

## **2017 ITASCA MEDICAL CARE PROGRAM EVALUATION**

Approved by:

IMCare QI/UM Committee: 03/21/2018

Itasca County Board of Commissioners: 04/24/2018

### **Mission Statement...**

An organized and coordinated Minnesota Health Care Program Delivery System that addresses the goals of improving access to quality care, assuring appropriate utilization of services, enhancing patient and provider satisfaction, and achieving cost efficiencies in the delivery of health care.

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## **Executive Summary**

Itasca Medical Care (IMCare) is committed to identifying opportunities to improve the care and services enrollees receive from IMCare and its network of providers. To attain quality improvement, IMCare utilizes an incorporated Quality Improvement (QI) and Utilization Management (UM) Program and dynamic QI/UM Work Plan to direct QI/UM program activities that enhance enrollee health and well-being. The following is an evaluation and summary of the 2017 QI/UM activities.

In 2017, IMCare made many strides towards quality improvement with a strong focus on staff, provider and enrollee education. Development of an internal Quality Workgroup occurred in September of 2017, with the intent of enhancing staff knowledge of ongoing quality projects and opportunities for improvement, in addition to promoting the exchange of ideas and solutions.

IMCare provided enrollee education through community outreach, monthly education sessions, the IMCare website and biannual newsletters. IMCare staff also provided enrollees with a wealth of information through activities of care coordination, disease management and complex case management. Education ranged from ongoing IMCare quality programs and navigating the IMCare network, to appropriate preventative care.

IMCare notified providers of new or ongoing quality programs, and changes to the IMCare program via outreach, provider updates, the IMCare website and biannual mailings. Additionally, IMCare committee members attended quarterly meetings, at which time they were provided updates of the program.

IMCare revised its Service Advisory Committee to be more enrollee-centered and it is now called the Stakeholder Advisory Committee (SAC). This group focuses primarily on seniors or enrollees receiving Long Term Services and Supports (LTSS); and will work on gathering information regarding satisfaction with care, problem identification and suggestions for improvement of the delivery system. The group includes enrollees or individuals who work in the capacity to represent them. The long term goal of SAC is to improve access to and quality of care.

In addition to the quality improvements, IMCare appreciated enhancements to the Utilization Management department in 2017. IMCare developed an updated resource manual for UM staff to use for UM activities. This manual promotes consistency for UM processes and decisions. Throughout 2017, IMCare provided ongoing education for UM staff at the internal Utilization Management Operations workgroup. Additionally, IMCare modified or reduced authorization requirements during 2017, to improve enrollee access to appropriate care.

## **Program Overview**

The IMCare program is administered by Itasca County Health and Human Services (ICHHS). IMCare enrollees are those who are eligible for benefits under Minnesota Health Care Programs. IMCare was established in 1982 with General Assistance Medical Care (GAMC). Prepaid Medicaid was implemented on July 1, 1985, as a demonstration project and expanded to include MinnesotaCare in 1996. In 2001, IMCare became a County Based Purchasing (CBP) organization. Minnesota Senior Care Plus (MSC+) was added in July of 2005 and a Medicare Advantage product, Minnesota Senior Health Options (MSHO), was added in January 2006. Accountability for the management and improvement of the quality of clinical care and service provided to enrollees rests on the ICHHS Board of Commissioners (BOC). The BOC consists of five County commissioners and is responsible for ensuring the implementation of all aspects of the Quality Improvement (QI) and Utilization Management (UM) programs. The BOC delegates day-to-day operational responsibilities for the program to the IMCare Director. The IMCare Director, Medical Director, Pharmacy Director, Quality Director and Contract Compliance Officer report quality program activities and outcomes to the Provider Advisory Subcommittee (PAC), the Quality Improvement/Utilization Management Subcommittee (QI/UM), and the BOC quarterly. Annually, the BOC reviews and approves IMCare QI and UM Program Descriptions, the QI/UM Work Plan, and the QI/UM Program Evaluation.

The purpose of the Quality Improvement and Utilization Management Programs is to support the mission, vision and values of Itasca County and IMCare through ongoing improvement, evaluation and monitoring of patient safety and delivery of services to our enrollees, including medical and behavioral health services. IMCare partners with providers, public and private community organizations, and delegated entities to support the Quality and Utilization Management Programs.

Quality Improvement and Utilization Management goals and objectives are based upon information gathered through a variety of sources, such as survey results, utilization and claims data, Healthcare Effectiveness Data and Information Set (HEDIS) data, Minnesota Department of Health (MDH) Quality Assurance Examination, and Minnesota Department of Human Services (DHS) Triennial Compliance Audit (TCA). The dynamic QI/UM Work Plan is developed to identify the goals and objectives that IMCare recognized during the evaluation of monitoring and tracking of quality activities and progress throughout the year. The QI/UM Work Plan activities and outcome measurements collected throughout the year are outlined below.

## 2017 Quality Program Activities

### Healthcare Effectiveness Data and Information Set (HEDIS)

IMCare collects HEDIS data to comply with contract requirements for both DHS and CMS. The Healthcare Effectiveness Data and Information Set (HEDIS) is one of the most widely used set of healthcare performance measures in the United States. HEDIS is a nationally recognized and comprehensive set of clinical indicators to assess and compare performance by all health plans, physician groups and employers. Claims data is used to generate administrative results (Admin) and for selected measurements, a chart audit methodology (Hybrid) was used. In measures with more than 411 eligible enrollees, a random sample of 411 is taken to represent the measure. Measures with less than 411 eligible enrollees have no sampling taken. Rates are calculated using NCQA HEDIS specifications and results are verified by an external audit vendor and submitted to MDH, DHS and CMS.

IMCare's HEDIS 2017 results for the MNCare and Medicaid population exceeded the MN state average in many areas including annual dental visit rates for all ages, medication management, controlling high blood pressure (as demonstrated in Figure 3), weight counseling for adolescents and initiation/ engagement of drug or alcohol treatment for adults, among others. To the contrary, IMCare Medicaid results were below the MN state average were preventative health measures including, childhood immunizations, chlamydia screening, diabetes eye examinations and follow up care after an inpatient stay for behavioral health diagnosis. Overall, IMCare aims to maintain measures that are successful and close gaps for those not meeting the MN state average.

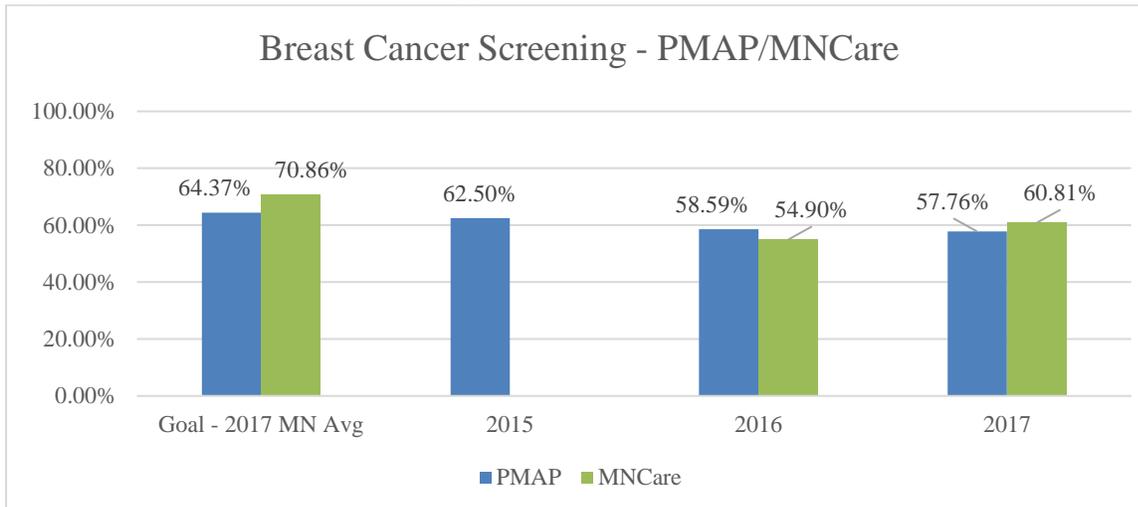
Overall a majority of IMCare's HEDIS 2017 results for the MSHO population were within 5% of, or exceeded the MN state average. Results that are well above the MN state average include medication management for multiple conditions, statin adherence, controlling blood pressure (as demonstrated in Figure 6), and medication reconciliation.

### **HEDIS – Medicaid**

#### **Breast Cancer Screening**

IMCare saw a 6% increase in the MNCare Breast Cancer Screening rate in 2017; however, the PMAP Breast Cancer screening rate decreased by 0.83%. IMCare was below the state average goal for both products. In 2017, IMCare implemented mammogram reminder letters for women in the appropriate age group. Additionally, in the fall of 2017, IMCare included information regarding breast cancer screening in the enrollee newsletter. Annually, IMCare reviews the Medicaid HEDIS report at the Provider Advisory Committee and the External Quality Improvement Utilization Management committee, to obtain input and identify opportunities for improvement.

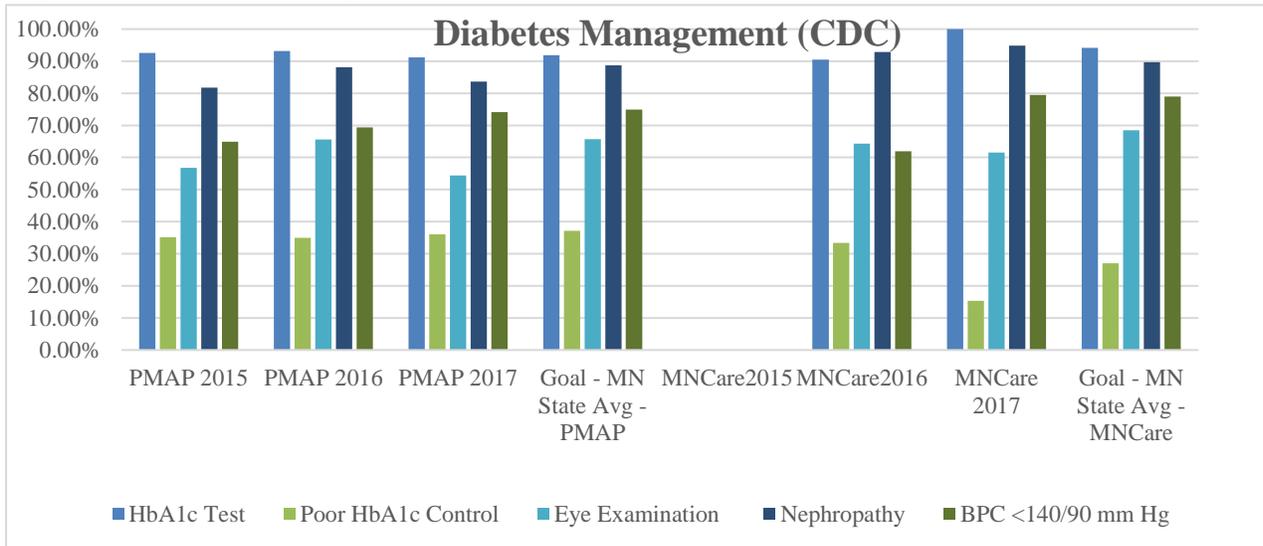
**Figure 1: Breast Cancer Screening- PMAP/MNCare**



### **Diabetes Management (CDC)**

Overall, IMCare saw some year-to-year fluctuations in the diabetes management measures. For PMAP enrollees, there was a 5% increase in the Blood Pressure Control for Diabetics measure, exceeding the state average. PMAP rates fell below state average and showed a year-to-year decrease for HbA1C Testing (91.16%), Diabetes Eye Examination (54.42%) and Diabetes Nephropathy Screening (83.67%). The Poor HbA1C Control measure had a 1% increase from 2016 and met the state average goal. For MNCare enrollees, the state average goal was met and there was significant year-to-year improvement for the following measures: HbA1C Testing, Poor HbA1C Control, Blood Pressure Control for Diabetics and Nephropathy Screening. The Diabetic Eye Examination measure showed a slight decrease (<5%) from 2016 and fell below goal. The areas that demonstrated improvement, may be attributed to ongoing diabetes management interventions. Enrollees that opted-in to the diabetes Disease Management Program were sent quarterly evidence-based educational mailings. In the spring of 2017, education regarding the importance of diabetic eye exams was sent to enrollees via the enrollee newsletter. Diabetic nephropathy screening information was included in the spring 2017 provider newsletter. In the 4<sup>th</sup> quarter of 2017, diabetes was changed from an opt-in program to an opt-out program, to attempt to reach and educate additional enrollees regarding their care needs.

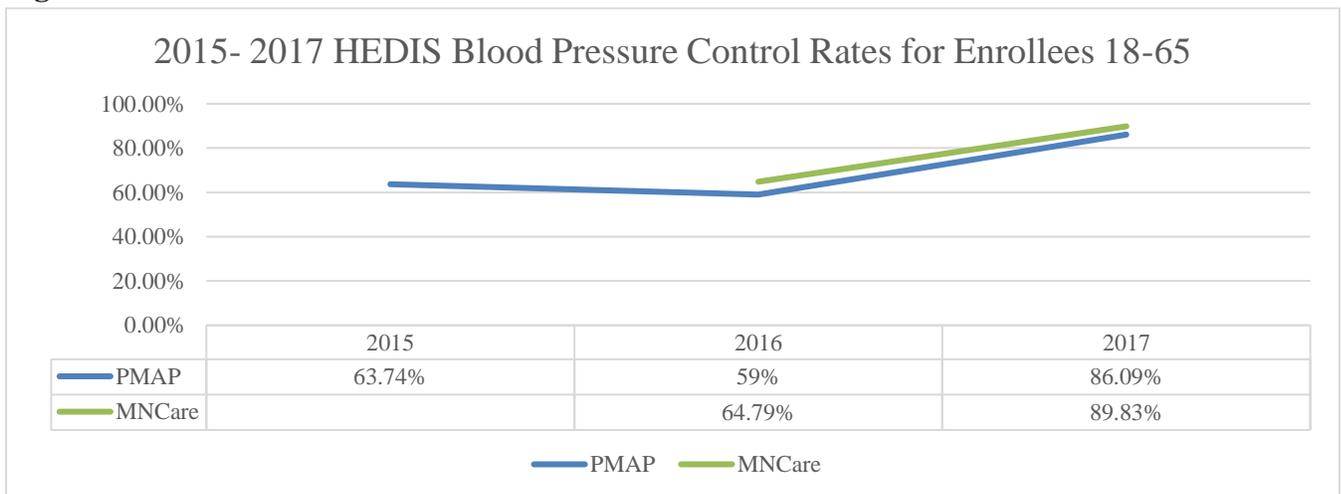
**Figure 2: Diabetes Management (CDC)**



**Controlling Blood Pressure**

IMCare Controlling Blood Pressure rates for both PMAP and MNCare enrollees has increased substantially since 2016; both products are well above state averages (PMAP = 65.54%; MNCare = 70.34%). The Hypertension (HTN) disease management program was implemented in 2012 as an opt-out program, in which all enrollees with hypertension participated, unless they requested to opt-out. Those enrolled in disease management for HTN received quarterly mailings with evidence-based information related to controlling blood pressure and additional interventions as indicated. Lastly, IMCare adopted and disseminated the UpToDate practice guideline, ‘*Overview of Hypertension in Adults*’ to both enrollees and providers via the biannual provider and enrollee newsletters.

**Figure 3: 2015-2017 HEDIS Blood Pressure Control Rates for Enrollees 18-65**

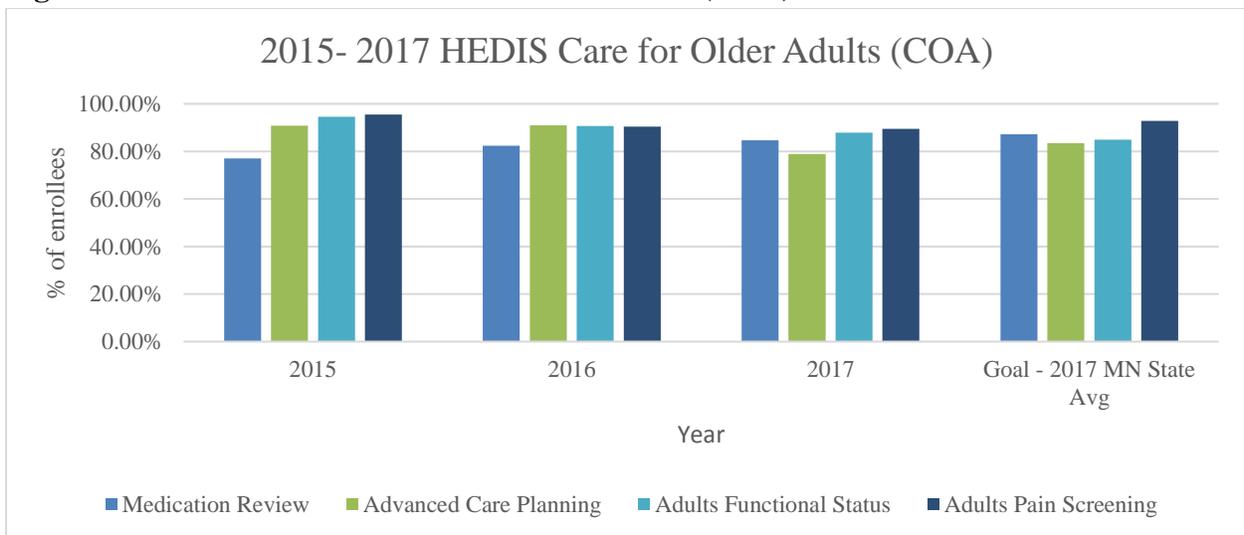


## **2017 HEDIS – MSHO**

### **Care for Older Adults**

Overall, Care for Older Adults HEDIS measures were stable from year-to-year, but continued to land just below state averages. IMCare appreciated a slight increase in the Medication Review measure from the previous measurement year. During biannual contacts, senior care coordinators provided enrollees with information regarding Health Care Directives and encouraged them to discuss it with their providers. In addition, IMCare provided information regarding Health Care Directives in biannual newsletters for both providers and enrollees. Annually, IMCare reviews the MSHO HEDIS report at the Provider Advisory Committee, Stakeholder Advisory Committee and the QI/UM Committee, to obtain input and identify opportunities for improvement.

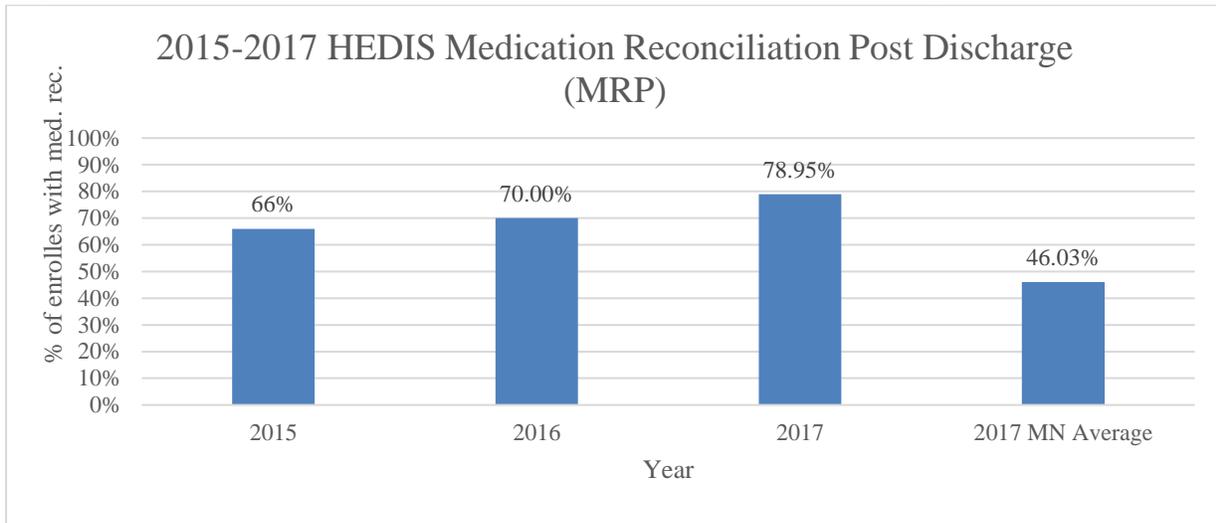
**Figure 4: 2015-2017 HEDIS Care for Older Adults (COA)**



### **Medication Reconciliation Post Discharge**

The IMCare Medication Reconciliation Post Discharge rate continued to experience an upward trend from year-to-year, still coming in well above the MN state average. IMCare leads the state in this measure. IMCare partnered with network Skilled Nursing Facilities (SNF), through a pay-for-performance Integrated Care System Partnership (ICSP), to improve rates of medication reconciliation post discharge. Each SNF that had a 5% increase from the previous year would receive a bonus payment of \$5000, if they experienced a 10% increase they would receive \$10,000. If they maintained 100% from year-to-year they would receive the full \$10,000. While there was a year-to-year increase as demonstrated in Figure 5, none of the individual facilities had enough of an increase to warrant the incentive payment.

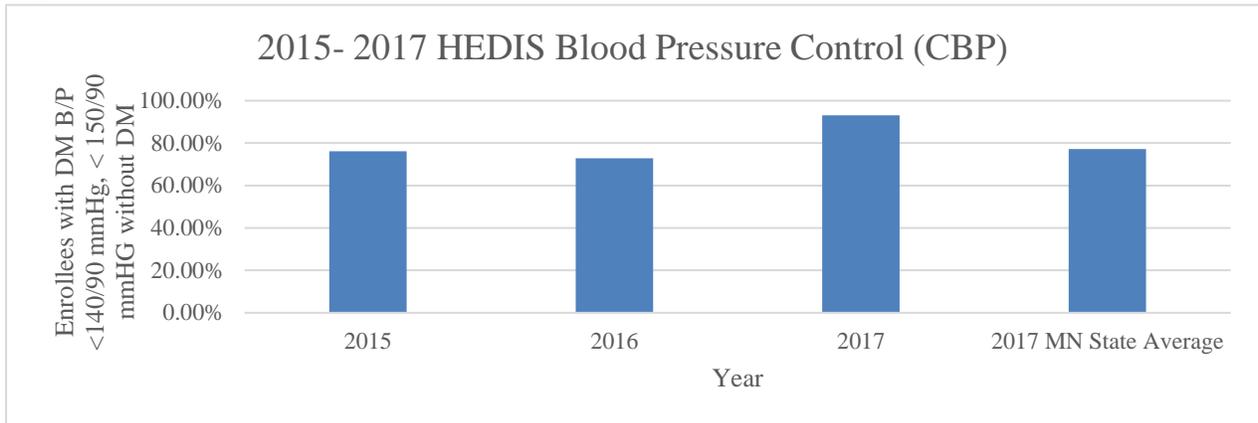
**Figure 5: 2015-2017 HEDIS Medication Reconciliation Post Discharge**



**Blood Pressure Control (CBP) - MSHO**

IMCare senior Blood Pressure Control rates had over a 20% increase from 2016 to 2017 and were notably higher than the Minnesota State Average. IMCare has implemented many different interventions over the years to try and improve this area of care. As part of the Controlling High Blood Pressure Chronic Care Improvement Program (CCIP), the Hypertension (HTN) disease management program was implemented in 2012 as an opt-out program in which all enrollees with a hypertension participated, unless they requested to opt-out. Those enrolled in disease management for HTN received quarterly mailings with evidence-based information related to controlling blood pressure and additional intervention as indicated. Senior care coordinators checked blood pressures and reviewed enrollee medications during their annual visits. Enrollees receiving medications for hypertension were provided with education on the importance of medication compliance, and checking blood pressure regularly. Any concerns addressed during visits were communicated to the primary care provider. Lastly, IMCare adopted and disseminated the UpToDate practice guideline, ‘*Overview of Hypertension in Adults*’ to both enrollees and providers via the biannual provider and enrollee newsletters.

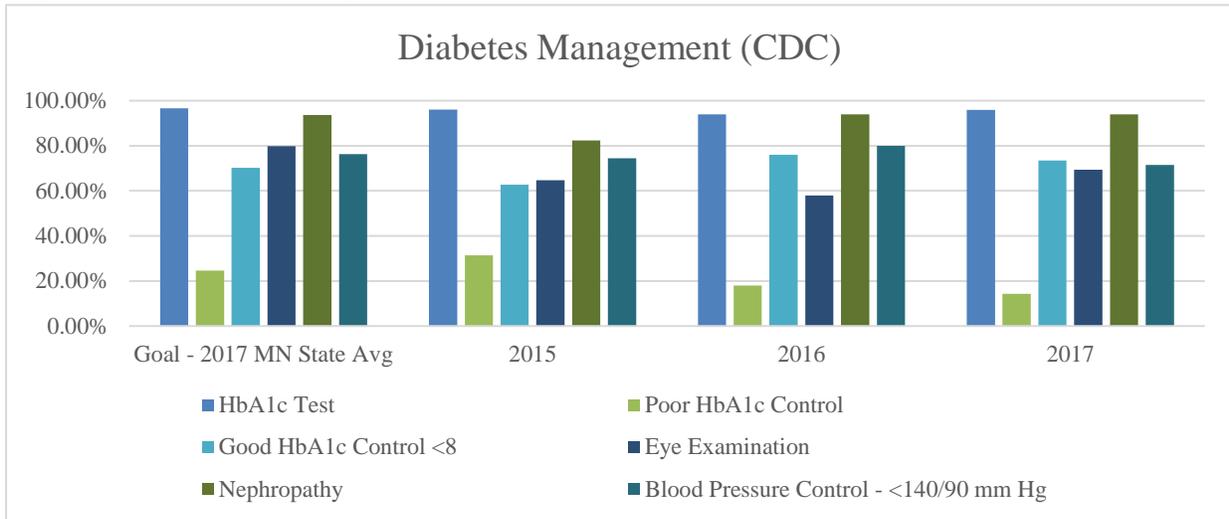
**Figure 6: 2015-2017 HEDIS Blood Pressure Control (CBP)**



### **Diabetes Management (CDC) - MSHO**

Overall, IMCare diabetes management rates were stable from year-to-year for seniors. Most rates were at the Minnesota State Average or had less than a 5% difference. HEDIS 2017 rates indicated that IMCare had less than 15% of senior enrollees with Diabetes who had a poorly controlled A1C (greater than 9), well below the state average. Additionally, HEDIS 2017 rates for seniors indicated that 73.47% have good control (A1C of 8 or less), exceeding the Minnesota State Average for MSHO enrollees. While IMCare saw an 11.39% increase in the rate of Diabetic Eye examinations from 2016, the Minnesota State Average still exceeded the IMCare rate; IMCare believes this may be related to the audit process. IMCare did not meet the goal and saw a 9.54% decrease in the number of enrollees with diabetes who had a controlled blood pressure (<140/90). Enrollees that opted-in to Disease Management with diabetes were sent quarterly evidence-based educational mailings. In the spring of 2017, education regarding the importance of diabetic eye exams was sent to enrollees via the enrollee newsletter. Diabetic nephropathy screening information was included in the spring 2017 provider newsletter. In 4<sup>th</sup> quarter of 2017, Diabetes was changed from an opt-in program to an opt-out program, to attempt to reach and educate additional enrollees regarding their care needs.

**Figure 7: Diabetes Management (CDC)**



### Performance Improvement Projects

#### 2015-2017 PIP: Elimination of Race and Ethnic Disparities in the Management of Depression

This Performance Improvement Project (PIP) was designed to improve IMCare’s HEDIS Antidepressant Medication Management (AMM) Effective Continuation Phase Treatment rate for the study population by an absolute 8% by HEDIS 2017 and sustain the improvement for HEDIS 2018. If the measure of success was met (as measured by HEDIS 2017), the planned interventions were designed to be sustainable over time. Process measures were used to determine which interventions were most successful and IMCare is considering continuation of these interventions beyond the timeframe of the PIP.

In 2017, IMCare exceeded the PIP goal with a rate of 35%. IMCare provided general enrollee education regarding depression, the relatively slow onset-of-action of antidepressant medications, common side effects of antidepressant medications and the importance of antidepressant medication adherence in enrollee newsletters. Instructions for accessing this information in another language was also included. IMCare identified a total of 88 currently-eligible enrollees within the study population throughout 2017, on the monthly report and analyzed their antidepressant medication prescription fill data. Thirty-three enrollees who were eligible during the previous month and did not fill their antidepressant medication were contacted by telephone (or mail if not available by telephone), in order to evaluate and address causes for the gap. During monthly individual enrollee antidepressant medication utilization review, it was noted that enrollees were frequently on antidepressant medications for diagnoses other than major depression. Lastly, general network provider education regarding the PIP was included in provider newsletters.

**Figure 8: Results (by HEDIS year)**

Measurement	Goal	Baseline (2014)	2015	2016	2017	Status
HEDIS AMM Effective Continuation Phase Treatment rate for the study population	Increase 8% over baseline by 2017	0%	25%	50%	35%	Goal Met.

**2016-2018 QIP: A Collaborative Approach to Optimize Depression Care for Seniors**

Per a CMS memo dated July 1, 2015, all Special Needs Plans (SNPs) were required to develop and implement a three-year QIP that promoted effective management of chronic disease. Following internal data analysis, IMCare chose depression as the topic of the 2016-2018 QIP.

The goal of the QIP was to increase the IMCare HEDIS Antidepressant Medication Management (AMM) Effective Continuation Phase Treatment rate for the study population by 10% over baseline by HEDIS 2019. The baseline rate (2015 HEDIS) was 53.85%. The IMCare MSHO 2017 HEDIS AMM Effective Continuation Phase Treatment rate was 80%, exceeding the 10% increase goal.

In 2017, IMCare provided general enrollee education regarding depression, the relatively slow onset-of-action of antidepressant medications, common side effects of antidepressant medications and the importance of antidepressant medication adherence in the enrollee newsletters. Instructions for accessing this information in another language was also included. IMCare identified 79 currently-eligible enrollees within the study population, throughout 2017, on the monthly report and analyzed their antidepressant medication prescription fill data. Eight enrollees who were eligible during the previous month and did not fill their antidepressant medication were contacted by telephone (or mail if not available by telephone), in order to evaluate and address causes for the gap. During monthly individual enrollee antidepressant medication utilization review, it was noted that enrollees were frequently on antidepressant medications for diagnoses other than major depression. IMCare hosted a Depression Education Seminar on 6/14/17. Two community mental health professionals provided staff education on the prevalence of depression in the elderly, signs and symptoms of depression, and appropriate interventions/goals for treatment. In attendance were IMCare Care Coordinators and Itasca County Public Health Elderly Waiver Case Managers. Lastly, general network provider education regarding the QIP was included in provider newsletters.

In 2017, CMS delegated oversight of QIP projects to DHS, subsequently IMCare was instructed to transition this project to a Chronic Care Improvement Program for 2018 and choose a separate QIP topic.

**Figure 9: Results (by HEDIS year)**

Measurement	Goal	Baseline (2015)	2016	2017	Status
HEDIS AMM Effective Continuation Phase Treatment rate for the study population	Increase 10% over baseline by 2019	53.85%	80%	80%	Goal met.

### Focus Studies

#### Emergency Department (ED) Utilization Focus Study (FS)

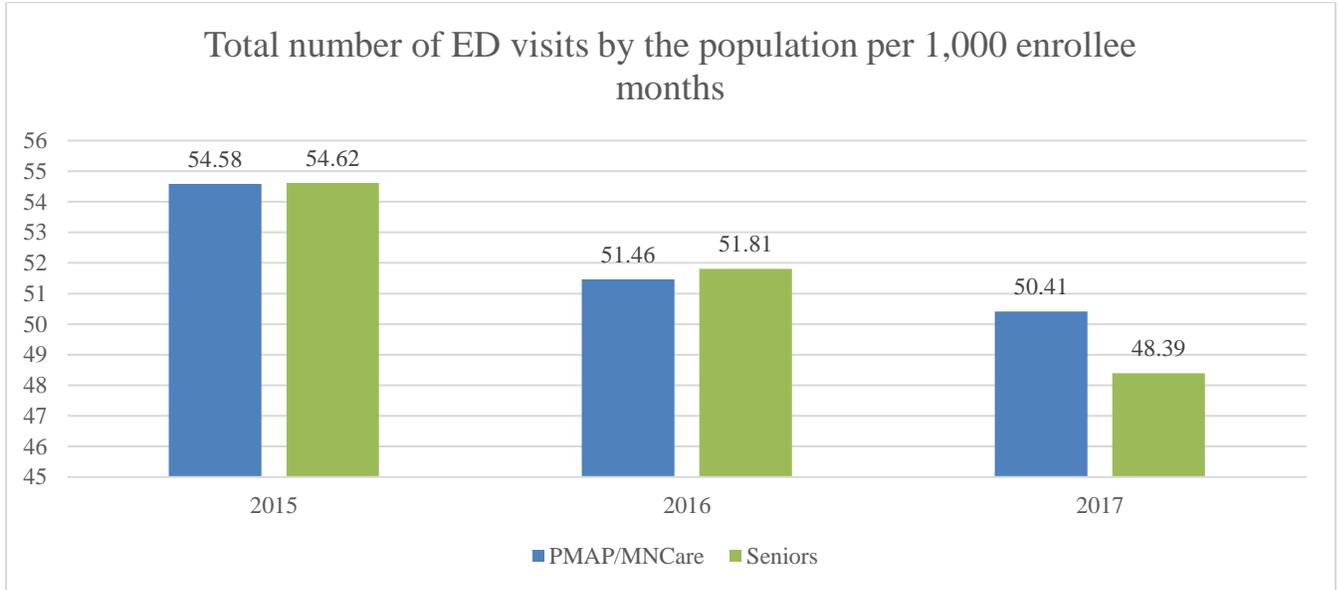
IMCare identified enrollees with high ED utilization in order to provide timely and appropriate enrollee education and case management (CM), as well as to identify and intervene in cases of potential fraud, waste and/or abuse by enrollees with high ED utilization. The monthly methodology for identifying enrollees with high utilization was modified in July of 2017 to include enrollees with four or more cumulative visits (since the beginning of the year). Specific diagnosis codes were also excluded (cancer, neoplasm/blood disorders, pregnancy, perinatal, and congenital anomalies).

IMCare provided global enrollee education regarding appropriate use of the ED and network urgent care options in the April 2017 enrollee newsletter. Individual enrollee/caregiver education and CM regarding appropriate use of the ED and network clinic/urgent care options was administered by an IMCare QI/UM Nurse or Senior Care Coordinator throughout 2017. When appropriate, Restricted Recipient Program (RRP) enrollee education/warning/placement occurred throughout 2017. The IMCare Spring/Summer 2017 provider newsletter included the following: 2016 ED FS results and a request for intervention suggestions, the process for reporting suspected fraud, waste and abuse to IMCare and education regarding IMCare CM services and the process for referral. Additionally, the IMCare Medical Director and Compliance staff attended DHS Universal Restricted Recipient Program (URRP) meetings throughout 2017.

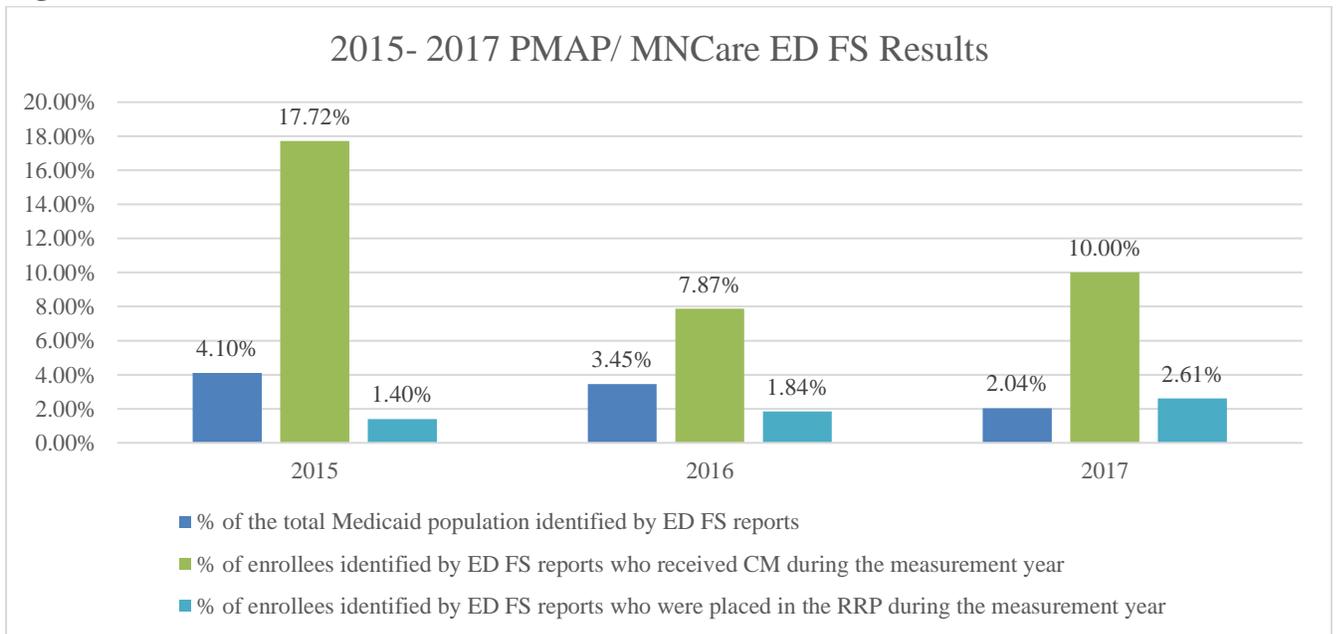
IMCare identified 230 enrollees on the ED FS Report, of those 230, 23 received case management services and six were placed into the restricted recipient program; Figure 11 & 12 demonstrate population-based, year-to-year comparisons of interventions and identification. As demonstrated in Figure 10, the total number of ED visits by enrollees under 65, (per 1,000 enrollee months) decreased 2.04% from 2016 to 2017, and met goal; the total number of ED visits by enrollees over 65, (per 1,000 enrollee months) decreased by 6.60%, also meeting goal.

This measure is reflective of the effectiveness of global enrollee education regarding appropriate use of the ED. IMCare met all ED FS goals in 2017.

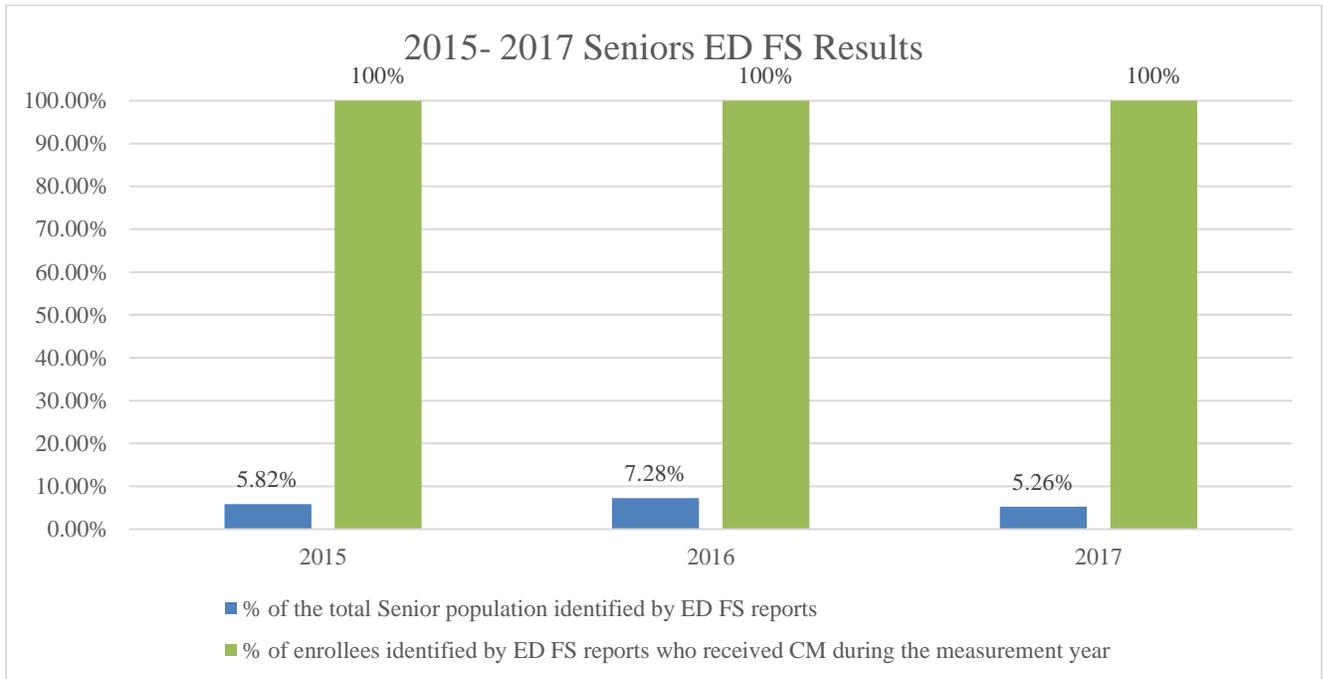
**Figure 10: Total number of ED visits by the population per 1,000 enrollee months**



**Figure 11: 2015-2017 PMAP/MNCare ED FS Results**



**Figure 12: 2015-2017 Seniors ED FS Results**



**Controlled Substance (CS) Focus Study (FS)**

IMCare identified enrollees with a high number of controlled substance prescription fills and use of multiple providers/pharmacies to obtain controlled substance prescriptions, in order to provide timely and appropriate case management (CM) and intervene in cases of potential fraud, waste and/or abuse.

IMCare had a number of interventions to reduce inappropriate controlled substance use in 2017. IMCare provided global enrollee education regarding appropriate use and disposal of over-the-counter and prescription medications (including controlled substances) in the Spring 2017 enrollee newsletter. The CVS/Caremark Safety and Monitoring Solutions (SMS) and Enhanced Safety and Monitoring Solution (ESMS) programs were administered by CVS/Caremark for IMCare throughout 2017. Additionally, individual enrollee education/CM regarding CS use and the potential dangers of using multiple providers/pharmacies for CS prescriptions was administered by an IMCare QI/UM nurse throughout 2017. When appropriate, Restricted Recipient Program (RRP) enrollee education/warning/placement occurred throughout 2017. The IMCare spring/summer 2017 provider newsletter included the following: 2016 CS FS results and a request for intervention suggestions, the process for reporting suspected fraud, waste and abuse to IMCare and education regarding IMCare CM services and the process for referral. Additionally, the IMCare Medical Director and Compliance staff attended DHS Universal Restricted Recipient Program (URRP) meetings throughout 2017. The IMCare Pharmacy Director attended DHS Universal Pharmacy Policy Workgroup (UPPW) meetings throughout 2017. The workgroup included representatives from all MN Medicaid health plans and DHS. In

mid-2017, IMCare removed the prior authorization requirement for Medicaid Formulary buprenorphine products used to treat opioid dependence. In late 2017, IMCare removed the prior authorization requirement for out-of-network methadone treatment centers. In late 2017, two IMCare network mental health practitioners began offering in-network buprenorphine treatment for opioid dependence. This reduced barriers for enrollees to receive treatment related to Opioid Use Disorders, it is unknown whether this contributed to the opioid use rates.

In 2017, IMCare identified 185 enrollees through the CS FS. Thirty-three (17.84%) received case management and seven (3.78%) were placed in the RRP. Use of medication assisted treatment for opioid use disorder (e.g., methadone treatment center or buprenorphine products) remained steady for the past three years.

IMCare met all CS FS goals for 2017. CVS/Caremark SMS and ESMS program enrollment and interventions were similar to 2016, but resulted in greater reductions in the use of CS medications and multiple pharmacies/providers. The total days-supply of controlled substances dispensed per IMCare enrollee decreased and met goal in 2017. This finding was likely due to consistent QI/UM nurse staffing, as well as the implementation and/or enforcement of CS prescribing policies and procedures at several IMCare network clinics. IMCare expects this measurement to continue to decrease with the implementation of an Opioid Performance Improvement Project (OPIP) in 2018.

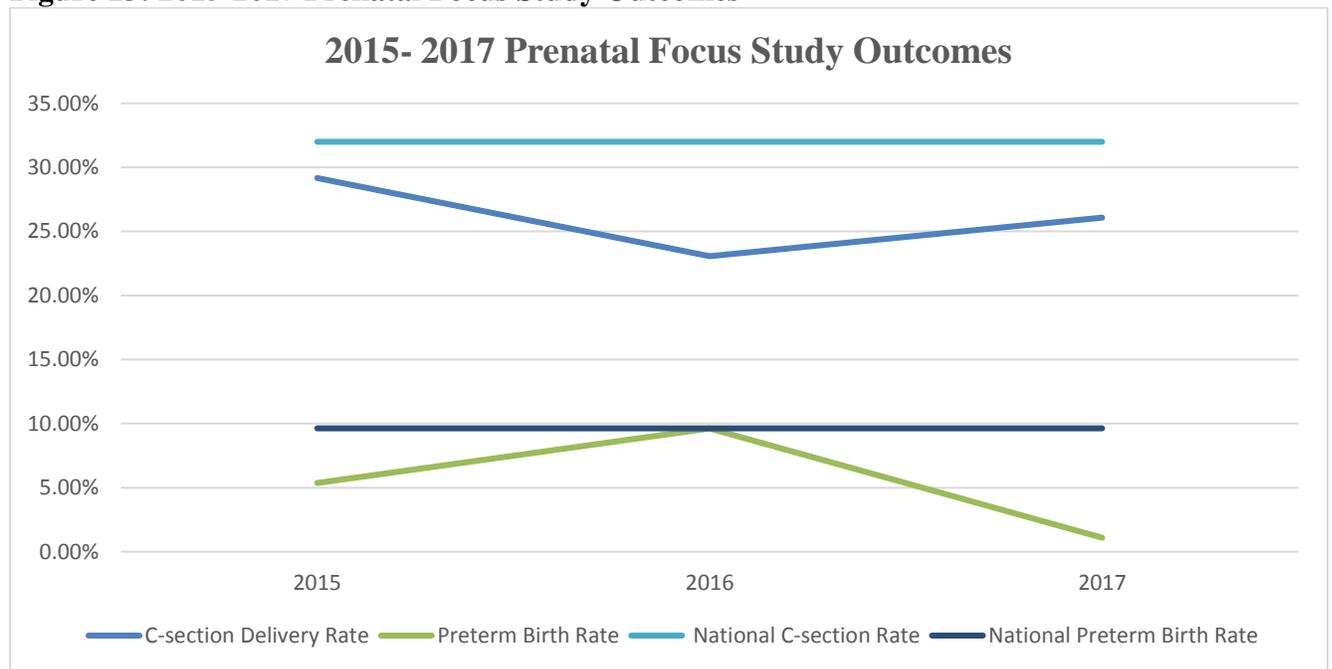
### **A Healthy Pregnancy Prenatal Initiative Focus Study**

A Healthy Pregnancy' prenatal initiative focus study was implemented in 2007 to identify at-risk pregnancies through referrals from physicians, Women, Infants and Children (WIC), Teenage Parenting Program (TAPP), IMCare, Project Clean Start, schools, and self-referrals in order to provide the opportunity for education and support, to reduce the risk of preterm labor and delivery, and to ensure a postpartum provider visit. The Minnesota Health Care Program (MHCP) Provider Manual states, "At-risk is used to describe a pregnant woman who requires additional prenatal care services because of factors that increase the probability of a preterm delivery, a low birth weight infant, or a poor birth outcome." During the prenatal period, IMCare enrollees who accepted prenatal visits with Itasca County Public Health Maternal Child Health (MCH) received a \$40.00 Target gift card for the first visit, and a \$30.00 Target gift card for the second visit. During the postpartum period, IMCare enrollees were eligible to receive a \$30.00 Target gift card if they accepted a visit from MCH and had a postpartum visit with their provider within the prescribed 21-56 day postpartum timeframe. It was the intent of IMCare and Itasca County Public Health's MCH division, through A Healthy Pregnancy program, to facilitate positive behaviors conducive to a favorable pregnancy outcome by providing education that may preclude an enrollee's risk for preterm labor and delivery. In spring of 2017, IMCare opted to offer gift cards solely to those enrollees who had not previously participated in the program, although all enrollees continued to have access to the MCH program.

IMCare continued to work closely with the Maternal Child Public Health Nurses, providers and enrollees to reduce the number of adverse events during pregnancy and childbirth. In 2017, Itasca County Public Health MCH staff augmented their physical visits with telephonic communication for IMCare enrollees participating in A Healthy Pregnancy program, reinforcing education and support and increasing trust in Itasca County support systems. Additionally, Public Health staff offered alternate site or evening/weekend visits, if needed. All Itasca County Public Health prenatal referrals were reviewed to determine trends/barriers in provider referrals. Enrollees received a congratulatory letter, explaining A Healthy Pregnancy program. All IMCare enrollees were informed of A Healthy Pregnancy program and preterm labor risks through the enrollee newsletter.

IMCare has consistently had lower rates of C-section and Preterm Birth than the National Average, which is the intent of the Prenatal Focus Study. This is likely due to ongoing collaboration with Itasca County Public Health and network providers.

**Figure 13: 2015-2017 Prenatal Focus Study Outcomes**



## Special Health Care Needs

### Medicaid Special Health Care Needs

IMCare identified enrollees with special health care needs through regular analysis of claims, hospital admissions and utilization management information. Enrollees identified were referred to case management and disease management, if indicated. Prepaid Medical Assistance Program (PMAP) and MinnesotaCare (MNCare) populations were included in the Medicaid Special Health Care Needs Report.

IMCare analyzed claims data to identify enrollees aged 18-64 with an identified special health care need including:

- at least one inpatient stay with the primary diagnosis of asthma, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), dehydration, hypertension, pneumonia or urinary tract infection (UTI);
- at least one quarter with more than three Emergency Department (ED) visits;
- at least one hospital readmission within five days for same or similar diagnosis;
- enrollment in complex case management or the IMCare disease management program;
- use of home care services; and/or
- total claims exceeded \$100,000.

#### 2017 Interventions:

- Enrollee education regarding the IMCare Ways to Wellness disease management program, which offered health management services for enrollees with asthma, diabetes, hypertension and heart failure, was included in a member newsletter.
- Those enrolled in Complex Case Management and Disease Management had a comprehensive assessment and treatment plan to identify any ongoing special conditions.
- The IMCare QI/UM nurses completed all authorization requests, case management interventions and focus study interventions for their alpha split, to better assure continuity of care.
- IMCare staff reviewed daily admission information, when provided by area hospitals, to identify any needed referrals or follow-up.
- Pharmacy and medical claims costs were combined, to better report total cost of care. Information regarding how to make a case management referral was included in the Spring/Summer 2017 provider newsletter.

As a whole, admissions related to special health care needs decreased; however, in 2017, the number of enrollees with an inpatient stays related to the primary diagnosis of bacterial pneumonia increased. Although the number of cases reported were 12, the ICD-10 diagnosis codes for each of these cases was J18.9, which is "Pneumonia, unspecified organism." IMCare could not exclude bacterial pneumonia and, therefore, chose to report these cases. There were no inpatient admissions coded as J15-J15.9, which are the bacterial pneumonia diagnosis codes. Enrollment in disease management increased significantly in 2017, accounting for 532 of the 556 Complex Case Management/Disease Management cases. The increase in 2017 could be attributed to the diabetes disease management program being changed from opt-in to opt-out programming to allow for more intensive enrollee intervention. Total Claims Exceeding \$100,000 increased in 2017. In 2017, IMCare was required by DHS to change the Hepatitis C treatment criteria, which was partially, related to the identified increase. Of the identified total enrollees, four had a diagnosis of malignancy and two had psoriasis, requiring ongoing costly treatment.

**Figure 14: Number of Enrollees with the Specified Special Health Care Need**

Special Health Care Need	2015	2016	2017
At least one inpatient stay for Asthma	3	3	2
At least one inpatient stay for CHF	2	3	2
At least one inpatient stay for COPD	5	4	5
At least one inpatient stay for Dehydration	0	0	1
At least one inpatient stay for Hypertension	0	0	0
At least one inpatient stay for Bacterial Pneumonia	8	7	12
At least one inpatient stay for UTI	1	3	0
ED Visits*	80	68	230
Readmission within 5 days for same/similar dx	7	6	3
Complex Case Management/Disease Management	205	354	556
Home Care Services	42	44	37
Total Claims Exceeding \$100,000	25	10	14

\*ER Visit Identification Methodology changed from more than two visits in a quarter to more than four visits during the measurement year effective 07/01/2017.

### **Seniors (MSHO and MSC+) Special Health Care Needs**

Pursuant to 2017 IMCare Minnesota Senior Health Options (MSHO)/Minnesota Senior Care Plus (MSC+) contract with the Minnesota Department of Human Services (DHS), IMCare must:

- complete a comprehensive assessment or screening for all senior enrollees;
- identify ongoing special conditions which may require treatment or regular monitoring;
- develop and implement a care plan; and
- allow enrollees to directly access specialists, as appropriate for identified conditions and needs.

Social Workers or Public Health Certified Registered Nurses conducted all activities of care coordination and case management for IMCare seniors. From the time of initial assignment, the MN Choices Assessment or Long-Term Care Consultation (LTCC) screening was completed within ten business days for the Elderly Waiver (EW) population and within 30 days for the community well and nursing home populations. Annually, IMCare audited records for timeliness of screenings and reassessments.

#### **2017 Interventions:**

- Education regarding IMCare case management/care coordination services and the process for referral was included in an enrollee newsletter.
- Individual case management/care coordination was administered throughout 2017.
- The final 2017 Seniors (MSHO and MSC+) Special Health Care Needs report was reviewed/approved by the IMCare Provider Advisory Committee on 02/08/2017 and the IMCare External QI/UM Committee on 03/15/2017.

The 2017 Care Coordination Delegate Report was reviewed/approved by the IMCare Provider Advisory Subcommittee (PAC) on 11/08/17, the Stakeholder Advisory Committee (SAC) on 11/22/2017, and the IMCare External QI/UM Committee on 12/13/17. IMCare has an active program for the development, implementation, and assessment of every enrollee aged 65 years and older. IMCare care coordinator/case managers arranged for an initial face-to-face comprehensive health assessment of the enrollee's strengths, needs, choices and preferences in life domain areas, within 30 days of enrollment. An annual face-to-face assessment, or more frequently if directed by the enrollee's comprehensive care plan or a change in condition, was completed within 12 months of the previous health assessment. The MnCHOICES or LTCC assessment tool was used to complete the comprehensive health assessment. The tool assessed health status including condition specific issues, supports and services based on the enrollee's strengths, needs, choices and preferences in life domain areas, documentation of clinical health history and medications, activities of daily living (ADL) and instrumental activities of daily living (IADL), mental health status and cognitive functioning, life planning activities, evaluation of visual and hearing needs, preferences and limitations, evaluation of care giver resources and involvement, evaluation of cultural and linguistic needs, preferences or limitations, as well as the evaluation of available benefits and community resources.

IMCare also worked with this population during a transition. The transition program utilized the Eric A. Coleman conceptual model, "Four Pillars", thereby improving quality of care and the discharge planning process. When an enrollee experienced a transition in care, the enrollee's care coordinator/case manager contacted the enrollee and assessed whether they had a follow-up appointment scheduled, if they knew the signs/symptoms to report to the provider, their knowledge of their medications and how to take them, and if they had and/or utilized a personal health record. If the enrollee needed assistance in any of these areas, the care coordinator/case manager assisted them.

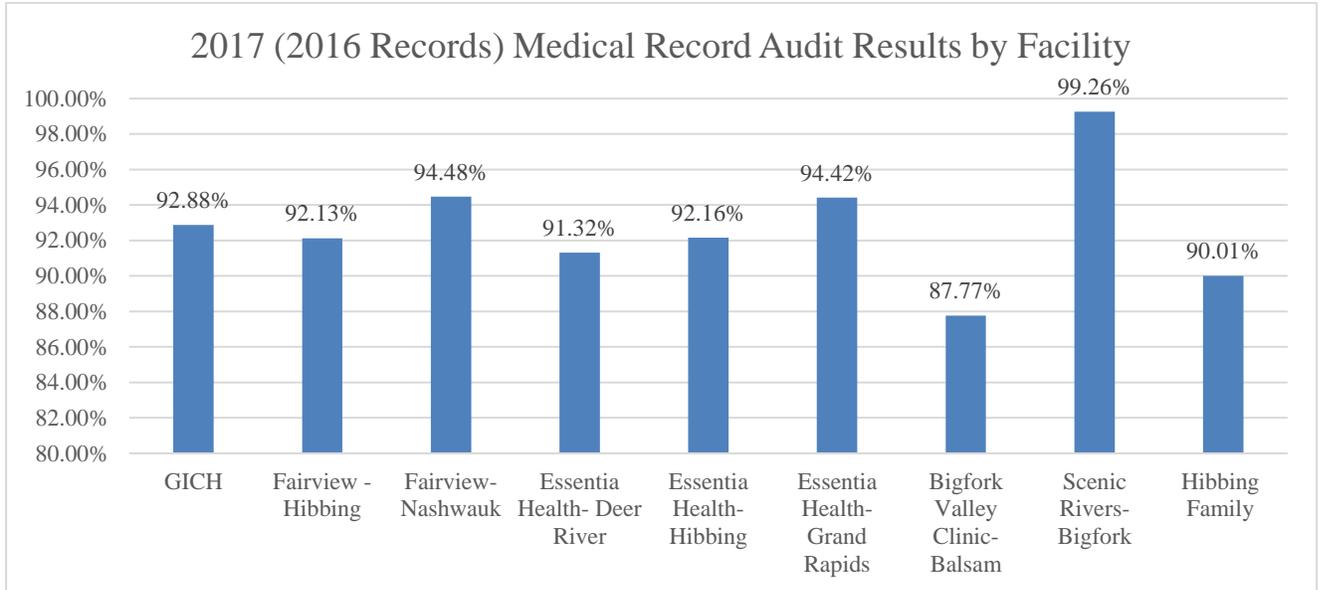
## **Record Audits**

### **Medical Record Audit**

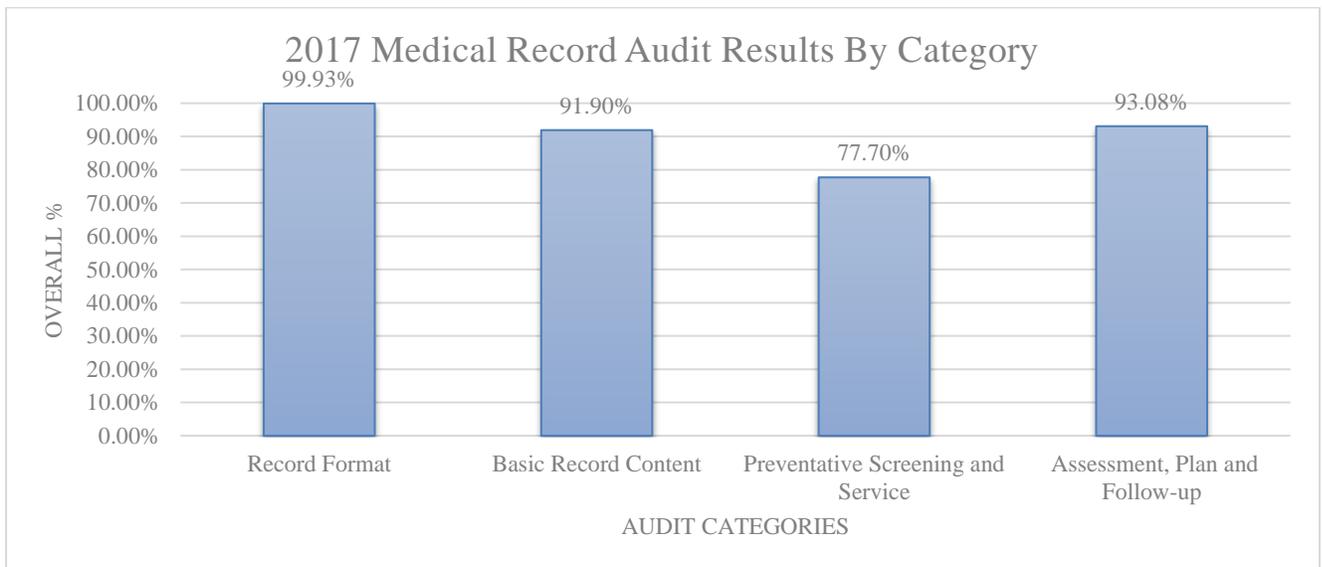
Itasca Medical Care (IMCare) audited enrollee medical records to determine if providers were compliant with regulatory requirements and National Committee for Quality Assurance (NCQA) standards. Additionally, IMCare ensured that medical records were maintained with timely, legible and accurate documentation of patient information per IMCare's medical record documentation standards. The medical record could be paper, electronic (EHR) or consist of both. In 2017, IMCare audited records of enrollees receiving health care during the previous year (2016) from one of the following primary care providers: Grand Itasca Clinic and Hospital, Essentia Health (Grand Rapids, Deer River and Hibbing), Fairview Clinic (Nashwauk and Hibbing), Hibbing Family Medical Center, Scenic Rivers Health Services, and Bigfork Valley Clinic. In 2017, IMCare reviewed the audit tool and provided training to the auditors prior to the audit. Additionally, IMCare included information about health care directives in both enrollee and provider newsletters.

IMCare audited a total of 245 medical records, with 30 records reviewed at each facility except Bigfork Valley Clinic-Balsam, which only had five records to review for 2016 visits. Measures were consistently high among all facilities in the Record Format, Record Content and Assessment Plan & Follow-up. Individual measures that did not meet the 80% goal and need improvement include Health Care Directives, Preventative Screening for enrollees 21 & over, and Assessment for Maltreatment and Abuse.

**Figure 15: 2017 (2016 Records) Medical Record Audit Results by Facility**



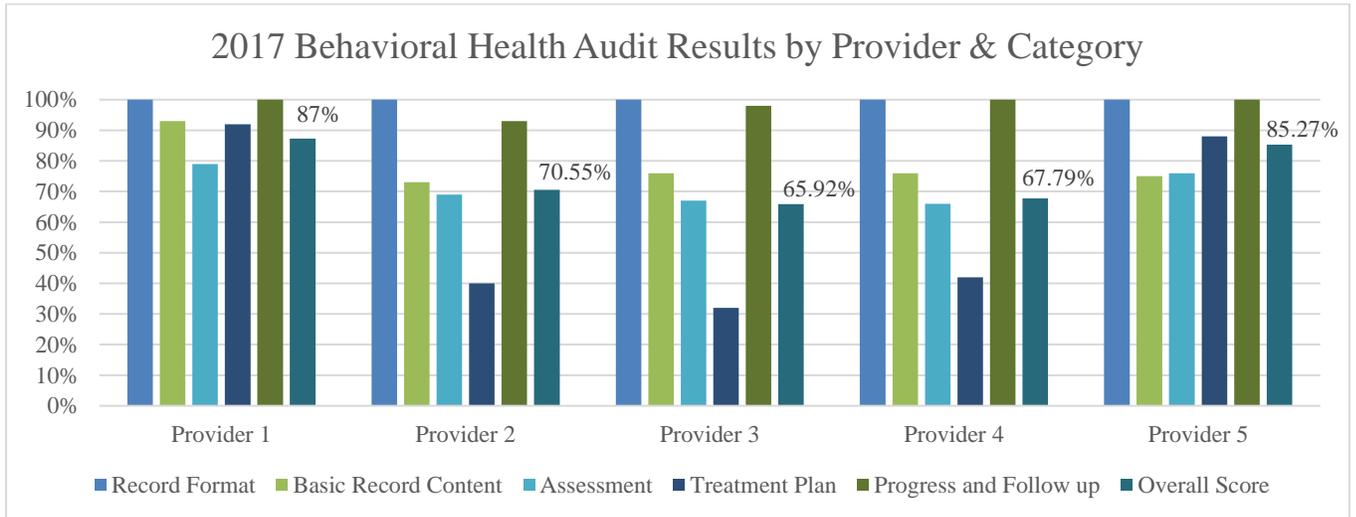
**Figure 16: 2017 Medical Record Audit Results by Category**



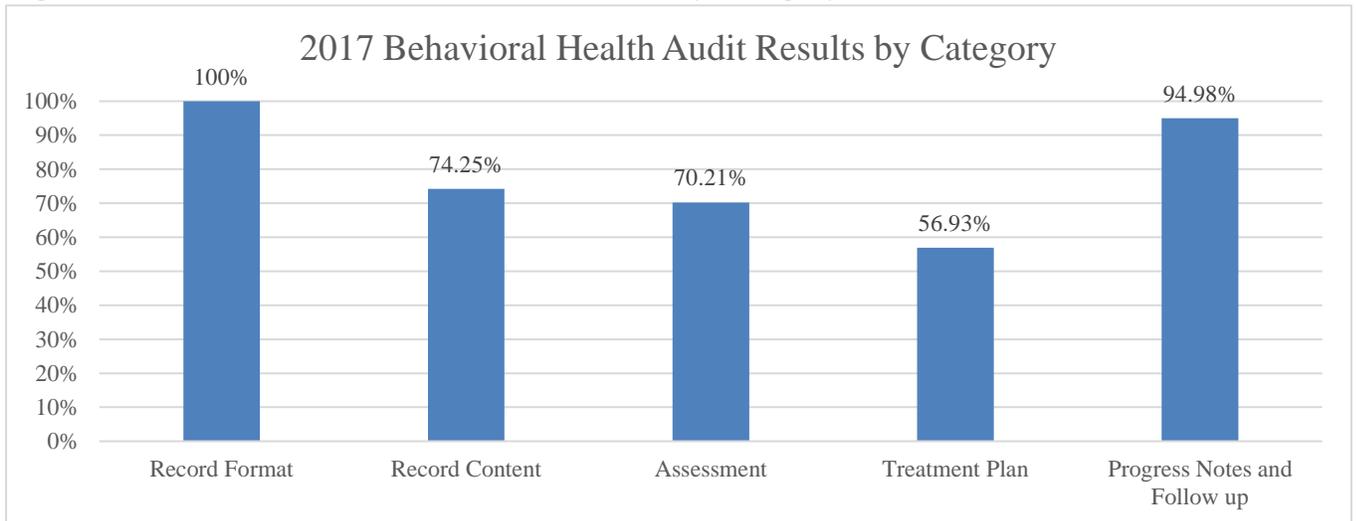
### Behavioral Health Treatment Record Audit

Itasca Medical Care (IMCare) audited enrollee behavioral health treatment records to determine documentation of important elements of behavioral health treatment, according to regulatory requirements and National Committee for Quality Assurance (NCQA) standards in the assessment and treatment plan, progress notes, and follow-up of IMCare enrollees. Additionally, IMCare assured that behavioral health treatment records were maintained with timely, legible and accurate documentation of patient information per IMCare’s behavioral health treatment record documentation standards. The treatment record could be paper, electronic (EHR) or consist of both. IMCare audited 140 behavioral health records in 2017. Two of the five providers audited met the 80% goal overall. Areas that were consistently above goal include Record Format and Progress Notes & Follow up. Areas needing improvement include Basic Record Content, Assessment and Treatment Plan.

**Figure 17: 2017 Behavioral Health Audit Results by Provider & Category**



**Figure 18: 2017 Behavioral Health Audit Results by Category**



## **Credentialing**

### **Timeliness of Credentialing Appointments**

Initial credentialing applications were tracked from date of receipt through date of approval to ensure established timeframes were met. Recredentialing applications were tracked by appointment expiration date, to ensure the recredentialing process was completed within the three-year timeframe. Timeliness of credentialing appointments was reported to the IMCare Provider Advisory Subcommittee (PAC) quarterly.

#### 2017 Interventions:

- Quarterly *Timeliness of Credentialing and Recredentialing* reports were reviewed/approved by the IMCare PAC throughout 2017 to assure compliance with the required timeframes.
- A draft of the *2017 Timeliness of Credentialing Appointments Report* was reviewed/approved by the IMCare PAC on 02/08/17. (Previously, the year included in the title of this report was reflective of the year the report was written, rather than the study period. This has been corrected to match the study period for this report.)
- The final *2017 Timeliness of Credentialing Appointments Report* was reviewed/approved by the IMCare External QI/UM Committee on 03/15/17.
- Initial appointment and reappointment credentialing/recredentialing checklists were updated throughout the year when indicated.
- In November of 2017, all IMCare credentialing policies and procedures were reviewed/updated.

In 2017, IMCare processed all initial credentialing and recredentialing applications within the required timeframes. No extensions to the timeframes were granted.

### **Organizational Provider Credentialing**

In 2017, organizational providers included hospitals, home health agencies (HHA), skilled nursing facilities (SNF), free-standing surgical centers, and behavioral health care facilities (inpatient, residential and ambulatory). IMCare credentialed organizational providers at the time of initial contracting and at least every three years thereafter to ensure that the provider was in good standing with federal/state regulatory bodies and had been reviewed/approved by an accrediting body. Site visits audits were completed at the time of initial credentialing; when an organizational provider relocated or opened an additional office; when a complaint was received about a provider site; when provider site issues were noted during a scheduled quality improvement visit by IMCare staff; and at least every three years thereafter (unless they were accredited/certified by an approved governing body, or were a hospital, HHA, free standing surgical center or SNF in a rural area as defined by the U.S. Census Bureau).

#### 2017 Interventions:

- A draft of the *2017 Facility Provider Credentialing Report* was reviewed by the IMCare Provider Advisory Subcommittee (PAC) on 02/08/17. It was suggested that the title be

changed to *Organizational Provider Credentialing Report* to better match NCQA language. (Previously, the year included in the title of this report was reflective of the year the report was written, rather than the study period. This has been corrected to match the study period for this report.)

- The final *2017 Organizational Provider Credentialing Report* was reviewed/approved by the IMCare External QI/UM Committee on 03/15/17.
- Quarterly credentialing reports, including organizational provider credentialing/recredentialing information, were reviewed/approved by the IMCare PAC throughout 2017.
- The *Organizational Provider Credentialing/Recredentialing Checklist* was updated throughout the year as needed.
- IMCare credentialing staff maintained the *Organizational Provider Recredentialing Log* throughout the year.
- In November of 2017, all IMCare credentialing policies and procedures were reviewed/updated.

Organizational provider credentialing is completed on a three-year cycle. The two organizational providers credentialed in 2017 met all required elements.

### **Site Visit Audit**

IMCare conducted site visits to ensure that individual practitioners and organizational providers met IMCare's office site standards, including the assessment of the quality, safety and accessibility of office sites where care is delivered. In 2017, organizational providers included hospitals, home health agencies, skilled nursing facilities, free-standing surgical centers, and behavioral health care facilities (inpatient, residential and ambulatory). Site visit audits were completed prior to the completion of the initial credentialing process; when an individual or organizational provider relocated or opened an additional office; when a complaint was received about a provider site; and when provider site issues were noted during a scheduled quality improvement visit by IMCare staff. In addition, a site visit was completed every three years for organizational providers, unless they were accredited/certified by an approved governing body, or were a hospital, home health agency, free standing surgical center or skilled nursing facility in a rural area (as defined by the U.S. Census Bureau).

### **2017 Interventions:**

- A draft of the *2017 Site Visit Audit Report* was reviewed/approved by the IMCare Provider Advisory Subcommittee (PAC) on 02/08/17. (Previously, the year included in the title of this report was reflective of the year the report was written, rather than the study period. This has been corrected to match the study period for this report.)
- The final *2017 Site Visit Audit Report* was reviewed/approved by the IMCare External QI/UM Committee on 03/15/17.
- Quarterly credentialing reports, including office site visit audit results, were reviewed/approved by the IMCare PAC throughout 2017.

- IMCare credentialing staff maintained the *Organizational Provider Recredentialing Log*, including accreditation/certification and office site visit information, throughout the year.

In November of 2017, all IMCare credentialing policies and procedures were reviewed/updated. All nine individual practitioner and four organizational provider office site visits completed in 2017 exceeded goal. Providers received a letter explaining their audit results and encouraging correction of any deficiencies, if applicable.

### **Credentials File Audit**

IMCare completes an annual audit of initial and reappointment credentialing files to ensure that the required elements were present at the time of the credentialing/recredentialing decision and applicable timeframes were met.

#### 2017 Interventions:

- A draft of the *2017 Credentials File Audit Report* was reviewed by the IMCare Provider Advisory Subcommittee (PAC) on 02/08/17. PAC suggestions were incorporated into the final report. (Previously, the year included in the title of this report was reflective of the year of the audit, rather than the study period. This has been corrected to match the study period for this report.)
- The final *2017 Credentials File Audit Report* was reviewed/approved by the IMCare External QI/UM Committee on 03/15/17.
- Initial appointment and reappointment credentialing/recredentialing checklists were updated throughout the year as needed.
- In November of 2017, all IMCare credentialing policies and procedures were reviewed/updated.

In November of 2017, the *Individual Practitioner Credentialing File Audit Tool* was updated to align with credentialing policy and procedure updates.

The IMCare Quality Director initially audited a random sample of ten individual practitioner credentialing files with initial credentialing (five) or recredentialing (five) completed in 2017.

The results were forwarded to the Medical Director for review, who reviewed and agreed with the findings. All but two of the measures met the 100% goal, IMCare modified the credentialing checklist to improve outcomes.

## **Provider Services Contracting**

### **Provider Participation Agreements/Contracted Partners**

IMCare contracts with individual practitioners and providers, including those making utilization management (UM) decisions. IMCare providers must cooperate with QI/UM Program activities, maintain confidentiality of enrollee information and records, and allow IMCare to use provider performance data. IMCare provider participation agreements also include compliance with applicable federal and state regulations, statutes, rules and laws, including reporting requirements. In 2017, IMCare prepared and distributed an addendum for current signed agreements, addressing the requirement of providers to report to IMCare, within five days, any

information regarding individuals or entities who have been excluded from participation in Medicaid.

In addition to the Medical Director, IMCare contracts with a primary care physician, pharmacist, dentist and behavioral health associate to provide administrative support to IMCare. These individuals attend all applicable committee meetings, and provide valuable input regarding IMCare QI and UM programs.

### **Affirmative Statement**

The IMCare Affirmative Statement is reviewed at least annually and disseminated to all providers and enrollees. In 2017, it was included in the Enrollee Handbook, enrollee newsletters, updated provider contracts, and the IMCare Provider Manual. It is also reviewed annually by IMCare staff.

### **Health Care Directives**

IMCare distributes health care directive information at least annually to enrollees and providers and it is reviewed annually by IMCare staff. The IMCare Health Care Directive Information notice was updated in July 2010. Health care directive information is included in provider contracts. The policy and procedure for health care directives is included in the IMCare Provider Manual.

The Health Care Directive Information notice is included in the Enrollee Handbook. To enhance enrollee education, IMCare has consistently included this information in enrollee newsletters. Health care directive information was included in the Spring/Summer 2017 and Fall/Winter 2017 Enrollee Newsletters. Additionally, Casetrakker includes health care directives so they can be documented by care coordinators.

### **Accessibility of Services**

IMCare ensures enrollee access to Primary Care Providers (PCP), Specialty Care Providers (SCP), Behavioral Health Care Providers and certain Ancillary Providers by identifying gaps in network adequacy through data analysis, as required by the National Committee for Quality Assurance (NCQA) and the Minnesota Department of Human Services (DHS). In 2017, IMCare identified potential gaps in the accessibility of primary care, specialty care, behavioral health care and ancillary service providers by analysis and comparison of network performance against accessibility standards., through the following interventions:

- An IMCare QI/UM nurse completed monthly calls to network providers in order to assess network accessibility of primary, specialty, behavioral, chiropractic, dental and optometry care. Calls were placed to the general appointment or reception line to ask if the provider could meet established timeframes.
- An IMCare QI/UM nurse called each network primary care clinic after business hours to ensure that an answering service or phone message instructed enrollees how to access

care. Primary care providers are contractually obligated to provide or arrange for services to enrollees 24 hours a day, 7 days a week, 365 days a year.

- Accessibility call logs were saved to the IMCare shared drive with password protection to maintain data validity.
- IMCare incorporated CAHPS results for “Getting Needed Care” and “Getting Care Quickly” into the analysis of accessibility of care.
- IMCare incorporated grievance data relating to accessibility categories based on an expression of dissatisfaction about any matter other than an action. Such actions included, but were not limited to, the quality of care or services provided, a failure to respect the enrollee’s rights, an oral or written request from an enrollee, a provider acting on behalf of an enrollee with the enrollee’s written request to IMCare for review of an action, or an enrollee’s written request for review of a grievance.
- IMCare ensured access to providers for minority and special needs populations by conducting cultural, ethnic, racial and linguistic needs assessments of all enrollees at enrollment (and additionally as needed) through Health Screening Surveys and Long-Term Care Consultations (LTCC). IMCare also received and reviewed a monthly list of enrollees identified as having potential cultural, ethnic, racial and linguistic needs from DHS. The IMCare Provider Care Network Listing (PCNL) included the languages spoken at each of the primary care clinics. American Indians were able to utilize tribal and Indian Health Services clinics, in addition to network providers, without prior authorization by IMCare.
- A reminder system was utilized to facilitate timely reporting of clinic grievances by providers. Each provider was emailed/faxed/mailed a copy of the report and a reminder one to two weeks prior to the deadline dates. A follow-up reminder was emailed/faxed/phoned if IMCare still had not received the form after the due date.
- The 2016 Access and Availability Report was reviewed/approved by the IMCare Provider Advisory Subcommittee (PAC) on 8/10/16 and the External Quality Improvement/Utilization Management (QI/UM) Committee on 12/14/16.
- The 2016 Consumer Assessment of Healthcare Providers and Systems (CAHPS) Report results were reviewed at the PAC meeting on 2/8/2017 and the External QI/UM Committee meeting on 3/15/2017.
- The 2016 Clinic Grievance Report was reviewed/approved by the PAC on 2/8/2017 and the External QI/UM Committee on 3/15/2017.
- The 2017 Credentials File Audit Report was reviewed/approved by the PAC on 2/8/2017.
- The 2017 Site Visit Audit Report was reviewed/approved by the PAC on 2/8/2017.

During the study period, IMCare met goal for all accessibility measurements and maintained an adequate care network as it relates to provider accessibility. In addition, multiple other avenues to care also were available to IMCare enrollees. For example, the Itasca County Crisis Response Team provided around-the-clock urgent/emergent behavioral health care to Itasca County residents. Network urgent care facilities and emergency departments also ensured accessibility of urgent/emergent care. In 2017, both CAHPS survey measurements applicable to provider accessibility exceeded goal for all populations. Analysis of enrollee grievances revealed no grievances related to cultural/ethnic/racial/linguistic enrollee needs or accessibility of IMCare providers during the study period.

## **Practitioner Availability and Network Adequacy**

In 2017, IMCare ensured the availability of practitioners and services by identifying gaps in network adequacy through data analysis, as required by National Committee for Quality Assurance (NCQA) and IMCare contracts with the Minnesota Department of Human Services (DHS). IMCare evaluated potential gaps in availability of primary care, specialty care, behavioral health care, ancillary service care, pharmacies, home health agencies, hospitals and skilled nursing facilities by analysis and comparison of network performance against standards for availability.

### 2016-2017 Interventions:

- IMCare ensured practitioner availability for minority and special needs populations by conducting cultural, ethnic, racial and linguistic needs assessments of all enrollees at enrollment (and additionally as needed) through Health Screening Surveys and Long-Term Care Consultations (LTCC). IMCare also received and reviewed a monthly list of enrollees identified as having potential cultural, ethnic, racial and linguistic needs from DHS. The IMCare Provider Care Network Listing (PCNL) included the languages spoken at each of the primary care clinics. American Indians were able to utilize tribal and Indian Health Services clinics, in addition to network providers, without prior authorization by IMCare.
- A reminder system was utilized to facilitate timely reporting by providers of clinic grievances. Each provider was emailed/faxed/mailed a copy of the report and a reminder one to two weeks prior to the deadline dates. A follow-up reminder was e-mailed/faxed/or phoned if IMCare still had not received the form after the due date.
- The 2016 Access and Availability Report was reviewed/approved by the IMCare Provider Advisory Subcommittee (PAC) on 8/10/16 and the External Quality Improvement/Utilization Management (QI/UM) Committee on 12/14/16.
- The 2016 Clinic Grievance Report was reviewed/approved by PAC on 2/8/2017 and the External QI Committee on 3/15/2017.
- The 2017 Credentials File Audit Report was reviewed/approved by PAC on 2/8/2017. During the study period, IMCare met goal for all primary care and most specialty care availability measures. Practitioner to enrollee ratios for orthopedics and oncology nearly met goal. In order to ensure specialty care availability, IMCare allows enrollees to see all network and outreach specialty practitioners in the IMCare service area. In addition, IMCare allows enrollees to see specialty care practitioners at the nearest out-of-network tertiary care center without a referral or prior authorization.

In 2017, IMCare met goal for nearly all behavioral health practitioner to enrollee ratios, but not geographic availability measures. All psychiatrists in the IMCare service area are IMCare network providers; however, there is a long-standing national and rural shortage of this practitioner type. IMCare allowed enrollees to see psychiatrists at the nearest out-of-network tertiary care center without a referral or prior authorization and participated in local recruitment efforts. During the study period, seven households in northwest Itasca County did not have access to a mental health provider within 30 miles. A recent increase in telemedicine mental health services has improved enrollee access to these services. IMCare network facilities

provided medical stabilization for enrollees requiring behavioral health and chemical dependency assessment/admission, when necessary. In addition, the Itasca County Crisis Response Team provided around-the-clock urgent/emergent behavioral health care to Itasca County residents.

Nearly all ancillary service practitioner/organizational provider measures met goal for the study period. There were eight households in northwest Itasca County that did not have access to a hospital within 30 minutes. The noted enrollee households must travel approximately 40 minutes to the nearest hospital. This group of enrollees account for less than one percent of the total IMCare enrollment. IMCare contracts with all hospitals within Itasca County and through analysis; it was identified that no hospitals in the surrounding counties would be closer to access for these households, due to the very rural area.

IMCare completed a quantitative and qualitative analysis, by product line, of enrollee DTRs, grievances and appeals data related to network adequacy and experience. During the study period, there were only six denials based on the out-of-network status of the practitioner/provider, when a network option was available. None were appealed. In addition, there were no enrollee grievances related to issues with practitioner availability or network adequacy. The current IMCare tracking system for authorizations does not allow for retroactive review by network status of the requesting provider, which would aid in determining the volume of enrollees utilizing out-of-network services. IMCare is currently in the process of transitioning to a new computer program platform that may have the capability for better tracking and analysis of in-network versus out-of-network services in the future.

## **Enrollee Experience**

### **Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey**

IMCare contracts with an external vendor to administer NCQA's Consumer Assessment of Healthcare and Provider Systems (CAHPS) survey to its enrollees. CAHPS is a nationally recognized and comprehensive survey instrument designed to capture the experiences of consumers and enrollees with a range of health care products and services such as customer service, access to care and claims processing. By providing consumers with standardized data and presenting it in a way that is easy to understand and use, CAHPS is intended to help people make decisions that support better health care and better health. Annual CAHPS reports are reviewed by the PAC and External QI/UM Committee in order to evaluate the findings for potential future interventions.

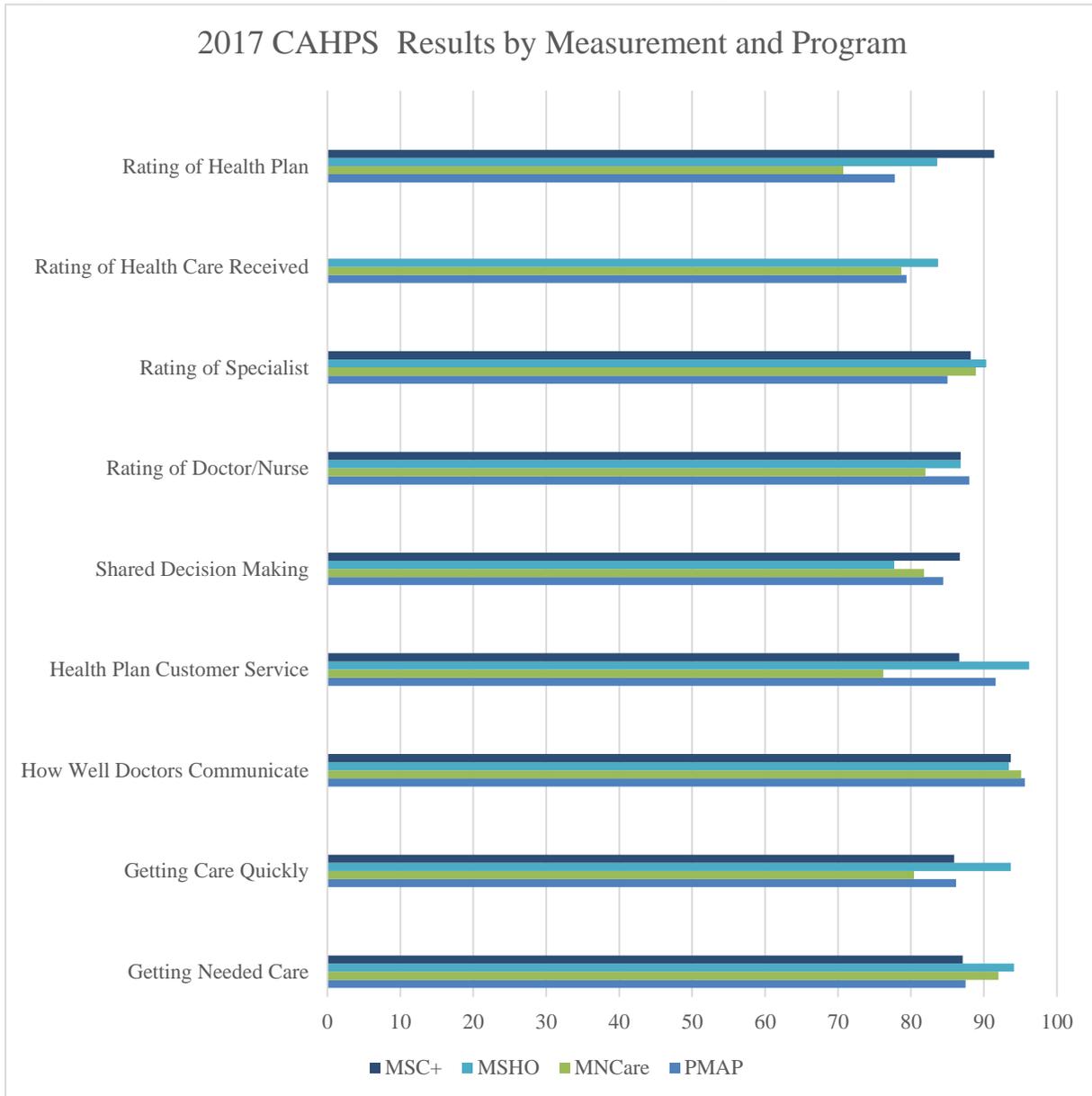
In 2017, enrollee satisfaction levels had small fluctuations, but remained overall stable. IMCare met its 80% goal in Rating of Doctor/Nurse and Rating of Specialist in all programs. IMCare continues to struggle with improving and meeting its 80% goal in Rating of Health Care and Rating of Health Plan for PMAP and MNCare. Of note, there was a small increase in Rating of Health Care in the MSC+ population. IMCare does not participate in the enrollment process for

any product groups. This is handled by the state for MNCare enrollees and the Itasca County Financial Workers for all other populations. There are known wait times and difficulty contacting those representatives, which may attribute to the decrease in Health Plan Satisfaction, as enrollees may have misconceptions regarding who they are contacting.

Composite scores have remained stable overall, each with less than 10% variability from year-to-year. IMCare maintained its 80% goal for Getting Needed Care, Getting Care Quickly, and How Well Doctors Communicate across all populations (PMAP, MNCare, MSC+, and MSHO).

IMCare maintained results above 80% for Shared Decision making for three of the four programs (PMAP, MNCare, & MSHO). Similarly, Health Plan Customer Service results were above goal for three of the four programs (PMAP, MSC+ and MSHO). Due to the small sample size for MSC+ and MNCare, the data is not statistically significant. Health Plan Customer Service was below goal for surveyed MNCare enrollees.

**Figure 19: 2017 CAHPS Results by Measurement and Program**



**MSHO Enrollee Satisfaction with Care Coordination Survey**

Itasca Medical Care (IMCare) surveys enrollees to assess their level of satisfaction with care coordination services. This includes coordinating services for enrollees across settings of care, including but not limited to needs assessment, service authorization, care communication, and risk assessment. An important element to the care coordination process is evaluating enrollee satisfaction with his or her care coordinator. This evaluation is a contract and NCQA requirement.

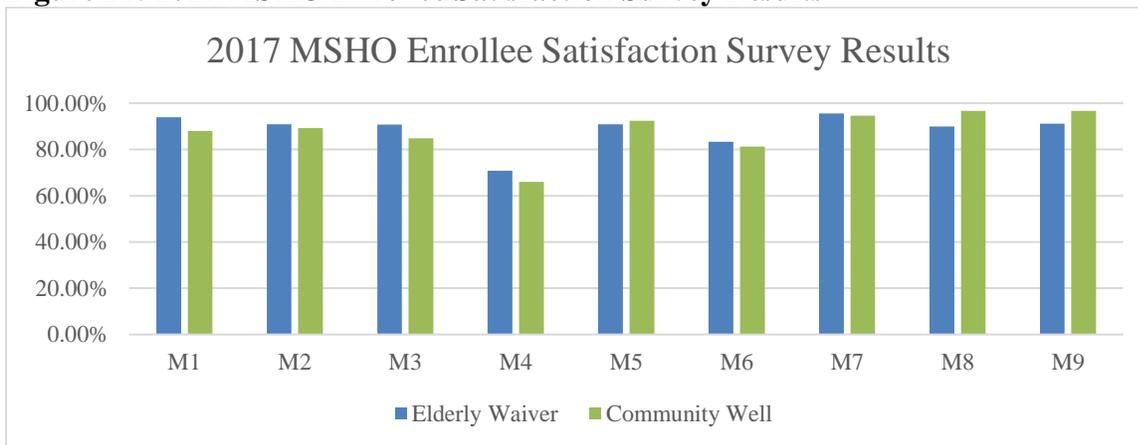
In 2017, IMCare updated the enrollee satisfaction survey to better assess enrollee experience with care coordination services. The returned surveys were separated by Elderly Waiver and IMCare care coordination, which allowed us to determine specific opportunities for improvement. In July of 2017, IMCare mailed the Care Coordinator Satisfaction Survey to 475 MSHO enrollees. Survey data was analyzed and compiled October 2017. One-hundred seventy two enrollees responded to the survey, for a response rate of 36.21%.

As a county-based purchasing plan, IMCare capitalizes on its arrangement with Itasca County Public Health, to deliver localized care coordination services. All care coordinators are either IMCare staff or public health staff. In 2017, care coordinators continued to exceed goal in overall enrollee satisfaction with their care coordinator. This is indicative of IMCare’s commitment to a strong focus on person-centered planning, as well as the wealth of experience our care coordinators bring to our enrollees. Care coordinators are also very knowledgeable of resources and services available within their immediate and surrounding communities. This commitment, experience and knowledge help IMCare ensure compliance with its mission of empowering, engaging enrollees in their health care goals and ensures the care coordination model is effective and efficient in its service delivery. Some of the survey areas in which the goals were not met were not necessarily low enough to warrant concerns over the quality of care or services being provided or indicate enrollee dissatisfaction.

**Figure 20: Enrollee Satisfaction Survey Measures**

<b>Enrollee Satisfaction Survey Measures</b>
<b>M1.</b> My Care Coordinator educated me about services and supports I can receive.
<b>M2.</b> My Care Coordinator was able to answer my questions about services and supports I can receive.
<b>M3.</b> My Care Coordinator gave me choices about services and supports I might need or benefit from.
<b>M4.</b> When I requested, my Care Coordinator made changes to the services I received.
<b>M5.</b> I was able to talk to my Care Coordinator when I had questions or concerns.
<b>M6.</b> My Care Coordinator returned my calls within two days.
<b>M7.</b> My Care Coordinator treated me with dignity and respect.
<b>M8.</b> How would you rate your overall satisfaction with your Care Coordinator?
<b>M9.</b> How would you rate your overall satisfaction with the services you received from your providers?

**Figure 21: 2017 MSHO Enrollee Satisfaction Survey Results**



### **Enrollee Education Sessions**

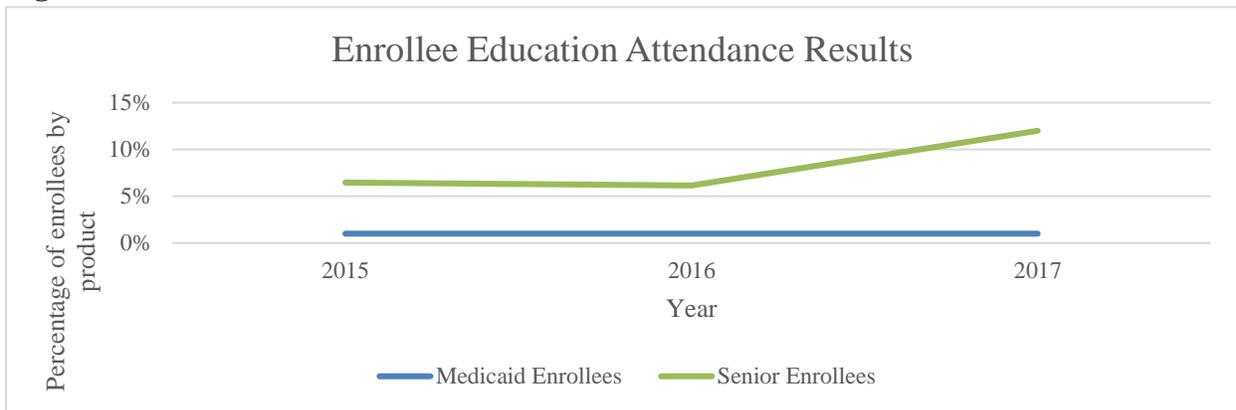
IMCare provides monthly enrollee education. Enrollees new to IMCare are notified in writing of the monthly education sessions when they receive their new IMCare medical cards.. The purpose of the education is for enrollees to understand how to use their IMCare medical card, review of the Enrollee Handbook and learn how to obtain medical care.

#### **2017 Interventions:**

- Written notification of monthly enrollee education was sent to individuals who were newly enrolled during 2017.
- Information regarding enrollee education was included in the biannual provider newsletters.
- Information regarding monthly education was included in the biannual enrollee newsletters which were sent to all enrollees.
- Information regarding enrollee education was available on the IMCare website.

Historically, IMCare has had a low number of enrollees attending the monthly educational sessions. IMCare did appreciate a spike in the number of senior enrollees in attendance in 2017. Although the enrollee attendance at educational sessions continues to be very low, IMCare does provide informal enrollee education through phone calls received by enrollee services and through the quality and utilization management department.

**Figure 22: Enrollee Education Attendance Results**



### **Customer Service Call Center Performance**

IMCare must ensure that providers, enrollees, and staff members are able to reach the IMCare Customer Service Representatives (CSRs) according to regulatory and accreditation standards. IMCare must maintain low abandonment rates for customer services lines. CMS requires a disconnect rate of 5% or less. IMCare uses the CMS benchmark for internal monitoring.

2017 Interventions:

- The IMCare Quality Director was given access to Prairie Fyre (automatic call distribution system) so that regular, routine monitoring could be performed to identify any issues. Early intervention and problem resolution was beneficial to improving call abandonment rates.
- IMCare required at least one CSR to be available during regular business hours, with the exception of all-staff or CSR meetings, at which time calls were answered by alternative staff or First Call for Help (FCFH).

Additional IMCare staff were cross-trained on addressing calls to allow for additional coverage during high volume periods.

IMCare's internal rate of abandonment is 1%, below the CMS benchmark. IMCare's disconnect rate for Part C and Part D Beneficiary Customer Services Center calls (IMCare) and Pharmacy Customer Services Center (CVS Caremark) calls also met goal, below the 5% benchmark; however, the Prospective Beneficiary Customer Services Center (IMCare) Calls for both Part C and for Part D were above the 5% benchmark and did not meet goal. These calls consisted of Limited English Proficiency (LEP) calls or TTY/TTD services. The majority of abandoned calls were LEP calls and occurred after IMCare business hours. The Limited English Proficiency (LEP) calls were connected to a Language Line for a three-way call to answer foreign language calls. Prospective and current beneficiaries were directed to Minnesota Relay for TTY/TTD services.

## **Case Management/Care Coordination**

### **Complex Case Management**

The IMCare Complex Case Management (CCM) program identifies enrollees with complex healthcare needs based upon their chronic condition, potential disability, health care activity or any other identified need for case management. The goal of complex case management is to assist enrollees regain optimum health and/or improved functional capacity, educate enrollees regarding their condition, educate enrollees about self-management and preventative care, reinforce the primary care physician (PCP) prescribed treatment plan and provide information on resources that are available to the enrollees. IMCare assists enrollees with multiple or complex conditions to obtain access to care and services, and coordinate their care.

Conditions include, but are not limited to, the following:

- Cancer
- Chemical Dependency
- Hepatitis C
- Mental Health
- Pain
- Restricted Recipient
- Serious medical condition
- State Medical Review Team (SMRT) allowable conditions

IMCare utilizes two distinct processes to identify enrollees for enrollment in CCM that include both administrative/electronic data and/or referral sources. Administrative data reports are reviewed at least monthly and referrals sources are reviewed as received.

Electronic identification sources include:

- Claims Data
- Pharmacy Data
- Stop Loss Report
- Hospital Discharge Data
- Social Security Compassionate Allowance conditions Report
- Restricted Recipient Report
- Health Screening Surveys

Referral identification sources include:

- Provider Referrals
- Disease Management Program Referrals
- Discharge Planner (Inpatient Case Manager) Referrals
- Enrollee Service Referrals
- Enrollee Self-Referrals

The case management program involves a comprehensive initial assessment of the enrollee's condition, determination of available benefits and resources, development and implementation of a care plan and coordination of services. After an enrollee has been identified for CCM, a registered nurse (RN) will contact the enrollee to offer case management services and offer an initial assessment and develop a plan of care as indicated. The RN case manager works closely with the enrollee, the enrollee's legal representative, the enrollee's PCP and other providers identified by the enrollee's treatment team to coordinate care and access to needed services. The CCM program is an included benefit to the enrollee. Restricted Recipients are automatically enrolled into the CCM program. Non-restricted enrollees meeting criteria can voluntarily enroll with verbal and/or written consent. The program is most successful with participation of the enrollee's family, caregivers and other natural support systems as identified by the enrollee.

The CCM program utilizes a standardized case management process for all of its assigned enrollees and consists of several key areas including, but not limited to:

- Comprehensive initial assessment and/or re-assessment of enrollees health
- Development of an individualized care plan
- Facilitation of enrollees referrals to resources
- Follow-up and communication with enrollees
- Self-management plans
- Assessment of progress against case management plans for enrollees

Case managers provide ongoing case management for as long as the enrollee has identified needs and are willing to receive support and services from the program. Case managers maintain scheduled contact, with the frequency based on varying enrollee need. Generally, case managers provide the following to all enrollees enrolled in the program:

- Support enrollee's adherence to care plans to improve complexities
- Advocate to ensure appropriate services and resources are received
- Education and promotion of self-management in order to empower enrollees to take more active role in their care
- Coordinated and seamless integration of complex services and/or special needs
- Appropriate and timely communication with enrollees, PCPs and other identified team members
- Systematic approach to assessing, planning and provision of case management services to improve health outcomes
- Referral to appropriate medical, behavioral, social, chemical dependency services, specialists and community resources to address enrollee needs

Case management for MSC+ enrollees is the assignment of an individual who assesses the need for services and coordinates Medicaid health and long-term services for an MSC+ enrollee receiving Elderly Waiver (EW) Services and Medicare services among different health and social service professionals and across settings of care. IMCare provides for case management

for community non-EW MSC+ enrollees, community EW MSC+ enrollees, and MSC+ nursing facility residents.

Case Management for community non-EW MSC+ enrollees includes:

- Risk screening and assessment that addresses medical, social, environmental, and mental health factors
- Encouraging enrollees to establish a relationship with a Primary Care Physician (PCP) or clinic
- Establishing a communication system of significant health events (i.e., emergency room use, inpatient stays) between primary care and IMCare/Public Health

Case Management for community EW MSC+ enrollees includes:

- Risk screening and assessment that addresses medical, social, environmental, and mental health factors
- Case management requirements of the Home and Community Based Services (HCBS) waiver
- Assignment of a case manager to assist with coordination of EW services, state plan home care services and other informal or formal services
- Development of a care plan that incorporates an interdisciplinary, holistic and preventive focus and includes advance directive planning and enrollee/family participation
- Protocol to assure a regular schedule of case management contacts with each EW enrollee based on health, and long term care needs
- Annual face-to-face reassessments
- Communication of the care plan to the PCP
- Communication of significant health events including, emergency room use, hospital and nursing facility admissions between primary care and EW case managers
- Procedures for promoting rehabilitation of enrollees following acute events and for ensuring smooth transitions and coordination of information and services between acute, subacute, rehabilitation and nursing facilities and HCBS settings
- Facilitation of consumer and family involvement in care planning and preservation of consumer choices
- Provision of care giver supports and facilitation of care giver respite to assist enrollees with remaining at home
- Facilitation and coordination of informal supports and addresses preservation of community relationships
- Provision of care giver supports and facilitations of care giver respite to assist enrollee in remaining at home
- Facilitation and coordination with informal supports and preservation of community relationships
- Provision that consumer directed options such as PCA Choice and consumer directed consumer supports waiver services are offered and facilitated at the consumer's choice
- Care plans that identify, address and accommodate the specific cultural and linguistic needs of MSC+ enrollees

- Designation of a case manager who has lead responsibility for creating and implementing the care plan
- Evaluation of the performance of individual case managers including enrollee input

Case Management for MSC+ nursing facility residents includes:

- Assistance with transition during placement of enrollees in nursing facilities and with discharges back to the community
- Periodic review to determine whether discharge to the community is feasible
- Relocation Targeted Case Management services for any nursing facility enrollee who is planning to return to the community and who requires support services to do so

### **Care Coordination**

Care coordination is required for MSHO enrollees. Care coordination ensures access and integrates the delivery of all Medicare and Medicaid preventive, primary, acute, post-acute, rehabilitation, and long term care services, including State Plan Home Care Services and Elderly Waiver Services. Care coordination ensures communication and coordination of an enrollee's care across the Medicare and Medicaid network provider types and settings, to ensure smooth transitions for enrollees who move among various settings in which care may be provided over time, to strive to facilitate and maximize the level of enrollee self-determination and enrollee choice of services, providers and living arrangements. It also promotes and assures services accessibility, attention to individual needs, continuity of care, comprehensive and coordinated service delivery, culturally-appropriate care and fiscal and professional accountability. Each enrollee is provided a primary contact person who assists them in simplifying access to services and information. Care coordination includes:

- A comprehensive assessment that addresses medical, social and environmental and mental health factors, including the physical, psychosocial, and functional needs of the enrollee
- Comprehensive care plan development that incorporates an interdisciplinary/holistic and preventive focus and includes advance directive planning and enrollee participation
- Care plan implementation based on the needs assessment, the establishment of goals and objectives, the monitoring of outcomes through regular follow-up, and a process to ensure that care plans are revised as necessary
- Care plan evaluation that supports a proactive, preventive approach including an annual (or upon change of condition) comprehensive reassessment and risk assessment
- Establishment of care coordination caseload ratios
- Evaluation of care coordinator performance, including enrollee input

Other care coordination/case management requirements for MSHO include:

- Rehabilitative services following acute events, and for ensuring smooth transitions and coordination of information between acute, subacute, rehabilitation, nursing facilities, and Home and Community Based Services settings

- Ensuring access to an adequate range of EW and nursing facility services and for providing appropriate choices among nursing facilities and/or EW services to meet the individual needs of enrollees who are found to require a nursing facility level of care
- Coordinating the medical needs of a enrollee with his/her social service needs including coordination with social service staff and other community resources such as Area Agencies on Aging
- Notification to enrollees of their care coordinator/case manager
- Coordination with Veterans Administration
- Referrals to specialists
- Coordination with other care management and risk assessment functions conducted by appropriate professionals to identify special needs such as common geriatric medical conditions, functional problems, difficulty living independently, polypharmacy problems, health and long term care risks due to lack of social supports, mental and/or chemical dependency problems, mental retardation, high risk health conditions, and language or comprehension barriers
- Provision of Relocation Targeted Case Management services for any nursing facility resident enrollees who are planning to return to the community and who require support services to do so

Annually, IMCare completes a care plan audit for both internal care coordinators and Itasca County Public Health case managers to ensure quality standards are met and opportunities for improvement are identified and issues corrective action plans, if warranted. This facilitates an interdisciplinary, holistic and preventive approach to determine and meet the health care and supportive services needs of enrollees. IMCare randomly samples 60 cases of eligible EW and 60 cases of eligible community well, MSHO and MSC+ care plans that were 30 due for initial assessment and 30 due for reassessment during the measurement year, of which eight are randomly selected for review. If any of the eight records produce a “not met” score for any of the outcomes in the Audit Protocol/Data Collection Guide, then the remaining 22 files are examined for the outcome(s) resulting in the “not met” findings. Because some elements pertaining to assessment apply to new enrollees, new enrollees are defined as enrollees within the last 12 months and others to existing cases, existing cases are defined as enrollees for more than 12 months. IMCare ensures that there is an adequate number of cases to evaluate compliance per these elements. Itasca County Public Health EW Care plans met 100% of all elements within the audit; therefore no corrective action plan was required. Internal IMCare non-EW care plans were noted to be less than the 95% mark in four areas: Choice of HCBS, Appeal rights, Service Plan, and Data Privacy; a corrective action plan was implemented.

### **Disease Management**

IMCare identifies enrollees with the chronic conditions of asthma, diabetes, heart failure, and hypertension, and provides those enrollees with an opportunity for education, support and self-management. Disease management does not take the place of existing medical providers or educators, but supports the plan of care and the enrollee. IMCare’s disease management program, ‘Ways to Wellness’, was developed based on NCQA guidelines. Many of the annual

IMCare disease management program outcome measurements are HEDIS measures, resulting in a data lag. In 2017, IMCare analyzed interventions and outcome measurements for 2016.

#### 2016 Interventions:

- Enrollees received verbal and written flu vaccine reminders individually and with their quarterly mailings
- Referrals made to health care providers, complex case management and public health when appropriate
- Inclusion of Ways to Wellness information related to diabetic eye exams in enrollee newsletters
- Education on disease states and action plans
- Enrollees informed of local community resources through telephone contact with disease management and care coordinators
- Enrollee newsletter with Ways to Wellness information
- Provider newsletter with Ways to Wellness information
- Disease management program surveys were mailed to all enrolled in disease management
- Provider update sent to individual provider locations indicating the numbers of enrollees served for each disease state
- Utilization of an electronic disease management mailing system
- Review of educational materials to ensure the mailings follow the ICSI guidelines for education and self-management recommendations
- Additional educational materials added to each disease program following ICSI guidelines for education and self-management recommendations

In 2016, the IMCare Ways to Wellness program served 336 enrollees with the chronic conditions of asthma, diabetes, heart failure and/or hypertension. Some of these enrollees may have had one or more of the listed chronic conditions. These enrollees received quarterly educational mailings and/or nurse phone calls. Enrollment was higher in 2016 than in previous years. Asthma, diabetes and hypertension participation rates increased; however, there was a slight decrease in the heart failure participation rate. Both the total number of enrollees participating in the heart failure program and the total number of IMCare enrollees with a heart failure diagnosis decreased in 2016. Asthma enrollees with persistent asthma who remained on an asthma controller medication for at least 75% of their treatment period increased in 2016, but remained slightly below the state average. All other asthma measurements exceeded goal. The decline in heart failure participation and asthma medication adherence rates could, at least partially, be attributed to the relatively low denominator. IMCare exceeded each of the established measurement goals for the heart failure and hypertension programs. IMCare did not meet the established goals for diabetes in three of four stated measurements, with retinal eye exams being the measurement with the greatest deficit. Overall, enrollees participating the Ways to Wellness program who responded to the satisfaction survey were satisfied with the program. Each component of the survey exceeded goal. All noted comments on the survey were positive and

reflected satisfaction with the services. IMCare network provider satisfaction with the program also exceeded goal in 2016.

### **Practice Guidelines**

Annually, IMCare is required to adopt, disseminate and apply practice guidelines consistent with current NCQA *Standards and Guidelines for the Accreditation of Health Plans*. The NCQA guideline requires IMCare to adopt and disseminate evidence-based clinical practice guidelines for at least two medical conditions, at least two behavioral health conditions, perinatal care and preventive health for all ages. Two of the organization's adopted clinical practice guidelines must provide the clinical basis for disease management (DM) programs. In addition, IMCare must measure performance related to the practice guidelines annually. Most practice guideline outcome measurements are HEDIS measures, resulting in a data lag. In 2017, IMCare analyzed interventions and outcome measurements for 2016. In addition, updated practice guidelines were adopted and disseminated at the beginning of 2017.

#### 2016 Interventions:

- 2016 Practice Guidelines were reviewed and adopted by the Provider Advisory Subcommittee (PAC) on 02/10/2016.
- 2016 Practice Guidelines were reviewed and adopted by the External QI/UM Committee on 03/16/2016.
- Enrollees participating in the disease management program received calls and/or educational materials regarding their chronic condition/s.
- 2016 Practice Guidelines were disseminated to network providers in the Spring 2016 Provider Newsletter.

In 2016, IMCare met all goals for enrollee blood pressure control and antihypertensive medication adherence and nearly all goals related to the management of diabetes. IMCare demonstrated improvement in HbA1c screening rates in enrollees with diabetes in the MNCare and MSHO populations while showing a reduction in the PMAP population. There was a significant increase in HbA1c control (defined as less than 8%) for the MNCare and MSHO populations. Diabetes mellitus and hypertension are part of IMCare's Ways to Wellness disease management program, which focuses on adequate control and management of individual enrollee's blood sugars and HbA1c levels and adequate control and management of individual enrollee's blood pressure through diet, medication adherence and healthy life choices.

In 2016, IMCare antidepressant medication management rates were above goal for all populations for the 12-week measure. In 2016, IMCare had active performance/quality improvement projects aimed at the goal of improving the HEDIS AMM 6-month rate for the study population. The marked improvement in rates can at least partially be related to the global interventions for these projects.

In 2016, IMCare rates for ambulatory/preventative care visits showed improvement for both the PMAP and MNCare populations. The MSHO rate was only slightly below goal for the population and did not change significantly from 2015 to 2016. The percentage of enrollees 18-74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year were stable compared to 2015. The goal for PMAP and MNCare were above goal but below goal for the MSHO population.

In 2016, IMCare cancer screening rates varied among populations. Breast cancer screening rates were below goal for the PMAP and MNCare populations, with a noted decrease for each, while the MSHO goal was met. MSHO colorectal cancer screening was below the MN State average but did show a slight improvement from 2015. Cervical cancer screening rates were comparable to MN State averages for both PMAP and MNCare. These results may be at least partially related to relatively small denominators. IMCare continues to encourage enrollees and providers to complete recommended cancer and preventative screenings through enrollee and provider newsletters. The newsletter articles focus on the importance of periodic screenings, ages at which these screenings are recommended and enrollment/provider talking points surrounding each of the screenings.

### **Continuity and Coordination of Care**

IMCare assesses and ensures that proper notification of transitions is received and proper follow-up care is given to Minnesota Senior Health Options (MSHO) enrollees. IMCare analyzes transition data annually. Monitoring and managing care transitions decreases, reduces and eliminates unsafe and fragmented care which may occur with poorly coordinated transitions of care. Care coordination activities are documented and tracked in CaseTrakker Dynamo (CTD), including transitions. Entering real time information in CTD allows IMCare to minimize unplanned transitions and work to maintain enrollees in the least restrictive setting of care. Standards and goals related to transitions have been set. The data is measured in comparison to the goals and standards and opportunities for improvement are identified.

In 2017, the care coordination team did outreach to some network providers to promote more timely transition notification and involvement in the interdisciplinary care team at the time of discharge. Furthermore, IMCare worked closely with Itasca County Public Health to discuss and identify areas of the transition process that may benefit from process improvement.

For the 2017 reporting period, the total number of transitions decreased by 21.64%. It is not clear why the number of transitions decreased significantly. IMCare and its delegate consistently notified the enrollee or the responsible party of the care coordinator to provide support during transition process. All other measures were below the 95% goal, IMCare will continue to

collaborate with Itasca County Public Health and network providers to improve these outcome measures.

## **Delegation**

Annually, IMCare performs certain oversight functions on vendors who have a contractual responsibility to carry out tasks on behalf of IMCare. IMCare contracts with three vendors to carry out various responsibilities which are outlined in the Caremark Prescription Benefit Service Agreement, the Delegation Agreement and the Addendum Part D Services for CVS Caremark; the Third Party Agreement (TPA) *State of Minnesota Memorandum of Agreement between the Minnesota Department of Human Services and Itasca Medical Care*; and, the Provider Participation Agreement between Itasca Medical Care and Itasca County Public Health. IMCare's examination of delegates is based on three separate standards: NCQA Delegation Oversight Activities, Minnesota Department of Human Services (DHS) contract requirements, and the delegation agreement with the vendor.

### **CVS Caremark Delegation Agreement**

IMCare evaluates CVS Caremark's performance against the delegation agreement with IMCare. This agreement sets forth the duties and responsibilities of both parties.

The Delegation Report indicates the overall services IMCare is requiring CVS Caremark to provide on its behalf. These services include but are not limited to:

- Establishing a pharmacy network,
- Retail network auditing,
- Providing a pharmacy help desk
- Maintaining enrollee eligibility
- Maintaining point-of-sale claims processing as well as processing paper claims
- Formulary management
- Medication management
- Patient safety quality management
- Specialty pharmacy
- Orchestrating rebate arrangements

Caremark maintains a nationwide network and IMCare received zero enrollee complaints in 2017 regarding pharmacy access. IMCare exceeds CMS expectations regarding retail pharmacy adequacy. The point-of-sale process adjudicates claims quickly and accurately. IMCare relies completely on the Part D formulary developed by CVS Caremark, as well as, the preparation of reports to CMS. CVS Caremark was timely in 2017 for all HPMS reporting requirements. In addition, CVS Caremark provided additional reporting in 2017, in the Medicare Part D Operational Performance Monitoring Tool, which satisfied many oversight requirements. This monthly report details numerous metrics which provides an executive summary of many areas of overall monitoring: TrOOP and Drug Spend Accumulations, Adjudication Accuracy, Phone Time Responsiveness, appropriate Cover Gap Discount applications, etc.

To the best of our knowledge, CVS Caremark has kept all protected health information (PHI) and confidential information in a safe and protected environment. IMCare is not aware of any inappropriate disclosures of PHI.

CVS Caremark has provided numerous evidences of compliance education to both staff and pharmacies. The following reports were provided to IMCare in 2017:

- Med D Compliance Training Annual Attestation
- Compliance Matters Newsletter
- CVS Caremark (Health) Code of Conduct Manual
- Annual FWA Training for Pharmacy Colleagues
- Medicare Part C & D FWA and General Compliance Training

Overall, CVS Caremark is meeting the NCQA standards regarding their delegated responsibilities.

#### **Minnesota Department of Human Services (DHS) Memorandum of Agreement**

MSHO is a program for dual-eligible enrollees, who must be eligible for Medicare and Medicaid to voluntarily enroll in MSHO. Due to the need to be eligible for both programs, IMCare contracts with DHS to enroll individuals through CMS and the state eligibility program. DHS is responsible for performing all enrollment functions, including required notices, and submitting a file to IMCare for systems upload. IMCare performs monthly random audits on DHS enrollment files to ensure that all CMS requirements are met and documented as needed. Overall, DHS is meeting the CMS standards regarding their delegated responsibilities.

#### **Itasca County Public Health Provider Participation Agreement**

IMCare contracts with Itasca County Public Health, as their one and only delegate to provide care coordination and case management services to enrollees over the age of 65 utilizing EW services. IMCare monitors the timeliness and comprehensiveness of enrollee care plans, MN Choices assessments and Long-Term Care Consultations (LTCC) to facilitate an interdisciplinary, holistic, and preventive approach to determine and meet the health care and supportive services needs of enrollees. IMCare audits a random sample of care plans, using the DHS care plan audit protocol. Overall, Itasca County Public Health is meeting the requirements of care coordination for EW enrollees.

## **2017 Utilization Management Program Activities**

### **Clinical Criteria for UM Decisions**

IMCare establishes criteria used to make UM decisions annually. The IMCare Medical Director reviews the criteria used in previous years to determine the effectiveness of continued use. Other available sources are also reviewed. The Medical Director makes a recommendation to the PAC based on research and findings for clinical criteria use in the current year. The PAC is responsible for adopting the clinical criteria. Once adopted, the criteria is distributed to providers via provider upand provider newsletter. The criteria is also linked to the provider area of the IMCare website.

In 2017, IMCare utilized the following policies and guidelines when making UM authorization decisions:

- Centers for Medicare and Medicaid Services (CMS)
- Clinical Practice Guidelines (e.g., UpToDate, Institute for Clinical Systems Improvement (ICSI), National Guideline Clearinghouse (NGC))
- Community Standards
- Drug Coverage Criteria (e.g., CVS/Caremark)
- IMCare Medical, Behavioral, and Pharmacy Policies and Procedures
- Internet Evidence-Based Literature Search (e.g., PubMed)
- InterQual
- Minnesota Department of Human Services (DHS)

Annually, IMCare assesses the consistency in applying these criteria/policies for physician and non-physician reviewers through the interrater reliability review process.

### **Under and Over Utilization**

#### **Medicaid Under and Over Utilization**

Ensuring appropriate utilization of services is required as per Article 7.1.3 of the 2017 DHS Families and Children contract. “The MCO shall adopt a utilization management structure consistent with state and federal regulations and current NCQA “Standards and Guidelines or the Accreditation of Health Plans.”” Pursuant to 42 CFR § 330(b)(3), this structure must include an effective mechanism and written description to detect both under and over utilization of services. HEDIS measures are used to evaluate potential under and over utilization of services. In 2017, 2016 interventions and outcome measures were analyzed.

2016 Interventions:

- Emergency Department (ED) Focus Study interventions, including IMCare QI/UM Nurse and Senior Care Coordinator interventions, were aimed at reducing ED over-utilization.
- Enrollee education regarding appropriate use of the ED was included in the Spring/Summer 2016 enrollee newsletter.

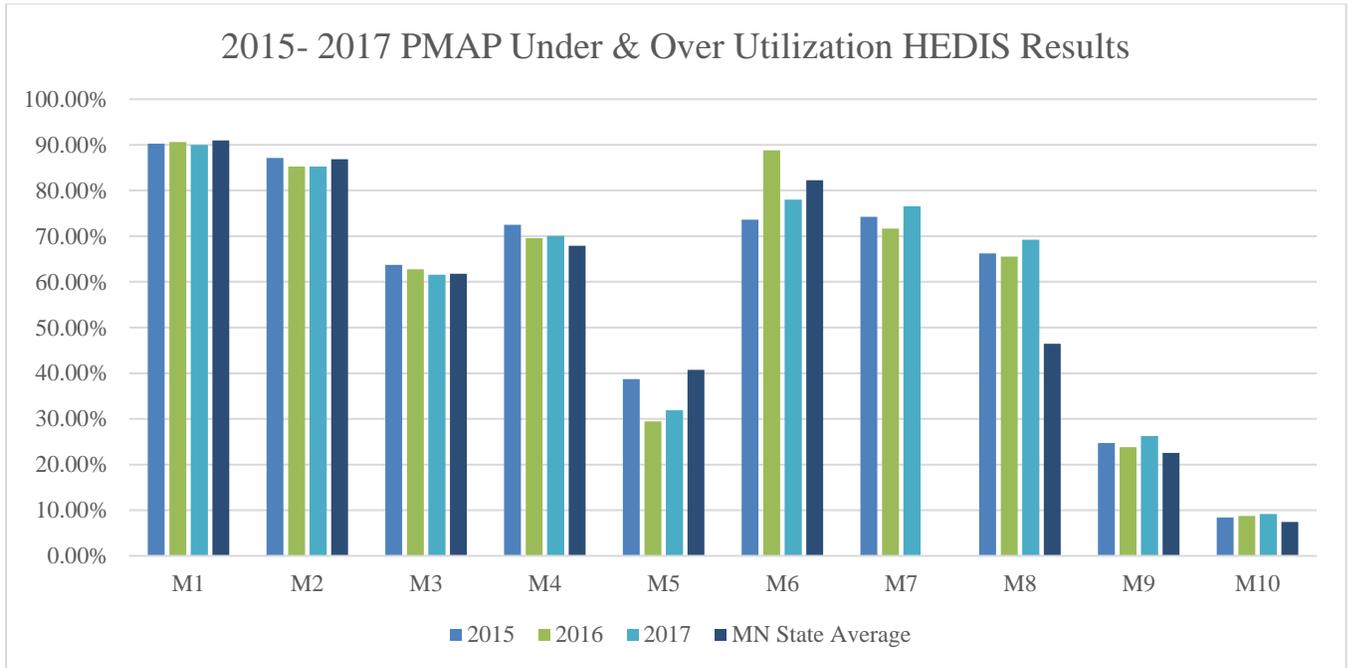
- Enrollee education regarding disease management, healthy pregnancies, mental health education, dental health, and care coordination was included in the Fall/Winter 2016 enrollee newsletter.
- The Spring/Summer 2016 provider newsletter included information about how to refer enrollees for case management, care coordination and disease management services.

Educational letters were sent to newly-identified pregnant enrollees.

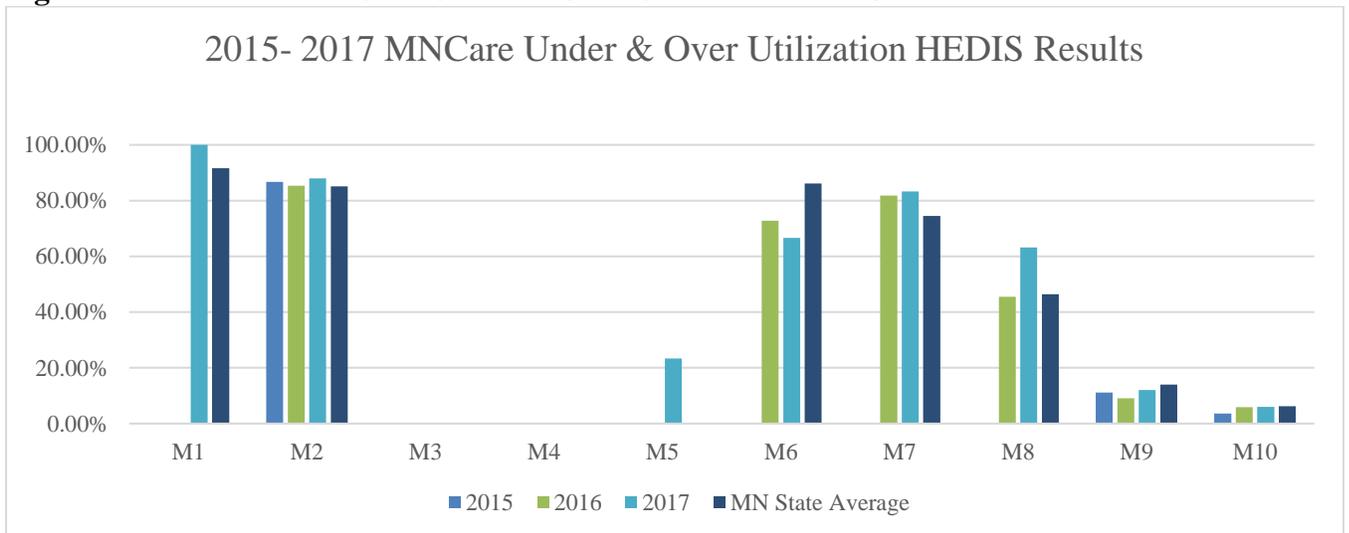
**Figure 23: Medicaid Under and Over Utilization HEDIS Measurement Methodology**

M1.	Percentage of enrollees 12 months-19 years of age who had a visit with a PCP during the measurement year.	HEDIS Data
M2.	The percentage of enrollees 20 years and older who had an ambulatory or preventative care visit during the measurement year.	HEDIS Data
M3.	The percentage of enrollee who turned 15 months old during the measurement year and who had 0-6 well-child visits with a PCP during their first 15 months of life.	HEDIS Data
M4.	The percentage of enrollees 3-6 years of age who had one or more well-child visit with a PCP during the measurement year.	HEDIS Data
M5.	The percentage of enrolled enrollees 12-21 years who had at least one comprehensive well care visit with PCP or an OB/GYN during the measurement year.	HEDIS Data
M6.	The percentage of deliveries that received a prenatal care visit as an enrollee of the organization during the first trimester, on the enrollment date or within 42 days of enrollment in the organization.	HEDIS Data
M7.	The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.	HEDIS Data
M8.	The percentage of enrollees 2-20 years of age who had at least one dental visit during the measurement year. This measure applies only if dental is a covered benefit in the organization's Medicaid contract.	HEDIS Data
M9.	The number and percentage of enrollees receiving the following mental health services during the measurement year: any services, inpatient, intensive outpatient or partial hospitalization, outpatient or ED.	HEDIS Data
M10.	The number and percentage of enrollees with an alcohol and other drug (AOD) claim who received the following chemical dependency services during the measurement year: any services, inpatient, intensive outpatient or hospitalization, outpatient or ED.	HEDIS Data

**Figure 24: 2015-2017 PMAP Under & Over Utilization HEDIS Results**



**Figure 25: 2015-2017 MNCare Under & Over Utilization HEDIS Results**



\*\*Blank measures are data that was not recorded for one or all of the measurement years.

IMCare continues to perform well in almost all areas. While Adolescent Well Care (AWC) has increased from the previous year, it is still well below the MN State average (8.88% below average for PMAP enrollees). There was a significant decline in the percentage of Timeliness of Prenatal Care (PPC) for both PMAP and MNCare enrollees over the last year (10.78% and 6.06% decrease, respectively). In regard to the Identification of Alcohol and Other Drug Dependence Services (IAD), percentages reflect a minimal, yet steady, increase over the last few

years. This is in-line with national statistics. Mental Health Utilization has also increased. This too, is in proportion to national statistics. Satisfactorily, there was a considerable increase (17.71%) in percentage of Annual Dental Visits for MNCare enrollees (16.71% over the state average). PMAP enrollees were 12.2% over the state average. One barrier to improvement and goal setting is the NCQA national benchmarks and thresholds are not available until March of the year following the end of the measurement year. This impedes the ability to implement new interventions for the current measurement year. IMCare will revisit this issue annually, but for now, will continue to use the MN State Average rates to measure under and over utilization.

**Medicare Over and Under Utilization**

Ensuring appropriate utilization of services is required as per Article 7.1.3 of the 2017 DHS Seniors contract, “The MCO shall adopt a utilization management structure consistent with state and federal regulations and current NCQA “Standards and Guidelines or the Accreditation of Health Plans.”” Pursuant to 42 CFR § 330(b)(3), this structure must include an effective mechanism and written description to detect both under and over utilization of services.

2016 Interventions:

- Emergency Department (ED) Focus Study interventions, including IMCare QI/UM Nurse and Senior Care Coordinator interventions, were aimed at reducing ED over utilization.
- Enrollee education regarding disease management, appropriate ED use and care coordination was included in the Spring & Fall 2016 enrollee newsletter.
- MSHO enrollees who agreed to have a long term care consultation (LTCC) were screened for substance use and depression and educated on the importance of preventative care.

**Figure 26: Medicare Under and Over Utilization HEDIS Measurement Methodology**

M1. Percentage of Medicare enrollees who had one or more ambulatory or preventative care visits during the measurement year.	HEDIS Data
M2. Number of acute discharges per 1,000 enrollee years in the measurement year for Medicare-eligible enrollees.	HEDIS Data
M3. Average length of stay, in days, for acute inpatient encounters during the measurement year for Medicare-eligible enrollees.	HEDIS Data
M4. Number of outpatient visits per 1,000 enrollee years for Medicare-eligible enrollees, during the measurement year.	HEDIS Data
M5. Number of emergency department visits per 1,000 enrollee years for Medicare-eligible enrollees, during the measurement year.	HEDIS Data
M6. Percentage of mental health services obtained per 1,000 enrollees months for Medicare-eligible enrollees.	HEDIS Data
M7. Percentage of alcohol and other drug services obtained per 1,000 enrollees months during the measurement year for Medicare-eligible enrollees.	HEDIS Data

**Figure 27: Medicare Under and Over Utilization HEDIS Results**

Measurement	Goal	2015	2016	2017	Status
<b>M1. Adults' Access (AAP) 65+ years</b>	Above MN State Avg of 98.05%	96.54% (391/405)	98.20% (382/389)	96.59% (368/381)	Goal not met.
<b>M2. Inpatient Utilization General Hospital/Acute Care (IPU): Discharges/ 1,000 Enrollee Years</b>	Below MN State Avg of 415.9	438.17	400.76	416.53	Rate nearly equal to state average.
<b>M3. Inpatient Utilization General Hospital/Acute Care (IPU): Avg LOS (days)</b>	Below MN State Avg of 4.66	4.18	3.83	4.48	Goal met. Rate below state average.
<b>M4. Ambulatory Outpatient Visits/1,000 Enrollee Years (AMB)</b>	Above MN State Avg of 11,887.20	11,358.62	11,886.15	12,715.34	Goal met. Rate above state average.
<b>M5. Emergency Department Visits/1,000 Enrollee Years (AMB)</b>	Below MN State Avg of 620.12	751.46	678.56	581.78	Goal met. Rate below state average.
<b>M6. Mental Health Utilization/1,000 Enrollee Months (MPT)</b>	Below MN State Avg of 12.85%	11.22%	11.16%	10.41%	Goal met. Rate below state average.
<b>M7. Identification of Alcohol and Other Drug(IAD) Dependence services/ 1,000 Enrollee Months</b>	Below MN State Avg of 5.01%	3.81%	5.00%	6.11%	Goal not met. Rate above state average.

IMCare uses the Minnesota state averages as a benchmark for success. IMCare continues to perform well in almost all areas. Adult’s Access to Preventive/Ambulatory health services (AAP) for 65+ is marginally below state average, however, it is similar to 2015. There was a marked increase in Ambulatory Outpatient Visits (AMB) (829.19) in 2017. This demonstrates improved access to services. There was also a considerable decrease in Emergency Department Visits (AMB) (96.78) from 2016 to 2017. This is a continuation of steady decline in this area. Mental Health Utilization (MPT) is also in steady decline, going from 11.16 % in 2016 to 10.41% in 2017. Identification of Alcohol and Other Drug (IAD) Dependence Services continues to increase, which is comparable to national trends.

### **Provider Satisfaction Survey**

As per IMCare contracts with the Minnesota Department of Human Services (DHS), “The MCO shall adopt a utilization management structure consistent with state and federal regulations and current NCQA “*Standards and Guidelines for the Accreditation of Health Plans.*”” The Utilization Program Structure section (UM 1) requires that IMCare consider practitioners’ experience data when evaluating the Utilization Management (UM) program. Annually, IMCare surveys network providers to assess their level of satisfaction with and knowledge of IMCare services. Survey questions cover topics such as authorizations, pharmacy management and

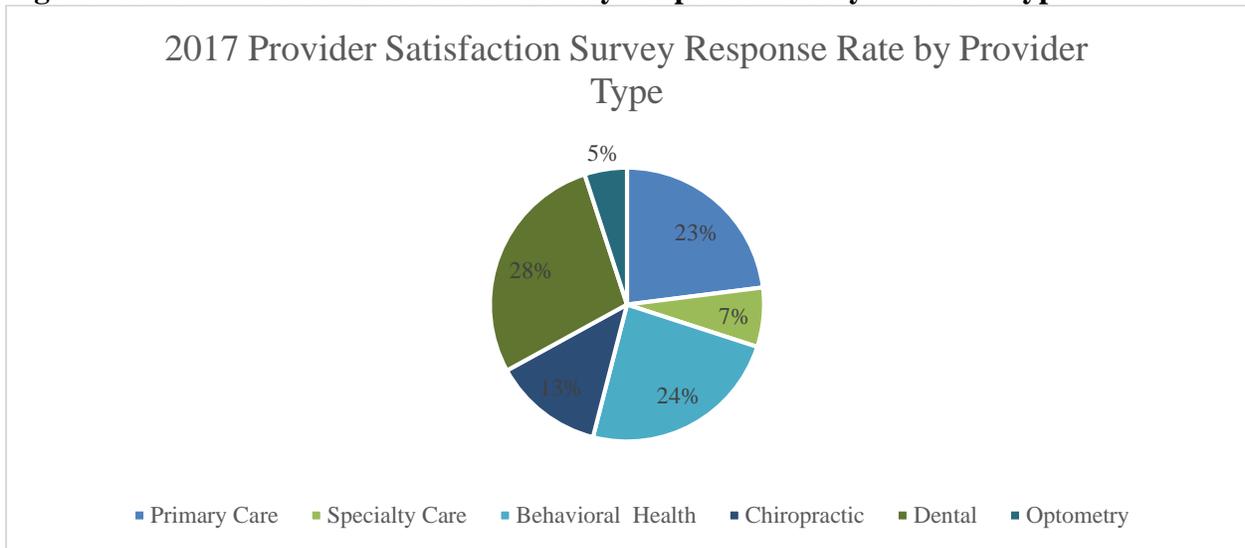
overall satisfaction. Provider responses offer valuable information that is used by IMCare to make program changes, contributing to the overall goal of delivering optimal service to both enrollees and providers.

#### 2016 Interventions:

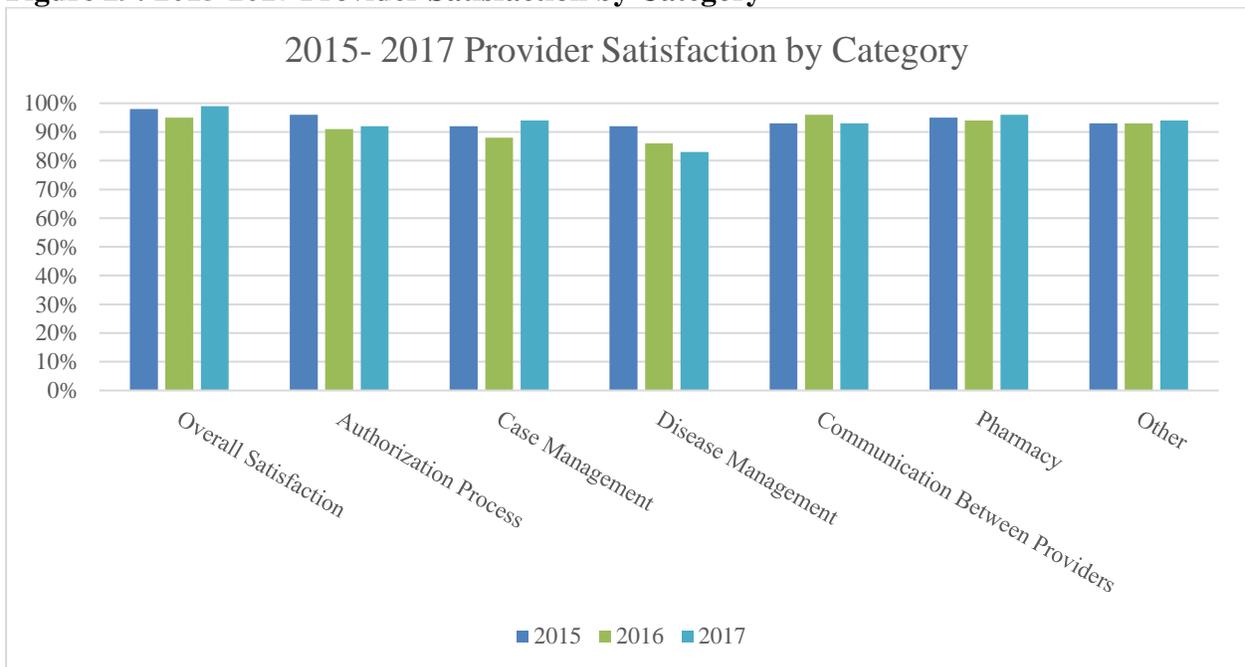
- Throughout 2016, IMCare authorization requirements were communicated to providers via multiple provider updates and the Spring/Summer 2016 provider newsletter. IMCare followed regulatory requirements regarding the process for and timeliness of authorization review.
- 2016 Utilization Management Criteria resources were reviewed/approved by the IMCare Provider Advisory Subcommittee (PAC) on 02/10/16 and by the IMCare QI/UM Committee on 03/16/16.
- Throughout 2016, IMCare staff contact information was included in all newly credentialed provider packets and was available on the IMCare website and to providers upon request.
- IMCare network provider education regarding IMCare case management services and the process for referral was included in the Spring/Summer 2016 provider newsletter.
- IMCare network provider education regarding the IMCare Disease Management Program and the process for referral was explained in a June 2016 provider update.
- IMCare network providers were educated about the 2016 formularies via a December 2015 provider update. Formulary updates/changes were communicated to providers via provider updates throughout 2016.
- In 2016, network providers were educated about IMCare's Quality Improvement Program efforts (e.g., focus studies, performance improvement projects, etc.) via the Spring/Summer provider newsletter.
- Throughout 2016, IMCare followed NCQA guidelines for credentialing individual practitioners and organizational providers.
- The 2016 IMCare Provider Satisfaction Survey Report was reviewed and approved by PAC on 05/11/16 and the QI/UM Committee on 06/15/16.

The 2017 Provider Satisfaction Survey had a response rate of 29%. Of the 75 responses, the below pie chart demonstrates what percentage of response was from each provider type. The overall provider satisfaction rate was impressive at 99%, increased from 95% in 2016. Of all respondents, only one dental provider expressed overall dissatisfaction with IMCare and this appears to be related to dental claims issues. All 2017 survey question measurements exceeded the 80% goal. Although small variations in individual measurements are difficult to interpret due to relatively small denominators, it is notable that the provider satisfaction rates for IMCare, as compared to other health plans and to State Medical Assistance, both increased to 94% and 98%, respectively.

**Figure 28: 2017 Provider Satisfaction Survey Response Rate by Provider Type**



**Figure 29: 2015-2017 Provider Satisfaction by Category**



## Communication Services

### Access to Staff/Customer Service Call Center Performance

IMCare provides access to UM staff for enrollees and providers seeking information about the UM process and authorization of care through:

- IMCare staff is available at least eight hours a day during normal business hours for inbound calls regarding UM issues. Staffing varies but the core hours are 8:00 AM to

4:30 PM. IMCare contracts with an agency to answer and triage after hours and weekend calls. Any UM issues can be forwarded to UM on call staff.

- Staff is accessible to callers who have questions about the UM process. Enrollees and providers have direct access to UM staff.
- Staff can receive inbound communication regarding UM issues after normal business hours. IMCare accepts inbound communication 24/7 through telephone, email and fax. The IMCare Director and Quality Director monitor incoming communication, and involve UM staff and the Medical Director as necessary.
- Staff can send outbound communication regarding UM inquiries during normal business hours and after hours as necessary.
- Staff identify themselves by name, title and organization name when initiating or returning calls regarding UM issues. IMCare provides a toll-free number and staff are available to accept collect calls regarding UM issues.
- IMCare offers TDD/TTY services for deaf, hard of hearing, or speech impaired enrollees through Minnesota Relay Service.
- Language assistance is available for enrollees through Language Line to discuss UM issues.

IMCare must ensure that providers, enrollees, and staff enrollees are able to reach the IMCare Customer Service Representatives (CSRs) according to regulatory and accreditation standards. IMCare must maintain low abandonment rates for customer services lines. CMS requires a disconnect rate of 5% or less. See Customer Service Call Center Performance section for further details regarding 2017 rates.

### **Appropriate Professionals**

#### **Licensed Health Professionals and Review of Non-Behavioral Healthcare, Behavioral Healthcare and Pharmacy Denials**

IMCare is required to ensure that qualified health professionals assess the clinical information used to support UM decisions, and that UM decisions are made by qualified health professionals. IMCare Policies and Procedures (P&Ps) require appropriately licensed professionals to supervise all medical necessity decisions, and specify which staff is responsible for each level of decision making. IMCare has several P&Ps to address UM decisions, including Pre-Service Review (Preauthorization or Service Authorization), Post-Service Review, and Concurrent Review. These P&Ps state that any decision to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested, must be made by a healthcare professional who has appropriate clinical expertise in treating the enrollee's condition or disease. Decisions will be made by qualified licensed health professionals. Appropriate professionals include the Medical Director, Dental Director, Behavioral Health Consultant, chiropractor, or other board-certified physicians contracted with IMCare. These professionals are involved in non-behavioral healthcare denials, behavioral healthcare denials, and pharmacy denials.

### **Affirmative Statement about Incentives**

IMCare's policy states that no individual who is performing utilization review may receive financial incentive based on the number of denials or certifications made. IMCare reviews and updates its Affirmative Statement annually, and distributes it to providers and enrollees through direct mail, newsletters, and the IMCare provider manual. The Affirmative Statement P&P is also posted on the IMCare website. In 2016, the Affirmative Statement was reviewed, included in the Fall/Winter IMCare enrollee newsletter, and distributed with the IMCare privacy notice in all new enrollee and annual EOC mailings.

### **Timeliness of UM Decisions**

An initial determination on all standard (not expedited) requests for utilization review, behavioral health and non-behavioral health, must be communicated to the provider and enrollee within ten business days of the request, provided that all information reasonably necessary to make a determination on the request has been made available to IMCare. An expedited initial determination must be utilized if the attending health care professional believes that an expedited determination is warranted. Notification of an expedited initial determination to either certify or not to certify must be provided to the facility, the attending health care professional, and the enrollee as expeditiously as the enrollee's medical condition requires, but no later than 72 hours from the initial request. For post-service decisions, IMCare makes determinations within 30 calendar days of receipt of the request.

IMCare utilizes CaseTrakker Dynamo (CTD) to manage authorization requests. CTD has been designed to track timeliness, including a technical denial option. A technical denial occurs when the set time for review of an authorization has expired. IMCare has never had a technical denial. UM reviewers are able to see the status of an authorization request in real-time, including time remaining to complete the request. CTD tracks pre-authorization requests, post-authorization requests, and concurrent review requests in an expedited or standard status in queues. UM queues are monitored by the Quality Director, Medical Director, and Contract Compliance Officer on a daily basis. IMCare met all timelines for UM decisions in 2017.

### **Notification of UM Decisions**

When an initial determination is made to certify for standard requests, notification is provided promptly by written notification to the provider via facsimile. When an initial determination is made not to certify for standard requests, notification is provided by telephone, and by facsimile to a verified number, or by electronic mail to a secure electronic mailbox within one working day after making the determination to the attending health care professional and hospital if applicable. Written notification must also be sent to the facility as applicable and attending healthcare professional if notification occurred by telephone. Written notification must be sent to the enrollee. An expedited initial determination must be utilized if the attending healthcare

professional believes that an expedited determination is warranted. Notification of an expedited initial determination to either certify or not to certify is provided to the facility, the attending healthcare professional, and the enrollee as expeditiously via phone, no later than 72 hours from the initial request. Upon request, IMCare must provide the provider or enrollee with the criteria used to determine the necessity, appropriateness, and efficacy of the health care service, and identify the basis for the criteria. Written notice must also inform the enrollee and the attending healthcare professional of the right to submit and appeal to IMCare, and include the procedure for initiating an appeal.

IMCare monitors the timeliness of decision making and of notifications for all requests, and calculates the percentage of decisions that adhere to timelines. CTD can be reviewed at any time by generating a search by authorization type and a date span. IMCare monitors timelines daily through frequent review of CTD pending authorization requests. IMCare met all timelines for notification of UM decisions in 2017.

### **Clinical Information and Interrater Reliability**

IMCare's Quality Director regularly evaluates the consistency with which clinical staff (non-physician, physician reviewers, and medical directors) involved in utilization management applies criteria, medical, pharmacy and behavioral policies, regulatory directives, and benefits outlined in the benefit documents in their decision making. At least annually, IMCare assesses the consistency in applying these criteria/policies by physician and non-physician reviewers through the interrater review process. When inconsistencies are identified, corrective action plans are put into place to promote consistency.

A random sample of cases are reviewed for:

- Sufficient clinical information to make the determination (Measure 1)
- Reviewer request of information per policy (Measure 2)
- Case handled within established standards (Measure 3)
- Correct criteria set/policy used (Measure 4)
- Nurse/physician apply criteria correctly (Measure 5)
- Health care professional contacted by phone or fax within one working day (Measure 6)

### **2017 Interventions:**

- The 2016 Interrater Reliability Report was reviewed/approved by the Provider Advisory Subcommittee (PAC) on 02/08/2017 and the External QI/UM Committee on 03/15/17.
- 2017 Utilization Management Criteria were reviewed/approved by the Provider Advisory Subcommittee (PAC) on 02/08/2017 and the External QI/UM Committee on 03/15/17.
- InterQual criteria updates were loaded into CaseTrakker (authorization review system) as they became available, throughout 2017.

- CVS/Caremark drug criteria sets were updated in January of 2017, and as they became available thereafter.
- Updated authorization forms to note required clinical documentation.
- Outreach and education provided to high volume authorization facility to aide in obtaining needed information to make determinations.
- Updated the QI/UM Nurse Manual to reflect current processes and standards.
- A monthly Utilization Management Operations Workgroup (UM Ops) was initiated to evaluate, discuss and modify UM criteria and/or processes as needed. Additionally at the UM Ops Workgroup, education was provided regarding the application of this criteria.
- Throughout 2017, authorization review process changes were promptly communicated to staff and implemented.

IMCare strives for 100% accuracy of application of adopted clinical criteria. In 2017, IMCare audited a total of 179 determinations. QI/UM Nurses were audited on 150 determinations and the Medical Director was audited on 29 determinations. In each measure, the Medical Director maintained the goal of 100%. The QI/UM Nurses met four of the six goals. The unmet areas, both at 99.33%, include measures around the correct criteria being utilized and applied correctly. The discrepancies applied to one determination by one reviewer, who is no longer in that position. IMCare had significant turnover of UM staff in 2017, and as a result, had intensive UM training in the latter half of 2017. The errors noted on the audit occurred in second quarter, prior to training.

### **Denial Notices**

IMCare's written Denial, Termination or Reduction (DTR) Notice of behavioral healthcare, non-behavioral healthcare and pharmacy denials that is provided to enrollees and their attending health care professionals must:

- Be understandable to a person who reads at the 7<sup>th</sup> grade reading level
- Be available in alternative formats
- Be approved in writing by the State
- Maintain confidentiality for Family Planning Services
- Be sent to the enrollee

IMCare uses the State approved format for all DTRs. The DTRs are prepared by the IMCare QI/UM Nurses, and are reviewed by the IMCare Quality Director, Health Plan Compliance Coordinator (HPCC), or IMCare Contract Compliance Officer. The HPCC maintains DTR files, and is responsible for analyzing for trends, identifying issues, implementing corrective action as necessary, and reporting to the State on a quarterly basis.

In 2017, IMCare had 2,953 service authorizations. Of these, 213 were for behavioral health services and 2,740 were for non-behavioral health services. This is a decline in behavioral health service authorization requests from previous years, due to modification of the behavioral health

authorization process. There were a total of 47 denials in 2017 (20 behavioral health) and no partial approvals. There were 1,013 drug authorizations. Of these, 1,001 were approved and 12 were denied.

IMCare was timely on verbal and written notifications for all approvals and adverse actions. All written notifications received the enrollee rights notice, civil rights notice and language block. Verbal notification included a discussion regarding requesting and filing an appeal when services or drug requests are denied. Expedited requests that are denied are afforded the right to an expedited appeal, which is also discussed in verbal notifications. The IMCare QI/UM Nurses are very diligent in their documentation of each authorization review for approvals and denials. Notifications are documented as well.

### **Appeals**

IMCare has a full and fair process for resolving enrollee disputes and responding to enrollees' requests to reconsider a decision they find unacceptable regarding their care and service. IMCare must resolve each appeal as expeditiously as the enrollee's health requires, but cannot exceed 30 days after receipt of a standard appeal and within 72 hours after receipt of an expedited appeal. An extension of 14 days is available for standard and expedited appeals if the enrollee requests the extension, or IMCare justifies both the need for more information and that an extension is in the enrollee's interest. IMCare provides a written notice of resolution for all appeals, and includes a copy of the enrollee rights notice and a language block. IMCare utilizes CTD to document, track and report appeals.

IMCare ensures that the individual making the decision on appeal was not involved in any previous level of review or decision-making. When deciding an appeal regarding denial of a service for medical necessity, IMCare ensures that the individual making the decision is a healthcare professional with appropriate clinical expertise in treating the enrollee's condition or disease. When a decision is reversed by the appeal process, IMCare complies with the appeal decision promptly and as expeditiously as the enrollee's health condition requires, and pays for any services the enrollee received that are the subject of the appeal.

In 2017, IMCare received nine appeals. All appeals were for services and/or benefits, as follows:

- Placement in the Universal Restricted Recipient Program (3)
- Denial of epidural steroid or SI joint injection (3)
- Denial of spinal fusion surgery (2)
- Denial of cochlear device implantation (1)

Due to the receipt of additional information through the appeal process, one spinal fusion surgery appeal was overturned, resulting in approval of the enrollee's request. The other eight appeals were upheld. Four of the upheld appeals were reviewed by Advanced Medical Strategies (AMS) consulting physicians (two injections, one spinal fusion surgery, and the cochlear device

implantation). All of the appeals were under the standard timeframe, none were marked as expedited. Ten of the appeals were resolved under 10 working days, four were over 10 days, but all were under the 30 day appeal timeframe given and no extensions to timeframes were needed. In 2017, IMCare met all timeframes and documentation requirements.

Enrollees have the right to request a State Fair Hearing to appeal an adverse action by IMCare. State Fair Hearings afford the enrollee's appeal to be heard and decided by a State Hearing Judge. Based on the decision of a State Fair Hearing, the enrollee has the right to appeal to the District Court, and the State Appeals Court if the District Court upholds the denial. In 2017, IMCare had one enrollee request a State Fair Hearing; however after two attempts the enrollee did not appear for the hearing and the original determination was upheld.

### **Emergency Services**

Enrollees have the right to available and accessible emergency services, 24 hours a day and seven days a week. IMCare informs its enrollees, through the Enrollee Handbook, how to obtain emergency care for treatment of emergency medical conditions. Emergency services are covered whether provided by participating or non-participating providers and whether provided within or outside of the IMCare service area. IMCare does not require a service authorization as a condition for providing medical emergent services; hold the enrollee liable for payment concerning the screening and treatment necessary to diagnose and stabilize the condition; or prohibit the treating provider from determining when the enrollee is sufficiently stabilized for transfer or discharge. IMCare claims procedures include reviewing for inappropriate denials in queued claims, prior to payment. The IMCare QI/UM Staff monitor claims to verify that all emergency room and stabilization of care services are paid according to benefit and not denied because of lack of service authorization. If claims have denied for lack of authorization, they are reprocessed.

IMCare monitors over-utilization of emergency department (ED) visits as well. A report is generated monthly for all enrollees who have four or more ED visit claims paid in a calendar year. The IMCare QI/UM Nurses and/or Care Coordinators review the reports to identify enrollees for case management, fraud waste and/or abuse activities and enrollee education. Refer to emergency department utilization focus study for further details.

### **Pharmaceutical Management**

IMCare has developed and regularly reviews and updates policies and procedures for pharmaceutical management based on sound clinical evidence. Policy and Procedure 2.07.17 titled Pharmacy Management identifies the clinical evidence to adopt pharmaceutical management procedures, including government agencies, medical associations, national commissions, peer-review journals and authorized compendia. IMCare collaborates with

pharmacists, practitioners, and the Pharmacy Benefit Manager (PBM) on the development of the formulary and management procedures. Pharmaceutical management procedures are communicated to providers via direct mail, e-mail, fax, the IMCare web site, and/or the formulary booklet annually and as needed.

In 2017, Pharmaceutical and Pharmaceutical Management procedures were communicated to enrollees and prescribing practitioners. This information included co-payment information, prior authorization requirements, limits on refills, doses or prescriptions, use of generic substitutions, and covered pharmaceuticals. All information was available on the IMCare web site as well.

The PBM, on behalf of IMCare, identifies and notifies enrollees and prescribing practitioners affected by a Class II recall or voluntary drug withdrawal from the market for safety reasons. IMCare requires an expedited process for prompt identification and notification of enrollees and prescribing practitioners affected by a Class I recall of the PBM. Policies and procedures reflect this.

The IMCare Pharmacy Exceptions P&P describes the process for exceptions, including making an exception request based on medical necessity; obtaining medical necessity information from the prescribing physician; using appropriate practitioners to consider exception requests; timely handling of requests; and communicating the reason for a denial and an explanation of the appeal process when it does not approve an exception request. The P&P was reviewed in January, 2017.

### **Contact Information**

If you have questions or comments about any information contained in this report, please contact the IMCare Quality Director, Alexis Martire, at (218)327-6199, (800)843-9536 ext. 2199, or by email to [alexis.martire@co.itasca.mn.us](mailto:alexis.martire@co.itasca.mn.us).