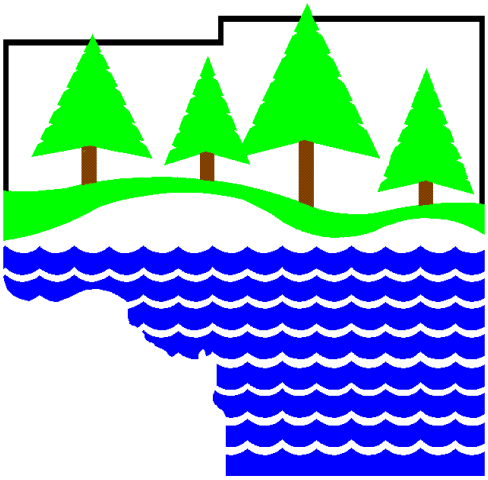

2020 ITASCA MEDICAL CARE PROGRAM EVALUATION

Approved by:

IMCare External QI/UM Committee: 03/17/2021
Itasca County Board of Commissioners: 4/27/2021

Mission Statement...

- The IMCare mission is to ensure access to high-quality, patient-centered, cost-effective health care for Itasca County residents through coordination and collaboration with local community partners and providers.

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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 2020 QI/UM activities.

In 2020, IMCare made many strides towards quality improvement, with a strong focus on staff development, provider and enrollee education. IMCare provided enrollee education through the IMCare website and biannual newsletters. IMCare staff also provided enrollees with a wealth of information through activities of care. Education ranged from ongoing IMCare quality programs to navigating the IMCare network during the COVID-19 pandemic. IMCare made efforts to ensure enrollees had access to any needed COVID-19 services, as well as ongoing health maintenance care.

Providers were kept informed of ongoing quality programs, as well as the many COVID-19 service changes through the biannual provider newsletters, provider updates and COVID-19 Provider Manual Chapter located on the IMCare website.

In addition to quality improvements, IMCare developed measures to create a more uniform and robust UM program in 2020. Throughout 2020, IMCare provided periodic group education for UM staff at the internal UM Operations workgroup, as well as daily one-on-one instruction as needed from lead staff. Additionally, through the work of the IMCare Utilization Review Workgroup, IMCare modified or reduced authorization requirements during 2020, to improve enrollee access to appropriate care. IMCare continued ongoing improvement of grievance and appeal processes, and all staff and Itasca County Elderly Waiver Case Manager delegates completed training in early 2020. This initiative began in 2018, but efforts have been ongoing since then.

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). The Prepaid Medical Assistance Program (PMAP) was implemented on July 1, 1985, as a demonstration project, and expanded to include MinnesotaCare (MNCare) in 1996. In 2001, IMCare become 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 services 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 QI and UM programs. The BOC delegates day-to-day operational responsibilities for the program to the IMCare Director. The IMCare Director, Medical Director, Pharmacy Director, QI/UM Director/s and Compliance Officer report quality

program activities and outcomes to the Provider Advisory Subcommittee (PAC), the External QI/UM Committee, 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 QI and UM 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 QI and UM programs.

QI and UM 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 Examinations, and Minnesota Department of Human Services (DHS) Triennial Compliance Audits (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 QI/UM activities and progress throughout the year. The 2020 QI/UM Work Plan activities and outcome measurements collected throughout the year are outlined below.

2020 Quality Program Activities

Healthcare Effectiveness Data and Information Set (HEDIS)

IMCare collects HEDIS data, to comply with contract requirements for both DHS and the Centers for Medicare & Medicaid Services (CMS). The Healthcare Effectiveness Data and Information Set (HEDIS) is one of the most widely used sets of healthcare performance measures in the United States. HEDIS is a nationally-recognized and comprehensive set of clinical indicators used to assess and compare the performance of health plans, physician groups and employers. Claims data is used to generate administrative results (Admin) and for selected measurements, a chart audit methodology (Hybrid) is used. In measures with more than 411 eligible enrollees, a random sample of 411 is used to represent the measure. Sampling is not used for measures with fewer than 411 eligible enrollees. Rates are calculated using NCQA HEDIS specifications and results are verified by an external audit vendor and submitted to MDH, DHS and CMS.

2020 HEDIS – Medicaid

IMCare performed well in several 2020 HEDIS measures. Breast cancer screening, while below goal for both populations, showed a modest increase in the PMAP population, coming in just under goal. Cervical cancer screening met goal for both populations. Network facilities continue to offer preventive health reminders on the home page of the patient's access to their electronic health record, with the ability to schedule an appointment from the reminder.

Chlamydia Screening
Chlamydia screening remained below goal for both populations in 2020, but the MNCare population showed a significant increase from 2019 data.

Childhood Immunizations (CIS)
The PMAP childhood immunization combo 10 rate did not meet goal in 2020, showing a slight decline from 2019. This measure was met in the MNCare population, but with an extremely small representation of the population.

Controlling Blood Pressure (CBP)
In 2020, IMCare exceeded goals for blood pressure control for enrollees with and without diabetes.

Prenatal and Postpartum Care (PPC)
IMCare continues to perform well in perinatal measures, largely in part to *A Health Pregnancy* program and working collaboratively with Itasca County Public Health.

2020 HEDIS - MSHO
Overall, goals were met in several measures in 2020. Good diabetes control, as evidenced by HbA1c less than 8%, and blood pressure control in enrollees with diabetes improved considerably from 2019. These findings may be correlated with increased provider education via provider newsletter articles focused on practice guidelines for medical care in adults with diabetes. Diabetic eye exams and nephropathy testing/treatment fell below goal in 2020. Secondary chart review for enrollee eye exams yielded no additional data. Practice guidelines disseminated to providers by IMCare in 2020 included current evidence-based recommendations regarding care of patients with diabetes, including regular eye exams and screening for nephropathy.

The increase in the potentially harmful drug-disease interactions rate from 2019 to 2020 was due to an increase in the number of enrollees with dementia on the target drugs. The high-risk medication rate also increased from 2019 to 2020 and did not meet goal. While medication review and medication reconciliation post discharges measures exceeded goal, pain screening and functional status assessment measures fell just below goal in 2020. Pain screening is also measured in the annual care plan audit, at which time IMCare regularly reminds care coordinators to address all components of the assessment.

Performance Improvement Projects
2018-2020 Opioid Prescribing Improvement Project (OPIP)

The Opioid Prescribing Improvement Project (OPIP) was designed to decrease the number of New Chronic Users (NCUsers) of opioid pain medications in the study population by the end of CY2019, and sustain the improvement through CY2020. The OPIP is required by and defined in the 2020 DHS Families & Children Contract with Itasca Medical Care, Section 7.2.1, "In 2018, the STATE selected the Preventing Chronic Opioid Use topic for the PIP to be conducted over a three-year period (calendar years 2018, 2019, and 2020). The PIP must be consistent with CMS' published protocol entitled *"Protocol for Use in Conducting Medicaid External Quality Review Activities:*

Conducting Performance Improvement Projects," STATE requirements, and include steps one through seven of the CMS protocol."

In 2020, IMCare carried out numerous interventions aimed at reducing the number of new chronic opioid users. The most impactful were in the IMCare pharmacy claims system, including continued programming of hard rejects, which required prior authorization to bypass the following items: initial opioid fills limited to a 7-day supply for enrollees who were opioid naïve for 90 days prior; opioid quantity limits exceeding 90 morphine milligram equivalents (MME)/day for all cumulative opioids within designated categories; and step therapy for extended release opioids, requiring fill of immediate release opioids within the last 90 days.

Global provider education via newsletter included the Centers for Disease Control and Prevention (CDC) *Checklist For Prescribing Opioids for Chronic Pain*, and 2018-2020 IMCare opioid project updates. Global enrollee education via newsletter included information about alternative therapies for the treatment of chronic pain, over the counter and prescription drug disposal, chronic pain self-management workshops in the area, and IMCare 2018-2020 IMCare opioid projects. Lastly, the IMCare Pharmacy Director, in collaboration with University of Minnesota School of Pharmacy, provided education regarding Medication Assisted Therapy (MAT) to Itasca County employees on 08/31/2020 and 09/04/2020.

The goal of the OPIP is to decrease the IMCare NCUsers rate (as defined by DHS) to 3.0. The baseline rate (2016 NCUsers Rate) was 3.1. The 2017 rate for the Medicaid population was 3.4, with a lower rate of 2.7 in 2018 and 2019. The 2020 NCUsers rate has not been provided by DHS to date, but has an anticipated release date of May 2021. The delay in data and lack of enrollee-specific data makes it difficult to determine effectiveness of current interventions and modify accordingly. The point of sale opioid rejects seemed to be the most impactful intervention for IMCare throughout the OPIP. Due to the high number of opioid-related rejects at the pharmacy point-of-sale, and low-level opioid-related drug authorization requests, it appears that the pharmacy is contacting providers at the time of reject messaging and the provider is modifying prescribing to comply with best practice guidelines. This pattern of change may also be correlated with the strong focus of network facilities to reduce opioid misuse and abuse.

2018-2020 Opioid Prescribing Quality Improvement Project (OPQIP)

As per the 2020 *Contract For Minnesota Senior Health Options and Minnesota Senior Care Plus Services with Itasca Medical Care*, Section 7.2.1.1, "The STATE and MCOs selected the topic for the PIP to be conducted over a three-year period (calendar years 2018, 2019, and 2020). Topics should address the full spectrum of clinical and nonclinical areas associated with the MCO and not consistently eliminate any particular subset of Enrollees or topics when viewed over multiple years. The PIP must be consistent with CMS' published protocol entitled "*Protocol for Use in Conducting Medicaid External Quality Review Activities: Conducting Performance Improvement Projects*," STATE requirements, and include steps one through seven of the CMS protocol." DHS selected the 2018-2020 Quality Improvement Project topic, hereafter referred to as the Opioid Prescribing Quality Improvement Project (OPQIP). IMCare implemented the OPQIP for its Minnesota Senior Health Options (MSHO) and Minnesota Senior Care Plus Services (MSC+) populations on January 1, 2018. The OPQIP is designed to decrease

the number of New Chronic Users (NCUsers) of opioid pain medications in the study population by the end of CY2019, and sustain this improvement through CY2020.

In 2020, IMCare carried out numerous interventions aimed at reducing the number of new chronic opioid users in the senior population. The IMCare pharmacy claims system continued programming of soft rejects, requiring pharmacist intervention to bypass the following items: cumulative opioid quantity limits exceeding 90 morphine milligram equivalents (MME)/day for all cumulative opioids; four or more opioid prescribers in 30 days; or four or more pharmacies used to obtain opioids in 30 days. Global provider education via newsletter included the CDC *Checklist For Prescribing Opioids for Chronic Pain*, and 2018-2020 IMCare opioid project updates. Global enrollee education via newsletter included information about alternative therapies for the treatment of chronic pain, over the counter and prescription drug disposal, chronic pain self-management workshops in the area, and IMCare 2018-2020 IMCare opioid projects.

The IMCare Pharmacy Director, in collaboration with University of Minnesota School of Pharmacy, provided education regarding MAT to Itasca County employees on 08/31/2020 and 09/04/2020. In addition, senior care coordinators and elderly waiver case managers were provided an update regarding the OPQIP at the Stakeholders Advisory Committee meeting on 04/01/2020. Lastly, IMCare partnered with our Pharmacy Benefit Manager (PBM), CVS Caremark, to administer the Medicare Point of Sale Drug Utilization Review (POS DUR) program, to help ensure clinically-appropriate use of opioids in seniors.

The goal of this OPQIP is to decrease the IMCare NCUsers rate (as defined by DHS) to 12 or less. The baseline rate (2016 NCUsers Rate) was 25.4. The 2019 rate for the MSHO/MSC+ population was 26.2, not meeting goal. Because DHS does not provide IMCare with enrollee-level data, it is difficult to determine the reason that seven additional enrollees met NCUser specifications in 2019. The 2020 NCUsers rate has not been provided by DHS to date, but has an anticipated release date of May 2021. While it is difficult to fully evaluate the effectiveness of the current opioid interventions without the 2020 NCUsers rate, it is apparent that this project has limited ability to impact change, due to the small number of individuals included in the study population and the inability to reproduce the data as generated by DHS. In review of CMS Opioid Patient Safety Analysis reports, IMCare has little to no inappropriate utilization of opioids among the senior population and met all goals. The POS DUR reports support this conclusion as well.

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. Monthly ED FS reports included enrollees with four or more cumulative ED visits since the beginning of the calendar year (excluding visits for cancer, neoplasm/blood disorders, pregnancy, perinatal, and/or congenital anomalies).

In 2020, IMCare provided global enrollee education regarding appropriate use of the ED and network urgent care options in both the Spring/Summer and Fall/Winter enrollee newsletters.

Individual enrollee/caregiver education and CM regarding appropriate use of the ED and network clinic/urgent care options were administered by an IMCare Managed Care Nurse (MCN) or senior care coordinator. When appropriate, enrollee Restricted Recipient Program (RRP) warning or placement occurred. Provider newsletters included the 2019 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 Compliance staff attended DHS Universal Restricted Recipient Program (URRP) meetings throughout 2020.

Of the 129 Medicaid enrollees identified through the ED FS in 2020, fifteen received individualized written education regarding their ED use; three received RRP warning letters; and one was enrolled in the RRP. Of the 38 senior enrollees identified through the ED FS in 2020, 100% received case management.

Medicaid ED utilization relative to enrollment decreased 28.47% from 2019 to 2020, meeting goal. Senior ED utilization relative to enrollment decreased 11.73% from 2019 to 2020, also meeting goal. The global pandemic may have contributed to decreased ED utilization, with fewer people seeking care overall during the pandemic. IMCare first saw an increase in COVID-related ED utilization in the last quarter of 2020.

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 enrollee education/CM and intervene in cases of potential fraud, waste and/or abuse.

IMCare completed a number of interventions to reduce inappropriate controlled substance use in 2020. Global provider education via newsletter included the 2019 CS FS results and a request for CS FS intervention suggestions; the CDC *Checklist For Prescribing Opioids for Chronic Pain*; a recommendation to use the MN Prescription Monitoring Program (PMP); information about IMCare opioid pharmacy edits and prescribing guidelines/recommendations; the process for reporting suspected fraud waste and abuse; and 2018-2020 IMCare Opioid Project updates. IMCare Compliance staff attended DHS URRP meetings and the IMCare Pharmacy Director attended DHS Universal Pharmacy Policy Workgroup (UPPW) meetings. IMCare continued to list buprenorphine products, used to treat opioid dependence, on the Medicaid Formulary with no prior authorization requirement. In addition, IMCare continued to allow enrollees to receive out-of-network methadone treatment with no prior authorization requirement.

Global enrollee education via newsletter included information about alternative therapies for the treatment of chronic pain; over the counter and prescription drug disposal; chronic pain self-management workshops in the area; and opioid use in seniors. The CVS/Caremark Safety and Monitoring Solutions (SMS) and Enhanced Safety and Monitoring Solution (ESMS) programs were administered by CVS/Caremark for IMCare throughout 2020. 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 MCN throughout

2020. When appropriate, enrollee Restricted Recipient Program (RRP) warning or placement occurred.

CVS/Caremark SMS program interventions were less robust in 2020 than in 2019, but still resulted in decreased use of controlled substances (four enrollees), duplicate therapy (one enrollee) and multiple pharmacies/prescribers to obtain controlled substances (16 enrollees). In 2020, IMCare identified 217 enrollees through the CS FS, increased from 176 enrollees in 2019. Eleven enrollees received individualized education regarding their CS fills, one received an RRP warning letter, and one was enrolled in the RRP.

Although the number of enrollees receiving methadone treatment for opioid use disorder showed minimal change from 2018 to 2020, the number of enrollees utilizing buprenorphine drugs significantly increased each year, from 39 enrollees in 2018 to 86 enrollees in 2020. While IMCare does not have an in-network methadone MAT provider, network providers began offering buprenorphine MAT in 2017, which likely accounts for the increase in this treatment option over the past three years.

The total days-supply (TDS) of controlled substances (DEA schedules II-V, excluding buprenorphine MAT) dispensed per Medicaid enrollee increased 20.52% from 2019 to 2020, not meeting goal. In addition, IMCare did not meet the 2020 PMAP High Dosage Opioids (HDO) goal (MN state average rate of 5.92%), but did meet the MNCare goal for the measure.

The TDS of opioids (excluding buprenorphine drugs) dispensed decreased each year; however, the dispensed TDS of stimulants, benzodiazepines and hypnotics all increased from 2019 to 2020.

A Healthy Pregnancy Prenatal Initiative Focus Study

A prenatal focus study, referred to as *A Healthy Pregnancy* program, was developed in 2007, in collaboration with the Itasca County Public Health Maternal Child Health (MCH) Division. This program is for at-risk IMCare pregnant enrollees. 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." The program includes prenatal education and support and is free to pregnant enrollees.

IMCare sends a pregnancy congratulatory letter to each pregnant enrollee. The letter encourages her to seek early prenatal care and informs her about the program and who she can contact for additional information. After enrollment in the program, each pregnant enrollee is matched to an MCH nurse in the *Prenatal and Healthy Beginnings* program. The education provided through the program follows the *MHCP Provider Manual* guidelines for enhanced services. Topics include information about normal body changes in pregnancy, fetal development, self-care, pregnancy danger warning signs, preventing preterm labor, review of signs and symptoms of preterm labor, lifestyle and parenting support, breastfeeding, and labor and delivery education. Postpartum education is also included in *A Healthy Pregnancy* program, providing education and support to new mothers. It is the intent of IMCare and the Itasca County Public Health 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.

Pregnant IMCare enrollees who have not previously participated in *A Healthy Pregnancy* program are eligible for gift cards for their participation. During the prenatal period, those who accept prenatal visits with MCH receive 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, enrollees are eligible to receive a $30.00 Target gift card, if they accept a visit from the MCH and have a postpartum visit with their doctor within the prescribed 7-84 days postpartum timeframe.

The number of congratulatory letters sent in 2020 increased slightly from 2019, but 16 enrollees received two letters during 2020. This was in part due to eligibility rules during the COVID-19 pandemic, when the Itasca County Eligibility Specialist was unable to change eligibility for any individual who would be negatively impacted by the change; therefore, many people remained on the pregnancy benefit beyond the standard postpartum period. IMCare updated methodology for determining *A Healthy Pregnancy* program participation rates by using claims data to capture all pregnant enrollees receiving MCH nursing services, rather than just capturing those who were eligible and received gift cards for their participation. This change may result in an increase of identified participants over time. There are some limitations to this method, if the visits are not billed timely to IMCare after fourth quarter.

The IMCare C-section delivery rate increased by just over 5% from 2019 to 2020, and was above the most recent national average (recorded in 2018) in 2020. The increase was due to only six additional c-sections in 2020, so it is difficult to determine if this is a trend, or just correlated with increased enrollment. In addition, there may have been an increase in planned inductions at network facilities to allow for COVID-19 testing prior to admission, and if the inductions were unsuccessful, this may have contributed to the increased C-section rate. In contrast, the rate of preterm births decreased from 2019 to 2020. This finding may correlate with COVID-19 shelter-at-home orders, allowing pregnant enrollees more time to rest and access pregnancy resources both in-person and virtually.

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 were referred to case management for screening. In 2020, IMCare PMAP and MNCare enrollees ages 18-64 years old with an identified special health care need included enrollees with:

- at least one inpatient stay with the primary diagnosis of asthma, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), hypertension, bacterial pneumonia or urinary tract infection (UTI);
- four or more Emergency Department visits during the measurement year;
- at least one hospital readmission within five days for same or similar diagnosis;
- referred to complex case management program for screening or have care coordination contact log present;
- use of home care services; and/or
- total claims exceeding $100,000.

In 2020, all but three of the measures identifying enrollees with special health care needs showed year-to-year decrease. This decrease correlated with the COVID-19 pandemic, which resulted in lower utilization of services. Hospital stays that may have previously been attributed to areas identified in the above measures may have had a primary diagnosis of COVID-19 and; therefore, would not be included in this data. Readmissions within 5 days for same or similar diagnoses increased from 2019 to 2020. Per review of enrollee-level data, in 2020, there were seven unique enrollees with readmissions, three of which had more than one readmission. In 2019, there were seven unique enrollees who each only had one readmission. The number of enrollees impacted from year-to-year was the same, but the acuity of the conditions appears to have increased. This may be attributed to the shutdown of preventative services for several months due to the COVID-19 pandemic, which resulted in lower utilization of preventative or outpatient services. Those who were hospitalized presented in a more severe or acute stage of their condition and required longer or additional hospitalizations.

ED utilization has consistently declined over the last three years, largely in part to ED FS interventions. Additionally, the facility that serves the highest volume of IMCare enrollees added ED care coordinators, one social worker and one registered nurse. They are available during business hours to help with coordination of care and/or follow up for enrollees who frequent the ED. The social worker assists enrollees who present with mental health, substance use disorder diagnosis or other social factors. The registered nurse assists enrollees who present with complex medical problems as needed. The addition of this service may explain reduced ED rates overall.

There was a significant decrease in the number of enrollees identified for Complex Case Management (CCM) from 2019 to 2020. Previously, enrollees enrolled in the Disease Management (DM) program were included in this measure; however, the DM program was discontinued in 2019 and replaced by the Population Health Management program, which has primarily a preventative health approach and would not be reflected in CCM data. Total claims exceeding $100,000 increased by three enrollees in 2020. This was primarily due to additional enrollees receiving specialty medication for the treatment of psoriasis.

Seniors (MSHO and MSC+) Special Health Care Needs

IMCare assesses the quality and timeliness of case management/care coordination provided to seniors through the annual audit of case management/care coordination record documentation. A Social Worker (SW) or a Public Health Certified Registered Nurse (PHN) conducts all activities of care coordination and case management for IMCare seniors. From the time of an initial request, the MNChoices Assessment (MNChoices) or Long-Term Care Consultation Services Assessment (LTCC) is completed within 20 calendar days for the Elderly Waiver (EW) population. Within 30 days of enrollment, a Health Risk Assessment (HRA) or LTCC must be completed for Community-Well (CW) enrollees, and a nursing facility assessment is completed for skilled nursing facility (SNF) enrollees. Annually, IMCare audits records for timeliness of screenings and reassessments.

Public Health (PH) provides care coordination/case management for IMCare MSHO and MSC+ enrollees who, through their assessment, have been determined to meet Nursing Facility Level of

Care criteria, and so qualify for Home and Community-Based Services (HCBS) under the EW. In addition, IMCare care coordinators manage care for the CW and SNF populations. The assessment process for all enrollees includes information to improve health care delivery and promote positive health outcomes.

IMCare has an active program to reach out to all CW and SNF enrollees aged 65 years and older. A nursing facility assessment is completed within 30 days of enrollment for all SNF enrollees. If CW enrollees agree to a face-to-face visit, IMCare care coordinators/case managers complete a comprehensive health assessment within 30 days of enrollment. Reassessments are offered annually, within 364 days of the previous assessment, or more frequently if indicated by the enrollee's comprehensive care plan or a change in condition. The HRA or LTCC assessment tool is used to complete the comprehensive health assessment for CW enrollees. These tools assess enrollee health status, including condition-specific issues; supports and services needed based on strengths, 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 caregiver resources and involvement; evaluation of cultural and linguistic needs, preferences or limitations; and evaluation of available benefits and community resources.

IMCare also works with senior enrollee during a transition. The transition process utilizes the Eric A. Coleman "Four Pillars" conceptual model, thereby improving quality of care and preventing readmissions. During the transition process, when CW and EW enrollees discharge to their usual care setting, the enrollee's Care Coordinator/Case Manager contacts them to determine if they have a follow-up appointment scheduled; if they have transportation to their appointment; if they know the signs/symptoms to report to the provider; if they have knowledge of their medications and how to take them; and if they have and/or utilize a personal health record. If the enrollee needs help in any of these areas, the Care Coordinator/Case Manager assists them.

Record Audits

Medical Record Audit

IMCare annually audits enrollee medical records to determine provider compliance with regulatory requirements and National Committee for Quality Assurance (NCQA) standards. Additionally, IMCare ensures that medical records are maintained with timely, legible and accurate documentation of patient information, per IMCare medical record documentation standards.

In 2020, IMCare audited a total of 221 medical records, with the following breakdown: Fairview Nashwauk was audited on 11 charts; Hibbing Family Medical Center was audited on 30 charts; Scenic Rivers Bigfork was audited on 30 charts; Grand Itasca Clinic and Hospital was audited on 30 charts; Fairview Hibbing was audited on 30 charts; Essentia Health Grand Rapids was audited on 30 charts; Essentia Health Deer River was audited on 30 charts; and Essentia Health Hibbing

was audited on 30 charts. Overall, 94.14% of measures were met for the medical record audit, which is above the goal of 80%.

This year, there were several occurrences of auditor omissions identified and inconsistency with audit format, leading to some deviation among denominators. In addition, this year's audit was completed with the 8/30 audit methodology (as supported by NCQA), versus the 30/30 audit methodology, as used in previous audits. Most measures met goal in 2020. Measures below goal included tobacco cessation information offered to those who identified that they were smokers, and health care directives for individuals over 18 years of age. These measures have been below goal for three consecutive audit cycles. Future auditor training will focus on better understanding individual measurement supporting data, such as data stating refusal or declining of an advance directive meets the applicable measure.

The 2020 (2019 data) post audit review of audit tools and data spreadsheets identified the need to contact facilities to request either additional EMR access or submission of print screens of data that was not available to auditors during the review. Two of the facilities confirmed that auditors did not have access to the tabs necessary to validate the data required in some of the measurements, specifically measurement that addresses necessary enrollee demographic data. Auditors have been instructed to reach out to the identified contact at the facility or bring concerns to the QI/UM Director if there is difficulty accessing data.

Behavioral Health Treatment Record Audit

IMCare conducts annual behavioral health (BH) treatment record audits to determine if providers are documenting 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 assures that behavioral health treatment records are maintained with timely, legible and accurate documentation of patient information, per IMCare behavioral health treatment record documentation standards.

In 2020, IMCare audited a total of 157 BH records at 14 BH clinics, with an overall average of 80.86%, above the 80% goal. For each clinic, five initial records were reviewed. For any unmet measures, all remaining records were then reviewed for the unmet measures. The methodology explains the varying denominators among the measures. Measures that were consistently met in the first five charts have lower denominators than those that were initially unmet. It is also important to note that enrollee records randomly selected from 2019 may not reflect measures facilities put into place as a result of feedback from the 2019 BH audit.

Record content deficiencies were noted in demographic data collection, with one missing component resulting in an unmet measure, meaning all five components must be present to meet this measure. Auditor instruction included the necessity of all components being present. If they were unable to find data, they were instructed to contact the facility lead identified on the 2020 Facility Contact List, and/or reach out to the QI/UM Director. Assessment content deficiencies were related to the specific type of Diagnostic Assessment (DA) being completed and the measurement data necessary for each DA type. Treatment plan deficiencies were present in 2018 (2017 data), 2019 (2018 data) and 2020 (2019 data), with the treatment plan being reviewed and signed every 90 days and informed consent for individual treatment plan not

meeting measurement goal. Progress notes and follow-up deficiencies were also present in 2018 (2017 data), 2019 (2018 data) and 2020 (2019 data), regarding follow-up of any unresolved problems being addressed at the follow up visit.

Three measures that did not meet goal in 2019, but met goal in the 2020 audit, included:

- Enrollee authorization to release private information and enrollee information obtained from outside sources must be documented.
- Assessment methods are documented for standard and extended diagnostic assessments.
- Evidence of coordination of care with other relevant mental health providers and/or medical professionals must be documented.

Credentialing

Individual Practitioner Credentialing

DHS requires that IMCare, "adopt a uniform credentialing and recredentialing process and comply with that process consistent with State regulations and current NCQA *Standards and Guidelines for the Accreditation of Health Plans.*" IMCare credentials individual practitioners who:

- are licensed, certified or registered by Minnesota to practice independently;
- have an independent relationship with IMCare; and
- provide medical, dental or behavioral healthcare services to IMCare enrollees.

Credentialed practitioners may work in a variety of settings, including individual practices, group practices, facilities and/or telemedicine. IMCare requires initial credentialing for practitioners new to IMCare, as well as practitioners with any break in network participation. Practitioners must complete the IMCare credentialing process prior to providing care to IMCare enrollees. IMCare makes the final decision whether to approve or deny a practitioner's initial credentialing application within 180 calendar days of the practitioner's signed attestation date on the application.

IMCare recredentials individual practitioners at least every 36 months. This timeframe is only extended when a practitioner cannot be recredentialed due to active military assignment, medical leave or sabbatical. In these instances, practitioners are recredentialed within 60 calendar days of his/her return to practice. IMCare also performs ongoing monitoring of practitioner sanctions, complaints and quality issues between recredentialing cycles, and takes appropriate action against practitioners when quality issues are identified.

IMCare ensures that all network office sites meet defined standards by performing/reviewing site visit audits in order to assess the quality, safety and accessibility of office sites where care is delivered. IMCare audits the office sites of individual practitioners:

- Prior to the completion of the initial credentialing process.
- When a practitioner relocates or opens an additional office.
- When a complaint is received about an office site.
- When office site issues are identified during other quality improvement activities.
- Otherwise, as deemed necessary by IMCare staff/leadership.

IMCare requires that credentialing/recredentialing processes are conducted in a nondiscriminatory manner (Policy and Procedure 1.08.05). In addition, IMCare has credentialing system controls in place to ensure the integrity, accuracy, confidentiality and security of credentialing/recredentialing processes and all related information (Policy and Procedure 1.08.14).

IMCare completes an annual audit of individual practitioner initial credentialing and recredentialing files to ensure that all required elements were present at the time of the credentialing/recredentialing decision, applicable timeframes were met, and there is no evidence of discrimination during the credentialing/recredentialing process.
In 2020, IMCare individual practitioner credentialing interventions included:

- All 2019 annual credentialing reports were reviewed/approved by the IMCare Provider Advisory Subcommittee (PAC), which serves as the IMCare Credentialing Committee, on 02/12/2020.
- Quarterly credentialing and timeliness of credentialing/recredentialing reports were reviewed/approved by the PAC.
- Individual practitioner credentialing/recredentialing files and ongoing monitoring concerns were presented to the PAC, who recommended a course of action.
- IMCare credentialing policies and procedures were updated to meet the 2020 NCQA *Standards and Guidelines for the Accreditation of Health Plans*, and reviewed/approved by the PAC on 08/12/2020.
- Initial appointment and reappointment credentialing/recredentialing checklists were updated throughout the year as needed.
- IMCare credentialing staff maintained the *Individual Practitioner Credentialing Roster, Site Visit Log,* and IMCare provider directories throughout the year.

In 2020, IMCare credentialed/recredentialed a total of 135 individual practitioners, increased from 109 practitioners in 2019. All credentialing/recredentialing applications were processed within the required timeframes for completion. All 16 of the practitioner terminations in 2020 were not for cause (e.g., practitioner moved out of the area, retired, etc.). The IMCare network continues to grow, from a total of 278 credentialed practitioners in 2018, to 314 practitioners in 2020. All audited individual practitioner office site visit audits exceeded the 80% goal in 2020. In addition, all credentialing/recredentialing file audit measures met the 100% goal in 2020.

Organizational Provider Credentialing
DHS requires, "For organizational Providers, including nursing facilities, hospitals, and Medicare certified home health care agencies; the MCO shall adopt a uniform credentialing and recredentialing process and comply with that process consistent with State regulations." IMCare follows the NCQA *Standards and Guidelines for the Accreditation of Health Plans* to ensure a consistent, thorough credentialing process that meets community standards and current contractual and legal requirements. Organizational providers credentialed by IMCare include network:

- Hospitals
- Medicare Certified Home Health Agencies (HHA)
- Skilled Nursing Facilities (SNF)
- Free-Standing Surgical Centers

- Behavioral Healthcare Facilities (that are licensed by the State of Minnesota to provide mental health (MH) and/or substance abuse (CD) services in inpatient, residential, and/or ambulatory settings)

Organizational providers are credentialed at the time of initial contracting and recredentialed at least every 36 months thereafter, to ensure that the provider is in good standing with federal/state regulatory bodies and has been reviewed/approved by an appropriate accrediting body (Policy and Procedure 1.08.11). An onsite quality assessment is not required if the provider is accredited by an applicable accrediting body or is in a rural area, as defined by the U.S. Census Bureau. Onsite quality assessments of non-accredited organizational providers are completed:

- Prior to the completion of the initial credentialing process and at least every three years thereafter.
- When a provider relocates or opens an additional site.
- When a complaint is received about a provider site.
- When provider site issues are identified during other quality improvement activities.
- Otherwise, as deemed necessary by IMCare staff/leadership.

For non-accredited providers, IMCare may use a state or federal quality review in lieu of a site visit, if the review is no more than three years old, and IMCare obtains the survey report/letter stating that the provider was reviewed and passed inspection. IMCare makes the final decision whether to approve or deny an organizational provider's initial credentialing application within 180 calendar days of the signed attestation date on the *Organizational Provider Credentialing/Recredentialing Application*. IMCare recredentials organizational providers at least every 36 months.

In 2020, IMCare organizational provider credentialing interventions included:

- The *2019 Organizational Provider Credentialing Report* and the *2019 Site Visit Audit Report* were reviewed/approved by the IMCare Provider Advisory Subcommittee (PAC) on 02/12/2020.
- Quarterly credentialing reports, including organizational provider credentialing/ recredentialing information, were reviewed/approved by the PAC throughout 2020.
- IMCare credentialing policies and procedures were updated to meet the 2020 NCQA *Standards and Guidelines for the Accreditation of Health Plans* and reviewed/approved by the PAC on 08/12/2020.
- The *Organizational Provider Credentialing/Recredentialing Checklist* was updated throughout the year as needed.
- IMCare credentialing staff maintained the *Organizational Provider Recredentialing Log, Site Visit Log,* and IMCare provider directories throughout the year.

No organizational provider initial credentialing applications were submitted to IMCare in 2020, and no organizational providers were due for recredentialing in 2020. In addition, no IMCare onsite quality assessments of organizational providers were required during 2020.

Provider Service Contracting

Provider Participation Agreements/Contracted Partners

IMCare contracts with individual practitioners and providers, including those making 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 an Internal Medicine 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 affirmative statement declares that IMCare does not use incentives or encourage barriers to care and/or service. Additionally, it states IMCare does not specifically reward or incentivize providers and/or IMCare staff for denial of service determinations.

The IMCare Affirmative Statement is reviewed at least annually and disseminated to all providers and enrollees. In 2020, 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.

IMCare includes Affirmative Statement requirements in provider participation agreements. IMCare updates the Affirmative Statement Policy and Procedure to meet federal and state requirements and includes it in the Provider Manual. The affirmative statement is reviewed and distributed to all providers, annually.

Health Care Directives

IMCare distributes health care directive information at least annually to enrollees and providers and it is reviewed annually by IMCare staff. 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. Health care directive information was included in the Spring/Summer 2020 and Fall/Winter 2020 enrollee newsletters. Additionally, CaseTrakker includes health care directives so they can be documented by care coordinators.

Historically, IMCare has not met goal on documentation of health care records in the medical and behavioral health record audits. The most recent audits showed a compliance rate of 37.91%, which is a decrease of 22.09% over the previous year's record reviews. The measure is

applicable to enrollees 18 years old and older. While low rates in the 18-64 year olds could be expected, the rate for all IMCare populations (18+) is well below the goal of 80%.

Documentation of health care directives in medical records is the desired method of measuring compliance with health care directive requirements. Consequently, all practitioners and facilities do not employ the same electronic medical record (EHR) system. This makes it a challenge for IMCare chart abstractors to identify documentation. In addition, encouraging the younger, healthier population to consider a health care directive is challenging.

Accessibility of Services

In 2020, IMCare ensured 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 DHS and NCQA standards.

2019-2020 Interventions:

- 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 Directory 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.
- IMCare complied with the Mental Health Parity and Addiction Equity Act (MHPAEA, Pub.L. 110-343) making it easier for enrollees with mental health and substance use disorders to get the care they need by prohibiting certain discriminatory practices that limit coverage for behavioral health treatment and services.
- 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 2019 Accessibility of Services Report was reviewed/approved by the IMCare Provider Advisory Subcommittee (PAC) on 11/13/2019 and the External Quality Improvement/Utilization Management (QI/UM) Committee on 12/18/2019.
- The 2019 Practitioner/ Facility Grievance Report was reviewed/approved by the PAC on 02/12/2020 and the External QI/UM Committee on 03/18/2020.
- The 2019 Credentialing File Audit Report was reviewed/approved by the PAC on 02/12/2020 and the External QI/UM Committee on 03/18/2020.
- The 2019 Site Visit Audit Report was reviewed/approved by the PAC on 02/12/2020 and the External QI/UM Committee on 03/18/2020.
- An article regarding IMCare Accessibility Standards was included in the Fall 2019 Provider Newsletter.
- IMCare conducted individual outreach to behavioral health providers who did not meet IMCare Access Standards during the 2018-2019 reporting period to determine how providers would work to meet standards during the next reporting period.

- Provider surveys were modified to clarify questions that providers indicated they initially misunderstood through individual outreach.

During the study period, IMCare met goal for all accessibility measurements and provider types. Overall, IMCare maintained an adequate care network as it relates to provider accessibility. In addition to the provider accessibility measurements included in the report, multiple other avenues to care also are available to IMCare enrollees. IMCare adheres to the Mental Health Parity and Addiction Equity Act (MHPAEA, Pub.L. 110-343), making it easier for enrollees with mental health and substance use disorders to get the care they need by prohibiting certain discriminatory practices that limit coverage for behavioral health treatment and services. Coverage for mental health and substance use disorders is less restrictive than the coverage that generally is available for medical/surgical conditions. IMCare entertains all individual behavioral health practitioner requests for credentialing and all providers who can meet NCQA credentialing standards are added to the IMCare network. Furthermore, the Itasca County Crisis Response Team provides around-the-clock urgent/emergent behavioral health care to Itasca County residents. Network urgent care facilities and emergency departments also ensure accessibility of urgent/emergent care. 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 2020, IMCare ensured the availability of providers and services by identifying gaps in network adequacy through data analysis, as required by NCQA and IMCare contracts with the DHS. IMCare maintains and monitors a network of providers, supported by written agreements, and provides adequate availability to covered services to meet the needs of the population served in accordance with Minnesota Statutes §62D.124, §62K.10, Minnesota Rules, part 4685.1010, 42 C.F.R. § 438.68, DHS Contract section 11.6.1, and CMS contracts.

2019-2020 Interventions:

- IMCare ensured provider 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 Initial Enrollee Screening 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 Directory 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.
- The 2019 Provider Availability and Network Adequacy Report was reviewed/approved by the IMCare Provider Advisory Subcommittee (PAC) on 11/13/2019 and the External Quality Improvement/Utilization Management (QI/UM) Committee on 12/18/2019.
- The 2019 Practitioner/Facility Grievance Report was reviewed/approved by the PAC on 02/12/2020 and the External QI/UM Committee on 03/18/2020.
- An article regarding IMCare Accessibility Standards was included in the Fall 2019 Provider Newsletter.

During the study period, IMCare met goal for primary care providers and all specialty care availability measures. There were nine households that were not within 30 miles of a primary care provider with admitting privileges specifically, however the primary care providers in network generally work collaboratively to meet enrollee needs, so this is not seen as a barrier for enrollees. Provider to enrollee ratios for obstetrics/gynecology, orthopedics, cardiology and oncology all met goal. In order to ensure specialty care availability, IMCare allows enrollees to see all network and outreach specialty providers in the IMCare service area. In addition, IMCare allows enrollees to see specialty care providers at the nearest out-of-network tertiary care center without a referral or prior authorization.

IMCare met goal for nearly all behavioral health provider 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 provider type. IMCare allows enrollees to see psychiatrists at the nearest out-of-network tertiary care center without a referral or prior authorization and has participated in local recruitment efforts. During the study period, eight 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, which would not be reflected on the current GeoAccess map. IMCare network facilities provide medical stabilization for enrollees requiring mental health and chemical dependency assessment/admission, when necessary. In addition, the Itasca County Crisis Response Team provides around-the-clock urgent/emergent behavioral health care to Itasca County residents.

Nearly all ancillary service provider, pharmacy and hospital measures met goal for the study period. Eleven households in northwest Itasca County 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, IMCare identified that no hospitals in the surrounding counties would be closer to access for these households, due to the very rural area.

In July 2018, IMCare implemented a tracking system for authorizations to allow for retroactive review of in and out-of-network requests by provider specialty. Per review of this data for the 2019-2020 measurement period, enrollee's utilization of specialty care services out-of-network do not appear to be correlated with unmet access standards. Overall, the ratio of enrollees seeking care out-of-network remains quite low in comparison to total enrollment.

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 provider, when a network option was available. None were appealed. In addition, there were no enrollee grievances related to issues with provider availability or network adequacy.

Enrollee Experience

Medicaid Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey

An external vendor, as delegated by DHS and CMS, conducted the survey and compiled a report for all public Managed Care Organizations (MCOs). The standardized survey instrument used was the CAHPS. Samples for each IMCare population were generated as outlined below.

- PMAP: A random sample of 1,350 eligible IMCare enrollees, ages 18-64 years, was used.
- MNCare: IMCare data was combined with PrimeWest Health, Hennepin Health and South Country Health Alliance, for a total sample size of 1,350 enrollees.
- MSC+: IMCare data was combined with PrimeWest Health and South Country Health Alliance, for a total sample size of 1,200 enrollees.

Table 1. 2020 CAHPS Survey Completion Rate

	Eligible Sample Size	# of Enrollees who Completed the Survey	Survey Completion Rate
PMAP	1,350	326	24.33%
MNCare	1,350*	467*	35.30%
MSC+	1,224*	664*	56.10%

* Combined Sample

The Medicare CAHPS Survey, extracted by a separate vendor than the Medicaid populations, was cancelled in 2020 due to the COVID-19 pandemic; therefore, data is not available for analysis. DHS used the Health Survey Advisory Group (HSAG) vendor again in 2020 and as a result there was a combined enrollee sample for the MNCare and MSC+ population due to inclusion criteria. Of those who responded in the combined samples, IMCare enrollees accounted for 10.5% of responses for MNCare and 10.8% of responses for MSC+.

In 2020, less than 50% of measures across populations were above the MN state average goal. However, all measures below the MN state average were within 5% of goal. One measure, Getting Care Quickly, had year-to-year increases across all populations. This may be attributed to hiring of new providers at many IMCare network facilities, allowing for more appointment availability. Health Plan Customer Services had large year-to-year increases for both PMAP and MNCare populations; MSC+ rates did not show year-to-year increase, but remained consistently above 90% and met goal. IMCare has increased success in retention of customer service staff, creating a better, more efficient experience for IMCare enrollees. Rating of Health Plan had significant year-to-year drop for MNCare population; however, IMCare only made up a small fraction of the overall responses, so it is difficult to determine the reason for decrease. The MSC+ responses were overall more satisfied across all measures, which is consistent with previous years. Each senior enrollee has a designated care coordinator, who assists with navigating the IMCare network and acts as a point of contact. This may improve overall healthcare experience for these enrollees.

CAHPS survey results are self-limiting, in that they do not identify specific enrollees who responded with dissatisfaction, to allow for further exploration by IMCare to identify and resolve any specific patterns or problems. Additionally, results for the survey are not available until well into the following year, which make real-time interventions unrealistic.

Senior Enrollee Satisfaction with Care Coordination Survey

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 DHS contract and NCQA requirement.

In August 2020, IMCare mailed the Care Coordinator Satisfaction Survey to 669 MSHO and MSC+ enrollees. Two hundred fifty-nine responses were received. Ninety-two were from EW enrollees, 140 were from CW enrollees, and 27 were from SNF enrollees. The overall response rate was 38.71%, which is an increase of 8.97% over the response rate of 29.74% in 2019.

As a CBP plan, IMCare capitalizes upon the arrangement with our delegate, Itasca County Public Health, to deliver localized care coordination services. All care coordinators are either IMCare staff or public health staff. The survey data displays that the care coordinators exceed the 80% goal in all aspects of EW and CW care coordination. 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 about resources and services available within their immediate and surrounding communities. This commitment, experience and knowledge helps IMCare ensure compliance with its mission of empowering and engaging enrollees in their health care goals. It also ensures the care coordination model is effective and efficient in its service delivery.

In past years, CW and SNF facility enrollee responses were included in one chart. These two populations have very different needs, and some aspects of their care coordination are very different. For these reasons, their responses to this year's survey have been separated, and the 80% goal was not met for SNF enrollees in three questions – M2, M6, and M7. This reflects the fact that SNF enrollees are most often not contacted by phone, and they are not offered services above and beyond what they receive in their facility. Also, in 2019, it was decided to make changes to the survey to tailor it to the three different populations; however, it became apparent that CTD does not allow for separate surveys to be created and mailed to each population. Because of this, the questions were revised, and the same survey was again mailed to all enrollees. It is evident that several questions remain not applicable to many enrollees. Finally, IMCare decided to include some examples of enrollee comments in this year's report. Most of these comments were positive. When they were not, most of them were either neutral or were related to not knowing who the care coordinator is and/or not having met them yet.

Table 2. Enrollee Satisfaction Survey Measures

M1. Do you know who your care coordinator is?
M2. Have you talked with your care coordinator in person or on the phone?
M3. Do you know how to reach your care coordinator?
M4. Does your care coordinator return your calls in a timely manner?
M5. If you reside in a skilled nursing facility, has your care coordinator attended a care conference with you?
M6. Did your care coordinator inform you of health and wellness opportunities that might be helpful to you?

M7. Did your care coordinator offer you choices about which services and supports are available to you?
M8. Did your care coordinator answer questions about services and supports that are available to you?
M9. Were you able to talk to your care coordinator about questions or concerns you have regarding your services & supports?

Table 2. Enrollee Satisfaction Survey Measures (continued)

M10. If you requested, did your care coordinator make changes to your services and supports?
M11. Has your care coordinator treated you with dignity and respect?
M12. How would you rate your overall satisfaction with your care coordinator?
M13. How would you rate your overall satisfaction with the services & supports you receive?
M14. How would you rate your overall satisfaction with the care you receive in your skilled nursing facility, foster care, adult day services or customized living facility?

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 to learn how to obtain medical care.

2020 Interventions:

- Written notification of monthly enrollee education was sent to individuals who were newly enrolled from January-March 2020.
- IMCare staff were available from 8am-8pm every day of the year to answer questions enrollees may have had regarding their IMCare benefits.

Due to the COVID-19 pandemic, enrollee education sessions were only held in person January-March of 2020. During this timeframe, five PMAP/MNCare enrollees attended enrollee education. During the pandemic, IMCare was able to address enrollee needs via the enrollee services line and tracking of contact logs.

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.

2020 Interventions:

- IMCare Director, QI/UM Director and Compliance Officer were in close contact with First Call for Help (FCFH) during 2020 to discuss opportunities for improvement and communicated expectations via email, on an ongoing basis.
- IMCare QI/UM Director/s conducted routine monitoring of Prairie Fyre to review call abandonment rates and followed up with staff accordingly.
- IMCare required at least one CSR to be available during regular business hours, except for all-staff or CSR meetings, at which time calls were answered by alternative staff or FCFH.
- Additional IMCare staff were cross trained on addressing calls, to allow for additional coverage during high volume periods.

IMCare uses the CMS benchmark for internal monitoring. The call abandonment rate is not available at this time to determine if IMCare was below the 5% threshold. Per IMCare's internal call monitoring system, Prairie Fyre, only 1.09% of the 8,829 calls handled were abandoned during 2020.

Population Health Management (PHM)

In 2020, IMCare implemented a Population Health Management program to meet DHS Contracts section 7.3, utilizing NCQA PHM Standards. The primary areas of focus for the PHM program are:

- Keeping enrollees healthy
- Managing enrollees with emerging risk
- Patient safety or outcomes across settings
- Managing multiple chronic illnesses

Specific goals developed for the PHM program include the following:

1. Goal: Annual increase of enrollees in the target population receiving influenza vaccine.
   Target population: All enrollees enrolled in the plan who exceeded 6 months of age in the measurement year with or without risk factors.
2. Goal: Increase in annual age appropriate wellness exams for enrollees as captured in the following HEDIS measures: Well-Child Visits in the First 15 Months of Life (W15); Well-Child Visits in the 3rd-6th years of life (W34); and Adolescent Well-Care Visits (AWC).
   Target population: All enrollees enrolled in the plan who met age requirements within the measurement year.
3. Goal: Increase in annual age appropriate wellness exams for enrollees as captured in the following HEDIS measures: Breast Cancer Screening (BCS); Colorectal Cancer Screening (COL); Cervical Cancer Screening (CCS); and Chlamydia Screening in Women (CHL).
   Target population: All enrolled adults that meet age requirements in measurement year.
4. Goal: Improve statin therapy for enrollees with diabetes by two percentage points.
   Target population: Enrollees aged 40-75 with diabetes.
5. Goal: Increase follow up after ED visits for mental illness or substance use disorder (SUD) as identified by the following HEDIS measures: Follow-Up After ED Visit for Mental Illness (FUM) and Follow-Up after ED Visit for Alcohol and Other Drug Abuse or Dependence (FUA).

Target population: Enrolled individuals 13 years of age and older in the measurement year.

6. Goal: Annual reduction in inpatient readmissions in target population.
   Target population: Enrollees 18 years of age and older in the measurement year with two or more chronic illnesses.

2020 Interventions:

- IMCare MCNs were provided Case Management training in May of 2020. Complex Case Management is a component of the PHM program and addressed in the next section.
- IMCare collaborated with a network facility ED Care Coordinator to identify enrollees who frequented the emergency room for conditions secondary to mental health and/or substance use disorders.
- IMCare collaborated with a network facility on addressing enrollees with chronic conditions or frequent ED use through their Community Health Worker.
- Enrollee education via biannual enrollee newsletters included the following topics:
    - Preventing hospital readmissions
    - National Alliance on Mental Illness
    - Classes for chronic conditions and pain
    - The importance of influenza vaccinations
    - Maintaining routine care during the COVID-19 pandemic
    - Routine vaccine information
    - Itasca County Public Health vaccine clinics
- Provider education via biannual provider newsletters included the following topics:
    - New Population Health Management program
    - Case Management and Care Coordination
    - E-visits (another option for enrollees to manage chronic conditions)
- The Population Health Appraisal was made available on the IMCare website, for enrollees to complete a self-rating of their current health status.
- A PHM section was developed on the IMCare website with resources for enrollees regarding the following topics:
    - Child & Teen Checkups schedule
    - Birth to six years of age immunizations
    - Seven to 18 years of age immunizations
    - Adult immunizations
    - Preventative health screening for men
    - Preventative health screening for women

IMCare is required to evaluate effectiveness of the PHM program annually; however, HEDIS 2021 (2020 data) results will be utilized, which are not currently available. The initial report is due to DHS on 07/01/2021, and effectiveness of the IMCare PHM program will be evaluated at that time.

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 CCM is to assist enrollees in regaining 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 enrollees. IMCare assists enrollees with multiple or complex conditions, to obtain access to care and services and coordinate their care.

CCM conditions include, but are not limited to, the following:

- Cancer
- Substance Use Disorder
- 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 admission data
- Compassionate Allowance Conditions Report
- Restricted Recipient Report
- Initial enrollee screening

Referral identification sources include:

- Provider referrals
- Discharge planner (inpatient case manager) referrals
- Enrollee service referrals
- Enrollee self–referrals

The CCM program involves a screening, 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 complete screening, offer case management services, complete 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 assist with access to needed services. The CCM program is an included benefit to the enrollee. Enrollees 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 enrollees and consists of several key areas including, but not limited to:

- CCM screening to identify need for CCM
- Comprehensive initial assessment and/or reassessment of enrollee's health
- Development of an individualized care plan with Specific, Measurable, Achievable, Realistic and Timely (SMART) goals
- Facilitation of enrollee's 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 until goals are met, or for as long as the enrollee has identified needs and is 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 an 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, substance use disorder 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 PCP or clinic
- Establishing a communication system of significant health events (e.g., ED 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 (conducted over the phone during the COVID-19 pandemic)
- Communication of the care plan to the PCP
- Communication of significant health events, including ED 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 caregiver supports and facilitation of caregiver respite to assist enrollees with remaining at home
- Facilitation and coordination of 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 service 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 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 providing for appropriate choices among nursing facilities and/or EW services to meet the individual needs of enrollees who require a nursing facility level of care
- Coordinating the medical needs of an 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 the 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 30 cases of eligible EW and 30 cases of eligible CW MSHO and MSC+ care plans, 15 due for initial assessment and 15 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. Some elements pertaining to assessment apply only to new enrollees (new to IMCare within the last 12 months) and others apply to existing cases (enrolled for more than 12 months). IMCare ensures that there is an adequate number of cases to evaluate compliance per these elements. In 2020, Itasca County Public Health EW care plans were deficient in four elements that did not meet the 95% goal. Internal IMCare non-EW care plans were deficient in one element that did not meet the 100% goal. Corrective action plans were implemented.

2020 MSHO/MSC+ Transitions Report

In accordance with the DHS Minnesota Senior Health Options (MSHO) and Minnesota Senior Care Plus Services (MSC+) contract and IMCare Model of Care (MOC), Care transition protocols were implemented to ensure continuity of care for MSHO and MSC+ enrollees who move from one care setting to another, related to changes in their health status (e.g., a hospital admission from their home, a hospital discharge to a nursing facility, or a facility discharge back to their home).

IMCare' s contracted providers are required to notify IMCare of planned and unplanned transitions of care within one business day of the transition. Care Coordinators (CC) are required to complete specific tasks related to the transition, within one business day of the provider notification. The goal of these tasks is to reduce hospital readmissions and improve enrollee outcomes by providing consistent enrollee support during the transition.

IMCare analyzes transition data annually. Monitoring and managing care transitions reduces or eliminates unsafe and fragmented care, which may occur with poorly coordinated transitions of care. Care coordination activities, including transitions, are documented and tracked in CaseTrakker Dynamo (CTD). 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 were set. In 2020, data for transitions conducted in 2019 were audited. IMCare assessed and ensured that proper notification of transitions was received, and proper follow-up care was given to MSHO and MSC+ enrollees. The data was measured in comparison to the goals and standards, and opportunities for improvement were identified.

In 2019, letters were sent to providers, reminding them of the requirements listed in Chapter 13 of the IMCare Provider Manual (Inpatient Hospital Notification and Authorization), including the requirements for transition notification and sharing of information. In addition:

- IMCare provided CC training to our delegate on the transition process, the importance of each task, and required documentation.
- IMCare CCs attended the monthly MCO Care Coordination Workgroup meetings to exchange ideas and learn from other health plans.
- Annual MOC training was conducted with IMCare delegates.

- IMCare continued to develop relationships and communicated transition needs and requirements to facility discharge planners/social workers.

Adoption of Practice Guidelines

The adoption, dissemination and application of clinical practice guidelines are required by IMCare 2020 Families and Children and Seniors contracts with DHS and 42 CFR §438.236. Per Article 7.1.6 of the 2020 Seniors contracts, "The MCO shall adopt preventive and chronic disease practice guidelines appropriate for Enrollees age sixty-five (65) and older, consistent with accepted geriatric practices." Both contracts require that the practice guidelines:

- are based on valid and reliable clinical evidence or a consensus of Health Care Professionals in the particular field;
- consider the needs of the MCO Enrollees;
- are adopted in consultation with contracting Health Care Professionals; and
- are reviewed and updated periodically as appropriate.

The guidelines must also be disseminated to all affected providers and, upon request, to enrollees and potential enrollees. In addition, IMCare must ensure that the practice guidelines are applied to utilization management decisions, coverage of service decisions, enrollee education, and any other applicable areas.

In 2020, IMCare adopted, disseminated and applied the following UpToDate evidence-based clinical practice guidelines:

- Overview of General Medical Care in Nonpregnant Adults with Diabetes Mellitus
- Overview of Preventive Care in Adults
- Geriatric Health Maintenance
- Screening Tests in Children and Adolescents
- Guidelines for Adolescent Preventive Services
- Prenatal Care: Initial Assessment
- Prenatal Care: Second and Third Trimesters

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 CVS 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, DHS contract requirements, and the delegation agreement with the vendor.

CVS Caremark Delegation Agreement

IMCare is accountable for overseeing the delegated services outlined in the *Delegation Agreement Addendum to Pharmacy Benefit Services Agreement (PBSA)* with CVS Caremark. Each year, IMCare completes a performance review of CVS Caremark to assure all delegated services are being performed in accordance with national quality standards, applicable state and

federal laws and regulations, contract terms, and other accrediting and regulatory agencies as appropriate. Additionally, IMCare reviews additional performance metrics to ensure timely delivery of services related to formulary operationalization, claims resolution, and reporting requirements. If it is found that CVS Caremark is not performing the delegated responsibilities, IMCare may require corrective action and repeal any portion of the delegation.

In 2020, thirteen categories were assessed as part of the CVS Caremark oversight process. Assessment was completed through review of each categorical material set which, in total, included over 20 reports and policy and procedure documents. The following is a summary of the oversight categories:

1. Establishing a Retail Pharmacy Network
2. Pharmacy Network Auditing
3. Custom Medicaid Formulary/Uniform PDL/Formulary Management
4. Pharmacy Helpdesk
5. Point of Sale Utilization Management
6. Maintaining Eligibility Data
7. Maintaining Point of Sale Claims Processing
8. Communication Materials
9. Standard Management and Utilization Reports
10. Quality Management Programs
11. DUR Services/Clinical Programs
12. Safety and Monitoring Solution Program
13. General Performance and Monitoring
    a. MAC Performance Oversight
    b. Encounter Data Review
    c. Invoiced and Paid Amount Reconciliation

IMCare found CVS Caremark to be compliant with all oversight categories. There were no identified deficiencies or mandatory improvements.

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 not meeting the IMCare standards regarding their delegated responsibilities and IMCare is working to implement a corrective action plan with DHS.

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 MN Choices assessments and enrollee care plans 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.

2020 Utilization Management Program Activities

Clinical Criteria for Utilization Management Decisions

At least annually, IMCare evaluates criteria used to make UM decisions. 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 update and provider newsletter. The criteria is also linked to the provider area of the IMCare website.

In 2020, 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)
- Community Standards
- Drug Coverage Criteria (e.g., MN Department of Human Services (DHS), 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.

Medicaid Under and Over Utilization

Ensuring appropriate utilization of services is required as per Article 7.1.4 of the 2020 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 for the Accreditation of Health Plans*."" Pursuant to 42 CFR § 438.330(b)(3), this structure must include, "mechanisms to detect both underutilization and overutilization of services."

2019 Interventions:

- Enrollee newsletters were sent out in spring and fall of 2019. Article topics included information about preventative wellness visits and screening, vaccines, alternative pain management, cancer screenings, dental visits, opioid abuse, transportation information, and mental health awareness.
- Individual enrollee letters were sent out for well child reminders, mammograms, colonoscopy, and cervical screenings.
- IMCare developed a Facebook page to share upcoming vaccine clinics, preventative screening guidelines and health/wellness events within the community with enrollees and providers.

- IMCare continued the controlled substance (CS) focus study to identify those at risk for substance use conditions.
- IMCare continued the emergency department (ED) focus study to identify individuals who regularly visit the emergency room for mental health or substance use disorders, and made referrals as needed.

A majority of IMCare Medicaid HEDIS utilization measures met goal and were relatively static from 2019 to 2020. The 2020 Children and Adolescents' Access to Primary Care Practitioners (CAP) rate was just below the MN state average for both PMAP and MNCare enrollees; however, there was a year-to-year increase for the MNCare population and a less than 1% decrease from 2019 for the PMAP population.

The Mental Health Utilization (MPT) goal was unmet for both PMAP and MNCare populations, as both were above the MN state average and had continued year-to-year increase in utilization. Due to the increase in new network mental health services, and overall improved access to those services, IMCare anticipates that the MPT measure may continue to increase annually. The measure is somewhat limiting in that it includes all levels of mental health care. This makes it difficult to distinguish what levels of care are being utilized by IMCare enrollees. Utilization of outpatient mental health services for the management of a mental health diagnosis is most cost-effective and can prevent the need for higher levels of care.

The Identification of Alcohol and Other Drug Services (IAD) measure did not meet goal for the PMAP population, as it fell just above the MN state average, with a 2% increase from 2019. Much like the MPT measure, there has been an increase in the number and availability of Substance Use Disorder (SUD) services due to the SUD Reform led by DHS. IMCare also anticipates that IAD rates will continue with an upward trend in the next few years.

The Well-Child Visits in the 3rd-6th Years of Life (W34) rate was below goal for the MNCare population, but had a 6% increase from 2019 for the PMAP population. IMCare had increases in Well-Child Visits in the First 15 Months of Life (W15) and Adolescent Well-Care Visits (AWC) from 2019 to 2020. This may be a result of IMCare Well Child Visit individual outreach letters, preventative health visit reminders in the IMCare enrollee newsletters, and/or electronic reminders for enrollees from their primary network clinics.

IMCare Annual Dental Visit (ADV) rates continue to exceed the MN state average rate for both MNCare and PMAP populations. This is likely due to IMCare's strong dental network, consisting of providers that work collaboratively with one another and with IMCare to ensure enrollees have access to needed dental care.

Table 3. Medicaid Under and Over Utilization HEDIS Measurement Methodology

Measurement Methodology	Data Source
M1. Percentage of enrollees 12 months-6 years of age who had a visit with a PCP during the measurement year and 7-19 years of age who had a visit with a PCP during the measurement year or the year prior to the measurement year. (CAP)	HEDIS Data
M2. The percentage of enrollees 20 years and older who had an ambulatory or preventive care visit during the measurement year. (AAP)	HEDIS Data

M3. The percentage of enrollees 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. (W15)	HEDIS Data
M4. The percentage of enrollees 3-6 years of age who had one or more well-child visits with a PCP during the measurement year. (W34)	HEDIS Data
M5. The percentage of enrollees 12-21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year. (AWC)	HEDIS Data
M6. The percentage of enrollees 2-20 years of age who had at least one dental visit during the measurement year. (ADV)	HEDIS Data
M7. The percentage of enrollees receiving any mental health services during the measurement year (including inpatient, intensive outpatient or partial hospitalization, outpatient, ED, or telehealth). (MPT)	HEDIS Data
M8. The percentage of ED visits for enrollees 6 years of age and older with a principal diagnosis of mental illness, who had a follow-up visit for mental illness within 7 days. (FUM)	HEDIS Data
M9. The percentage of enrollees with an alcohol and other drug (AOD) claim who received any chemical dependency service during the measurement (including inpatient, intensive outpatient or partial hospitalization, outpatient or an ambulatory MAT dispensing event, ED, or telehealth). (IAD)	HEDIS Data
M10. The percentage of ED visits for enrollees 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD within 7 days. (FUA)	HEDIS Data

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

Medicare Under and Over Utilization

Ensuring appropriate utilization of services is required as per Article 7.1.4 of the 2020 DHS Seniors contract, "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*."" Pursuant to 42 CFR § 438.330(b)(3), this structure must include, "mechanisms to detect both underutilization and overutilization of services."

2019 Interventions:

- Enrollee education regarding mental health care was included in the Spring/Summer and Fall/Winter 2019 enrollee newsletters.
- Enrollee education regarding senior care coordination was included in the Fall/Winter 2019 enrollee newsletter.
- Enrollee education regarding transitions of care was included in the Fall/Winter 2019 enrollee newsletter.
- MSHO enrollees who agreed to have a MNChoices or Health Risk Assessment (HRA) were screened for substance use and depression and educated on the importance of preventative care.
- Enrollee education regarding colorectal cancer screening was included in the Fall/Winter 2019 enrollee newsletter.
- The 2019 Medicare Under and Over Utilization Report was reviewed/approved by the IMCare Provider Advisory Subcommittee (PAC) on 11/13/2019 and the IMCare External QI/UM Committee on 12/18/2019.

For 2020, IMCare had relatively stagnant year-to-year results for most measures, with a majority within 5% of the previous measurement year. The rate of outpatient visits (AAP) decreased slightly from 2019, but was within 1% of the MN state average. Mental Health Utilization (MPT) increased 1.1% from 2019, but continued to meet goal and fell just below the state average. Colorectal Cancer Screening (COL) fell just below the state average in 2020, but showed slight improvement from 2019. Transitions of Care (TRC), with four measurable components, met goal for all areas, except Receipt of Discharge Information. There was a significant year-to-year decrease in this component, which was attributed to a change in the wording of the technical specifications. The reviewers were very strict in their review in 2020. For next year, IMCare will request clarification from NCQA and/or the HEDIS auditor to determine what meets the standards.

One ongoing barrier to improvement and goal setting is the NCQA national benchmarks and thresholds, which 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 in the interim, will continue to use the MN state average HEDIS rates to measure under and over utilization.

Table 4. Medicare Under and Over Utilization HEDIS Measurement Methodology

Measurement Methodology	Data Source
M1. The percentage of MSHO enrollees who had one or more ambulatory or preventive care visits during the measurement year. (AAP)	HEDIS Data
M2. The percentage of MSHO enrollees who received any mental health services during the measurement year (including inpatient, intensive outpatient or partial hospitalization, outpatient, emergency department and telehealth). (MPT)	HEDIS Data
M3. The percentage of MSHO enrollees with an alcohol and other drug (AOD) claim who received any chemical dependency service during the measurement year (including inpatient, intensive outpatient or partial hospitalization, outpatient or an ambulatory MAT dispensing event, ED, or telehealth). (IAD)	HEDIS Data
M4. The percentage of MSHO enrollees 65-75 years of age who had appropriate screening for colorectal cancer. (COL)	HEDIS Data
M5. The percentage of discharges for MSHO enrollees that had documentation of receipt of notification of inpatient admission on the day of admission or the following day. (TRC)	HEDIS Data
M6. The percentage of discharges for MSHO enrollees that had documentation of receipt of discharge information on the day of discharge or the following day. (TRC)	HEDIS Data
M7. The percentage of discharges for MSHO enrollees that had documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge. (TRC)	HEDIS Data

Table 4. Medicare Under and Over Utilization HEDIS Measurement Methodology (cont.)

Measurement Methodology	Data Source
M8. The percentage of discharges for MSHO enrollees that had documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days). (TRC)	HEDIS Data

Medication Therapy Management (MTM) Program

The IMCare MTM program is a targeted medication therapy management program for Medicare Part D enrollees intended to optimize therapeutic outcomes through improved medication use. The program identifies individuals with multiple medications and complex health needs and

offers them a comprehensive medication review to ensure their medications are working to improve their health. CMS requires that all Part D sponsors incorporate an MTM program into their plan's benefit structure, as described in § 423.153(d)(1). CMS defines MTM program eligibility requirements and core program components. In 2020, CVS Caremark's MTM vendor, for the third year, was Outcomes MTM.

In 2020, plan participants targeted for the IMCare MTM program were those individuals who met the following targeted eligibility criteria:

- Had three or more of the targeted chronic diseases (Asthma, Chronic Heart Failure, Depression, Diabetes, Cardiovascular Disorders, COPD and Osteoporosis-Arthritis-Bone Disease);
- Taking at least eight covered Part D maintenance medications; and
- Likely to incur annual costs for covered Medicare Part D drugs in excess of $4,255.

The MTM program targeted beneficiaries using the following three core interventional components:

- Interventions for both beneficiaries and prescribers
- A comprehensive medication review (CMR)
- Quarterly targeted medication reviews (TMRs) with follow up interventions when necessary

2020 Interventions:

- Comprehensive Medication Review (CMR) – A CMR is an interactive person-to-person or telehealth medication review and consultation conducted in real-time between the patient and/or other authorized individual, such as prescriber or caregiver, and the pharmacist or other qualified provider. The CMR is designed to improve patients' knowledge of their prescriptions, over-the-counter (OTC) medications, herbal therapies and dietary supplements; identify and address problems or concerns that patients may have; and empower patients to self-manage their medications and their health conditions. CMRs are how the MTM program offers interventions to beneficiaries.
- Targeted Medication Review (TMR) – TMR's identified and addressed prescriber opportunities to improve medication-related issues or unresolved issues post-CMR. TMR's are how the MTMP offers interventions to prescribers.
- Similar to 2019, in the first quarter of 2020, the Pharmacy Director shared a list of MTM program eligible enrollees with IMCare case managers. The intent was for nurse case managers to use the list to identify MTM program eligible enrollees currently in case management. The nurses provided education, as part of the annual visit, to enrollees eligible for the MTM program and offered referrals to a local pharmacist to complete a comprehensive medication review.

Overall, the number of complex cases targeted for the MTM program have remained consistent over time. In 2020, a similar percentage (22.98%) of the total IMCare MSHO population met MTM program targeting criteria. CMR completion rates exceeded the increased goal of 70% in 2020, and significantly improved over the previous year. Of the 111 targeted eligible enrollees, 75.67% completed a CMR with a pharmacist, compared to 66.95% in 2019. Local retail

pharmacists and IMCare nurses continued to do a great job engaging patients, creating relationships, and completing cases.

In 2020, the TMR success rate was 26.19%. The most common TMR reasons were related to adherence to chronic drugs and use of a high-risk therapy (antidepressant). The most prevalent adherence related TMRs were for statins, inhaled steroids, beta blockers and long-acting insulin. Historically, adherence responds positively to patient engagement and education.

Provider Satisfaction Survey

As per IMCare contracts with 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 Management (UM) Program Structure section (UM 1) requires that IMCare consider practitioners' experience data when evaluating the 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. The 2020 Provider Satisfaction Survey was mailed in January.

2019 Interventions:

- 2019 IMCare UM criteria sources were reviewed/approved by the IMCare PAC on 02/13/2019 and by the IMCare QI/UM Committee on 03/20/2019.
- IMCare authorization/referral requirements were updated throughout 2019 and changes were communicated to providers via provider updates/newsletter.
- Provider education regarding IMCare care coordination and case management services, and the process for referral, was included in the Spring 2019 provider newsletter.
- Annual comprehensive review of IMCare formularies and drug authorization requirements/process was completed and communicated to providers via provider update/newsletter.
- The IMCare website was regularly updated throughout 2019.
- Provider education regarding IMCare's QI Program efforts (e.g., focus studies, performance improvement projects, etc.) was included in the Spring 2019 provider newsletter.
- Provider education regarding the IMCare PHM program was included in the Fall/Winter 2019 provider newsletter.
- Throughout 2019, IMCare followed NCQA guidelines for credentialing individual practitioners and organizational providers.
- The 2019 IMCare Provider Satisfaction Survey Report was reviewed and approved by PAC on 05/8/2019 and the QI/UM Committee on 06/19/2019.

The 2020 Provider Satisfaction Survey had a response rate of 22%. The overall provider satisfaction rate was 98%, increased from 94% in 2019. All but one 2020 survey question measurement exceeded goal. The only measurement that did not meet goal, provider satisfaction with the level of communication from IMCare's case managers/care coordinators, increased by 3% from 2019, and nearly met the 80% goal in 2020 at 79%. Variations in individual

measurements are difficult to interpret due to relatively small denominators; however, IMCare continues to show a high level of overall provider satisfaction.

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 QI/UM Director/s 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 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 2021 information.)

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 2020, the Affirmative Statement was reviewed; included in the Spring/Summer and Fall/Winter IMCare enrollee and provider newsletters; and distributed with the IMCare privacy notice in all new enrollee and annual Member Handbook mailings.

Timeliness of Utilization Management Decisions
An initial determination on all standard (not expedited) requests for utilization review, including behavioral health and non-behavioral health requests, 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 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 can 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. The UM queues are monitored by the QI/UM Director/s and Contract Compliance Officer daily. IMCare met all timelines for UM decisions in 2020.

Notification of Utilization Management 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 an appeal to IMCare and includes the procedure for initiating an appeal.

IMCare monitors the timeliness of UM decision making and 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 2020.

Clinical Information and Interrater Reliability

The IMCare QI/UM Director regularly evaluates the consistency with which UM clinical staff (non-physician and physician reviewers) 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:

- Adequate information to make the determination (M1)
- Correct criteria set/policy used (M2)
- Nurse/physician applied criteria correctly (M3)
- Health care professional contacted by phone or fax within 24 hours (M4)

2020 Interventions:

- 2020 UM criteria were reviewed/approved by the PAC on 02/12/2020 and the External QI/UM Committee on 03/18/2020.
- InterQual criteria updates were loaded into CTD (authorization review system) as they became available, throughout 2020.
- CVS/Caremark drug criteria sets were updated in January of 2020, and as they became available thereafter.
- Monthly Utilization Management Operations Workgroup (UM Ops) meetings were held to evaluate, discuss and modify UM criteria, application of criteria and/or processes as needed.
- Interrater audit tool was updated in March 2020 and training provided at UM Ops.

In 2020, IMCare audited a total of 236 determinations with the following breakdown: MCNs were audited on 200 determinations; the Medical Director and QI/UM Physician Consultant were audited on 36 determinations. The MCNs met three of four measurement goals. The unmet area was notification to healthcare provider within 24 hours. Two notifications did not occur within the 24-hour period due to a technical issue with CTD creating documents on a specific date. The notifications occurred on the next business day once the technical issue was resolved. In each measure, the Medical Director and QI/UM Physician Consultant maintained the goal of 100%.

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 7th 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 MCNs and are reviewed by the IMCare QI/UM 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.

2020 Interventions:

- The MCNs worked proactively with practitioners/practitioner staff on authorization requests to minimize lack of information denials.
- The 2019 DTR Report was reviewed/approved by the IMCare PAC on 02/12/2020 and the IMCare External QI/UM Committee on 03/18/2020.
- Continued collaboration with DHS via DHS/MCO workgroup to address service code mapping. Purpose was to align all MCO's service code reporting.
- Worked with claims vendor to identify misidentification of service categories and update claims system as necessary. IMCare now participates in classifying new CPT/HCPCS codes with claims vendor.

In 2020, IMCare sent 340 DTR Notices of action. Consistent with previous years, a majority of the DTRs were for Service Authorization (82%). Most of the remaining DTRs were requests for services where more information was needed in order to make a decision, followed by the submitted records did not meet coverage criteria. This endorses IMCare's service and drug authorization requirements.

IMCare's 2020 DTR numbers were significantly less compared to previous years. This can be attributed to reduced requests for elective services and reduced change in service agreements for EW due to COVID-19. Dental denials were drastically reduced, and again, that can be attributed to COVID-19. The reduced number of dental preventive visits for a good portion of the year led to a reduced number of restorative services being requested.

An enrollee is assessed for eligibility of some services that are consumer driven services (e.g., EW and Personal Care Assistance (PCA)) and there are services for which Itasca County Health and Human Services determines eligibility (e.g., Mental Health Targeted Case Management (MH-TCM) for adults and children). These services are typically approved though a service agreement (service authorization), for a period of time. Denied, terminated or reduced services provided under a service agreement are largely enrollee choice, with the balance typically being

loss of, or change in eligibility for the program. IMCare is required to issue notices, even when the services are denied, terminated or reduced upon enrollee request.

IMCare MCNs focus on provider outreach when processing drug and service authorizations, allowing them to inform practitioners of the requirements for requested procedures, medications, and/or services throughout the review process. In instances where there was lack of information or documentation to support a request, the nurses worked diligently to coordinate with the practitioner's support staff to complete the process. This outreach reduced the number of denials for lack of information, subsequently reducing appeals. In addition, the IMCare Pharmacy Director assists with practitioner and pharmacy education of the drug authorization request process. The experience and knowledge of the Pharmacy Director affords enhanced collaboration between IMCare, practitioners/pharmacies and CVS Caremark, IMCare's PBM.

Appeals

IMCare must investigate and respond to all appeals to remain compliant with federal and state statutes, rules and regulations, and CMS and DHS contracts. This includes establishing and implementing a corrective action plan when appropriate. An appeal can be initiated verbally or in writing by:

- An IMCare enrollee or an enrollee's authorized representative;
- The legal representative of a deceased enrollee's estate;
- The enrollee's attending healthcare professional for medical necessity; or
- A healthcare professional acting on behalf of the IMCare enrollee, with the enrollee's written consent.

MN Statutes, § 62Q.72 (Record Keeping; Reporting) and 62M.06 (Appeals of Determinations not to Certify), DHS Contracts (Families & Children/130029; Seniors/130037), Sections 8.4 (MCO Appeals Process Requirements), 8.6 (Maintenance of Grievance and Appeal Records) and 8.9 (Reporting of Appeals to the State); and, 42 CFR 438, Subpart F (Grievance and Appeal System) direct the IMCare appeals process.

The Health Plan Compliance Coordinator (HPCC) is responsible for coordinating the appeal process from the initial contact through enrollee notice of the final appeal resolution/ determination. The HPCC documents the entire process through reporting and maintenance of appeal records for future reference and audits.

An appeal is an oral or written request from the enrollee, an enrollee's representative or a provider acting on behalf of the enrollee with the enrollee's written consent, to IMCare for review of an adverse benefit determination by IMCare. IMCare has written procedures in place for thorough and consistent handling and response to appeals. Any reasonable assistance in completing forms and taking other procedural steps, including but not limited to providing interpreter services and toll-free numbers that have adequate TTY and interpreter capability is provided to enrollees.

If IMCare receives additional information and/or documentation that was not initially submitted in the original request, the information is used during the appeal investigation and review. All information and/or documentation that accompanies the appeal request is reviewed by the

reviewer who made the initial determination. If the additional information and/or documentation does not reverse the initial adverse benefit determination, the appeal request must be reviewed by an independent physician, other than the physician who made the adverse benefit determination. IMCare must ensure the physician is in the same or a similar specialty as the requesting attending healthcare professional. IMCare has contracted with the Medical Review Institute of America (MRIoA) to conduct appeal reviews and determinations that cannot be conducted by the IMCare Medical Director, the IMCare QI/UM Consultant, or an IMCare dental reviewer.

IMCare utilizes a case management system (CTD) as the source of data collection and maintenance of appeals records. Quarterly and annual appeal reports are also generated from CTD.

IMCare has a full and fair process for resolving enrollee disputes and responding to enrollee 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 best 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.

2020 Interventions:

- Developed staff education regarding appeals. Education included what appeals are, how they are applicable to each staff's job duties and how to elevate issues to the HPCC. Training was delivered in small groups to facilitate questions applicable to each department within IMCare. The training was conducted in January and February 2020.
- Presented an overview of the appeal program and initiatives happening within the program to the Itasca County Board of Commissioners (IMCare's governing body).
- A weekly internal Appeals and Grievances Workgroup (Internal AG) continued to monitor, review, discuss and analyze appeal documentation and processes as needed to identify potential issues and/or training needs.
- Continued to update the prior authorization list to streamline the process, and remove select authorization requirements.
- Continued collaboration with DHS and claims vendor to identify mis-identification of service categories and update systems as necessary.
- The 2019 Appeal Report was reviewed/approved by the IMCare PAC on 02/12/2020 and the IMCare QI/UM Committee on 03/18/2020.

In 2020, IMCare received 76 appeals due to billing & financial issues and eight appeals related to services and/or benefits. Categories of service were:

- Dental (3)
- DME (2)
- Emergency Room (5)
- Hospital (9)
- Pharmacy (2)
- Professional Medical Services (55)
- Therapies (1)
- Transportation – Ambulance (4)
- Vision Services (1)
- Elderly Waiver (2)

Eight Service Appeals

An enrollee's parent submitted an appeal on behalf of minor child. The septoplasty procedure was denied as not meeting InterQual criteria. Additional clinical documentation was obtained at the request of enrollee's parent and the denial was overturned.

A provider appealed denial of a diagnostic nerve block to determine whether surgery would be a viable option to help enrollee discontinue pain medication. InterQual criteria was not met after review by level 1 and 2 reviewers. Level 2 reviewer did not overturn the denial and appeal was sent to MRIOA to be reviewed due to the specialty of the requesting provider. It was found that the planned procedure was medically necessary, and the denial was overturned.

A provider appeal was for an epidural injection for spinal stenosis. The service was denied for not medical standard for condition and care requested would not maintain enrollee's health. Additional documentation was submitted by the provider and the denial was overturned.

An enrollee's parent submitted an appeal on behalf of minor child. The procedure was for a circumcision which was denied as not meeting medical necessity in UpToDate. Appeal was reviewed, the procedure was determined medically necessary due to a birth anomaly, not cosmetic in nature. The denial was overturned.

An enrollee appealed denial of dental crowns. The procedure was denied as not covered in enrollee's benefit set. Appeal was reviewed and the denial was upheld.

A provider appealed denial of open periprosthetic capsulotomy, breast (bilateral) and plastic, reconstructive, and aesthetic breast procedure with prosthetic implant (bilateral). The request was denied as the right side did not meet UpToDate criteria for medical necessity. The provider submitted a subsequent request for the left side only and it was approved. The enrollee had the procedure on both sides and the provider submitted additional documentation of clinical information that was found during the procedure that supported medical necessity. The denial was overturned.

IMCare received a state appeal from MN DHS. The appeal was regarding an LTC assessment and denial of initial EW services. IMCare contacted the MN DHS state appeal office as it was felt the appeal was assigned to IMCare incorrectly. MN DHS agreed and retracted the appeal from IMCare. IMCare dismissed the appeal.

A provider appealed denial of split prescription for 2 pairs of glasses. The request was denied as not meeting the dispensing standard for MDHS which allows for 1 pair of glasses every 2 years. Provider submitted additional information and the denial was overturned.

2020 General Appeal Information and Opportunities

IMCare's appeal and grievance program received a deficiency in the Triennial MDH Quality Assurance Examination (QAE) & DHS Triennial Compliance Audit (TCA) conducted by MDH in August 2018. Based on the audit findings, IMCare drafted a corrective action plan (CAP) that was accepted by MDH and DHS in January 2019. All objectives outlined in the CAP were completed in 2019 and 2020. A key component of the CAP was staff education. Staff training was developed and administered to all IMCare and Public Health nurse case managers early in 2020. The goal of the education was to help staff identify how their job intersects with enrollee grievances and appeals and the processes in place to elevate issues to the HPCC when appropriate. IMCare was required to participate in an MDH QAE & TCA mid-cycle examination in June 2020, to assess IMCare's progress with the deficiency. IMCare was found to have corrected the deficiency and to be compliant with all requirements in handling of appeals and grievances.

IMCare's 2020 appeal numbers were significantly higher than the previous year. This can be contributed to a change in process. There were 55 unique enrollees with appeals that accounted for 84 appeals. An example of why one complaint may generate multiple appeals would be if an enrollee receives one bill from a provider, but there were multiple claims that accounted for the bill. Per guidance, one appeal is processed for each claim.

Overall, IMCare has a thorough utilization review process that is reviewed regularly and adjusted as needed. An IMCare MCN reviews a request, and if the request does not meet medical necessity criteria, it is transferred to the IMCare Medical Director or QI/UM Consultant for further review in the timeframes set out in policy. This affords the member careful consideration to all available criteria and community standard resources by the physician reviewer. Upon adverse benefit (denial) determination, the Denial, Termination or Reduction (DTR) Notice is issued to the enrollee and attending healthcare professional. The DTR provides specific, clear information why the request was denied and contains health plan appeal rights should the enrollee choose to exercise the next level of appeal. Once a health plan appeal is processed a resolution letter is issued to the enrollee and attending healthcare professional which contains state appeal rights. If the enrollee feels the outcome is still adverse, they can file a state appeal and can request IMCare help them with that process. The attending healthcare professional can also file a state appeal with written permission from the enrollee.

The Utilization Review (UR) Workgroup continues to review requirements that inhibit payment of claims or were not flagging for utilization review in the adjudication process. Processes were

developed to communicate with providers, especially those not in network, as to the outcome of submitted claims.

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 Member 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 medically 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. 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 ED visits through the ED Utilization Focus Study. A report is generated monthly for all enrollees who have four or more ED visit claims paid in a calendar year. IMCare MCNs and/or Care Coordinators review the reports to identify enrollees for case management, fraud waste and/or abuse activities and enrollee education. Refer to the ED Utilization Focus Study section for further details.

Pharmaceutical Management
IMCare has developed and regularly reviews and updates policies and procedures for pharmaceutical management based on sound clinical evidence. P&P 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 PBM (CVS Caremark) on the development of the formulary, within compliance of the DHS PDL and management procedures. Pharmaceutical management procedures are communicated to providers via direct mail, e-mail, fax, and the IMCare website.

In 2020, 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 website as well.

CVS Caremark, 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 CVS Caremark to have an expedited process for prompt identification and notification of enrollees and prescribing practitioners affected by a Class I recall. Policies and procedures reflect this.

The IMCare Pharmacy Exceptions P&P 2.07.16 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.

Contact Information

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