN	Ellsworth	56129	1	0	1	100.0	34.7
	Magnolia	56158	2	0	2	100.0	33.6
Norman, MN	Ada	56510	1	0	1	100.0	31.5
	Twin Valley	56584	1	0	1	100.0	30.5
Pipestone, MN	Pipestone	56164	6	0	6	100.0	33.2
Swift, MN	Danvers	56231	2	0	2	100.0	33.4
Yellow Medicine, MN	Canby	56220	3	0	3	100.0	30.6
Grand Totals			**22**	**0**	**19**	**86.4**	**33.9**

Obstetrics & Gynecology (OB-GYN) – Requirement is 30 miles

99.9% of our membership met the requirement for an Ob-Gyn provider within 30 miles. There are 5 members who live more than 30 miles from an Ob-Gyn provider at an average of 44.6 miles; however there are primary care providers within the standard 30 miles that also provide obstetrics and gynecology services. No further action will be taken at this time as HealthPartners already holds contracts with these area Ob-Gyn providers.

Members Without Access

County	City	Zip Code	Member #	Counts #	Without Access[1] #	Without Access[1] %	Average Distance 1
Lake of the Woods, MN	Baudette	56623	4	0	4	100.0	47.9
	Roosevelt	56673	1	0	1	100.0	31.6
Grand Totals			**5**	**0**	**5**	**100.0**	**44.6**

Otolaryngology (ENT) – Requirement is 60 miles

99.9 % of our membership met the requirement for an ENT provider within 60 miles. There is 1 member who lives more than 60 miles from an ENT provider at an average of 61.0 miles. No further action will be taken at this time as HealthPartners already holds contracts with these area ENT providers.

Members Without Access

County	City	Zip Code	Member #	Counts #	Without Access[1] #	Without Access[1] %	Average Distance 1
Kittson, MN	Humboldt	56731	1	0	1	100.0	61.0
Grand Totals			**1**	**0**	**1**	**100.0**	**61.0**

Hospitals – Requirement is 30 miles

99.7% of our membership met the 30 mile requirement. There are 88 members who live more than 30 miles from a hospital at an average of 38.2 miles. No further action will be taken at this time as HealthPartners already holds contracts with these area hospitals.

Members Without Access

County	City	Zip Code	Member Counts		Without Access[1]		Average Distance
			#	#	#	%	1
Beltrami, MN	Kelliher	56650	2	0	2	100.0	40.8
Cass, MN	Akeley	56433	1	0	1	100.0	36.0
	Backus	56435	17	0	17	100.0	34.4
	Hackensack	56452	16	0	16	100.0	38.9
	Longville	56655	19	0	16	84.2	32.7
	Pine River	56474	5	0	1	20.0	30.5
	Walker	56484	8	0	7	87.5	34.0
Hubbard, MN	Akeley	56433	2	0	2	100.0	36.4
	Nevis	56467	5	0	5	100.0	34.9
	Park Rapids	56470	8	0	8	100.0	34.3
Kittson, MN	Humboldt	56731	1	0	1	100.0	70.5
Lake of the Woods, MN	Baudette	56623	4	0	4	100.0	57.7
	Roosevelt	56673	1	0	1	100.0	71.8
Roseau, MN	Greenbush	56726	4	0	4	100.0	41.2
	Roseau	56751	1	0	1	100.0	55.3
	Salol	56756	2	0	2	100.0	64.0
Grand Totals			**96**	**0**	**88**	**91.7**	**38.2**

HealthPartners 2022 Service Area Analysis – Ratio Standards*

HealthPartners Minnesota Medicare Advantage (Journey) Product

HealthPartners Service Area Analysis – Provider Type	Ratio Access Standard	Total Pop.	Provider Counts	Actual Ratio (Provider to Member)	% Pop. Meeting Standard	Member Count-Pop. Meeting Standard	Member Count-Pop.-Not Meeting ratio standard	Action Needed
Primary Care Providers	1 per 1,500 members	*34,996	19,351	1 per 2 members	100%	34,996	0	No
Family Medicine/ General Medicine	1 per 1,500 members	*34,996	14,608	1 per 2 members	100%	34,996	0	No
Internal Medicine – 18 and over	1 per 1,500 members	*34,996	2,446	1 per 14 members	100%	34,996	0	No
Pediatrics – 18 and under	1 per 1,500 members	*0	2,324	n/a	n/a	0	0	No
Behavioral Health								
Behavioral Health	1 per 10,000 members	*34,996	23,355	1 per 1 member	100%	34,996	0	No
Licensed Marriage and Family Therapists	1 per 10,000 members	*34,996	2,743	1 per 13 members	100%	34,996	0	No
Licensed Psychologists	1 per 10,000 members	*34,996	3,824	1 per 9 members	100%	34,996	0	No
Licensed Social Workers	1 per 10,000 members	*34,996	5,150	1 per 7 members	100%	34,996	0	No
Psychiatrists	1 per 10,000 members	*34,996	2,107	1 per 17 members	100%	34,996	0	No
Specialty Care	1 per 10,000 members	*34,996	136,119	4 per 1 member	100%	34,996	0	No
High Volume Specialists								
Cardiology	1 per 10,000 members	*34,996	4,566	1 per 8 members	100%	34,996	0	No
Ob-Gyn	1 per 10,000 members	*34,996	5,039	1 per 7 members	100%	34,996	0	No
Orthopedics	1 per 10,000 members	*34,996	5,226	1 per 7 members	100%	34,996	0	No
Otolaryngology (ENT)	1 per 10,000 members	*34,996	893	1 per 39 members	100%	34,996	0	No
High Impact Specialists								
Oncology	1 per 10,000 members	*34,996	3,937	1 per 9 members	100%	34,996	0	No
Additional Specialties Analyzed for Informational Purposes Only								
Dermatology	1 per 10,000 members	*34,996	1,380	1 per 25 members	100%	34,996	0	No
Gastroenterology	1 per 10,000 members	*34,996	1,723	1 per 20 members	100%	34,996	0	No
Ophthalmology	1 per 10,000 members	*34,996	1,138	1 per 31 members	100%	34,996	0	No
Surgery	1 per 10,000 members	*34,996	4,505	1 per 8 members	100%	34,996	0	No
Chiropractic	1 per 10,000 members	*34,996	3,102	1 per 11 members	100%	34,996	0	No

*Ratio standards are in accordance with community standards based on a survey of HMOs in HealthPartners Service Area.

HealthPartners ratio standards have been met for the provider types defined in the "Network Assessment of Practitioner Availability" policy.

HealthPartners Service Area Analysis – Provider Type	Access Standard	Total Pop.	Provider Counts	% Pop. Meeting Standard	Average Distance to a Provider	Member Count- Pop. Meeting Standard	Member Count- Pop. Not Meeting standard	Additional information when % Pop. Meeting Standard is not 100%
Primary Care Providers	1 provider within 30 miles	*2,688	23,570	99.9%	4.3 miles	2,685	3	Yes. See Section II.
Family/General Medicine	1 provider within 30 miles	*2,688	17,938	99.9%	4.3 miles	2,685	3	Yes. See Section II
Internal Medicine – 18 and over	1 provider within 30 miles	*2,688	3,004	97.2%	5.6 miles	2,612	76	Yes. See Section II
Pediatrics – 18 and under	1 provider within 30 miles	*0	2,655	0%	n/a	0	0	None
Behavioral Health								
Behavioral Health	1 provider within 30 miles	*2,688	27,306	99.7%	4.3 miles	2,680	8	Yes. See Section II
Licensed Marriage and Family Therapists	1 provider within 30 miles	*2,688	2,772	96.2%	6.6 miles	2,587	101	Yes. See Section II
Licensed Psychologists	1 provider within 30 miles	*2,688	3,995	99.7%	5.4 miles	2,680	8	Yes. See Section II
Licensed Social Workers	1 provider within 30 miles	*2,688	5,632	99.3%	5.0 miles	2,668	20	Yes. See Section II
Psychiatrists	1 provider within 30 miles	*2,688	2,119	95.5%	6.4 miles	2,119	121	Yes. See Section II
Specialty Care	1 provider within 60 miles	*2,688	163,420	100%	3.2 miles	2,688	0	None
High Volume Specialists								
Cardiology	1 provider within 60 miles	*2,688	6,192	98.7%	8.2 miles	2,653	35	Yes. See Section II
Ob-Gyn Specialists	1 provider within 30 miles	*2,688	5,993	97.5%	5.1 miles	2,620	68	Yes. See Section II
Orthopedics	1 provider within 60 miles	*2,688	6,059	98.7%	5.5 miles	2,653	35	Yes. See Section II
Otolaryngology (ENT)	1 provider within 60 miles	*2,688	1,095	97.2%	8.1 miles	2,612	76	Yes. See Section II
High Impact Specialty								
Oncology	1 provider within 60 miles	*2,688	4,338	98.2%	8.0 miles	2,640	48	Yes. See Section II
Additional Specialties Analyzed for Informational Purposes Only								
Dermatology	1 provider within 60 miles	*2,688	1,558	98.2%	9.9 miles	2,640	48	Yes. See Section II
Gastroenterology	1 provider within 60 miles	*2,688	1,947	97.2%	10.0 miles	2,612	76	Yes. See Section II
Ophthalmology	1 provider within 60 miles	*2,688	1,403	98.2%	8.3 miles	2,640	48	Yes. See Section II
Surgeons	1 provider within 60 miles	*2,688	5,348	99.6%	6.7 miles	2,677	11	Yes. See Section II
Chiropractors	1 provider within 60 miles	*2,688	3,102	100%	4.9 miles	2,688	0	None
Hospitals	1 hospital within 30 miles	*2,688	276	99.6%	6.3 miles	2,678	10	Yes. See Section II

*2,688 members live in the service area; those who do not live in the service area are not included in this table.

HealthPartners Medicare Cost (Freedom) Membership Summary

HealthPartners practitioner availability standards have been met for over 99% of the membership for the provider types defined in the "Network Assessment of Practitioner Availability" policy. Due to the large geographic service area available in this product, accessibility for some members has exceeded the criteria. Most of these members live in rural areas and do not have specialists available within the geographic standards. We investigated how we could meet the standard for all members.

Primary Care – Requirement is 30 miles

99.9% of our membership met the requirement for a primary care provider available within 30 miles. There are 3 members who live more than 30 miles from a primary care physician at an average of 30.8 miles. No further action will be taken at this time as HealthPartners already holds contracts with these area primary care providers.

Members Without Access							
County	City	Zip Code	Member #	Counts #	Without Access[1] #	Without Access[1] %	Average Distance 1
Cook, MN	Grand Marais	55604	28	9	3	10.7	30.8
Grand Totals			**28**	**9**	**3**	**10.7**	**30.8**

Each category of primary care was also analyzed independently.

Primary Care – Family & General Medicine – Requirement is 30 miles

99.9% of our membership met the requirement for a Primary Care-Family & General Medicine provider within 30 miles. There are 3 members who live more than 30 miles from a Family & General Medicine provider at an average of 30.8 miles. No further action will be taken at this time as HealthPartners already holds contracts with these area primary care providers.

Members Without Access							
County	City	Zip Code	Member #	Counts #	Without Access[1] #	Without Access[1] %	Average Distance 1
Cook, MN	Grand Marais	55604	28	9	3	10.7	30.8
Grand Totals			**28**	**9**	**3**	**10.7**	**30.8**

Primary Care – Internal Medicine – Requirement is 30 miles

97.2% of our membership met the requirement for a Primary Care-Internal Medicine provider within 30 miles. There are 76 members who live more than 30 miles from an Internal Medicine provider at an average of 48.0 miles. No further action will be taken at this time as HealthPartners already holds contracts with these area Internal Medicine providers.

Members Without Access							
County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
			#	#	#	%	1
Burnett, WI	Danbury	54830	25	0	2	8.0	30.7
	Spooner	54801	4	0	2	50.0	30.4
Cook, MN	Grand Marais	55604	28	0	28	100.0	54.2
	Grand Portage	55605	1	0	1	100.0	87.2
	Hovland	55606	9	0	9	100.0	74.0
	Lutsen	55612	7	0	7	100.0	41.7
	Tofte	55615	3	0	1	33.3	31.0
Koochiching, MN	Big Falls	56627	2	0	2	100.0	31.4
	International Falls	56649	19	0	19	100.0	36.0
	Loman	56654	2	0	2	100.0	42.8
	Northome	56661	3	0	1	33.3	31.1
	Ranier	56668	2	0	2	100.0	36.4
Grand Totals			**105**	**0**	**76**	**72.4**	**48.0**

Behavioral Health – Requirement is 30 miles

99.7% of our members met the 30 mile requirement for Behavioral Health. There are 8 members who live more than 30 miles from a behavioral health provider at an average of 32.7 miles. HealthPartners has contracts with known behavioral health providers in these rural areas and continues to pursue contracts with behavioral health providers as they become known.

Members Without Access							
County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
			#	#	#	%	1
Cook, MN	Grand Marais	55604	28	6	3	10.7	30.8
Koochiching, MN	Big Falls	56627	2	0	2	100.0	31.4
	Northome	56661	3	0	1	33.3	31.2
St. Louis, MN	Crane Lake	55725	2	0	2	100.0	37.5
Grand Totals			**35**	**6**	**8**	**22.9**	**32.7**

Each category of behavioral health was also analyzed independently.

Behavioral Health – Licensed Marriage & Family Therapy – Requirement is 30 miles

96.2% met the standard for Marriage and Family Therapists. There are 101 members who live more than 30 miles from a behavioral health provider at an average of 69.7 miles. HealthPartners has contracts with known behavioral health providers in these rural areas and continues to pursue contracts with behavioral health providers as they become known.

Members Without Access							
County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
			#	#	#	%	1
Cook, MN	Grand Marais	55604	28	0	28	100.0	101.1
	Grand Portage	55605	1	0	1	100.0	136.3
	Hovland	55606	9	0	9	100.0	123.3
	Lutsen	55612	7	0	7	100.0	88.9
	Tofte	55615	3	0	3	100.0	79.2
Douglas, WI	Gordon	54838	4	0	1	25.0	36.3
	Solon Springs	54873	13	0	2	15.4	33.7
Itasca, MN	Bigfork	56628	7	0	3	42.9	36.2
	Effie	56639	7	0	7	100.0	34.4
	Northome	56661	1	0	1	100.0	35.8
	Spring Lake	56680	1	0	1	100.0	34.6
	Wirt	56688	1	0	1	100.0	40.0
Koochiching, MN	Big Falls	56627	2	0	2	100.0	33.4
	Northome	56661	3	0	3	100.0	40.8
Lake, MN	Ely	55731	3	0	3	100.0	44.6
	Finland	55603	2	0	2	100.0	56.8
	Isabella	55607	1	0	1	100.0	54.3
	Silver Bay	55614	4	0	4	100.0	52.1
	Two Harbors	55616	17	0	2	11.8	36.2
St. Louis, MN	Babbitt	55706	4	0	4	100.0	30.7
	Cook	55723	8	0	1	12.5	30.3
	Crane Lake	55725	2	0	2	100.0	49.1
	Ely	55731	13	0	13	100.0	39.8
Grand Totals			141	0	101	71.6	69.7

Behavioral Health – Licensed Psychologists – Requirement is 30 miles

99.7% met the standard for Licensed Psychologists. There are 8 members who live more than 30 miles from a behavioral health provider at an average of 32.7 miles. HealthPartners has contracts with known behavioral health providers in these rural areas and continues to pursue contracts with behavioral health providers as they become known.

Members Without Access							
County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
			#	#	#	%	1
Cook, MN	Grand Marais	55604	28	2	3	10.7	31.0
Koochiching, MN	Big Falls	56627	2	0	2	100.0	31.4
	Northome	56661	3	0	1	33.3	31.2
St. Louis, MN	Crane Lake	55725	2	0	2	100.0	37.5
Grand Totals			35	2	8	22.9	32.7

Behavioral Health – Licensed Social Workers – Requirement is 30 miles

99.3% met the standard for Social Workers. There are 20 members who live more than 30 miles from a behavioral health provider at an average of 34.7 miles. HealthPartners has contracts with known behavioral health providers in these rural areas and continues to pursue contracts with behavioral health providers as they become known.

Members Without Access							
County	City	Zip Code	Member #	Counts #	Without Access[1] #	Without Access[1] %	Average Distance 1
Cook, MN	Grand Marais	55604	28	3	3	10.7	30.8
	Grand Portage	55605	1	0	1	100.0	34.2
Itasca, MN	Effie	56639	7	0	7	100.0	34.0
	Northome	56661	1	0	1	100.0	35.8
Koochiching, MN	Big Falls	56627	2	0	2	100.0	33.4
	Northome	56661	3	0	3	100.0	40.5
St. Louis, MN	Cook	55723	8	0	1	12.5	30.3
	Crane Lake	55725	2	0	2	100.0	37.6
Grand Totals			**52**	**3**	**20**	**38.5**	**34.7**

Behavioral Health – Psychiatry – Requirement is 30 miles

96.0% met the standard for Psychiatrists. There are 121 members who live more than 30 miles from a behavioral health provider at an average of 55.0 miles. HealthPartners has contracts with known behavioral health providers in these rural areas and continues to pursue contracts with behavioral health providers as they become known.

Members Without Access							
County	City	Zip Code	Member #	Counts #	Without Access[1] #	Without Access[1] %	Average Distance 1
Cook, MN	Grand Marais	55604	28	0	28	100.0	55.1
	Grand Portage	55605	1	0	1	100.0	88.2
	Hovland	55606	9	0	9	100.0	75.0
	Lutsen	55612	7	0	7	100.0	42.6
	Tofte	55615	3	0	1	33.3	32.0
Douglas, WI	Gordon	54838	4	0	3	75.0	32.8
	Minong	54859	3	0	3	100.0	34.2
	Solon Springs	54873	13	0	2	15.4	33.7
Itasca, MN	Bigfork	56628	7	0	3	42.9	36.2
	Effie	56639	7	0	7	100.0	34.4
	Northome	56661	1	0	1	100.0	35.8
	Spring Lake	56680	1	0	1	100.0	34.6
	Wirt	56688	1	0	1	100.0	40.0
Koochiching, MN	Big Falls	56627	2	0	2	100.0	63.6
	International Falls	56649	19	0	19	100.0	82.8
	Kabetogama	56669	2	0	2	100.0	70.0
	Littlefork	56653	1	0	1	100.0	73.0
	Loman	56654	2	0	2	100.0	84.1
	Northome	56661	3	0	3	100.0	40.8
	Ranier	56668	2	0	2	100.0	83.0
Lake, MN	Ely	55731	3	0	3	100.0	45.4
St. Louis, MN	Babbitt	55706	4	0	4	100.0	31.2
	Cook	55723	8	0	1	12.5	31.1
	Crane Lake	55725	2	0	2	100.0	51.8
	Ely	55731	13	0	13	100.0	40.5
Grand Totals			**146**	**0**	**121**	**82.9**	**55.0**

Cardiology – Requirement is 60 miles

98.7% of our members met the 60 mile requirement for Cardiology. There are 35 members who live more than 60 miles from a cardiologist at an average of 71.7 miles. HealthPartners contracts with providers that are available in these areas. There are no cardiologists available to pursue contracts with at the present time. Specialty care for those living along Lake Superior must usually be sought in Duluth.

Members Without Access							
County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
			#	#	#	%	1
Cook, MN	Grand Marais	55604	28	0	25	89.3	70.1
	Grand Portage	55605	1	0	1	100.0	76.3
	Hovland	55606	9	0	9	100.0	75.8
Grand Totals			**38**	**0**	**35**	**92.1**	**71.7**

Obstetrics & Gynecology (OB-GYN) – Requirement is 30 miles

97.5% of our members met the 30 mile requirement for Obstetrics and Gynecology. There are 68 members who live more than 30 miles from an obstetrician and gynecologist at an average of 58.3 miles; however there are primary care providers within the standard 30 miles that also provide obstetrics and gynecology services. Obstetric and Gynecologic care for those living in the northern rural areas must usually be sought in Duluth, Crookston, or Thief River Falls. No further action will be taken at this time as there are no additional Ob-Gyn providers available in these rural areas.

Members Without Access							
County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
			#	#	#	%	1
Cook, MN	Grand Marais	55604	28	0	28	100.0	68.2
	Grand Portage	55605	1	0	1	100.0	76.3
	Hovland	55606	9	0	9	100.0	75.8
	Lutsen	55612	7	0	7	100.0	57.9
	Tofte	55615	3	0	3	100.0	53.9
Douglas, WI	Gordon	54838	4	0	1	25.0	33.3
	Solon Springs	54873	13	0	2	15.4	33.1
Itasca, MN	Effie	56639	7	0	7	100.0	32.9
Koochiching, MN	Big Falls	56627	2	0	2	100.0	32.1
Lake, MN	Finland	55603	2	0	2	100.0	40.8
	Silver Bay	55614	4	0	4	100.0	47.0
	Two Harbors	55616	17	0	2	11.8	32.6
Grand Totals			**97**	**0**	**68**	**70.1**	**58.3**

Orthopedics – Requirement is 60 miles

98.7% of our members met the 60 mile requirement for Orthopedics. There are 35 members who live more than 60 miles from an orthopedist at an average of 68.8 miles. Currently, there is no specialty care available to contract with in this area of Minnesota. Specialty care for those living along Lake Superior must usually be sought in Duluth.

Members Without Access							
County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
			#	#	#	%	1
Cook, MN	Grand Marais	55604	28	0	25	89.3	66.0
	Grand Portage	55605	1	0	1	100.0	76.3
	Hovland	55606	9	0	9	100.0	75.8
Grand Totals			**38**	**0**	**35**	**92.1**	**68.8**

Otolaryngology (ENT) – Requirement is 60 miles

97.2% of our members met the 60 mile requirement for ENT. There are 76 members who live more than 60 miles from an ENT at an average of 85.8 miles. Currently, there is no specialty care available to contract with in this area of Minnesota. Specialty care for those living along Lake Superior must usually be sought in Duluth.

Members Without Access							
County	City	Zip Code	Member #	Counts #	Without Access[1] #	Without Access[1] %	Average Distance 1
Cook, MN	Grand Marais	55604	28	0	28	100.0	87.7
	Grand Portage	55605	1	0	1	100.0	112.0
	Hovland	55606	9	0	9	100.0	100.9
	Lutsen	55612	7	0	7	100.0	81.4
	Tofte	55615	3	0	3	100.0	70.4
Koochiching, MN	Big Falls	56627	2	0	2	100.0	67.3
	International Falls	56649	19	0	19	100.0	82.9
	Kabetogama	56669	2	0	2	100.0	70.2
	Littlefork	56653	1	0	1	100.0	74.1
	Loman	56654	2	0	2	100.0	85.8
	Ranier	56668	2	0	2	100.0	83.1
Grand Totals			**76**	**0**	**76**	**100.0**	**85.8**

Oncology – Requirement is 60 miles

98.2% of our members met the 60 mile requirement for Oncology. There are 48 members who live more than 60 miles from an oncology provider at an average of 79.7 miles. Currently, there is no specialty care available to contract with in this area of Minnesota. Specialty care for those living along Lake Superior must usually be sought in Duluth.

Members Without Access							
County	City	Zip Code	Member #	Counts #	Without Access[1] #	Without Access[1] %	Average Distance 1
Cook, MN	Grand Marais	55604	28	0	28	100.0	81.7
	Grand Portage	55605	1	0	1	100.0	76.3
	Hovland	55606	9	0	9	100.0	75.8
	Lutsen	55612	7	0	7	100.0	81.4
	Tofte	55615	3	0	3	100.0	70.4
Grand Totals			**48**	**0**	**48**	**100.0**	**79.7**

Dermatology – Requirement is 60 miles

98.2% of our members met the 60 mile requirement for Dermatologists. There are 48 members who live more than 60 miles from a dermatologist at an average of 79.1 miles. There are no dermatologists available to pursue contracts with in these areas at the present time. Specialty care for those living along Lake Superior must usually be sought in Duluth.

Members Without Access						
City	Zip Code	Member #	Counts #	Without Access[1] #	Without Access[1] %	Average Distance 1
Grand Marais, MN	55604	28	0	28	100.0	81.6
Grand Portage, MN	55605	1	0	1	100.0	76.3
Hovland, MN	55606	9	0	9	100.0	75.8
Lutsen, MN	55612	7	0	7	100.0	78.6
Tofte, MN	55615	3	0	3	100.0	67.7
Grand Totals		**48**	**0**	**48**	**100.0**	**79.1**

Gastroenterology – Requirement is 60 miles

97.2% of our members met the 60 mile requirement for gastroenterologists. There are 76 members who live more than 60 miles from a gastroenterologist at an average of 84.1 miles. There are no gastroenterologists available to pursue contracts with in these areas at the present time. Currently, there is no specialty care available to contract with in this area of Minnesota. Specialty care for those living along Lake Superior must usually be sought in Duluth.

Members Without Access							
County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
			#	#	#	%	1
Cook, MN	Grand Marais	55604	28	0	28	100.0	85.2
	Grand Portage	55605	1	0	1	100.0	109.0
	Hovland	55606	9	0	9	100.0	97.9
	Lutsen	55612	7	0	7	100.0	78.6
	Tofte	55615	3	0	3	100.0	67.7
Koochiching, MN	Big Falls	56627	2	0	2	100.0	67.3
	International Falls	56649	19	0	19	100.0	82.9
	Kabetogama	56669	2	0	2	100.0	70.2
	Littlefork	56653	1	0	1	100.0	74.1
	Loman	56654	2	0	2	100.0	85.8
	Ranier	56668	2	0	2	100.0	83.1
Grand Totals			**76**	**0**	**76**	**100.0**	**84.1**

Ophthalmology – Requirement is 60 miles

98.2% of our members met the 60 mile requirement for ophthalmologists. There are 48 members who live more than 60 miles from an ophthalmologist at an average of 84.3 miles. There are no ophthalmologists available to pursue contracts with in these areas at the present time. Specialty care for those living along Lake Superior must usually be sought in Duluth.

Members Without Access							
County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
			#	#	#	%	1
Cook, MN	Grand Marais	55604	28	0	28	100.0	87.5
	Grand Portage	55605	1	0	1	100.0	78.0
	Hovland	55606	9	0	9	100.0	82.1
	Lutsen	55612	7	0	7	100.0	81.3
	Tofte	55615	3	0	3	100.0	70.3
Grand Totals			**48**	**0**	**48**	**100.0**	**84.3**

Surgery – Requirement is 60 miles

99.6% of our members met the 60 mile requirement for surgeons. There are 11 members who live more than 60 miles from a surgeon at an average 73.1 miles. Currently, there is no specialty care available to contract with in this area of Minnesota. Specialty care for those living along Lake Superior must usually be sought in Duluth.

Members Without Access							
County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
			#	#	#	%	1
Cook, MN	Grand Marais	55604	28	0	1	3.6	62.5
	Grand Portage	55605	1	0	1	100.0	76.3
	Hovland	55606	9	0	9	100.0	74.0
Grand Totals			**38**	**0**	**11**	**28.9**	**73.1**

Hospitals – Requirement is 30 miles

99.6% of our members met the 30 mile requirement for hospitals. There are 10 members who live more than 30 miles from a hospital at an average of 32.2 miles. HealthPartners has pursued and obtained contracts with all willing hospitals in these areas. No further action will be taken at this time as HealthPartners already holds contracts with these area hospitals.

Members Without Access							
County	City	Zip Code	Member Counts		Without Access[1]		Average Distance
			#	#	#	%	1
Cook, MN	Grand Marais	55604	28	1	3	10.7	30.8
	Grand Portage	55605	1	0	1	100.0	34.2
Koochiching, MN	Big Falls	56627	2	0	2	100.0	31.4
	Northome	56661	3	0	1	33.3	31.2
Lake, MN	Finland	55603	2	0	2	100.0	33.6
	Silver Bay	55614	4	0	1	25.0	34.3
Grand Totals			**40**	**1**	**10**	**25.0**	**32.2**

HealthPartners 2022 Service Area Analysis – Ratio Standards*

Medicare Cost (Freedom) Products

HealthPartners Service Area Analysis – Provider Type	Ratio Access Standard	Total Pop.	Provider Counts	Actual Ratio (Provider to Member)	% Pop. Meeting Standard	Member Count-Pop. Meeting Standard	Member Count-Pop.-Not Meeting ratio standard	Action Needed
Primary Care Providers	1 per 1,500 members	*2,688	23,570	9 per 1 member	100%	2,688	0	No
Family Medicine/ General Medicine	1 per 1,500 members	*2,688	17,938	7 per 1 member	100%	2,688	0	No
Internal Medicine – 18 and over	1 per 1,500 members	*2,688	3,004	1 per 1 member	100%	2,688	0	No
Pediatrics – 18 and under	1 per 1,500 members	*0	2,655	n/a	n/a	0	0	No
Behavioral Health								
Behavioral Health	1 per 10,000 members	*2,688	27,306	10 per 1 member	100%	2,688	0	No
Licensed Marriage and Family Therapists	1 per 10,000 members	*2,688	2,772	1 per 1 member	100%	2,688	0	No
Licensed Psychologists	1 per 10,000 members	*2,688	3,995	1 per 1 member	100%	2,688	0	No
Licensed Social Workers	1 per 10,000 members	*2,688	5,632	2 per 1 member	100%	2,688	0	No
Psychiatrists	1 per 10,000 members	*2,688	2,119	1 per 1 member	100%	2,688	0	No
Specialty Care	1 per 10,000 members	*2,688	163,420	61 per 1 member	100%	2,688	0	No
High Volume Specialists								
Cardiology	1 per 10,000 members	*2,688	6,192	2 per 1 member	100%	2,688	0	No
Ob-Gyn	1 per 10,000 members	*2,688	5,993	2 per 1 member	100%	2,688	0	No
Orthopedics	1 per 10,000 members	*2,688	6,059	2 per 1 member	100%	2,688	0	No
Otolaryngology (ENT)	1 per 10,000 members	*2,688	1,095	1 per 2 members	100%	2,688	0	No
High Impact Specialists								
Oncology	1 per 10,000 members	*2,688	4,338	2 per 1 member	100%	2,688	0	No
Additional Specialties Analyzed for Informational Purposes Only								
Dermatology	1 per 10,000 members	*2,688	1,558	1 per 2 members	100%	2,688	0	No
Gastroenterology	1 per 10,000 members	*2,688	1,947	1 per 1 member	100%	2,688	0	No
Ophthalmology	1 per 10,000 members	*2,688	1,403	1 per 2 members	100%	2,688	0	No
Surgery	1 per 10,000 members	*2,688	5,348	2 per 1 member	100%	2,688	0	No
Chiropractic	1 per 10,000 members	*2,688	3,102	1 per 1 member	100%	2,688	0	No

*Ratio standards are in accordance with community standards based on a survey of HMOs in HealthPartners Service Area.

HealthPartners ratio standards have been met for the provider types defined in the "Network Assessment of Practitioner Availability" policy.

HealthPartners Service Area Analysis – Provider Type	Access Standard	Total Pop.	Provider Counts	% Pop. Meeting Standard	Average Distance to a Provider	Member Count- Pop. Meeting Standard	Member Count- Pop. Not Meeting standard	Additional information when % Pop. Meeting Standard is not 100%
Primary Care Providers	1 provider within 30 miles	*911	23,644	99.3%	2.0 miles	905	6	Yes. See Section II
Family/General Medicine	1 provider within 30 miles	*911	18,015	99.3%	2.0 miles	905	6	Yes. See Section II
Internal Medicine – 18 and over	1 provider within 30 miles	*911	3,010	98.9%	2.8 miles	901	10	Yes. See Section II
Pediatrics – 18 and under	1 provider within 30 miles	*0	2,644	0%	n/a	0	0	None
Behavioral Health								
Behavioral Health	1 provider within 30 miles	*911	27,427	98.0%	2.8 miles	893	18	Yes. See Section II
Licensed Marriage and Family Therapists	1 provider within 30 miles	*911	2,792	81.3%	3.7 miles	741	170	Yes. See Section II
Licensed Psychologists	1 provider within 30 miles	*911	3,996	95.7%	3.5 miles	872	39	Yes. See Section II
Licensed Social Workers	1 provider within 30 miles	*911	5,659	97.5%	3.1 miles	888	23	Yes. See Section II
Psychiatrists	1 provider within 30 miles	*911	2,127	93.6%	3.5 miles	853	58	Yes. See Section II
Specialty Care	1 provider within 60 miles	*911	164,438	100%	1.6 miles	911	0	None
High Volume Specialists								
Cardiology	1 provider within 60 miles	*911	6,256	100%	4.0 miles	911	0	None
Ob-Gyn Specialists	1 provider within 30 miles	*911	6,027	99.1%	2.9 miles	903	8	Yes. See Section II
Orthopedics	1 provider within 60 miles	*911	6,122	100%	3.2 miles	911	0	None
Otolaryngology (ENT)	1 provider within 60 miles	*911	1,103	100%	5.1 miles	911	0	None
High Impact Specialty								
Oncology	1 provider within 60 miles	*911	4,347	100%	4.4 miles	911	0	None
Additional Specialties Analyzed for Informational Purposes Only								
Dermatology	1 provider within 60 miles	*911	1,566	97.3%	5.2 miles	886	25	Yes. See Section II
Gastroenterology	1 provider within 60 miles	*911	1,948	95.8%	6.8 miles	873	38	Yes. See Section II
Ophthalmology	1 provider within 60 miles	*911	1,405	100%	4.5 miles	911	0	None
Surgeons	1 provider within 60 miles	*911	5,395	100%	3.6 miles	911	0	None
Chiropractors	1 provider within 60 miles	*911	3,370	100%	2.9 miles	911	0	None
Hospitals	1 hospital within 30 miles	*911	281	99.0%	3.4 miles	902	9	Yes. See Section II

*911 members live in the service area; those who do not live in the service area are not included in this table.

HealthPartners Medicare Cost (Sanford) Membership Summary

HealthPartners practitioner availability standards have been met for over 98% of the membership for the provider types defined in the "Network Assessment of Practitioner Availability" policy. Due to the large geographic service area available in this product, accessibility for some members has exceeded the criteria. Most of these members live in rural areas and do not have specialists available within the geographic standards.

Primary Care – Requirement is 30 miles

99.3% of our membership met the requirement for a primary care provider available within 30 miles. There are 6 members who live more than 30 miles from a primary care physician at an average of 43.8 miles. No further action will be taken at this time as HealthPartners already holds contracts with these area primary care providers.

Members Without Access							
County	City	Zip Code	Member Counts #		Without Access[1] #	Without Access[1] %	Average Distance 1
Kidder, ND	Dawson	58428	2	0	2	100.0	47.7
	Steele	58482	2	0	2	100.0	40.6
	Tappen	58487	1	0	1	100.0	42.1
Morton, ND	Glen Ullin	58631	1	0	1	100.0	43.8
Grand Totals			**6**	**0**	**6**	**100.0**	**43.8**

Each category of primary care was also analyzed independently.

Primary Care – Family & General Medicine – Requirement is 30 miles

99.3% of our membership met the requirement for a Primary Care-Family & General Medicine provider within 30 miles. There are 6 members who live more than 30 miles from a Primary Care provider at an average of 43.8 miles. No further action will be taken at this time as HealthPartners already holds contracts with these area primary care providers.

Members Without Access							
County	City	Zip Code	Member Counts #		Without Access[1] #	Without Access[1] %	Average Distance 1
Kidder, ND	Dawson	58428	2	0	2	100.0	47.7
	Steele	58482	2	0	2	100.0	40.6
	Tappen	58487	1	0	1	100.0	42.1
Morton, ND	Glen Ullin	58631	1	0	1	100.0	43.8
Grand Totals			**6**	**0**	**6**	**100.0**	**43.8**

Primary Care – Internal Medicine – Requirement is 30 miles

98.9% of our membership met the requirement for a Primary Care-Internal Medicine provider within 30 miles. There are 10 members who live more than 30 miles from an Internal Medicine provider at an average of 39.5 miles. No further action will be taken at this time as HealthPartners already holds contracts with these area Internal Medicine providers.

Members Without Access							
County	City	Zip Code	Member Counts #		Without Access[1] #	%	Average Distance 1
Day, SD	Bristol	57219	1	0	1	100.0	30.9
	Webster	57274	1	0	1	100.0	33.2
Kidder, ND	Dawson	58428	2	0	2	100.0	47.7
	Steele	58482	2	0	2	100.0	40.6
	Tappen	58487	1	0	1	100.0	42.1
LaMoure, ND	Kulm	58456	1	0	1	100.0	34.7
Morton, ND	Glen Ullin	58631	1	0	1	100.0	45.6
Oliver, ND	Center	58530	1	0	1	100.0	31.4
Grand Totals			**10**	**0**	**10**	**100.0**	**39.5**

Behavioral Health – Requirement is 30 miles

98.0% of our members met the 30 mile requirement for Behavioral Health. There are 18 members who live more than 30 miles from a behavioral health provider at an average of 36.1 miles. HealthPartners has contracts with known behavioral health providers in these rural areas and continues to pursue contracts with behavioral health providers as they become known.

Members Without Access							
County	City	Zip Code	Member Counts #		Without Access[1] #	%	Average Distance 1
Brown, SD	Hecla	57446	1	0	1	100.0	32.6
Day, SD	Bristol	57219	1	0	1	100.0	36.3
	Webster	57274	1	0	1	100.0	35.4
Dickey, ND	Fullerton	58441	2	0	2	100.0	31.1
LaMoure, ND	Lamoure	58458	1	0	1	100.0	31.5
Ransom, ND	Enderlin	58027	3	0	1	33.3	31.5
	Lisbon	58054	10	0	10	100.0	37.7
Sargent, ND	Rutland	58067	1	0	1	100.0	43.3
Grand Totals			**20**	**0**	**18**	**90.0**	**36.1**

Each category of behavioral health was also analyzed independently.

Behavioral Health – Licensed Marriage & Family Therapy – Requirement is 30 miles

81.3% met the standard for Marriage and Family Therapists. There are 170 members who live more than 30 miles from a behavioral health provider at an average of 79.0 miles. HealthPartners has contracts with known behavioral health providers in these rural areas and continues to pursue contracts with behavioral health providers as they become known.

Members Without Access

County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
			#	#	#	%	1
Barnes, ND	Oriska	58063	1	0	1	100.0	44.6
	Pillsbury	58065	1	0	1	100.0	50.3
	Valley City	58072	6	0	6	100.0	54.5
	Wimbledon	58492	1	0	1	100.0	75.8
Brookings, SD	Brookings	57006	2	0	2	100.0	30.9
	Volga	57071	4	0	4	100.0	38.3
Brown, SD	Hecla	57446	1	0	1	100.0	32.9
Burleigh, ND	Bismarck	58501	25	0	25	100.0	101.2
		58503	32	0	32	100.0	99.0
		58504	14	0	14	100.0	104.9
	Menoken	58558	1	0	1	100.0	99.7
Cass, ND	Page	58064	2	0	2	100.0	39.7
	Tower City	58071	4	0	4	100.0	39.1
Clay, SD	Vermillion	57069	5	0	5	100.0	50.6
Day, SD	Bristol	57219	1	0	1	100.0	36.9
	Webster	57274	1	0	1	100.0	36.8
Dickey, ND	Ellendale	58436	2	0	2	100.0	37.2
	Fullerton	58441	2	0	2	100.0	47.1
Kidder, ND	Dawson	58428	2	0	2	100.0	113.5
	Steele	58482	2	0	2	100.0	115.7
	Tappen	58487	1	0	1	100.0	111.2
Lake, SD	Wentworth	57075	1	0	1	100.0	32.9
LaMoure, ND	Kulm	58456	1	0	1	100.0	70.1
	Lamoure	58458	1	0	1	100.0	62.7
Morton, ND	Glen Ullin	58631	1	0	1	100.0	101.1
	Mandan	58554	18	0	18	100.0	99.3
	New Salem	58563	3	0	3	100.0	96.2
Oliver, ND	Center	58530	1	0	1	100.0	77.3
Ransom, ND	Enderlin	58027	3	0	3	100.0	38.5
	Lisbon	58054	10	0	10	100.0	48.6
Richland, ND	Hankinson	58041	1	0	1	100.0	40.5
	Lidgerwood	58053	2	0	2	100.0	51.0
	Wyndmere	58081	5	0	3	60.0	41.0
Sargent, ND	Rutland	58067	1	0	1	100.0	56.9
Stutsman, ND	Jamestown	58401	5	0	5	100.0	87.6
	Ypsilanti	58497	1	0	1	100.0	81.3
Traill, ND	Clifford	58016	1	0	1	100.0	41.2
	Hillsboro	58045	3	0	3	100.0	32.4
	Mayville	58257	3	0	3	100.0	30.8
	Portland	58274	1	0	1	100.0	32.1

Continued on next page...

Marriage & Family Therapists Continued:

Members Without Access

County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
			#	#	#	%	1
Grand Totals			172	0	170	98.8	79.0

Behavioral Health – Licensed Psychologists – Requirement is 30 miles

95.7% met the standard for Licensed Psychologists. There are 39 members who live more than 30 miles from a behavioral health provider at an average of 38.1 miles. HealthPartners has contracts with known behavioral health providers in these rural areas and continues to pursue contracts with behavioral health providers as they become known.

Members Without Access							
County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
			#	#	#	%	1
Brookings, SD	Brookings	57006	2	0	2	100.0	32.1
	Volga	57071	4	0	4	100.0	40.2
Brown, SD	Hecla	57446	1	0	1	100.0	32.7
Day, SD	Bristol	57219	1	0	1	100.0	37.3
	Webster	57274	1	0	1	100.0	35.4
Dickey, ND	Ellendale	58436	2	0	2	100.0	36.6
	Fullerton	58441	2	0	2	100.0	46.5
Kidder, ND	Dawson	58428	2	0	2	100.0	46.5
	Steele	58482	2	0	2	100.0	39.0
	Tappen	58487	1	0	1	100.0	42.1
Lake, SD	Wentworth	57075	1	0	1	100.0	31.9
LaMoure, ND	Kulm	58456	1	0	1	100.0	35.3
	Lamoure	58458	1	0	1	100.0	41.6
Morton, ND	Glen Ullin	58631	1	0	1	100.0	49.0
Ransom, ND	Enderlin	58027	3	0	1	33.3	31.5
	Lisbon	58054	10	0	10	100.0	37.7
Sargent, ND	Rutland	58067	1	0	1	100.0	43.3
Traill, ND	Clifford	58016	1	0	1	100.0	39.7
	Hillsboro	58045	3	0	3	100.0	32.4
	Portland	58274	1	0	1	100.0	30.5
Grand Totals			**41**	**0**	**39**	**95.1**	**38.1**

Behavioral Health – Licensed Social Workers – Requirement is 30 miles

97.5% met the standard for Social Workers. There are 23 members who live more than 30 miles from a behavioral health provider at an average of 35.6 miles. HealthPartners has contracts with known behavioral health providers in these rural areas and continues to pursue contracts with behavioral health providers as they become known.

Members Without Access							
County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
			#	#	#	%	1
Brown, SD	Hecla	57446	1	0	1	100.0	32.9
Day, SD	Bristol	57219	1	0	1	100.0	36.9
	Webster	57274	1	0	1	100.0	35.4
Dickey, ND	Fullerton	58441	2	0	2	100.0	31.1
LaMoure, ND	Lamoure	58458	1	0	1	100.0	31.5
Ransom, ND	Enderlin	58027	3	0	1	33.3	31.5
	Lisbon	58054	10	0	10	100.0	37.7
Sargent, ND	Rutland	58067	1	0	1	100.0	43.3
Traill, ND	Clifford	58016	1	0	1	100.0	39.7
	Hillsboro	58045	3	0	3	100.0	32.4
	Portland	58274	1	0	1	100.0	30.4
Grand Totals			**25**	**0**	**23**	**92.0**	**35.6**

Behavioral Health – Psychiatry – Requirement is 30 miles

93.6% met the standard for Psychiatrists. There are 58 members who live more than 30 miles from a behavioral health provider at an average of 40.9 miles. HealthPartners has contracts with known behavioral health providers in these rural areas and continues to pursue contracts with behavioral health providers as they become known.

Members Without Access							
County	City	Zip Code	Member #	Counts #	Without Access[1] #	Without Access[1] %	Average Distance 1
Barnes, ND	Oriska	58063	1	0	1	100.0	38.2
	Pillsbury	58065	1	0	1	100.0	30.2
	Valley City	58072	6	0	6	100.0	33.2
Brookings, SD	Volga	57071	4	0	2	50.0	32.4
Brown, SD	Hecla	57446	1	0	1	100.0	32.6
Cass, ND	Tower City	58071	4	0	4	100.0	37.9
Codington, SD	Henry	57243	1	0	1	100.0	57.3
	Watertown	57201	21	0	21	100.0	44.0
Day, SD	Bristol	57219	1	0	1	100.0	36.3
	Webster	57274	1	0	1	100.0	47.9
Dickey, ND	Fullerton	58441	2	0	2	100.0	31.1
Lake, SD	Wentworth	57075	1	0	1	100.0	31.0
LaMoure, ND	Lamoure	58458	1	0	1	100.0	31.5
Ransom, ND	Enderlin	58027	3	0	3	100.0	37.5
	Lisbon	58054	10	0	10	100.0	47.7
Richland, ND	Lidgerwood	58053	2	0	1	50.0	30.6
Sargent, ND	Rutland	58067	1	0	1	100.0	44.9
Grand Totals			**61**	**0**	**58**	**95.1**	**40.9**

Obstetrics & Gynecology (OB-GYN) – Requirement is 30 miles

99.1% of our members met the 30 mile requirement for Obstetrics and Gynecology. There are 8 members who live more than 30 miles from an obstetrician and gynecologist at an average of 41.8 miles; however there are primary care providers within the standard 30 miles that also provide obstetrics and gynecology services.

Members Without Access							
County	City	Zip Code	Member #	Counts #	Without Access[1] #	Without Access[1] %	Average Distance 1
Kidder, ND	Dawson	58428	2	0	2	100.0	47.9
	Steele	58482	2	0	2	100.0	40.9
	Tappen	58487	1	0	1	100.0	42.1
LaMoure, ND	Kulm	58456	1	0	1	100.0	35.3
Morton, ND	Glen Ullin	58631	1	0	1	100.0	47.5
Oliver, ND	Center	58530	1	0	1	100.0	32.3
Grand Totals			**8**	**0**	**8**	**100.0**	**41.8**

Dermatology – Requirement is 60 miles

97.3% of our members met the 60 mile requirement for Dermatologists. There are 25 members who live more than 60 miles from a dermatologist at an average of 75.3 miles. There are no dermatologists available to pursue contracts with in these areas at the present time.

Members Without Access							
City	Zip Code	Member #	Counts #	Without Access[1] #	Without Access[1] %	Average Distance 1
Aberdeen, SD	57401	20	0	20	100.0	76.1
	57402	1	0	1	100.0	76.6
Ellendale, ND	58436	2	0	2	100.0	62.1
Hecla, SD	57446	1	0	1	100.0	74.5
Westport, SD	57481	1	0	1	100.0	83.9
Grand Totals		**25**	**0**	**25**	**100.0**	**75.3**

Gastroenterology – Requirement is 60 miles

95.8% of our members met the 60 mile requirement for gastroenterologists. There are 38 members who live more than 60 miles from a gastroenterologist at an average of 96.0 miles. There are no gastroenterologists available to pursue contracts with in these areas at the present time.

Members Without Access							
County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
			#	#	#	%	1
Barnes, ND	Wimbledon	58492	1	0	1	100.0	75.0
Brown, SD	Aberdeen	57401	20	0	20	100.0	105.8
		57402	1	0	1	100.0	107.1
	Hecla	57446	1	0	1	100.0	74.5
	Westport	57481	1	0	1	100.0	100.5
Day, SD	Bristol	57219	1	0	1	100.0	84.1
	Webster	57274	1	0	1	100.0	74.0
Dickey, ND	Ellendale	58436	2	0	2	100.0	93.5
	Fullerton	58441	2	0	2	100.0	83.4
LaMoure, ND	Kulm	58456	1	0	1	100.0	88.6
	Lamoure	58458	1	0	1	100.0	74.6
Stutsman, ND	Jamestown	58401	5	0	5	100.0	83.7
	Ypsilanti	58497	1	0	1	100.0	79.9
Grand Totals			**38**	**0**	**38**	**100.0**	**96.0**

Hospitals – Requirement is 30 miles

99.0% of our members met the 30 mile requirement for hospitals. There are 9 members who live more than 30 miles from a hospital at an average of 40.2 miles. HealthPartners has pursued and obtained contracts with all willing hospitals in these areas. No further action will be taken at this time as HealthPartners already holds contracts with these area hospitals.

Members Without Access							
County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
			#	#	#	%	1
Day, SD	Bristol	57219	1	0	1	100.0	30.9
	Webster	57274	1	0	1	100.0	31.7
Kidder, ND	Dawson	58428	2	0	2	100.0	47.9
	Steele	58482	2	0	2	100.0	41.1
	Tappen	58487	1	0	1	100.0	42.1
LaMoure, ND	Kulm	58456	1	0	1	100.0	35.4
Morton, ND	Glen Ullin	58631	1	0	1	100.0	43.7
Grand Totals			**9**	**0**	**9**	**100.0**	**40.2**

HealthPartners 2022 Service Area Analysis – Ratio Standards*

Medicare HP Cost (Sanford) Product

HealthPartners Service Area Analysis – Provider Type	Ratio Access Standard	Total Pop.	Provider Counts	Actual Ratio (Provider to Member)	% Pop. Meeting Standard	Member Count-Pop. Meeting Standard	Member Count-Pop.-Not Meeting ratio standard	Action Needed
Primary Care Providers	1 per 1,500 members	*911	23,644	26 per 1 member	100%	911	0	No
Family Medicine/ General Medicine	1 per 1,500 members	*911	18,015	20 per 1 member	100%	911	0	No
Internal Medicine – 18 and over	1 per 1,500 members	*911	3,010	3 per 1 member	100%	911	0	No
Pediatrics – 18 and under	1 per 1,500 members	*0	2,644	n/a	n/a	0	0	No
Behavioral Health								
Behavioral Health	1 per 10,000 members	*911	27,427	30 per 1 member	100%	911	0	No
Licensed Marriage and Family Therapists	1 per 10,000 members	*911	2,792	3 per 1 member	100%	911	0	No
Licensed Psychologists	1 per 10,000 members	*911	3,996	4 per 1 member	100%	911	0	No
Licensed Social Workers	1 per 10,000 members	*911	5,659	6 per 1 member	100%	911	0	No
Psychiatrists	1 per 10,000 members	*911	2,127	2 per 1 member	100%	911	0	No
Specialty Care	1 per 10,000 members	*911	164,438	181 per 1 member	100%	911	0	No
High Volume Specialists								
Cardiology	1 per 10,000 members	*911	6,256	7 per 1 member	100%	911	0	No
Ob-Gyn	1 per 10,000 members	*911	6,027	7 per 1 member	100%	911	0	No
Orthopedics	1 per 10,000 members	*911	6,122	7 per 1 member	100%	911	0	No
Otolaryngology (ENT)	1 per 10,000 members	*911	1,103	1 per 1 member	100%	911	0	No
High Impact Specialists								
Oncology	1 per 10,000 members	*911	4,347	5 per 1 member	100%	911	0	No
Additional Specialties Analyzed for Informational Purposes Only								
Dermatology	1 per 10,000 members	*911	1,566	2 per 1 member	100%	911	0	No
Gastroenterology	1 per 10,000 members	*911	1,948	2 per 1 member	100%	911	0	No
Ophthalmology	1 per 10,000 members	*911	1,405	2 per 1 member	100%	911	0	No
Surgery	1 per 10,000 members	*911	5,395	6 per 1 member	100%	911	0	No
Chiropractic	1 per 10,000 members	*911	3,370	4 per 1 member	100%	911	0	No

*Ratio standards are in accordance with community standards based on a survey of HMOs in HealthPartners Service Area.

HealthPartners ratio standards have been met for the provider types defined in the "Network Assessment of Practitioner Availability" policy.

HealthPartners Service Area Analysis – Provider Type	Access Standard	Total Pop.	Provider Counts	% Pop. Meeting Standard	Average Distance to a Provider	Member Count- Pop. Meeting Standard	Member Count- Pop. Not Meeting standard	Additional information when % Pop. Meeting Standard is not 100%
Primary Care Providers	1 provider within 30 miles	*216,393	20,022	99.9%	1.5 miles	216,378	15	Yes. See Section II
Family/ General Medicine	1 provider within 30 miles	*216,393	15,330	99.9%	1.6 miles	216,378	15	Yes. See Section II
Internal Medicine – 18 and over	1 provider within 30 miles	*171,411	2,383	99.8%	2.0 miles	170,996	415	Yes. See Section II
Pediatrics - 18 and under	1 provider within 30 miles	*44,990	2,322	99.5%	2.0 miles	44,749	241	Yes. See Section II
High Volume Specialists								
Behavioral Health	1 provider within 30 miles	*216,393	32,964	99.9%	1.0 mile	216,358	35	Yes. See Section II
Licensed Marriage and Family Therapists	1 provider within 30 miles	*216,393	4,004	99.5%	1.3 miles	215,349	1,044	Yes. See Section II
Licensed Psychologists	1 provider within 30 miles	*216,393	4,592	99.9%	1.4 miles	216,084	309	Yes. See Section II
Licensed Social Workers	1 provider within 30 miles	*216,393	6,645	99.8%	1.3 miles	215,976	417	Yes. See Section II
Psychiatrists	1 provider within 30 miles	*216,393	2,000	99.7%	2.4 miles	215,641	752	Yes. See Section II
Specialty Care	1 provider within 60 miles	*216,393	136,617	100%	0.8 mile	216,393	0	None
High Volume Specialists								
Cardiology	1 provider within 60 miles	*216,393	4,309	99.9%	2.5 miles	216,227	166	Yes. See Section II
Ob-Gyn	1 provider within 30 miles	*216,393	5,274	99.8%	1.8 miles	216,033	360	Yes. See Section II
Orthopedics	1 provider within 60 miles	*216,393	5,571	99.9%	1.9 miles	216,235	158	Yes. See Section II
Otolaryngology (ENT)	1 provider within 60 miles	*216,393	947	99.8%	2.9 miles	215,887	506	Yes. See Section II
High Impact Specialists								
Oncology	1 provider within 60 miles	*216,393	3,730	99.9%	3.4 miles	216,167	226	Yes. See Section II
Additional Specialties Analyzed for Informational Purposes Only								
Dermatology	1 provider within 60 miles	*216,393	1,448	99.9%	2.9 miles	216,168	225	Yes. See Section II
Gastroenterology	1 provider within 60 miles	*216,393	1,722	99.8%	3.5 miles	215,888	505	Yes. See Section II
Ophthalmology	1 provider within 60 miles	*216,393	1,236	99.9%	3.0 miles	216,167	226	Yes. See Section II
Surgery	1 provider within 60 miles	*216,393	4,604	99.9%	2.1 miles	216,352	41	Yes. See Section II
Chiropractor	1 provider within 60 miles	*216,393	3,369	100%	1.2 miles	216,393	0	None
Hospitals	1 hospital within 30 miles	*216,393	271	99.9%	3.9 miles	216,257	136	Yes. See Section II

*216,393 members live in the service area; those who do not live in the service area are not included in this table.

HealthPartners Care Membership Summary

HealthPartners practitioner availability standards have been met for over 99% of the membership for the provider types defined in the "Network Assessment of Practitioner Availability" policy. Due to the large geographic service area available in this product, accessibility for some members has exceeded the criteria. Most of these members live in rural areas and do not have specialists available within the geographic standards. We investigated how we could meet the standard for all members.

Primary Care – Requirement is 30 miles

99.9% of our membership met the requirement for a primary care provider available within 30 miles. There are 15 members who live more than 30 miles from a primary care physician at an average of 35.1 miles. No further action will be taken at this time as HealthPartners already holds contracts with these area primary care providers.

Members Without Access							
County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
			#	#	#	%	1
Cook, MN	Grand Marais	55604	157	9	13	8.3	35.8
St. Louis, MN	Crane Lake	55725	7	0	2	28.6	30.4
Grand Totals			164	9	15	9.1	35.1

Each category of primary care was also analyzed independently.

Primary Care – Family & General Medicine – Requirement is 30 miles

99.9% of our membership met the requirement for a Primary Care-Family & General Medicine provider within 30 miles. There are 15 members who live more than 30 miles from a Family & General Medicine provider at an average of 35.1 miles. No further action will be taken at this time as HealthPartners already holds contracts with these area primary care providers.

Members Without Access							
County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
			#	#	#	%	1
Cook, MN	Grand Marais	55604	157	9	13	8.3	35.8
St. Louis, MN	Crane Lake	55725	7	0	2	28.6	30.4
Grand Totals			164	9	15	9.1	35.1

Primary Care – Internal Medicine – Requirement is 30 miles

99.8% of our membership met the requirement for a Primary Care-Internal Medicine provider within 30 miles. There are 415 members who live more than 30 miles from an Internal Medicine provider at an average of 44.5 miles. No further action will be taken at this time as HealthPartners already holds contracts with these area Internal Medicine providers.

Members Without Access							
County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
			#	#	#	%	1
Cook, MN	Grand Marais	55604	136	0	136	100.0	55.9
	Grand Portage	55605	7	0	7	100.0	82.9
	Hovland	55606	11	0	11	100.0	73.5
	Lutsen	55612	14	0	14	100.0	40.0
	Schroeder	55613	8	0	1	12.5	37.2
	Tofte	55615	16	0	8	50.0	35.4
Koochiching, MN	Big Falls	56627	4	0	3	75.0	32.1
	International Falls	56649	198	0	197	99.5	35.9
	Littlefork	56653	11	0	5	45.5	33.3
	Loman	56654	17	0	17	100.0	42.6
	Northome	56661	7	0	2	28.6	34.4
	Ranier	56668	6	0	6	100.0	36.4
	South International Falls	56679	1	0	1	100.0	36.7
Lake, MN	Finland	55603	23	0	4	17.4	32.0
	Isabella	55607	7	0	1	14.3	32.3
St. Louis, MN	Crane Lake	55725	5	0	2	40.0	30.4
Grand Totals			**471**	**0**	**415**	**88.1**	**44.5**

Primary Care – Pediatrics – Requirement is 30 miles

99.5% of our membership met the requirement for a Primary Care provider within 30 miles for Pediatrics. There are 241 members who live more than 30 miles from a Pediatric provider at an average of 43.2 miles. No further action will be taken at this time as HealthPartners already holds contracts with these area primary care providers.

Members Without Access

County	City	Zip Code	Member Counts		Without Access[1]		Average Distance
			#	#	#	%	1
Aitkin, MN	Finlayson	55735	2	0	2	100.0	43.7
	Mc Grath	56350	4	0	4	100.0	35.6
	McGregor	55760	18	0	17	94.4	33.2
	Tamarack	55787	2	0	2	100.0	33.1
Cook, MN	Grand Marais	55604	21	0	21	100.0	66.4
	Grand Portage	55605	1	0	1	100.0	90.5
	Lutsen	55612	3	0	3	100.0	58.4
	Schroeder	55613	1	0	1	100.0	45.6
	Tofte	55615	1	0	1	100.0	50.3
Kittson, MN	Karlstad	56732	2	0	2	100.0	36.4
Koochiching, MN	Big Falls	56627	1	0	1	100.0	52.0
	International Falls	56649	31	0	31	100.0	54.8
	Littlefork	56653	1	0	1	100.0	52.5
	Loman	56654	3	0	3	100.0	38.5
	Margie	56658	2	0	2	100.0	52.3
	Mizpah	56660	1	0	1	100.0	46.9
	Northome	56661	1	0	1	100.0	42.4
	Orr	55771	2	0	2	100.0	38.0
Lake, MN	Beaver Bay	55601	1	0	1	100.0	36.0
	Ely	55731	5	0	5	100.0	45.0
	Finland	55603	2	0	2	100.0	44.7
	Silver Bay	55614	15	0	15	100.0	37.7
Mille Lacs, MN	Isle	56342	6	0	4	66.7	32.9
	Wahkon	56386	5	0	1	20.0	31.8
Pine, MN	Askov	55704	3	0	3	100.0	39.3
	Bruno	55712	2	0	2	100.0	35.4
	Finlayson	55735	11	0	11	100.0	39.7
	Hinckley	55037	46	0	46	100.0	36.1
	Sandstone	55072	13	0	13	100.0	42.5
	Sturgeon Lake	55783	11	0	2	18.2	30.5
	Willow River	55795	1	0	1	100.0	35.7
St. Louis, MN	Babbitt	55706	8	0	8	100.0	31.5
	Crane Lake	55725	2	0	2	100.0	50.8
	Ely	55731	25	0	25	100.0	39.6
	Orr	55771	4	0	4	100.0	41.4
Grand Totals			**257**	**0**	**241**	**93.8**	**43.2**

Behavioral Health – Requirement is 30 miles

99.9% of our members met the 30 mile requirement for Behavioral Health. There are 35 members who live more than 30 miles from a behavioral health provider at an average of 34.1 miles. HealthPartners has contracts with known behavioral health providers in these rural areas and continues to pursue contracts with behavioral health providers as they become known.

Members Without Access							
County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
			#	#	#	%	1
Cook, MN	Grand Marais	55604	157	7	13	8.3	35.5
Kittson, MN	Hallock	56728	7	0	7	100.0	32.8
	Halma	56729	1	0	1	100.0	40.5
	Karlstad	56732	4	0	4	100.0	35.2
	Lake Bronson	56734	1	0	1	100.0	40.3
Lake, MN	Finland	55603	25	0	5	20.0	31.7
Roseau, MN	Greenbush	56726	29	0	2	6.9	30.3
St. Louis, MN	Crane Lake	55725	7	0	2	28.6	30.4
Grand Totals			**231**	**7**	**35**	**15.2**	**34.1**

Each category of behavioral health was also analyzed independently.

Behavioral Health – Licensed Marriage & Family Therapy – Requirement is 30 miles

99.5% met the standard for Marriage and Family Therapists. There are 1,044 members who live more than 30 miles from a behavioral health provider at an average of 58.2 miles. HealthPartners has contracts with known behavioral health providers in these rural areas and continues to pursue contracts with behavioral health providers as they become known.

Members Without Access							
County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
			#	#	#	%	1
Polk, MN	Bagley	56621	1	0	1	100.0	31.5
	Erskine	56535	6	0	1	16.7	30.9
	Fosston	56542	43	0	43	100.0	38.9
	Gully	56646	1	0	1	100.0	37.8
	Lengby	56651	2	0	2	100.0	30.8
	McIntosh	56556	22	0	22	100.0	36.4
	Trail	56684	6	0	6	100.0	40.8
	Winger	56592	3	0	3	100.0	33.6
Red Lake, MN	Brooks	56715	8	0	4	50.0	30.6
	Oklee	56742	12	0	12	100.0	36.0
	Plummer	56748	9	0	3	33.3	33.5
Roseau, MN	Badger	56714	16	0	16	100.0	77.2
	Greenbush	56726	29	0	29	100.0	66.0
	Roosevelt	56673	3	0	3	100.0	80.0
	Roseau	56751	95	0	95	100.0	82.8
	Salol	56756	5	0	5	100.0	87.1
	Strathcona	56759	14	0	14	100.0	62.8
	Wannaska	56761	8	0	8	100.0	71.6
	Warroad	56763	78	0	78	100.0	89.0
St. Louis, MN	Babbitt	55706	36	0	34	94.4	30.8
	Brimson	55602	5	0	3	60.0	32.4
	Crane Lake	55725	7	0	7	100.0	46.4
	Ely	55731	133	0	126	94.7	40.0
	Orr	55771	15	0	15	100.0	38.6
	Winton	55796	3	0	3	100.0	44.1
Grand Totals			**1,266**	**0**	**1,044**	**82.5**	**58.2**

Behavioral Health – Licensed Psychologists – Requirement is 30 miles

99.9% met the standard for Licensed Psychologists. There are 309 members who live more than 30 miles from a behavioral health provider at an average of 50.5 miles. HealthPartners has contracts with known behavioral health providers in these rural areas and continues to pursue contracts with behavioral health providers as they become known.

Members Without Access							
County	City	Zip Code	Member Counts		Without Access[1]		Average Distance
			#	#	#	%	1
Cook, MN	Grand Marais	55604	157	2	13	8.3	36.0
Kittson, MN	Hallock	56728	7	0	7	100.0	57.6
	Halma	56729	1	0	1	100.0	42.3
	Karlstad	56732	4	0	4	100.0	35.2
	Kennedy	56733	1	0	1	100.0	48.9
	Lake Bronson	56734	1	0	1	100.0	48.0
Koochiching, MN	Big Falls	56627	5	0	4	80.0	31.9
	Northome	56661	9	0	2	22.2	34.5
Lake, MN	Finland	55603	25	0	5	20.0	32.4
Marshall, MN	Stephen	56757	1	0	1	100.0	35.6
Roseau, MN	Badger	56714	16	0	16	100.0	48.6
	Greenbush	56726	29	0	29	100.0	39.4
	Roosevelt	56673	3	0	3	100.0	67.1
	Roseau	56751	95	0	95	100.0	52.5
	Salol	56756	5	0	5	100.0	56.0
	Strathcona	56759	14	0	14	100.0	33.4
	Wannaska	56761	8	0	8	100.0	40.5
	Warroad	56763	78	0	78	100.0	65.1
St. Louis, MN	Crane Lake	55725	7	0	7	100.0	37.1
	Orr	55771	15	0	15	100.0	36.9
Grand Totals			**481**	**2**	**309**	**64.2**	**50.5**

Behavioral Health – Licensed Social Workers – Requirement is 30 miles

99.8% met the standard for Social Workers. There are 417 members who live more than 30 miles from a behavioral health provider at an average of 45.7 miles. HealthPartners has contracts with known behavioral health providers in these rural areas and continues to pursue contracts with behavioral health providers as they become known.

Members Without Access							
County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
			#	#	#	%	1
Cook, MN	Grand Marais	55604	157	3	13	8.3	35.8
	Grand Portage	55605	8	0	4	50.0	33.4
Kittson, MN	Hallock	56728	7	0	7	100.0	32.8
	Halma	56729	1	0	1	100.0	40.6
	Karlstad	56732	4	0	4	100.0	35.2
	Lake Bronson	56734	1	0	1	100.0	40.3
Lake, MN	Finland	55603	25	0	5	20.0	32.4
Mahnomen, MN	Bejou	56516	1	0	1	100.0	36.1
	Fosston	56542	5	0	5	100.0	39.9
	Lengby	56651	6	0	6	100.0	33.7
	Mahnomen	56557	23	0	23	100.0	33.3
	Naytahwaush	56566	6	0	6	100.0	31.4
Norman, MN	Ada	56510	22	0	1	4.5	30.9
	Fertile	56540	4	0	3	75.0	30.8
	Gary	56545	3	0	3	100.0	32.0
	Twin Valley	56584	8	0	7	87.5	34.5
Polk, MN	Bagley	56621	1	0	1	100.0	31.5
	Erskine	56535	6	0	1	16.7	30.2
	Fosston	56542	43	0	43	100.0	38.8
	Gully	56646	1	0	1	100.0	34.9
	Lengby	56651	2	0	2	100.0	30.8
	McIntosh	56556	22	0	21	95.5	33.9
	Trail	56684	6	0	5	83.3	30.7
	Winger	56592	3	0	3	100.0	33.0
Roseau, MN	Badger	56714	16	0	16	100.0	48.3
	Greenbush	56726	29	0	29	100.0	39.2
	Roosevelt	56673	3	0	3	100.0	66.5
	Roseau	56751	95	0	95	100.0	52.1
	Salol	56756	5	0	5	100.0	55.5
	Strathcona	56759	14	0	14	100.0	33.1
	Wannaska	56761	8	0	8	100.0	40.0
	Warroad	56763	78	0	78	100.0	64.5
St. Louis, MN	Crane Lake	55725	7	0	2	28.6	30.4
Grand Totals			**620**	**3**	**417**	**67.3**	**45.7**

Behavioral Health – Psychiatry – Requirement is 30 miles

99.5% met the standard for Psychiatrists. There are 752 members who live more than 30 miles from a behavioral health provider at an average of 59.2 miles. HealthPartners has contracts with known behavioral health providers in these rural areas and continues to pursue contracts with behavioral health providers as they become known.

Members Without Access							
County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
			#	#	#	%	1
Cook, MN	Grand Marais	55604	157	0	157	100.0	56.1
	Grand Portage	55605	8	0	8	100.0	84.4
	Hovland	55606	11	0	11	100.0	74.5
	Lutsen	55612	17	0	17	100.0	41.2
	Schroeder	55613	9	0	1	11.1	38.0
	Tofte	55615	17	0	8	47.1	36.4
Kittson, MN	Karlstad	56732	4	0	1	25.0	30.4
Koochiching, MN	Big Falls	56627	5	0	5	100.0	63.2
	International Falls	56649	229	0	229	100.0	82.7
	Kabetogama	56669	1	0	1	100.0	69.2
	Littlefork	56653	12	0	12	100.0	73.9
	Loman	56654	20	0	20	100.0	83.3
	Margie	56658	5	0	5	100.0	59.8
	Mizpah	56660	3	0	3	100.0	47.2
	Northome	56661	9	0	9	100.0	40.9
	Orr	55771	5	0	5	100.0	37.5
	Ranier	56668	6	0	6	100.0	83.0
	South International Falls	56679	1	0	1	100.0	83.6
Lake, MN	Ely	55731	16	0	16	100.0	45.0
	Finland	55603	25	0	5	20.0	32.6
	Isabella	55607	7	0	1	14.3	32.1
Mahnomen, MN	Mahnomen	56557	23	0	3	13.0	30.2
Norman, MN	Ada	56510	22	0	22	100.0	31.3
	Fertile	56540	4	0	3	75.0	31.1
	Gary	56545	3	0	3	100.0	32.2
	Twin Valley	56584	8	0	7	87.5	35.4
Roseau, MN	Greenbush	56726	29	0	2	6.9	30.4
	Roosevelt	56673	3	0	1	33.3	30.5
St. Louis, MN	Babbitt	55706	36	0	35	97.2	31.5
	Cook	55723	15	0	1	6.7	30.2
	Crane Lake	55725	7	0	7	100.0	51.3
	Ely	55731	133	0	128	96.2	40.7
	Kabetogama	56669	1	0	1	100.0	68.2
	Orr	55771	15	0	15	100.0	40.1
	Winton	55796	3	0	3	100.0	44.9
Grand Totals			**869**	**0**	**752**	**86.5**	**59.2**

Cardiology – Requirement is 60 miles

99.9% of our members met the 60 mile requirement for Cardiology. There are 166 members who live more than 60 miles from a cardiologist at an average of 73.5 miles. HealthPartners contracts with providers that are available in these areas. There are no cardiologists available to pursue contracts with at the present time. Specialty care for those living along Lake Superior must usually be sought in Duluth.

Members Without Access							
County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
			#	#	#	%	1
Cook, MN	Grand Marais	55604	157	0	138	87.9	71.6
	Grand Portage	55605	8	0	8	100.0	99.1
	Hovland	55606	11	0	11	100.0	88.8
	Lutsen	55612	17	0	9	52.9	61.9
Grand Totals			**193**	**0**	**166**	**86.0**	**73.5**

Obstetrics & Gynecology (OB-GYN) – Requirement is 30 miles

99.8% of our members met the 30 mile requirement for Obstetrics and Gynecology. There are 360 members who live more than 30 miles from an obstetrician and gynecologist at an average of 58.1 miles; however there are primary care providers within the standard 30 miles that also provide obstetrics and gynecology services. Specialty care for those living along Lake Superior must usually be sought in Duluth.

Members Without Access							
County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
			#	#	#	%	1
Cook, MN	Grand Marais	55604	157	0	157	100.0	69.1
	Grand Portage	55605	8	0	8	100.0	99.1
	Hovland	55606	11	0	11	100.0	88.8
	Lutsen	55612	17	0	17	100.0	60.3
	Schroeder	55613	9	0	9	100.0	49.6
	Tofte	55615	17	0	17	100.0	53.3
Kittson, MN	Hallock	56728	7	0	7	100.0	30.6
	Halma	56729	1	0	1	100.0	40.6
	Karlstad	56732	4	0	4	100.0	36.4
	Kennedy	56733	1	0	1	100.0	34.1
	Lake Bronson	56734	1	0	1	100.0	42.2
Koochiching, MN	Big Falls	56627	5	0	5	100.0	33.1
	Margie	56658	5	0	5	100.0	37.8
Lake, MN	Beaver Bay	55601	5	0	5	100.0	43.7
	Finland	55603	25	0	25	100.0	42.9
	Isabella	55607	7	0	1	14.3	31.2
	Silver Bay	55614	69	0	69	100.0	46.1
	Two Harbors	55616	192	0	8	4.2	35.3
Marshall, MN	Stephen	56757	1	0	1	100.0	35.6
Roseau, MN	Greenbush	56726	29	0	2	6.9	30.4
	Roosevelt	56673	3	0	1	33.3	30.5
St. Louis, MN	Brimson	55602	5	0	3	60.0	32.8
	Crane Lake	55725	7	0	2	28.6	30.4
Grand Totals			**586**	**0**	**360**	**61.4**	**58.1**

Orthopedics – Requirement is 60 miles

99.9% of our members met the 60 mile requirement for Orthopedics. There are 158 members who live more than 60 miles from an orthopedist at an average of 68.6 miles. There are no orthopedists available to pursue contracts with in these areas at the present time. Specialty care for those living along Lake Superior must usually be sought in Duluth.

Members Without Access							
County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
			#	#	#	%	1
Cook, MN	Grand Marais	55604	157	0	138	87.9	66.4
	Grand Portage	55605	8	0	8	100.0	89.2
	Hovland	55606	11	0	11	100.0	81.5
	Lutsen	55612	17	0	1	5.9	61.7
Grand Totals			**193**	**0**	**158**	**81.9**	**68.6**

Otolaryngology (ENT) – Requirement is 60 miles

99.8% of our members met the 60 mile requirement for ENT. There are 506 members who live more than 60 miles from an ENT at an average of 83.7 miles. There are no otolaryngologists available to pursue contracts with in these areas at the present time. Specialty care for those living along Lake Superior must usually be sought in Duluth.

Members Without Access							
County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
			#	#	#	%	1
Cook, MN	Grand Marais	55604	157	0	157	100.0	87.8
	Grand Portage	55605	8	0	8	100.0	108.4
	Hovland	55606	11	0	11	100.0	101.4
	Lutsen	55612	17	0	17	100.0	78.1
	Schroeder	55613	9	0	9	100.0	67.0
	Tofte	55615	17	0	17	100.0	73.3
Koochiching, MN	Big Falls	56627	5	0	5	100.0	66.1
	International Falls	56649	229	0	229	100.0	82.9
	Kabetogama	56669	1	0	1	100.0	69.2
	Littlefork	56653	12	0	12	100.0	75.2
	Loman	56654	20	0	20	100.0	84.7
	Margie	56658	5	0	5	100.0	60.2
	Ranier	56668	6	0	6	100.0	83.1
	South International Falls	56679	1	0	1	100.0	83.7
Lake, MN	Finland	55603	25	0	7	28.0	69.4
St. Louis, MN	Kabetogama	56669	1	0	1	100.0	68.1
Grand Totals			524	0	506	96.6	83.7

Oncology – Requirement is 60 miles

99.9% of our members met the 60 mile requirement for Oncology. There are 226 members who live more than 60 miles from an oncology provider at an average of 86.0 miles. There are no oncologists available to pursue contracts with in these areas at the present time. Specialty care for those living along Lake Superior must usually be sought in Duluth.

Members Without Access							
County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
			#	#	#	%	1
Cook, MN	Grand Marais	55604	157	0	157	100.0	87.9
	Grand Portage	55605	8	0	8	100.0	108.4
	Hovland	55606	11	0	11	100.0	101.4
	Lutsen	55612	17	0	17	100.0	78.1
	Schroeder	55613	9	0	9	100.0	67.0
	Tofte	55615	17	0	17	100.0	73.3
Lake, MN	Finland	55603	25	0	7	28.0	69.5
Grand Totals			244	0	226	92.6	86.0

Dermatology – Requirement is 60 miles

99.9% of our members met the 60 mile requirement for dermatologists. There are 225 members who live more than 60 miles from a dermatologist at an average of 83.6 miles. There are no dermatologists available to pursue contracts with in these areas at the present time. Specialty care for those living along Lake Superior must usually be sought in Duluth.

Members Without Access						
City	Zip Code	Member	Counts	Without Access[1]		Average Distance
		#	#	#	%	1
Finland, MN	55603	25	0	6	24.0	71.0
Grand Marais, MN	55604	157	0	157	100.0	85.3
Grand Portage, MN	55605	8	0	8	100.0	105.4
Hovland, MN	55606	11	0	11	100.0	98.5
Lutsen, MN	55612	17	0	17	100.0	75.3
Schroeder, MN	55613	9	0	9	100.0	64.8
Tofte, MN	55615	17	0	17	100.0	70.9
Grand Totals		**244**	**0**	**225**	**92.2**	**83.6**

Gastroenterology – Requirement is 60 miles

99.8% of our members met the 60 mile requirement for gastroenterologists. There are 505 members who live more than 60 miles from a gastroenterologist at an average of 82.7 miles. There are no gastroenterologists available to pursue contracts with in these areas at the present time. Currently, there is no specialty care available to contract with in this area of Minnesota. Specialty care for those living along Lake Superior must usually be sought in Duluth.

Members Without Access							
County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
			#	#	#	%	1
Cook, MN	Grand Marais	55604	157	0	157	100.0	85.3
	Grand Portage	55605	8	0	8	100.0	105.4
	Hovland	55606	11	0	11	100.0	98.5
	Lutsen	55612	17	0	17	100.0	75.3
	Schroeder	55613	9	0	9	100.0	64.8
	Tofte	55615	17	0	17	100.0	70.9
Koochiching, MN	Big Falls	56627	5	0	5	100.0	66.1
	International Falls	56649	229	0	229	100.0	82.9
	Kabetogama	56669	1	0	1	100.0	69.2
	Littlefork	56653	12	0	12	100.0	75.2
	Loman	56654	20	0	20	100.0	84.7
	Margie	56658	5	0	5	100.0	60.2
	Ranier	56668	6	0	6	100.0	83.1
	South International Falls	56679	1	0	1	100.0	83.7
Lake, MN	Finland	55603	25	0	6	24.0	71.0
St. Louis, MN	Kabetogama	56669	1	0	1	100.0	68.1
Grand Totals			**524**	**0**	**505**	**96.4**	**82.7**

Ophthalmology – Requirement is 60 miles

99.9% of our members met the 60 mile requirement for ophthalmologists. There are 226 members who live more than 60 miles from an ophthalmologist at an average of 85.9 miles. There are no ophthalmologists available to pursue contracts with in these areas at the present time. Specialty care for those living along Lake Superior must usually be sought in Duluth.

Members Without Access							
County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
			#	#	#	%	1
Cook, MN	Grand Marais	55604	157	0	157	100.0	87.7
	Grand Portage	55605	8	0	8	100.0	108.3
	Hovland	55606	11	0	11	100.0	101.3
	Lutsen	55612	17	0	17	100.0	78.0
	Schroeder	55613	9	0	9	100.0	66.9
	Tofte	55615	17	0	17	100.0	73.2
Lake, MN	Finland	55603	25	0	7	28.0	69.2
Grand Totals			**244**	**0**	**226**	**92.6**	**85.9**

Surgery – Requirement is 60 miles

99.9% of our members met the 60 mile requirement for surgeons. There are 41 members who live more than 60 miles from a surgeon at an average of 70.6 miles. There are no surgeons available to pursue contracts with in these areas at the present time. Specialty care for those living along Lake Superior must usually be sought in Duluth.

Members Without Access							
County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
			#	#	#	%	1
Cook, MN	Grand Marais	55604	157	0	22	14.0	64.5
	Grand Portage	55605	8	0	8	100.0	83.4
	Hovland	55606	11	0	11	100.0	73.5
Grand Totals			**176**	**0**	**41**	**23.3**	**70.6**

Hospitals – Requirement is 30 miles

99.9% of our members met the 30 mile requirement for hospitals. There are 136 members who live more than 30 miles from a hospital at an average of 33.0 miles. HealthPartners has pursued and obtained contracts with all willing hospitals in these areas. No further action will be taken at this time as HealthPartners already hold contracts with these area hospitals.

Members Without Access							
County	City	Zip Code	Member Counts		Without Access[1]		Average Distance
			#	#	#	%	1
Cass, MN	Backus	56435	49	0	11	22.4	31.4
	Hackensack	56452	44	0	23	52.3	33.5
	Longville	56655	37	0	30	81.1	32.0
	Pine River	56474	87	0	2	2.3	31.3
	Walker	56484	43	0	5	11.6	32.2
Cook, MN	Grand Marais	55604	157	1	13	8.3	35.8
	Grand Portage	55605	8	0	4	50.0	33.4
	Schroeder	55613	9	0	8	88.9	33.5
Koochiching, MN	Big Falls	56627	5	0	4	80.0	31.9
	Northome	56661	9	0	2	22.2	34.5
Lake, MN	Finland	55603	25	0	25	100.0	33.9
	Isabella	55607	7	0	1	14.3	31.2
	Silver Bay	55614	69	0	6	8.7	31.7
St. Louis, MN	Crane Lake	55725	7	0	2	28.6	30.4
Grand Totals			**556**	**1**	**136**	**24.5**	**33.0**

HealthPartners 2022 Service Area Analysis – Ratio Standards*

HealthPartners Care Products

HealthPartners Service Area Analysis – Provider Type	Ratio Access Standard	Total Pop.	Provider Counts	Actual Ratio (Provider to Member)	% Pop. Meeting Standard	Member Count-Pop. Meeting Standard	Member Count-Pop.-Not Meeting ratio standard	Action Needed
Primary Care Providers	1 per 1,500 members	*216,393	20,022	1 per 10 members	100%	216,393	0	No
Family Medicine/ General Medicine	1 per 1,500 members	*216,393	15,330	1 per 14 members	100%	216,393	0	No
Internal Medicine – 18 and over	1 per 1,500 members	*171,411	2,383	1 per 72 members	100%	171,411	0	No
Pediatrics – 18 and under	1 per 1,500 members	*44,990	2,322	1 per 19 members	100%	44,990	0	No
Behavioral Health								
Behavioral Health	1 per 10,000 members	*216,393	32,964	1 per 7 members	100%	216,393	0	No
Licensed Marriage and Family Therapists	1 per 10,000 members	*216,393	4,004	1 per 54 members	100%	216,393	0	No
Licensed Psychologists	1 per 10,000 members	*216,393	4,592	1 per 47 members	100%	216,393	0	No
Licensed Social Workers	1 per 10,000 members	*216,393	6,645	1 per 33 members	100%	216,393	0	No
Psychiatrists	1 per 10,000 members	*216,393	2,000	1 per 108 members	100%	216,393	0	No
Specialty Care	1 per 10,000 members	*216,393	136,617	1 per 2 members	100%	216,393	0	No
High Volume Specialists								
Cardiology	1 per 10,000 members	*216,393	4,309	1 per 50 members	100%	216,393	0	No
Ob-Gyn	1 per 10,000 members	*216,393	5,274	1 per 41 members	100%	216,393	0	No
Orthopedics	1 per 10,000 members	*216,393	5,571	1 per 39 members	100%	216,393	0	No
Otolaryngology (ENT)	1 per 10,000 members	*216,393	947	1 per 229 members	100%	216,393	0	No
High Impact Specialists								
Oncology	1 per 10,000 members	*216,393	3,730	1 per 58 members	100%	216,393	0	No
Additional Specialties Analyzed for Informational Purposes Only								
Dermatology	1 per 10,000 members	*216,393	1,448	1 per 149 members	100%	216,393	0	No
Gastroenterology	1 per 10,000 members	*216,393	1,722	1 per 126 members	100%	216,393	0	No
Ophthalmology	1 per 10,000 members	*216,393	1,236	1 per 175 members	100%	216,393	0	No
Surgery	1 per 10,000 members	*216,393	4,604	1 per 47 members	100%	216,393	0	No
Chiropractic	1 per 10,000 members	*216,393	3,369	1 per 64 members	100%	216,393	0	No

*Ratio standards are in accordance with community standards based on a survey of HMOs in HealthPartners Service Area.

HealthPartners ratio standards have been met for the provider types defined in the "Network Assessment of Practitioner Availability" policy.

HealthPartners Service Area Analysis – Provider Type	Access Standard	Total Pop.	Provider Counts	% Pop. Meeting Standard	Average Distance to Provider	Member Count- Pop. Meeting Standard	Member Count- Pop. Not Meeting Standard	Additional information when % Pop. Meeting Standard is not 100%
Primary Care Providers	1 provider within 30 miles	*5,346	7,735	100%	1.4 miles	5,346	0	None
Family/ General Medicine	1 provider within 30 miles	*5,346	6,486	100%	1.4 miles	5,346	0	None
Internal Medicine – 18 and over	1 provider within 30 miles	*5,346	1,197	100%	1.8 miles	5,346	0	None
Pediatrics – 18 and under	1 provider within 30 miles	*0	53	0%	n/a	0	0	None
Behavioral Health								
Behavioral Health	1 provider within 30 miles	*5,346	34,255	100%	0.7 mile	5,346	0	None
Licensed Marriage and Family Therapists	1 provider within 30 miles	*5,346	3,749	100%	0.9 mile	5,346	0	None
Licensed Psychologists	1 provider within 30 miles	*5,346	4,548	100%	1.0 mile	5,346	0	None
Licensed Social Workers	1 provider within 30 miles	*5,346	6,446	100%	0.9 mile	5,346	0	None
Psychiatrists	1 provider within 30 miles	*5,346	1,942	100%	1.7 miles	5,346	0	None
Specialty Care	1 provider within 60 miles	*5,346	135,594	100%	0.6 mile	5,346	0	None
High Volume Specialists								
Cardiology	1 provider within 60 miles	*5,346	5,035	100%	1.9 miles	5,346	0	None
Obstetrics & Gynecology	1 provider within 30 miles	*5,346	5,654	100%	1.4 miles	5,346	0	None
Orthopedics	1 provider within 60 miles	*5,346	5,864	100%	1.5 miles	5,346	0	None
Otolaryngology (ENT)	1 provider within 60 miles	*5,346	1,024	100%	2.3 miles	5,346	0	None
High Impact Specialists								
Oncology	1 provider within 60 miles	*5,346	4,026	100%	2.7 miles	5,346	0	None
Additional Specialties Analyzed for Informational Purposes Only								
Dermatology	1 provider within 60 miles	*5,346	1,512	100%	2.3 miles	5,346	0	None
Gastroenterology	1 provider within 60 miles	*5,346	1,801	100%	2.7 miles	5,346	0	None
Ophthalmology	1 provider within 60 miles	*5,346	1,324	100%	2.2 miles	5,346	0	None
Surgeons	1 provider within 60 miles	*5,346	4,920	100%	1.6 miles	5,346	0	None
Chiropractors	1 provider within 60 miles	*5,346	3,369	100%	0.8 mile	5,346	0	None
Hospitals	1 hospital within 30 miles	*5,346	269	100%	3.4 miles	5,346	0	None

*5,346 members live in the service area; those who do not live in the service area are not included in this table

HealthPartners Minnesota Senior Health Options (MSHO) Membership Summary

HealthPartners practitioner availability standards have been met for the membership for the provider types defined in the "Network Assessment of Practitioner Availability" policy.

HealthPartners 2022 Service Area Analysis – Ratio Standards*

HealthPartners MSHO Product

HealthPartners Service Area Analysis – Provider Type	Ratio Access Standard	Total Pop.	Provider Counts	Actual Ratio (Provider to Member)	% Pop. Meeting Standard	Member Count-Pop. Meeting Standard	Member Count-Pop.-Not Meeting ratio standard	Action Needed
Primary Care Providers	1 per 1,500 members	*5,346	7,735	1 per 1 member	100%	5,346	0	No
Family Medicine/ General Medicine	1 per 1,500 members	*5,346	6,486	1 per 1 member	100%	5,346	0	No
Internal Medicine – 18 and over	1 per 1,500 members	*5,346	1,197	1 per 4 members	100%	5,346	0	No
Pediatrics – 18 and under	1 per 1,500 members	*0	53	n/a	n/a	0	0	No
Behavioral Health								
Behavioral Health	1 per 10,000 members	*5,346	34,255	6 per 1 member	100%	5,346	0	No
Licensed Marriage and Family Therapists	1 per 10,000 members	*5,346	3,749	1 per 1 member	100%	5,346	0	No
Licensed Psychologists	1 per 10,000 members	*5,346	4,548	1 per 1 member	100%	5,346	0	No
Licensed Social Workers	1 per 10,000 members	*5,346	6,446	1 per 1 member	100%	5,346	0	No
Psychiatrists	1 per 10,000 members	*5,346	1,942	1 per 3 members	100%	5,346	0	No
Specialty Care	1 per 10,000 members	*5,346	135,594	25 per 1 member	100%	5,346	0	No
High Volume Specialists								
Cardiology	1 per 10,000 members	*5,346	5,035	1 per 1 member	100%	5,346	0	No
Ob-Gyn	1 per 10,000 members	*5,346	5,654	1 per 1 member	100%	5,346	0	No
Orthopedics	1 per 10,000 members	*5,346	5,864	1 per 1 member	100%	5,346	0	No
Otolaryngology (ENT)	1 per 10,000 members	*5,346	1,024	1 per 5 members	100%	5,346	0	No
High Impact Specialists								
Oncology	1 per 10,000 members	*5,346	4,026	1 per 1 member	100%	5,346	0	No
Additional Specialties Analyzed for Informational Purposes Only								
Dermatology	1 per 10,000 members	*5,346	1,512	1 per 4 members	100%	5,346	0	No
Gastroenterology	1 per 10,000 members	*5,346	1,801	1 per 3 members	100%	5,346	0	No
Ophthalmology	1 per 10,000 members	*5,346	1,324	1 per 4 members	100%	5,346	0	No
Surgery	1 per 10,000 members	*5,346	4,920	1 per 1 member	100%	5,346	0	No
Chiropractic	1 per 10,000 members	*5,346	3,369	1 per 2 members	100%	5,346	0	No

*Ratio standards are in accordance with community standards based on a survey of HMOs in HealthPartners Service Area.

HealthPartners ratio standards have been met for the provider types defined in the "Network Assessment of Practitioner Availability" policy.

HealthPartners Service Area Analysis – Provider Type	Access Standard	Total Pop.	Provider Counts	% Pop. Meeting Standard	Average Distance to a Provider	Member Count- Pop. Meeting Standard	Member Count- Pop. Not Meeting standard	Additional information when % Pop. Meeting Standard is not 100%
Primary Care Providers	1 provider within 30 miles	*8,769	9,168	100%	2.1 miles	8,769	0	None
Family/ General Medicine	1 provider within 30 miles	*8,769	8,061	100%	2.1 miles	8,769	0	None
Internal Medicine – 18 and over	1 provider within 30 miles	*8,769	1,052	98.8%	3.0 miles	8,665	104	Yes. See Section II
Pediatrics – 18 and under	1 provider within 30 miles	*0	56	0%	n/a	0	0	None
Behavioral Health								
Behavioral Health	1 provider within 30 miles	*8,769	32,962	99.9%	1.7 miles	8,765	4	Yes. See Section II
Licensed Marriage and Family Therapists	1 provider within 30 miles	*8,769	4,004	97.8%	2.2 miles	8,572	197	Yes. See Section II
Licensed Psychologists	1 provider within 30 miles	*8,769	4,592	99.4%	2.2 miles	8,717	52	Yes. See Section II
Licensed Social Workers	1 provider within 30 miles	*8,769	6,645	98.8%	2.1 miles	8,666	103	Yes. See Section II
Psychiatrists	1 provider within 30 miles	*8,769	2,000	98.4%	3.6 miles	8,629	140	Yes. See Section II
Specialty Care	1 provider within 60 miles	*8,769	147,600	100%	1.2 miles	8,769	0	None
High Volume Specialists								
Cardiology	1 provider within 60 miles	*8,769	4,309	99.9%	3.5 miles	8,760	9	Yes. See Section II
Obstetrics & Gynecology	1 provider within 30 miles	*8,769	5,274	99.7%	2.5 miles	8,739	30	Yes. See Section II
Orthopedics	1 provider within 60 miles	*8,769	5,571	99.9%	2.6 miles	8,760	9	Yes. See Section II
Otolaryngology (ENT)	1 provider within 60 miles	*8,769	947	99.0%	4.1 miles	8,685	84	Yes. See Section II
High Impact Specialists								
Oncology	1 provider within 60 miles	*8,769	3,730	99.0%	4.7 miles	8,757	12	Yes. See Section II
Additional Specialties Analyzed for Informational Purposes Only								
Dermatology	1 provider within 60 miles	*8,769	1,448	99.9%	3.8 miles	8,757	12	Yes. See Section II
Gastroenterology	1 provider within 60 miles	*8,769	1,722	99.0%	5.6 miles	8,685	84	Yes. See Section II
Ophthalmology	1 provider within 60 miles	*8,769	1,236	99.9%	4.9 miles	8,757	12	Yes. See Section II
Surgeons	1 provider within 60 miles	*8,769	4,604	99.9%	2.8 miles	8,765	4	Yes. See Section II
Chiropractors	1 provider within 60 miles	*8,769	3,369	100%	2.1 miles	8,769	0	None
Hospitals	1 hospital within 30 miles	*8,769	271	99.7%	4.4 miles	8,747	22	Yes. See Section II

*8,769 members live in the service area; those who do not live in the service area are not included in this table.

HealthPartners SNBC Membership Summary

HealthPartners practitioner availability standards have been met for over 99% of the membership for the provider types defined in the "Network Assessment of Practitioner Availability" policy. Due to the large geographic service area available in this product, accessibility for some members has exceeded the criteria. Most of these members live in rural areas and do not have specialists available within the geographic standards.

Primary Care – Internal Medicine – Requirement is 30 miles

98.8% of our membership met the requirement for a Primary Care-Internal Medicine provider within 30 miles. There are 104 members who live more than 30 miles from an Internal Medicine provider at an average of 52.9 miles. No further action will be taken at this time as HealthPartners already holds contracts with these area primary care providers.

Members Without Access							
County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
			#	#	#	%	1
Cook, MN	Grand Marais	55604	6	0	6	100.0	54.8
	Grand Portage	55605	2	0	2	100.0	85.7
	Hovland	55606	2	0	2	100.0	72.2
	Lutsen	55612	1	0	1	100.0	38.2
Koochiching, MN	Big Falls	56627	4	0	3	75.0	31.3
	International Falls	56649	62	0	62	100.0	58.9
	Littlefork	56653	4	0	4	100.0	43.6
	Loman	56654	2	0	2	100.0	57.3
Lake, MN	Ely	55731	1	0	1	100.0	41.9
	Isabella	55607	1	0	1	100.0	32.7
St. Louis, MN	Babbitt	55706	8	0	8	100.0	31.1
	Ely	55731	11	0	11	100.0	38.2
	Winton	55796	1	0	1	100.0	41.1
Grand Totals			105	0	104	99.0	52.9

Behavioral Health – Requirement is 30 miles

99.9% of our members met the 30 mile requirement for Behavioral Health. There are 4 members who live more than 30 miles from a behavioral health provider at an average of 34.7 miles. HealthPartners has contracts with known behavioral health providers in these rural areas and continues to pursue contracts with behavioral health providers as they become known.

Members Without Access							
County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
			#	#	#	%	1
Kittson, MN	Hallock	56728	3	0	3	100.0	32.6
	Lancaster	56735	1	0	1	100.0	41.1
Grand Totals			4	0	4	100.0	34.7

Each category of behavioral health was also analyzed independently.

Behavioral Health – Licensed Marriage & Family Therapy – Requirement is 30 miles

97.8% met the standard for Marriage and Family Therapists. There are 197 members who live more than 30 miles from a behavioral health provider at an average of 48.2 miles. HealthPartners has contracts with known behavioral health providers in these rural areas and continues to pursue contracts with behavioral health providers as they become known.

Members Without Access							
County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
			#	#	#	%	1
Becker, MN	Park Rapids	56470	1	0	1	100.0	32.9
Cook, MN	Grand Marais	55604	6	0	6	100.0	82.2
	Grand Portage	55605	2	0	2	100.0	104.4
	Hovland	55606	2	0	2	100.0	92.4
	Lutsen	55612	1	0	1	100.0	70.0
	Schroeder	55613	1	0	1	100.0	59.5
Kittson, MN	Hallock	56728	3	0	3	100.0	60.5
	Lancaster	56735	1	0	1	100.0	66.9
Koochiching, MN	Big Falls	56627	4	0	4	100.0	33.9
	Mizpah	56660	1	0	1	100.0	47.9
	Northome	56661	2	0	2	100.0	44.1
Lake, MN	Ely	55731	1	0	1	100.0	43.7
	Finland	55603	2	0	2	100.0	55.5
	Isabella	55607	1	0	1	100.0	42.7
	Silver Bay	55614	5	0	5	100.0	47.2
Mahnomen, MN	Bejou	56516	1	0	1	100.0	37.9
	Mahnomen	56557	12	0	12	100.0	34.7
	Naytahwaush	56566	6	0	5	83.3	32.4
Marshall, MN	Argyle	56713	1	0	1	100.0	31.3
	Gatzke	56724	1	0	1	100.0	59.1
	Middle River	56737	2	0	2	100.0	52.4
	Newfolden	56738	2	0	2	100.0	38.8
	Stephen	56757	2	0	2	100.0	38.1
	Thief River Falls	56701	1	0	1	100.0	38.8
	Viking	56760	1	0	1	100.0	34.8
Norman, MN	Ada	56510	13	0	12	92.3	31.0
	Halstad	56548	4	0	4	100.0	30.5
	Twin Valley	56584	7	0	7	100.0	34.7
Pennington, MN	Goodridge	56725	2	0	2	100.0	48.3
	Thief River Falls	56701	19	0	18	94.7	31.7
Polk, MN	Erskine	56535	3	0	2	66.7	30.9
	Fosston	56542	19	0	19	100.0	39.3
	Gully	56646	1	0	1	100.0	37.8
	Lengby	56651	2	0	2	100.0	34.2
	McIntosh	56556	5	0	5	100.0	35.4
	Winger	56592	3	0	3	100.0	33.7
Red Lake, MN	Oklee	56742	1	0	1	100.0	36.3
Roseau, MN	Badger	56714	4	0	4	100.0	74.3
	Greenbush	56726	6	0	6	100.0	68.4
	Roosevelt	56673	1	0	1	100.0	83.8

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Marriage & Family Therapists Continued:

Members Without Access							
County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
			#	#	#	%	1
Roseau, MN	Roseau	56751	10	0	10	100.0	82.8
	Salol	56756	3	0	3	100.0	92.0
	Warroad	56763	11	0	11	100.0	89.9
St. Louis, MN	Babbitt	55706	8	0	8	100.0	30.6
	Brimson	55602	1	0	1	100.0	33.2
	Ely	55731	11	0	11	100.0	41.0
	Orr	55771	4	0	4	100.0	38.7
	Winton	55796	1	0	1	100.0	44.0
Grand Totals			**201**	**0**	**197**	**98.0**	**48.2**

Behavioral Health – Licensed Psychologists – Requirement is 30 miles

99.4% met the standard for Licensed Psychologists. There are 52 members who live more than 30 miles from a behavioral health provider at an average of 50.0 miles. HealthPartners has contracts with known behavioral health providers in these rural areas and continues to pursue contracts with behavioral health providers as they become known.

Members Without Access							
County	City	Zip Code	Member Counts		Without Access[1]		Average Distance
			#	#	#	%	1
Kittson, MN	Hallock	56728	3	0	3	100.0	57.4
	Lancaster	56735	1	0	1	100.0	58.7
Koochiching, MN	Big Falls	56627	4	0	3	75.0	31.3
Marshall, MN	Stephen	56757	2	0	2	100.0	35.3
Norman, MN	Halstad	56548	4	0	4	100.0	30.5
Roseau, MN	Badger	56714	4	0	4	100.0	45.0
	Greenbush	56726	6	0	6	100.0	41.2
	Roosevelt	56673	1	0	1	100.0	64.3
	Roseau	56751	10	0	10	100.0	52.4
	Salol	56756	3	0	3	100.0	61.0
	Warroad	56763	11	0	11	100.0	66.7
St. Louis, MN	Orr	55771	4	0	4	100.0	36.9
Grand Totals			53	0	52	98.1	50.0

Behavioral Health – Licensed Social Workers – Requirement is 30 miles

98.8% met the standard for Social Workers. There are 103 members who live more than 30 miles from a behavioral health provider at an average of 41.6 miles. HealthPartners has contracts with known behavioral health providers in these rural areas and continues to pursue contracts with behavioral health providers as they become known.

Members Without Access							
County	City	Zip Code	Member Counts		Without Access[1]		Average Distance
			#	#	#	%	1
Cook, MN	Grand Portage	55605	2	0	2	100.0	32.7
Kittson, MN	Hallock	56728	3	0	3	100.0	32.6
	Lancaster	56735	1	0	1	100.0	41.1
Mahnomen, MN	Bejou	56516	1	0	1	100.0	37.5
	Mahnomen	56557	12	0	12	100.0	33.2
	Naytahwaush	56566	6	0	5	83.3	30.9
Norman, MN	Ada	56510	13	0	1	7.7	30.1
	Halstad	56548	4	0	4	100.0	30.3
	Twin Valley	56584	7	0	7	100.0	34.4
Polk, MN	Erskine	56535	3	0	2	66.7	30.2
	Fosston	56542	19	0	19	100.0	39.3
	Gully	56646	1	0	1	100.0	34.1
	Lengby	56651	2	0	2	100.0	34.2
	McIntosh	56556	5	0	5	100.0	34.2
	Winger	56592	3	0	3	100.0	33.2
Roseau, MN	Badger	56714	4	0	4	100.0	44.7
	Greenbush	56726	6	0	6	100.0	41.0
	Roosevelt	56673	1	0	1	100.0	63.8
	Roseau	56751	10	0	10	100.0	52.0
	Salol	56756	3	0	3	100.0	60.6
	Warroad	56763	11	0	11	100.0	66.2
Grand Totals			117	0	103	88.0	41.6

Behavioral Health – Psychiatry – Requirement is 30 miles

98.4% met the standard for Psychiatrists. There are 140 members who live more than 30 miles from a behavioral health provider at an average of 61.2 miles. HealthPartners has contracts with known behavioral health providers in these rural areas and continues to pursue contracts with behavioral health providers as they become known.

Members Without Access							
County	City	Zip Code	Member #	Counts #	Without Access[1] #	Without Access[1] %	Average Distance 1
Cass, MN	Bena	56626	4	0	3	75.0	30.9
	Federal Dam	56641	3	0	3	100.0	31.7
Cook, MN	Grand Marais	55604	6	0	6	100.0	55.7
	Grand Portage	55605	2	0	2	100.0	86.7
	Hovland	55606	2	0	2	100.0	73.2
	Lutsen	55612	1	0	1	100.0	39.1
Koochiching, MN	Big Falls	56627	4	0	4	100.0	62.2
	International Falls	56649	62	0	62	100.0	82.6
	Littlefork	56653	4	0	4	100.0	71.3
	Loman	56654	2	0	2	100.0	87.9
	Mizpah	56660	1	0	1	100.0	47.9
	Northome	56661	2	0	2	100.0	44.7
Lake, MN	Ely	55731	1	0	1	100.0	44.5
	Isabella	55607	1	0	1	100.0	32.4
Mahnomen, MN	Mahnomen	56557	12	0	3	25.0	30.3
Norman, MN	Ada	56510	13	0	12	92.3	31.4
	Twin Valley	56584	7	0	7	100.0	35.5
St. Louis, MN	Babbitt	55706	8	0	8	100.0	31.3
	Ely	55731	11	0	11	100.0	41.9
	Orr	55771	4	0	4	100.0	42.1
	Winton	55796	1	0	1	100.0	44.8
Grand Totals			**151**	**0**	**140**	**92.7**	**61.2**

Cardiology – Requirement is 60 miles

99.9% of our members met the 60 mile requirement for Cardiology. There are 9 members who live more than 60 miles from a cardiologist at an average of 82.0 miles. HealthPartners contracts with providers that are available in these areas. There are no cardiologists available to pursue contracts with at the present time. Specialty care for those living along Lake Superior must usually be sought in Duluth.

Members Without Access							
County	City	Zip Code	Member #	Counts #	Without Access[1] #	Without Access[1] %	Average Distance 1
Cook, MN	Grand Marais	55604	6	0	5	83.3	71.5
	Grand Portage	55605	2	0	2	100.0	100.8
	Hovland	55606	2	0	2	100.0	89.6
Grand Totals			**10**	**0**	**9**	**90.0**	**82.0**

Obstetrics & Gynecology (OB-GYN) – Requirement is 30 miles

99.7% of our members met the 30 mile requirement for Ob-Gyn. There are 30 members who live more than 30 miles from an Ob-Gyn provider at an average of 52.7 miles; however there are primary care providers within the standard 30 miles that also provide obstetrics and gynecology services. Specialty care for those living along Lake Superior must usually be sought in Duluth.

Members Without Access

County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
			#	#	#	%	1
Cook, MN	Grand Marais	55604	6	0	6	100.0	69.1
	Grand Portage	55605	2	0	2	100.0	100.8
	Hovland	55606	2	0	2	100.0	89.6
	Lutsen	55612	1	0	1	100.0	58.2
	Schroeder	55613	1	0	1	100.0	48.1
Kittson, MN	Hallock	56728	3	0	3	100.0	30.6
	Lancaster	56735	1	0	1	100.0	37.2
Koochiching, MN	Big Falls	56627	4	0	4	100.0	32.6
Lake, MN	Finland	55603	2	0	2	100.0	40.7
	Silver Bay	55614	5	0	5	100.0	47.2
Marshall, MN	Stephen	56757	2	0	2	100.0	35.3
St. Louis, MN	Brimson	55602	1	0	1	100.0	33.7
Grand Totals			**30**	**0**	**30**	**100.0**	**52.7**

Orthopedics – Requirement is 60 miles

99.9% of our members met the 60 mile requirement for Orthopedics. There are 9 members who live more than 60 miles from an orthopedist at an average of 74.6 miles. Currently, there is no specialty care available to contract with on the North Shore of Minnesota. Specialty care for those living along Lake Superior must usually be sought in Duluth.

Members Without Access

County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
			#	#	#	%	1
Cook, MN	Grand Marais	55604	6	0	5	83.3	66.1
	Grand Portage	55605	2	0	2	100.0	91.3
	Hovland	55606	2	0	2	100.0	79.1
Grand Totals			**10**	**0**	**9**	**90.0**	**74.6**

Otolaryngology (ENT) – Requirement is 60 miles

99.0% of our members met the 60 mile requirement for ENT. There are 84 members who live more than 60 miles from an ENT at an average of 82.8 miles. Currently, there is no specialty care available to contract with on the North Shore of Minnesota. Specialty care for those living along Lake Superior must usually be sought in Duluth.

Members Without Access

County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
			#	#	#	%	1
Cook, MN	Grand Marais	55604	6	0	6	100.0	88.0
	Grand Portage	55605	2	0	2	100.0	110.5
	Hovland	55606	2	0	2	100.0	98.8
	Lutsen	55612	1	0	1	100.0	77.2
	Schroeder	55613	1	0	1	100.0	66.7
Koochiching, MN	Big Falls	56627	4	0	4	100.0	65.9
	International Falls	56649	62	0	62	100.0	82.8
	Littlefork	56653	4	0	4	100.0	72.5
	Loman	56654	2	0	2	100.0	88.6
Grand Totals			**84**	**0**	**84**	**100.0**	**82.8**

Oncology – Requirement is 60 miles

99.9% of our members met the 60 mile requirement for Oncology. There are 12 members who live more than 60 miles from an oncology provider at an average of 90.9 miles. Currently, there is no specialty care available to contract with on the North Shore of Minnesota. Specialty care for those living along Lake Superior must usually be sought in Duluth.

Members Without Access							
County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
			#	#	#	%	1
Cook, MN	Grand Marais	55604	6	0	6	100.0	88.0
	Grand Portage	55605	2	0	2	100.0	110.5
	Hovland	55606	2	0	2	100.0	98.8
	Lutsen	55612	1	0	1	100.0	77.2
	Schroeder	55613	1	0	1	100.0	66.7
Grand Totals			**12**	**0**	**12**	**100.0**	**90.9**

Dermatology – Requirement is 60 miles

99.9% of our members met the 60 mile requirement for dermatologists. There are 12 members who live more than 60 miles from a dermatologist at an average of 88.2 miles. There are no dermatologists available to pursue contracts with in these areas at the present time. Specialty care for those living along Lake Superior must usually be sought in Duluth.

Members Without Access						
City	Zip Code	Member	Counts	Without Access[1]		Average Distance
		#	#	#	%	1
Grand Marais, MN	55604	6	0	6	100.0	85.6
Grand Portage, MN	55605	2	0	2	100.0	107.6
Hovland, MN	55606	2	0	2	100.0	95.8
Lutsen, MN	55612	1	0	1	100.0	74.4
Schroeder, MN	55613	1	0	1	100.0	64.3
Grand Totals		**12**	**0**	**12**	**100.0**	**88.2**

Gastroenterology – Requirement is 60 miles

99.0% of our members met the 60 mile requirement for gastroenterologists. There are 84 members who live more than 60 miles from a gastroenterologist at an average of 82.4 miles. There are no gastroenterologists available to pursue contracts with in these areas at the present time. Currently, there is no specialty care available to contract with in this area of Minnesota. Specialty care for those living along Lake Superior must usually be sought in Duluth.

Members Without Access							
County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
			#	#	#	%	1
Cook, MN	Grand Marais	55604	6	0	6	100.0	85.6
	Grand Portage	55605	2	0	2	100.0	107.6
	Hovland	55606	2	0	2	100.0	95.8
	Lutsen	55612	1	0	1	100.0	74.4
	Schroeder	55613	1	0	1	100.0	64.3
Koochiching, MN	Big Falls	56627	4	0	4	100.0	65.9
	International Falls	56649	62	0	62	100.0	82.8
	Littlefork	56653	4	0	4	100.0	72.5
	Loman	56654	2	0	2	100.0	88.6
Grand Totals			**84**	**0**	**84**	**100.0**	**82.4**

Ophthalmology – Requirement is 60 miles

99.9% of our members met the 60 mile requirement for ophthalmologists. There are 12 members who live more than 60 miles from an ophthalmologist at an average of 90.8 miles. There are no ophthalmologists available to pursue contracts with in these areas at the present time. Specialty care for those living along Lake Superior must usually be sought in Duluth.

Members Without Access							
County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
			#	#	#	%	1
Cook, MN	Grand Marais	55604	6	0	6	100.0	87.9
	Grand Portage	55605	2	0	2	100.0	110.4
	Hovland	55606	2	0	2	100.0	98.6
	Lutsen	55612	1	0	1	100.0	77.1
	Schroeder	55613	1	0	1	100.0	66.6
Grand Totals			**12**	**0**	**12**	**100.0**	**90.8**

Surgery – Requirement is 60 miles

99.9% of our members met the 60 mile requirement for Surgeons. There are 4 members who live more than 60 miles from a surgeon at an average of 78.9 miles. Currently, there is no specialty care available to contract with on the North Shore of Minnesota. Specialty care for those living along Lake Superior must usually be sought in Duluth.

Members Without Access							
County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
			#	#	#	%	1
Cook, MN	Grand Portage	55605	2	0	2	100.0	85.7
	Hovland	55606	2	0	2	100.0	72.2
Grand Totals			**4**	**0**	**4**	**100.0**	**78.9**

Hospitals – Requirement is 30 miles

99.7% of our members met the 30 mile requirement for hospitals. There are 22 members who live more than 30 miles from a hospital at an average of 32.4 miles. HealthPartners has pursued and obtained contracts with all willing hospitals in these areas. No further action will be taken at this time as HealthPartners already hold contracts with these area hospitals.

Members Without Access							
County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
			#	#	#	%	1
Cass, MN	Backus	56435	13	0	2	15.4	31.6
	Hackensack	56452	7	0	5	71.4	32.2
	Longville	56655	5	0	4	80.0	32.3
	Walker	56484	20	0	2	10.0	31.4
Cook, MN	Grand Portage	55605	2	0	2	100.0	32.7
	Schroeder	55613	1	0	1	100.0	34.7
Koochiching, MN	Big Falls	56627	4	0	3	75.0	31.3
Lake, MN	Finland	55603	2	0	2	100.0	35.2
	Silver Bay	55614	5	0	1	20.0	32.3
Grand Totals			**59**	**0**	**22**	**37.3**	**32.4**

HealthPartners 2022 Service Area Analysis – Ratio Standards*

HealthPartners SNBC Product

HealthPartners Service Area Analysis – Provider Type	Ratio Access Standard	Total Pop.	Provider Counts	Actual Ratio (Provider to Member)	% Pop. Meeting Standard	Member Count-Pop. Meeting Standard	Member Count-Pop.-Not Meeting ratio standard	Action Needed
Primary Care Providers	1 per 1,500 members	*8,769	9,168	1 per 1 member	100%	8,769	0	No
Family Medicine/ General Medicine	1 per 1,500 members	*8,769	8,061	1 per 1 member	100%	8,769	0	No
Internal Medicine – 18 and over	1 per 1,500 members	*8,769	1,052	1 per 8 members	100%	8,769	0	No
Pediatrics – 18 and under	1 per 1,500 members	*0	56	n/a	n/a	0	0	No
Behavioral Health								
Behavioral Health	1 per 10,000 members	*8,769	32,962	4 per 1 member	100%	8,769	0	No
Licensed Marriage and Family Therapists	1 per 10,000 members	*8,769	4,004	1 per 2 members	100%	8,769	0	No
Licensed Psychologists	1 per 10,000 members	*8,769	4,592	1 per 2 members	100%	8,769	0	No
Licensed Social Workers	1 per 10,000 members	*8,769	6,645	1 per 1 member	100%	8,769	0	No
Psychiatrists	1 per 10,000 members	*8,769	2,000	1 per 4 members	100%	8,769	0	No
Specialty Care	1 per 10,000 members	*8,769	147,600	17 per 1 member	100%	8,769	0	No
High Volume Specialists								
Cardiology	1 per 10,000 members	*8,769	4,309	1 per 2 members	100%	8,769	0	No
Ob-Gyn	1 per 10,000 members	*8,769	5,274	1 per 2 members	100%	8,769	0	No
Orthopedics	1 per 10,000 members	*8,769	5,571	1 per 2 members	100%	8,769	0	No
Otolaryngology (ENT)	1 per 10,000 members	*8,769	947	1 per 9 members	100%	8,769	0	No
High Impact Specialists								
Oncology	1 per 10,000 members	*8,769	3,730	1 per 2 members	100%	8,769	0	No
Additional Specialties Analyzed for Informational Purposes Only								
Dermatology	1 per 10,000 members	*8,769	1,448	1 per 6 members	100%	8,769	0	No
Gastroenterology	1 per 10,000 members	*8,769	1,722	1 per 5 members	100%	8,769	0	No
Ophthalmology	1 per 10,000 members	*8,769	1,236	1 per 7 members	100%	8,769	0	No
Surgery	1 per 10,000 members	*8,769	4,604	1 per 2 members	100%	8,769	0	No
Chiropractic	1 per 10,000 members	*8,769	3,369	1 per 3 members	100%	8,769	0	No

*Ratio standards are in accordance with community standards based on a survey of HMOs in HealthPartners Service Area.

HealthPartners ratio standards have been met for the provider types defined in the "Network Assessment of Practitioner Availability" policy.

HealthPartners Service Area Analysis – Provider Type	Access Standard	Total Pop.	Provider Counts	% Pop. Meeting Standard	Average Distance to a Provider	Member Count- Pop. Meeting Standard	Member Count- Pop. not Meeting standard	Additional information when % Pop. Meeting Standard is not 100%
Primary Care Providers	1 provider within 30 miles	*2,190	1,702	100%	4.3 miles	2,190	0	None
Family/General Medicine	1 provider within 30 miles	*2,190	1,396	100%	4.3 miles	2,190	0	None
Internal Medicine – 18 and over	1 provider within 30 miles	*2,190	180	99.5%	6.5 miles	2,178	12	Yes. See Section II
Pediatrics – 18 and under	1 provider within 30 miles	*0	126	0%	n/a	0	0	None
Behavioral Health								
Behavioral Health	1 provider within 30 miles	*2,190	2,531	99.6%	4.4 miles	2,181	9	Yes. See Section II
Licensed Marriage and Family Therapists	1 provider within 30 miles	*2,190	83	69.9%	9.3 miles	1,525	665	Yes. See Section II
Licensed Psychologists	1 provider within 30 miles	*2,190	668	85.7%	8.4 miles	1,877	313	Yes. See Section II
Licensed Social Workers	1 provider within 30 miles	*2,190	561	98.2%	6.3 miles	2,151	39	Yes. See Section II
Psychiatrists	1 provider within 30 miles	*2,190	424	79.5%	6.9 miles	1,740	450	Yes. See Section II
Specialty Care	1 provider within 60 miles	*2,190	42,156	100%	2.9 miles	2,190	0	None
High Volume Specialists								
Cardiology	1 provider within 60 miles	*2,190	1,483	100%	5.1 miles	2,190	0	None
Obstetrics & Gynecology	1 provider within 30 miles	*2,190	904	99.5%	5.5 miles	2,180		Yes. See Section II
Orthopedics	1 provider within 60 miles	*2,190	1,224	100%	5.2 miles	2,190	0	None
Otolaryngology (ENT)	1 provider within 60 miles	*2,190	288	100%	9.7 miles	2,190	0	None
High Impact Specialists								
Oncology	1 provider within 60 miles	*2,190	1,195	100%	8.0 miles	2,190	0	None
Additional Specialties Analyzed for Informational Purposes Only								
Dermatology	1 provider within 60 miles	*2,190	438	100%	7.2 miles	2,190	0	None
Gastroenterology	1 provider within 60 miles	*2,190	384	98.4%	14.0 miles	2,156	34	Yes. See Section II
Ophthalmology	1 provider within 60 miles	*2,190	276	98.4%	10.6 miles	2,156	34	Yes. See Section II
Surgery	1 provider within 60 miles	*2,190	1,496	100%	7.3 miles	2,190	0	None
Chiropractic	1 provider within 60 miles	*2,190	3,097	100%	6.6 miles	2,190	0	None
Hospitals	1 hospital within 30 miles	*2,190	53	97.7%	7.8 miles	2,139	51	Yes. See Section II

*2,190 members live in the service area; those who do not live in the service area are not included in this table.

HealthPartners NE WI Medicare Advantage (Robin)

HealthPartners practitioner availability standards have been met for over 96% of the membership for the provider types defined in the "Network Assessment of Practitioner Availability" policy. Due to the large geographic service area available in this product, accessibility for some members has exceeded the criteria. Most of these members live in rural areas and do not have specialists available within the geographic standards.

Primary Care – Internal Medicine – Requirement is 30 miles

99.5% of our membership met the requirement for a Primary Care-Internal Medicine provider within 30 miles. There are 12 members who live more than 30 miles from an Internal Medicine provider at an average of 34.3 miles. No further action will be taken at this time as HealthPartners already holds contracts with these area primary care providers.

Members Without Access							
County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
			#	#	#	%	1
Shawano, WI	Birnamwood	54414	3	0	3	100.0	33.4
	Bowler	54416	2	0	1	50.0	30.2
	Eland	54427	2	0	2	100.0	40.4
	Tigerton	54486	9	0	4	44.4	31.2
	Wittenberg	54499	2	0	2	100.0	37.9
Grand Totals			**18**	**0**	**12**	**66.7**	**34.3**

Behavioral Health – Requirement is 30 miles

99.6% of our members met the 30 mile requirement for Behavioral Health. There are 9 members who live more than 30 miles from a behavioral health provider at an average of 31.1 miles. HealthPartners has contracts with known behavioral health providers in these rural areas and continues to pursue contracts with behavioral health providers as they become known.

Members Without Access							
County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
			#	#	#	%	1
Oconto, WI	Townsend	54175	13	0	9	69.2	31.1
Grand Totals			**13**	**0**	**9**	**69.2**	**31.1**

Each category of behavioral health was also analyzed independently.

Behavioral Health – Licensed Marriage & Family Therapy – Requirement is 30 miles

69.6% met the standard for Marriage and Family Therapists. There are 665 members who live more than 30 miles from a behavioral health provider at an average of 53.6 miles. HealthPartners has contracts with known behavioral health providers in these rural areas and continues to pursue contracts with behavioral health providers as they become known.

Members Without Access							
			Member Counts		Without Access[1]		Average Distance
County	City	Zip Code	#	#	#	%	1
Florence, WI	Fence	54120	4	0	4	100.0	85.4
	Florence	54121	56	0	56	100.0	93.1
	Long Lake	54542	2	0	2	100.0	81.1
	Niagara	54151	23	0	23	100.0	89.9
Green Lake, WI	Dalton	53926	1	0	1	100.0	39.6
	Markesan	53946	3	0	2	66.7	34.6
	Marquette	53947	1	0	1	100.0	33.9
	Princeton	54968	3	0	2	66.7	30.3
Kewaunee, WI	Algoma	54201	19	0	14	73.7	30.7
Manitowoc, WI	Cleveland	53015	3	0	3	100.0	35.9
	Manitowoc	54220	62	0	50	80.6	31.3
	Two Rivers	54241	14	0	8	57.1	31.1
Marinette, WI	Amberg	54102	8	0	8	100.0	70.8
	Athelstane	54104	19	0	19	100.0	64.9
	Coleman	54112	13	0	13	100.0	41.0
	Crivitz	54114	55	0	55	100.0	54.9
	Dunbar	54119	6	0	6	100.0	81.0
	Fence	54120	3	0	3	100.0	80.8
	Goodman	54125	3	0	3	100.0	77.8
	Marinette	54143	92	0	92	100.0	46.4
	Niagara	54151	20	0	20	100.0	88.8
	Pembine	54156	28	0	28	100.0	78.5
	Peshtigo	54157	37	0	37	100.0	42.7
	Porterfield	54159	11	0	11	100.0	51.1
	Pound	54161	13	0	13	100.0	45.9
	Wausaukee	54177	27	0	27	100.0	62.7
Marquette, WI	Montello	53949	4	0	4	100.0	39.6
	Neshkoro	54960	9	0	1	11.1	31.3
	Princeton	54968	1	0	1	100.0	34.1
	Westfield	53964	3	0	3	100.0	35.1
Menominee, WI	Gillett	54124	1	0	1	100.0	35.5
	Keshena	54135	20	0	20	100.0	36.9
	Neopit	54150	1	0	1	100.0	40.9
Oconto, WI	Cecil	54111	1	0	1	100.0	31.7
	Coleman	54112	4	0	4	100.0	39.1
	Crivitz	54114	3	0	3	100.0	55.4
	Gillett	54124	13	0	11	84.6	33.1
	Lakewood	54138	2	0	2	100.0	61.9
	Lena	54139	8	0	4	50.0	34.6
	Mountain	54149	7	0	7	100.0	52.6

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Marriage & Family Therapists Continued:

Members Without Access							
County	City	Zip Code	Member #	Counts #	Without Access[1] #	Without Access[1] %	Average Distance 1
Oconto, WI	Oconto	54153	15	0	7	46.7	32.7
	Oconto Falls	54154	12	0	5	41.7	33.3
	Pound	54161	6	0	6	100.0	44.8
	Suring	54174	18	0	18	100.0	42.7
	Townsend	54175	13	0	13	100.0	56.6
Shawano, WI	Birnamwood	54414	3	0	2	66.7	31.1
	Bowler	54416	2	0	1	50.0	31.1
	Cecil	54111	12	0	11	91.7	31.3
	Gresham	54128	8	0	8	100.0	32.1
	Shawano	54166	91	0	28	30.8	31.8
	Tigerton	54486	9	0	1	11.1	30.5
Waushara, WI	Coloma	54930	2	0	1	50.0	30.5
Grand Totals			**794**	**0**	**665**	**83.8**	**53.6**

Behavioral Health – Licensed Psychologists – Requirement is 30 miles

85.7% met the standard for Licensed Psychologists. There are 313 members who live more than 30 miles from a behavioral health provider at an average of 43.7 miles. HealthPartners has contracts with known behavioral health providers in these rural areas and continues to pursue contracts with behavioral health providers as they become known.

Members Without Access							
County	City	Zip Code	Member #	Counts #	Without Access[1] #	Without Access[1] %	Average Distance 1
Florence, WI	Fence	54120	4	0	4	100.0	58.3
	Florence	54121	56	0	56	100.0	61.0
	Long Lake	54542	2	0	2	100.0	73.0
	Niagara	54151	23	0	23	100.0	52.8
Marinette, WI	Amberg	54102	8	0	8	100.0	32.7
	Athelstane	54104	19	0	17	89.5	36.7
	Crivitz	54114	55	0	11	20.0	31.7
	Dunbar	54119	6	0	6	100.0	45.2
	Fence	54120	3	0	3	100.0	56.7
	Goodman	54125	3	0	3	100.0	52.6
	Niagara	54151	20	0	20	100.0	49.5
	Pembine	54156	28	0	28	100.0	38.7
	Wausaukee	54177	27	0	3	11.1	31.2
Marquette, WI	Westfield	53964	3	0	2	66.7	34.7
Menominee, WI	Gillett	54124	1	0	1	100.0	34.8
	Keshena	54135	20	0	20	100.0	36.9
	Neopit	54150	1	0	1	100.0	41.6
Oconto, WI	Cecil	54111	1	0	1	100.0	30.3
	Crivitz	54114	3	0	3	100.0	36.0
	Gillett	54124	13	0	9	69.2	31.9
	Lakewood	54138	2	0	2	100.0	44.0
	Mountain	54149	7	0	7	100.0	39.9
	Oconto Falls	54154	12	0	2	16.7	30.4
	Suring	54174	18	0	14	77.8	37.2
	Townsend	54175	13	0	13	100.0	49.1
Shawano, WI	Birnamwood	54414	3	0	3	100.0	42.4
	Bowler	54416	2	0	2	100.0	30.9
	Cecil	54111	12	0	7	58.3	30.8
	Eland	54427	2	0	2	100.0	35.7
	Gresham	54128	8	0	8	100.0	32.4
	Shawano	54166	91	0	28	30.8	31.8
	Tigerton	54486	9	0	1	11.1	30.6
	Wittenberg	54499	2	0	2	100.0	35.6
Waushara, WI	Coloma	54930	2	0	1	50.0	30.5
Grand Totals			**479**	**0**	**313**	**65.3**	**43.7**

Behavioral Health – Licensed Social Workers – Requirement is 30 miles

98.2% met the standard for Social Workers. There are 39 members who live more than 30 miles from a behavioral health provider at an average of 33.8 miles. HealthPartners has contracts with known behavioral health providers in these rural areas and continues to pursue contracts with behavioral health providers as they become known.

Members Without Access							
County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
			#	#	#	%	1
Marinette, WI	Athelstane	54104	19	0	7	36.8	31.1
	Crivitz	54114	55	0	9	16.4	30.7
Marquette, WI	Westfield	53964	3	0	2	66.7	34.7
Oconto, WI	Crivitz	54114	3	0	3	100.0	33.6
	Lakewood	54138	2	0	2	100.0	38.2
	Mountain	54149	7	0	2	28.6	30.9
	Townsend	54175	13	0	13	100.0	37.4
Waushara, WI	Coloma	54930	2	0	1	50.0	30.5
Grand Totals			**104**	**0**	**39**	**37.5**	**33.8**

Behavioral Health – Psychiatry – Requirement is 30 miles

79.5% met the standard for Psychiatrists. There are 450 members who live more than 30 miles from a behavioral health provider at an average of 45.2 miles. HealthPartners has contracts with known behavioral health providers in these rural areas and continues to pursue contracts with behavioral health providers as they become known.

Members Without Access							
County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
			#	#	#	%	1
Florence, WI	Fence	54120	4	0	4	100.0	60.8
	Florence	54121	56	0	56	100.0	56.2
	Long Lake	54542	2	0	2	100.0	75.6
	Niagara	54151	23	0	23	100.0	50.1
Marinette, WI	Amberg	54102	8	0	8	100.0	46.6
	Athelstane	54104	19	0	19	100.0	47.4
	Coleman	54112	13	0	13	100.0	35.1
	Crivitz	54114	55	0	55	100.0	42.8
	Dunbar	54119	6	0	6	100.0	51.5
	Fence	54120	3	0	3	100.0	63.6
	Goodman	54125	3	0	3	100.0	61.1
	Marinette	54143	92	0	92	100.0	43.8
	Niagara	54151	20	0	20	100.0	43.8
	Pembine	54156	28	0	28	100.0	42.2
	Peshtigo	54157	37	0	37	100.0	40.1
	Porterfield	54159	11	0	11	100.0	46.7
	Pound	54161	13	0	13	100.0	34.9
	Wausaukee	54177	27	0	27	100.0	48.1
Marquette, WI	Westfield	53964	3	0	2	66.7	30.6
Oconto, WI	Coleman	54112	4	0	1	25.0	30.9
	Crivitz	54114	3	0	3	100.0	34.9
	Lakewood	54138	2	0	2	100.0	38.2
	Mountain	54149	7	0	2	28.6	30.9
	Oconto	54153	15	0	4	26.7	32.1
	Pound	54161	6	0	2	33.3	33.7
	Townsend	54175	13	0	13	100.0	37.4
Shawano, WI	Eland	54427	2	0	1	50.0	30.3
Grand Totals			**475**	**0**	**450**	**94.7**	**45.2**

Obstetrics & Gynecology (OB-GYN) – Requirement is 30 miles

99.5% of our membership met the requirement for an Ob-Gyn provider within 30 miles. There are 10 members who live more than 30 miles from an Ob-Gyn provider at an average of 31.0 miles; however there are primary care providers within the standard 30 miles that also provide obstetrics and gynecology services. No further action will be taken at this time as HealthPartners already holds contracts with these area Ob-Gyn providers.

Members Without Access							
County	City	Zip Code	Member Counts		Without Access[1]		Average Distance
			#	#	#	%	1
Oconto, WI	Townsend	54175	13	0	9	69.2	31.1
Shawano, WI	Eland	54427	2	0	1	50.0	30.3
Grand Totals			15	0	10	66.7	31.0

Gastroenterology – Requirement is 60 miles

98.4% of our members met the 60 mile requirement for gastroenterologists. There are 34 members who live more than 60 miles from a gastroenterologist at an average of 64.7 miles. There are no gastroenterologists available to pursue contracts with in these areas at the present time.

Members Without Access							
County	City	Zip Code	Member Counts		Without Access[1]		Average Distance
			#	#	#	%	1
Florence, WI	Florence	54121	56	0	32	57.1	64.1
	Long Lake	54542	2	0	2	100.0	73.0
Grand Totals			58	0	34	58.6	64.7

Ophthalmology – Requirement is 60 miles

98.4% of our members met the 60 mile requirement for ophthalmologists. There are 34 members who live more than 60 miles from an ophthalmologist at an average of 64.4 miles. There are no ophthalmologists available to pursue contracts with in these areas at the present time.

Members Without Access							
County	City	Zip Code	Member Counts		Without Access[1]		Average Distance
			#	#	#	%	1
Florence, WI	Florence	54121	56	0	32	57.1	63.9
	Long Lake	54542	2	0	2	100.0	72.6
Grand Totals			58	0	34	58.6	64.4

Hospitals – Requirement is 30 miles

97.7% of our members met the 30 mile requirement for hospitals. There are 51 members who live more than 30 miles from a hospital at an average of 33.2 miles. HealthPartners has pursued and obtained contracts with all willing hospitals in these areas. No further action will be taken at this time as HealthPartners already hold contracts with these area hospitals.

Members Without Access							
County	City	Zip Code	Member Counts		Without Access[1]		Average Distance
			#	#	#	%	1
Marinette, WI	Athelstane	54104	19	0	12	63.2	31.2
	Crivitz	54114	55	0	18	32.7	31.3
Oconto, WI	Crivitz	54114	3	0	3	100.0	33.6
	Lakewood	54138	2	0	2	100.0	38.2
	Mountain	54149	7	0	2	28.6	30.9
	Townsend	54175	13	0	13	100.0	37.4
Shawano, WI	Eland	54427	2	0	1	50.0	30.3
Grand Totals			**101**	**0**	**51**	**50.5**	**33.2**

HealthPartners 2022 Service Area Analysis – Ratio Standards*

HealthPartners NE Wisconsin Medicare Advantage (Robin) Product

HealthPartners Service Area Analysis – Provider Type	Ratio Access Standard	Total Pop.	Provider Counts	Actual Ratio (Provider to Member)	% Pop. Meeting Standard	Member Count-Pop. Meeting Standard	Member Count-Pop.-Not Meeting ratio standard	Action Needed
Primary Care Providers	1 per 1,500 members	*2,190	1,702	1 per 1 member	100%	2,190	0	No
Family Medicine/ General Medicine	1 per 1,500 members	*2,190	1,396	1 per 1 member	100%	2,190	0	No
Internal Medicine – 18 and over	1 per 1,500 members	*2,190	180	1 per 12 members	100%	2,190	0	No
Pediatrics – 18 and under	1 per 1,500 members	*0	126	n/a	n/a	0	0	No
Behavioral Health								
Behavioral Health	1 per 10,000 members	*2,190	2,531	1 per 1 member	100%	2,190	0	No
Licensed Marriage and Family Therapists	1 per 10,000 members	*2,190	83	1 per 26 members	100%	2,190	0	No
Licensed Psychologists	1 per 10,000 members	*2,190	668	1 per 3 members	100%	2,190	0	No
Licensed Social Workers	1 per 10,000 members	*2,190	561	1 per 4 members	100%	2,190	0	No
Psychiatrists	1 per 10,000 members	*2,190	424	1 per 5 members	100%	2,190	0	No
Specialty Care	1 per 10,000 members	*2,190	42,156	19 per 1 member	100%	2,190	0	No
High Volume Specialists								
Cardiology	1 per 10,000 members	*2,190	1,483	1 per 1 member	100%	2,190	0	No
Ob-Gyn	1 per 10,000 members	*2,190	904	1 per 2 members	100%	2,190	0	No
Orthopedics	1 per 10,000 members	*2,190	1,224	1 per 2 members	100%	2,190	0	No
Otolaryngology (ENT)	1 per 10,000 members	*2,190	288	1 per 8 members	100%	2,190	0	No
High Impact Specialists								
Oncology	1 per 10,000 members	*2,190	1,195	1 per 2 members	100%	2,190	0	No
Additional Specialties Analyzed for Informational Purposes Only								
Dermatology	1 per 10,000 members	*2,190	438	1 per 5 members	100%	2,190	0	No
Gastroenterology	1 per 10,000 members	*2,190	384	1 per 6 members	100%	2,190	0	No
Ophthalmology	1 per 10,000 members	*2,190	276	1 per 8 members	100%	2,190	0	No
Surgery	1 per 10,000 members	*2,190	1,496	1 per 1 member	100%	2,190	0	No
Chiropractic	1 per 10,000 members	*2,190	3,097	1 per 1 member	100%	2,190	0	No

*Ratio standards are in accordance with community standards based on a survey of HMOs in HealthPartners Service Area.

HealthPartners ratio standards have been met for the provider types defined in the "Network Assessment of Practitioner Availability" policy.

HealthPartners Service Area Analysis – Provider Type	Access Standard	Total Pop.	Provider Counts	% Pop. Meeting Standard	Average Distance to a Provider	Member Count- Pop. Meeting Standard	Member Count- Pop. not Meeting standard	Additional information when % Pop. Meeting Standard is not 100%
Primary Care Providers	1 provider within 30 miles	*10,976	11,932	99.9%	2.0 miles	10,973	3	Yes. See Section II
Family/General Medicine	1 provider within 30 miles	*10,976	9,220	99.9%	2.2 miles	10,973	3	Yes. See Section II
Internal Medicine – 18 and over	1 provider within 30 miles	* 9,754	1,147	99.9%	2.7 miles	9,749	5	Yes. See Section II
Pediatrics – 18 and under	1 provider within 30 miles	*1,222	1,590	100%	2.5 miles	1,222	0	None
Behavioral Health								
Behavioral Health	1 provider within 30 miles	*10,976	33,743	100%	1.0 mile	10,976	0	None
Licensed Marriage and Family Therapists	1 provider within 30 miles	*10,976	4,055	100%	1.2 miles	10,976	0	None
Licensed Psychologists	1 provider within 30 miles	*10,976	4,467	100%	1.4 miles	10,976		None
Licensed Social Workers	1 provider within 30 miles	*10,976	7,470	100%	1.2 miles	10,976	0	None
Psychiatrists	1 provider within 30 miles	*10,976	2,071	100%	2.3 miles	10,976	0	None
Specialty Care	1 provider within 60 miles	*10,976	180,898	100%	0.9 miles	10,976	0	None
High Volume Specialists								
Cardiology	1 provider within 60 miles	*10,976	5,848	99.9%	3.7 miles	10,973	3	Yes. See Section II
Obstetrics & Gynecology	1 provider within 30 miles	*10,976	6,176	100%	2.3 miles	10,976	0	None
Orthopedics	1 provider within 60 miles	*10,976	7,375	100%	2.4 miles	10,976	0	None
Otolaryngology (ENT)	1 provider within 60 miles	*10,976	1,149	99.9%	3.6 miles	10,973	3	Yes. See Section II
High Impact Specialists								
Oncology	1 provider within 60 miles	*10,976	4,500	99.9%	4.1 miles	10,974	2	Yes. See Section II
Additional Specialties Analyzed for Informational Purposes Only								
Dermatology	1 provider within 60 miles	*10,976	1,914	99.9%	3.6 miles	10,972	4	Yes. See Section II
Gastroenterology	1 provider within 60 miles	*10,976	2,306	99.9%	3.9 miles	10,973	3	Yes. See Section II
Ophthalmology	1 provider within 60 miles	*10,976	1,836	100%	3.0 miles	10,976	0	None
Surgery	1 provider within 60 miles	*10,976	5,611	100%	2.5 miles	10,976	0	None
Chiropractic	1 provider within 60 miles	*10,976	4,724	100%	1.0 mile	10,976	0	None
Hospitals	1 hospital within 30 miles	*10,976	416	99.9%	4.5 miles	10,969	7	Yes. See Section II

**10,976 members live in the service area; those who do not live in the service area are not included in this table.

HealthPartners Achieve Small Exchange Membership Summary

HealthPartners practitioner availability standards have been met for over 99% of the membership for the provider types defined in the "Network Assessment of Practitioner Availability" policy. We investigated how we could meet the standard for all members.

Primary Care – Requirement is 30 miles

99.9% of our membership met the requirement for a Primary Care provider within 30 miles. There are 3 members who live more than 30 miles from a Primary Care provider at an average of 54.8 miles. No further action will be taken at this time as HealthPartners already holds contracts with these area primary care providers.

Members Without Access							
County	City	Zip Code	Member #	Counts #	Without Access[1] #	Without Access[1] %	Average Distance 1
Douglas, WI	Foxboro	54836	1	0	1	100.0	43.7
	Superior	54880	2	0	2	100.0	60.3
Grand Totals			3	0	3	100.0	54.8

Each category of primary care was also analyzed independently.

Primary Care – Family & General Medicine – Requirement is 30 miles

99.9% of our membership met the requirement for a Primary Care-Family & General Medicine provider within 30 miles. There are 3 members who live more than 30 miles from a Primary Care provider at an average of 54.8 miles. No further action will be taken at this time as HealthPartners already holds contracts with these area primary care providers.

Members Without Access							
County	City	Zip Code	Member #	Counts #	Without Access[1] #	Without Access[1] %	Average Distance 1
Douglas, WI	Foxboro	54836	1	0	1	100.0	43.7
	Superior	54880	2	0	2	100.0	60.3
Grand Totals			3	0	3	100.0	54.8

Primary Care – Internal Medicine – Requirement is 30 miles

99.9% of our membership met the requirement for a Primary Care-Internal Medicine provider within 30 miles. There are 5 members who live more than 30 miles from a Primary Care provider at an average of 61.1 miles. No further action will be taken at this time as HealthPartners already holds contracts with these area primary care providers.

Members Without Access							
County	City	Zip Code	Member #	Counts #	Without Access[1] #	Without Access[1] %	Average Distance 1
Burnett, WI	Danbury	54830	3	0	2	66.7	38.6
Douglas, WI	Foxboro	54836	1	0	1	100.0	64.9
	Superior	54880	2	0	2	100.0	81.7
Grand Totals			6	0	5	83.3	61.1

Cardiology – Requirement is 60 miles

99.9% of our membership met the requirement for a Cardiology provider within 60 miles. There are 3 members who live more than 60 miles from a Cardiology provider at an average of 85.8 miles. No further action will be taken at this time as HealthPartners already holds contracts with these area cardiology providers.

Members Without Access							
County	City	Zip Code	Member #	Counts #	Without Access[1] #	Without Access[1] %	Average Distance 1
Douglas, WI	Foxboro	54836	1	0	1	100.0	77.7
	Superior	54880	2	0	2	100.0	89.8
Grand Totals			3	0	3	100.0	85.8

Otolaryngology (ENT) – Requirement is 60 miles

99.9 % of our membership met the requirement for an ENT provider within 60 miles. There are 3 members who live more than 60 miles from an ENT provider at an average of 94.3 miles. No further action will be taken at this time as HealthPartners already holds contracts with these area ENT providers.

Members Without Access							
County	City	Zip Code	Member #	Counts #	Without Access[1] #	Without Access[1] %	Average Distance 1
Douglas, WI	Foxboro	54836	1	0	1	100.0	83.5
	Superior	54880	2	0	2	100.0	99.7
Grand Totals			3	0	3	100.0	94.3

Oncology – Requirement is 60 miles

99.9 % of our membership met the requirement for an oncology provider within 60 miles. There are 2 members who live more than 60 miles from an oncology provider at an average of 75.9 miles. No further action will be taken at this time as HealthPartners already holds contracts with these area Oncology providers.

Members Without Access							
County	City	Zip Code	Member #	Counts #	Without Access[1] #	Without Access[1] %	Average Distance 1
Douglas, WI	Superior	54880	2	0	2	100.0	75.9
Grand Totals			2	0	2	100.0	75.9

Dermatology – Requirement is 60 miles

99.9% of our membership met the 60 mile requirement. There are 4 members who live more than 60 miles from a dermatologist at an average of 88.7 miles. No further action will be taken at this time as HealthPartners already holds contracts with these area Dermatology providers.

Members Without Access						
City	Zip Code	Member #	Counts #	Without Access[1] #	Without Access[1] %	Average Distance 1
Danbury, WI	54830	3	0	1	33.3	64.2
Foxboro, WI	54836	1	0	1	100.0	85.4
Superior, WI	54880	2	0	2	100.0	102.5
Grand Totals		6	0	4	66.7	88.7

Gastroenterology – Requirement is 60 miles

99.9% of our membership met the 60 mile requirement. There are 3 members who live more than 89.1 miles from a gastroenterologist at an average of 89.0 miles. No further action will be taken at this time as HealthPartners already holds contracts with these area gastroenterology providers.

Members Without Access							
County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
			#	#	#	%	1
Douglas, WI	Foxboro	54836	1	0	1	100.0	77.7
	Superior	54880	2	0	2	100.0	94.8
Grand Totals			3	0	3	100.0	89.1

Hospitals – Requirement is 30 miles

99.9% of our membership met the 30 mile requirement. There are 7 members who live more than 30 miles from a hospital at an average of 64.0 miles. No further action will be taken at this time as HealthPartners already hold contracts with these area hospitals.

Members Without Access							
County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance
			#	#	#	%	1
Burnett, WI	Danbury	54830	3	0	3	100.0	49.1
	Siren	54872	1	0	1	100.0	33.1
Douglas, WI	Foxboro	54836	1	0	1	100.0	77.7
	Superior	54880	2	0	2	100.0	94.8
Grand Totals			7	0	7	100.0	64.0

HealthPartners 2022 Service Area Analysis – Ratio Standards*

Achieve SE Products Summary

HealthPartners Service Area Analysis – Provider Type	Ratio Access Standard	Total Pop.	Provider Counts	Actual Ratio (Provider to Member)	% Pop. Meeting Standard	Member Count-Pop. Meeting Standard	Member Count-Pop.- Not Meeting ratio standard	Action Needed
Primary Care Providers	1 per 1,500 members	*10,976	11,932	1 per 1 member	100%	10,976	0	No
Family Medicine/ General Medicine	1 per 1,500 members	*10,976	9,220	1 per 1 member	100%	10,976	0	No
Internal Medicine – 18 and over	1 per 1,500 members	* 9,754	1,147	1 per 9 members	100%	9,754	0	No
Pediatrics – 18 and under	1 per 1,500 members	*1,222	1,590	1 per 1 member	100%	1,222	0	No
Behavioral Health								
Behavioral Health	1 per 10,000 members	*10,976	33,743	3 per 1 member	100%	10,976	0	No
Licensed Marriage and Family Therapists	1 per 10,000 members	*10,976	4,055	1 per 3 members	100%	10,976	0	No
Licensed Psychologists	1 per 10,000 members	*10,976	4,467	1 per 2 members	100%	10,976	0	No
Licensed Social Workers	1 per 10,000 members	*10,976	7,470	1 per 1 member	100%	10,976	0	No
Psychiatrists	1 per 10,000 members	*10,976	2,071	1 per 5 members	100%	10,976	0	No
Specialty Care	1 per 10,000 members	*10,976	180,898	16 per 1 member	100%	10,976	0	No
High Volume Specialists								
Cardiology	1 per 10,000 members	*10,976	5,848	1 per 2 members	100%	10,976	0	No
Ob-Gyn	1 per 10,000 members	*10,976	6,176	1 per 2 members	100%	10,976	0	No
Orthopedics	1 per 10,000 members	*10,976	7,375	1 per 1 member	100%	10,976	0	No
Otolaryngology (ENT)	1 per 10,000 members	*10,976	1,149	1 per 10 members	100%	10,976	0	No
High Impact Specialists								
Oncology	1 per 10,000 members	*10,976	4,500	1 per 2 members	100%	10,976	0	No
Additional Specialties Analyzed for Informational Purposes Only								
Dermatology	1 per 10,000 members	*10,976	1,914	1 per 6 members	100%	10,976	0	No
Gastroenterology	1 per 10,000 members	*10,976	2,306	1 per 5 members	100%	10,976	0	No
Ophthalmology	1 per 10,000 members	*10,976	1,836	1 per 6 members	100%	10,976	0	No
Surgery	1 per 10,000 members	*10,976	5,611	1 per 2 members	100%	10,976	0	No
Chiropractic	1 per 10,000 members	*10,976	4,724	1 per 2 members	100%	10,976	0	No

*Ratio standards are in accordance with community standards based on a survey of HMOs in HealthPartners Service Area.

HealthPartners ratio standards have been met for the provider types defined in the "Network Assessment of Practitioner Availability" policy.

HealthPartners Service Area Analysis – Provider Type	Access Standard	Total Pop.	Provider Counts	% Pop. Meeting Standard	Average Distance to a Provider	Member Count- Pop. Meeting Standard	Member Count- Pop. not Meeting standard	Additional information when % Pop. Meeting Standard is not 100%
Primary Care Providers	1 provider within 30 miles	*328	15,514	100%	3.5 miles	328	0	None
Family/General Medicine	1 provider within 30 miles	*328	12,167	100%	3.5 miles	328	0	None
Internal Medicine – 18 and over	1 provider within 30 miles	*275	1,512	100%	7.6 miles	275	0	None
Pediatrics – 18 and under	1 provider within 30 miles	*53	1,859	100%	7.4 miles	53	0	None
Behavioral Health								
Behavioral Health	1 provider within 30 miles	*328	26,414	100%	3.0 miles	328	0	None
Licensed Marriage and Family Therapists	1 provider within 30 miles	*328	3,852	100%	4.5 miles	328	0	None
Licensed Psychologists	1 provider within 30 miles	*328	3,861	100%	5.3 miles	328	0	None
Licensed Social Workers	1 provider within 30 miles	*328	6,090	100%	4.8 miles	328	0	None
Psychiatrists	1 provider within 30 miles	*328	1,616	97.0%	13.6 miles	318	10	Yes. See Section II
Specialty Care	1 provider within 60 miles	*328	142,275	100%	2.7 miles	328	0	None
High Volume Specialists								
Cardiology	1 provider within 60 miles	*328	4,000	100%	4.8 miles	328	0	None
Obstetrics & Gynecology	1 provider within 30 miles	*328	5,060	100%	6.2 miles	328	0	None
Orthopedics	1 provider within 60 miles	*328	6,177	100%	5.3 miles	328	0	None
Otolaryngology (ENT)	1 provider within 60 miles	*328	924	100%	6.3 miles	328	0	None
High Impact Specialists								
Oncology	1 provider within 60 miles	*328	4,005	100%	9.5 miles	328	0	None
Additional Specialties Analyzed for Informational Purposes Only								
Dermatology	1 provider within 60 miles	*328	1,609	100%	11.3 miles	328	0	None
Gastroenterology	1 provider within 60 miles	*328	1,953	100%	9.7 miles	328	0	None
Ophthalmology	1 provider within 60 miles	*328	1,470	100%	10.3 miles	328	0	None
Surgery	1 provider within 60 miles	*328	4,796	100%	4.6 miles	328	0	None
Chiropractic	1 provider within 60 miles	*328	3,392	100%	3.4 miles	328	0	None
Hospitals	1 hospital within 30 miles	*328	284	100%	6.7 miles	328	0	None

*328 members live in the service area; those who do not live in the service area are not included in this table.

HealthPartners CentraChoice Small Exchange Membership Summary

HealthPartners practitioner availability standards have been met for over 99% of the membership for the provider types defined in the "Network Assessment of Practitioner Availability" policy. We investigated how we could meet the standard for all members.

Behavioral Health – Psychiatry – Requirement is 30 miles

97.0% met the standard for Psychiatrists. There are 10 members who live more than 30 miles from a behavioral health provider at an average of 31.6 miles. HealthPartners has contracts with known behavioral health providers in these rural areas and continues to pursue contracts with behavioral health providers as they become known.

Members Without Access							
County	City	Zip Code	Member Counts		Without Access[1]		Average Distance
			#	#	#	%	1
Kandiyohi, MN	Belgrade	56312	1	0	1	100.0	30.6
	Kandiyohi	56251	2	0	1	50.0	30.3
	New London	56273	10	0	8	80.0	31.9
Grand Totals			13	0	10	76.9	31.6

HealthPartners 2022 Service Area Analysis – Ratio Standards*

CentraChoice SE Products Summary

HealthPartners Service Area Analysis – Provider Type	Ratio Access Standard	Total Pop.	Provider Counts	Actual Ratio (Provider to Member)	% Pop. Meeting Standard	Member Count-Pop. Meeting Standard	Member Count-Pop.-Not Meeting ratio standard	Action Needed
Primary Care Providers	1 per 1,500 members	*328	15,514	47 per 1 member	100%	328	0	No
Family Medicine/ General Medicine	1 per 1,500 members	*328	12,167	37 per 1 member	100%	328	0	No
Internal Medicine – 18 and over	1 per 1,500 members	*275	1,512	5 per 1 member	100%	275	0	No
Pediatrics – 18 and under	1 per 1,500 members	*53	1,859	35 per 1 member	100%	53	0	No
Behavioral Health								
Behavioral Health	1 per 10,000 members	*328	26,414	86 per 1 member	100%	328	0	No
Licensed Marriage and Family Therapists	1 per 10,000 members	*328	3,852	12 per 1 member	100%	328	0	No
Licensed Psychologists	1 per 10,000 members	*328	3,861	12 per 1 member	100%	328	0	No
Licensed Social Workers	1 per 10,000 members	*328	6,090	19 per 1 member	100%	328	0	No
Psychiatrists	1 per 10,000 members	*328	1,616	5 per 1 member	100%	328	0	No
Specialty Care	1 per 10,000 members	*328	142,275	434 per 1 member	100%	328	0	No
High Volume Specialists								
Cardiology	1 per 10,000 members	*328	4,000	12 per 1 member	100%	328	0	No
Ob-Gyn	1 per 10,000 members	*328	5,060	15 per 1 member	100%	328	0	No
Orthopedics	1 per 10,000 members	*328	6,177	19 per 1 member	100%	328	0	No
Otolaryngology (ENT)	1 per 10,000 members	*328	924	3 per 1 member	100%	328	0	No
High Impact Specialists								
Oncology	1 per 10,000 members	*328	4,005	12 per 1 member	100%	328	0	No
Additional Specialties Analyzed for Informational Purposes Only								
Dermatology	1 per 10,000 members	*328	1,609	5 per 1 member	100%	328	0	No
Gastroenterology	1 per 10,000 members	*328	1,953	6 per 1 member	100%	328	0	No
Ophthalmology	1 per 10,000 members	*328	1,470	5 per 1 member	100%	328	0	No
Surgery	1 per 10,000 members	*328	4,796	15 per 1 member	100%	328	0	No
Chiropractic	1 per 10,000 members	*328	3,392	10 per 1 member	100%	328	0	No

*Ratio standards are in accordance with community standards based on a survey of HMOs in HealthPartners Service Area.

HealthPartners ratio standards have been met for the provider types defined in the "Network Assessment of Practitioner Availability" policy.

HealthPartners Service Area Analysis – Provider Type	Access Standard	Total Pop.	Provider Counts	% Pop. Meeting Standard	Average Distance to a Provider	Member Count- Pop. Meeting Standard	Member Count- Pop. not Meeting standard	Additional information when % Pop. Meeting Standard is not 100%
Primary Care Providers	1 provider within 30 miles	*113	25,026	100%	2.4 miles	113	0	None
Family/General Medicine	1 provider within 30 miles	*113	19,385	100%	2.4 miles	113	0	None
Internal Medicine – 18 and over	1 provider within 30 miles	*100	3,016	100%	3.0 miles	100	0	None
Pediatrics – 18 and under	1 provider within 30 miles	*13	2,650	100%	13.9 miles	13	0	None
Behavioral Health								
Behavioral Health	1 provider within 30 miles	*113	49,987	100%	2.6 miles	113	0	None
Licensed Marriage and Family Therapists	1 provider within 30 miles	*113	4,519	100%	8.3 miles	113	0	None
Licensed Psychologists	1 provider within 30 miles	*113	6,400	100%	3.3 miles	113	0	None
Licensed Social Workers	1 provider within 30 miles	*113	9,895	100%	2.9 miles	113	0	None
Psychiatrists	1 provider within 30 miles	*113	3,751	100%	11.2 miles	113	0	None
Specialty Care	1 provider within 60 miles	*113	265,555	100%	2.2 miles	113	0	None
High Volume Specialists								
Cardiology	1 provider within 60 miles	*113	9,393	100%	8.0 miles	113	0	None
Obstetrics & Gynecology	1 provider within 30 miles	*113	8,628	100%	3.1 miles	113	0	None
Orthopedics	1 provider within 60 miles	*113	10,101	100%	11.6 miles	113	0	None
Otolaryngology (ENT)	1 provider within 60 miles	*113	1,809	100%	13.5 miles	113	0	None
High Impact Specialists								
Oncology	1 provider within 60 miles	*113	6,885	100%	13.5 miles	113	0	None
Additional Specialties Analyzed for Informational Purposes Only								
Dermatology	1 provider within 60 miles	*113	2,683	100%	14.0 miles	113	0	None
Gastroenterology	1 provider within 60 miles	*113	2,886	100%	35.6 miles	113	0	None
Ophthalmology	1 provider within 60 miles	*113	2,401	100%	8.3 miles	113	0	None
Surgery	1 provider within 60 miles	*113	8,723	100%	3.2 miles	113	0	None
Chiropractic	1 provider within 60 miles	*113	4,767	100%	7.9 miles	113	0	None
Hospitals	1 hospital within 30 miles	*113	534	100%	3.4 miles	113	0	None

*113 members live in the service area; those who do not live in the service area are not included in this table.

HealthPartners Cornerstone Membership Summary

HealthPartners practitioner availability standards have been met for the membership for the provider types defined in the “Network Assessment of Practitioner Availability” policy.

HealthPartners 2022 Service Area Analysis – Ratio Standards*

Cornerstone Products Summary

HealthPartners Service Area Analysis – Provider Type	Ratio Access Standard	Total Pop.	Provider Counts	Actual Ratio (Provider to Member)	% Pop. Meeting Standard	Member Count-Pop. Meeting Standard	Member Count-Pop.-Not Meeting ratio standard	Action Needed
Primary Care Providers	1 per 1,500 members	*113	25,026	221 per 1 member	100%	113	0	No
Family Medicine/ General Medicine	1 per 1,500 members	*113	19,385	176 per 1 member	100%	113	0	No
Internal Medicine – 18 and over	1 per 1,500 members	*100	3,016	30 per 1 member	100%	113	0	No
Pediatrics – 18 and under	1 per 1,500 members	*13	2,650	204 per 1 member	100%	113	0	No
Behavioral Health								
Behavioral Health	1 per 10,000 members	*113	49,987	442 per 1 member	100%	113	0	No
Licensed Marriage and Family Therapists	1 per 10,000 members	*113	4,519	40 per 1 member	100%	113	0	No
Licensed Psychologists	1 per 10,000 members	*113	6,400	57 per 1 member	100%	113	0	No
Licensed Social Workers	1 per 10,000 members	*113	9,895	88 per 1 member	100%	113	0	No
Psychiatrists	1 per 10,000 members	*113	3,751	33 per 1 member	100%	113	0	No
Specialty Care	1 per 10,000 members	*113	265,555	2350 per 1 member	100%	113	0	No
High Volume Specialists								
Cardiology	1 per 10,000 members	*113	9,393	83 per 1 member	100%	113	0	No
Ob-Gyn	1 per 10,000 members	*113	8,628	76 per 1 member	100%	113	0	No
Orthopedics	1 per 10,000 members	*113	10,101	89 per 1 member	100%	113	0	No
Otolaryngology (ENT)	1 per 10,000 members	*113	1,809	16 per 1 member	100%	113	0	No
High Impact Specialists								
Oncology	1 per 10,000 members	*113	6,885	61 per 1 member	100%	113	0	No
Additional Specialties Analyzed for Informational Purposes Only								
Dermatology	1 per 10,000 members	*113	2,683	24 per 1 member	100%	113	0	No
Gastroenterology	1 per 10,000 members	*113	2,886	26 per 1 member	100%	113	0	No
Ophthalmology	1 per 10,000 members	*113	2,401	21 per 1 member	100%	113	0	No
Surgery	1 per 10,000 members	*113	8,723	77 per 1 member	100%	113	0	No
Chiropractic	1 per 10,000 members	*113	4,767	42 per 1 member	100%	113	0	No

*Ratio standards are in accordance with community standards based on a survey of HMOs in HealthPartners Service Area.

HealthPartners ratio standards have been met for the provider types defined in the "Network Assessment of Practitioner Availability" policy.

HealthPartners Service Area Analysis – Provider Type	Access Standard	Total Pop.	Provider Counts	% Pop. Meeting Standard	Average Distance to a Provider	Member Count- Pop. Meeting Standard	Member Count- Pop. not Meeting standard	Additional information when % Pop. Meeting Standard is not 100%
Primary Care Providers	1 provider within 30 miles	*5,226	27,118	100%	2.5 miles	5,226	0	None
Family/General Medicine	1 provider within 30 miles	*5,226	20,963	100%	2.5 miles	5,226	0	None
Internal Medicine – 18 and over	1 provider within 30 miles	*4,439	3,293	100%	3.4 miles	4,439	0	None
Pediatrics – 18 and under	1 provider within 30 miles	*787	2,889	99.9%	5.0 miles	786	1	Yes. See Section II
Behavioral Health								
Behavioral Health	1 provider within 30 miles	*5,226	50,511	100%	2.5 miles	5,226	0	None
Licensed Marriage and Family Therapists	1 provider within 30 miles	*5,226	4,503	95.4%	9.1 miles	4,984	242	Yes. See Section II
Licensed Psychologists	1 provider within 30 miles	*5,226	6,603	99.9%	4.3 miles	5,220	6	Yes. See Section II
Licensed Social Workers	1 provider within 30 miles	*5,226	10,021	100%	3.8 miles	5,226	0	None
Psychiatrists	1 provider within 30 miles	*5,226	3,911	95.8%	5.0 miles	5,006	220	Yes. See Section II
Specialty Care	1 provider within 60 miles	*5,226	272,944	100%	1.7 miles	5,226	0	None
High Volume Specialists								
Cardiology	1 provider within 60 miles	*5,226	9,623	100%	3.8 miles	5,226	0	None
Obstetrics & Gynecology	1 provider within 30 miles	*5,226	9,079	100%	3.8 miles	5,226	0	None
Orthopedics	1 provider within 60 miles	*5,226	10,532	100%	3.2 miles	5,226	0	None
Otolaryngology (ENT)	1 provider within 60 miles	*5,226	1,909	100%	4.8 miles	5,226	0	None
High Impact Specialists								
Oncology	1 provider within 60 miles	*5,226	7,149	100%	5.1 miles	5,226	0	None
Additional Specialties Analyzed for Informational Purposes Only								
Dermatology	1 provider within 60 miles	*5,226	2,760	100%	4.6 miles	5,226	0	None
Gastroenterology	1 provider within 60 miles	*5,226	2,987	100%	5.8 miles	5,226	0	None
Ophthalmology	1 provider within 60 miles	*5,226	2,469	100%	5.7 miles	5,226	0	None
Surgery	1 provider within 60 miles	*5,226	9,242	100%	4.3 miles	5,226	0	None
Chiropractic	1 provider within 60 miles	*5,226	4,507	100%	2.5 miles	5,226	0	None
Hospitals	1 hospital within 30 miles	*5,226	558	99.8%	5.7 miles	5,216	10	Yes. See Section II

*5,226 members live in the service area; those who do not live in the service area are not included in this table.

HealthPartners Robin Focused Membership Summary

HealthPartners practitioner availability standards have been met for over 99 % of the membership for the provider types defined in the "Network Assessment of Practitioner Availability" policy. We investigated how we could meet the standard for all members.

Primary Care – Pediatrics – Requirement is 30 miles

99.9% of our membership met the requirement for a Primary Care-Pediatrics provider within 30 miles. There is 1 member who lives more than 30 miles from a Primary Care provider at an average of 33.2 miles. No further action will be taken at this time as HealthPartners already holds contracts with these area primary care providers.

Members Without Access							
County	City	Zip Code	Member Counts #		Without Access[1] #	%	Average Distance 1
Marinette, WI	Amberg	54102	1	0	1	100.0	33.2
Grand Totals			**1**	**0**	**1**	**100.0**	**33.2**

Behavioral Health – Licensed Marriage & Family Therapy – Requirement is 30 miles

95.4% met the standard for Marriage and Family Therapists. There are 242 members who live more than 30 miles from a Licensed Marriage and Family Therapy provider at an average of 45.2 miles. HealthPartners has contracts with known behavioral health providers in these rural areas and continues to pursue contracts with behavioral health providers as they become known.

Members Without Access							
County	City	Zip Code	Member Counts #		Without Access[1] #	%	Average Distance 1
Door, WI	Sturgeon Bay	54235	8	0	8	100.0	41.0
Manitowoc, WI	Two Rivers	54241	133	0	5	3.8	31.6
Marinette, WI	Amberg	54102	3	0	3	100.0	58.7
	Athelstane	54104	3	0	3	100.0	48.2
	Coleman	54112	9	0	9	100.0	41.0
	Crivitz	54114	23	0	23	100.0	51.4
	Goodman	54125	1	0	1	100.0	47.2
	Marinette	54143	113	0	113	100.0	46.8
	Pembine	54156	2	0	2	100.0	63.7
	Peshtigo	54157	38	0	38	100.0	42.5
	Porterfield	54159	11	0	11	100.0	50.6
	Pound	54161	7	0	7	100.0	44.7
Oconto, WI	Gillett	54124	3	0	3	100.0	32.4
	Lakewood	54138	1	0	1	100.0	33.9
	Lena	54139	6	0	3	50.0	36.6
	Oconto Falls	54154	6	0	4	66.7	33.6
	Suring	54174	1	0	1	100.0	35.2
Shawano, WI	Shawano	54166	22	0	7	31.8	31.5
Grand Totals			**390**	**0**	**242**	**62.1**	**45.2**

Behavioral Health – Licensed Psychologists – Requirement is 30 miles

99.9% met the standard for Psychologists. There are 6 members who live more than 30 miles from a Psychologist provider at an average of 35.5 miles. HealthPartners has contracts with known behavioral health providers in these rural areas and continues to pursue contracts with behavioral health providers as they become known.

Members Without Access							
County	City	Zip Code	Member #	Counts #	Without Access[1] #	Without Access[1] %	Average Distance 1
Marinette, WI	Amberg	54102	3	0	3	100.0	33.2
	Athelstane	54104	3	0	1	33.3	30.1
	Pembine	54156	2	0	2	100.0	41.7
Grand Totals			**8**	**0**	**6**	**75.0**	**35.5**

Behavioral Health – Psychiatry – Requirement is 30 miles

95.8% met the standard for Psychiatrists. There are 220 members who live more than 30 miles from a Psychiatry provider at an average of 42.0 miles. HealthPartners has contracts with known behavioral health providers in these rural areas and continues to pursue contracts with behavioral health providers as they become known.

Members Without Access							
County	City	Zip Code	Member #	Counts #	Without Access[1] #	Without Access[1] %	Average Distance 1
Door, WI	Sturgeon Bay	54235	8	0	8	100.0	36.9
Marinette, WI	Amberg	54102	3	0	3	100.0	40.2
	Athelstane	54104	3	0	3	100.0	34.1
	Coleman	54112	9	0	9	100.0	35.9
	Crivitz	54114	23	0	23	100.0	41.7
	Marinette	54143	113	0	113	100.0	44.2
	Pembine	54156	2	0	2	100.0	36.5
	Peshtigo	54157	38	0	38	100.0	39.9
	Porterfield	54159	11	0	11	100.0	46.0
	Pound	54161	7	0	7	100.0	36.4
Marquette, WI	Westfield	53964	12	0	1	8.3	30.9
Oconto, WI	Lena	54139	6	0	2	33.3	33.5
Grand Totals			**235**	**0**	**220**	**93.6**	**42.0**

Hospitals – Requirement is 30 miles

99.8% of our membership met the 30 mile requirement. There are 10 members who live more than 30 miles from a hospital at an average of 36.5 miles. No further action will be taken at this time as HealthPartners already hold contracts with these area hospitals.

Members Without Access							
County	City	Zip Code	Member #	Counts #	Without Access[1] #	Without Access[1] %	Average Distance 1
Marinette, WI	Amberg	54102	3	0	3	100.0	34.1
	Athelstane	54104	3	0	2	66.7	37.1
	Crivitz	54114	23	0	1	4.3	34.5
	Goodman	54125	1	0	1	100.0	34.8
	Pembine	54156	2	0	2	100.0	42.6
Oconto, WI	Lakewood	54138	1	0	1	100.0	34.3
Grand Totals			**33**	**0**	**10**	**30.3**	**36.5**

HealthPartners 2022 Service Area Analysis – Ratio Standards*

Robin Focused Products Summary

HealthPartners Service Area Analysis – Provider Type	Ratio Access Standard	Total Pop.	Provider Counts	Actual Ratio (Provider to Member)	% Pop. Meeting Standard	Member Count-Pop. Meeting Standard	Member Count-Pop.-Not Meeting ratio standard	Action Needed
Primary Care Providers	1 per 1,500 members	*5,226	27,118	5 per 1 member	100%	5,226	0	No
Family Medicine/ General Medicine	1 per 1,500 members	*5,226	20,963	4 per 1 member	100%	5,226	0	No
Internal Medicine – 18 and over	1 per 1,500 members	*4,439	3,293	1 per 1 member	100%	4,439	0	No
Pediatrics – 18 and under	1 per 1,500 members	*787	2,889	1 per 4 members	100%	787	0	No
Behavioral Health								
Behavioral Health	1 per 10,000 members	*5,226	50,511	10 per 1 member	100%	5,226	0	No
Licensed Marriage and Family Therapists	1 per 10,000 members	*5,226	4,503	1 per 1 member	100%	5,226	0	No
Licensed Psychologists	1 per 10,000 members	*5,226	6,603	1 per 1 member	100%	5,226	0	No
Licensed Social Workers	1 per 10,000 members	*5,226	10,021	2 per 1 member	100%	5,226	0	No
Psychiatrists	1 per 10,000 members	*5,226	3,911	1 per 1 member	100%	5,226	0	No
Specialty Care	1 per 10,000 members	*5,226	272,944	52 per 1 member	100%	5,226	0	No
High Volume Specialists								
Cardiology	1 per 10,000 members	*5,226	9,623	2 per 1 member	100%	5,226	0	No
Ob-Gyn	1 per 10,000 members	*5,226	9,079	2 per 1 member	100%	5,226	0	No
Orthopedics	1 per 10,000 members	*5,226	10,532	2 per 1 member	100%	5,226	0	No
Otolaryngology (ENT)	1 per 10,000 members	*5,226	1,909	1 per 3 members	100%	5,226	0	No
High Impact Specialists								
Oncology	1 per 10,000 members	*5,226	7,149	1 per 1 member	100%	5,226	0	No
Additional Specialties Analyzed for Informational Purposes Only								
Dermatology	1 per 10,000 members	*5,226	2,760	1 per 2 members	100%	5,226	0	No
Gastroenterology	1 per 10,000 members	*5,226	2,987	1 per 2 members	100%	5,226	0	No
Ophthalmology	1 per 10,000 members	*5,226	2,469	1 per 2 members	100%	5,226	0	No
Surgery	1 per 10,000 members	*5,226	9,242	2 per 1 member	100%	5,226	0	No
Chiropractic	1 per 10,000 members	*5,226	4,507	1 per 1 member	100%	5,226	0	No

*Ratio standards are in accordance with community standards based on a survey of HMOs in HealthPartners Service Area.

HealthPartners ratio standards have been met for the provider types defined in the "Network Assessment of Practitioner Availability" policy.

HealthPartners Service Area Analysis – Provider Type	Access Standard	Total Pop.	Provider Counts	% Pop. Meeting Standard	Average Distance to a Provider	Member Count- Pop. Meeting Standard	Member Count- Pop. not Meeting standard	Additional information when % Pop. Meeting Standard is not 100%
Primary Care Providers	1 provider within 30 miles	*27,846	26,520	100.0%	1.9 miles	27,846	0	None
Family/General Medicine	1 provider within 30 miles	*27,846	20,533	100.0%	2.0 miles	27,846	0	None
Internal Medicine – 18 and over	1 provider within 30 miles	*24,361	3,187	99.9%	2.5 miles	24,337	24	Yes. See Section II
Pediatrics – 18 and under	1 provider within 30 miles	*3,485	2,825	99.7%	3.1 miles	3,476	9	Yes. See Section II
Behavioral Health								
Behavioral Health	1 provider within 30 miles	*27,846	45,260	100.0%	1.5 miles	27,846	0	None
Licensed Marriage and Family Therapists	1 provider within 30 miles	*27,846	4,379	99.9%	2.0 miles	27,810	36	Yes. See Section II
Licensed Psychologists	1 provider within 30 miles	*27,846	5,975	99.9%	2.0 miles	27,838	8	Yes. See Section II
Licensed Social Workers	1 provider within 30 miles	*27,846	9,241	99.9%	1.9 miles	27,842	4	Yes. See Section II
Psychiatrists	1 provider within 30 miles	*27,846	3,372	99.8%	3.4 miles	27,801	45	Yes. See Section II
Specialty Care	1 provider within 60 miles	*27,846	269,027	100%	1.1 miles	27,846	0	None
Cardiology	1 provider within 60 miles	*27,846	9,593	99.9%	3.3 miles	27,825	21	Yes. See Section II
Obstetrics & Gynecology	1 provider within 30 miles	*27,846	8,985	99.9%	2.4 miles	27,820	26	Yes. See Section II
Orthopedics	1 provider within 60 miles	*27,846	10,422	99.9%	2.4 miles	27,825	21	Yes. See Section II
Otolaryngology (ENT)	1 provider within 60 miles	*27,846	1,873	99.9%	3.6 miles	27,822	24	Yes. See Section II
High Impact Specialists								
Oncology	1 provider within 60 miles	*27,846	7,075	99.9%	4.1 miles	27,822	24	Yes. See Section II
Additional Specialties Analyzed for Informational Purposes Only								
Dermatology	1 provider within 60 miles	*27,846	2,765	99.9%	3.8 miles	27,822	24	Yes. See Section II
Gastroenterology	1 provider within 60 miles	*27,846	2,946	99.9%	4.7 miles	27,822	24	Yes. See Section II
Ophthalmology	1 provider within 60 miles	*27,846	2,443	99.9%	3.6 miles	27,822	24	Yes. See Section II
Surgery	1 provider within 60 miles	*27,846	9,091	100%	2.6 miles	27,846	0	None
Chiropractic	1 provider within 60 miles	*27,846	4,766	100%	1.5 miles	27,846	0	None
Hospitals	1 hospital within 30 miles	*27,846	550	99.9%	4.8 miles	27,844	2	Yes. See Section II

*27,846 members live in the service area; those who do not live in the service area are not included in this table.

HealthPartners Perform Open Access Membership Summary

HealthPartners practitioner availability standards have been met for over 99% of the membership for the provider types defined in the "Network Assessment of Practitioner Availability" policy. We investigated how we could meet the standard for all members.

Primary Care – Internal Medicine – Requirement is 30 miles

99.9% of our membership met the requirement for a Primary Care-Internal Medicine provider within 30 miles. There are 24 members who live more than 30 miles from a Primary Care provider at an average of 49.6 miles. No further action will be taken at this time as HealthPartners already holds contracts with these area primary care providers.

Members Without Access								
County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance	
			#	#	#	%	1	2
Beltrami, MN	Kelliher	56650	2	0	2	100.0	34.5	34.5
Cook, MN	Grand Marais	55604	19	0	19	100.0	53.3	79.4
	Lutsen	55612	2	0	2	100.0	39.1	65.3
	Tofte	55615	1	0	1	100.0	31.0	57.3
Grand Totals			24	0	24	100.0	49.6	73.6

Primary Care – Pediatrics – Requirement is 30 miles

99.7% of our membership met the requirement for a Primary Care-Pediatrics provider within 30 miles. There are 9 members who live more than 30 miles from a Primary Care provider at an average of 41.8 miles. No further action will be taken at this time as HealthPartners already holds contracts with these area primary care providers.

Members Without Access								
County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance	
			#	#	#	%	1	2
Aitkin, MN	McGregor	55760	1	0	1	100.0	35.1	35.1
	Tamarack	55787	1	0	1	100.0	34.4	38.1
Cook, MN	Grand Marais	55604	2	0	2	100.0	65.4	85.9
Mille Lacs, MN	Isle	56342	1	0	1	100.0	32.9	32.9
Pine, MN	Askov	55704	1	0	1	100.0	40.4	46.4
Stevens, MN	Chokio	56221	1	0	1	100.0	40.7	40.7
Swift, MN	Benson	56215	3	0	2	66.7	30.8	30.8
Grand Totals			10	0	9	90.0	41.8	47.4

Behavioral Health – Licensed Marriage & Family Therapy – Requirement is 30 miles

99.9% met the standard for Marriage and Family Therapists. There are 36 members who live more than 30 miles from a Licensed Marriage and Family Therapy provider at an average of 66.6 miles. HealthPartners has contracts with known behavioral health providers in these rural areas and continues to pursue contracts with behavioral health providers as they become known.

Members Without Access								
County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance	
			#	#	#	%	1	2
Beltrami, MN	Kelliher	56650	2	0	2	100.0	34.2	34.2
Cook, MN	Grand Marais	55604	21	0	21	100.0	80.3	86.4
	Lutsen	55612	2	0	2	100.0	71.4	77.6
	Tofte	55615	1	0	1	100.0	64.6	70.9
Lake of the Woods, MN	Baudette	56623	1	0	1	100.0	59.8	59.8
Lake, MN	Silver Bay	55614	1	0	1	100.0	46.7	46.9
Mahnomen, MN	Lengby	56651	1	0	1	100.0	34.1	34.1
	Naytahwaush	56566	1	0	1	100.0	32.9	33.2
Roseau, MN	Warroad	56763	1	0	1	100.0	88.7	88.7
St. Louis, MN	Ely	55731	1	0	1	100.0	46.8	46.8
Traverse, MN	Wheaton	56296	4	0	4	100.0	31.7	32.2
Grand Totals			**36**	**0**	**36**	**100.0**	**66.6**	**70.8**

Behavioral Health – Licensed Psychologists – Requirement is 30 miles

99.9% met the standard for Psychologists. There are 8 members who live more than 30 miles from a Psychologist provider at an average of 40.5 miles. HealthPartners has contracts with known behavioral health providers in these rural areas and continues to pursue contracts with behavioral health providers as they become known.

Members Without Access								
County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance	
			#	#	#	%	1	2
Beltrami, MN	Kelliher	56650	2	0	2	100.0	34.2	34.2
Lake of the Woods, MN	Baudette	56623	1	0	1	100.0	59.8	59.8
Roseau, MN	Warroad	56763	1	0	1	100.0	67.4	67.4
Traverse, MN	Wheaton	56296	4	0	4	100.0	32.0	32.0
Grand Totals			**8**	**0**	**8**	**100.0**	**40.5**	**40.5**

Behavioral Health – Licensed Social Workers – Requirement is 30 miles

99.9% met the standard for Social Workers. There are 4 members who live more than 30 miles from a Social Work provider at an average of 47.4 miles. HealthPartners has contracts with known behavioral health providers in these rural areas and continues to pursue contracts with behavioral health providers as they become known.

Members Without Access								
County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance	
			#	#	#	%	1	2
Lake of the Woods, MN	Baudette	56623	1	0	1	100.0	57.1	59.8
Mahnomen, MN	Lengby	56651	1	0	1	100.0	34.1	34.1
	Naytahwaush	56566	1	0	1	100.0	31.5	31.5
Roseau, MN	Warroad	56763	1	0	1	100.0	66.9	67.1
Grand Totals			**4**	**0**	**4**	**100.0**	**47.4**	**48.1**

Behavioral Health – Psychiatry – Requirement is 30 miles

99.8% met the standard for Psychiatrists. There are 45 members who live more than 30 miles from a Psychiatry provider at an average of 44.0 miles. HealthPartners has contracts with known behavioral health providers in these rural areas and continues to pursue contracts with behavioral health providers as they become known.

Members Without Access								
County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance	
			#	#	#	%	1	2
Beltrami, MN	Kelliher	56650	2	0	2	100.0	34.2	34.2
Chippewa, MN	Appleton	56208	2	0	2	100.0	32.5	38.3
	Milan	56262	1	0	1	100.0	32.6	32.6
	Montevideo	56265	43	0	2	4.7	31.4	31.4
	Watson	56295	3	0	1	33.3	32.4	32.4
Cook, MN	Grand Marais	55604	21	0	21	100.0	54.2	79.3
	Lutsen	55612	2	0	2	100.0	40.0	65.3
	Tofte	55615	1	0	1	100.0	32.0	57.3
Lake of the Woods, MN	Baudette	56623	1	0	1	100.0	48.8	48.8
St. Louis, MN	Ely	55731	1	0	1	100.0	47.7	49.0
Swift, MN	Appleton	56208	6	0	6	100.0	36.4	42.7
	Benson	56215	17	0	5	29.4	31.2	31.2
Grand Totals			**100**	**0**	**45**	**45.0**	**44.0**	**58.6**

Cardiology – Requirement is 60 miles

99.9% of our membership met the requirement for a Cardiology provider within 60 miles. There are 21 members who live more than 60 miles from a Cardiology provider at an average of 69.9 miles. No further action will be taken at this time as HealthPartners already holds contracts with these area cardiology providers.

Members Without Access								
County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance	
			#	#	#	%	1	2
Cook, MN	Grand Marais	55604	21	0	21	100.0	70.0	70.0
Grand Totals			**21**	**0**	**21**	**100.0**	**70.0**	**70.0**

Obstetrics & Gynecology (OB-GYN) – Requirement is 30 miles

99.9% of our membership met the requirement for an Ob-Gyn provider within 30 miles. There are 26 members who live more than 30 miles from an Ob-Gyn provider at an average of 77.3 miles; however there are primary care providers within the standard 30 miles that also provide obstetrics and gynecology services. No further action will be taken at this time as HealthPartners already holds contracts with these area Ob-Gyn providers.

Members Without Access								
County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance	
			#	#	#	%	1	2
Cook, MN	Grand Marais	55604	21	0	21	100.0	70.0	80.3
	Lutsen	55612	2	0	2	100.0	57.7	74.5
	Tofte	55615	1	0	1	100.0	54.8	69.2
Lake of the Woods, MN	Baudette	56623	1	0	1	100.0	48.8	59.1
Lake, MN	Silver Bay	55614	1	0	1	100.0	45.6	47.1
Grand Totals			**26**	**0**	**26**	**100.0**	**66.7**	**77.3**

Orthopedics – Requirement is 60 miles

99.9% of our membership met the requirement for an orthopedic provider within 60 miles. There are 21 members who live more than 60 miles from an Orthopedist at an average of 66.6 miles. No further action will be taken at this time as HealthPartners already holds contracts with these area orthopedic providers.

Members Without Access								
County	City	Zip Code	Member #	Counts #	Without Access[1] #	Without Access[1] %	Average Distance 1	Average Distance 2
Cook, MN	Grand Marais	55604	21	0	21	100.0	66.6	70.0
Grand Totals			21	0	21	100.0	66.6	70.0

Otolaryngology (ENT) – Requirement is 60 miles

99.9 % of our membership met the requirement for an ENT provider within 60 miles. There are 24 members who live more than 60 miles from an ENT provider at an average of 85.9 miles. No further action will be taken at this time as HealthPartners already holds contracts with these area ENT providers.

Members Without Access								
County	City	Zip Code	Member #	Counts #	Without Access[1] #	Without Access[1] %	Average Distance 1	Average Distance 2
Cook, MN	Grand Marais	55604	21	0	21	100.0	87.2	102.4
	Lutsen	55612	2	0	2	100.0	78.6	88.1
	Tofte	55615	1	0	1	100.0	71.9	82.5
Grand Totals			24	0	24	100.0	85.9	100.4

Oncology – Requirement is 60 miles

99.9 % of our membership met the requirement for an oncology provider within 60 miles. There are 24 members who live more than 60 miles from an oncology provider at an average of 80.1 miles. No further action will be taken at this time as HealthPartners already holds contracts with these area Oncology providers.

Members Without Access								
County	City	Zip Code	Member #	Counts #	Without Access[1] #	Without Access[1] %	Average Distance 1	Average Distance 2
Cook, MN	Grand Marais	55604	21	0	21	100.0	80.6	87.2
	Lutsen	55612	2	0	2	100.0	78.6	78.6
	Tofte	55615	1	0	1	100.0	71.9	71.9
Grand Totals			24	0	24	100.0	80.1	85.9

Dermatology – Requirement is 60 miles

99.9% of our membership met the 60 mile requirement. There are 24 members who live more than 60 miles from a dermatologist at an average of 79.5 miles. No further action will be taken at this time as HealthPartners already holds contracts with these area orthopedic providers.

Members Without Access								
City	Zip Code	Member #	Counts #	Without Access[1] #	Without Access[1] %	Average Distance 1	Average Distance 2
Grand Marais, MN	55604	21	0	21	100.0	80.4	84.7
Lutsen, MN	55612	2	0	2	100.0	75.8	85.9
Tofte, MN	55615	1	0	1	100.0	69.2	81.2
Grand Totals		24	0	24	100.0	79.5	84.7

Gastroenterology – Requirement is 60 miles

99.7% of our membership met the 60 mile requirement. There are 24 members who live more than 60 miles from a gastroenterologist at an average of 83.0 miles. No further action will be taken at this time as HealthPartners already holds contracts with these area gastroenterology providers.

Members Without Access								
County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance	
			#	#	#	%	1	2
Cook, MN	Grand Marais	55604	21	0	21	100.0	84.3	87.2
	Lutsen	55612	2	0	2	100.0	75.8	78.6
	Tofte	55615	1	0	1	100.0	69.2	71.9
Grand Totals			**24**	**0**	**24**	**100.0**	**83.0**	**85.9**

Ophthalmology – Requirement is 60 miles

99.9 % of our membership met the requirement for an Ophthalmology provider within 60 miles. There are 24 members who live more than 60 miles from an Ophthalmology provider at an average of 85.8 miles. No further action will be taken at this time as HealthPartners already holds contracts with these area ophthalmology providers.

Members Without Access								
County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance	
			#	#	#	%	1	2
Cook, MN	Grand Marais	55604	21	0	21	100.0	87.1	87.1
	Lutsen	55612	2	0	2	100.0	78.5	78.5
	Tofte	55615	1	0	1	100.0	71.8	71.8
Grand Totals			**24**	**0**	**24**	**100.0**	**85.8**	**85.8**

Hospitals – Requirement is 30 miles

99.9% of our membership met the 30 mile requirement. There are 2 members who live more than 30 miles from a hospital at an average of 34.5 miles. No further action will be taken at this time as HealthPartners already hold contracts with these area hospitals.

Members Without Access								
County	City	Zip Code	Member	Counts	Without Access[1]		Average Distance	
			#	#	#	%	1	2
Beltrami, MN	Kelliher	56650	2	0	2	100.0	34.5	41.8
Grand Totals			**2**	**0**	**2**	**100.0**	**34.5**	**41.8**

HealthPartners 2022 Service Area Analysis – Ratio Standards*

HealthPartners Perform Open Access Product

HealthPartners Service Area Analysis – Provider Type	Ratio Access Standard	Total Pop.	Provider Counts	Actual Ratio (Provider to Member)	% Pop. Meeting Standard	Member Count-Pop. Meeting Standard	Member Count-Pop.-Not Meeting ratio standard	Action Needed
Primary Care Providers	1 per 1,500 members	*27,846	26,520	1 per 1 member	100%	27,846	0	No
Family Medicine/ General Medicine	1 per 1,500 members	*27,846	20,533	1 per 1 member	100%	27,846	0	No
Internal Medicine – 18 and over	1 per 1,500 members	*24,361	3,187	1 per 8 members	100%	24,361	0	No
Pediatrics – 18 and under	1 per 1,500 members	*3,485	2,825	1 per 1 member	100%	3,485	0	No
Behavioral Health								
Behavioral Health	1 per 10,000 members	*27,846	45,260	2 per 1 member	100%	27,846	0	No
Licensed Marriage and Family Therapists	1 per 10,000 members	*27,846	4,379	1 per 6 members	100%	27,846	0	No
Licensed Psychologists	1 per 10,000 members	*27,846	5,975	1 per 5 members	100%	27,846	0	No
Licensed Social Workers	1 per 10,000 members	*27,846	9,241	1 per 3 members	100%	27,846	0	No
Psychiatrists	1 per 10,000 members	*27,846	3,372	1 per 8 members	100%	27,846	0	No
Specialty Care	1 per 10,000 members	*27,846	269,027	10 per 1 member	100%	27,846	0	No
High Volume Specialists								
Cardiology	1 per 10,000 members	*27,846	9,593	1 per 3 members	100%	27,846	0	No
Ob-Gyn	1 per 10,000 members	*27,846	8,985	1 per 3 members	100%	27,846	0	No
Orthopedics	1 per 10,000 members	*27,846	10,422	1 per 3 members	100%	27,846	0	No
Otolaryngology (ENT)	1 per 10,000 members	*27,846	1,873	1 per 15 members	100%	27,846	0	No
High Impact Specialists								
Oncology	1 per 10,000 members	*27,846	7,075	1 per 4 members	100%	27,846	0	No
Additional Specialties Analyzed for Informational Purposes Only								
Dermatology	1 per 10,000 members	*27,846	2,765	1 per 10 members	100%	27,846	0	No
Gastroenterology	1 per 10,000 members	*27,846	2,946	1 per 9 members	100%	27,846	0	No
Ophthalmology	1 per 10,000 members	*27,846	2,443	1 per 11 members	100%	27,846	0	No
Surgery	1 per 10,000 members	*27,846	9,091	1 per 3 members	100%	27,846	0	No
Chiropractic	1 per 10,000 members	*27,846	4,766	1 per 6 members	100%	27,846	0	No

*Ratio standards are in accordance with community standards based on a survey of HMOs in HealthPartners Service Area.

HealthPartners ratio standards have been met for the provider types defined in the "Network Assessment of Practitioner Availability" policy.

HealthPartners Service Area Analysis – Provider Type	Access Standard	Total Pop.	Provider Counts	% Pop. Meeting Standard	Average Distance to a Provider	Member Count- Pop. Meeting Standard	Member Count- Pop. not Meeting standard	Additional information when % Pop. Meeting Standard is not 100%
Primary Care Providers	1 provider within 30 miles	*10,606	1,834	100.0%	2.3 miles	10,606	0	None
Family/General Medicine	1 provider within 30 miles	*10,606	1,015	100.0%	2.4 miles	10,606	0	None
Internal Medicine – 18 and over	1 provider within 30 miles	*9,900	231	100.0%	3.0 miles	9,900	0	None
Pediatrics – 18 and under	1 provider within 30 miles	*706	591	100.0%	2.6 miles	706	0	None
Behavioral Health								
Behavioral Health	1 provider within 30 miles	*10,606	24,178	100.0%	0.9 mile	10,606	0	None
Licensed Marriage and Family Therapists	1 provider within 30 miles	*10,606	3,056	100.0%	1.2 miles	10,606	0	None
Licensed Psychologists	1 provider within 30 miles	*10,606	2,407	100.0%	1.2 miles	10,606	0	None
Licensed Social Workers	1 provider within 30 miles	*10,606	4,224	100.0%	1.2 miles	10,606	0	None
Psychiatrists	1 provider within 30 miles	*10,606	860	100.0%	2.0 miles	10,606	0	None
Specialty Care	1 provider within 60 miles	*10,606	31,414	100.0%	0.8 mile	10,606	0	None
High Volume Specialists								
Cardiology	1 provider within 60 miles	*10,606	285	100.0%	4.2 miles	10,606	0	None
Obstetrics & Gynecology	1 provider within 30 miles	*10,606	734	100.0%	2.7 miles	10,606	0	None
Orthopedics	1 provider within 60 miles	*10,606	639	100.0%	3.8 miles	10,606	0	None
Otolaryngology (ENT)	1 provider within 60 miles	*10,606	75	100.0%	5.0 miles	10,606	0	None
High Impact Specialists								
Oncology	1 provider within 60 miles	*10,606	378	100.0%	4.3 miles	10,606	0	None
Additional Specialties Analyzed for Informational Purposes Only								
Dermatology	1 provider within 60 miles	*10,606	103	100.0%	4.4 miles	10,606	0	None
Gastroenterology	1 provider within 60 miles	*10,606	134	100.0%	5.9 miles	10,606	0	None
Ophthalmology	1 provider within 60 miles	*10,606	47	100.0%	4.5 miles	10,606	0	None
Surgery	1 provider within 60 miles	*10,606	343	100.0%	3.4 miles	10,606	0	None
Chiropractic	1 provider within 60 miles	*10,606	3,366	100.0%	1.0 mile	10,606	0	None
Hospitals	1 hospital within 30 miles	*10,606	10	99.8%	7.9 miles	10,588	18	None

*10,606 members live in the service area; those who do not live in the service area are not included in this table.

HealthPartners Perform Open Access Membership Summary

HealthPartners practitioner availability standards have been met for over 99 % of the membership for the provider types defined in the "Network Assessment of Practitioner Availability" policy. We investigated how we could meet the standard for all members.

Hospitals – Requirement is 30 miles

99.9% of our membership met the 30 mile requirement. There are 18 members who live more than 30 miles from a hospital at an average of 30.7 miles. No further action will be taken at this time as HealthPartners already hold contracts with these area hospitals.

Members Without Access

County	City	Zip Code	Member Counts	Without Access[1]		Average Distance
			#	#	%	1
Anoka, MN	Saint Francis	55070	22	0	14	63.6	30.5
Dakota, MN	Northfield	55057	8	0	3	37.5	32.1
Scott, MN	New Prague	56071	11	0	1	9.1	30.6
Grand Totals			**41**	**0**	**18**	**43.9**	**30.7**

HealthPartners 2022 Service Area Analysis – Ratio Standards*

Select ACO Summary

HealthPartners Service Area Analysis – Provider Type	Ratio Access Standard	Total Pop.	Provider Counts	Actual Ratio (Provider to Member)	% Pop. Meeting Standard	Member Count-Pop. Meeting Standard	Member Count-Pop.-Not Meeting ratio standard	Action Needed
Primary Care Providers	1 per 1,500 members	*10,606	1,834	1 per 6 members	100%	10,606	0	No
Family Medicine/ General Medicine	1 per 1,500 members	*10,606	1,015	1 per 10 members	100%	10,606	0	No
Internal Medicine – 18 and over	1 per 1,500 members	*9,900	231	1 per 43 members	100%	9,900	0	No
Pediatrics – 18 and under	1 per 1,500 members	*706	591	1 per 1 member	100%	706	0	No
Behavioral Health								
Behavioral Health	1 per 10,000 members	*10,606	24,178	2 per 1 member	100%	10,606	0	No
Licensed Marriage and Family Therapists	1 per 10,000 members	*10,606	3,056	1 per 3 members	100%	10,606	0	No
Licensed Psychologists	1 per 10,000 members	*10,606	2,407	1 per 4 members	100%	10,606	0	No
Licensed Social Workers	1 per 10,000 members	*10,606	4,224	1 per 3 members	100%	10,606	0	No
Psychiatrists	1 per 10,000 members	*10,606	860	1 per 12 members	100%	10,606	0	No
Specialty Care	1 per 10,000 members	*10,606	31,414	3 per 1 member	100%	10,606	0	No
High Volume Specialists								
Cardiology	1 per 10,000 members	*10,606	285	1 per 37 members	100%	10,606	0	No
Ob-Gyn	1 per 10,000 members	*10,606	734	1 per 14 members	100%	10,606	0	No
Orthopedics	1 per 10,000 members	*10,606	639	1 per 17 members	100%	10,606	0	No
Otolaryngology (ENT)	1 per 10,000 members	*10,606	75	1 per 141 members	100%	10,606	0	No
High Impact Specialists								
Oncology	1 per 10,000 members	*10,606	378	1 per 28 members	100%	10,606	0	No
Additional Specialties Analyzed for Informational Purposes Only								
Dermatology	1 per 10,000 members	*10,606	103	1 per 103 members	100%	10,606	0	No
Gastroenterology	1 per 10,000 members	*10,606	134	1 per 79 members	100%	10,606	0	No
Ophthalmology	1 per 10,000 members	*10,606	47	1 per 226 members	100%	10,606	0	No
Surgery	1 per 10,000 members	*10,606	343	1 per 31 members	100%	10,606	0	No
Chiropractic	1 per 10,000 members	*10,606	3,366	1 per 3 members	100%	10,606	0	No

*Ratio standards are in accordance with community standards based on a survey of HMOs in HealthPartners Service Area.

HealthPartners ratio standards have been met for the provider types defined in the "Network Assessment of Practitioner Availability" policy.

Concurrent Monitoring-Results

Provider Relations and Network Management staff monitors and evaluates the impact of clinic closings, contract terminations, and large membership influx on the designated standards. This process is managed through a work group led by staff from Provider Relations and Network Management. The network changes to date have not resulted in a deficiency in provider types, numbers, or locations. Only three primary care clinics were not accepting new patients during 2022.

- To determine where improvements are indicated and to ensure that availability standards continue to be met, the Senior Director of Provider Relations and Network Management has participated in the monitoring activities listed in Section I which were reviewed in the Service Quality Council. The presentation of information and discussion ensure timely access to service and provider accessibility information. The committee members assess performance against the established standards, identify improvement opportunities, implement improvement strategies and continue to monitor performance.

- As referenced in the "Concurrent Monitoring" section above, we reviewed the Commercial, HealthPartners Care, and the Medicare CAHPS Survey (Consumer Assessment of Health Plans Survey).

Commercial Group Results

We reviewed the 2022 CAHPS results for two measures.

1. The first is #4: **"When you needed care right away, how often did you get the care as soon as you thought you needed?"** For 2022, our combined "always" + "usually" score was not reported due to a small number of responses. **The NCQA national average was 85 percent.**

The second is #6: **"How often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?"**

2. For 2021, our combined "always" + "usually" score was 85 percent, which is consistent with the NCQA National Average of 81 percent.

HealthPartners Care Results

We also reviewed the 2022 Medicaid CAHPS results for the same measures.

1. The first is #4: **"When you needed care right away, how often did you get care as soon as you needed?"** Our combined "always" + "usually" score was 81 percent for our members enrolled in Families & Children-MA, below the state's F&C-MA Average of 88 percent. The score for our members enrolled in MinnesotaCare, at 82 percent, is below the state's MinnesotaCare Average (87 percent). The score for our members enrolled in Minnesota Senior Care Plus, at 86 percent, is slightly below the state's Minnesota Senior Care Plus Average (89 percent). The score for our members enrolled in Special Needs Basic Care is 83 percent for this measure, which is consistent with the state's Special Needs Basic Care Average of 83 percent.

2. The second is question #6: **"How often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you thought you needed?"** Our combined "always" + "usually" score was 72 percent for our members enrolled in F&C-MA. This score is below the state's

F&C-MA Average (80 percent). The score for our members enrolled in MinnesotaCare, at 73 percent, is below the state's MinnesotaCare Average (78 percent). The score for our members enrolled in Minnesota Senior Care Plus, at 79 percent, is below the state's Minnesota Senior Care Plus Average (83 percent). The score for our members enrolled in Special Needs Basic Care is 79 percent for this measure, which is slightly below the state's Special Needs Basic Care Average of 81 percent.

Medicare Results

HealthPartners Medicare Cost with Prescription Drug Coverage

We also reviewed the 2022 Medicare CAHPS results on the same access measures. For HealthPartners Medicare Cost, the Getting Care Quickly composite which comprises questions 4 and 6 was awarded 5 Stars (above average statistical significance) by CMS.

1. The first is #4: **"When you needed care right away, how often did you get care as soon as you needed?"** This measure was not reported for 2022 due to a small number of responses. The Medicare National Average was 90 percent.

2. The second is #6: **"How often did you get an appointment for a check-up or routine care as soon as you needed?"** Our combined "always" + "usually" score was 91 percent for our members, which is the above the Medicare National Average (87 percent).

HealthPartners Medicare Advantage with Prescription Drug Coverage

For HealthPartners Medicare Advantage, the Getting Care Quickly composite which comprises questions 4 and 6 was awarded 5 Stars (above average statistical significance) by CMS.

1. The first is #4: **"When you needed care right away, how often did you get care as soon as you needed?"** This measure was not reported for 2022 due to a small number of responses. The Medicare National Average was 90 percent.

2. The second is #6: **"How often did you get an appointment for a check-up or routine care as soon as you needed?"** Our combined "always" + "usually" score was 88 percent for our members, which is slightly above the Medicare National Average (87 percent).

HealthPartners Minnesota Senior Health Options (MSHO) with Prescription Drug Coverage

For HealthPartners MSHO, the Getting Care Quickly composite which comprises questions 4 and 6 was also awarded 4 Stars by CMS in 2022.

1. The first is #4: **"When you needed care right away, how often did you get care as soon as you needed?"** This measure was not reported for 2022 due to a small number of responses. The Medicare National Average was 90 percent.

2. The second is #6 **"How often did you get an appointment for a check-up or routine care as soon as you needed?"** Our combined "always" + "usually" score was 85 percent for our members, which is slightly below the Medicare National Average (87 percent).

HealthPartners UnityPoint Health Medicare Advantage with Prescription Drug Coverage

For HealthPartners UnityPoint Health Medicare Advantage, the Getting Care Quickly composite which comprises questions 4 and 6 was awarded 5 Stars (above average statistical significance) by CMS in 2022.

1. The first is #4: **"When you needed care right away, how often did you get care as soon as you needed?"** This measure was not reported for 2022 due to a small number of responses. The Medicare National Average was 90 percent.

2. The second is #6: **"How often did you get an appointment for a check-up or routine care as soon as you needed?"** Our combined "always" + "usually" score was 94 percent for our members, which is above the Medicare National Average (87 percent).

The 2020 United States Census results (most recent available) have been reviewed to assess HealthPartners practitioner network. Analysis of 2020 race classifications for Minnesota point to a growing diversity, with 82.85% of residents classified as "White." The next largest groups are Black (6.41percent) and Asian (4.82 percent). Net international migration continues to increase.

The Census Bureau information gives the following Minnesota State General Profile. People of Hispanic origin can be of any race.

Total Population in Minnesota – 5,706,400 (2020 Census figures Estimated data released by US Census)

- White: 82.85%
- Black or African American: 6.41%
- Asian: 4.82%
- Two or more races: 2.97%
- Other race: 1.87%
- Native American: 1.04%
- Native Hawaiian or Pacific Islander: 0.04%

Census data reveal that the largest population of these ethnic groups – except for the American Indian/Alaska Native group – lives in the seven county metro areas, where the HealthPartners network has the largest set of culturally competent practitioners. Examples of how HealthPartners is taking into consideration ethnic, cultural, linguistic, and other individual needs and preferences of our members are listed below under "Equitable Care and Diversity".

Equitable Care and Diversity

Health Disparities

DESCRIPTION

As an organization dedicated to the health and well-being of every person, we have the responsibility and opportunity to help build a stronger organization and community where racism and inequity have no place. HealthPartners has a long history of addressing structural racism and health equity; grounded in the mission, vision and values established by our consumer-elected Board of Directors. Our mission is to improve health and well-being in partnership with our members, patients and the community. Our Partners for Better Health Goals 2025 reflects this mission. We seek to deliver outstanding care and service that is safe, timely, effective, equitable, efficient and patient/member/family centered.

We have been an industry leader in creating health and well-being programs aimed at reducing disparities in care, increasing diversity within our workplaces, and honoring the communities we serve. This focus is embedded in everything we do, and we partner meaningfully in our communities to address social determinants of health and act as an anchor tenant to improve health and economic development. Achieving health equity requires addressing disparate health outcomes and recognizing its relationship to structural racism and racial bias.

GOALS

Our goal is to eliminate health disparities among our members and patients to improve their health and experience. We seek to develop community partnerships to support social, economic and environmental health and well-being for our patients and members, and to decrease the gaps in socioeconomic and physical environmental health determinants.

INITIATIVES/INTERVENTIONS

HealthPartners has a longstanding commitment to improve the health of the diverse communities we serve. We've been recognized for outstanding care outcomes and performance, and we continue to partner with our communities to eliminate disparities. Our Equity, Inclusion and Anti-Racism Cabinet provides strategic leadership in planning and executing activities aimed at improving racial equity and health equity through reducing health care disparities, improving access and supporting an inclusive culture.

Our strong leadership in this area is reflected in the awards and recognitions we've received for these efforts:

- Top 15 Health System – IBM Watson Health named HealthPartners one of the Top 15 Health Systems in the nation five years in a row (2017-2021). Compared to other health systems, top performers had fewer patient deaths, fewer infections and complications, lower readmission rates, shorter lengths of stay, higher patient satisfaction and lower costs. It's a testament to our unique ability to partner across care, health plan and research to improve the health and well-being of our members, patients and community.
- No. 1 in member satisfaction – HealthPartners received the highest ranking in overall satisfaction among commercial health plans in the Minnesota-Wisconsin region four years in a row (2018-2021),

according to the J.D. Power U.S. Commercial Member Health Plan Study. In addition, we received the highest rating in coverage and benefits, customer service, information and communication and billing and payment.

- Top-rated health plan – HealthPartners is one of the top-rated commercial health plans in Minnesota with a rating of 4.5 out of 5, according to the National Committee for Quality Assurance (NCQA) commercial Health Plan Ratings 2022. This is the 18th year in a row that NCQA recognized us as one of the highest performing plans in the nation.
- Medicare 5 Star Ratings – HealthPartners has consistently been a highly rated Medicare plan by the Centers for Medicare and Medicaid Services (CMS). For the second year in a row, our Medicare Advantage plans in Minnesota and Wisconsin were awarded an overall 5 out of 5-Star Rating for 2023. For 2022, all five HealthPartners Medicare plans across our six-state service area were awarded an overall 5 out of 5-Star Rating. In addition, HealthPartners was the first and only MSHO plan in Minnesota to earn 5 stars for 2021 and one of only three such plans in the nation to earn the top rating.
- Consumer experience leader – HealthPartners receives high scores from its health plan members in the annual CAHPS survey. Thirteen key areas are addressed in the survey, including doctor communication, customer service and getting care quickly, and members rate their experience with each. Compared to all Minnesota health plans, HealthPartners has received the highest overall plan rating from members every year since 2007.
- Exceptional care – HEDIS® – This year, 64% of our commercial HEDIS measures are in the top 25% in the nation, with 21% in the top 10%. This outscores our local competitors.
- CMS Health Equity Award – In January 2019, HealthPartners was one of only two organizations in the nation to receive the Health Equity Award from CMS. The award recognizes areas where HealthPartners has implemented new models to increase access to care and reduce health disparities, including for behavioral health.
- AMGA Acclaim Award – HealthPartners was named an Acclaim Award honoree by the American Medical Group Association (AMGA) for our Children's Health Initiative and its collaborative approach to improving child and family health. This effort included collecting data and eliminating gaps in care, supporting language access, partnering with communities and building an understanding of equity, diversity, inclusion and bias.
- Colorectal Cancer Organization of the Year – In 2018, HealthPartners was named the Colorectal Cancer Organization of the Year by the American Cancer Society for its work to improve colorectal cancer screening rates among patients of color.
- Improved Total Cost of Care – HealthPartners continues to be a top performer in MN Community Measurement's Minnesota Health Care Quality Report. In 2021, our care system, including HealthPartners and Park Nicollet, performed better than average among medical groups in Minnesota. The findings underscore the importance of our integrated work across care delivery and health plan to improve total cost of care for patients and members.
- Best places to work – For the second year in a row, HealthPartners was named one of the Top Workplaces in Minnesota by the Star Tribune. The award recognizes organizations dedicated to creating cultures of high engagement, inclusivity and trust. HealthPartners has also been recognized as one of the best places to work by Forbes and the Minneapolis/St. Paul Business Journal.

- Top hospitals – Our hospitals are consistently ranked among the best in nation. In 2022, Regions and Methodist hospitals were ranked among Newsweek's list of World's Best Hospitals and U.S. News and World Report's list of Best Regional Hospitals. In addition, Methodist Hospital was named among IBM Watson Health's list of 100 Top Hospitals in 2021 – the sixth time the hospital has earned this distinguished recognition. Regions Hospital was named one of HealthGrades' 50 Best Hospitals in America in 2020.
- Gold-level stroke treatment and care – HealthPartners was recognized by the American Heart Association and American Stroke Association as a Gold-level practice for our commitment to high-quality stroke treatment and care.
- National leader in sustainability practices – Health Care Without Harm named our organization a worldwide Climate Champion four years in a row (2019-2022). In 2022, HealthPartners also received 27 awards from Practice Greenhealth in recognition of our outstanding accomplishments in sustainability, including the System for Change award for the eighth consecutive year.
- Health care leadership – HealthPartners President and CEO Andrea Walsh has been named to Modern Healthcare's list of 100 Most Influential People in Healthcare three years in a row (2020-2022). In addition, the Minneapolis/St. Paul Business Journal named Andrea their 2021 Executive of the Year. Andrea also received the 21st Century Pinnacle Leader Award from the Women's Health Leadership TRUST in 2020, which recognizes women who are trailblazers in leadership, transformation and innovation in health care. Minnesota Physician included Andrea among their list of 100 Most Influential Health Care Leaders in 2020.

Individual Awards

- 2022 – DeLinda Washington, senior vice president and chief people officer, was recognized by Modern Healthcare as a Top Diversity Leader. She is one of the nation's 10 "Leaders to Watch," recognized for their outstanding achievement in promoting diversity, equity and inclusion in their organizations and the health care industry.
- 2022 – Toweya Brown-Ochs, director of diversity and inclusion, was recognized by Twin Cities Business as a Notable DEI Executive for creating and leading initiatives that foster inclusion within the organization and community.
- 2021 – Methodist Hospital ICU nurse Jeanette Rupert received the inaugural Bernard J. Tyson Award for Excellence in Pursuit of Healthcare Equity from the Alliance of Community Health Plans (ACHP). She was recognized for her work to establish a local medical tent as a brick-and-mortar non-profit clinic in the community and for her collaboration with local nursing students to bring health care to underserved populations.
- 2020 – Park Nicollet nurse Jenn Bourgoine received the Business of Pride – Ally Award from the Minneapolis/St. Paul Business Journal for her work supporting transgender patients.
- 2019 – Dr. Deb Thorp, director of Park Nicollet gender services, received the Business of Pride award from the Minneapolis/St. Paul Business Journal for her work to improve access to compassionate care for LGBTQ patients and patients in immigrant and refugee communities.

Equity, Inclusion and Anti-Racism Cabinet

In 2020, HealthPartners established the Equity, Inclusion, and Anti-Racism Cabinet to aggressively accelerate our efforts to advance racial equity and health equity. The Cabinet provides strategic leadership in planning and executing activities aimed at improving racial equity and health equity through reducing health care disparities, improving access, and supporting an inclusive culture. The Cabinet aligns racial equity and health equity activities across the organization through inclusion in annual plans and supports tracking, monitoring and measuring progress. The Cabinet:

- Provides an organization-wide approach to measure and reduce health care disparities.
- Supports workforce development initiatives that reinforce cultural humility and respect.
- Improves care for members with limited English proficiency and who are hearing impaired.
- Involves members in planning and implementing racial equity and health equity approaches.
- Engages with communities across the seven-county metropolitan area in partnerships to promote racial equity and health equity.
- Provides direction for data collection, analysis, and reporting across the organization.
- Communicates progress on initiatives across the organization, and externally as appropriate.

The Equity, Inclusion and Anti-Racism Cabinet provides leadership, direction and oversight through four cornerstones to accelerate the pace of our work and cultivate alignment and partnership across the organization.

The image below illustrates the four cornerstones' approach of the Health Equity, Inclusion, and Anti-Racism Cabinet.

Community collaboration to gain insights and engage community

We have built a culture of health equity in our organization through partnerships with community organizations. In our 2021 Community Health Needs Assessments and Plans, conducted by each of our hospitals, priority needs, were reviewed within the contextual factors of structural racism and COVID-19. During that process, we engaged community members, public health, and our own clinicians to more deeply understand how we might impact the health of our community.

Community partnership development is a core strategy in our work to promote and make change towards health equity. We invest in six general areas: healthy children, mental health, nutrition and fitness, health

equity, wellness and prevention and research and education. We also have larger, multi-year partnerships and campaigns with community-based organizations to impact and improve community health including the MakeItOK campaign, PowerUp and Little Moments Count. Examples of partners include organizations such as the Keystone Community Services, Open Arms Minnesota, Reach Out and Read MN, American Red Cross Blood Services, Northside Achievement Zone (NAZ), the National Alliance on Mental Illness (NAMI), St. Paul Bookmobile, over 60 schools throughout the region, Hunger Solutions, and many others.

Healthy Children and Maternal Health

- Little Moments Count: LMC is a growing social movement seeking to increase awareness of the importance and increase parent and caregiver behaviors of talking, playing, reading, singing and storytelling with children, in the first 1000 days of life (0-3 years old). LMC achieves this through collective impact partnership with over 70 cross-sector organizations, including early childhood, healthcare, non-profit community and cultural, faith community, media, governmental and other private sector organizations. LMC partners work together to magnify key family support resources and opportunities, as well as identify gaps to fill through collective impact strategies.

  In 2022, LMC reached many Minnesota and WI families and professionals through:
  - Over 14 million MN Public Radio (MPR) radio and digital public service announcements (PSAs).
  - Over 90,000 prints, 525,000 radio and 182,000 digital cultural community media impressions within Latinx, Hmong, Somali, African American and indigenous communities through strategic trusted community media and social media partnerships.
  - Reaching approximately 22,000 community event impressions through large events like the MN State Fair, and smaller community outreach efforts, like the Ramsey County Mother's First Community Baby Shower.
  - Over 1000 views of the LMC Annual Conference featuring keynote speaker, Dr. Rosemarie Allen, MEd, "Racism and the Developing Brain."
  - 150,000 families receiving Reach Out & Read early brain development education and over 214,000 children's books at well child visits across 10 health care systems.
  - Over 1100 family LMC LEARN Survey responses from African American, Latinx, Hmong, Somali, Indigenous and Medicaid-insured communities – showing community-specific assets and needs to help guide LMC strategy in the future.
  - Over 5000 families reached through a new family birth center pilot introducing LMC resources to new parents delivering at 5 MN family birth centers.
  - In partnership with The Itasca Project, new and enhanced employer communication campaign and family support best practices and policy examples tools.

- Children's Health Council: It's clear that there is a strong link between health and well-being early in life, and health and well-being later in life. HealthPartners is working to improve the health and well-being of children and their families by concentrating on areas of focus known as our Children's Health Council (previously known as Initiative). The four main guiding principles of the initiative are: promoting early brain development, providing family centered care, strengthening our communities and Eliminate disparities in

maternal, infant and pediatric health. In 2022, our areas of focus include: early brain development, adolescent health, pediatric, adolescent, and maternal mental health access and outcomes, healthy beginnings (maternal and newborn care), and lactation. Through this investment, we're helping lay a foundation that will benefit generations to come.

- Reach Out and Read and early brain development messaging: Reach Out and Read reaches children from 6 months to age five. At the beginning of every visit, a child's healthcare provider will give the child an age and language appropriate book to share with their family. The provider uses this opportunity to gauge the child's early development and give the parents or caregivers guidance on how language-rich interactions, such as reading, singing, and playing together, help a child learn and grow healthily. In efforts to start this messaging early on, we added a black and white book to the 32-week prenatal visit and explain to families that there are benefits of talking, reading and singing to their baby still in the womb. Each year, this program hands out approximately 95,000 books between our well child checks and prenatal visits and offers books in over 12 different languages.

- Well Child and Childhood Immunization Outreach: During the pandemic, we saw declines in many preventive care measures including well child visits and childhood immunizations. Delays in immunizations put children at increased risk for many preventable diseases, and lack of well care can delay identification of developmental delays or other health concerns. Our Medicaid membership had the lowest utilization of these health care services across our membership. HealthPartners utilized information from our care group and claims to identify 10,000 members up to 18 years old who were in need of immunizations, well child care or both. We worked with WellShare International, a local Community Health Worker organization, to conduct outreach to these members to educate on the importance of preventive care, encourage visits to their clinician and offer assistance in scheduling these visits.

  WellShare has a roster of CHWs from the community and were able to make calls in members' native languages when possible or utilize an interpreter when needed. Calls were made to members beginning in October and continue into 2023. As of the end of 2022, 5479 (55%) of the members on the list had been contacted at least once. CHWs were able to successfully engage 26% of the members they reached out to. Reasons for not reaching included disconnected or wrong phone numbers, messages left but not returned, and members who declined the intervention. CHWs were able to educate 1556 families on the importance of getting up to date on immunizations and well child exams and assisted 104 to actually schedule the appointment.

  In addition to this outreach, we worked with the other MN Medicaid plans and the Minnesota Council of Health Plans to create a blog post about the importance of getting caught back up on immunizations and well visits. The blog is available in written and audio form and is being translated to Spanish, Somali and Hmong for access to those communities.

- Think Small Positive Parent Texting program: This easy, free program provides fun facts and easy tips each week with ideas on how parents/caregivers can promote their child's learning. Research shows when parents participate in this program their children are more prepared for kindergarten. In 2021, we included

a Little Moments Count bookmark, which promotes Think Small, to our 32-week prenatal visit and 1 month well child check. This bookmark is offered in English, Spanish and Somali and we continue to use this bookmark throughout those respective visits.

- PowerUp Teen Leadership Council: In 2020, the Children's Health Council started to partner with PowerUp's Teen Council to provide feedback on care for teens. In the first year, they provided feedback on our adolescent questionnaire to ensure we are asking relevant questions, which we were then able to update. In 2021, CHC chairs were added to the advisory committee to help enhance their engagement through the program and into the community. Through 2022, the teen council provided feedback on relevant topics to ensure clinicians covered important topics with teens. In 2023, HealthPartners is dedicated to a refresh training on adolescent health where the council will play an integral part in content developed to ensure relevancy during well child visits.

- St. Paul Promise Neighborhood (SPPN): The Promise Neighborhood (Wilder Foundation, Ramsey County, and St. Paul Public Schools) is a community-wide initiative to provide academic, social and health supports children need to succeed in school and life. The focus is on families with children birth to age 5. HealthPartners is a partner on the Advisory Council.

- Penumbra Theater: HealthPartners partners with Penumbra Theater, a local theater company that creates professional productions focused on the African American experience. Penumbra has evolved into a Center for Racial Healing that nurtures black artists, advances equity, and facilitates wellness for individuals and community. HealthPartners began a partnership with Penumbra to support the commissioning and development of a new play written by Harrison David Rivers as a response to the growing awareness of racial disparities in maternal health. While it could not be performed on the stage in 2021 due to COVID, Penumbra performed excerpts of Weathering in a virtual reading format for HealthPartners employees who serve on our pregnancy council, health equity and children's health initiative cabinet. The session was recorded and continues to be used for training across our organization.
  Weathering was brought to the stage in 2022 with rave reviews. Weathering puts a human face on those stagging statistics that black infants are more than twice as likely to die as white infants and lets us experience the tragedy of one family, as well as the healing that can happen within a community.

- The Black Pregnancy and Post-birth Journey: In 2021, with support from the Park Nicollet Foundation, HealthPartners & Park Nicollet partnered with a consulting agency, Heart of the Customer, to improve outcomes for Black expectant mothers by capturing their experiences during and after pregnancy in order to build empathy, undermine systemic racism, and improve outcomes for them and their babies. Black expectant and post-birth patients face far worse health and mortality outcomes that their white counterparts both in Minnesota and nationally. Studies show Black patients are less satisfied with their care and use fewer healthcare services. As a system, we want to build trust with our Black patients and their partners in order to provide timely and culturally competent care. As a result of our Journey Mapping inquiry with Heart of the Customer and our Community Consultants, a top identified program strategy was to offer a perinatal concierge that would stay connected to Black patients throughout their pregnancy care.

- Healthy Black Pregnancies (formally known as ICHRP): To better serve our African American patient population, HealthPartners has partnered with Healthy Black Pregnancies. This group provides professional expertise; knowledge of prenatal African American maternal and child health issues; knowledge of the African American community; and connections to local, national or international resources and colleagues. In 2021, our care group piloted referring our patients to their program. In partnership with Healthy Black Pregnancies, we continue to work through some barriers with this referral process. Our Healthy Pregnancy care coordinators and staff from our clinics make referrals to their DIVA Moms program and other support services. In 2022, HP gifted Healthy Black Pregnancies a $50,000 grant to support the formalization of their structure as a 501c3 and to increase access to their support services.

- Healthy Beginnings: This program helps women achieve a healthy pregnancy and birth by providing comprehensive screening and support to pregnant patients who are experiencing substance use issues, mental health struggles, homelessness, poverty, domestic violence, and/or other complex psychosocial issues. This evidence-based program reduces preterm births, and low birthweights. More than 10,000 pregnant patients per year receive screening and are eligible for support with all these challenging life circumstances.

  Partnerships with the community:

  - Cradle of Hope – Apply for portable cribs, provide safe sleep education and distribute cribs to patients
  - Bundles of Love Charity – Distribution partner for the charity (bundles have handmade baby clothes, blankets, and baby care items)
  - Everyday Miracles – Provide grant-funded scholarships for childbirth prep, breastfeeding and newborn care classes; refer patients for doula services, car seat and breast pump distribution
  - Participation in Scott Co. Early Childhood Multidisciplinary Team (case consultation meetings with child protection and other community child welfare agencies)
  - Ongoing referrals to WIC, MVNA and other county family home-visiting programs, Portico Healthnet, Hennepin County Project Child, HousingLink, Diaper Bank of Minnesota, Minnesota Day One Crisis Hotline, local food shelves and many other resources and supports.

- Everyday Miracles: Through grant support, women seeking prenatal care through a HealthPartners clinic can seek support from Everyday Miracles and we will help fund the cost of the classes. Everyday Miracles is committed to improving maternal health, and specifically to reducing health disparities in communities at risk for poor outcomes. They strive to provide compassionate, culturally aware support and a nonjudgmental, welcoming community.

- Lactation Café: With support from a grant, Park Nicollet was able to expand upon their Lactation Café at Methodist Hospital (previously Mom & Baby Café) to four ambulatory clinics. This free Café provides support, camaraderie, and lactation support for mothers postpartum. Lactation also partnered with the interpreter services department to provide interpreters at known, diverse clinics to assist patients who are English language learners. In 2023, there is a plan to expand partnership with Hennepin County WIC to assist with the Cafes as a way to help provide more culturally congruent care and help connect patients to community resources.

- Doula Services: HealthPartners is pleased to note we are committed to expanding and funding doula services. Research shows that doulas can improve outcomes for both mother and baby. For example, studies show that doulas help reduce the rate of caesarean surgeries, which is higher among black women than other racial groups, and other costly interventions. Doulas also increase the rate of breastfeeding, which improves the health of new moms and babies and is less common among black or low-income women.

  Many people in the community are unfamiliar with doulas and how they can provide support to birthing people. HealthPartners created a video explaining what a doula is, the value they bring to the birth experience and how pregnant people can be connected with a doula. This video has been translated with sub-titles into Spanish, Somali and Hmong and will be shared widely to promote the use of doulas for families in the community.

  As voiced by the Ramsey County Birth Equity Community Council (BECC), the community has expressed a desire for more doula support that "looks like them." Through conversations with community doula programs and other community representatives, it is clear that capacity as an issue, especially for women of color. HealthPartners has an ongoing relationship with Everyday Miracles as our primary doula provider for our Medicaid members. Everyday Miracles is committed to improving maternal health, and specifically to reducing health disparities in communities at risk for poor outcomes. They strive to provide compassionate, culturally aware support and a nonjudgmental, welcoming community. In 2021, along with another MN Medicaid health plan, funded the training and certification costs for additional doulas of color to serve Medicaid members. Since that time, Everyday Miracles roster of Doulas of color went from 40% of their doulas to 70% of their doulas identifying as people of color. We gifted Everyday Miracles a $50,000 grant in 2022 to further support their work to provide supports to the community.

  We are also engaged with a group of community members and organizations to encourage the state to update the allowable doula certifications to include culturally congruent trainings relevant for Black and Indigenous pregnant people. In 2022, the health department established a process for additional certifying agencies to become Medicaid eligible providers.

  We have been working with Division of Indian Work to support their Ninde Doula program. Previously their program was funded by grants which couldn't fully fulfill the needs of the community for services. We have been working with them to become Medicaid billable to increase their funding capacity. In 2022, we provided a $50,000 grant to DIW to support the services and to formalize processes to be able to contract with them.

- Referral partners: We continue to expand our collaboration with community partners to further support our most vulnerable patients and members. We work to identify and refer our eligible mothers who are patients or members to family home visiting and other county public health nurse home visiting programs, and community-based programs to support diverse communities including doulas and other maternal health supports. We refer pregnant members on Medicaid to county home visiting for support and resources at the local level.

- Perinatal Measurements: In November 2021, HealthPartners began participating in the U.S. Department of Health and Human Services (HHS) Perinatal Improvement Collaborative, a large-scale, data-driven collaborative of 200+ leading hospitals caring for diverse populations in all 50 states. The collaborative is overseen by the HHS Office on Women's Health (OWH), using relevant data, analytics and performance improvement methodologies from Premier Inc. The HHS Perinatal Improvement Collaborative will be testing interventions and protocols to reduce preventable deaths and complications among mothers and their babies. Using Premier's comprehensive and standardized data collection system, the program will be able to quickly generate solutions for safer obstetric and neonatal care that can be implemented nationwide. The effort is guided by an external advisory panel comprising more than 20 expert clinicians and thought leaders, and patient partners from MoMMA's Voices, a coalition of advocacy organizations focused on leading causes of maternal mortality and morbidity.
- Postpartum Hemorrhage and Hypertension in Pregnancy Safety Bundle: In June 2021, all 8 inpatient hospital Birth Center leaders, providers, nurse educators, quality improvement specialist, pharmacy, lab and Epic builders collaborated to roll out a robust program to improve maternal morbidity and mortality related to postpartum hemorrhage and hypertension in pregnancy. More than 1000 perinatal clinical providers completed education and training aimed at standardizing care of patients experiencing these obstetric emergencies. Standardization included policies, protocols, tools, order sets, medications, education, simulation, measurement and monitoring. This work will impact over 9000 deliveries across the HealthPartners family of care hospital Birth Centers.

Mental Health

- Partnership with NAMI Minnesota: HealthPartners has had a mutually beneficial 16-year partnership with the Minnesota chapter of NAMI, a nonprofit organization dedicated to improving the lives of children and adults with mental illnesses and their families (namimn.org). HealthPartners has continuously been a sponsor of the NAMIWalks since 2007. HealthPartners continues to sponsor and participate in the NAMIWalks annually, on an organization-wide level, helping to raise funds and promote the walk. In 2022, our team was back in person at Minnehaha Park and raised over $18,000 for NAMI. We have collaborated with NAMI on the Make It OK anti-stigma campaign (described below), in which NAMI is a committed and expert organization that has pledged to help change hearts and minds about the misperceptions of mental illnesses by encouraging open conversations and education on mental illness.

- Make It Ok: Make It OK is a community campaign to reduce stigma by increasing understanding and creating caring conversations about mental illness.

  Make It OK is celebrating 10 years of progress in helping to stop the stigma of mental illnesses. Launched in collaboration with HealthPartners, Regions Hospital, the National Alliance on Mental Illness (NAMI), and other partners, the campaign works through community engagement, trained ambassadors, partners, online resources and more to mobilize and share Make It OK throughout communities. By creating open and caring conversations and helping to change attitudes about mental health and illnesses, Make It OK is increasing understanding and reducing the stigma so those living with a mental illness get the care and support they deserve. Read more in the 10-year report, linked here.

2022 Make it Ok Highlights:
In 2022, Make It Ok continued to expand reach and engagement:
209 Ambassadors trained through 17 virtual trainings
533 Reached through 32 virtual presentations
2,175 Engaged in Make It OK with a full return to community events
Launched resources to promote mental well-being and resiliency, reduce stigma of substance use disorder, and equip adults to effectively support youth mental health.

- Science Museum of Minnesota: Since 2018, HealthPartners supported the Science Museum of Minnesota's development of the Mental Health: Mind Matters exhibit. This exhibit was originally developed in Finland but did not use culturally appropriate language or approaches for the United States, as well as did not provide culturally relevant resources. HealthPartners provided important financial support and subject matter expertise and content on resources, including creation of a dedicated resource area for adults and children. This resource area included culturally relevant resources in many languages and also included dedicated pieces for perinatal psychiatric disorders, and African American, recent refugee immigrant, Somali and Latin American communities. https://www.smm.org/toolkit/mindmatters

Nutrition and Fitness

- PowerUp: The PowerUp initiative makes it easy and fun for everyone to eat better, move more and live healthier lives. We do this important work in partnership with our members, patients, colleagues and communities through programs, tools and resources that support and inspire change.

  PowerUp has a special focus on kids and families because childhood overweight and obesity tripled in the past 30 years and remains a critical issue for the future of children's health. Research shows that today, kids are expected to live shorter, less healthy lives than their parents for the first time. Research also shows that it takes a multi-level approach, including schools, organizations and the entire community working together to change these trends.

  In 2022, the PowerUp community health initiative continued to inspire and support kids and families to eat better, move more and feel good, while increasing focus and commitment to equity and the numerous factors that influence health and well-being in children. New resources were created to expand resources focused on 'feeling good" with ways to relax and recharge, and resources were translated into three additional languages: Spanish, Hmong, and Somali. Community outreach was robust, both virtual and in person, and in 2022, PowerUp reached 64,686+ virtually, through classes, website, and e-newsletters, and 805 kids and families at 50 community events.

  PowerUp School Challenge:
  The School Challenge is an innovative program focused on encouraging elementary-aged students to get curious and excited to try fruits and veggies and move their bodies in fun, new ways. In 2022, schools told us it is a priority to help students feel good and recharge their bodies and brains. Therefore, "feel good" was added as a key focus alongside "eat better" and "move more," helping kids explore the mind-body connection and ways to relax and recharge.

The School Challenge pivoted to increase flexibility and adaptability for any learning platform, whether inside a classroom or virtually from home. The Challenge offers easy modules with digital tools, resources, and lesson plans, allowing teachers to choose when, where, and how to use them with their class. Teachers can now participate as an individual classroom or as part of an overall school program. This program is provided at no cost to schools or youth organizations.

By participating, teachers and youth leaders:

- Choose when, where and how to implement the Challenge
- Support and encourage students to eat better, move more and feel good
- Earn classroom incentives to further promote student well-being
- Receive fun and engaging PowerUp resources to share with students and families, available in multiple languages
- Are guided through the Challenge with weekly program communications
- Prioritize student wellness and do what's best for kids!

Now going into its tenth year, the classroom-based program includes more than 50 schools and on average, reaches more than 19,000 students throughout the region. As a result of participating in the Challenge, 83% of staff and 74% of families reported positive changes in the eating habits, observing kids eating more fruits and vegetables.

Power Up School Challenge and Health Equity:
PowerUp is actively trying to reach and recruit more vulnerable communities to participate in the School Challenge. Using the Center for Disease Control's Social Vulnerability Index, which uses census variables to identify communities that need extra support, we reassessed our recruitment strategy to target socially vulnerable districts and zips codes through partnerships, outreach and social media ads.

With our increased focus on social needs and health equity, PowerUp convened the newly formed Community Health Education Advisory Council at HealthPartners to review and advise on the PowerUp Family Magazine, distributed to kids and families during the School Challenge. The group provided their perspectives and insights, keeping in mind inclusiveness, cultural relevance, health literacy, physical abilities and body sizes, and social needs.

- Hunger Solutions: Through our partnership with Hunger Solutions Minnesota (a nonprofit organization in Minnesota committed to ending hunger in MN), members/patients who screen positive for food insecurity are referred to the Minnesota Food Helpline. Hunger Solutions also helps screen for other needs the person may have such as housing or transportation. This partnership started as a pilot program with three HealthPartners clinics in 2017 and expanded to the health plan in early 2020. Electronic referral to Hunger Solutions continued to expand through 2022.
- SuperShelf: HealthPartners and Lakeview Hospital are founding partners of SuperShelf, an innovative project to transform food shelves by offering a positive, grocery store-like experience for members to access healthy and appealing foods. SuperShelf uses behavioral economics to make the healthiest choice the easiest choice while respecting individual preferences. There are now 40 SuperShelf sites across Minnesota who provide a welcoming and dignified experience for community members who are food insecure to access appealing, healthy food. https://www.supershelfmn.org/

- Unlockit: A program developed by Cycle Health and now integrated into the YMCA programming, is a map based outdoor scavenger hunt set at a variety of parks. HealthPartners is proud to be a sponsor in 2021 which tested the initial program. Programming expanded in 2022 including 16 parks. Participants may go anytime the park is open. Participants download the map, follow the clues, and unlock letters that, when unscrambled, form a keyword. They then submit that keyword to be entered to win fun prizes. https://www.ymcanorth.org/sites/default/files/Y-Adventure-Lab-UnLockIt-St-Croix.pdf?openyts=1675275840248

Health Equity

- TPT: Racism Unveiled: HealthPartners is the sponsor of the new Twin Cities Public Television production, "Racism Unveiled." The project is a collaboration with community members and leaders that examines the impact of systemic racism on Black, Indigenous and communities of color in Minnesota. https://www.tptoriginals.org/projects/racismunveiled/

- Higher Ground Academy: Is a K-12 grade charter school located in Saint Paul that serves primarily children of East African immigrants from Somalia and Ethiopia. Annually, Higher Ground Academy plans a career fair for their junior and senior high students. HealthPartners has recruited volunteers to participate since 2015. In 2022, six HealthPartners colleagues participated and reaching about 95 students.

- Habitat for Humanity: Stable housing impacts educational achievement and a families' overall health. When HealthPartners and Park Nicollet combined in 2012, our organizations used volunteerism as a means to learn about each other and share our values. According to The Positive Impacts of Affordable Housing on Health A Research Summary, when families pay excessive amounts of their income for housing often, they have insufficient funds remaining to meet other essential needs, including food, medical insurance and health care. In 2022, HealthPartners sponsored 2 builds. 72 volunteers participated providing 576 volunteer hours.

- Pride Festival: For 24 years, HealthPartners has participated in the Pride Festival and over 5 years in the parade. In honor of the 50th Year Anniversary of Pride in the Twin Cities, the HealthPartners booth at pride hosted a polling question and distributed a charity gift of $5000 among three nonprofit charities based on participant's voting percentage.
  We asked, what is your biggest barrier to care? And we heard the following responses:

  - Cost of care/insurance (45%)
  - Finding an LGBTQ+ friendly clinician (17%)
  - Transportation/Location (9%)
  - I do not currently experience any barriers to care (29%)

  Our Charity Gift was then distributed to these local nonprofits who support the GLBTQ+ community: Reclaim; Twin Cities Pride; and Open Arms MN

- Early Risers Podcast: HealthPartners is a proud ongoing sponsor of this impactful series and collaborates with Little Moments Count, Minnesota Public Radio and Think Small on this important anti-racism and anti-

bias parenting and early childhood project. Each season of Early Risers features 6-episodes, released bi-weekly, in a podcast mini-series exploring talking with our youngest children about race and racism. Short, sweet, sometimes funny and always relatable, each episode runs between 20-30 minutes and helps parents, caretakers and educators tackle this big topic with their little ones. As of December 2022, the Early Risers podcast has been downloaded over 58,000 times, received nearly 175,000 impressions across social media pages, was ranked 13th in the Parenting Category for Apple Podcasts. Additionally, there have been almost 1300 community downloads of episode discussion guides.
https://www.littlemomentscount.org/earlyriserspodcast

- Gender Services Navigator: Supported by the Park Nicollet Foundation, Park Nicollet Gender Services Department funds a gender services navigator role to build trust and help patients navigate often complicated care situations across our system. Examples include: planning for gender affirmation surgery, connecting to transgender care, self-injection education, care coordination, and legal issues including name and gender marker changes. Since the start of the role in 2019, the Care Navigator has met with over 400 unique patients.

- Saint Paul Public Library Bookmobile: Since 2014, HealthPartners has sponsored the Saint Paul Public Library Bookmobile, which is one of the last urban bookmobiles still in operation. The book mobile visits 45-50 sites on a regular basis in a two-week cycle reaching about 120,000 people per year. The Bookmobile ensures that the library is accessible to communities that face barriers in using the library's fixed facility due to transportation, cultural, language or other barriers. In addition to a financial contribution, HealthPartners also volunteers helping the Bookmobile at local events. The bookmobile continued to operate in 2021 following COVID masking and distancing guidelines. And with additional grants, the bookmobile also expanded their wi-fi services for patrons. This was especially helpful when the fixed libraries were closed. In 2022, the bookmobile served over 1,500 children and families each week! https://sppl.org/bookmobile/

- Twin Cities 32nd Annual MLK Holiday Breakfast: we sponsored the breakfast by purchasing steaming links to watch the virtual breakfast and distributed the links for colleagues to watch from their locations. We sponsored one in-person table at this annual event to celebrate Dr. King's legacy of service. In addition to sponsoring the breakfast, we encourage our colleagues to commit acts of service in the community and we provide community resources for colleagues to connect with in honor of Dr. King's legacy.

Wellness and Prevention

- Diabetes and Hypertension outreach: In partnership with our care group, we identified Medicaid members who have diabetes and hypertension and created a program to get home blood pressure monitors out to these members. In total, we sent 3143 monitors to members on our Medicaid products. The mailing included instructions on how to take a blood pressure reading at home and how to inform your care provider of the results. Our care group continues to work to engage with members whose blood pressure is outside of the recommended range.
- Breast Cancer GAPS Project: HealthPartners care group participated in the Breast Cancer GAPS project which is focused on reducing disparities for Black breast cancer screening. This project heard from community members about why they are reluctant to get screened, then is using principles of community

co-design to create solutions for these barriers. The project has created videos emphasizing that "We Matter" to encourage women of color to get screened. HealthPartners is working on how we will integrate those videos into our outreach on an ongoing basis.

- Other targeted outreach: In partnership with CHW Solutions, HealthPartners implemented targeted outreach to our diverse MSHO membership to encourage them to receive breast cancer screening. As trusted members of the community, CHW Solutions staff were able to reach out to our members to remind them of important cancer screenings. They reached out to members in their native language when possible and utilized interpreters when needed. Languages included in the outreach list included English, Spanish, Hmong, Karen, Oromo, Russian, Romanian, Somali, Swahili and Vietnamese. Of the 163 members identified, CHW Solutions was able to engage with 83 members, for a 51% engagement rate (61% if bad phone numbers are removed from the total). Members widely reported appreciating the outreach. Members who spoke English accepted help scheduling an appointment at a rate of 21% and those who spoke a language other than English accept assistance making an appointment with their clinic 17% of the time. Even for people who do not have a language barrier, engaging with the health care system can be intimidating. The support of a CHW helped to break down barriers to care for these members.

  In addition to this outreach, our Breast Cancer Screening reminder campaign was translated into Somali, Spanish and Vietnamese to increase access to this information for more of our members.

- Keystone Community Services: For over 80 years, Keystone Community Services has been serving Ramsey County with senior care, enrichment for children, basic needs and crisis assistance. Keystone began as a small neighborhood community center. Today, Keystone reaches more than 40,000 people, and we share many patients and members. Keystone currently operates two food shelves Rice Street Food Shelf and Midway Food Shelf. And when HealthPartners was piloting our SuperShelf initiative, the Rice Street Food Shelf was a pilot! Our 3 year commitment made in 2022 has been used to support the expansion of their new warehouse and food mobile providing better access to neighborhoods with barriers. Keystone food shelves and foodmobile provide quality, healthy food for the community, helping them be self-sufficient, stable and successful.
  - Express Bike is a social enterprise of Keystone Community Services. Express Bike is a full-service bike shop specializing in refurbished bicycles and a nonprofit youth employment program - all rolled into one! In April of 2022, we hosted bicycle drives at four HealthPartners locations collecting 136 bicycles to support this program.

- Open Arms: Since 1986, Open Arms of Minnesota prepares and delivers tasty, nourishing meals to critically ill Minnesotans and their families in need—100 percent free of charge. HealthPartners is proud to support the capital campaign to expand their services and opening a new kitchen in Saint Paul. https://www.openarmsmn.org/about-us/

Research and Education

- Minnesota Health Literacy Partnership: This group shares information and engages in joint planning on health literacy issues from a statewide perspective. The group is committed to advancing health literacy, so all people in our community can understand and engage in their health and health care.

- The Exchange: We participate in The Exchange, a collaborative of Minnesota health-related organizations. Members combine resources and collaborate to create and maintain an online library of health-related materials in languages most commonly spoken in Minnesota. The Exchange also disseminates information on issues of literacy, class, culture, race and spirituality as they affect health disparities.
- Make It. MSP: HealthPartners sponsors and is a key player in the Greater Minneapolis/St. Paul initiative called Make It. MSP, which is an initiative to help make the Minneapolis/St. Paul region a top performer in attracting and retaining people. As part of this initiative, we have representation on (1) the Make It. MSP People of Color Cohort, which is focusing on recruiting and retaining people of color to positions in the region and (2) the enterprise talent team, which focuses on recruitment into the region.

- Shadow Program with Roosevelt High School: For the past 4 years, Park Nicollet has partnered with Minneapolis Roosevelt High School's Health Careers Program to offer mentorship opportunities for career exploration in the health care setting. Due to COVID-19, the structure had to change so there were no student shadowing opportunities, but Park Nicollet leaders still participated in the board and job fair. This will resume in 2023 with 15 students mentoring in February and March 2023.

- Patient Care Assistant Apprenticeship: This program seeks to provide individuals with a place to begin a career in healthcare by providing them with the training needed to work in patient care. It also offers a career path for current employees in more entry level environmental services roles. With two pilot group completed in 2021 and an additional cohort in 2022, we are assessing this program and hope to continue this program with modifications to enhance effectiveness.

- Below are other 2022 school/student partnerships:
    - Washington Magnet School partnership: Regions partnered with this school to provide a diverse group of students with introductions to careers in health care. Each school year Regions engages with a student cohort of about 20 racially diverse students for four interactive learning events that introduce them to health care occupations and inspire them to consider their future careers.

    - HEIP/Scrubs Camp: Regions Hospital continues to support this important student experience that introduces young people to a variety of careers within healthcare. Regions Hospital supports this program in a variety of ways including advisory, facilitating learning sessions or tours, and at times through financial contributions to provide scholarships.

    - HOSA (Health Occupations Students of America): As a supporting member of HOSA, we help promote health care careers to high school students providing leadership on their board of directors, hosting student tours, and participating in numerous student experiences and competitions each year.
    - Enhanced Tuition Assistance Program: In 2022, we continued our enhanced tuition assistance program. This program exists through a partnership with Eastside Financial Center to increase economic growth and jobs for residents of St. Paul's eastside community and help increase the diversity of healthcare workers at all levels of employment.

- Career Fairs: HealthPartners actively seeks to hire a diverse staff and our recruitment team participated in several career fairs that focused on diversity. These events with local community organizations help

promote their events and provide an opportunity for recruiters to meet with community members in an effort to increase diverse hiring. Examples of events we attended include:

- Inver Hills Community College Allied Health Careers
- CareerForce Veterans Employment Services and MDVA Career Fair
- CLUES
- Ramsey County Career Fair
- Hmong Nurses Association Conference
- Law Enforcement Opportunities Job Fair
- St. Catherine's University Career Fair
- MN Society of Radiologic Technologists Conference
- Minneapolis College Career Services Event
- Irondale High School Healthcare Career Fair
- Mounds View High School Career Fair

Career growth and development

- Accelerated Development program: In 2022 Regions resumed its Accelerated Development program which serves to inform, inspire, and prepare a diverse group of employees who have interest in advancing their career into future leadership roles.
- Right Track and Right Track Plus programs: Regions hosted two interns from the St. Paul Right Track program in 2022.

- Throughout 2022 we partnered with the International Institute of Minnesota who serves individuals new to the U.S. with job preparation and employment. Our partnership includes hosting their clients for tours of our hospital, informational sessions about health careers, mock interviews, and job placement.

- In April of 2022 we supported Hospitality Career Pathway by conducting mock interviews with individuals with English as their second language to support their preparation for success job interviews.

- CompTIA Tech Career Academy: We partner with CompTIA Tech Career Academy's IT Ready program to host interns in our IS&T department. The IT Ready program specifically recruits women, people of color and veterans into their programs. In 2021, our IS&T department hosted 3 interns and all were hired into permanent positions.

- Prime Academy's "Prime Career Day": In January, 2021 our IT hiring leaders participated in Prime Academy's "Prime Career Day" mock interviews. Prime Academy's focus is to humanize technology by bringing diverse and driven problem-solvers to the challenge of creating a better tomorrow. They assist students in launching their tech careers through their Full Stack Engineering and User Experience Design programs.

- Minneapolis Community & Technical College: In September, 2021, the recruitment team participated in a panel discussion of local employers regarding the job market and healthcare careers with the

Minneapolis Community & Technical College and their students. Minneapolis Community & Technical College students are 62% racially diverse.

- AchieveMPLS : In November, 2021, the recruitment team also participated in a panel discussion and mock interviews for college student interns via AchieveMPLS which is the Minneapolis Public Schools career and college readiness program.

Recruitment:

- Through HealthPartners/GHI's partnership with Minnesotadiversity.com, HealthPartners/GHI recruits diverse, local candidates through online advertisements on: JobsinMinneapolis.com, JobsinStPaul.com, MinneapolisDiversity.com, StPaulDiversity.com, and MinnesotaDiversity.com. These sites attract over 2 million monthly visitors and help us connect with local, diverse, quality applicants. This site promotes HealthPartners/GHI's open positions through 383 community and diversity outreach organizations within 50 miles of the city of Minneapolis. These organizations assist women, Racially Diverse Individuals, individuals with disabilities and veterans with employment. Each of HealthPartners/GHI's open positions is emailed with a request for referrals to matched organizations. Some organizations include local workforce offices and their veteran employment representatives, Goodwill, YWCA, and the local vocational rehabilitation offices.

- In addition, the recruitment team also posts position in a variety of websites sites including MinorityNurse.com, NursingDiveristy.com, MABL (Minnesota Assoc. of Black Lawyers), National Native American Bar, Clinical Lab management Association (CLMA), Health Care Compliance Association (HCCA), MN Council of Non-Profits, and many college web sites.

Recruitment staff development:

- Participation on several DE&I focused webinars and/or seminars including: Talent Flow - A workshop by The Diversity Institute in Honor of Black History Month, Reckoning with Women of Color, Money & The Workplace put on by the Center for Economic Inclusion, MN Dept of Labor & Industry webinar "Race + Gender Matter at Work- How to Truly Value Different Perspectives Across Identity", MN Talent & Recruiting Network seminar "Hiring Non Traditional Candidates in the Underserved population" which focused on hiring veterans, individuals with disabilities, etc.

- Participated in mock interviews through Achieve College Internships. Achieve College Internships connects diverse college students with professional internships in the Twin Cities.

- HealthPartners sponsored the 1st annual national Hmong Nurses Conference in May, 2022 and attended their conference career fair.

- HealthPartners participated in the 30,000 feet Tech Geek intern program by hiring 3 diverse students as interns in our IT Department.

- HealthPartners IS&T sponsored the Open Source North conference and attended their conference career fair.

- Several recruiters participated in a 4 part internal "Bias for HR Professionals" course including information on recognizing and mitigating bias in HR.

- We participated in the Ramsey County Healthcare Futures event including participating in a panel discussion about careers in healthcare for high school students.

- We hosted several virtual career fairs through Indeed.

- We participated in 2 virtual career fairs put on by Dakota County Department of Employment & Economic Development

Other Partnerships and Campaigns

- School-Based Health Centers: in 4 high-need school district locations provided no-fee medical care, prescription support, dental services and insurance navigation to 4,272 children and youth from birth through high school graduation. This service also provided 740 no cost immunizations to children. Additional dental education and education/outreach was provided to 1,700 children and families. Services are provided in the Brooklyn Center, Burnsville, Richfield and St. Louis Park school districts.
    - Interpreted visits: There were 242 no-cost interpreted visits in the four school clinics in 2022
    - Naloxone (NARCAN): Park Nicollet partnered with Burnsville/Eagan/Savage District 191 health staff leaders to create a Naloxone policy and train staff and provide advisory and standing orders service.
    - Mantoux testing: Central Clinic clinicians and support staff partnered with St. Louis Park Public Schools and other partners, to provide a Certified Nursing Assistant program so that they have a career tract upon graduating from high school. HealthPartners/Park Nicollet provided Mantoux testing services at the school that supported 48 participants to gain medical eligibility to participate.
    - Central and Diamondhead Clinics provided extra catch-up immunization and STI testing days to meet emerging needs identified by school health staff.
    - Brooklyn Center Health Resource Center Equity Assessment: Park Nicollet Foundation is partnering with Brooklyn Center Community Schools and the NW Hennepin Family Resource Collaborative to conduct a health equity assessment at our school clinic in Brooklyn Center High School

- Growing Through Grief Program: (GTG) includes eight Park Nicollet counselors provided group and one-on-one grief counseling to students who experienced the death of a family member or friend. Provided in 114 schools across 16 partnering school districts, the program supported more than 665 students per week. Assistance was also provided to support school districts in responding to 18 death-related crisis events supporting about 25,383 students, parents and school staff. 10,281 contact hours of support for students and parents. In addition
    - GTG staff partnered with Minneapolis Public Schools to create an eight-week grief curriculum focused around community unrest and death and related loss. This program was piloted with combined white and BIPOC staff from both organizations and will be rolled out to Brooklyn Center

and Richfield school districts who have also experienced recent elevated levels of community violence and unrest
    - GTG staff partnered with New York Life Foundation to assist Westonka and Osseo school districts in presenting Grief Sensitive information and becoming Grief Sensitive School Districts
    - Growing Through Grief Changemakers Cohort: GTG was chosen to be part of a national cohort of child bereavement service providers to develop and enhance their data collection, evaluation and assessment capacity

- The NOW! (No Obstacles to Well-Being!) Tele mental Health Program: provides no cost school based mental health services in partnership with school districts via secure video technology and virtual platforms to children and adolescents in need. In 2022, mental health services were provided to 52 students with 744 hours of therapy in the Burnsville, Richfield and St. Louis Park school districts.

- Mobile Mammo-a-Go-Go Community Outreach Program: Park Nicollet Foundation and Jane Brattain Breast Center partnered to support 66 events providing no-fee 3-D breast cancer screening, diagnostic services, and breast health education to 1,186 women-in need across our communities. 11% required follow up and 4 were diagnosed with cancer.

- COVID-19 Vaccine Catch up Initiative: Park Nicollet Foundation provided support to enable two COVID-19 vaccine clinics in low income, vaccine hesitant communities partnering with the St. Louis Park firefighters, and our Methodist Hospital MDA pharmacists to provide COVID-19 vaccines to vulnerable community members in St. Louis Park.

- Spiritual Care in Methodist Hospital. Park Foundation provides funding to ensure patient services are available in all religious faiths.

- The Grove: Park Nicollet Foundation and Methodist Hospital created an intentional outdoor space of healing with trees, paths and sitting places convenient to hospital patients, families and staff to meditate, reflect and promote mental health.

- Hospice program for veterans: Park Foundation provides funding to our hospice programs to provide care and special needs items and supports to veterans in hospice. In 2022, over 436 veterans have been served through this program.

- Diabetes health literacy: Park Foundation provided funding for our diabetes program to support the creation of a set of special illustrations for patients with low-vision, low-literacy related to diabetes care to use in education and care materials A set of those tools focus on describing hyperglycemia and hypoglycemia to low-literacy audiences or those who speak English as a second language—using primarily quality illustrations that depict symptoms of both conditions.

- Diabetes disparities: Park Foundation has been providing funding for, and in partnership with the Internal Diabetes Center and the Park Nicollet Brookdale Clinic to conduct a series of targeted patient care programs with research to address/improve outcomes for diabetic patients of color.

- George Floyd Global Memorial Art & Offerings Exhibit: Methodist Hospital, supported by Park Nicollet Foundation, began planning and partnering with the George Floyd Global Memorial Foundation to bring a 100 piece exhibit of community expressions to the hospital public spaces during January-March of 2023. Planning began in September 2022 and is expressly designed to promote healing, acceptance and equity in care.
- Itasca Project: We continue our work with the Itasca Project. This is an employer-led alliance to address regional issues that affect our future competitiveness and quality of life. A major focus of the Itasca Project is closing the gap on socioeconomic disparities in the region through collective action by businesses. The Itasca Project, a cross-sector alliance of employers, launched the First 1,000 Days initiative to help raise awareness among employers of the lifelong impact of early experiences prenatal to age 3 – and the crucial. Our Little Moments Count collaborative helped to create the employee toolkit: https://www.littlemomentscount.org/employer-tool-kit
- Rondo Neighborhood: HealthPartners is a proud sponsor of the Rondo Commemorative Plaza. In the 1930s, the Rondo neighborhood was a thriving and vibrant community. By the 1950s, about 85% of Saint Paul's African American population lived in the neighborhood. The community bond was strong, local businesses were thriving, and residents were gaining financial stability that comes with home ownership. In the 1960's, however, the neighborhood of Rondo was removed from the map for the construction of Interstate 94. 600 families lost their homes along with numerous businesses and institutions. The Rondo Commemorative Plaza was installed to capture the history of loss endured, lessons learned and the will to reconnect. In 2022, we participated in Rondo Juneteenth festival sharing health education and blood pressure checks.

- One Campaign: The One Campaign is HealthPartners' biggest campaign for internal team member support of our hospitals' foundations and community nonprofits. The campaign was a success and $642,362 was raised supporting patient care and community programs and organizations.

Collection and Use of Data on Race, Ethnicity and Language Preferences

- HealthPartners systematically collects data on race, ethnicity, language and country of origin directly from patients and members in a variety of ways, all of them voluntary. These data collection sources include healthpartners.com, online through our health assessment, and the electronic medical record in our care delivery system and in our dental group. We've found that collecting this information face-to-face from patients at the point of care or health plan contact is an effective data collection method. Across our care delivery system, we have collected race and language information for over 90% of our patients, with language and race collection rates at our hospitals exceeding 97% in 2022. In addition, we receive data from the Minnesota Department of Human Services, Minnesota Community Measurement, and Minnesota Immunization Information Connection (MIIC) for our members covered by Minnesota Health Care Programs. When we combine all these data sources, we have this information documented for over 97% of our Medicaid members under age 65.

- We use these data to monitor the quality of care delivered and patient/member experience by race, ethnicity and language. We also use the data to identify strategies to reduce health disparities in treatment, outcomes and service.

- We include race, ethnicity and language data on the member registries we make available to network providers, so they can identify and address disparities among their patients.

- Where data are voluntarily available on provider race, ethnicity, language and/or country of origin, we use those data as a resource to respond to patient/member requests. Some of this data is available in the provider directories as well.

- Hospital equity alignment: Using recently published hospital health equity standards from the Minnesota Hospital Association, Joint Commission, and CMS Hospital Inpatient Quality Reporting Program (HIQRP), we set out to document progress towards meeting the standards across all hospitals in our care system, identify gaps, and set clear goals to close these gaps.
    - Cross-walked equity standards to understand requirements

      Key elements across the standards include:
      1. Health Equity as a strategic priority and an organizational culture & structure to advance the work
      2. Valid and reliable data collection and the ability to stratify key measures to identify disparities and address health-related social needs.
      3. Documented work to address identified disparities and health-related social needs.
      4. Regular communication to and engagement of key stakeholders
    - Documented system level work being done to meet standards and shared with all hospitals.
    - Set 2023 hospital system equity goals to address identified gaps, building on work in progress.
        - Valid and reliable data collection:
            - Standardize and train on data collection best practices across all hospitals.
        - Addressing patient's social needs:
            - Standardize collection of SDoH data and use of Unite Us to address social needs with a focus on transportation, food, and housing.
        - Quality improvement work to eliminate disparities:
            - Continue work with Premier Perinatal Collaborative. Target improvements in emergency treatment of hypertension.
            - Bring disparity data to the Hospital Quality Steering Committee for prioritization to the appropriate committee.
            - Continue to build capacity and commitment at the local level
        - Routine communication to stakeholders:
            - Annual reporting (minimum of 1x per year):
                - Hospital Board of Directors
                - Patient Family Advisory Committee (PFAC)
                - Medical Executive Committee

    - Patient Care Committee
  - Additional quarterly reporting through:
    - HP Health Equity & Eliminating Disparities Cornerstone
    - Joint meetings of Methodist and Regions HEC
- Health Equity Accreditation: Starting in 2022, HealthPartners implemented NCQA Health Equity accreditation standards for our Medicaid products. According to NCQA, this accreditation program focuses on the foundation of health equity work and supports health care organizations in evaluating and elevating the health of the populations they serve. Specific focus areas include building an internal culture that supports the organization's external health equity work; collecting data that help the organization create and offer language services and provider networks mindful of individuals' cultural and linguistic needs; identifying opportunities to reduce health inequities and improve care. HealthPartners will formally apply for this accreditation in January 2023.
- MN Community Measurement (MNCM): is a collaborative HealthPartners is part of to improve health by publicly reporting health care information. The 2022 MNCM Health Care Disparities Report includes 8 publicly reported measures.

Language Assistance

- We provide interpreter services in all key languages spoken by patients and have access to over 200 languages through telephone and the use of video remote interpretation. We consistently provide high quality face-to-face (including dedicated staff in high-volume locations), telephone and video remote interpreter services to our patients in their preferred language for health care.
- 100% of employed interpreters at HealthPartners have a minimum of 40 hours of professional training. 71% of HealthPartners employed interpreters hold national medical interpreting certification.
- Updated annually, our Language Assistance Plan sets organizational best practices and expectations and is accompanied by the practical Your Guide to Interpreter Services. Your Guide provides answers to questions such as how to access an interpreter and how to talk with patients who wish to rely on family members to interpret. Training is conducted on these tools to support continued improvement in health and experience outcomes. Most recently, it has been further updated to reflect the most current federal government guidance on notification to members and patients on their right to language services (ACA 1557), updated data to reflect our membership, and updated organization structure information.
- HealthPartners Interpreter Services leaders meet with all contracted agencies as needed to ensure they are meeting service standards and to engage them in improvement activities that support the Triple Aim.
- Vocera units have been activated and dual handset phones are available at our largest hospital to support improved access to and use of telephonic language services. Several clinic sites also made improvements to their infrastructure and workflow to offer improved telephonic language services, and video remote services are available widely throughout our hospitals and clinics.
- HealthPartners Interpreter Services facilitates the Interpreter Services Leadership Group, a Minnesota-based group of health care interpreter services leaders who meet to share best practices and work towards

common goals related to service delivery, quality improvement, education, and affordability of language access services.

- Interpreter awareness education continues to be offered in multiple new employee settings as a regular part of the agenda, including provider NEO at HealthPartners, HSC NEW, Regions NEO, and New Resident Orientation. HealthPartners member services, sales, case management and other representatives also are trained in how to use telephonic interpreter services. HealthPartners also sponsors several interpreter continuing education workshops each year for both employed and contracted interpreters. In 2022, workshops were offered on (1) building an LGBTQ+ inclusive environment and (2) best practices for health care remote interpreting.

- HealthPartners interpreters were involved in a number of activities that benefit our patients, members and community. In 2022, these activities included:

  Participating in community benefit activities, including:

  - Translating health and financial education materials into Hmong, Spanish, Oromo, Somali and Vietnamese
  - Providing training to interpreters through two continuing education events
  - Providing translation and voicemail interpretation services to Diamondhead Clinic, a free school-based program
  - Making outreach calls to select Somali-speaking patients who are overdue for a mammogram
  - Providing Spanish interpretation services to patients attending Lactation Cafés at several Park Nicollet clinics and Methodist Hospital
  - Three student interns from Century College were trained by our staff in 2022. Students were also invited to attend our continuing education events.
- HealthPartners Government Programs provides an annual virtual interpreter training for contracted interpreters. The training topic for 2022 was "Hospital to Home: Safe Discharge Planning." The presenters for the training were Sue Oestreich, RN, BSN/PHN, CCM: Director - Care Coordination Programs, HealthPartners Comprehensive Care Advocacy; Florence Okoampa, LGSW, CCM: MSHO/MSC+ Program Manager, HealthPartners Comprehensive Care Advocacy; and Thomas von Sternberg, MD: HealthPartners Associate Medical Director. Participants for the training were eligible to receive 0.15 CEUs through the International Medical Interpreters Association. The training generated good discussions between the participants and presenters.

- NCQA Health Equity Accreditation: As part of implementing NCQA Health Equity Accreditation standards, HealthPartners deployed surveys to gather information on member and staff experiences with language services. HealthPartners also surveyed network practitioners on providing culturally responsive care; this survey included questions about practitioner comfort and experience with providing language services to members.
  - Based on results from the staff survey, we developed a guide to assist health plan staff process requests for written translations, including decision support tips and a step-by-step guide on working with our written translation vendor. Member-facing departments also identified high-value member-facing documents and completed translated approximately 38 member-facing documents in 2022.
  - Member experience with language surveys are sent only to Medicaid members, but results are shared with business areas that serve all members so insights can be applied broadly. These surveys

assess experience during both health plan and health care encounters at our own care group and beyond.
    - Practitioner cultural responsiveness survey goes to network practitioners that may provide services to members with any form of HealthPartners coverage. In 2022, survey results provided insights into the need to provide more resources to practitioners on providing culturally responsive care, which led to HP issuing a Health Equity edition of Fast Facts (a newsletter available to all network practitioners). We also collaborated with UCare and Stratis Health to create a website with resources to help providers advance culturally responsive care in their practices: https://culturecareconnection.org/cultural-responsiveness/.
    - Staff and member survey results are shared with the enterprise Interpreter Services Workgroup who will continue to assess trends and implement changes around our language services as needed based on year-over-year data.

- After-visit summary translation: Our static after-visit summary (AVS) content is now available in both Spanish and Vietnamese. We deployed this functionality in Emergency Centers across our system effective August 2021 and in the inpatient setting on February 22, 2023. We continue to collect user feedback as we move forward for deployment in other settings in 2023.

- Patient instructions: Through our partnership with Healthwise, more than 3,600 Patient Instructions are now available in Epic in English and Spanish. These instructions can be added to the After Visit Summary/Discharge Instructions and printed for patients.

- Patient education: Park Nicollet Foundation funded the production of low-literacy versions of patient education content on recognition and management of high and low blood glucose. We received federal funding to translate a variety of preventive services and disease management patient education documents in multiple languages, including Spanish, Somali, Vietnamese and Hmong. In 2023, we plan to translate our colonoscopy prep content, heart failure and Ramadan-focused nutrition patient education content, among a host of others that we hope will advance health equity.

Member Materials & Communications

- Member materials are created using a consumer-friendly checklist to ensure that communications are understandable, conversational and consistent.
- The MSHO Summary of Benefit is available in Spanish, Hmong and Somali, or other languages as needed, upon request. In addition to the Summary of Benefits, we can translate most materials upon request and in languages other than Spanish, Hmong, and Somali. We also translate some member outreach for preventive health services into Spanish, Hmong, Somali and Vietnamese.
- Promotional materials, websites, and blog posts reflect the demographics that exist in the population, making photos racially, ethnically, ability and age diverse.
- Custom communications developed for some employer groups have been translated to better serve our Spanish and Somali speaking members.

- Open enrollment materials for commercial products are available in Spanish and English.
- HealthPartners Minnesota Health Care Programs and MSHO: The required DHS Language Block (LB) must be included with all member communications and materials. For small-sized materials, a condensed version of the language block is permissible. Additionally, materials that cover the following topics must include the DHS required Civil Rights Complaint Block (CB).
    - Determine eligibility for programs
    - Require information needed for program eligibility
    - Inform members that their benefits have been increased, decreased terminated or denied, or
    - Include important information about the member's rights and responsibilities

  The DHS Civil Rights Complaint Block contains information about member civil rights and how a member can file a complaint if they believe they have been discriminated against.
- The Minnesota Health Care Programs materials are translated upon request, including the Medicaid/MSHO/SNBC and welcome letter.

- The MSHO Sales Cover Letter is translated in Spanish, Hmong, Korean, Vietnamese, Russian, and other languages upon request.
- The Multi-Language Insert (MLI) is a standalone document that must be included with all CMS required materials for Medicare individual and group plans. The MLI is a standardized notification that informs the reader that interpreter services are available in 15 of the most common non-English languages in the United States.
- The Affordable Care Act Section 1557 Non-Discrimination Notice and Taglines are provided to all members. This occurs in our annually mandated information mailing in June.

- Created advertising on local radio stations and/or in diverse community publications for Somali, Hmong, Native American, African American, and Hispanic populations.

- Development and promotion of unique supplemental benefits for MSHO members address social determinants of health and support members with chronic conditions, including benefits such as FarmboxRx fresh produce delivery, animatronic support pets, caregiver support and tablets with education and wellness tools.

- Pregnant members in the Healthy Pregnancy program have access to personalized digital support through the My Pregnancy experience when they log into healthpartners.com. This includes personalized resources based on the pregnant person's race, ethnicity, language and insurance product. For example, D.I.V.A. Moms is surfaced as a resource for Black pregnant members. It is an African American led program designed for pregnant and postpartum Black women. Similarly, members on a Medicaid product receive personalized information about unique benefits such as covered Doula support.

Building an Effective Workforce to Support Health Equity, Diversity and Inclusion

- Twin Cities Pride Festival and March: 115 colleagues volunteered at the festival and walked in the Pride march that was held in-person for the first time since 2019. HealthPartners donated $5,000 to three LGBTQ organizations in the community.

- Continuous updating of the internal Diversity, Equity and Inclusion (DE&I) website: As a part of the organization-wide effort to migrate two different internal platforms into one, the DE&I internal website is continuously updated with relevant and timely DEI related information.

- Diversity, Equity and Inclusion Dashboard: Created and shared first ever colleague diversity dashboard that shared the racial experiences of colleagues within the organization and specific organizations. Met with all senior leaders and direct reports to share their dashboard with them. Trained HR colleagues on usage of, creation of and understanding of data behind demographic data. Leaders utilize the findings in the dashboard to create annual plans and DEI goals.

- Inclusive Leader Workshop: a 4 part module offered to leaders build tools to create an inclusive workplace for their teams and the community were serve. Leaders develop skills to have coaching conversations with their teams, learn how to use the equity lens toolkit to bring equity to policies, practices and procedures, and build a DEI strategy for their respective teams. In 2023, we had 14 cohorts complete the training (130 leaders), 50 different applications of the equity framework, and 15 DEI plans created.

- Unconscious Bias Training: is offered to all colleagues. This 4 part module deepens our understanding of how unconscious bias can impact others and the work that we do. Colleagues learn to identify bias, mitigate bias and how to move beyond bias to actionable anti-racist results. In 2022, there were 38 facilitated sessions (926 colleagues completed 1 session and 113 completed all 4 sessions). Post surveys show significant increase in understanding and confidence explaining bias to others.

- LGBTQ+ Training: Revised available training for colleagues on LGBTQ+ using updated language and more inclusive examples in collaboration with the Diversity, Equity and Inclusion department and the LGBTQ+ colleague resource group.

- Colleague Resource Groups: are voluntary, employee-led groups organized around shared underrepresented identities throughout HealthPartners, such as race, gender, age, sexuality, veteran status, and disabilities. Additionally, groups may be organized around shared interests that affirm diversity and inclusion throughout the organization. They help us serve the diverse and individual needs of patients, members and customers, as well as strengthen respect and inclusion in our workplace. In 2022, we had three active groups: Black and African American, LGBTQ+ and leaders of color resource group.

- Clinician Affinity Groups: similar in nature to colleague resource groups, clinician affinity groups are voluntary, clinician lead groups organized around areas of identities and areas of collective interests.

- DEI Simulations: In efforts to create an anti-racism workplace, HealthPartners pulled together colleagues from Clinical Simulation, Diversity & Inclusion and Nursing education to create scenarios rooted in bias,

many created off of actual colleague experiences, to help others understand how to respond and what to do next in bias situations.

- Listening Sessions: HealthPartners offered quarterly listening sessions to our staff a panel discussion around areas of diversity. 2022 we held four listening sessions that reflected different dimensions of diversity, including ageism, disability, LGBTQ and being a racial ally.

- Gender Care Coordination: The Gender Services team has been leading efforts to coordinate patient access and consistent, quality care and experience across the organization, which has included collaborating with clinicians and teams across multiple departments and locations who provide gender care to patients. This collaboration has focused on multiple areas of gender care and created standards of care, patient education materials, and clinician trainings and resources to support quality care.

- Culture Roots: We have extensive internal communications to build staff understanding and capabilities in cultural humility. The bimonthly "Culture Roots" newsletter continues to be an organization-wide educational tool. The Culture Roots subscriber list is currently at 841. Topics for 2022 included addressing breastfeeding disparities, partnering to advance health literacy, eliminating disparities in childhood immunizations, ageism in health care, and improving accessibility to advance health equity.

- Health Equity Champions: The HealthPartners Health Equity Champions program continued in 2022. The champions are staff members and providers who receive expert training so they can become advocates and serve as local resources for their colleagues in caring for patients from diverse cultures and those with limited English proficiency.

    - Nearly 338 Champions were participating by end of 2022; we had 52 new Champions join us this year.

    - In addition to producing Culture Roots, the Health Equity Champions team distributed announcements to help increase Champions' awareness of and participation of various health-equity-related events and activities.

    - We continue to use our Teams channel to communicate in real time to share insights, news and announcements. Champions opt-in to this dedicated Teams space. Currently, 113 members stay connected through this channel.

    - Our 2022 annual event was held virtually in October. The topic was on ageism. Our presenter was Dr. Rajean Moone, Associate Director of Education at the Center for Healthy Aging & Innovation at the University of Minnesota. Dr. Moone's presentation included an age-friendly organization assessment tool that we can use to address ageism in our organization's culture, practices and policies.

    - The Health Equity Champions program held several additional virtual events in 2022. The presentations were well-attended and generated positive feedback.
        - We held four quarterly Teams presentations in 2022 to help Champions stay updated on health equity activities, programs and initiatives happening across our system. Each

presentation focused on initiatives cascading up to the “eliminating disparities” cornerstone of our organization’s equity, inclusion and anti-racism work. Topics included health equity research updates, the HealthPartners Children’s Health Council, using our organization’s framework for designing for equity, and our Addressing Health Disparities Maintenance of Certification (MOC) project.
        - We held two “community organization spotlights,” designed to highlight organizations that had volunteer opportunities and whose mission aligned with our vision to advance equity and inclusion and eliminate racism.

- Champions continued to have opportunities this year to participate in small-group feedback sessions or pilot trainings to lend a diversity lens to various projects we have happening across the organization.
    - Early in 2022, we sent out a survey to Champions asking them about the organizations they volunteer with. This was in partnership with Community Relations. We evaluated the responses to inform how we might proceed with our Volunteer Spotlight presentations done throughout 2022.
    - We sent out an invitation in October for Champions to participate in focus groups to discuss member communication for Indigenous populations.

Equity, Diversity and Anti-racism website: This is a landing page for our Cabinet and links to our Cornerstone work. The site helps provide structure to our work, easily shares information about that work, resources and calls out ways colleagues can get engaged.

Assessment of Effectiveness

We routinely review and analyze race and ethnicity data to identify, test and implement strategies to reduce disparities in treatment outcomes and service. We have found that developing consistent workflows that help caregivers identify and offer needed services to all patients—and then customizing those services based on cultural, linguistic, socioeconomic or other differences—helps reduce health disparities. Our approach is to continually improve our performance. Following are examples of disparities-reduction initiatives that we continued to refine and improve in 2022.

Example #1: Mammography Screening Improvement

Accountable owner

Paula Indehar – Improvement Specialist

Member Populations Targeted

x	Commercial
x	Medicare Freedom (Cost)
x	Medicaid
x	MSHO
x	HPUPH
x	WI Marketplace

Description

In 2007, we identified disparities in mammography screening rates between patients of color and white patients and between government programs patients and other patients. Since then, we have conducted many interventions to continually improve our performance. Interventions included culturally humble scripting on preventive services, same-day mammograms, and telephone outreach to patients of color and government program populations of women ages 50 to 75 who were not up-to-date on a mammogram. We implement focused interventions with consultant support at clinics with the greatest opportunities.

For 2020, we continued to work across all families of care with an additional focus of delivering screening mammograms safely within a pandemic. We have 27 locations with onsite mammography and almost all sites offer 3D Technology. We have extended hours at our locations to include weekends and some evenings to accommodate patients' needs. Mammo- a Go-Go truck has added two additional HealthPartners sites to their list of locations they travel to. We had to adjust some of our processes for same day mammography to allow for a safer environment for our patients for screenings. Same day mammograms started back up in September of 2020. Breast Cancer screening Registry outreach was put on hold for a few months but was resumes in October of 2020 and revised the communication we provided sharing the steps we have taken to make it safe to come in for screenings.

Our focus for 2021 will be around Access, Innovation and Communication. We want to partner with the Health Equity Saint Paul Anchor strategy cornerstone on building trust with our patients and communities. All this to increase screenings and decrease our disparity rates for patients of color and government program patients. We continue to learn about how we can best reach our patients and get them in for the screening tests they need. The goals for mammography screening rates are to increase rates for all women and to decrease the disparity in rates between patients of color and white patients (as well as between government program patients and other-insured patients).

For 2022, we are continuing to attempt to decrease our disparity gaps between patients of color and white patients as well as between commercial payor and government plans. We had some challenges with staffing issues as well as women fearing exposure to COVID while visiting our locations for their mammogram.

For 2023 our focus continues to be on our disparity gaps between patients of color and white patients as well as our disparity gaps in our commercial payors and government plans. We currently are having staffing challenges which is contributing to our access and availability on weekends and evenings. Our radiology groups have been actively recruiting and working with schools seeking candidates. We are continuing to offer same day and walk in availability at our sites and working towards a 10% increase from the 2022 totals. We are seeing success in our current outreach to our patients when using the channels of a direct email, text, or letter.

Goals

Main objective is to close the disparity gaps we are seeing in our women of color vs white women. We will see the impact of this work by seeing a decrease in the gap over the year.

We are focusing on women who are 52-74 years and who have had a mammogram in the last twenty-seven months. We exclude women who have a bilateral mastectomy, deceased, Frail, permanent nursing home resident, and those currently enrolled in Hospice.

As of January 2022, in our care group we have 116,465 eligible women and 78.02% of those women have been screened for Breast Cancer. Patients of color account for 13.5% of the eligible population at a screening rate of 67.39%. White women account for 85% with a screening rate of 80.02%. The remaining 1.5% have an identified race and are screening at a 57.92%

As of January 2023, in our care group has in our care group we have 117,878 eligible women and 81.59% of those women have been screened for Breast Cancer. Patients of color account for 14.1% of the eligible population at a screening rate of 72.08%. White women account for 84.1% with a screening rate of 83.66%. The remaining 1.7% have an unknown race and are screening at a 58.49%. For our disparity gap between commercial payors and government payors our care group is at a 65.43%. Our commercial payor patients are 91.3% of the eligible population and our government programs patients are 8.7% of the eligible population.

Initiatives/Interventions

This year our initiatives will be focused on recruitment for staffing, offering of the Addressing Health Disparities MOC using Breast Cancer screening for a measure clinician can make improvements to. We worked with the

Breast Gap project to produce videos for patients of color on why they matter and what to expect when having a mammogram. We hope to add these into our clinical reminders campaign.
We continue to monitor the clinical reminders campaign and look for ways we can optimize the success of the campaign. At the end of 2022 we had an overall conversion rate of 28.6%, our email conversion rate was 31.5%, text conversion rate was 12.7% and the us mail conversion rate was 17.8%

We are in the process of translating materials and investigating the opportunity to add QR codes to some of our patient education material for breast cancer screening.

Barrier Analysis

Member/patient barriers include cultural perceptions about health and medical care, role of the individual in health and decision making, socioeconomic factors, language, access to care, lack of understanding of the health care system, and limited health literacy.
Staff and provider barriers include not understanding cultural beliefs and approaches of patients and members, comfort with using interpreters and translated information, sufficiency of translated information in needed languages, and time to spend on increasing knowledge and using equitable care resources.

Organization and system barriers include: the many competing priorities that are part of a changing health care system, keeping up with best practices, and keeping care and service affordable.

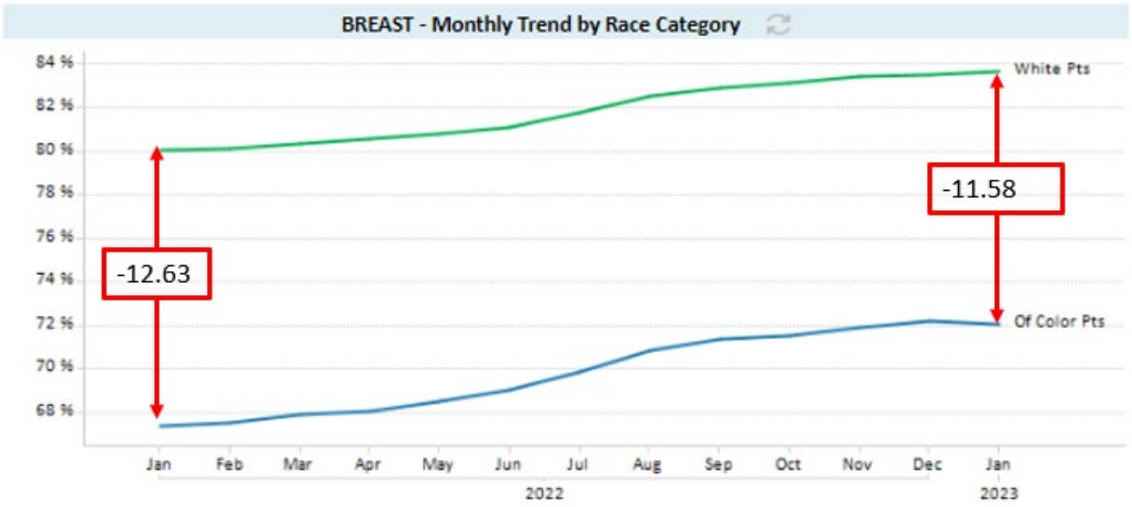
I believe we still have some residue with the pandemic barriers which include patients fear of being exposed to COVID/illnesses when in the clinic for mammogram which contributes to delay in care. We have staffing challenges causing a decrease in access and availability during the week (evenings and weekends) to mammograms.

Gaps in Care

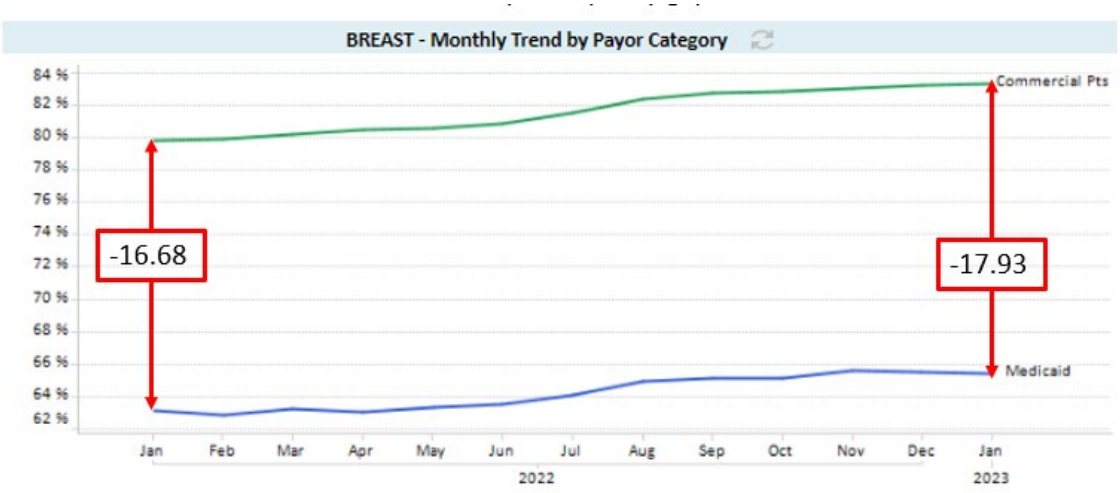
- Staffing issues that caused us to not offer mammograms in the evening and weekends and contributes to the decrease in capacity of the Mammo A Go Go truck to 65% and the events we can do out in the community.

Opportunities for Improvement: Results/Outcomes

Breast Cancer Screening by Race



Breast Cancer Screening by Payor



Example #2: Colorectal Cancer Screening Improvement

Accountable owner

Greg Fedio, Clinical Project manager

Member Populations Targeted

X	Commercial
X	Medicare Freedom (Cost)
X	Medicaid
X	MSHO
X	HPUPH
X	WI Marketplace

Description

Our goal is to increase colorectal cancer screening rates in patients to at least 80 percent, while also bringing race and payer rates into alignment with the overall population. In order to achieve this goal, we have developed a care model process that allows us to easily and effectively initiate the process, while also taking into account disparities in colorectal screenings and making proactive strides to reduce this gap.

Goals

- Decrease disparity gaps in colorectal cancer screening between patients of color and white patients
- Decrease disparity gaps in colorectal cancer screening between patients with government insurance and patients with commercial insurance
- Increase understanding of community needs for colorectal cancer screening
- Expand projects that focus on closing disparity gaps
- Improve colorectal cancer screening outreach and access
- Improve processes related to electronic medical record

Initiatives/Interventions

- Increasing visibility and stressing the importance of colorectal screenings in patients. A health maintenance modifier is added to a patient's record once they reach the age in which they should begin regular screenings. In 2021, this modifier was updated to reflect the changes in colorectal cancer screening recommendations from the United States Preventive Services Task Force (USPSTF). It is now active for all patients between the ages of 45 and 75.
- While completing pre-visit planning nursing staff are prompted when a patient is due for a colorectal cancer screening.

- During the rooming process, our staff use pre-approved scripting to inquire as to whether or not the patient has had screenings, and to offer education on the importance of colorectal screenings as well as how the process works.
- Other tactics we utilize to increase awareness and education for patients include social media postings and advertising on our waiting room monitors in March for Colon Cancer Awareness Month; letter reminders sent to patients that are due for screenings; and by developing education materials in six different languages to reach a broader patient base.
- Approximately 8,500 Fecal Immunochemical Tests (FIT) were sent to patients that have never been screened for colorectal cancer, along with information about the importance of screening. This is a useful tactic in helping increase screening rates while offering patients a non-invasive screening option.
- Twentynine clinicians took part in a 6-month long Maintenance of Certification (MOC) project that focused on closing disparity gaps in colorectal cancer screening rates between white patients and patients of color. The project showed success as all screening rates increased and the cohort of participating clinicians was able to increase their screening rates of patients of color at a higher rate than their screening rates of white patients.
- While these systems have proven effective, we have an expert panel of senior leaders, doctors and researchers that meets twice a year to review evidence and set goals related to colorectal cancer screening. Additionally, we have a multi-disciplinary team that meets on a monthly basis to review data and discuss strategies, in order to continue our progress without stagnating.

Barrier Analysis

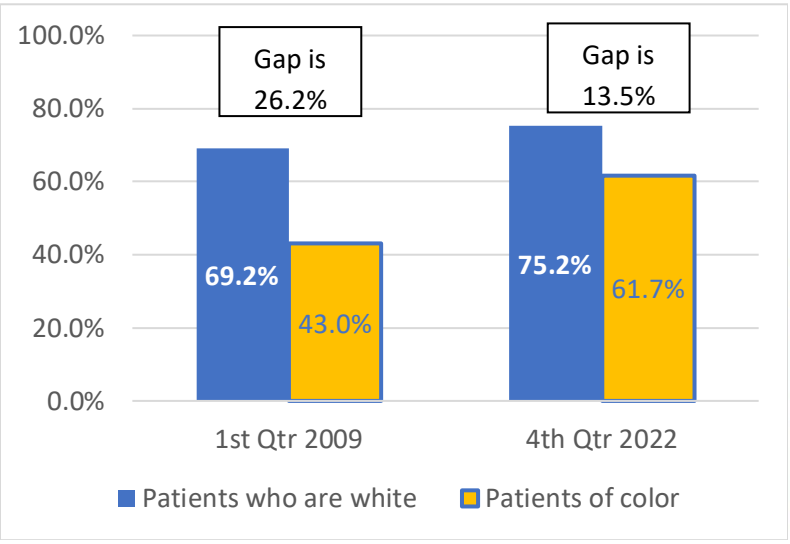
Often there are misconceptions about the screening process, and we work to make patients feel comfortable. We demonstrate at-home screening kits, known as FIT (fecal immunochemical test) kits, provide in-room educational materials, and answer questions about colonoscopy and FIT screening options. When the patient agrees to the services, our staff orders the screening. If they do not agree to the screening, the clinician will re-affirm the importance of colorectal screenings. If the FIT test is the screening method chosen, and a patient completes the test, the patient will be automatically mailed a follow up kit in a year. In addition, a letter will be sent to the patient after the kit has been mailed, if they have not returned the kit within 2 weeks.

Gaps in Care

As a result of the efforts mentioned, colorectal screening percentage for patients of color at HealthPartners Medical Group has gone from 43% in 2009, to 61.7% percent by end of 2022. These rates increased from 2020 to 2021, despite the continued pandemic. This data speaks to the fact that our systems are making an impact on improving the number of screenings.

Opportunities for Improvement–Results/Outcomes

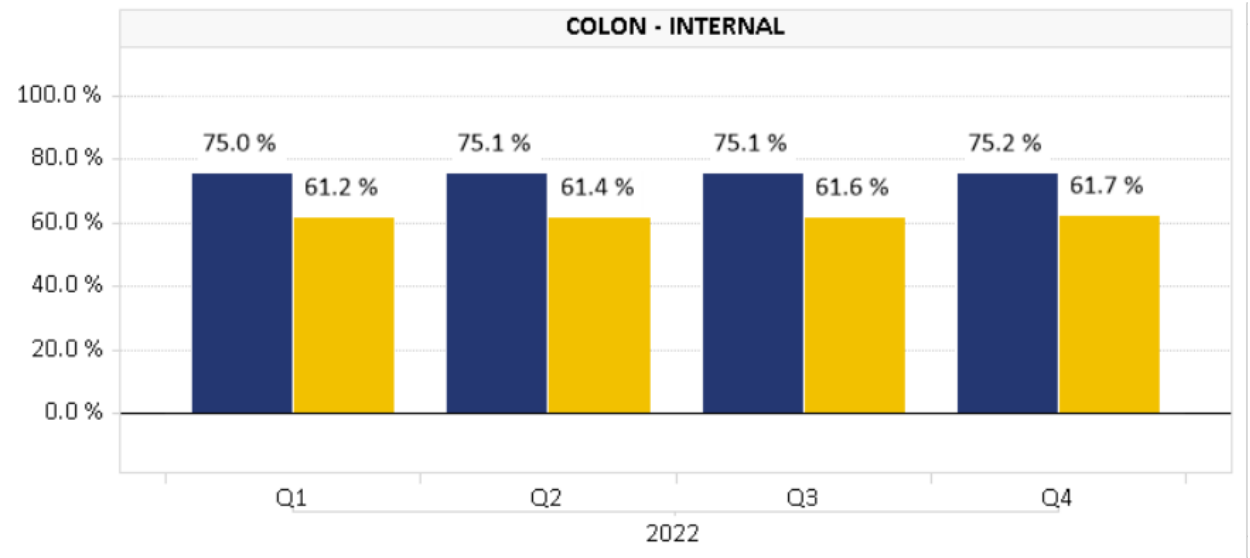
Colorectal Cancer Screening by Race



Interventions

- Shared decision making (FIT/colonoscopy)
- Addressing clinician unconscious bias (FIT/colonoscopy)
- Patient outreach
- Addressing health disparities MOC

Definition:
All patients: *Percent patients who have been screened for colorectal cancer by Colonoscopy in the last 10 years, Flexible Sigmoidoscopy in the last 5 years, and/or Fecal Occult Blood Test (FOBT) or Fecal Colorectal Screening (FIT) in the last 12 months.*
Patients of color: *Eligible patients of color, African Americans and Native Americans age 46-75, who have been screened for colorectal cancer by Colonoscopy in the last 10 years, Flex Sig in the last 5 years, or FOBT/FIT in the last 12 months.*



Example #3: Addressing Health Disparities Maintenance of Certification (MOC) Project

Accountable owner

Greg Fedio, Clinical Project manager

Member Populations Targeted

X	Commercial
X	Medicare Freedom (Cost)
X	Medicaid
X	MSHO
X	HPUPH
X	WI Marketplace

Description

Maintenance of Certification (MOC) projects have proven to be effective tools to help improve quality metrics while enabling clinicians to meet their ongoing specialty board requirements. In 2021, HealthPartners launched a new MOC project focused on closing health disparity gaps between patients of color and white patients.

Goals

- Define the role bias management, cultural humility, and social determinants of health play in reducing health disparities in personal practice.
- Analyze and identify health disparities that exist within personal practice.
- Adopt strategies, tools and resources to close health equity gaps in selected focus areas of practice.
- Report an increase in health equity by reducing health disparities in selected focus areas. (Asthma, Breast cancer screening, Colorectal cancer screening or Child Immunizations)

Initiatives/Interventions

- Participating clinicians were provided with educational videos to enhance their knowledge and enhance their ability to close health disparity gaps. Video subject matter included:
    - Information on Health disparities and health disparity work at HealthPartners
    - Social Determinants of HealthPartners
    - Three modules on Bias
    - Specific information related to their measure of choice (Asthma, Breast cancer screening, Colorectal cancer screening or Child Immunizations)
- Participants were provided with lists of eligible patients of color and monthly updates on their metric(s).
- Based upon the curricula and the patient lists, providers had the freedom to implement interventions of their choice to help close disparity gaps.

Barrier Analysis

There continues to be substantial barriers to the work to close health disparity gaps. Clinicians brought up well-known existing barriers such as time, resources, and insurance. Clinicians also were able to utilize their learnings from the project to identify other barriers such as systemic racism, language proficiency, their own biases, and social determinants of health.

Gaps in Care

Clinician feedback suggested that without improvements to social determinants of health, gap closure was difficult to obtain. Through this pilot other opportunities that have been identified are:

- The importance of learning the patient's story
- Involving the whole team (hall nurse, care coordinator, MTM) is vital to make progress
- Clinician confidence in overcoming barriers to close disparity gaps fluctuates and varies.

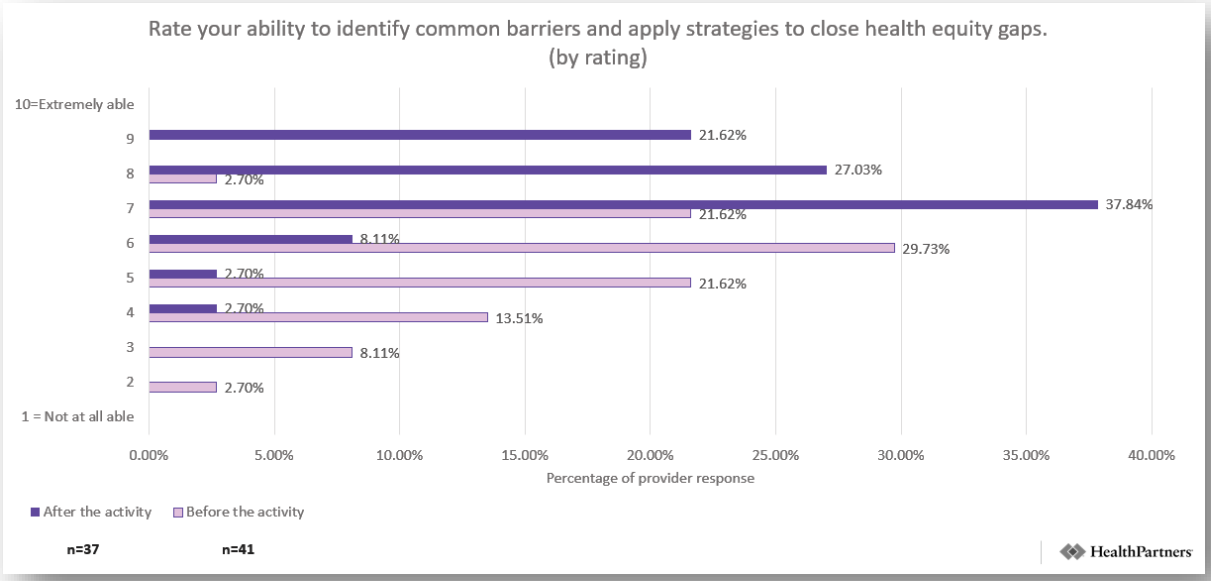
Opportunities for Improvement–Results/Outcomes

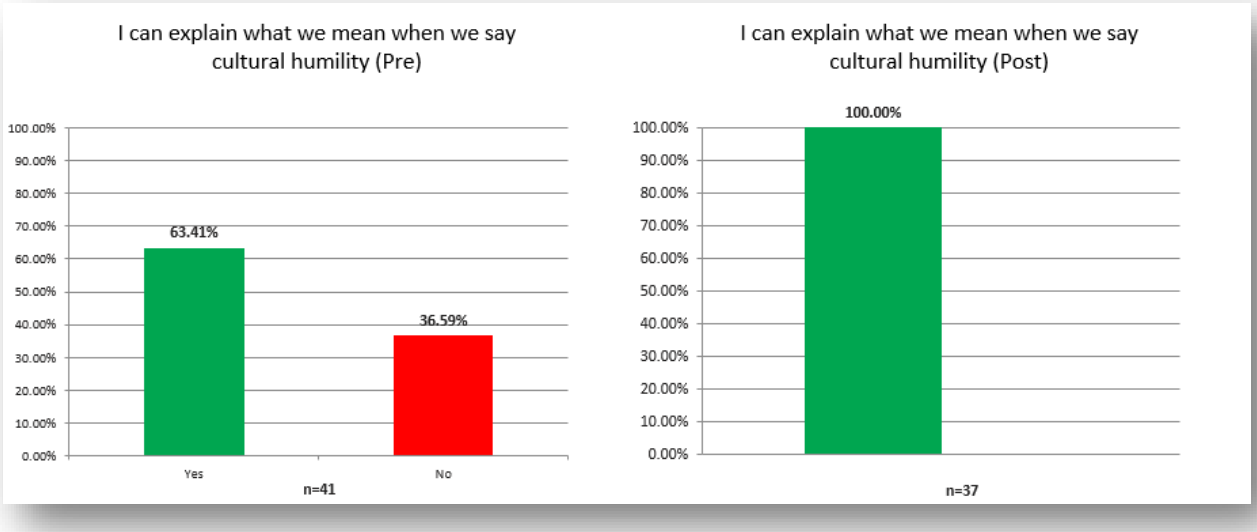
Overall, the MOC is a tangible way to connect the dots between equity work and quality. This is evidenced by:

- Disparity gap closure in breast cancer screening and colorectal cancer screening metrics
- Clinicians improved their ability to identify barriers and apply resources
- Clinicians improved their knowledge of equity and bias related topics
- Most clinicians reported making changes to their practice as a result of the project
- Most clinicians feel they can sustain progress

Cohort Summary - Race

	COLON - 2021 _1								
Report Date	# Eligible	% Met ALL	% Rate Change	# Eligible Pts Of Color	% Met - Pts Of Color	# Eligible - White	% Met - White	Race - Disparity Gap	
3/1/2021	11,156	75.55 %		1,514	60.11 %	9,493	78.19 %	-18.09 %	Before MOC
4/1/2021	11,428	75.71 %	0.21 %	1,551	60.67 %	9,716	78.33 %	-17.66 %	
5/1/2021	11,605	76.12 %	0.54 %	1,610	61.06 %	9,828	78.82 %	-17.76 %	
6/1/2021	11,740	76.12 %	0.00 %	1,635	61.83 %	9,936	78.69 %	-16.86 %	
7/1/2021	11,860	76.18 %	0.07 %	1,675	62.99 %	10,016	78.55 %	-15.57 %	
8/1/2021	11,823	76.11 %	-0.10 %	1,680	63.33 %	9,977	78.40 %	-15.07 %	
9/1/2021	11,905	76.16 %	0.07 %	1,702	62.87 %	10,039	78.55 %	-15.69 %	After MOC


Rate your ability to identify common barriers and apply strategies to close health equity gaps.
(by rating)
10=Extremely able
9
8
7
6
5
4
3
2
1 = Not at all able
21.62%
27.03%
2.70%
37.84%
21.62%
8.11%
29.73%
2.70%
21.62%
2.70%
13.51%
8.11%
2.70%
0.00%
5.00%
10.00%
15.00%
20.00%
25.00%
30.00%
35.00%
40.00%
Percentage of provider response
After the activity
Before the activity
n=37
n=41
HealthPartners


I can explain what we mean when we say cultural humility (Pre)
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
63.41%
36.59%
Yes
No
n=41
I can explain what we mean when we say cultural humility (Post)
100.00%
n=37

Example #4: Immunization Disparities Improvement

Accountable owner

Alison Salita, Quality and Measurement

Member Populations Targeted

X	Commercial
	Medicare Freedom (Cost)
X	Medicaid
	MSHO
	HPUPH
	WI Marketplace

Description

The primary functions of the Immunization Disparities Workgroup are to (1) increase and maintain vaccination completion rates of childhood immunizations and adolescent immunizations, and (2) reduce disparities in our vaccination completion rates, for Race and Payor, across all Families of Care including the HP Health Plan, which include HPMG, Hutchinson, Olivia, Park Nicollet and the Valley/Western Wisconsin.

Goals

Goals are still being determined for 2022. We believe there will be an overall goal for the total population and a gap closure goal in addition.

Interventions for reducing disparities with immunizations include:

- Coordination of existing work across the organization that is focused on improving vaccination rates.
    - Continued education on best practice check list for immunizations and well child visits
    - Clinician and staff education available around vaccine hesitancy,
    - Participation in the MDH Childhood Immunization Workgroup specifically focusing on health disparities in childhood immunizations
    - Participation in No Shots No School campaign, 25th year
    - Partnering with the Health Plan on immunization campaigns including Medicaid outreach for Overdue Well Child and immunizations
    - Translation of Immunization materials into top 4 languages
    - Partnership with OB on educating mom prenatally about the importance of immunizing infants

- Immunization and Well Child Outreach Registries
    - Continue to produce overdue immunization and well child lists for sites to review and do additional outreach

    - Clinical reminders team outreach for all ages for overdue well child visits started in September 2022 (email, text) translations and 3rd option for outreach happening in 2023
    - Clinical reminders for immunizations will happen in 2023
    - Participating in the MDH overdue immunization texting program

- Maintenance of Certification/CME opportunities:
    - Offered Addressing Health Disparities MoC – Childhood Immunization Track – did not see the results we had hoped for with regards to closing the disparity gaps in this cohort.
    - Offered MoC for improvement of overall rates for Combo 10 and Combo 2 vaccines, although there was a slight decline in overall rates during the project, the decreases happened at a much smaller rate than overall clinician population and we saw decreases in 3 out of 4 disparity gaps with the MoC cohort.

Barrier Analysis

Member and patient barriers may include:

- Cultural perceptions or misconceptions around vaccines. There can be cultural differences that make it more challenging to complete the course of certain vaccines, such as MMR and HPV.
- Anti-vaccine movements exist in pockets. In these cases, families are choosing not to vaccinate their children at all
- Confusion and myths related to COVID vaccine in children have increased vaccine hesitancy with all childhood immunizations.
- Anticipation of COVID vaccines for children has led to delaying other routine vaccinations.
- Access

Staff and provider barriers include:

- Standard rooming is not standard within families of care or across the organization. Consequently, standard rooming audits have revealed that HMAs are not always being reviewed and/or offered at the appropriate times.
- Variation can occur in the way providers or staff introduce vaccines to the patient and the family, allowing the family to think certain vaccines are considered “optional.” (For instance, some clinicians may simply be omitting the non-school required vaccines in the discussion.)

Opportunities for Improvement: Results/Outcomes

While we saw a decrease in rates for both childhood and adolescent immunizations in the first half of 2022 (national and statewide trend), as a result of these efforts we saw our rates start to rebound in August of 2022, and we have continued to increase and maintain those rates throughout the remainder of 2022. We believe this rebound in multifactorial. This is probably the result of children under 2 years catching up on well child visits and immunizations. We continue to have access issues due to staffing which could be contributing to slow rebound. Prevalent and early influenza season in 2022 could explain the higher rate of influenza vaccination in younger population.

We decreased both Race and Payor gaps over the course of 2022. We surpassed our goal for race in childhood imms and made progress in our payor gap to goal as well.

Community needs and community partnerships:

- Minnesota school project, review, learn, expand – work with school districts on vaccine clinics – like Moundsview did for COVID vaccine, expand to other vaccines as well
- "Catch Up" clinic opportunities – can we focus on areas where we see the most disparities in outcomes and create pop up clinics to provide vaccine services – resource dependent, may need to partner with the State of County to achieve
- Peds SW partnership – understanding from those doing the work where the biggest gaps with the community are
- Dental partnership around HPV to reduce oropharyngeal cancers
- IHI project with Somali community coming in 2023

Improving Immunization outreach

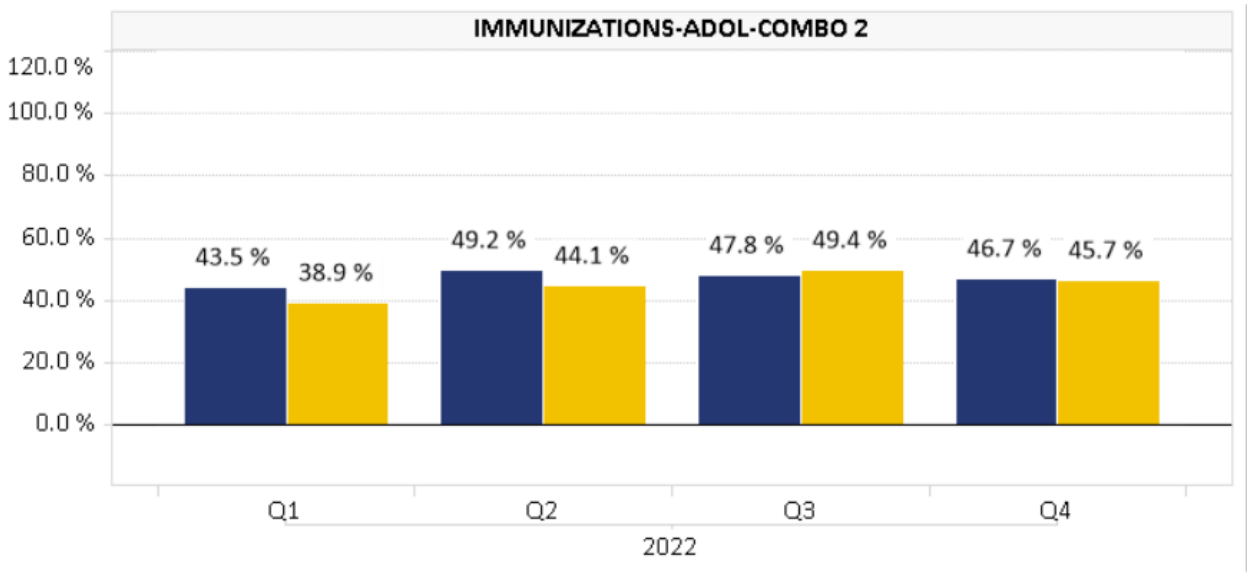
- Work with the digital products team to shift and expand outreach to clinical reminders team, Imms coming in 2023
- Encourage sites to utilize the Overdue Immunization site lists for phone outreach when other methods have not worked
- Continue MDH partnership for overdue immunization texting

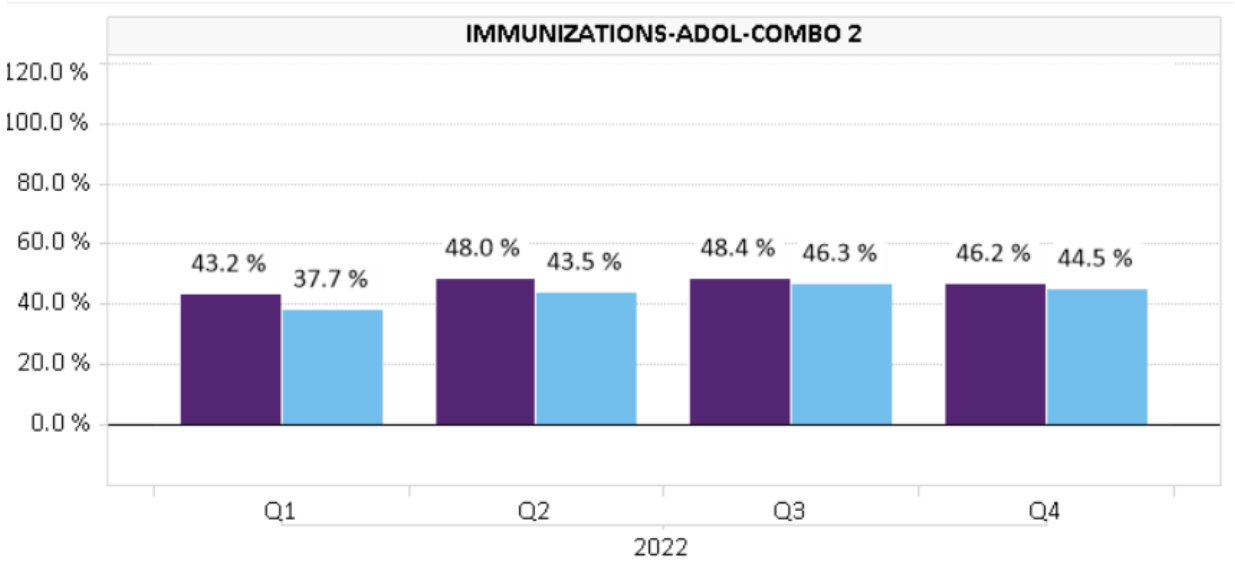
Projects focused on increasing overall rates and decreasing disparity gaps

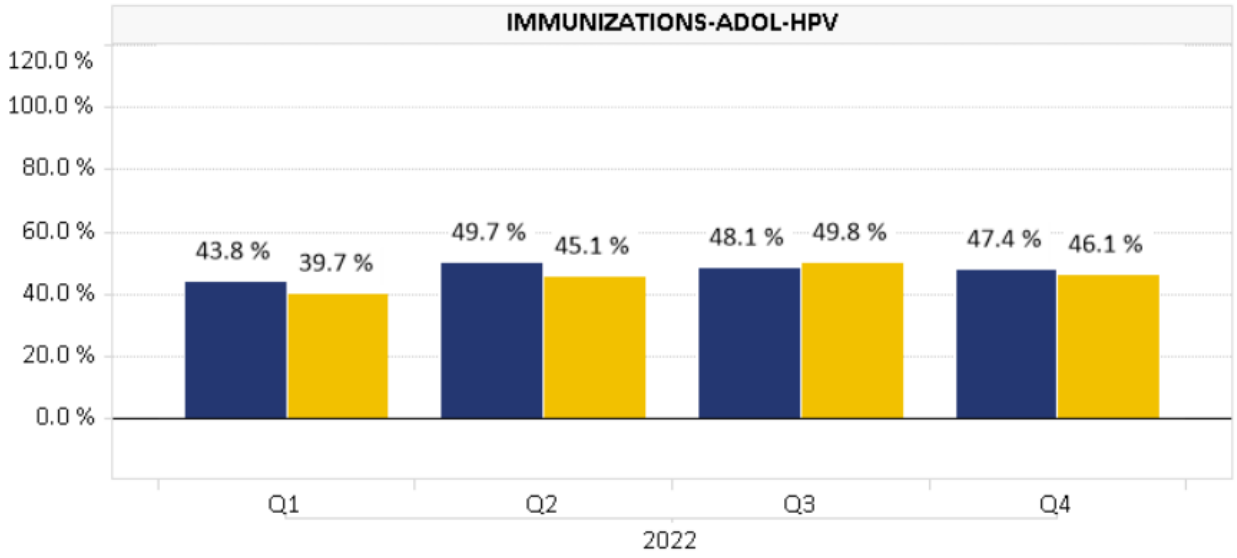
- Work to improve and expand "Addressing Health Disparities" MOC Project for childhood immunizations will be available in 2023
- Combo 2 and Combo 10 MoC projects will be available in 2023
- Vaccinate children at every opportunity (WCC, acute visits, UC)
- Continued work with Dental on HPV vaccination
- Leverage Best Practice check list to increase your measure
- Starting work on Rise to Immunize – adult vaccinations

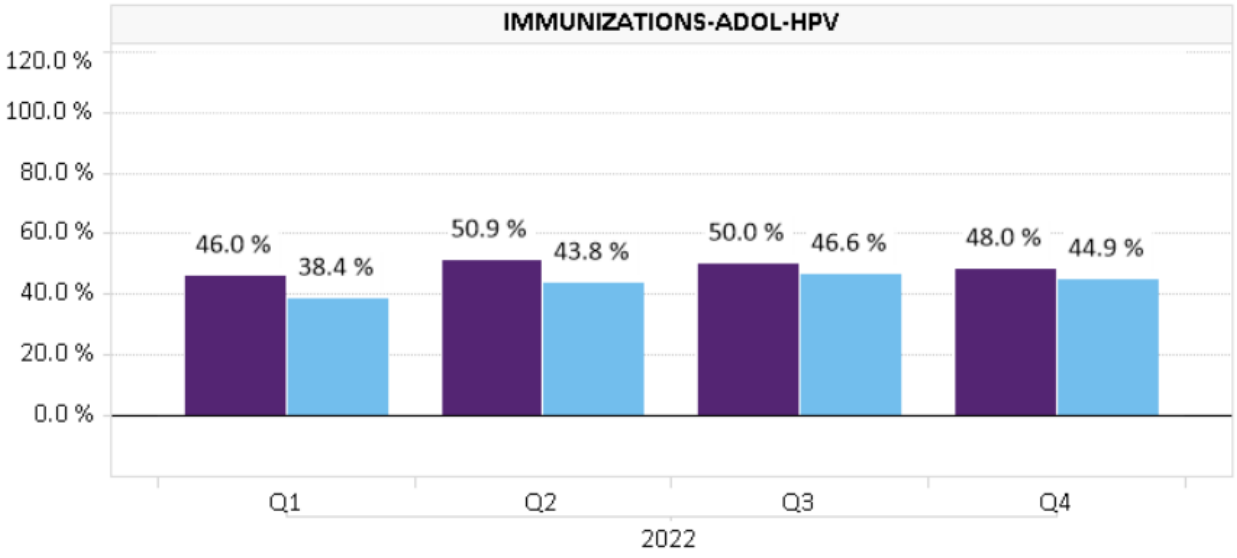
Improving data and Epic related processes

- Simplification of HMA with new ACIP recommendations
- Simplification of contraindications screening questionnaire in EPIC
- Leverage Quick Schedule for efficient and accurate follow-up for delayed or series based vaccinations
- New Immunizations Analysis will transition to PowerBI in 2023 – will enable us to slice and dice data in different ways, much more robust than the current HBI highlight






IMMUNIZATIONS-ADOL-HPV
120.0 %
100.0 %
80.0 %
60.0 %
40.0 %
20.0 %
0.0 %
43.8 %
39.7 %
49.7 %
45.1 %
48.1 %
49.8 %
47.4 %
46.1 %
Q1
Q2
Q3
Q4
2022


IMMUNIZATIONS-ADOL-HPV
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60.0 %
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20.0 %
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38.4 %
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50.0 %
46.6 %
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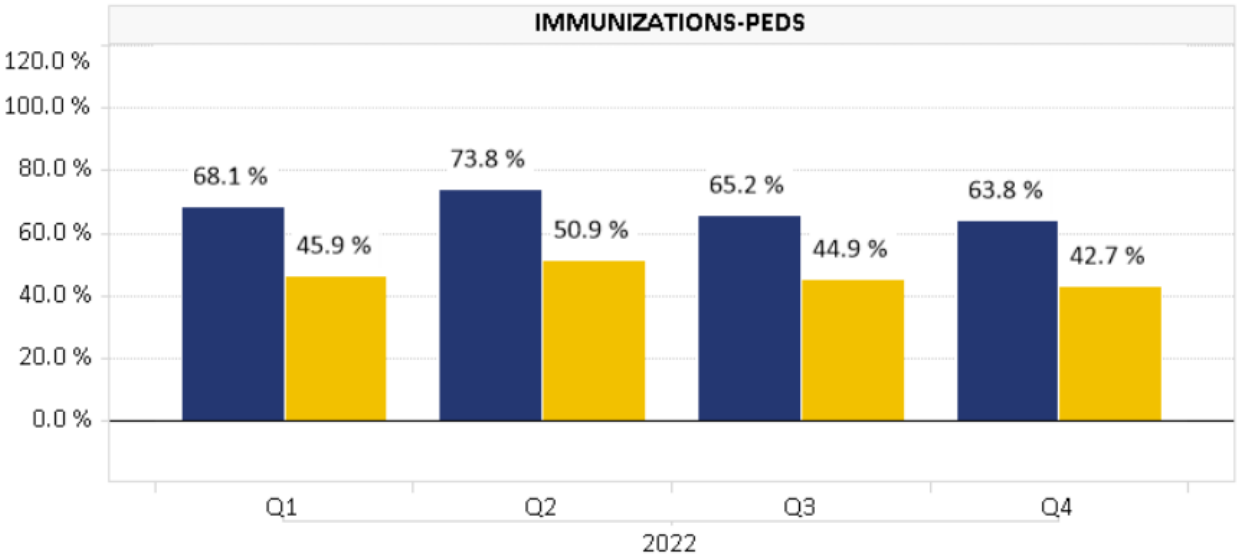
44.9 %
Q1
Q2
Q3
Q4
2022


IMMUNIZATIONS-PEDS
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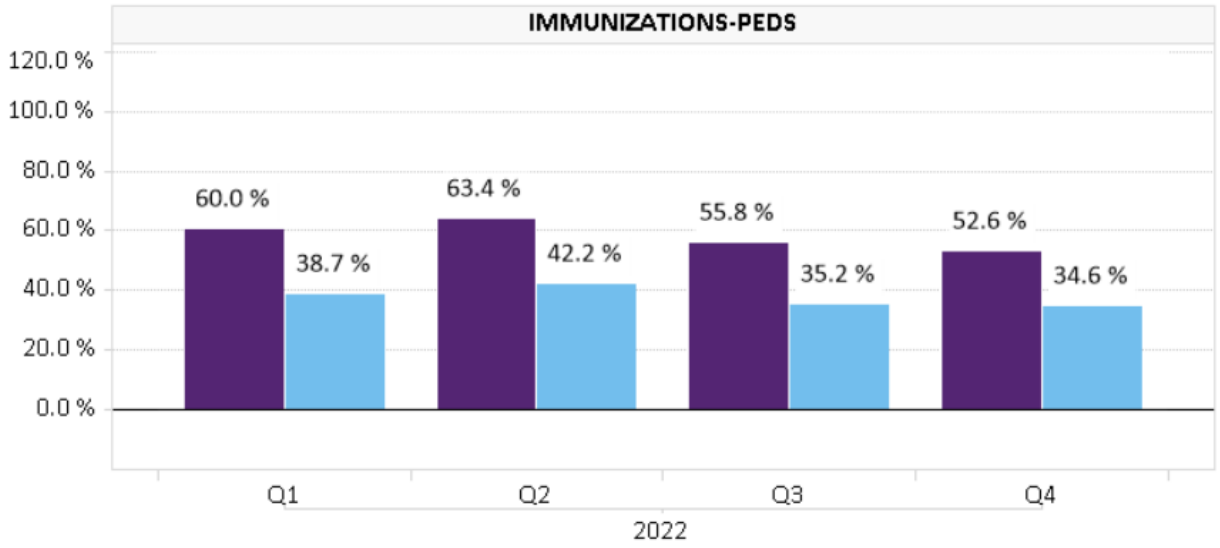
60.0 %
40.0 %
20.0 %
0.0 %
68.1 %
45.9 %
73.8 %
50.9 %
65.2 %
44.9 %
63.8 %
42.7 %
Q1
Q2
Q3
Q4
2022


IMMUNIZATIONS-PEDS
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40.0 %
20.0 %
0.0 %
60.0 %
38.7 %
63.4 %
42.2 %
55.8 %
35.2 %
52.6 %
34.6 %
Q1
Q2
Q3
Q4
2022

Appendix 5:
Access Assessment – Medical

2022 Access Assessment
Medical Care

Background

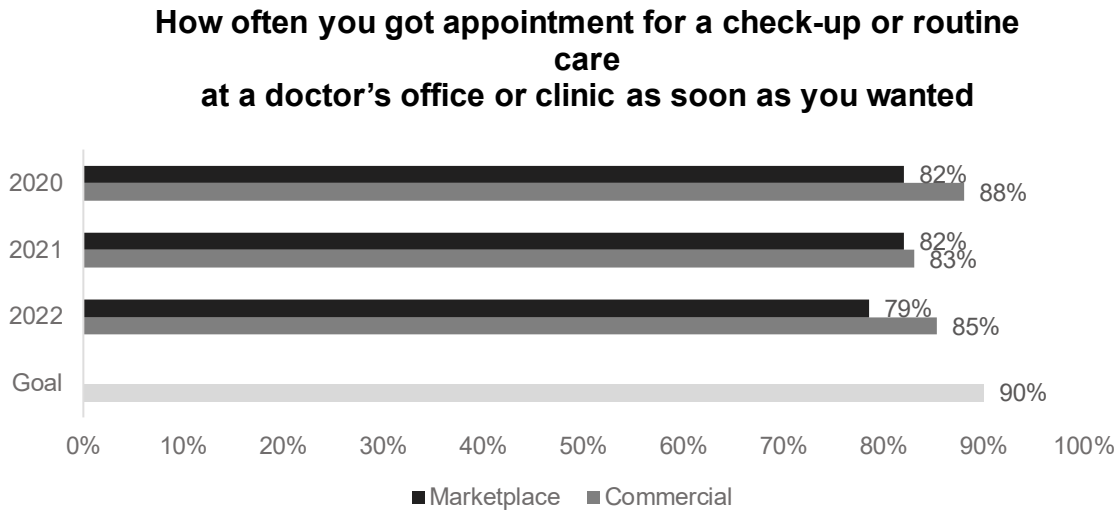
To ensure timely access to care, HealthPartners establishes standards, collects data and assesses performance against the standards, identifies improvement opportunities, implements improvement strategies and monitors performance annually. HealthPartners is committed to ensuring services are available in a timely manner.

This assessment includes both commercial and marketplace (Wisconsin).

Analysis of Performance against Standards

1. **Routine, Non-**Urgent**, Symptomatic Appointments**

Standard:	As soon as members want
Goal:	88% of members report they always or usually received access as soon as they wanted (90th percentile for commercial)
Dates of Service:	2019-2021
Measurement Dates:	2020-2022
Methodology:	CAHPS 5.1 Survey



Analysis: Striving to meet goal

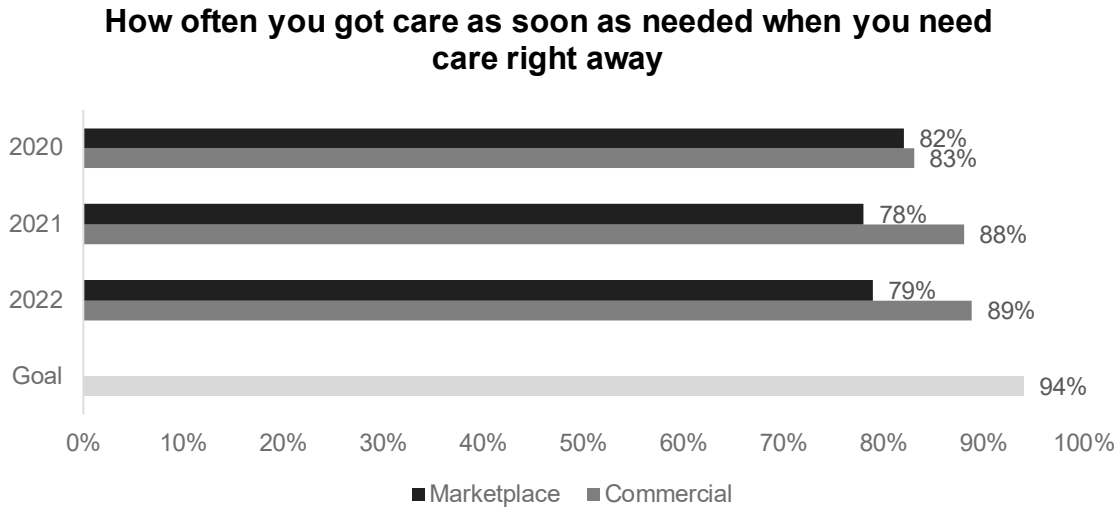
- The goal decreased two points from 90% to 88% for 2022 which is equivalent to 90th percentile performance nationally in the Commercial CAHPS survey.
- Although Commercial performance increased three percent it is still performing slightly below the goal.
- The Marketplace performance declined slightly from 82% to 79% also putting it below the goal.

Barriers:

- The COVID-19 pandemic continued to burden care systems network wide in 2022.
- Staffing challenges created substantial constraints around access to care for all systems and members of all products.
- In 2022 as COVID positivity rates declined patients began resuming preventive care schedules and catching up on care that had previously been delayed or deferred.
- An annual review of the Practitioner Availability Report indicates that our primary care network meets availability standards, assessed using distance to a provider, for commercial and Marketplace. As a result, we would conclude that practitioner availability is not a barrier to access to specialty care. However, it appears appointment availability is not meeting member expectations.
- The CAHPS question wording asks about access to appointments 'as soon as wanted/needed' The subjective nature of the wording leaves it open to individual interpretation which varies from person to person and makes it difficult to quantify from a system perspective.

2. Urgent Care Office Visits

Standard:	As soon as members want
Goal:	92% of members report they always or usually received access as soon as they wanted (90th percentile for commercial)
Dates of Service:	2019-2021
Measurement Dates:	2020-2022
Methodology:	CAHPS 5.1 Survey



Analysis: Striving to meet goal

- The goal for 2022 decreased two percent to 92% in 2022 which is equivalent to the 90th percentile nationally in the Commercial CAHPS survey.
- Neither Commercial nor Marketplace met the goal.
- Though still below goal, Commercial performance continues to trend in the right direction, increasing one percent from 88% in 2021 to 89% in 2022.

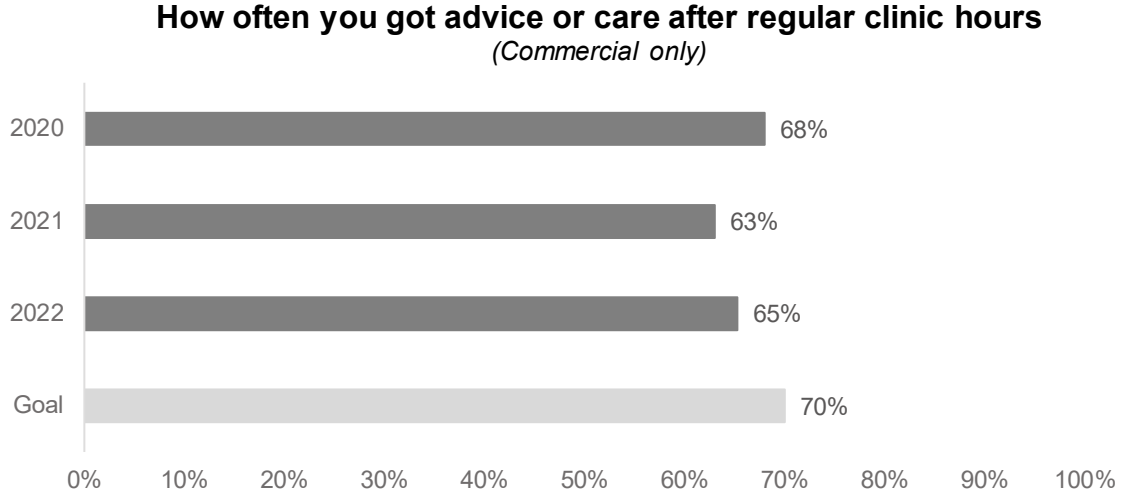
- After a decline in 2021 Marketplace performance saw a slight increase improving one percent and going from 78% in 2021 to 79% in 2022. The gap between Marketplace and Commercial remains at 10% as it was in 2021.

Barriers:

- The burden placed on care systems by the COVID-19 pandemic applies to urgent care as much as it does routine care when it comes to capacity and staffing.
- While video visits are an option in some urgent care settings, they are not as prevalent as video visit options for routine care.
- Even when members have options for getting care right away, some members may not be inclined to use a new service or even seek care at a different clinic. Members who do not like or do not feel that video visits adequately address their needs for care may choose to wait a few extra days or a week for an in-person visit.
- Staffing challenges lead to changing hours and in some cases availability of urgent care locations which often result in significant wait times for patients.

3. After-Hours Care

Standard:	As soon as members want
Goal:	70% of members report they always or usually were able to get advice or care after regular clinic hours as soon as you needed
Dates of Service:	2019-2021
Measurement Dates:	2020-2022
Methodology:	CAHPS 5.1 Survey (custom question)



Analysis: Striving to meet goal

- At 65% Commercial still falls below the goal of 70% but has increased two percent over the 2021 score. This measure is from a custom question in the Commercial CAHPS survey and parallels the

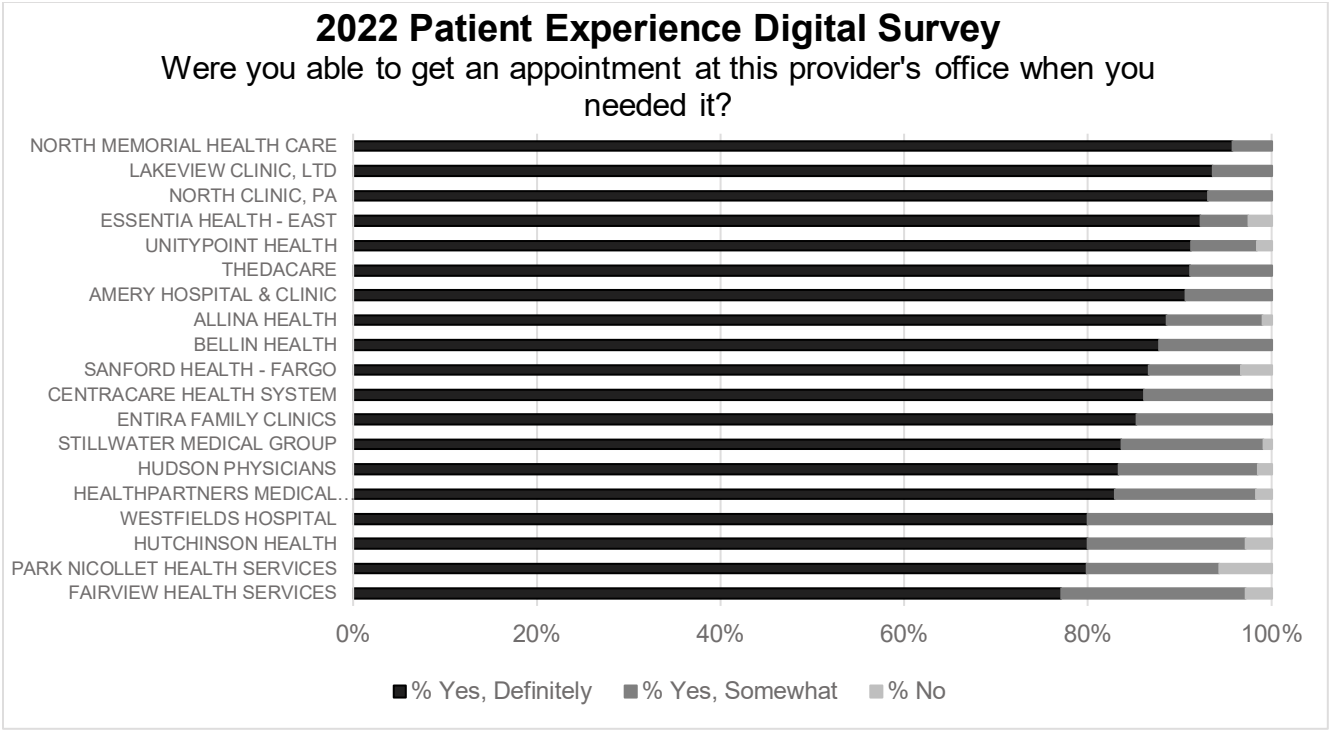
CAHPS questions that assess access to routine care and urgent care. This question is not included in the Marketplace or QHP CAHPS survey.

Barriers:

- There is no national benchmark, such as from CAHPS, to help establish the goal for access to after-hours care.
- The HealthPartners CareLine operates 24/7 and is available to all members. CareLine nurses help callers choose the most appropriate care option, whether it's an Urgent Care clinic, Emergency Room or a scheduled appointment with a doctor. The registered nurses also consult on-call physicians. To ensure that they obtained care and to offer them further assistance, follow-up calls are made to patients who have been directed to an Urgent Care or Emergency Room.
- In addition to the CareLine, members also have plan-wide access to Urgent Care clinics.
- Member awareness of the CareLine, as well as preferences or habits about where to seek advice after clinic hours is a potential barrier.
- Members using contracted clinics may be more likely to call their medical group's after-hours service. Those services may be more difficult to reach or more likely to use answering services than the CareLine, which could influence member satisfaction with availability.

4. Access to Primary Care

Standard:	Access when needed
Goal:	N/A
Dates of Service:	2020, 2021, 2022
Measurement Dates:	2020, 2021, 2022
Methodology:	HealthPartners Patient Experience Digital Survey



Analysis:

- As a supplement to our CAHPS surveys, we continue to monitor access to care for our network through the HealthPartners Patient Experience Digital Survey which gathers member feedback related to the following question: “Were you able to get an appointment at this provider’s office when you needed it?” In addition to being a closer look at access for key in-network care systems, this question also informs our annual cost and quality assessment that awards a star rating based on provider performance. Many of our provider contracts have incentive programs to maintain a high star rating. We also track whether providers are accepting new patients. Both the star rating and “accepting new patients” status is available to members when they search our Find Care network directory online.
- A review of the results of the Patient Experience Digital survey shows that top box scores range from 77%-96% in 2022 which is down from 2021 where scores on the access measure ranged from 88%-100%.
- Of the 19 care systems reported in 2022, 9 have bottom box scores of 0%. For the other ten, bottom box scores range from 1-6% of respondents indicate they were not able to get an appointment.
- No negative trends were identified at the group level with any individual group, so no further follow-up is needed at the practice level.
- The Patient Experience Digital Survey continues to show a more positive view of access to care than the CAHPS survey results. This is likely due in part to the timing of the survey (closer to the appointment than CAHPS) and also the link to a specific appointment rather than access to care more generally as asked in the CAHPS survey.

Plan for Improvement

In addition to continuing to monitor, analyze and interpret member satisfaction and complaints to understand trends and member expectations and to evaluate the impact of improvement activities, the following have also been identified as plans for improvement.

Support For Virtual Care Channels

- Continue to offer and promote virtual options beyond the pandemic to maximize access to care and minimize barriers to care. Support members who've developed a preference for virtual care channels.
- Clarify language about virtual care in member materials and on the website to reflect the prominence of these care modalities.

Personalization Campaigns

- Use segmentation and personalization to simplify care and coverage and encourage members to stay up to date on their care. This includes the My Pregnancy digital experience for members who are pregnant, campaigns to encourage members to get routine preventive care as well as campaigns that proactively identify members at increased risk of chronic conditions to help them make decisions about where to go when care needs occur. And to educate members who've used the ER when they could have gone to Urgent Care about the care needs that can be treated at urgent care, so they select the most appropriate site of care in the future.
- Through marketing and member communications, build member awareness of CareLine nurse triage program as a 24/7 service.

Online Accounts & Tools

- Development of next available appointment scheduling capabilities beginning with colon cancer screenings and primary care appointments
- Ongoing optimization to the online scheduling experience including rolling out additional specialties.
- Continued roll out of quick scheduling and quick referral scheduling options.

Actions Taken

1. In an effort to create flexibility for members and patients and to alleviate call volume from clinics and the appointment center, the HealthPartners Web & Mobile team improved ease of use within the Find Care and scheduling functions and expanded the access to online scheduling through HealthPartners.com.
    a. Increased member communication and education related to finding in-network care.
    b. Filters have been added to the Find Care tool on HealthPartners.com for race/ethnicity for doctors, information on language services and added in-network/cost level status plus link to benefits in results list.
    c. Continue enhancements to the Find Care experience as well as efforts around online account creation and increase member awareness and use of myHealthPartners, our mobile app, and HealthPartners.com to search for care locations, schedule appointments and check urgent care wait times.
    d. Ensure information about appointment availability on the web site is accurate and consistent.
2. The Patient Access team regularly reviews scheduling templates to maximize appointment availability and adjust hours within the HealthPartners family of care. Key actions taken as a result of these reviews in 2022 that will carry over into 2023 include:

a. Urgent access strategies which are used to assess care demand within a week and build capacity for ease of scheduling.
b. Dedicated specialty scheduling and a single scheduling phone number
c. E-consults, an internal pathway that allows patients to receive timely specialist recommendations for lower complexity care needs.
d. Emergency Department/Hospital Discharge scheduling to assist patients at the point of discharge with scheduling for follow-up care needs.
e. Triage consult and follow-up care for non-urgent care needs.

Appendix 6:
Access Assessment - Telephone

2022 Member Services Telephone Access Assessment

Accountable Owner

Member Services – Michelle Anderson
Riverview Member Services – Kate Sahnow

Member Populations Targeted

X	Commercial
	Medicare Advantage/Cost/PDP
	Medicaid
	MSHO
X	HPUPH
X	WI Marketplace

Background

To ensure timely member access to care and service, HealthPartners establishes standards, collects data and assesses performance against the standards, identifies improvement opportunities, implements improvement strategies and monitors performance annually. HealthPartners is committed to ensuring services are available in a timely manner. This report is focused on our commercial, HPUPH and marketplace business.

Analysis of Performance Against Standards

Table 1

Telephone Service

Goal:	Average speed of answer 30 seconds or less Abandonment rate 3.0% or less for calls
Dates of Service:	2020, 2021, 2022
Measurement Dates:	2020, 2021, 2022
Methodology:	Avaya's CentreVu Call Management System

Table 2

Data

Commercial including Marketplace	Year	Call volume*	Average speed of answer for member calls	Member abandonment rate
	2020	923,867	86 seconds	4%
	2021	832,172	115 seconds	5%
	2022	842,373	132 seconds	6%

**Call volumes include both member and provider calls received; starting in 2022, this also includes calls to our Behavioral Health Navigators.*

Analysis:

- Results include all our commercial business including Marketplace.

- Call volumes increased in 2022 across all lines of business.
- The average speed of answer and abandonment rates continued to increase.
- The goals for speed of answer and abandonment rate for member calls were not met for commercial and marketplace.

Barriers:

1. The COVID-19 pandemic continued to have several impacts on our service level.

2. The time to handle a call increased due to both complexity and staff tenure impacts, with average hold timeincreasing by 20 seconds from 2021 to 2022.

3. Members were impacted by limited access to providers for their care, as well as having difficulty being able to reach their providers to address other concerns. This resulted in more complexity in the calls Member Services received, as we sought to remove members from the middle. However, providers offices with reduced staff made for very long hold times pulling team members off incoming calls to resolve member concerns.

4. While ongoing efforts are being made to reduce the amount of provider calls coming into our contact centers, these calls continue to be a high percentage of all calls received in member services. Provider calls still accounted for 25% of total calls received in 2022.

5. COVID-19 brought calls related to testing, the vaccine, submitting out of network claims as well as over-the-counter test reimbursements.

6. Throughout the year various organizational challenges caused unexpected increases in member calls, including but not limited to, claim adjustment projects, mismailed documents, system down time, and premium related complaints with the transition to a new bank which impacted many departments in addition to Riverview Member Services.

7. There were more unplanned absences among representatives than anticipated.

8. Chat interactions continue to be popular with members, and is the most resource intensive communication channel. To provide needed support to our phone lines, the option to chat was strategically shut down at times, however, the automated chatbot “Harper” (launched 7/19/22) was still available to address basic member chat inquiries.

9. Overall Commercial Member Services email volumes increased by 18% and Riverview Member Services email volumes increased by 34% from 2021 to 2022, creating the need to pull additional staff from answering calls, to shift to responding to emails.

10. We continue to experience high turnover and we are challenged by the employment market and the difficulty in finding people to hire andretain.

11. There is a significant lead time and learning curve to get new employees up to speed, having a direct impact on our average handle time. At the end of 2022, Commercial Member Services had over 34% and Riverview Member Services had 57% of their representatives with less than one year of tenure.

Initiatives/Interventions:

1. New retention strategies implemented in 2022 for Riverview Member Services, related to the mentor program to provide additional support to the new employees. Commercial Member Services is currently piloting similar strategy changes in 2023.
2. While Riverview Member Services converted to 100% remote team members since 2020, Commercial Member Services now offers fully-remote work from day 1 for new hires as of July 2022.
3. Offered overtime to contact center representatives to provide additional phone staffing.
4. Strategically closed chat at times in effort to improve phone service levels.
5. Ongoing cross-functional workgroup to improve digital adoption and reduce inbound phone calls from providers.
6. Continued utilization of a work queue for outbound calls to providers, allowing off-phone team members to multitask while waiting on hold.
7. Compensation adjustment introduced in May 2022 as retention strategy, as well as recognition of the importance and complexity of the work .
8. Ongoing analysis of phone statistical data, leveraging phone technology and making adjustments as needed to impact service levels.
9. Continue working to enhance the web to promote member self-service. We recognize the resulting impact could be that the interactions the contact centers receive will be more complex in nature (since members would be able to self-serve on the “simple things”), resulting in an increased average handle time for calls.

Appendix 7:
Assessment of Behavioral Health Access

Assessment of Behavioral Health Access

Report Date: *November 2022*
Analysis Date: *2021*
Accountable Owner: *Mary Holland, Behavioral HealthPartners*
Member Populations Targeted: *Commercial & WI Marketplace*

Data Collection

HealthPartners measures the adequacy of access to behavioral health care through a member satisfaction survey as well as through an analysis of complaints regarding behavioral health services. These approaches explore access to the following care:

1. Care for a non-life-threatening emergency within 6 hours.
2. Urgent care within 48 hours.
3. Initial visits for routine care within 10 business days.
4. Follow-up routine care.

Behavioral Health Access Survey

The HealthPartners Behavioral Health Access survey is conducted annually and alternates between surveying adult members and surveying child/ adolescent members each year.

For each survey, a random stratified sample is drawn from the pool of members who had two consecutive outpatient behavioral health appointments at the same clinic system in the 12-month measurement period. The sample size is selected with a goal to achieve a 95% confidence interval with plus or minus 5 percentage points of error.

In 2021, the survey focused on behavioral health care for adults and surveys were sent to eligible adult members. 2021 was the third year (2019 and 2017) survey data has been gathered on the satisfaction of access to behavioral health care for adults. Results were by type of care – emergency, urgent, and routine, -as well as by type of provider - prescriber vs. non-prescriber.

Complaints regarding Behavioral Healthcare

HealthPartners also conducts an analysis of complaints received from members, including complaints that are specific to behavioral health. Complaints are gathered and reviewed annually to identify issues or improvement opportunities regarding behavioral health.

Quantitative Analysis

Behavioral Health Access Survey

Quantitative analysis of member satisfaction rates (percentage of members who responded “satisfied” or “very satisfied”) by type of care – emergency, urgent, and routine – gathered through the 2021 Behavioral Health Access survey revealed the following outcomes and conclusions:

Table 1:

Care within 6 hours in a non-life-threatening emergency

Provider	Goal	2021	2019	2017
Prescribers	**85%**	62.5	70.6	55.6

Non-Prescribers	**85%**	46.9	55.6	55.3

Conclusion: ***Goal Not Met for both Prescribers and Non-Prescribers*** - In 2021, 62.5% of survey respondents were satisfied with the ability to get care from prescribers and 46.9% of respondents were satisfied with the ability to get care from non-prescribers within 6 hours in a non-life-threatening emergency. These rates were both lower than they were in 2019 and both fell below the goal of 85%.

Table 2:

Care within 48 hours when there was an urgent need

Provider	Goal	2021	2019	2017
Prescribers	**85%**	60.7	75.0	56.9
Non-Prescribers	**85%**	54.9	65.8	62.4

Conclusion: ***Goal Not Met for both Prescribers and Non-Prescribers*** - In 2021, 60.7% of survey respondents were satisfied with the ability to get care from prescribers and 54.9% of respondents were satisfied with the ability to get care from non-prescribers within 48 hours when there was an urgent need. These rates were both lower than they were in 2019 and both fell below the goal of 85%.

Table 3:

Appointments within 10 days

Provider	Goal	2021	2019	2017
Prescribers	**85%**	76.9	86.2	81.3
Non-Prescribers	**85%**	78.9	83.5	82.7

Conclusion: ***Goal Not Met for both Prescribers and Non-Prescribers*** - In 2021, 76.9% of survey respondents were satisfied with the availability of convenient appointments with prescribers and nearly 78.9% of respondents were satisfied with the availability of convenient appointments for non-prescribers. These rates were both lower than they were in 2019 and both fell below the goal of 85%.

Table 4:

Length of time between scheduling and the day of an initial appointment

Provider	Goal	2021	2019	2017
Prescribers	**85%**	66.7	79.0	77.9
Non-Prescribers	**85%**	65.4	78.8	80.1

Conclusion: ***Goal Not Met for both Prescribers and Non-Prescribers*** - In 2021, 66.7% of survey respondents were satisfied with the length of wait time between scheduling the initial appointment and the day of the visit for care with prescribers and 65.4% of respondents were satisfied with this wait time

for non-prescribers. These rates were both lower than they were in 2019 and both fell below the goal of 85%.

Table 5:

Length of time between scheduling and the day of follow-up appointments

Provider	Goal	2021	2019	2017
Prescribers	**85%**	72.9	90.5	93.8
Non-Prescribers	**85%**	76.5	90.5	88.0

Conclusions: ***Goal Not Met for both Prescribers and Non-Prescribers*** - In 2021, 72.9% of survey respondents were satisfied with the length of wait time between scheduling ongoing appointments and the day of the visit for care for prescribers and 76.5% of respondents were satisfied with this wait time for non-prescribers. These rates were both lower than they were in 2019 and both fell below the goal of 85%.

Additional quantitative analysis of member satisfaction by type of provider also revealed the following:

- *Prescribers*
  - Appointments within 10 days was the type of care/survey area of highest satisfaction in 2021.
  - Urgent care was the type of care/survey area of lowest member satisfaction in 2021.
  - Whereas members' satisfaction for nearly all types of care/survey areas for prescribers increased from 2017 to 2019, all areas decreased in satisfaction from 2019 to 2021.

- *Non-Prescribers*
  - Appointments within 10 days was the type of care/survey area of highest satisfaction in 2021.
  - Non-life-threatening emergency care was the type of care/survey area of lowest member satisfaction for non-prescribers in 2021.
  - Whereas members' satisfaction for nearly all types of care/survey areas for prescribers increased from 2017 to 2019, all areas decreased in satisfaction from 2019 to 2021.

Complaints regarding Behavioral Healthcare

In 2021, HealthPartners received 550 complaints from members regarding behavioral health care and benefits. Majority of these complaints were not regarding access to behavioral health care but rather were regarding benefits, coverage, and billing of behavioral health care. Of the total volume of complaints, 60 were regarding access to behavioral health care, such as the availability of providers or wait time to get into a behavioral health appointment.

To understand the access issues being reported through complaints, an analysis of those 60 complaints was completed at the practitioner level to determine the volume of complaints by clinic systems. 23 of the 60 complaints revealed dissatisfaction toward a particular clinic system whereas the remaining complaints were not directed at a particular clinic system but revealed general dissatisfaction and difficulty identifying and accessing behavioral health care. The breakdown of the 23 complaints that did identify a clinic system revealed the following volumes:

Table 6:

Behavioral Health Access Complaints per Clinic System

Clinic Systems	# of Access Complaints
Allina	1
Fairview	0
HealthPartners	9
Nystrom & Associates	2
Park Nicollet	2
Other Direct Access Network in Twin Cities metro area	9
Other Direct Access Network in MN, excluding the groups above	0

Conclusions:

- Majority of the complaints received regarding access to behavioral health care pertained to the HealthPartners clinic system, with only a few complaints directed at other major clinic systems such as Allina, Nystrom & Associates, and Park Nicollet.
- Other complaints directed at smaller metro clinics were found to be limited to 1 per clinic. These clinics were categorized as "Other Direct Access Network in Twin Cities metro area."
- No complaints were found to be directed at Minnesota clinic systems outside of the metro.
    - The complaints directed at HealthPartners centered around:
    - Wait times to see a provider
    - Protocols around inability to schedule an appointment due to missing previous appointments

Qualitative Analysis

Behavioral Health Access survey results and complaint trends were reviewed by the following HealthPartners' committees to analyze issues, barriers, and potential opportunities for improvement:

- HealthPartners' Member Focused Behavioral Health Group which includes representatives of major behavioral health care delivery systems in Minnesota, including Park Nicollet, Associated Clinics of Psychology, and Minnesota Mental Health Clinics who are licensed mental health professionals.

- HealthPartners Behavioral Health Quality, Utilization, and Improvement Strategic Oversight Committee, a team composed of leaders throughout HealthPartners including Behavioral Health Case Management; Utilization Management; Provider Relations and Network Management; Care Delivery and Medical Directors.

Issues/Barriers

Emergency and Urgent Care

- Patients' definition and perception of an emergent or urgent behavioral health need may not only differ from what providers would determine to be emergent or urgent but may also have changed or increased in recent years with stressors related to COVID, racial injustice, and politics.

- While clinics may have staffing to field calls in real time, they may not have a practitioner available to field patient calls that are more urgent in nature, leaving members feeling as though care is not readily available to them through their preferred/established clinic for more immediate needs.

- Clinics work to get members into appointments as soon as possible and some have a small number of reserved appointments for patients with emergency needs, but many clinics are not set-up for members to attend appointments on a walk-in/as needed or emergency basis. Therefore, patients with urgent/emergent needs are deferred to the hospital where capacity may also be limited.

Routine Care

- Providers' – both prescribers and non-prescribers – availability for initial and follow-up appointments has decreased as more people are seeking and utilizing behavioral health care and as patients are utilizing care more frequently due to increased needs and acuity.

- Provider availability has also been impacted by workforce volumes. With increased utilization, providers are experiencing fatigue or burnout, leading to reductions/changes in practitioners' hours or changes in jobs. Additionally, the number of new practitioners may be changing/reduced as qualified professionals are recruited into other roles where pay, work hours, and training requirements are more accommodating.

Opportunities

- Review and revise payment models to better align with treatment approaches to adequately address complex conditions such as trauma, psychosis, and autism spectrum disorders that require more extensive and intensive training, experience, and provision of care by providers and that may lead to a need for more immediate care when symptoms arise.

- Embed social work or care coordination support within clinics or streamline referral processes to care coordination services that will allow providers to focus on treatment while also ensuring corresponding needs of patients can also be appropriately addressed.

- Explore and train scheduling staff on how to best access appointment availability through websites and search engines, as it is available.

- Gain further insight into survey respondent from new, various perspectives, such as patient vs. members or by care group as survey responses and comments imply that respondents may be confused about the orientation of the survey (plan vs. provider) and responses are currently unable to determine satisfaction and dissatisfaction rates by clinic system.

- Integrate behavioral health care with primary care to address health in a holistic manner and keep care as available as possible to patients.

Appendix 8:
Assessment of New Member Understanding

New Member Understanding Assessment

Production Date: March 28, 2023

Background

HealthPartners is committed to ensuring members have a positive experience. To complement the CAHPS survey, we conduct a Member Experience Survey to obtain more detailed feedback about members' experience with:

- Understanding of coverage and benefit information
- Using Member Services
- Getting prescription drugs
- Understanding claims information and statements

The above measures are central to all members' experience with the plan. These measures may be even more important to new members.

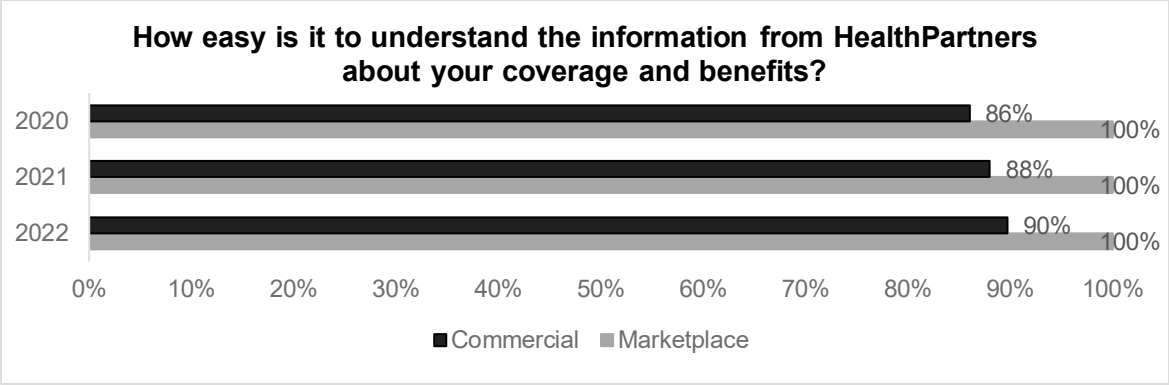
To conduct this survey, a random sample is generated of adult commercial members who have recently called Member Services, filled a prescription, or received an explanation of benefits (EOB). Members who have been enrolled in the plan for a minimum of six months without these experiences are also included. The sample frame includes NCQA-accredited products and contains roughly 160,000 members. A nine-minute phone survey is fielded and a minimum of 950 members, including 300 new members, are surveyed twice a year except for 2020 where members were only surveyed once due to the impact of the COVID-19 pandemic. New members are segmented to follow their experience and for comparison to returning members' experience. This analysis is supplemented with a review of a smaller set of responses from Marketplace members (minimum of 30 responses annually).

Our measurement of new member understanding of the plan encompasses four main dimensions: 1) understanding information about coverage and benefits 2) understanding the amount needed to pay out-of-pocket before getting care 3) understanding coverage for preventive care and 4) understanding information about pharmacy benefits. HealthPartners monitors performance against standards, identifies improvement opportunities, implements improvement strategies, and monitors performance quarterly. HealthPartners is committed to ensuring its new members understand their coverage and know how to use the fundamental services of their plan. An annual analysis of the results follows.

Analysis of Performance

I. Understanding information about coverage and benefits

Standard	Plan information for new members is easy to understand.
Goal	85% of new members agree that plan information is very easy + somewhat easy to understand.
Dates of Service	2020 – 2022
Dates of Measurement	2020 – 2022
Methodology	HealthPartners Member Experience Survey



*Note, low sample size for Marketplace

Analysis: Exceeded Goal

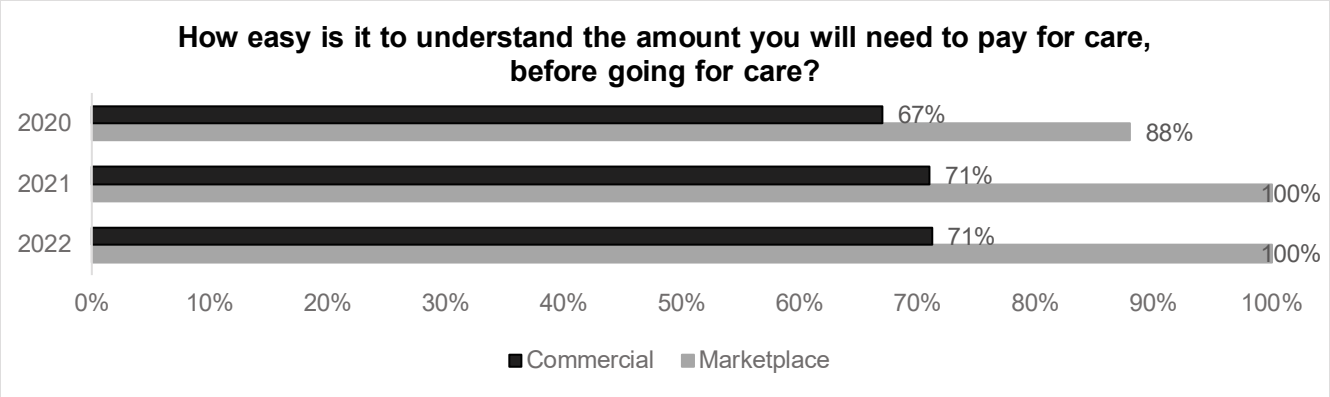
- Ninety percent of commercial members find it easy to understand their coverage and benefit information. Scores for the last three years show slow but steady positive progress.
- All marketplace members surveyed find it easy to understand coverage and benefit information.
- HealthPartners continues to promote the advantages of registering for an online account to new members. In 2022 the percentage of Commercial group members who said they have an online account in our Member Experience Survey increased significantly and is now more than seven in ten respondents. 52% of new members have an online account.

Barriers:

- As employers seek solutions to help address the high cost of health care, many look to high-deductible plans and or health plans paired with a health savings or health reimbursement account as a means of managing costs. While these plans can yield savings, they often require an increased level of engagement from consumers because of the increased complexity associated with them.
- Plans with high deductibles and those with accounts (FSA, HRA, HSA), require consumers to understand what a deductible, out-of-pocket maximum, annual maximum, and co-insurance are, as well as how they work together.
- HealthPartners isn't always able to provide new members with consumer-friendly communication materials since some employers and/or brokers provide plan materials to the employees directly.

II. Understanding the amount needed to pay out-of-pocket for care, before getting care

Standard	Out-of-pocket costs for care are easy for new members to understand, before getting care.
Goal	85% of new members agree that is very easy + somewhat easy to understand the amount needed to pay out-of-pocket for care, before getting care
Dates of Service	2020 - 2022
Dates of Measurement	2020 - 2022
Methodology	HealthPartners Member Experience Survey



*Note, low sample size for Marketplace

Analysis: Striving to Meet Goal

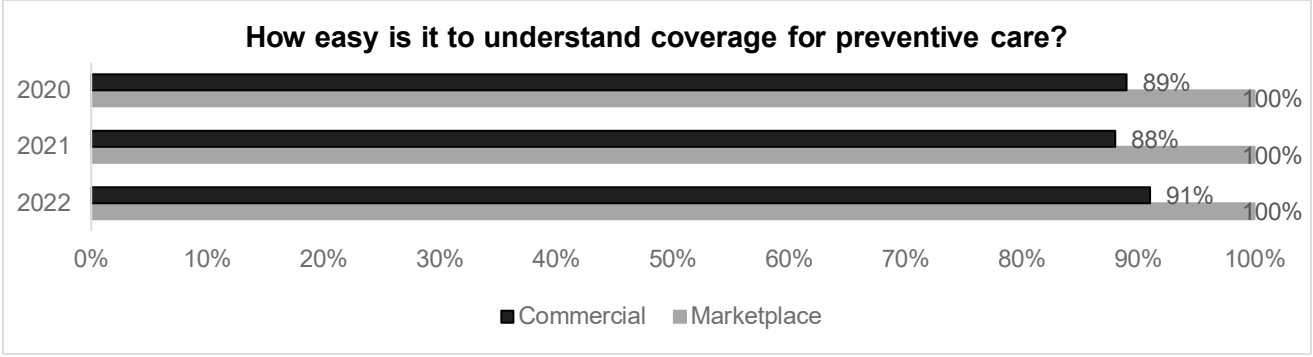
- After increasing in 2021, scores for Commercial members remained steady in 2022.
- Results for Marketplace members continue to surpass those of commercial members at 100% for 2022.
- New members outscore continuing members by 10% when it comes to understanding the amount they will need to pay before receiving care.

Barriers:

- Consumer awareness of the ability to access cost information from the plan and where to find it is low.
- Cost information available to consumers is often reported as an estimate or is too high-level to be meaningful to consumers. Consumers desire personalized, out-of-pocket cost information.
- Limited provider awareness of and access to cost information.
- Lack of cost information at point-of-service (clinic, hospital, etc.).
- HealthPartners centralized consumer cost tools and resources on the financial hub of HealthPartners.com in late 2022, making this information more accessible to consumers.

III. Understanding coverage for preventive care

Standard	Preventive care information for new members is easy to understand.
Goal	85% of new members agree that preventive care information is very easy + somewhat easy to understand
Dates of Service	2020 - 2022
Dates of Measurement	2020 - 2022
Methodology	HealthPartners Member Experience Survey



*Note, low sample size for Marketplace

Analysis: Exceeded Goal

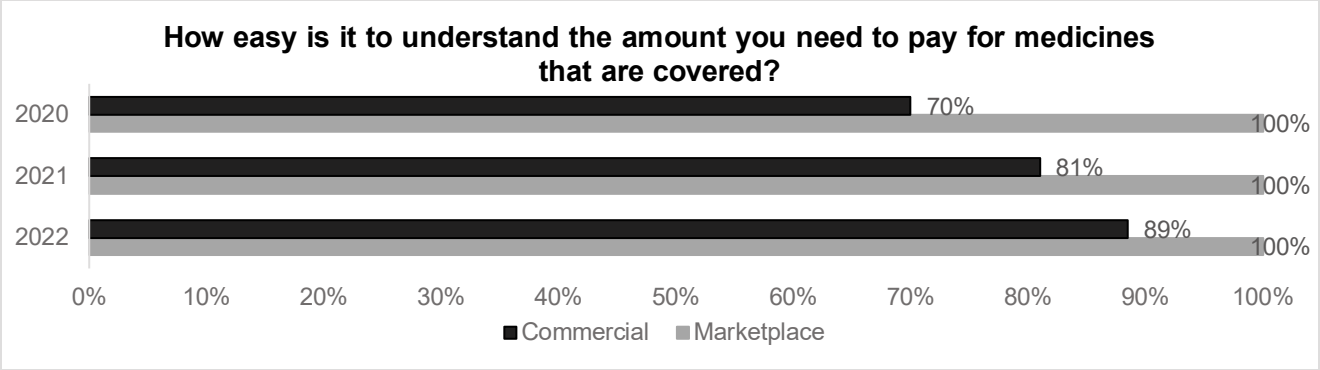
- 91% of Commercial members find it very or somewhat easy to understand their preventive care coverage. Results for Commercial members continue to exceed the goal and show a slight improvement over 2021.
- 2022 results for Marketplace members also exceed the goal and remain stable for understanding preventive care. The difference in results between Commercial and Marketplace members is not statistically significant.
- The score for new members is comparable with that of returning members. Much of the consistency in scores across new and continuing members is attributed to the plan's continued efforts to register new members for an online HealthPartners account, where specific, personalized coverage information is easily accessed.

Barriers:

- Differences between industry-definition of preventive screenings and consumers' impressions of what should be included under the umbrella of 'preventive' cause confusion.
- Members are surprised and dissatisfied when they seek care for something they believe to be preventive, and feel should be covered as preventive but are not.
- Benefits paid can vary depending upon medical history and the actual procedures/services provided during the office visit.
- Confusion related to preventive services is particularly challenging for members with high deductible plans who are responsible for the non-preventive services costs until their deductible is met.

IV. Understanding the amount needed to pay for covered medicines.

Standard	The amount to pay for covered medicines is easy to understand.
Goal	85% of new members agree that the amount to pay for covered medicines is very easy + somewhat easy to understand
Dates of Service	2020 - 2022
Dates of Measurement	2020 - 2022
Methodology	HealthPartners Member Experience Survey



*Note, low sample size for Marketplace

Analysis: Exceeded Goal

- Nearly 9 in 10 Commercial members new to HealthPartners find it very or somewhat easy to understand the amount they need to pay for covered medicines. Scores for Commercial members show a positive trend.
- All Marketplace members surveyed for 2021 say it is very or somewhat easy to understand what they'll pay for prescriptions. Though there is a sizeable gap between Commercial members and Marketplace members, it is not statistically significant due to low sample size.
- New members outscore continuing members 12% on ease of understanding the amount you need to pay for medicines that are covered.

Barriers:

- Pharmacy benefits and coverage is complex.
- Consumer awareness and use of cost tools related to prescription drug coverage is low.
- Formularies and authorization rules vary between different health plans and even between products and can change.
- Formularies change during the year which can impact a member's responsibility.
- Employers may choose to change pharmacy coverage when switching insurers and these changes can take members by surprise.

Plan for Improving New Member Understanding:

In addition to existing strategies to engage new members and monitor their experience, HealthPartners has placed a renewed focus on the onboarding process for members in the last couple of years, particularly around understanding their coverage and benefits and knowing how to use their plan.

Overall Coverage and Benefit Information

1. Continue to monitor experience of new members through the Member Experience Survey, online member panel and tracking Member Services complaints to help gauge members' understanding.
2. Enhanced the web & mobile log in experience to simplify the experience, highlight key features and deepen relationships with customers. Specific items related to coverage and benefits include:
    a. Redesigned the premium billing experience for Individual members.

b. Annual updates to formulary information.
c. Added member ID card alerts so new members could easily access and/or request additional ID cards.
d. Explanation of new cost transparency regulations for No Surprises Act.
e. Personalized, targeted messaging campaigns.
f. COVID-19 content hub with relevant, timely, information.
g. Redesigned the insurance overview pages.

3. We continue to make enhancements to our web & mobile experience based on consumer feedback, usability testing, and analytics. Our focus is customer-centric, mobile first and customer journeys that provide the most value to our members.
4. Continuing the out-bound email connection for a digital new member welcome program that has a life-cycle emphasis (e.g., learning about the plan prior to plan selection, first time that care is needed, and first claim).
5. Continue implementing new member engagement touch points: onboarding, IVR welcome calls for select populations, personalized outreach, health and well-being engagement, blog, and digital content.

Amount to Pay for Care Information

1. Surface information through the financial hub on HealthPartners.com that streamlines and brings better visibility to cost tools and resources for members.
2. Created new cost estimate tool that meets the Transparency in Coverage Phase 2 regulatory requirements.
3. Proactively share information on cost or cost resources with key member groups to build awareness.
4. Implementation of Get Connected campaigns for four commercial groups to encourage members to create an online account and go paperless.
5. Create linkages with point-of-care cost tools to enhance understanding of out-of-pocket maximums.
6. Continue to promote the pharmacy shopping tool and medical cost estimator among all members.

Preventive Care Information

1. HealthPartners continues to revise our approach for preventive screening information. Users of HealthPartners authenticated accounts receive customized preventive reminders. Some preventive reminder letters are customized by employer group, to include specific coverage information.
2. Preventive care information will be featured in blog posts, the All-Member Mailer as well as the new My Dashboard feature on HealthPartners.com.
3. Members calling the plan will receive preventive reminders as part of their experience.
4. Mobile app access to preventive care reminders.

Pharmacy Benefit Information

1. Members can access the online shopping tool, which provides comparative prescription cost information for different pharmacies.
2. Continued application of pharmacy navigator service to specifically assist new members with major changes to coverage with questions, concerns, or complex pharmacy issues. (Proactive member out-reach.)

Overall

1. Continue to use the Member Experience Survey to monitor new member experience and progress towards goals.
2. Continue to monitor Member Services complaints and appeals data though review and discussion at Service Quality Council.
3. Assess success of campaigns and programs that provide members with more personalized coverage information.

Appendix 9:
Recognitions & Awards

Recognitions and Awards

HealthPartners is proud to be a leading health plan provider in the region. True to our values of excellence, compassion, partnership, and integrity, we are committed to providing members with the tools they need to take care of their health. As shown below, we are frequently rated near or at the top of the industry in measures related to quality of care, affordability, and overall member satisfaction.

NCQA's health plan ratings

HealthPartners has once again been recognized by the National Committee for Quality Assurance (NCQA) as one of the top-rated health plans in Minnesota and among the highest-rated plans in the nation.

We earned a rating of 4.5 out of 5, according to the NCQA's commercial Health Plan Ratings for 2022. This is the 18th year in a row that NCQA recognized us as the highest or one of the highest performing plans in the state.

Despite the challenges presented by COVID-19, we still had a strong performance that shows our team's dedication to providing excellent care, service and support to members and patients.

Each year, the NCQA rates health plans based on key measures, including health prevention and treatment, member satisfaction and NCQA accreditation scores. The ratings are an important reflection on plan performance, and consumers use this information to compare health plans.

For clinical quality measures, Healthcare Effectiveness Data and Information Set (HEDIS) measures are analyzed and converted into a score by the NCQA. Member-satisfaction scores are determined based on Consumer Assessment of Healthcare Providers and Systems (CAHPS) scores. The work involved to achieve these measures closely aligns with our work in the areas of care measured by Minnesota Community Measurement.

These ratings are a perfect example of how working together and living our values helps us deliver better care and exceptional service for members and patients. To learn more or see the complete NCQA ratings, visit ncqa.org/ratings.

NCQA accreditation

The NCQA awarded HealthPartners "excellent" accreditation status for its health maintenance organization (HMO), point-of-service (POS) and preferred provider organization (PPO) commercial plans in April 2020. In September 2020, NCQA transitioned to a new scoring system and HealthPartners NCQA accreditation was updated to “Accredited” which is the highest accreditation level that NCQA now designates.

NCQA reserves its Accredited status for health plans that demonstrate levels of service and quality that meet or exceed its most stringent requirements for consumer protection and quality improvement. We share this information with consumers so they can compare health plans and choose the one that best fits their needs.

Exceptional care – HEDIS®

This year, 62% of our commercial HEDIS measures are in the top 25% in the nation, with 31% in the top 10%. This outscores our local competitors.

Consumer experience leader – CAHPS®

HealthPartners receives high scores from its health plan members in the annual CAHPS survey. Questions on

the survey address topics such as "doctor communication," "customer service" and "getting care quickly." Thirteen key areas are addressed in the survey and members rate their experience with each. Compared to all Minnesota health plans, HealthPartners has received the highest overall plan rating from members every year since 2007.

Medicare stars rating

The Centers for Medicare and Medicaid Services (CMS) publishes Star Ratings each year to measure the quality of health and pharmacy services for Medicare enrollees and rate plan performance between 1 and 5 stars. A 5-star rating is considered excellent. It scores a series of clinical and performance measures including quality of care, member experience, health plan administration and customer service. Medicare consumers can use Star Ratings when shopping for a plan during the Annual Enrollment Period (AEP) or when they become eligible for Medicare coverage.

All HealthPartners Medicare plans were awarded an overall 5 out of 5-Star Rating from the CMS for 2022. These strong results mean all HealthPartners Medicare members across the health plan's six-state service area – Minnesota, Iowa, Illinois, Wisconsin, North Dakota, and South Dakota – were enrolled in a 5-star plan for 2022.

Plans that earned a 5-star rating include:

- HealthPartners® Journey (PPO) and HealthPartners® Robin (PPO) Medicare Advantage
- HealthPartners UnityPoint Health (PPO) Medicare Advantage
- HealthPartners® Freedom (Cost)
- HealthPartners® Minnesota Senior Health Options (MSHO) (HMO SNP)
- HealthPartners® Retiree National Choice Prescription Drug Plan

The overall Star Rating focuses on the quality of care and member experience. Consumers use these ratings to measure the quality of plans available in the market. HealthPartners has a history of some of the highest Star Ratings in Minnesota. For more information on Star Ratings, visit medicare.gov.

Minnesota Health Care Quality Report, MN Community Measurement (MNCM) – This annual report identifies high-performing clinical groups in Minnesota based on overall quality performance. In 2021, we scored significantly above statewide average on the majority of the 21 quality measures – the highest in the state.

Twin Cities Business Magazine "Notable Leaders" – Penny Cermak, executive vice president and chief financial officer, was named one of 2022's Notable Chief Financial Officers for impactful contributions in improving efficiencies, maximizing funding, and setting strategic plans for the organization. Penny has played a key role in implementing new processes and tools that help our organization operate more effectively and efficiently as a system, including the transition to new Oracle Enterprise Resource Planning (ERP) software.

Dr. Mark Sannes, co-executive medical director, was also named to the list of Notable Leaders in Health Care for his efforts to educate and engage colleagues, partners, and community members on the latest information about viral illnesses and protective measures. He also helped establish an innovative triage system for patients to quickly get critical antiviral medications, providing better, more efficient care for our patients.

Twin Cities Business, Outstanding Directors Award – Amy Langer, HealthPartners board chair, was named one of 2022's Outstanding Directors. Amy is one of five Minnesota board members who were recognized for their outstanding service on business and nonprofit boards and her efforts in helping guide HealthPartners to provide quality and affordability.

U.S. News & World Report – Per its 2022-23 national rankings, Methodist and Regions Hospitals both ranked among the Best Regional Hospitals in the Twin Cities and Minnesota. They were also ranked as High Performing Hospitals in 16 categories overall. Lakeview and Westfields hospitals continued to be recognized as High Performing Hospitals in orthopedic specialties. For the first time, Amery, Hutchinson, and Hudson hospitals were rated as High Performing Hospitals for hip fracture care. Of the more than 6,000 adult hospitals in the U.S., only around one-third earn a single High Performing rating from U.S. News and World Report.

Twin Cities Business Magazine "Best Of" – As determined by subscribers, HealthPartners was the winner in two categories, Best Health Insurance Provider and Best Health Care System. Methodist Hospital, TRIA Orthopedics and HealthPartners Frauenshuh Cancer Center were also named finalists in their categories.

HealthPartners is a Top 15 Health System – For the third year in a row, IBM Watson Health named HealthPartners one of the Top 15 Health Systems in the nation. HealthPartners was selected from 337 health systems and 2,961 health system member hospitals, demonstrating top performance, better health outcomes and higher patient satisfaction while maintaining a lower cost per patient.

Practice Greenhealth – The nation’s leading organization dedicated to environmental stewardship in health care awarded our organization 27 total awards in 2022. These awards recognize our hospitals and our organization for being innovative in our approach to make health care a more sustainable industry.

Top Workplace – In 2022, HealthPartners was named a Top Workplace by the Star Tribune for the second year in a row. The Star Tribune chooses its list of top workplaces based on responses to an employee survey measuring satisfaction in key areas including engagement, leadership and organizational health, and responses are compared against industry benchmarks. HealthPartners is the largest company to make the list in 2022 and has held the title for the sixth time since the program began in 2010.

Laura Cranston Excellence in Quality Award – In 2021 and 2022, HealthPartners was awarded this by the Pharmacy Quality Alliance (PQA). This award recognizes Medicare plans for high achievement in PQA measures for medication safety and appropriate use. HealthPartners Retiree National Choice prescription drug plan (PDP) is one of only 12 PDPs in the nation to receive this award.

Director of Diversity and Inclusion Toweya Brown-Ochs named a Twin Cities Business 2022 Notable DEI Executive – Since joining our organization in 2020, Toweya has created or led many initiatives to foster inclusion, including colleague resource groups, listening sessions and leader trainings.

Chief Health Engagement and Informatics Officer Sue Knudson named a 2022's Notable Woman in Technology – This award recognizes women in the Twin Cities who have driven innovation at their companies, including implementing tech advances, minimizing cybersecurity threats, and mentoring the next generation of leaders in their field.

Bernard J. Tyson Award for Excellence in Pursuit of Healthcare Equity – In 2021, Methodist Hospital ICU nurse Jeanette Rupert received this inaugural award from the Alliance of Community Health Plans (ACHP).

She was recognized for establishing a local medical tent as a brick-and-mortar non-profit clinic in the community and bringing health care to underserved populations in collaboration with local nursing students.

American Medical Group Association (AMGA) Acclaim Award - In 2020, HealthPartners was named an Acclaim Award honoree by the AMGA for our Children's Health Initiative and its collaborative approach to improving child and family health.

Business of Pride Ally Award – In 2020, Park Nicollet nurse Jenn Bourgoine received this award from the Minneapolis/St. Paul Business Journal (MSPBJ) for her work supporting transgender patients.

2019 Health Equity Award – In January 2019, HealthPartners was one of only two organizations in the nation to receive the Health Equity Award from the Centers for Medicare and Medicaid Services. The award recognizes areas where HealthPartners has implemented new models to increase access to care and reduce health disparities.

Business of Pride – In 2019, Director of Park Nicollet gender services, Dr. Deb Thorp, received this award from the Minneapolis/St. Paul Business Journal (MSPBJ) for improving access to compassionate care for LGBTQ patients and those in immigrant and refugee communities.

Colorectal Cancer Organization of the Year - In 2018, HealthPartners was named the Colorectal Cancer Organization of the Year by the American Cancer Society for its work to improve colorectal cancer screening rates among patients of color.

Methodist Hospital – Methodist Hospital was one of four hospitals nationwide to receive the Quest for Quality Citation of Merit in 2018 by the America Hospital Association. All recipients of this award demonstrate a commitment to improving access, providing safe, high-quality care, creating value, partnering with patients and families, focusing on wellbeing, and providing seamless, coordinated care.

Becker's Healthcare – In June 2018, Becker's Healthcare named HealthPartners to the 2018 list of "52 great health systems to know," a companion to the "100 great hospitals in America" list. The health systems featured on this list strive to provide high quality patient care and grow programs beneficial to their communities.

Senior Leadership Awards – In June 2018, HealthPartners President and CEO Andrea Walsh, Regions Hospital President and CEO Megan Remark, and HealthPartners Park Nicollet Care Group Co-Executive Medical Director Steve Connelly, M.D., were named to Minnesota Monthly's first-ever "Minnesota Top 500" list.

Minnesota Hospital Association Awards – Methodist Hospital won Best Minnesota Hospital Workplace in the large hospital category from the Minnesota Hospital Association in June 2018. Regions Hospital was also awarded the Excellence in Donation Award in the large hospital category for outstanding support and commitment to saving lives through organ and tissue donation and transplantation.

Rural Health – In December 2017, Hudson Hospital and Clinic and Westfields Hospital and Clinic were recognized for overall excellence in quality and patient satisfaction by The Chartis Center for Rural Health/iVantage Health Analytics and the National Organization of State Office of Rural Health. Both hospitals scored in the top 25% among all rural hospitals in the nation.

Watson Health Top 15 Health System – HealthPartners was selected as a Top 15 Health System in 2017 by Watson Health. When compared to their peers, these systems typically have lower mortality and complication

rates, better 30-day readmission and mortality scores, as well as higher efficiency and patient perception of care.

Watson Health Top 100 Hospitals – In 2017, Lakeview Hospital was named a Top 100 Hospital by Watson Health, and in 2016 and 2017, Methodist Hospital was a Watson Health Top 100 Hospital. Methodist was highlighted as a top-20 teaching hospital, a top-50 cardiovascular hospital and received Watson Health's Everest Award, which honors hospitals that have both the highest current performance and fastest long-term improvement over five years.

Regions and Methodist among the nation's best – Regions Hospital and Methodist Hospital have been ranked among the best hospitals in the country by Healthgrades, a group that evaluates nationwide hospital quality based on clinical outcomes. Regions Hospital was recognized as one of Healthgrades' "America's 50 Best Hospitals." Methodist Hospital was recognized as one of Healthgrades "America's 100 Best Hospitals."

Chain Awards for Excellence – In September 2017, Park Nicollet Methodist Hospital in Minneapolis and Regions Hospital in St. Paul received CHAIN Awards for Excellence, which commend the infection prevention and antibiotic stewardship efforts of health care teams working to build safer health care environments. The awards are presented annually by the Collaborative Healthcare-Associated Infection Network (CHAIN). Park Nicollet Methodist Hospital also received the CHAIN Award for its Park Nicollet Infection Prevention and Control Service.

Top 25 Environmental Excellence – In 2017, Regions Hospital, Methodist Hospital, and Hudson Hospital and Clinic received the Top 25 Environmental Excellence Award from Practice Greenhealth. The award is for our sustainability programs and innovation, and for creating a culture of sustainability. (Improvement of Experience, Affordability)

Greening the OR – All six HealthPartners hospitals were honored by Practice Greenhealth for their work to reduce the environmental footprint of their operating rooms. Additional Awards from Practice Greenhealth in 2017 include:

- Amery Hospital & Clinic: Greenhealth Emerald Award; Making Medicine Mercury Free
- Hudson Hospital & Clinic: Circles of Excellence-Food; Circles of Excellence-Water
- Lakeview Hospital: Greenhealth Emerald Award
- Methodist Hospital: Circles of Excellence-Waste; Circles of Excellence-Water
- Westfields Hospital & Clinic: Greenhealth Emerald Award
- HealthPartners: System for Change Award – Recognizing health systems working cohesively across hospitals and other facilities to set and meet goals related to sustainability.

Minnesota Bridges to Excellence (MNBTE) – This program rewards clinics that meet or exceed a strict set of care standards for patients with diabetes, depression, and vascular disease. In 2017, fourteen HealthPartners clinics and 20 Park Nicollet clinics met at least one of the goals for achieving optimal diabetes, vascular and depression remission care. Several clinics met two goals. Park Nicollet's Golden Valley Clinic earned its third consecutive MNBTE Grand Slam.

Minnesota Business Ethics Award – In 2016, HealthPartners was honored as a large company that promotes and demonstrates ethical conduct in the workplace and community.

Excellence Award in care management strategies from the Pharmacy Benefit Management Institute (PBMI) – The award honors the medication optimization program at HealthPartners, which has helped improve care for hepatitis C patients.

Former CEO Mary Brainerd named one of the "Top 25 Women in Healthcare" by Modern Healthcare – The award is presented to female executives across the United States who are developing policy, leading change, and guiding the delivery of health care.

Appendix 10: Acknowledgements

Acknowledgements

The Quality Improvement and Compliance department wishes to acknowledge the practitioners and care delivery systems who work diligently every day to provide the highest quality care to HealthPartners members. A special