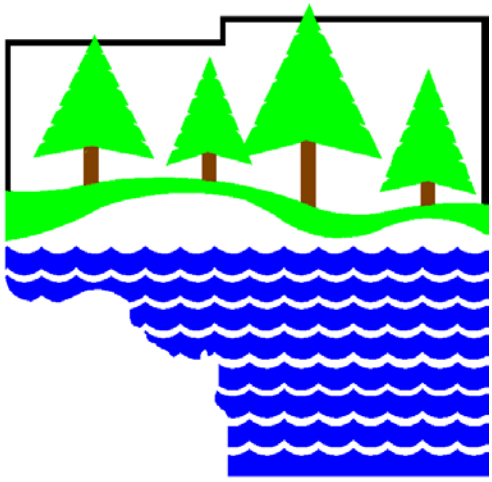

2018 ITASCA MEDICAL CARE PROGRAM EVALUATION

Approved by:
IMCare QI/UM Committee: 03/20/2019
Itasca County Board of Commissioners: 04/23/2019

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

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Executive Summary

Itasca Medical Care (IMCare) is committed to identifying opportunities to improve the care and services enrollees receive from IMCare and its network of providers. To attain quality improvement, IMCare utilizes an incorporated Quality Improvement (QI) and Utilization Management (UM) Program and dynamic QI/UM Work Plan to direct QI/UM program activities that enhance enrollee health and well-being. The following is an evaluation and summary of the 2018 QI/UM activities.

In 2018, IMCare made many strides towards quality improvement with a strong focus on staff, provider and enrollee education. IMCare provided enrollee education through community outreach, monthly education sessions, the IMCare website and biannual newsletters. IMCare staff also provided enrollees with a wealth of information through activities of care coordination, disease management and complex case management. Education ranged from ongoing IMCare quality programs and navigating the IMCare network, to appropriate preventative care.

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

In addition to the quality improvements, IMCare appreciated enhancements to the Utilization Management program in 2018. Throughout 2018, IMCare provided ongoing education for UM staff at the internal Utilization Management Operations workgroup. Additionally, IMCare, through the work of Utilization Review Workgroup, modified or reduced authorization requirements during 2018, to improve enrollee access to appropriate care.

Program Overview

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

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

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

2018 Quality Program Activities

Healthcare Effectiveness Data and Information Set (HEDIS)

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

IMCare continues to perform well in several measures. Although IMCare preventative screening measures continue to fall below the MN State Average for both PMAP and MNCare enrollees, there were improvements from HEDIS 2017 for Breast Cancer Screening, Cervical Cancer Screening, and Chlamydia Screening for the MNCare population. The PMAP population also saw an increase in the Chlamydia screening rate, with slight decreases in the other preventative screening measures. The Childhood Immunizations rates also continue to fall below MN State Average for PMAP and MNCare enrollees, however there was a year-to-year increase for the PMAP population. These slight increases may be attributed to IMCare enrollee newsletter education or outreach efforts of Itasca County Public Health. A network facility, that serves the largest volume of IMCare enrollees, implemented preventative 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. An increase of these measures in future HEDIS audits is anticipated, as a result.

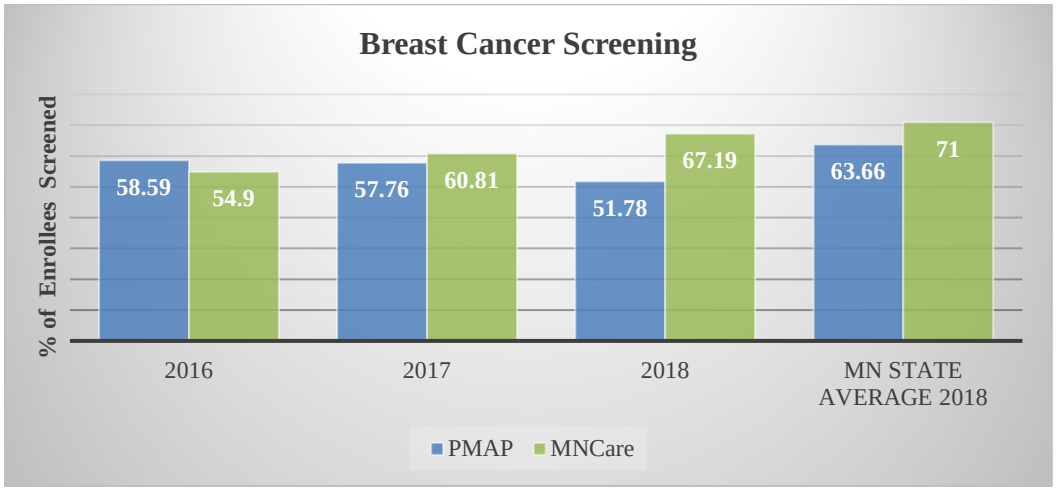
Overall, half of IMCare's HEDIS 2018 results for the MSHO population met or exceeded the MN state average. A measure of note, with a goal to be below the MN state average, includes Use of Opioids from Multiple Providers (both pharmacy and prescribers), IMCare had a rate of 0 in comparison to the MN State Average of 12.61. IMCare largely exceeded the MN State Average in several measures including Medication Reconciliation Post-Discharge, Follow-Up after Emergency Department Visit for People with High-Risk Multiple Chronic Conditions, Transitions of Care Admission, Transitions of Care Discharge and Transitions of Care Reconciliation. The IMCare 2018 Care for Older Adults had year-to-year increases but fell just below the MN State Average.

2018 HEDIS – Medicaid

Breast Cancer Screening

IMCare had a 6.38% increase in the MNCare Breast Cancer Screening rate in 2018; however, the PMAP Breast Cancer screening rate decreased by 5.98%. IMCare was below the state average goal for both products. In 2017, IMCare implemented mammogram reminder letters for women in the appropriate age group, these were also sent out in 2018. Additionally, in the fall of 2017 and 2018, IMCare included information regarding breast cancer screening in the enrollee newsletter. 2017 interventions may have had an impact on HEDIS 2018, but due to the delay in data, 2018 interventions may not be reflected until HEDIS 2019.

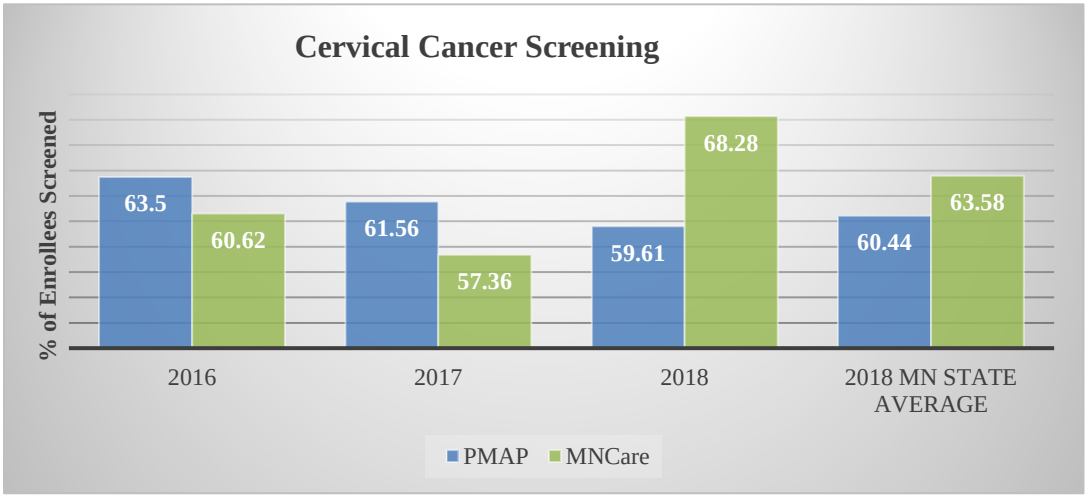
Figure 1: 2016- 2018 Breast Cancer Screening- PMAP/MNCare



Cervical Cancer Screening

IMCare had year-to-year variations in the cervical cancer screening rates PMAP rates decreased slightly and MNCare rates increased by more than 10%. Individual reminder letters for age-appropriate enrollees were sent out in the Fall of 2018, additionally education was sent out in the enrollee newsletter in Fall of 2018.

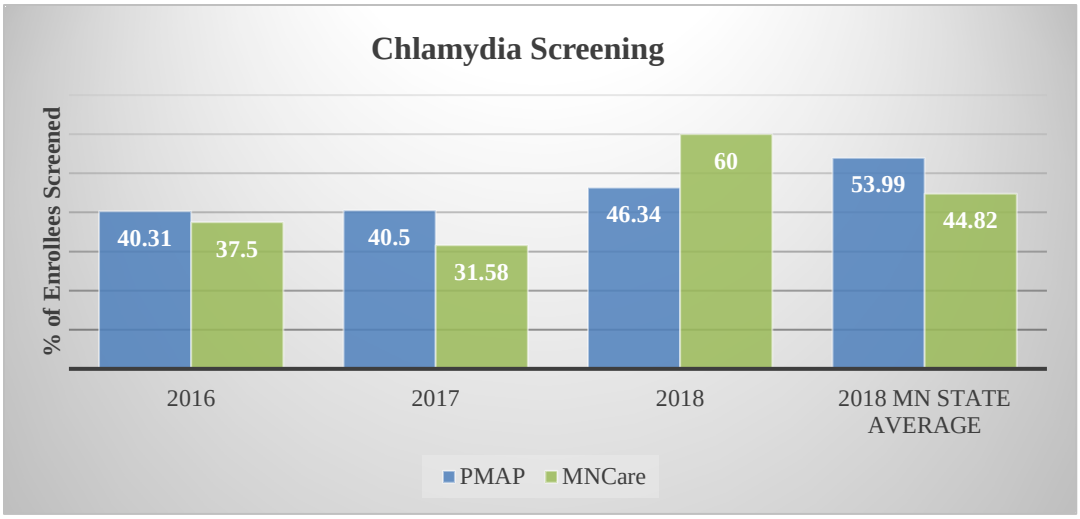
Figure 2: 2016- 2018 Cervical Cancer Screening- PMAP/MNCare



Chlamydia Screening

IMCare had large increases in chlamydia screening rates for both PMAP and MNCare populations, the MNCare rate almost doubled from the previous measurement year. IMCare provided enrollee education about chlamydia screening via the 2018 Spring/Summer newsletter.

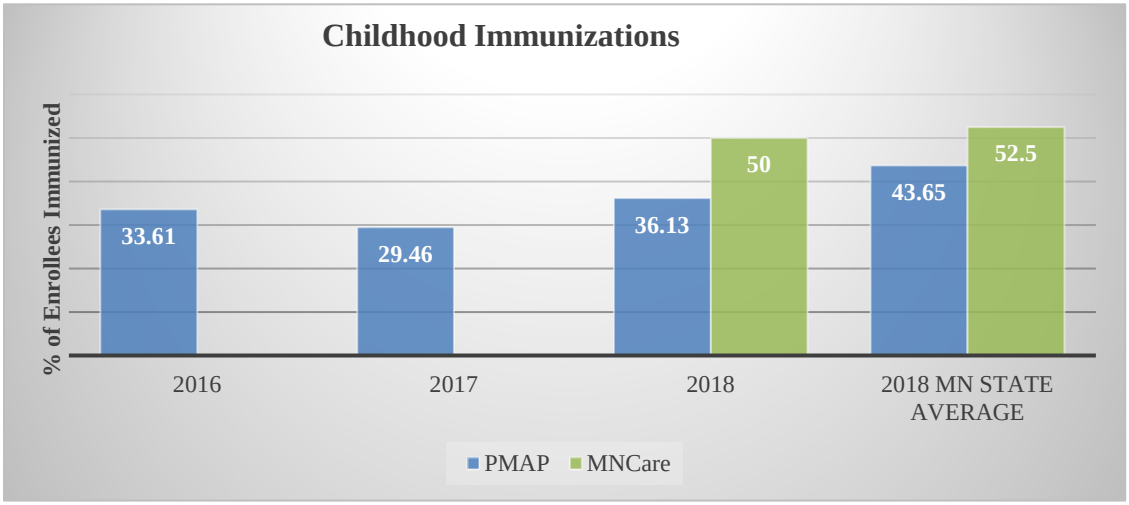
Figure 3: 2016- 2018 Chlamydia Screening PMAP/MNCare



Childhood Immunizations (CIS)

IMCare continues to fall below the MN State Average for childhood immunization rates, however there was a year-to-year increase for the PMAP population, this could be attributed to the enrollee mailing about the influenza vaccine in 2017 and the promotion of Itasca County Public Health vaccine clinics in the enrollee newsletters during 2017. Previously MNCare rates have not been available due to the lack of enrolled individuals that fall within the age range required for this measure, with a denominator of two the 2018 rate is not statistically significant.

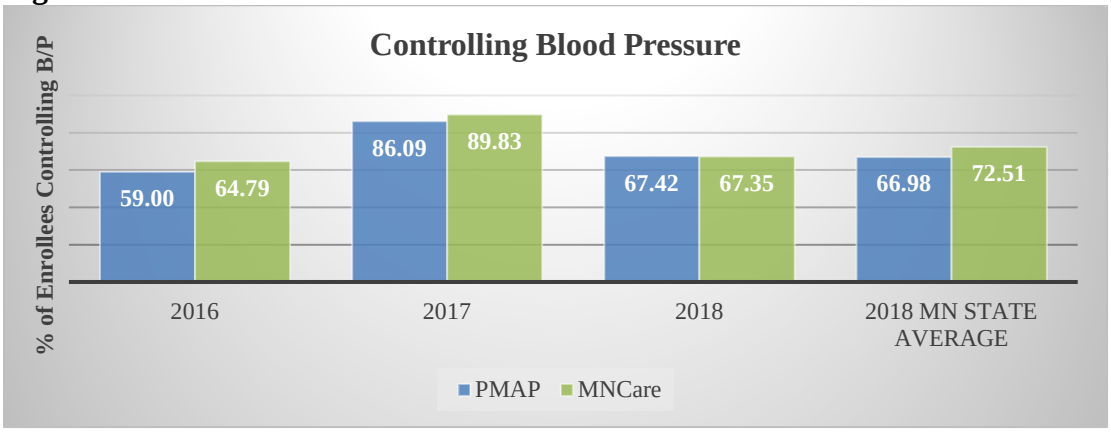
Figure 4: 2016- 2018 Childhood Immunizations PMAP/MNCare



Controlling Blood Pressure (CBP)

IMCare Controlling Blood Pressure rates for both PMAP and MNCare enrollees decreased from the HEDIS 2017 rates; the PMAP rate is just above the MN State Average and MNCare is below the MN State Average. The decreases may be related to data that was unable to be used due to missing components in the collection methods. The Disease Management Program continues to incorporate the Hypertension (HTN) program, which was implemented in 2012 as an opt-out program. All enrollees with hypertension participated, unless they requested to opt-out. Those enrolled in disease management for HTN received quarterly mailings with evidence-based information related to controlling blood pressure and additional interventions as indicated. Lastly, IMCare adopted and disseminated the UpToDate practice guideline, '*Overview of Hypertension in Adults'* to both enrollees and providers via the biannual provider and enrollee newsletters.

Figure 5: 2016- 2018 HEDIS Blood Pressure Control Rates for Enrollees 18-65

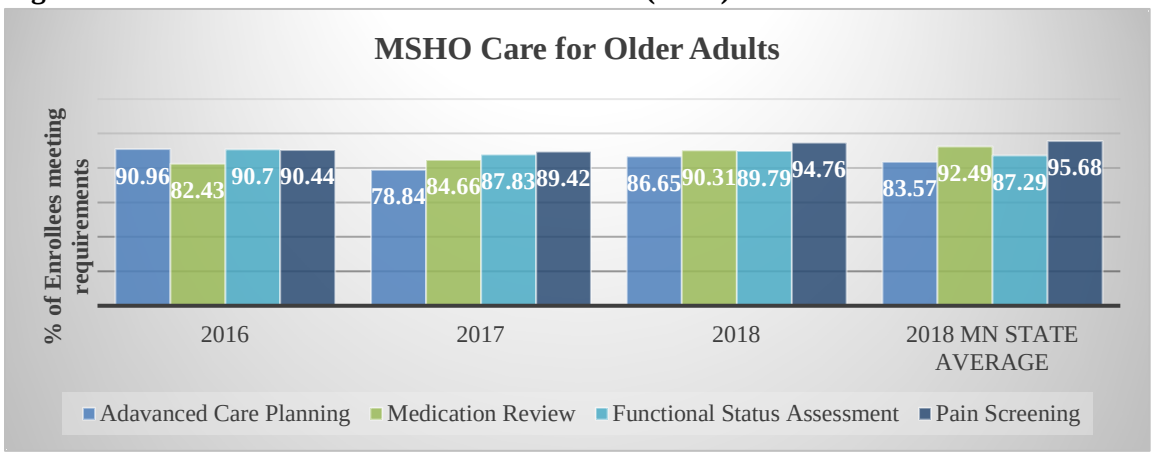


2018 HEDIS – MSHO

Care for Older Adults (COA)

Care for Older Adults HEDIS measures increased from HEDIS 2017 to 2018 across all measures. Although there was an annual increase, Medication Review and Pain Screening measures fell just below the MN State Average. During biannual contacts, senior care coordinators provided enrollees with information regarding Health Care Directives and encouraged them to discuss it with their providers. In addition, IMCare provided information regarding Health Care Directives in biannual newsletters for both providers and enrollees.

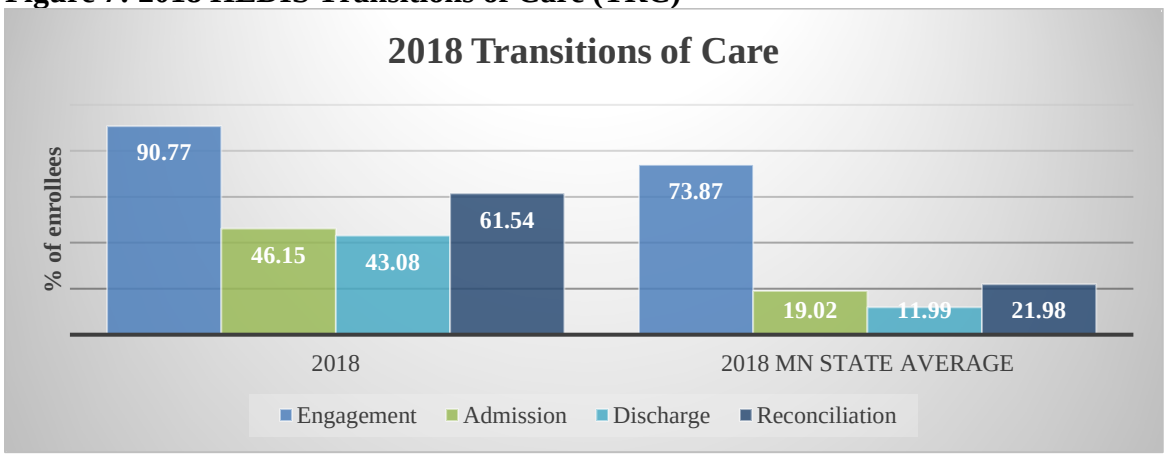
Figure 6: 2016-2018 HEDIS Care for Older Adults (COA)



Transitions of Care (TRC)

Transitions of Care was a new measure in HEDIS 2018, IMCare largely exceeded the MN State Average in all transitions of care measures. This measurement is centered around communication to the primary care provider upon admission to and discharge from an inpatient setting. Additionally, the engagement of the enrollee and medication reconciliation within 30 days of discharge. IMCare network facilities have a standard of care, in which the follow up visit for all inpatient stays is scheduled prior to the date of discharge and the medication reconciliation should occur at that follow up visit.

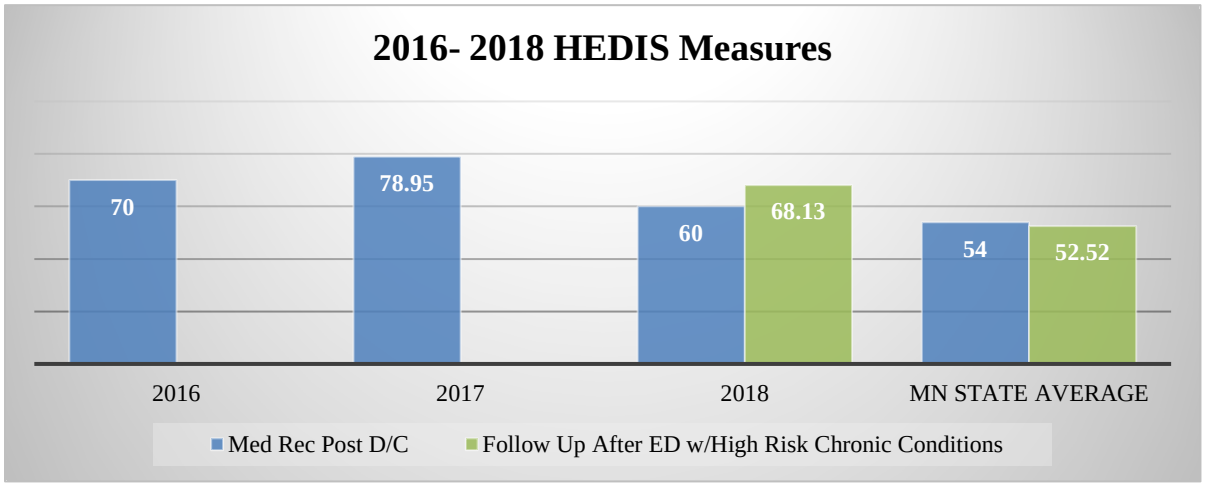
Figure 7: 2018 HEDIS Transitions of Care (TRC)



Medication Reconciliation Post Discharge (MRP)
The IMCare Medication Reconciliation Post Discharge rate had year-to-year decline, however, is still above the MN state average. IMCare leads the state in this measure. IMCare partnered with network Skilled Nursing Facilities (SNF), through a pay-for- performance Integrated Care System Partnership (ICSP), to improve rates of medication reconciliation post discharge. Each SNF that had a 5% increase from the previous year would receive a bonus payment of $5000, if they experienced a 10% increase, they would receive $10,000. If they maintained 100% from year-to-year they would receive the full $10,000. While IMCare does consistently well in this measure, none of the individual facilities had enough of an increase to warrant the incentive payment. Exceptional coordination of care may be attributed to the small, collaborative partnerships that IMCare has within the community that it serves.

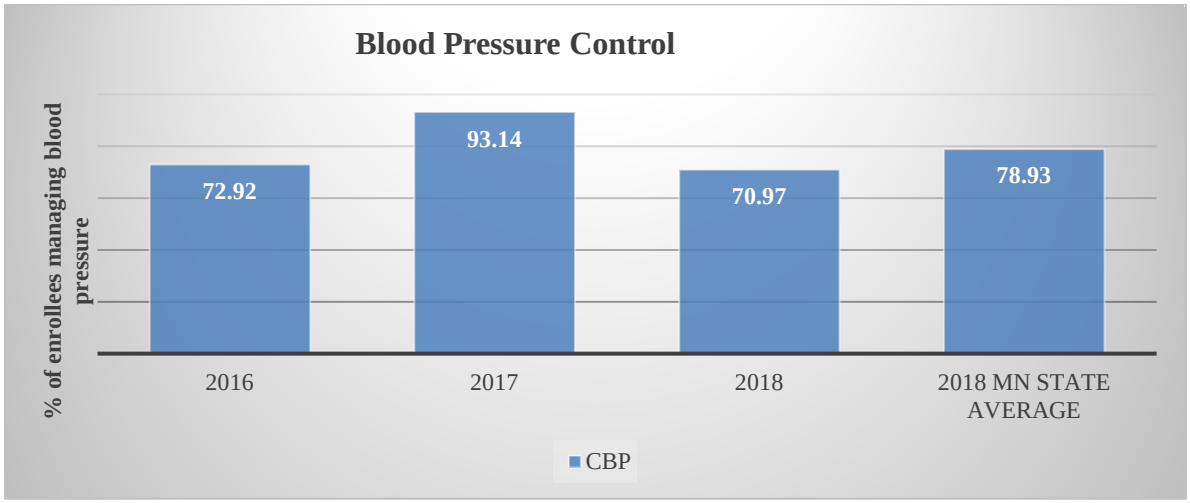
Follow Up After Emergency Department Visit for People with High-Risk Conditions Multiple Chronic Conditions (FMC)
FMC was a new measure in HEDIS 2018, that aims at capturing the follow up with enrollees who have high-risk chronic conditions, after they present to the emergency department (ED); in order to meet measure requirements, follow up must occur within 7 days of the ED visit. Due to the lack of historical data, IMCare only has the MN State Average to utilize as a benchmark for success. IMCare was well above the MN State Average for this measure, IMCare network facilities have placed high value on assisting enrollees in scheduling and obtaining follow up care, that is reflected in this measure.

Figure 8: 2016-2018 MSHO HEDIS MRP, FMC



Blood Pressure Control (CBP) - MSHO
IMCare senior Blood Pressure Control rates had over a 20% decrease from 2017 to 2018 and fell 8% below the Minnesota State Average. As noted above, IMCare continues with many different interventions to try and improve this area of care. The decreases may be related to data that was unable to be used due to missing components in the collection methods.

Figure 9: 2016-2018 HEDIS Blood Pressure Control (CBP)



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 2018 DHS Families & Children Contract with Itasca Medical Care, Section 7.2.2, "In 2017, the STATE selected the 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." The OPIP included PMAP and MNCare enrollees aged 12 years and older who are continuously enrolled in public programs for the measurement year (allowing for a one-month gap) and are continuously enrolled in IMCare for the 90-day look-back and look-forward periods surrounding the index event (the date of the first opioid pain reliever (OPR) prescription for an opioid naïve individual in the measurement year). Enrollees with cancer and those receiving hospice services are excluded.

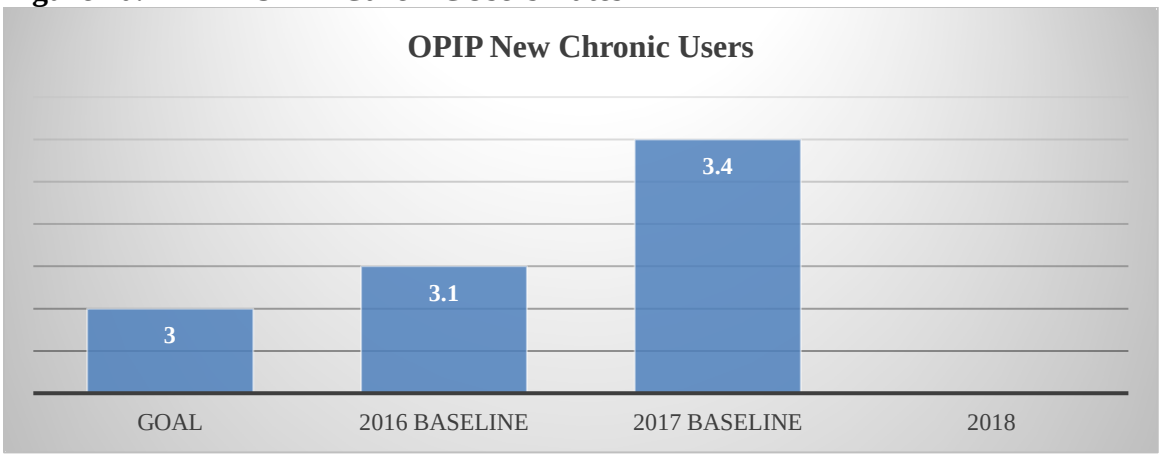
In 2018, IMCare implemented numerous interventions aimed at reducing the number of new chronic opioid users. The most substantial change was in the IMCare pharmacy claims system, it was programmed with hard rejects, requiring prior authorization to bypass the following items, initial opioid fills for enrollees who were opioid naïve for 90 days prior were limited to a 7-day fill, 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 was provided via newsletter regarding Prescribing Opioids for Chronic Pain, DHS Opioid Prescribing Guidelines, Covered Services for Alternative Pain Management and 2018-2020 IMCare Opioid Projects. Global enrollee education was provided via newsletter regarding alternative therapies for the treatment of chronic pain, over-the-counter and prescription drug abuse, correlation between mental illness and opioid abuse and 2018-2020 IMCare Opioid Projects. QI/UM Nurses

were provided education regarding new opioid edits and opioid review process at the January and February 2018 Utilization Management Operations (UM Ops) Meetings.

Lastly, IMCare QI/UM Nurses were provided education regarding new opioid edits and opioid review process at the January and February 2018 UM Ops Meetings.

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. The 2018 NCUsers rate has not been provided by DHS to date but has an anticipated release date of April 2019. The delay in data and lack of enrollee-specific data makes it difficult to determine effectiveness of current interventions and modify accordingly. 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 after reject messaging at point of sale and the provider is modifying prescribing to comply with best practice guidelines. It is difficult to determine if this is directly related to IMCare opioid projects or the strong focus of network facilities to reduce opioid misuse and abuse.

Figure 10: PMAP & MNCare NCUsers Rates



2018-2020 Opioid Prescribing Quality Improvement Project (OPQIP)

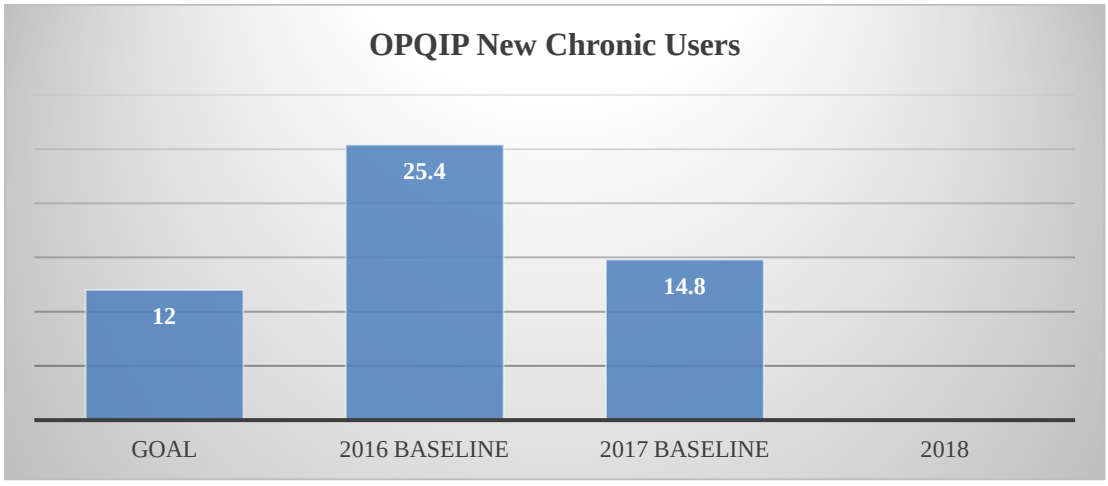
As per the 2018 *Contract For Minnesota Senior Health Options and Minnesota Senior Care Plus Services with Itasca Medical Care*, Section 7.2, DHS selected the 2018-2020 Quality Improvement Project topic, hereafter referred to as the Opioid Prescribing Quality Improvement Project (OPQIP). IMCare implemented 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. The OPQIP included MSHO and MSC+ enrollees, 65 years and older continuously enrolled in public programs for the measurement year (allowing for a one-month gap) and continuously enrolled in IMCare for the 90-day look-back and look-forward periods surrounding the index event (the date of the first opioid pain reliever (OPR) prescription for an opioid naïve individual in the measurement year). Enrollees with cancer and those receiving hospice services were excluded.

In 2018, IMCare implemented numerous interventions aimed at reducing the number of new chronic opioid users in the senior population. The IMCare pharmacy claims system was

programmed with 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 was provided via newsletter regarding Prescribing Opioids for Chronic Pain, DHS Opioid Prescribing Guidelines, Covered Services for Alternative Pain Management and 2018-2020 IMCare Opioid Projects. Global enrollee education was provided via newsletter regarding alternative therapies for the treatment of chronic pain, over-the-counter and prescription drug abuse, correlation between mental illness and opioid abuse and 2018-2020 IMCare Opioid Projects. QI/UM Nurses, who process opioid authorization requests, were provided education regarding new opioid edits and opioid review process at the January and February 2018 UM Ops Meetings. In addition, senior care coordinators and elderly waiver case managers were provided education regarding the OPQIP at a quarterly meeting. Lastly, IMCare, in partnership with our Pharmacy Benefit Manager (PBM) CVS Caremark, administered the Medicare Point of Sale Drug Utilization Review (POS DUR) program to manage 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 2017 rate for the MSHO/MSC+ population was 14.8. The 2018 NCUsers rate has not been provided by DHS to date but has an anticipated release date of April 2019. While it is difficult to fully evaluate the effectiveness of the current opioid interventions without the 2018 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. In review of the 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.

Figure 11: MSHO& MSC+ NCUsers Rates



Focus Studies

Emergency Department (ED) Utilization Focus Study (FS)

IMCare identified enrollees with high ED utilization in order to provide timely and appropriate enrollee education and case management (CM), as well as to identify and intervene in cases of potential fraud, waste and/or abuse by enrollees with high ED utilization. The monthly report included enrollees with four or more cumulative visits (since the beginning of the year). Specific

diagnosis codes were also excluded (cancer, neoplasm/blood disorders, pregnancy, perinatal, and congenital anomalies).

IMCare provided global enrollee education regarding appropriate use of the ED and network urgent care options in both the Spring/Summer and Fall/ Winter enrollee newsletter in 2018. Individual enrollee/caregiver education and CM regarding appropriate use of the ED and network clinic/urgent care options was administered by an IMCare QI/UM nurse or senior care coordinator throughout 2018. When appropriate, Restricted Recipient Program (RRP) enrollee education/warning/placement occurred throughout 2018. The IMCare Spring/Summer 2018 provider newsletter included the following: 2017 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 2018.

Medicaid ED FS goals were not met in 2018, and both measures showed minimal change from 2017. Even though the actual number of Medicaid ED visits decreased from 4,838 visits in 2017 to 4,774 visits in 2018, the population size decreased as well. Of the 239 Medicaid enrollees identified through the ED FS, twelve enrollees (5.02%) received case management and none were place in the RRP. Many of the identified enrollees had participated in or opted-out of case management in previous years. One enrollee was place in the RRP in 2017 and remained restricted throughout 2018.

Medicaid enrollees identified by the ED FS in 2018 accounted for 1,356 of the 4,774 total ED visits for the population. The top five primary diagnosis groups for this subset included:

1. Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified
2. Diseases of the respiratory system
3. Diseases of the digestive system
4. Injury
5. Mental and behavioral disorders

IMCare met both ED FS goals for the senior population in 2018. IMCare identified 34 seniors through the ED FS and notified their care coordinators, who provided case management. Senior enrollees identified by the ED FS in 2018 accounted for 200 of the 355 total ED visits for the population. The top five primary diagnosis groups for this subset included:

1. Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified
2. Diseases of the respiratory system
3. Diseases of the digestive system
4. Diseases of the circulatory system
5. Injury

Although ED utilization is a MN Department of Human Services withhold measure, imposing a monetary penalty if an annual 10% reduction is not met, the state also significantly limits MN Medicaid health plans regarding potential interventions proven to reduce ED utilization (e.g., copay amounts).

Figure 12: Total number of ED visits by the population per 1,000 enrollee months

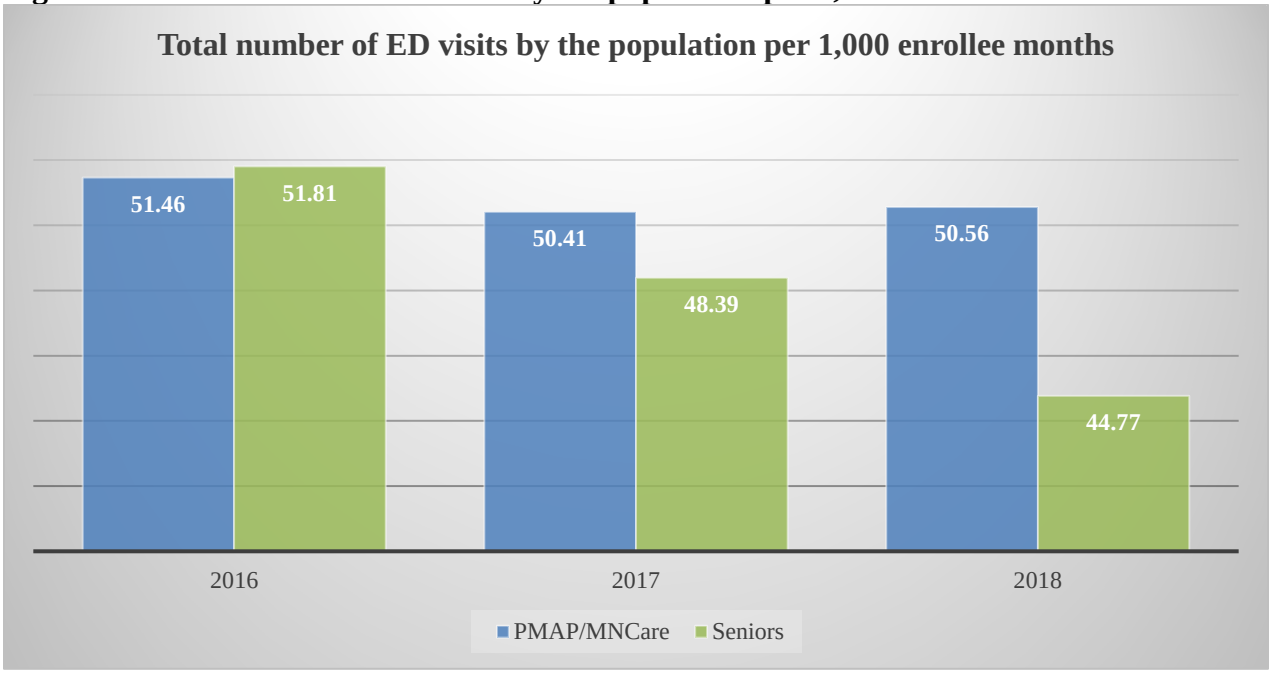


Figure 13: 2016-2018 PMAP/MNCare ED FS Results

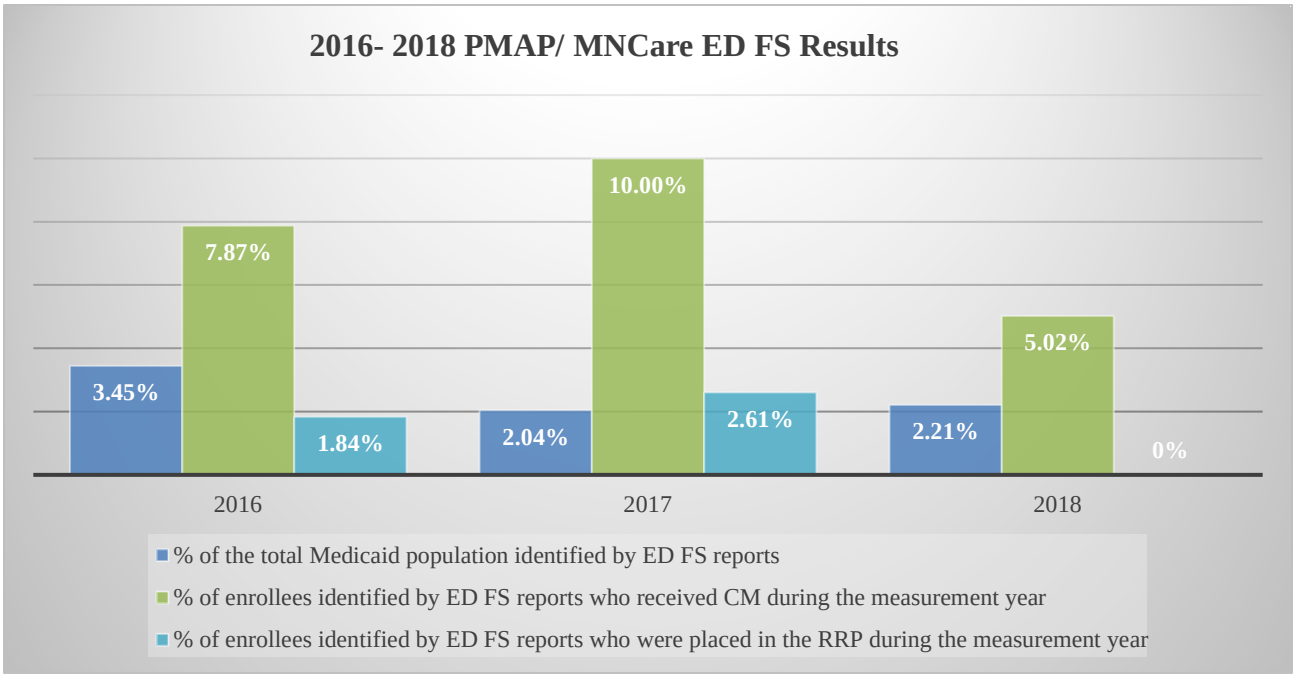
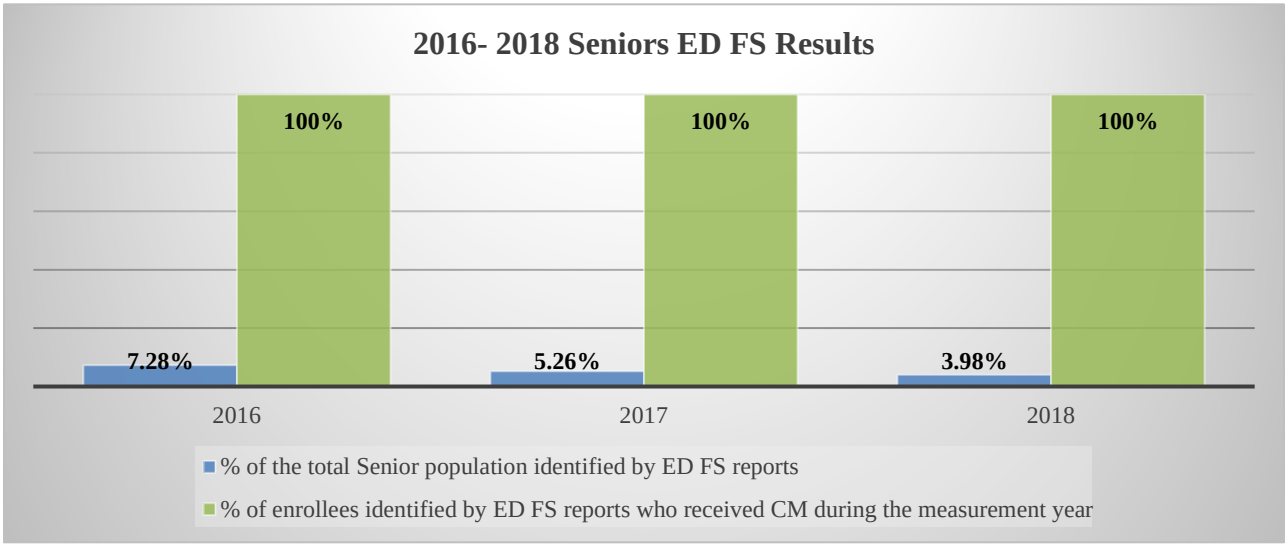


Figure 14: 2016-2018 Seniors ED FS Results



Controlled Substance (CS) Focus Study (FS)

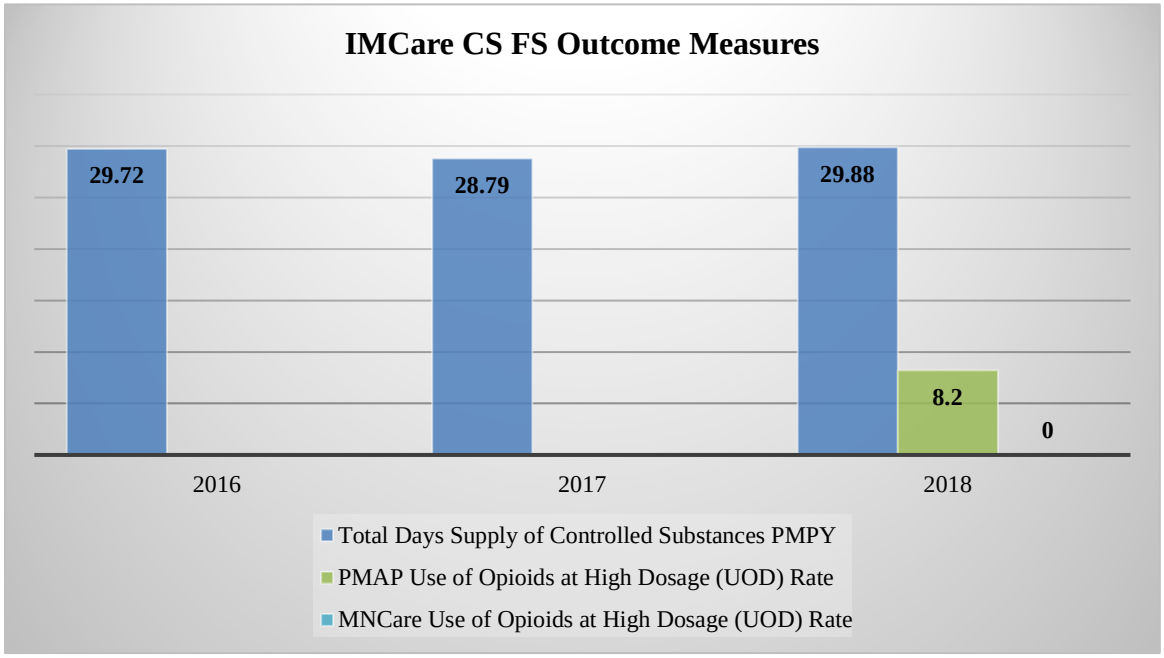
IMCare identified enrollees with a high number of controlled substance prescription fills and use of multiple providers/pharmacies to obtain controlled substance prescriptions, in order to provide timely and appropriate case management (CM) and intervene in cases of potential fraud, waste and/or abuse.

IMCare had a number of interventions to reduce inappropriate controlled substance use in 2018. IMCare provided global enrollee education regarding appropriate use and disposal of over-the-counter and prescription medications (including controlled substances) in the Spring 2018 enrollee newsletter. The CVS/Caremark Safety and Monitoring Solutions (SMS) and Enhanced Safety and Monitoring Solution (ESMS) programs were administered by CVS/Caremark for IMCare throughout 2018. Additionally, individual enrollee education/CM regarding CS use and the potential dangers of using multiple providers/pharmacies for CS prescriptions was administered by an IMCare QI/UM nurse throughout 2018. When appropriate, Restricted Recipient Program (RRP) enrollee education/warning/placement occurred throughout 2018. The IMCare spring/summer 2018 provider newsletter included the following: 2017 CS FS results and a request for intervention suggestions, the process for reporting suspected fraud, waste and abuse to IMCare and education regarding IMCare CM services and the process for referral. Additionally, the IMCare Compliance staff attended DHS Universal Restricted Recipient Program (URRP) meetings throughout 2018. The IMCare Pharmacy Director attended DHS Universal Pharmacy Policy Workgroup (UPPW) meetings throughout 2018. The workgroup included representatives from all MN Medicaid health plans and DHS. IMCare continued to have buprenorphine products, used to treat opioid dependence, on the Medicaid Formulary with no prior authorization requirement throughout 2018. IMCare also continued to allow enrollees to receive out-of-network methadone treatment with no prior authorization throughout 2018. IMCare had two network mental health practitioners who offered in-network buprenorphine treatment for opioid dependence. This reduced barriers for enrollees to receive treatment related to Opioid Use Disorders, it is unknown whether this contributed to the opioid use rates throughout 2018.

CVS Health SMS and ESMS program enrollment and interventions decreased from 2017 to 2018, but still resulted in decreased CS use and the number of pharmacies/prescribers used to obtain controlled substances. In 2018, IMCare identified 163 enrollees through the CS FS. Eight enrollees (4.91%) received case management and one enrollee's RRP status was renewed. Many of the identified enrollees had participated in or opted-out of case management in previous years. The number of enrollees receiving methadone treatment for opioid use disorder increased slightly from 2017 to 2018, but the number of enrollees utilizing buprenorphine drugs more than doubled.

The total days-supply of controlled substances (DEA schedules II-V) dispensed per IMCare enrollee increased 3.79% from 2017 to 2018; however, this was largely due to increased utilization of buprenorphine drugs, with a 98% increase in days-supply. The total days-supply of opioids (excluding buprenorphine drugs) decreased 13.18% from 2017 to 2018, while the total days-supply of stimulants, benzodiazepines and hypnotics showed little change. These results are encouraging, as more enrollees sought treatment for their opioid use disorder in 2018, with decreased utilization of other opioids. In addition, IMCare performed very well in the new Use of Opioids at High Dosages (UOD) HEDIS measure, as compared to the MN state average.

Figure 15: IMCare CS FS Outcome Measures



A Healthy Pregnancy Prenatal Initiative Focus Study

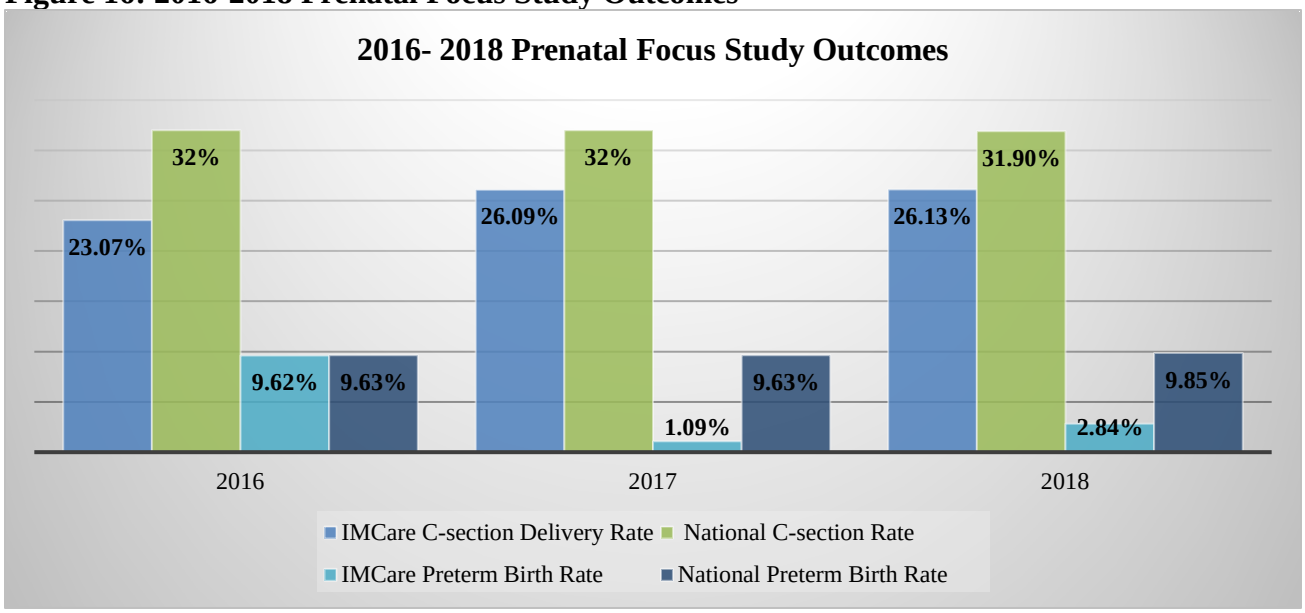
A Healthy Pregnancy' prenatal initiative focus study was implemented in 2007 to identify at-risk pregnancies through referrals from physicians, Women, Infants and Children (WIC), Teenage Parenting Program (TAPP), IMCare, Project Clean Start, schools, and self-referrals in order to provide the opportunity for education and support, to reduce the risk of preterm labor and delivery, and to ensure a postpartum provider visit. The Minnesota Health Care Program (MHCP) Provider Manual states, "At-risk is used to describe a pregnant woman who requires

additional prenatal care services because of factors that increase the probability of a preterm delivery, a low birth weight infant, or a poor birth outcome." During the prenatal period, IMCare enrollees who accepted prenatal visits with Itasca County Public Health Maternal Child Health (MCH) received a $40.00 Target gift card for the first visit, and a $30.00 Target gift card for the second visit. During the postpartum period, IMCare enrollees were eligible to receive a $30.00 Target gift card if they accepted a visit from MCH and had a postpartum visit with their provider within the prescribed 21-56 day postpartum timeframe. It was the intent of IMCare and Itasca County Public Health's MCH division, through A Healthy Pregnancy program, to facilitate positive behaviors conducive to a favorable pregnancy outcome by providing education that may preclude an enrollee's risk for preterm labor and delivery. In spring of 2017, IMCare opted to offer gift cards solely to those enrollees who had not previously participated in the program, although all enrollees continued to have access to the MCH program education materials.

IMCare continued to work closely with the Maternal Child Public Health Nurses, providers and enrollees to reduce the number of adverse events during pregnancy and childbirth. In 2018, Itasca County Public Health MCH staff augmented their physical visits with telephonic communication for IMCare enrollees participating in A Healthy Pregnancy program, reinforcing education and support and increasing trust in Itasca County support systems. Additionally, Public Health staff offered alternate site or evening/weekend visits, if needed. All Itasca County Public Health prenatal referrals were reviewed to determine trends/barriers in provider referrals. Enrollees received a congratulatory letter, explaining A Healthy Pregnancy program. All IMCare enrollees were informed of A Healthy Pregnancy program and preterm labor risks through the enrollee newsletter.

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

Figure 16: 2016-2018 Prenatal Focus Study Outcomes



Special Health Care Needs

Medicaid Special Health Care Needs

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

- IMCare analyzed claims data to identify enrollees aged 18-64 with an identified special health care need including: at least one inpatient stay with the primary diagnosis of asthma, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), dehydration, hypertension, 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;
- enrollment in complex case management or the disease management program;
- use of home care services; and/or
- total claims exceeded $100,000.

2018 Interventions:

- Enrollee education regarding the IMCare Ways to Wellness disease management program, which offers health management services for enrollees with asthma, diabetes, hypertension and heart failure, was included in the enrollee newsletter.
- Those enrolled in Complex Case Management and Disease Management had a comprehensive assessment and treatment plan to identify any ongoing special conditions.
- The IMCare QI/UM nurses completed all authorization requests, case management interventions and focus study interventions for their alpha split, to better assure continuity of care.
- IMCare staff review daily admission information, when provided by area hospitals, to identify any needed referrals or follow up.

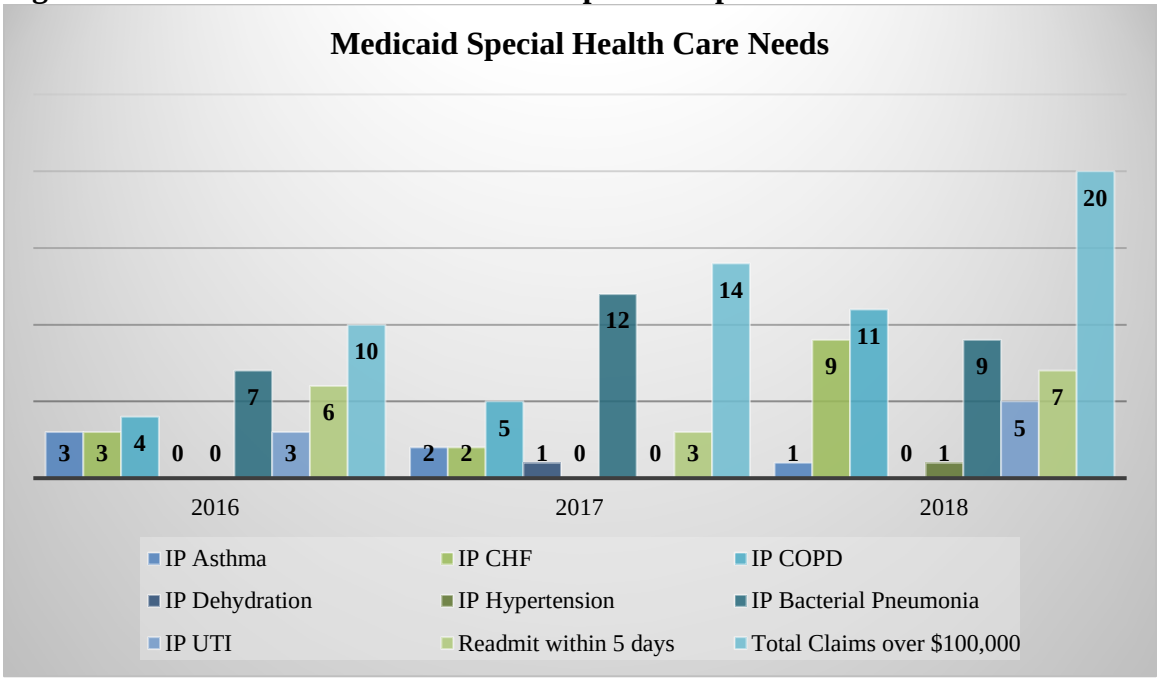
As a whole, admissions related to special health care needs increased; however, in 2018, IMCare used the most recent version of "*Guide to Prevention Quality Indicators: Hospital Admission for Ambulatory Care Sensitive Conditions*" by AHRQ, which provided updated International Classification of Disease (ICD) 10 codes in obtaining hospital inpatient data for various diagnoses. The data had previously been obtained by manually cross-walking ICD 9 to ICD 10 codes within the specifications, which resulted in a certain margin of error. Some of the year-to-year fluctuations can be attributed to correction to the data collection process.

Enrollment policies through the State of Minnesota shifted over the last year, allowing enrollees with disability designations, who were previously excluded from IMCare, to remain on IMCare if they had a family member in their household enrolled on the health plan. This is potentially leading to an enrollee population that is more infused with chronic conditions, increasing the risk of hospitalization, high-cost care and need for home care services.

Number of individuals with four or more ED visits was relatively static from 2017 (230) to 2018 (239). IMCare case managers review ED visits monthly and contact enrollees (who have four or

more visits during the measurement year) to initiate case management and provide education as indicated. During the process of ED utilization review, if abuse and or fraud are suspected, IMCare does further investigation and may ultimately place the enrollee in the restricted recipient program. Enrollment in complex case management (CCM) and disease management (DM) increased from 2017 (556) to 2018 (667) with the number of CCM cases increasing to 144 cases from 24 cases the previous year. Readmission within 5 days for same or similar diagnosis increased in the 2018 year. IMCare case managers continue to monitor and identify preventable readmissions quarterly and work to identify ways to prevent reoccurrence. Total Claims Exceeding $100,000 increased in 2018. Many of these claims are identified as enrollees being treated for malignancy (5), mental health treatment (3), and also disorders of the blood (3) which requires costly ongoing care.

Figure 17: Number of Enrollees with the Specified Special Health Care Need



Seniors (MSHO and MSC+) Special Health Care Needs

Pursuant to 2018 IMCare Minnesota Senior Health Options (MSHO)/Minnesota Senior Care Plus (MSC+) contract with the Minnesota Department of Human Services (DHS), IMCare must:

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

Social Workers or Public Health Certified Registered Nurses conducted all activities of care coordination and case management for IMCare seniors. From the time of initial assignment, the MN Choices Assessment screening was completed within ten business days for referrals to the Elderly Waiver (EW) population and within 30 days for new Elderly Waiver enrollees,

community well and nursing home populations. Annually, IMCare audited records for timeliness of screenings and reassessments.

2018 Interventions:

- Enrollee education regarding IMCare case management/care coordination services and the process for referral was included in a member newsletter. Individual case management/care coordination was administered throughout 2018.
- Utilization of Electronic Health Records (EHR's) at network clinics increased communication between care providers and IMCare.
- Educate case managers/care coordinators regarding assessment, documentation, and transition requirements.
- Delegate (PH) completing transitions on their waivered enrollees, which was previously completed by IMCare Care Coordinators.
- In house audit implemented for timeliness and completeness of transitions.

IMCare has an active program for the development, implementation, and assessment of every enrollee aged 65 years and older. IMCare care coordinator/case managers arranged for an initial face-to-face comprehensive health assessment of the enrollee's strengths, needs, choices and preferences in life domain areas, within 30 days of enrollment. An annual face-to-face assessment, or more frequently if directed by the enrollee's comprehensive care plan or a change in condition, was completed within 12 months of the previous health assessment. The MnCHOICES or Health Risk Assessment (HRA) tool was used to complete the comprehensive health assessment. The tool assessed health status including condition specific issues, supports and services based on the enrollee's strengths, needs, choices and preferences in life domain areas, documentation of clinical health history and medications, activities of daily living (ADL) and instrumental activities of daily living (IADL), mental health status and cognitive functioning, life planning activities, evaluation of visual and hearing needs, preferences and limitations, evaluation of care giver resources and involvement, evaluation of cultural and linguistic needs, preferences or limitations, as well as the evaluation of available benefits and community resources.

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

Record Audits

Medical Record Audit

Itasca Medical Care (IMCare) audited enrollee medical records to determine if providers were compliant with regulatory requirements and National Committee for Quality Assurance (NCQA) standards. Additionally, IMCare ensured that medical records were maintained with timely, legible and accurate documentation of patient information per IMCare's medical record documentation standards. The medical record could be paper, electronic (EHR) or consist of both. In 2018, IMCare audited records of enrollees receiving health care during the previous year (2017) from one of the following high-volume primary care providers: Grand Itasca Clinic and Hospital, Essentia Health (Grand Rapids, Deer River and Hibbing), Fairview Clinic (Nashwauk and Hibbing), Hibbing Family Medical Center, and Scenic Rivers Health Services. In 2018, IMCare reviewed the audit tool and provided training to the auditors prior to the audit. The auditors were instructed to look in areas outside of the provider notes for certain measures and were given a contact person for each site, if they were consistently unable to find measures. Lastly, IMCare included information about health care directives in the enrollee and provider newsletter.

IMCare audited a total of 240 medical records, with the following breakdown: Grand Itasca Clinic and Hospital was audited on 30 charts with an overall average of 98.2%. Fairview Hibbing was audited on 30 charts with an overall average of 98.0%. Fairview Nashwauk was audited on 30 charts with an overall average of 98.4%. Essentia Health Deer River was audited on 30 charts with an overall average of 94.9%. Essentia Health Hibbing was audited on 30 charts with an overall average of 94.8%. Essentia Health Grand Rapids was audited on 30 charts with an overall average of 96.2%. Scenic Rivers Bigfork was audited on 30 charts with an overall average of 100%. Hibbing Family Medical Center was audited on 30 charts with an overall average of 94.3%. All facilities demonstrated improvement from 2017 to 2018. Overall 96.8% of measures were met for the medical record audit, this is above the goal at 80%.

Most measures increased or remained the same. Health Care Directives present in the medical record for those eighteen and older increased by 13.31%, half of the audited facilities were below goal on this measure. Another measure that had historically been below target goal was addressing current maltreatment, trauma or abuse, however there was a significant increase of 69.7 % from the last audit year. This can be largely attributed to better communication with the audited facilities to find this element in the chart. The tobacco cessation information offered to enrollees who indicated that they use tobacco in another measure was just above target goal at 83.02%, which was an increase of 20.21% from the previous year. Lastly, the Screening and Brief Intervention (SBI), conducted annually and using a standardized tool for enrollees twelve and over that are identified as having unhealthy substance use had a 25% decrease from the previous year. The denominator for this measure is one. Due to the small number, the data is not significant, however further explanation may be required for this measure as it is not clear why there is only one applicable chart for this measure. In further review of the audit documentation, it was determined that many measures had varying denominators due to facility samples that included enrollees that were not seen for primary care. In some instances, the enrollees were only seen for one acute visit during the measurement year or were seen by a specialist with a referral from a primary care physician outside of the facility. In those instances, some of the measures were considered not applicable.

Figure 18: 2017-2018 Medical Record Audit Results by Facility

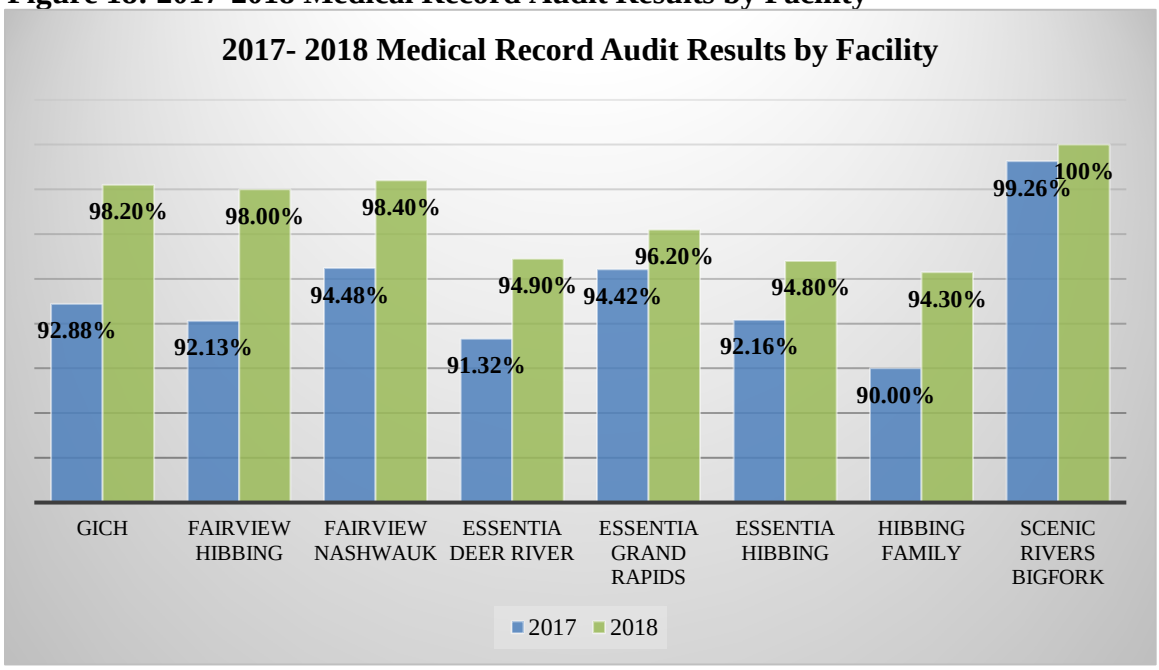
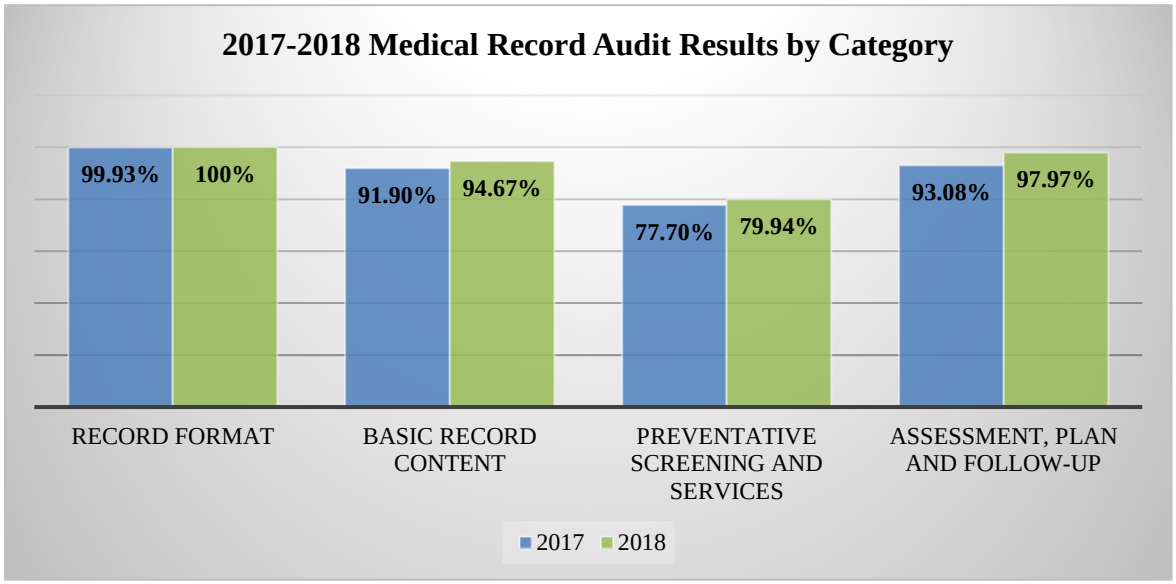


Figure 19: 2017-2018 Medical Record Audit Results by Category



Behavioral Health Treatment Record Audit

Itasca Medical Care (IMCare) audited enrollee behavioral health treatment records to determine documentation of important elements of behavioral health treatment, according to regulatory requirements and National Committee for Quality Assurance (NCQA) standards in the assessment and treatment plan, progress notes, and follow-up of IMCare enrollees. Additionally, IMCare assured that behavioral health treatment records were maintained with timely, legible and accurate documentation of patient information per IMCare's behavioral health treatment record

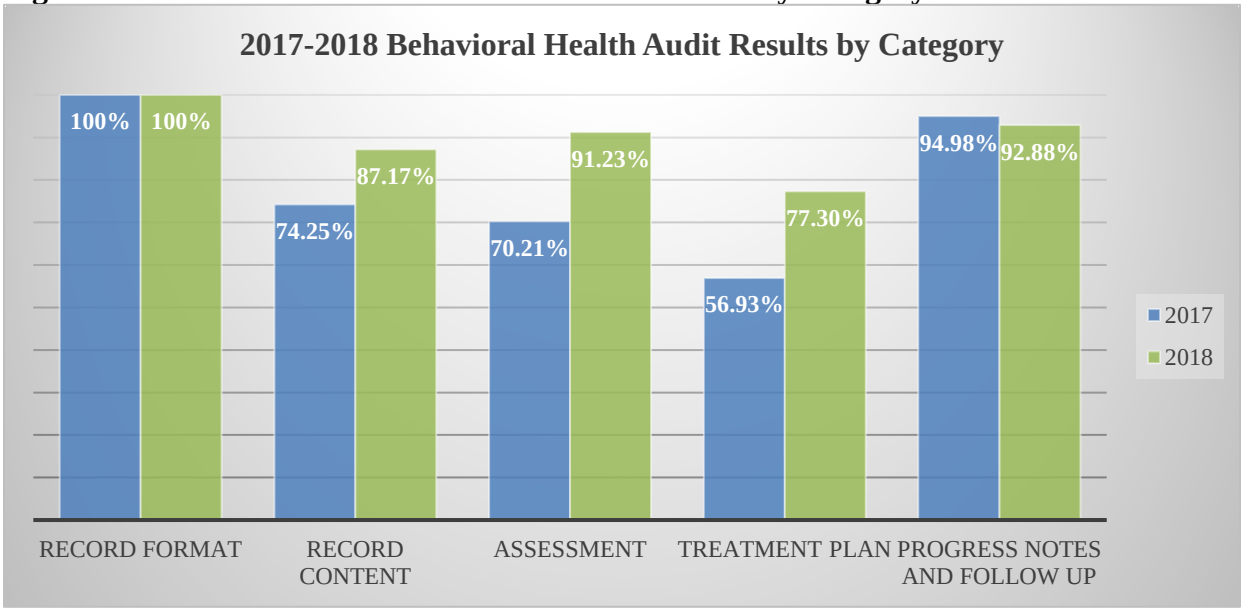
documentation standards. The treatment record could be paper, electronic (EHR) or consist of both.

IMCare audited a total of 269 behavioral health records among 12 high-volume providers, with the following breakdown: Stepping Stones Clinic was audited on 17 charts with an overall average of 99.74%. Northland Counseling Center was audited on 20 charts with an overall average of 93.77%. Anderson Jore Counseling was audited on 12 charts with an overall average of 71.89%. Children's Mental Health Services was audited on 20 charts with an overall average of 93.88%. Lakeview Behavioral Health was audited on 20 charts with an overall average of 91.04%. Modern Mojo was audited on 10 charts with an overall average of 96.92%. North Homes was audited on 20 charts with an overall average of 89.67%. Patricia Cortese was audited on 20 charts with an overall average of 82.23%. Range Mental Health Center was audited on 20 charts with an overall average of 97.11%. Rapids Counseling Center was audited on 15 charts with an overall average of 99.32%. Stapleton Psychological Services was audited on 20 charts with an overall average of 78.52%. Stenlund Psychological Services was audited on 20 charts with an overall average of 70.34%. Thomas Counseling was audited on 15 charts with an overall average of 93.82%. Toonstra Psychological Services was audited on 20 charts with an overall average of 85.00%. Victoria Beck MSW LICSW was audited on 20 charts with an overall average of 73.74%. Note, that for each facility 5 initial charts were reviewed, any unmet measures in those charts were reviewed in the remaining charts. This accounts for varying denominators for each measure, measures that were consistently met in the first five charts, will have much lower denominator than those that were consistently unmet. Additionally, with the sample focused primarily around providers that had billed a diagnostic assessment in the measurement year, some charts that were reviewed only applied to the assessment portion of the audit protocol as that was the only encounter that occurred with that provider.

IMCare changed the methodology for obtaining the sample for this audit period, shifting from focusing on mental health medication managers, to mental health professionals who completed diagnostic assessments during the measurement year. This added several new clinics to the sample, limiting the ability to evaluate year-to-year progress by provider. The goal of this modification was to more accurately capture the elements of audit protocol that are required in diagnostic assessments. Providers that had been part of the audit sample previously, all met the 80% goal, where as some clinics that were new to the audit sample were below the 80% goal. The audit tool was not disseminated to new providers prior to the audit period, which may have impacted their ability to meet expectations.

Overall, most measures met the 80% goal, and many that did not meet goal demonstrated an increase from the previous audit. Record Format, Record Content, Assessment, and Progress Note and Follow up sections had averages above 80%. The only section below 80% was the Treatment Plan section at 77.30%. The Record Content section was heavily impacted by the measure related to offering or discussing an advance health care or psychiatric directive, this was at 15.89% and rarely found in the records. IMCare has received new information since developing the audit protocol, and this requirement is not applicable to behavioral health records and has been removed from overall facility results. The Treatment Plan section had two measures that were well below 80%, including documentation of informed consent regarding the treatment plan at 55.83% and review and signing the treatment plans at least every 90 days at 65.26%.

Figure 20: 2017 -2018 Behavioral Health Audit Results by Category



Credentialing

Timeliness of Credentialing Appointments

IMCare follows the National Committee for Quality Assurance (NCQA) credentialing standards to ensure a consistent, thorough credentialing process that meets community standards and current contractual and legal requirements. NCQA defines the required timeframes for completion of initial appointments and reappointments. To ensure that all initial credentialing and recredentialing applications are reviewed and completed within the required timeframes, IMCare tracks timeliness at the time of credentialing/recredentialing and through quarterly reporting to the IMCare Provider Advisory Subcommittee (PAC).

2018 Interventions**:**

- Quarterly *Timeliness of Credentialing and Recredentialing* reports were reviewed/approved by the IMCare PAC throughout 2018 to assure compliance with the required timeframes.
- A draft of the *2017 Timeliness of Credentialing Appointments Report* was reviewed/approved by the IMCare PAC on 02/14/18.
- The final *2017 Timeliness of Credentialing Appointments Report* was reviewed/approved by the IMCare External QI/UM Committee on 03/21/18.
- Initial appointment and reappointment credentialing/recredentialing checklists were updated throughout the year when indicated.

In 2018, IMCare completed all initial individual practitioner credentialing applications within the required 180-day timeframe. IMCare did not meet the required 36-month timeframe for one individual practitioner recredentialing file, which was completed 17 days late. The root cause of this issue was identified and corrected to prevent this from happening again. All other individual practitioner recredentialing files were completed within the required timeframe.

Organizational Provider Credentialing
In 2018, IMCare followed the National Committee for Quality Assurance (NCQA) credentialing standards to ensure a consistent, thorough credentialing process that meets community standards and current contractual and legal requirements. Organizational providers include hospitals, Medicare-certified home health agencies (HHA), skilled nursing facilities (SNF), free-standing surgical centers, and behavioral health care facilities. Network behavioral healthcare organizational providers credentialed by IMCare include facilities licensed by the State of Minnesota that provide mental health and/or substance abuse services in inpatient, residential, and/or ambulatory settings. IMCare does not credential organizational providers that operate only as 12-step programs.

IMCare credentialed organizational providers at the time of initial contracting and at least every three years 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). Office site visit audits are completed prior to completion of the initial credentialing process; when an organizational provider relocates or opens an additional office; when a complaint is received about a provider site; when office site issues are noted during other quality improvement activities; and at least every three years thereafter (unless the facility is accredited/certified by an appropriate accrediting body, or in a rural area as defined by the U.S. Census Bureau) (Policy and Procedure 1.08.12).

2018 Interventions:

- A draft of the *2017 Facility Provider Credentialing Report* was reviewed by the IMCare Provider Advisory Subcommittee (PAC) on 02/14/18. It was suggested that the title be changed to *Organizational Provider Credentialing Report* to better match NCQA language.
- The final *2017 Organizational Provider Credentialing Report* was reviewed/approved by the IMCare External QI/UM Committee on 03/21/18.
- Quarterly credentialing reports, including organizational provider credentialing/ recredentialing information, were reviewed/approved by the IMCare PAC throughout 2018.
- The *Organizational Provider Credentialing/Recredentialing Checklist* was updated throughout the year as needed.
- IMCare credentialing staff maintained the *Organizational Provider Recredentialing Log* throughout the year.

Organizational provider credentialing is completed on a three-year cycle. The three organizational providers credentialed in 2018 met all required elements.

Site Visit Audit
In 2018, IMCare conducted office site visits to ensure that individual practitioners and organizational providers meet IMCare office site standards, including the assessment of the quality, safety and accessibility of office sites where care is delivered (Policy and Procedure 1.08.12). Site visit audits were completed prior to completion of the initial credentialing process;

when an individual or organizational provider relocates or opens an additional office; when a complaint is received about a provider site; and when provider site issues are noted during a scheduled quality improvement visit by IMCare staff. In addition, a site visit is completed every three years thereafter for organizational providers, unless they are accredited/certified by an approved governing body or are in a rural area (as defined by the U.S. Census Bureau).

2018 Interventions:

- A draft of the *2017 Site Visit Audit Report* was reviewed/approved by the IMCare Provider Advisory Subcommittee (PAC) on 02/14/18.
- The final *2017 Site Visit Audit Report* was reviewed/approved by the IMCare External QI/UM Committee on 03/21/18.
- Quarterly credentialing reports, including office site visit audit results, were reviewed/approved by the IMCare PAC throughout 2018.
- IMCare credentialing staff maintained the *Site Visit Log* throughout the year.
- IMCare credentialing staff maintained the *Organizational Provider Recredentialing Log*, including accreditation/certification and office site visit information, throughout the year.

All individual practitioner and organizational provider office site visits completed in 2018 met goal. Providers received a letter explaining their audit results and encouraging correction of any deficiencies.

Credentials File Audit

IMCare completes an annual audit of individual practitioner initial credentialing and recredentialing files to ensure that the 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.

2018 Interventions:

- A draft of the *2017 Credentials File Audit Report* was reviewed by the IMCare Provider Advisory Subcommittee (PAC) on 02/14/18. PAC suggestions were incorporated into the final report.
- The final *2017 Credentials File Audit Report* was reviewed/approved by the IMCare External QI/UM Committee on 03/21/18.
- Initial appointment and reappointment credentialing/recredentialing checklists were updated throughout the year as needed.

The IMCare Quality Director initially audited a random sample of ten individual practitioner credentialing files with initial credentialing (five) or recredentialing (five) completed in 2018. The results were forwarded to the Medical Director for review. All of the measures met the 100% goal.

Provider Services Contracting

Provider Participation Agreements/Contracted Partners

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

In addition to the Medical Director, IMCare contracts with 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 2018, 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. To enhance enrollee education, IMCare has consistently included this information in enrollee newsletters. Health care directive information was included in the Spring/Summer 2018 and Fall/Winter 2018 Enrollee Newsletters. Additionally, Case Trakker 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 an increase in percentage of

charts including documentation in both the behavioral health (8.75%) and medical (13.31%) record reviews. The measure is applicable to enrollees 18 years old and older. While low rates in the 18-64-year old could be expected, the rate for all IMCare populations (18+) is well below goal. Documentation of health care directives in medical and behavioral health 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 the IMCare Chart Abstractors to identify documentation. In addition, encouraging the younger, healthier population to consider a health care directive is challenging.

Accessibility of Services

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

- IMCare ensured access to providers for minority and special needs populations by conducting cultural, ethnic, racial and linguistic needs assessments of all enrollees at enrollment (and additionally as needed) through Health Screening Surveys and Long-Term Care Consultations (LTCC). IMCare also received and reviewed a monthly list of enrollees identified as having potential cultural, ethnic, racial and linguistic needs from DHS. The IMCare Provider Care Network Listing (PCNL) included the languages spoken at each of the primary care clinics. American Indians were able to utilize tribal and Indian Health Services clinics, in addition to network providers, without prior authorization by IMCare.
- 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 2017 Access and Availability Report was reviewed/approved by the IMCare Provider Advisory Subcommittee (PAC) on 11/08/2017 and the External Quality Improvement/Utilization Management (QI/UM) Committee on 12/13/2017.
- The 2017 Consumer Assessment of Healthcare Providers and Systems (CAHPS) Report results were reviewed at the PAC meeting on 05/10/2017 and the External QI/UM Committee meeting on 03/15/2017.
- The 2017 Clinic Grievance Report was reviewed/approved by the PAC on 11/08/2017 and the External QI/UM Committee on 03/15/2017.
- The 2017 Credentials File Audit Report was reviewed/approved by the PAC on 02/08/2017 and the External QI/UM Committee on 03/15/2017.

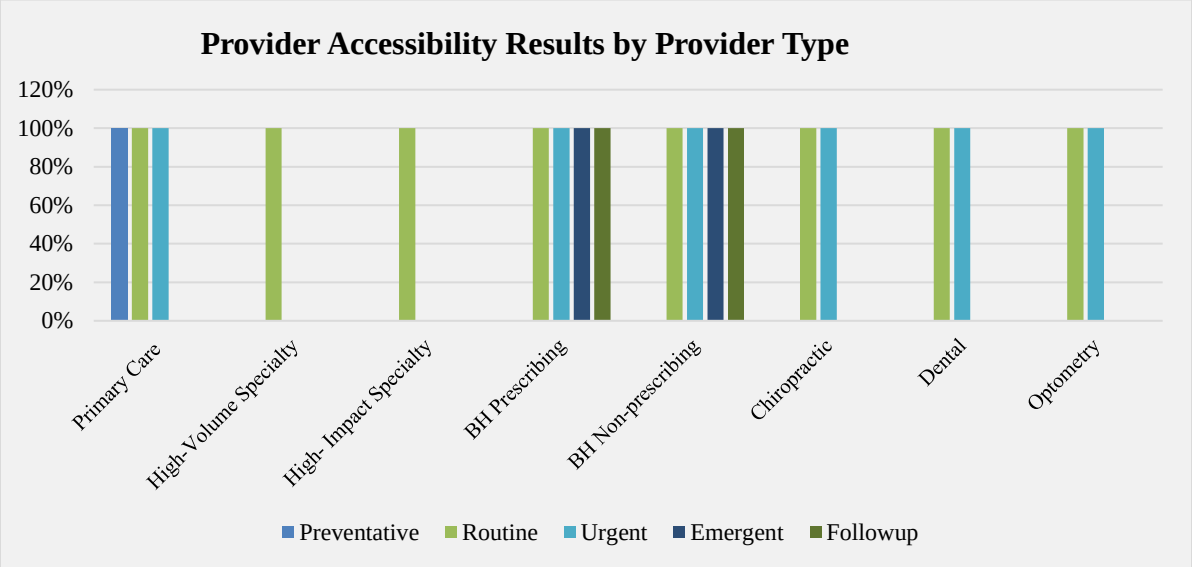
- The 2017 Site Visit Audit Report was reviewed/approved by the PAC on 02/08/2017 and the External QI/UM Committee on 03/15/2017.

During the study period, IMCare met goal for all accessibility measurements and maintained an adequate care network as it relates to provider accessibility. Each provider type was subject to different accessibility standards based on their provider type, Figure 21 below demonstrates that all pertinent access standards were met by all provider types. In addition to the provider accessibility measurements included in this 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. Furthermore, the Itasca County Crisis Response Team provides around-the-clock urgent/emergent behavioral health care to Itasca County residents.

In 2018, CAHPS survey measurements applicable to provider accessibility exceeded goal for all populations. Analysis of enrollee grievances revealed no grievances related to cultural/ethnic/racial/linguistic enrollee needs or accessibility of IMCare providers during the study period.

Figure 21: Provider Accessibility Results by Provider Type



Practitioner Availability and Network Adequacy

In 2018, IMCare ensured the availability of practitioners and services by identifying gaps in network adequacy through data analysis, as required by National Committee for Quality Assurance (NCQA) and IMCare contracts with the Minnesota Department of Human Services (DHS). IMCare evaluated potential gaps in availability of primary care, specialty care, behavioral health care, ancillary service care, pharmacies, home health agencies, hospitals and

skilled nursing facilities by analysis and comparison of network performance against standards for availability.

2017- 2018 Interventions:

- IMCare ensured practitioner availability for minority and special needs populations by conducting cultural, ethnic, racial and linguistic needs assessments of all enrollees at enrollment (and additionally as needed) through Health Screening Surveys and Long-Term Care Consultations (LTCC). IMCare also received and reviewed a monthly list of enrollees identified as having potential cultural, ethnic, racial and linguistic needs from DHS. The IMCare Provider Care Network Listing (PCNL) included the languages spoken at each of the primary care clinics. American Indians were able to utilize tribal and Indian Health Services clinics, in addition to network providers, without prior authorization by IMCare.
- The 2017 Access and Availability Report was reviewed/approved by the IMCare Provider Advisory Subcommittee (PAC) on 11/08/2017.
- The 2017 Clinic Grievance Report was reviewed/approved by PAC on 11/08/2017.

During the study period, IMCare met goal for all primary care and most specialty care availability measures. Practitioner to enrollee ratios for orthopedics and oncology nearly met goal. In order to ensure specialty care availability, IMCare allows enrollees to see all network and outreach specialty practitioners in the IMCare service area. In addition, IMCare allows enrollees to see specialty care practitioners at the nearest out-of-network tertiary care center without a referral or prior authorization.

IMCare met goal for nearly all behavioral health practitioner to enrollee ratios, but not geographic availability measures. All psychiatrists in the IMCare service area are IMCare network providers; however, there is a long-standing national and rural shortage of this practitioner type. IMCare 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, nine 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 practitioner/organizational provider measures met goal for the study period. Eleven households in northwest Itasca County do 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.

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 three denials based on the out-of-network status of the practitioner/provider, when a network option was available. None were appealed. In addition, there were no enrollee grievances related to issues with practitioner availability or network adequacy. In July 2018, IMCare has implemented a new tracking system for authorizations to allow for retroactive review by network status of the requesting provider, which will aid in determining the volume of enrollees utilizing out-of-network services for future evaluations.

Enrollee Experience

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

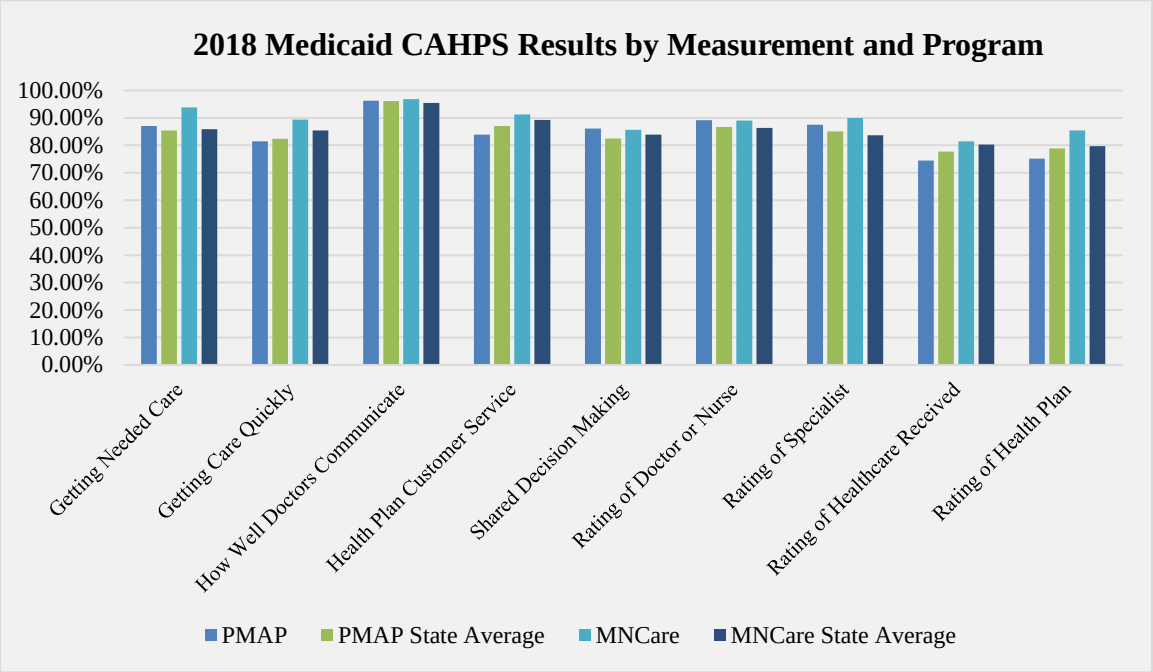
IMCare contracts with an external vendor to administer NCQA's Consumer Assessment of Healthcare and Provider Systems (CAHPS) survey to its enrollees. CAHPS is a nationally recognized and comprehensive survey instrument designed to capture the experiences of consumers and enrollees with a range of health care products and services such as customer service, access to care and claims processing. By providing consumers with standardized data and presenting it in a way that is easy to understand and use, CAHPS is intended to help people make decisions that support better health care and better health.

The CAHPS results appeared to be somewhat static from year-to-year for the PMAP population, to the contrary MNCare results had notable increases for several measures. In the 2018 CAHPS Survey results, measuring enrollee experience in 2017, IMCare met or exceeded the MN state average goal for all MNCare responses and half of the PMAP population responses. The PMAP population ratings for Getting Care Quickly, Health Plan Customer Service, Rating of Healthcare Received and Rating of Health Plan fell just below the MN state average but were within five percent of goal. IMCare network providers met all appointment accessibility standards and there were no enrollee grievances regarding delay in care or services. IMCare continues to struggle with improving Health Plan Customer Service and Rating of Health Plan for PMAP, enrollees may correlate their experience with enrollment and renewing eligibility. These processes are handled by Itasca County Financial Assistance Department and IMCare has limited ability to influence change in the customer service experience that enrollees receive from that entity. The CAHPS 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.

Figure 22: Medicaid CAHPS Response Rates by Product

	IMCare Eligible Sample Size	IMCare Enrollees Completing Surveys	IMCare Response Rate
PMAP	1660	377	22.71%
MNC	83	24	28.92%

Figure 23: 2018 Medicaid CAHPS Results by Measurement and Program



Seniors (MSHO & MSC+) Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey

IMCare contracts with an external vendor to administer NCQA's Consumer Assessment of Healthcare Providers and Systems (CAHPS) for IMCare's membership. CAHPS is a nationally recognized and comprehensive survey instrument designed to capture the experiences of consumers and enrollees with a range of health care products and services such as customer service, access to care and claims processing. By providing consumers with standardized data and presenting it in a way that is easy to understand and use, CAHPS is intended to help people make decisions that support better health care and better health.

In 2018, CAHPS results exceeded goal for all measures for both the MSHO and MSC+ populations. There is no state-wide data available for MSHO surveys so instead, the rating scores and percentile cut points along with year to year comparisons were used. IMCare, when ranked among other Medicare plans, was rated five for all measures, which indicates that IMCare was in the 80th percentile or greater. Results for the MSHO CAHPS survey were not provided in 2016, so as a result there is only one year, 2017, for the year-to-year comparison. The MSC+ survey results were reviewed in comparison to the MN state averages, with a three-year comparison, and were well above 80% for all measures, in addition to exceeding the state average.

Figure 24: Senior CAHPS Response Rates by Product

	IMCare Eligible Sample Size	IMCare Enrollees Completing Surveys	IMCare Adjusted Response Rate*
MSHO	355	144	42.0%
MSC+	70	32	45.71%

Figure 25: 2017- 2018 MSHO CAHPS Results by Measurement

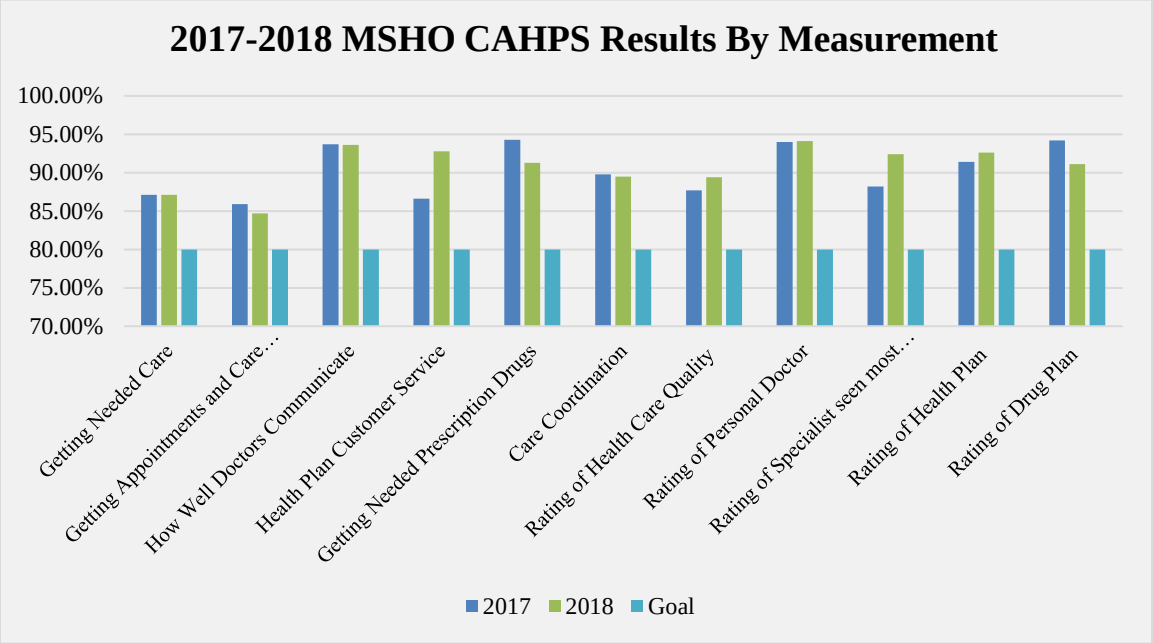
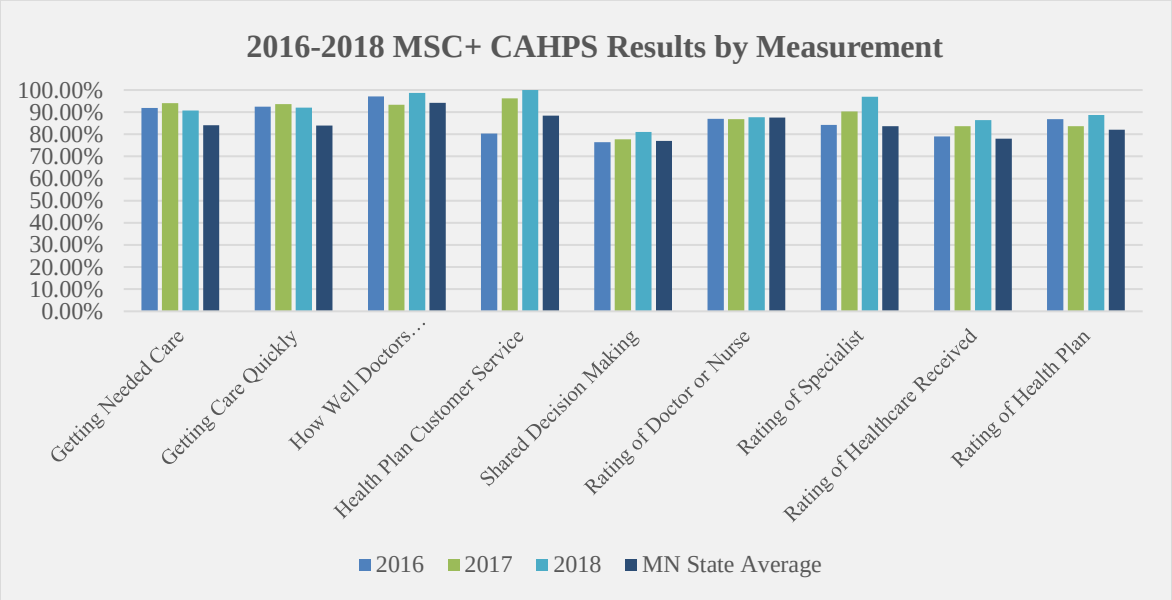


Figure 26: 2016- 2018 MSC+ CAHPS Results by Measurement



MSHO Enrollee Satisfaction with Care Coordination Survey

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

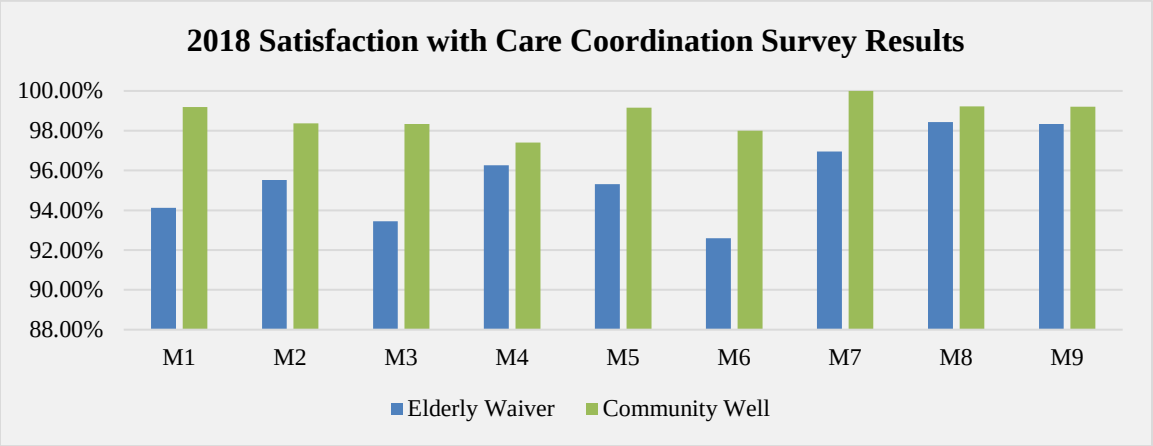
In 2018, MSC+ enrollees were added to the study population in order to expand the overall survey population and allow for a better picture of enrollee satisfaction. As a result, 678 total surveys were sent in 2018 compared to the 475 total surveys that were sent in 2017, and the total number of returned surveys increased to 237 from 172. The returned surveys were separated by Elderly Waiver and IMCare care coordination, in order to determine specific opportunities for improvement**.**

In 2018, the overall percentage of enrollees satisfied increased drastically. As a county-based purchasing plan, we capitalize 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 goal in all aspects of 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 of 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.

Figure 27: Enrollee Satisfaction Survey Measures

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

Figure 28: 2018 Senior Enrollee Satisfaction with Care Coordination Survey Results



Enrollee Education Sessions

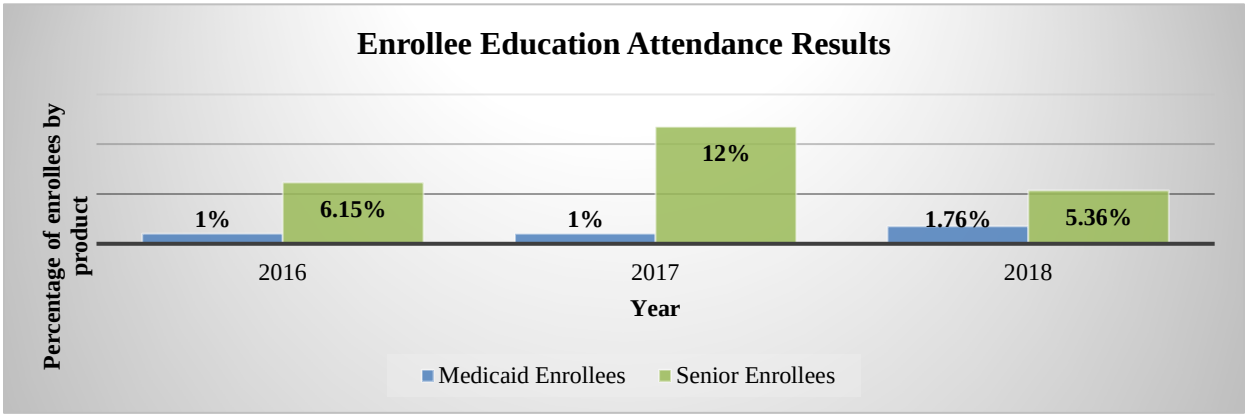
IMCare provides monthly enrollee education. Enrollees new to IMCare are notified in writing of the monthly education sessions when they receive their new IMCare medical cards. The purpose of the education is for enrollees to understand how to use their IMCare medical card, review of the Enrollee Handbook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

201 Interventions:

- Written notification of monthly enrollee education was sent to individuals who were newly enrolled during 2018.
- Information regarding monthly education was included in the biannual enrollee newsletters which are sent to all enrollees.
  Information regarding enrollee education is always available on the IMCare website.

IMCare has historically had low attendance rates for monthly enrollee educational sessions. In 2018, IMCare saw a significant decrease in the number of new enrollees in the Medicaid population, but it more closely aligns with the 2016 numbers. The significant drop in the denominator resulted in an increased participation rate of 1%. The MSHO population had a slight increase in the numbers of enrollees and had decrease in the number of attendees in that population, resulting in a year-to-year decrease from 11.76% to 5.36%. The educational sessions offered to enrollees are held the third Wednesday of the month at the Itasca Resource Center (IRC) and are not mandatory. There are several factors that may attribute to these low attendance rates, including the time of the education session may conflict with work or school, an enrollee may have attended during a previous enrollment that was over 90 days ago, or they may be unable to obtain transportation to the IRC building. Furthermore, IMCare serves enrollees who live in remote areas of rural Minnesota, the climate and distance alone may deter enrollees from attending the one-hour education session. Additionally, IMCare has not restructured its letters regarding education or the educational sessions in many years which may reduce the draw for enrollees to attend.

Figure 29: Enrollee Education Attendance Results



Customer Service Call Center Performance

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

2018 Interventions:

- IMCare Director provided education to First Call for Help (FCFH) via email about appropriate call response on two different occasions during 2018.
- IMCare Quality Director conducted routine monitoring of Prairie Fyre to review call abandonment rates and followed up with staff accordingly.
- Required at least one CSR to be available during regular business hours, except for all-staff or CSR meetings at which time calls are answered by alternative staff or First Call for Help (FCFH).
- Additional IMCare staff were cross-trained on addressing calls to allow for additional coverage during high volume periods.

IMCare used the CMS benchmark for internal monitoring. IMCare's internal rate of abandonment is 1.36%, which is below the CMS benchmark. IMCare's disconnect rate for Part C and Part D Beneficiary Customer Services Center calls (IMCare) met goal, by coming in below the 5% benchmark. The Pharmacy Customer Services Center (CVS Caremark) calls had a disconnect rate of 6.32%, not meeting the goal of 5% or less. Additionally, Prospective Beneficiary Customer Services Center (IMCare) Calls for both Part C and for Part D were above the 5% benchmark and did not meet goal. These calls consist of Limited English Proficiency (LEP) calls or TTY/TTD services. As indicated in Table 3, most abandoned calls were LEP calls and occurred after IMCare business hours. The Limited English Proficiency (LEP) calls are connected to Language Line for a three-way call to answer foreign language calls. Prospective and current beneficiaries are directed to Minnesota Relay for TTY/TTD services. FCFH primarily staff's volunteers. It is questionable whether each volunteer has been given adequate training regarding IMCare processes and this may be the cause for higher abandonment rates in the identified areas. IMCare has also hired new staff internally and the disconnected TTY call occurred a few weeks after one of the new staff was hired.

Case Management/Care Coordination

Complex Case Management

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

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

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

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

Electronic identification sources include:

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

Referral identification sources include:

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

The case management program involves a comprehensive initial assessment of the enrollee's condition, determination of available benefits and resources, development and implementation of a care plan and coordination of services. After an enrollee has been identified for CCM, a registered nurse (RN) will contact the enrollee to offer case management services and offer an

initial assessment and develop a plan of care as indicated. The RN case manager works closely with the enrollee, the enrollee's legal representative, the enrollee's PCP and other providers identified by the enrollee's treatment team to coordinate care and access to needed services. The CCM program is an included benefit to the enrollee. Restricted Recipients are automatically enrolled into the CCM program. Non-restricted enrollees meeting criteria can voluntarily enroll with verbal and/or written consent. The program is most successful with participation of the enrollee's family, caregivers and other natural support systems as identified by the enrollee.

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

- Comprehensive initial assessment and/or re-assessment of enrollee's health
- Development of an individualized care plan
- 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 for as long as the enrollee has identified needs and are willing to receive support and services from the program. Case managers maintain scheduled contact, with the frequency based on varying enrollee need. Generally, case managers provide the following to all enrollees enrolled in the program:

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

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

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

- Risk screening and assessment that addresses medical, social, environmental, and mental health factors
- Encouraging enrollees to establish a relationship with a Primary Care Physician (PCP) or clinic

- Establishing a communication system of significant health events (i.e., emergency room use, inpatient stays) between primary care and IMCare/Public Health

Case Management for community EW MSC+ enrollees include:

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

Case Management for MSC+ nursing facility residents includes:

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

Care Coordination

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

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

Other care coordination/case management requirements for MSHO include:

- Rehabilitative services following acute events, and for ensuring smooth transitions and coordination of information between acute, subacute, rehabilitation, nursing facilities, and Home and Community Based Services settings
- Ensuring access to an adequate range of EW and nursing facility services and for providing appropriate choices among nursing facilities and/or EW services to meet the individual needs of enrollees who are found to require a nursing facility level of care
- Coordinating the medical needs of 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 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 community well, 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. Because some elements pertaining to assessment apply to new enrollees, new enrollees are defined as enrollees within the last 12 months and others to existing cases, existing cases are defined as enrollees for more than 12 months. IMCare ensures that there is an adequate number of cases to evaluate compliance per these elements. In 2018, an issue raised by the delegates during the review, indicating if applicable, if not please indicate NA.

Itasca County Public Health EW Care plans were deficient in 2 of 3 elements requiring 100%, and 4 elements requiring 95%. Internal IMCare non-EW care plans were deficient in 1 of 3 elements requiring 100%, and 6 elements requiring 95%, and a corrective action plans will be required. A concern was raised by internal care coordinators identifying three of the four elements found deficient occur on the signature page. In the event that this is lost or not returned, all three elements indicate deficiency.

Disease Management

IMCare identifies enrollees with the chronic conditions of asthma, diabetes, heart failure, and hypertension, and provides those enrollees with an opportunity for education, support and self-management. Disease management does not take the place of existing medical providers or educators but supports the plan of care and the enrollee. IMCare's disease management program, 'Ways to Wellness', was developed based on NCQA guidelines. Many of the annual IMCare disease management program outcome measurements are HEDIS measures, resulting in a data lag. In 2018, IMCare analyzed interventions and outcome measurements for 2017.

2017 Interventions**:**

- Enrollees received verbal and written flu vaccine reminders individually and with their quarterly mailings
- Referrals to health care providers, complex case management and public health when appropriate
- Inclusion of Ways to Wellness information related to diabetic eye exams in enrollee newsletter
- Education on disease states and action plans
- Enrollees informed of local community resources through telephone contact with disease management and care coordinators

- Enrollee newsletter with Ways to Wellness information
- Provider newsletter with Ways to Wellness information
- Disease management program surveys were mailed to all enrolled in disease management
- Provider update sent to individual provider locations indicating the numbers of enrollees served for each disease state
- Utilization of an electronic disease management mailing system
- Review of educational materials to ensure the mailings follow current guidelines for education and self-management recommendations
- Additional educational materials added to each disease program following current guidelines for education and self-management recommendations

In 2017, the IMCare Ways to Wellness program served 555 enrollees with the chronic conditions of asthma, diabetes, heart failure and/or hypertension. Some of these enrollees may have had one or more of the listed chronic conditions. These enrollees received quarterly educational mailings and/or nurse phone calls. Participation rates increased for asthma, diabetes and heart failure but decreased for hypertension. Although the hypertension rated decreased by 11.51% points, the actual number enrolled in disease management for hypertension increased from 2016. In 2017, diabetes changed from an opt-in to opt out program. Due to volume, IMCare chose to auto-enroll 50% of enrollees in 2017 and the remaining 50% of enrollees with diabetes in 2018. As a result of this change, IMCare saw a significant increase in the total number of enrollees enrolled in the asthma, diabetes and hypertension programs.

In 2017, IMCare did not meet the established goals for HbA1C screenings, retinal eye exams or nephropathy screenings although the rate for retinal eye exams and nephropathy screenings did increase from the 2016 rates. During HEDIS audit process for 2017, IMCare did not do a secondary chart review for all medical records that did not contain the specified measurement data. Rather than collecting retinal eye exam data from eye care clinics, data was only collected in the primary care settings which may have contributed to a rate which is lower than the established goal. For 2018, IMCare will consider doing a secondary review at the eye care clinics, if the eye exam data is not available in the primary care records. In 2017, IMCare was below the National average for flu vaccinations and was significantly below goal among those enrolled in the disease management. IMCare did not use the Minnesota Immunization Information Connection (MIIC) system to obtain 2017 immunization data rather, IMCare only used medical and pharmacy claims data for the measurement. This could account for the decreased flu vaccination rate. IMCare will consider using MIIC to obtain future immunization rates. Annual reminder letters related to the importance of getting the flu vaccination were sent to all enrollees to increase awareness of the vaccination's importance. The letters included locations where the vaccine could be received. An annual reminder was also included in the Fall 2017 Enrollee Newsletter.

During the 2017 HEDIS audit process, an auditing error involving the hypertension measure occurred which was not identified until final results were compiled. This error resulted in a significant number of enrollee charts being excluded from the measurement numerator that were still required to be included in the denominator and thus skewing results. Extensive auditor training is to take place prior to next year's HEDIS audits to eliminate the likelihood of such an error reoccurring.

Overall, enrollees participating the Ways to Wellness program who responded to the satisfaction survey were satisfied with the program. Each component of the survey exceeded goal. All noted comments on the survey were positive and reflected satisfaction with the services. IMCare network provider satisfaction with the program also exceeded goal in 2017.

Figure 30: Year-to-Year Comparison of Disease Management Program Participation Rates by Condition

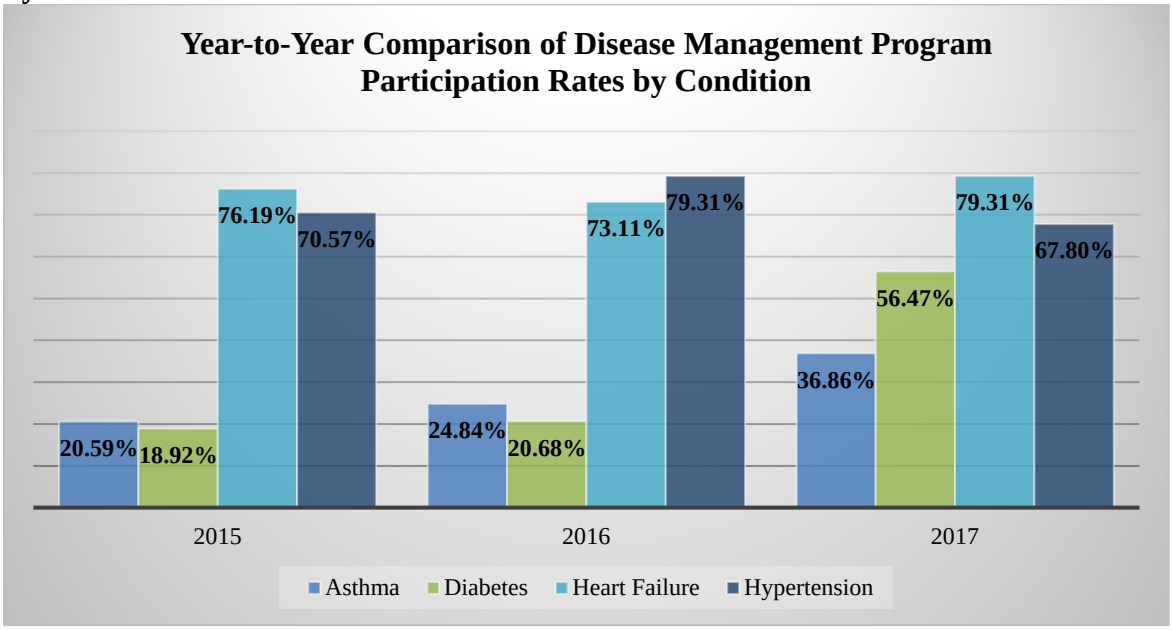


Figure 31: Asthma Disease Management Program Measurements

Measurement	Data Source
M1. Medication Management - The percentage of IMCare enrollees 5–85 years of age during the measurement year who were identified as having persistent asthma and remained on an asthma controller medication for at least 50% of their treatment period .	HEDIS MMA Measure
M2. Medication Management - The percentage of IMCare enrollees 5-85 years of age during the measurement year who were identified as having persistent asthma and remained on an asthma controller medication for at least 75% of their treatment period.	HEDIS MMA Measure
M3. Flu Vaccination - The percentage of IMCare enrollees enrolled in the IMCare Disease Management program for asthma who received an influenza vaccination during the measurement year.	Claims

Figure 32: Year-To-Year Comparison Asthma Disease Management Program Results

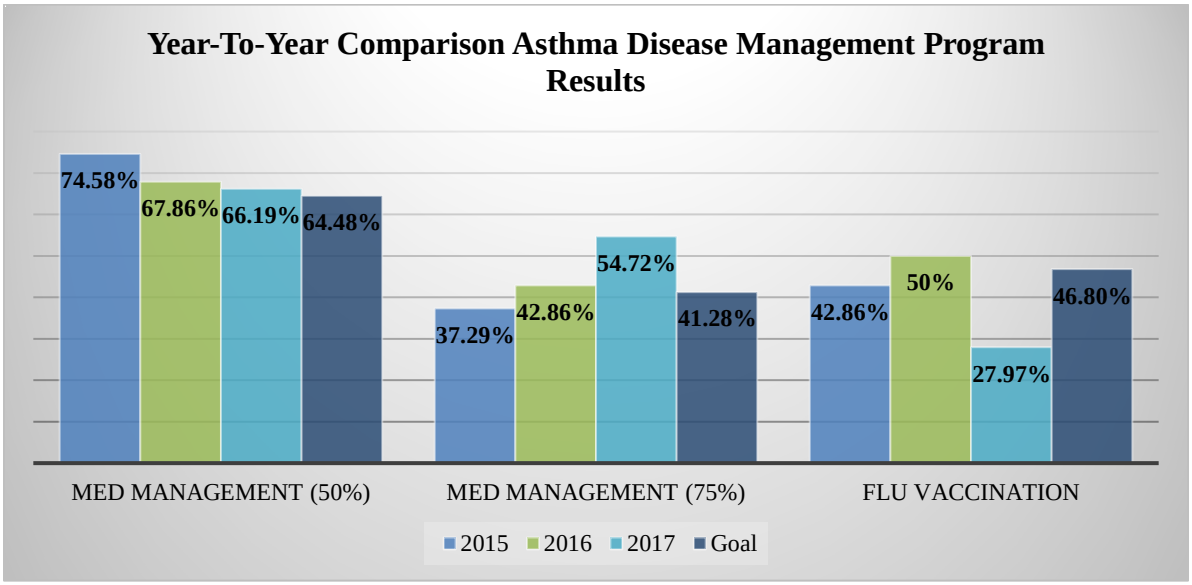


Figure 33: Diabetes Disease Management Program Measurements

Measurement	Data Source
M1. The percentage of IMCare enrollees 18-75 years of age with diabetes who had HbA1c screening during the measurement year.	HEDIS CDC Measure
M2. The percentage of IMCare enrollees 18-75 years of age with diabetes who had a dilated eye examination during the measurement year or a negative retinal eye exam in the year prior to the measurement year.	HEDIS CDC Measure
M3. The percentage of IMCare enrollees 18-75 years of age with diabetes who had nephropathy screening or evidence of nephropathy during the measurement year.	HEDIS CDC Measure
M4. The percentage of IMCare enrollees enrolled in the IMCare Disease Management program for diabetes who received an influenza vaccination during the measurement year.	Claims

Figure 34: Year-To-Year Comparison Diabetes Disease Management Program Results

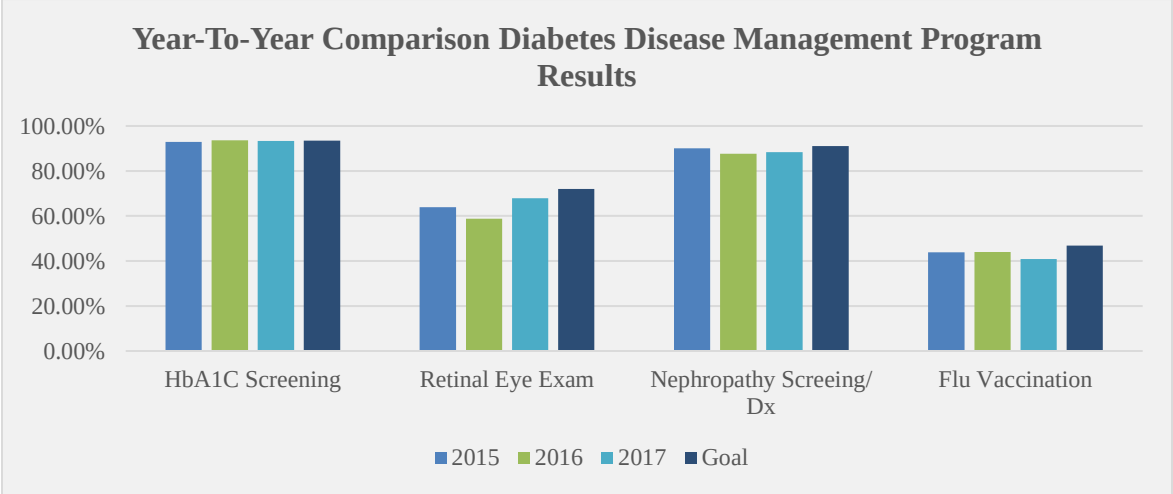


Figure 35: Heart Failure Disease Management Program Measurements

Measurement	Data Source
M1. The percentage of IMCare enrollees enrolled in the IMCare Disease Management program for heart failure who agreed to receive phone calls and reported that they monitor their weight daily.	Enrollee Report
M2. The percentage of IMCare enrollees enrolled in the IMCare Disease Management program for heart failure who agreed to receive phone calls and reported that they have a self-management goal.	Enrollee Report
M3. The percentage of IMCare enrollees enrolled in the IMCare Disease Management program for heart failure who had at least one inpatient stay with the primary diagnosis of congestive heart failure (CHF) during the measurement year.	Claims
M4. The percentage of enrollees enrolled in the IMCare Disease Management program for heart failure who received an influenza vaccination during the measurement year.	Claims

Figure 36: Year-To-Year Comparison Heart Failure Disease Management Program Results

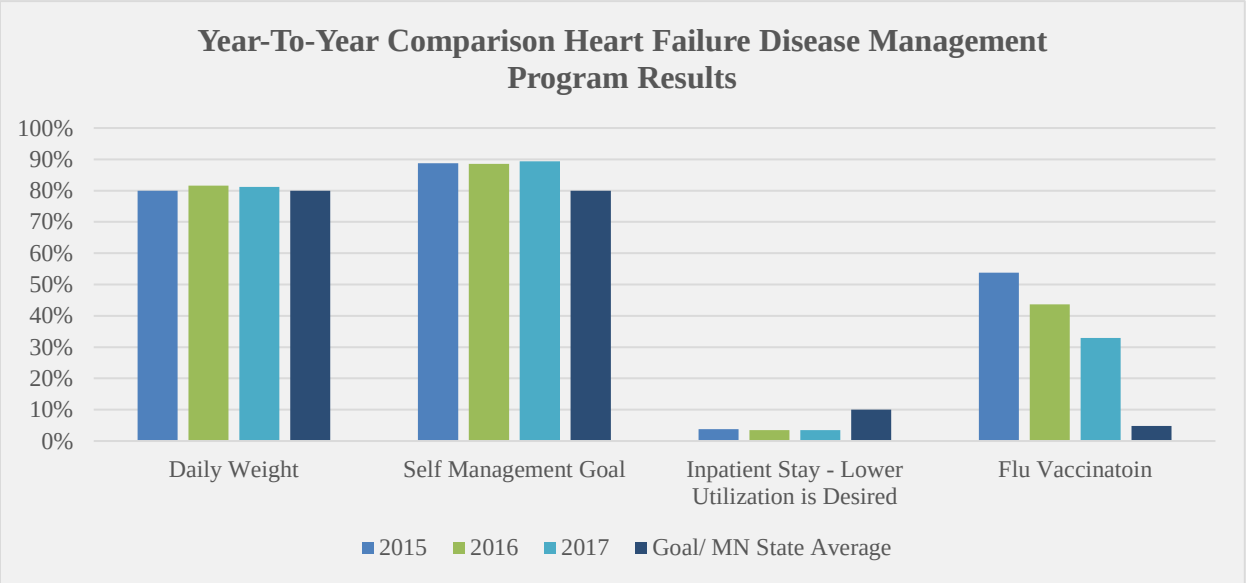
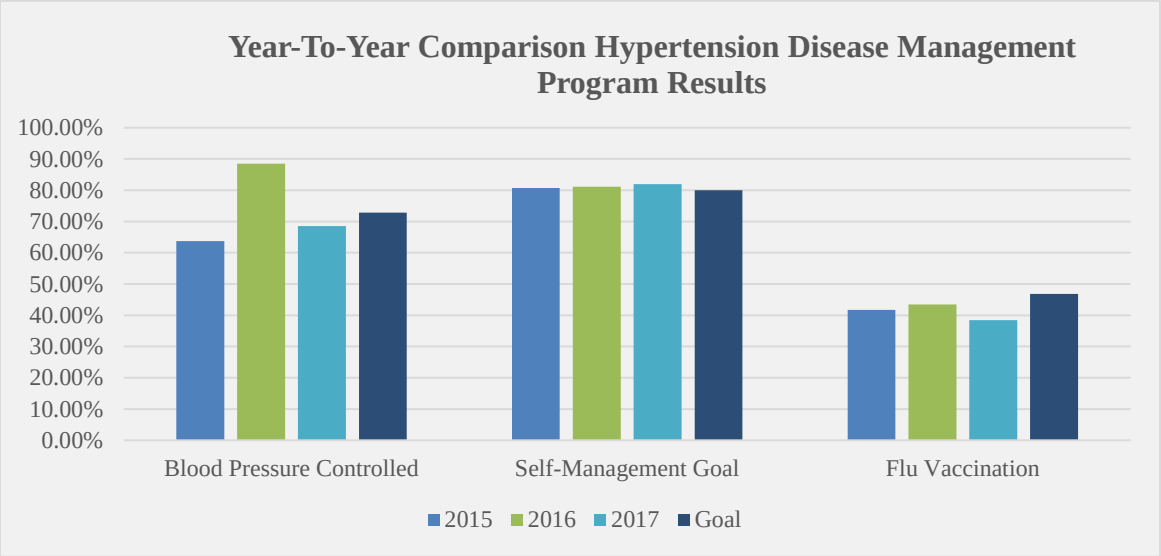


Figure 37: Hypertension Disease Management Program Measurements

Measurement	Data Source
M1. The percentage of IMCare enrollees 18-85 years of age who had a diagnosis of hypertension and whose most recent blood pressure during the measurement year was adequately controlled.	HEDIS CBP Measure
M2. The percentage of IMCare enrollees enrolled in the IMCare Disease Management program for hypertension who reported that they have a self-management goal.	Enrollee Report
M3. The percentage of enrollees enrolled in the IMCare Disease Management program for hypertension who received an influenza vaccination during the measurement year.	Claims

Figure 38: Year-To-Year Comparison Hypertension Disease Management Program Results



Practice Guidelines

Annually, IMCare is required to adopt, disseminate and apply practice guidelines consistent with current NCQA *Standards and Guidelines for the Accreditation of Health Plans*. The NCQA guideline requires IMCare to adopt and disseminate evidence-based clinical practice guidelines for at least two medical conditions, at least two behavioral health conditions, perinatal care and preventive health for all ages. Two of the organization's adopted clinical practice guidelines must provide the clinical basis for disease management (DM) programs. In addition, IMCare must measure performance related to the practice guidelines annually. Most practice guideline outcome measurements are HEDIS measures, resulting in a data lag. In 2018, IMCare analyzed interventions and outcome measurements for 2017. In addition, updated practice guidelines were adopted and disseminated at the beginning of 2018.

2017 Interventions**:**

- 2017 Practice Guidelines were reviewed and adopted by the Provider Advisory Subcommittee (PAC) on 02/08/2017.
- 2017 Practice Guidelines were reviewed and adopted by the External QI/UM Committee on 03/15/2017.
- Enrollees participating in the disease management program received calls and/or educational materials regarding their chronic condition/s.
- 2017 Practice Guidelines were disseminated to network providers in the Spring 2017 Provider Newsletter.
- 2017 Practice Guidelines were disseminated to enrollees in the Spring 2017 Enrollee Newsletter.
  IMCare began mailing out reminder letters to enrollees who did not have a medical claim for preventative cancer screens in 2017.

In 2017, IMCare did not meet the established goals for HbA1C screenings in both the PMAP and MSHO populations with a decrease in rates for both. The goal was met for the MNCare population despite a decrease in rate. HbA1c control (defined as less than 8%) goals were met for PMAP and MSHO but were below goal for the MNCare population. During the HEDIS audit process for 2017, IMCare did not do a secondary chart review for all medical records that did not contain the specified measurement data. IMCare met all goals for enrollee blood pressure control for the PMAP population but fell below goal for MNCare and MSHO for both measurements. The goals for antihypertensive medication adherence was met for both the Medicaid and Medicare populations. During the HEDIS audit process, an auditing error occurred which was not identified until final results were compiled. This error resulted in a significant number of enrollee charts being excluded from the measurement numerator and thus skewing results. Extensive auditor training is to take place prior to next year's HEDIS audits to eliminate the likelihood of such an error reoccurring. Diabetes mellitus and hypertension are part of IMCare's Ways to Wellness disease management program, which focuses on adequate control and management of individual enrollee's blood sugars and HbA1c levels and adequate control and management of individual enrollees blood pressure through diet, medication adherence and healthy life choices. In 2017, diabetes mellitus changed from an opt-in to an opt-out program. All enrollees with diabetes mellitus and hypertension are now automatically enrolled in disease management and must request to be excluded from the program.

In 2017, IMCare antidepressant medication management (AMM) rates were above goal for PMAP and MSHO populations for the 12-week measure. IMCare fell below goal for the 6-month measurement for all populations. In 2015, IMCare began active performance/quality improvement projects aimed at the goal of improving the AMM 6-month rate for the study population. The goal of this performance improvement project was to increase the IMCare HEDIS Antidepressant Medication Management (AMM) Effective Continuation Phase Treatment rate for the study population by an absolute 8% by HEDIS 2017 and sustain this improvement for HEDIS 2018. The baseline rate (2014 HEDIS AMM Effective Continuation Phase Treatment rate for the study population) was 0%. The 2017 HEDIS AMM Effective Continuation Phase Treatment rate for the study population was 35%, which exceeded the project goal.

In 2017, IMCare rates for ambulatory/preventative care visits were above goal for both the PMAP and MNCare populations. The MSHO rate was only slightly below goal for the population and improved from 2016 to 2017. The percentage of enrollees 18-74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year improved for all populations. The goal for MNCare and MSHO were above goal but below goal for the PMAP population.

In 2017, IMCare cancer screening rates varied among populations. Breast cancer screening rates were below goal for all populations with a noted decrease for PMAP and MSHO populations. The MNCare rate increased from 2016 to 2017. MSHO colorectal cancer screening was below the MN State average but did show a slight improvement from 2016. Cervical cancer screening rates were below MN State averages for both PMAP and MNCare. IMCare continues to encourage enrollees and providers to complete recommended cancer and preventative screenings through enrollee and provider newsletters. The newsletter articles focus on the importance of periodic screenings, ages at which these screenings are recommended and enrollee/provider

talking points surrounding each of the screenings. In addition, IMCare began mailing out reminder letters to enrollees who did not have a medical claim for preventative cancer screens in 2017.

Continuity and Coordination of Care

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

In 2018, the care coordination team did outreach to some network providers to promote more timely transition notification and involvement in the interdisciplinary care team at the time of discharge. Furthermore, IMCare worked closely with Itasca County Public Health to discuss and identify areas of the transition process that may benefit from process improvement. IMCare's Model of Care (MOC) was revised and submitted for approval to the Centers for Medicare and Medicaid Services (CMS) in February 2018. The MOC was approved for three years and includes some changes to the transitions process. The Transition of Care (TOC) Log was also modified in CTD to more accurately reflect the Collaborative TOC Log created and used by other Managed Care Organizations. The two major changes are:

- If CCs are notified more than 14 days after a transition takes place, they are no longer required to complete the TOC Log in CTD. However, it is still expected that they follow-up with the enrollee as they would in the case of a timely transition notification and then thoroughly document their actions.
- CCs are now required to contact the enrollee or their designated representative only upon discharge to their usual care setting or their 'new' usual care setting. This is a change from the previous requirement of contacting the enrollee or their designated representative after each transition, which can be very difficult if the enrollee is critically ill, in an ICU, etc.

For the 2018 reporting period, the total number of transitions increased only slightly from the previous report, by 1.8%, from 496 transitions to 505 transitions. Two measures regarding notification to the primary care provider and contact to the enrollee or their designated representative during the transition period were met, the remaining four measures were unmet. With the updated transitions process in CTD and a transitions audit for each care coordinator, the data is expected to be more substantive in future evaluations.

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

CVS Caremark Delegation Agreement
IMCare is accountable for overseeing the delegated services outlined in the Delegation agreement addendum to the pharmacy benefit services agreement (PBSA) with CVS Caremark. Each year, IMCare audits 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 multiple 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.

There are seventeen total categories that were assessed as part of the oversight process, which includes review of numerous materials and over 20 reports and policy and procedure documents as listed in the attachments. The following is a summary of the oversight categories:

1. Establishing a Pharmacy Network
2. Pharmacy Network Auditing
3. Custom Medicaid Formulary/Formulary Management
4. Pharmacy Help Desk
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 Solutions Program
13. General Performance and Monitoring
    1. Reference Report Reviews – FWA
    2. MAC Performance Oversight
    3. Encounter Data Review
    4. Account Management
    5. Invoiced and Paid amount reconciliation

IMCare found CVS Caremark to be compliant with oversight categories 1,2,3,4,5,6,7,8,9,10,13.1,13.2,13.3,13.5, deficient in no categories and require mandatory improvement in categories 11,12, 13.4 (DUR Services/Clinical Programs, Safety and Monitoring Solutions and account management).

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

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

2018 Utilization Management Program Activities

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

In 2018, IMCare utilized the following policies and guidelines when making UM authorization decisions:

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

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

Under and Over Utilization

Medicaid Under and Over Utilization

Ensuring appropriate utilization of services is required as per Article 7.1.3 of the 2017 DHS Families and Children contract. "The MCO shall adopt a utilization management structure consistent with state and federal regulations and current NCQA "Standards and Guidelines or the Accreditation of Health Plans."" Pursuant to 42 CFR § 330(b)(3), this structure must include an effective mechanism and written description to detect both under and over utilization of services. HEDIS measures are used to evaluate potential under and over utilization of services. In 2018, 2017 interventions and outcome measures were analyzed.

2017 Interventions:

- Enrollee newsletters were sent out in spring and fall of 2017. Article topics included information about preventative wellness visits and screening, vaccines, chronic medical conditions, dental care, emergency room utilization and depression.
- Individual well child visit reminders were sent out on the birth month of enrollees in the appropriate age bracket.
- The 2017 Medicaid Under and Over Utilization Report was reviewed/approved by the by the IMCare Provider Advisory Subcommittee (PAC) on 11/8/2017 and the IMCare External QI/UM Committee on 12/13/2017.

IMCare HEDIS utilization measures have been somewhat static over the past three years, with less than five percent variability from year-to-year, except for Adolescent Well Care visits, which had an increase of 7.3% from the previous measurement. IMCare preventive care in children measure rates were just below the MN state average rates for PMAP enrollees. It is unclear why IMCare consistently falls below the MN state average in these measures. It could be related to the rural location of Itasca County, resulting in longer travel to appointments or smaller denominators than other plans, resulting in weighted shifts. In contrast, Adults' Access to Preventive/Ambulatory Health Services (M2) consistently exceeds the MN state average for both PMAP and MNCare populations. A network facility that serves the largest volume of IMCare enrollees has recently implemented 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. Further increase in these measures in future HEDIS audits is anticipated as a result.

IMCare Annual Dental Visit (ADV) rates exceeded 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. Additionally, in response to the strong focus that DHS has placed on dental access in the 2018 Families and Children and Seniors contracts, IMCare has implemented several new dental interventions this year, which will likely cause an increase in HEDIS 2019 ADV rates.

Mental Health Utilization (MPT) and Identification of Alcohol and Other Drug Services (IAD) goals were unmet for the PMAP population, as they were above the MN state average and had slight year-to-year increases in utilization. In contrast, the MNCare population met goal for both measures, below the MN state average, with a slight decrease in the IAD measure rate. Follow-Up After Emergency Department (ED) Visit for Mental Illness (FUM) and Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) were two new measures for HEDIS 2018. These are centered on receiving follow-up care for the emergency department diagnosis (mental health or substance use disorders), within seven days of the ED visit. As noted in the Figure 39, these measures apply to different age groups. IMCare met the FUM goal for the PMAP population but did not meet the goal for MNCare. IMCare was well below the MN state average for FUA for the PMAP population, and there was no data for the MNCare population. There are several new mental health services that have been developed by DHS in the last two years. This likely has impacted our MPT rates and they may continue to trend upward. Substance Use Disorder (SUD) reform has also been a strong focus area for DHS and new regulations regarding substance use assessments and level of services may result in upward trends of IAD rates as well.

Figure 39: 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

Figure 40: 2016-2018 PMAP Under & Over Utilization HEDIS Results

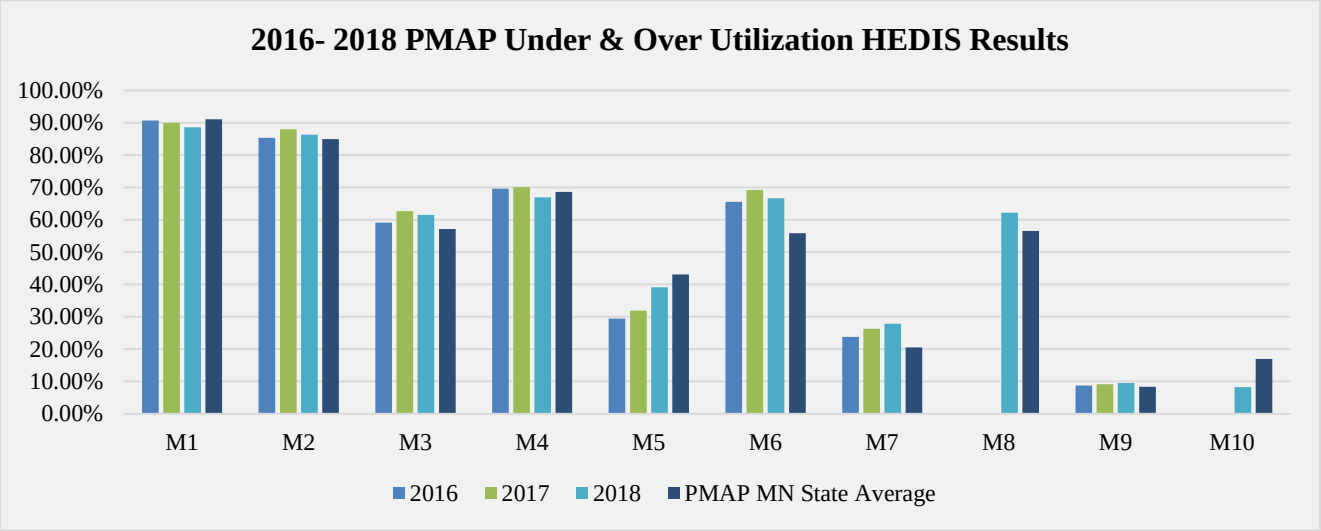
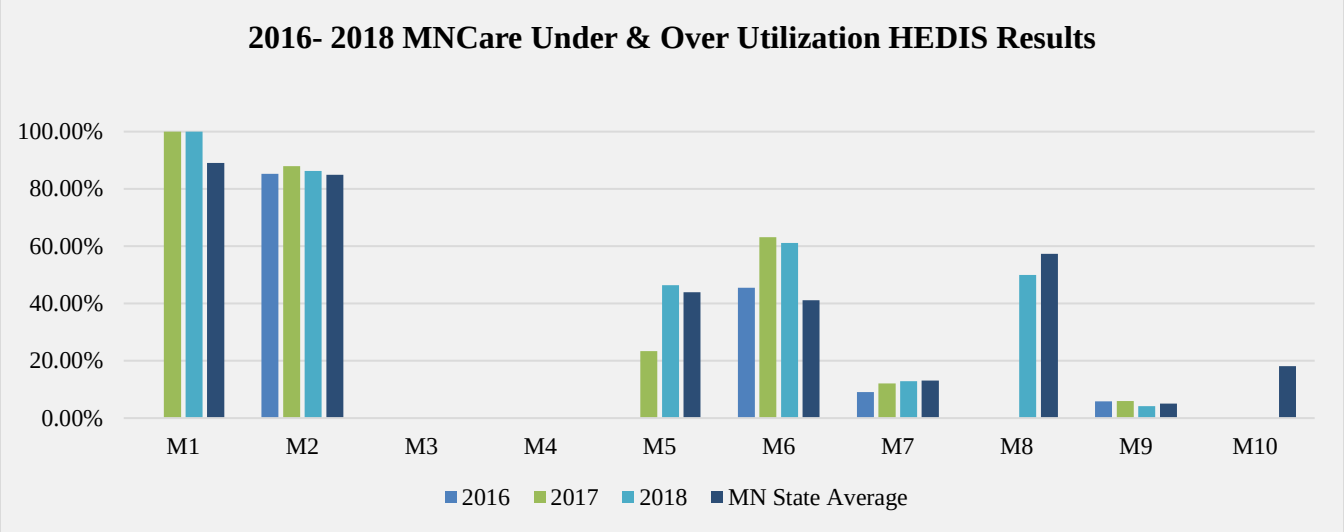


Figure 41: 2016-2018 MNCare Under & Over Utilization HEDIS Results



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

Medicare Over and Under Utilization

Ensuring appropriate utilization of services is required as per Article 7.1.4 of the 2017 DHS Seniors contract, "The MCO shall adopt a utilization management structure consistent with state and federal regulations and current NCQA "Standards and Guidelines or the Accreditation of Health Plans." Pursuant to 42 CFR § 330(b)(3), this structure must include an effective mechanism and written description to detect both under and over utilization of services. In 2018, 2017 interventions and outcome measures were analyzed.

2017 Interventions:

- IMCare continued the Emergency Department (ED) Focus Study. ED Utilization reports were run quarterly and reviewed by QI/UM nurses; MSHO Care Coordinators were also

included in this review for this population. IMCare QI/UM Nurse and Senior Care Coordinator interventions were aimed at reducing ED over-utilization.

- Enrollee education regarding appropriate use of the ED was included in the April 2017 enrollee newsletter.
- Enrollee education regarding disease management and care coordination was included in the April 2017 and October 2017 enrollee newsletter.
- MSHO enrollees who agreed to have a long-term care consultation (LTCC)/Health Risk Assessment (HRA) were screened for substance use and depression and educated on the importance of preventative care.
- The Spring 2017 enrollee newsletter included information about senior care coordination, and how to access this service.
- The 2017 Medicare Under and Over Utilization Report was reviewed/approved by the IMCare Provider Advisory Subcommittee (PAC) on 11/8/2017 and the IMCare External QI/UM Committee on 12/13/2017.

IMCare continues to perform well in most measures. Adult's Access (AAP) for 65+ increased from the previous year's data but remains marginally below state average. Access to transportation for medically based appointments has been implemented though the Volunteer Driver Program, and enrollees are educated at their annual LTCC/HRA home visits. Given the rural designation and weather-related conditions, this will be an ongoing focus to monitor accessibility for preventative care visits. Inpatient Utilization (IPU): Discharges increased from last year and remains above the state average; in contrast the average number of days per hospital decreased and was below the state average. Both Emergency Department Visits (AMB), and Outpatient Visits are up from 2017. Emergency Department Visit rates are comparable to data reported in 2016, to the contrary Outpatient Visits appear to be on an upward trend. Mental Health Utilization (MPT), was slightly up from 2017, but continues to meet goal and fall below the state average. Colorectal Cancer Screening (COL), a new measure selected to evaluate for utilization, is below the state average, but has shown improvement from 2016 to 2018. Transitions of Care, (TRC), with four measurable components, is a new measure for HEDIS 2018. IMCare is performing above the state average in all areas.

One on-going 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 re-visit this issue annually but in the interim will continue to use the MN State Average rates to measure under and over utilization**.**

Figure 42: Medicare Under and Over Utilization HEDIS Measurement Methodology

	Measurement Methodology	Data Source
M1.	Percentage of Medicare enrollees who had one or more ambulatory or preventative care visits during the measurement year.	HEDIS Data
M2.	Number of acute discharges per 1,000 enrollee years in the measurement year for Medicare-eligible.	HEDIS Data
M3.	Average length of stay, in days, for acute inpatient encounters during the measurement year for Medicare-eligible.	HEDIS Data

Figure 42: Medicare Under and Over utilization HEDIS Measurement Methodology

	Measurement Methodology	Data Source
M4.	Number of outpatient visits per 1,000 enrollee years for Medicare-eligible, during the measurement year.	HEDIS Data
M5.	Number of emergency department visits per 1,000 enrollee years for Medicare-eligible, during the measurement year.	HEDIS Data
M6.	Percentage of mental health services obtained per 1,000 enrollee years for Medicare-eligible.	HEDIS Data
M7.	Percentage of alcohol and other drug services obtained per 1,000 enrollee years during the measurement year for Medicare-eligible.	HEDIS Data
M8.	The percentage of enrollees 65 years of age and older who had appropriate screening for colorectal cancer.	HEDIS Data
M9.	The percentage of discharges for enrollees who had each of the following during the measurement year. Four rates are reported: Notification of Inpatient Admission	HEDIS Data
M10.	The percentage of discharges for enrollees who had each of the following during the measurement year. Four rates are reported: Receipt of Discharge Information.	HEDIS Data
M11.	The percentage of discharges for enrollees who had each of the following during the measurement year. Four rates are reported: Patient Engagement After Inpatient Discharge	HEDIS Data
M12.	The percentage of discharges for enrollees who had each of the following during the measurement year. Four rates are reported: Medication Reconciliation Post-Discharge	HEDIS Data

Figure 43: Medicare Under and Over Utilization HEDIS Results

Measurement	Goal	2016	2017	2018	Status
M1. Adults' Access (AAP) 65+ years	Above MN State Avg. of 98.32%	98.20% (382/389)	96.59% (368/381)	97.68% (379/388)	Goal not met, rate below state average.
M2. Inpatient Utilization General Hospital/Acute Care (IPU): **Discharges/1,000 Enrollee Months**	Below MN State Avg.* of 423.39	400.76	416.53	466.92	Goal not met. Rate above state average

Figure 43: Medicare Under and Over Utilization HEDIS Results

Measurement	Goal	2016	2017	2018	Status
M3. Inpatient Utilization **General Hospital/Acute Care (IPU):Avg Days**	Below MN State Avg.* of 4.53	3.83	4.48	4.16	Goal met. Rate below state average.
M4. Ambulatory Outpatient Visits/1,000 Enrollee Months (AMB)	Below MN State Avg. of 11893.37	11,886.15	12,715.34	13,227.07	Goal not met. Rate above state average.
M5. Emergency Department Visits/1,000 Enrollee Months (AMB)	Below MN State Avg. of 665.50	678.56	581.78	678.95	Goal not met. Rate above state average.
M6. Mental Health Utilization/1,000 Enrollee Months (MPT)	Below MN State Avg. of 13.90%	11.16%	10.41%	11.50%	Goal met. Rate below state average.
M7. Identification of Alcohol and Other Drug (IAD) Dependence Services/ 1,000 Enrollee Months	Below MN State Avg. of 5.29%	5.00%	6.11%	6.32%	Goal not met. Rate above state average.
M8. Colorectal Cancer Screening (COL)	Above MN State Avg. of 67.81%	57.89%	59.81%	63.30%	Goal not met. Rate below state average.

Figure 43: Medicare Under and Over Utilization HEDIS Results

Measurement	Goal	2016	2017	2018	Status
M9. Transitions of Care (TRC): **Notification of Inpatient Admission**	Above MN State Avg. of 19.02%	NR	NR	46.15%	Goal met. Rate above state average.
M10. Transitions of Care (TRC): Receipt of Discharge Information	Above MN State Avg. of 11.99%	NR	NR	43.06%	Goal met. Rate above state average.
M11. Transitions of Care (TRC): Patient Engagement After Inpatient Discharge	Above MN State Avg. of 73.87%	NR	NR	90.77%	Goal met. Rate above state average
M12. Transitions of Care (TRC): Medication Reconciliation Post-Discharge	Above MN State Avg. of 21.98%	NR	NR	61.54%	Goal met. Rate above state average

Provider Satisfaction Survey

As per IMCare contracts with the Minnesota Department of Human Services (DHS), "The MCO shall adopt a utilization management structure consistent with state and federal regulations and current NCQA "*Standards and Guidelines for the Accreditation of Health Plans.*"" The Utilization Program Structure section (UM 1) requires that IMCare consider practitioners' experience data when evaluating the Utilization Management (UM) program. Annually, IMCare surveys network providers to assess their level of satisfaction with and knowledge of IMCare services. Survey questions cover topics such as authorizations, pharmacy management and overall satisfaction. Provider responses offer valuable information that is used by IMCare to make program changes, contributing to the overall goal of delivering optimal service to both enrollees and providers. The 2017 results were evaluated in 2018.

2017 Interventions:

- Throughout 2017, IMCare authorization requirements were communicated to providers via multiple provider updates. IMCare followed regulatory requirements regarding the process for and timeliness of authorization review.

- 2017 Utilization Management Criteria resources were reviewed/approved by the IMCare Provider Advisory Subcommittee (PAC) on 02/8/17 and by the IMCare QI/UM Committee on 03/15/17.
- Throughout 2017, IMCare staff contact information was included in all newly credentialed provider packets and was available on the IMCare website and to providers upon request.
- IMCare network provider education regarding IMCare care coordination and case management services and the process for referral was included in the Spring 2017 provider newsletter.
- IMCare network provider education regarding the IMCare Disease Management Program and the process for referral was included in the Fall 2017 provider newsletter.
- IMCare network providers were educated about the 2017 formularies via provider updates throughout 2017.
- In 2017, network providers were educated about IMCare' s Quality Improvement Program efforts (e.g., focus studies, performance improvement projects, etc.) via the Spring provider newsletter.
- Throughout 2017, IMCare followed NCQA guidelines for credentialing individual practitioners and organizational providers.
- The 2017 IMCare Provider Satisfaction Survey Report was reviewed and approved by PAC on 05/10/17 and the QI/UM Committee on 06/21/17.

The 2018 Provider Satisfaction Survey had a response rate of 18%. The overall provider satisfaction rate was impressive at 100%, increased from 99% in 2017. All 2018 survey question measurements exceeded goal. Although small variations in individual measurements are difficult to interpret due to relatively small denominators, it is notable that the provider satisfaction rates for IMCare as compared to other health plans increased to 100%.

Figure 44: 2018 Provider Satisfaction Survey Response Rate by Provider Type

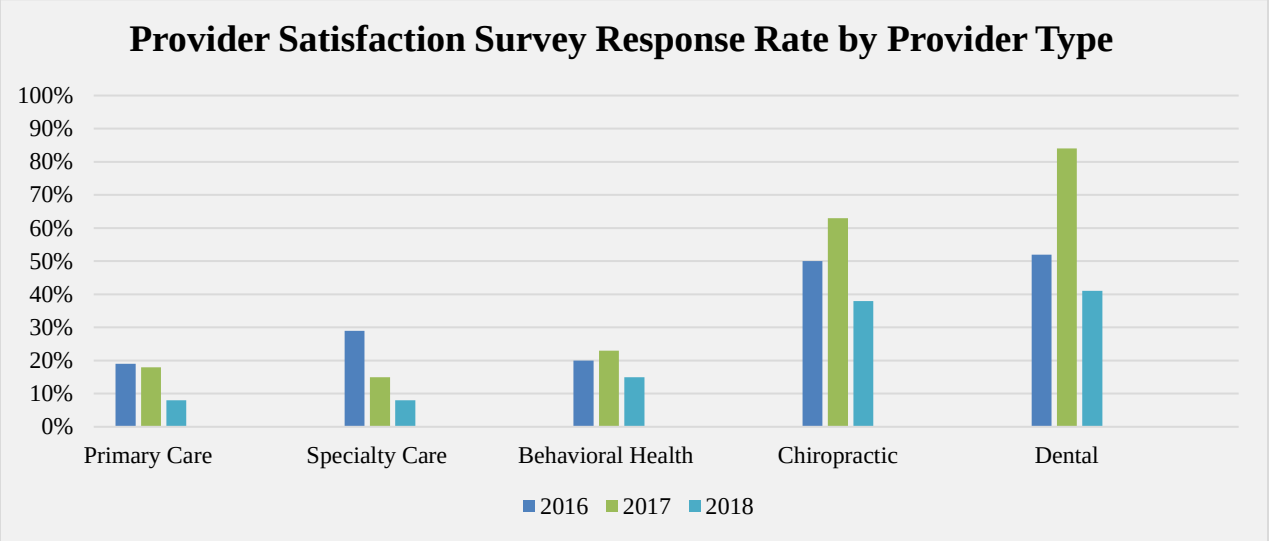
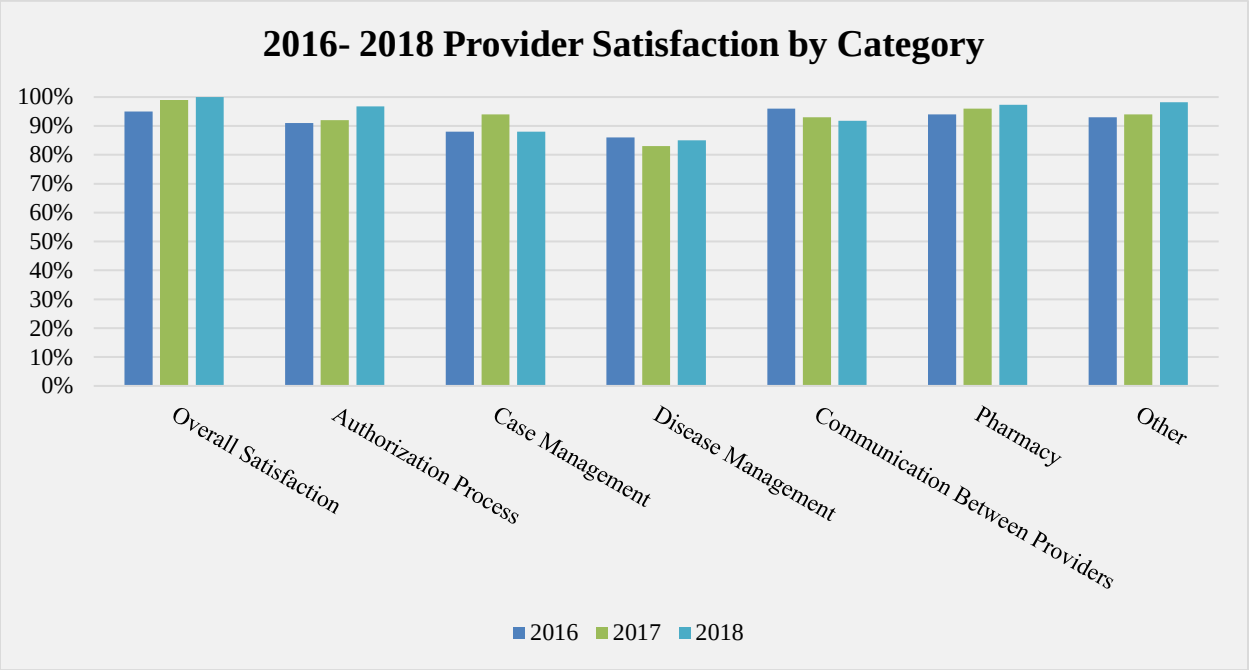


Figure 45: 2016-2018 Provider Satisfaction by Category



Communication Services

Access to Staff/Customer Service Call Center Performance

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

- IMCare staff is available at least eight hours a day during normal business hours for inbound calls regarding UM issues. Staffing varies but the core hours are 8:00 AM to 4:30 PM. IMCare contracts with an agency to answer and triage after hours and weekend calls. Any UM issues can be forwarded to UM on call staff.
- Staff is accessible to callers who have questions about the UM process. Enrollees and providers have direct access to UM staff.
- Staff can receive inbound communication regarding UM issues after normal business hours. IMCare accepts inbound communication 24/7 through telephone, email and fax. The IMCare Director and Quality Director monitor incoming communication and involve UM staff and the Medical Director as necessary.
- Staff can send outbound communication regarding UM inquiries during normal business hours and after hours as necessary.
- Staff identify themselves by name, title and organization name when initiating or returning calls regarding UM issues. IMCare provides a toll-free number and staff are available to accept collect calls regarding UM issues.
- IMCare offers TDD/TTY services for deaf, hard of hearing, or speech impaired enrollees through Minnesota Relay Service.
- Language assistance is available for enrollees through Language Line to discuss UM issues.

IMCare must ensure that providers, enrollees, and staff enrollees are able to reach the IMCare Customer Service Representatives (CSRs) according to regulatory and accreditation standards. IMCare must maintain low abandonment rates for customer services lines. CMS requires a disconnect rate of 5% or less. See Customer Service Call Center Performance section for further details regarding 2018 rates.

Appropriate Professionals

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

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

Affirmative Statement about Incentives

IMCare' s policy states that no individual who is performing utilization review may receive financial incentive based on the number of denials or certifications made. IMCare reviews and updates its Affirmative Statement annually and distributes it to providers and enrollees through direct mail, newsletters, and the IMCare provider manual. The Affirmative Statement P&P is also posted on the IMCare website. In 2018, the Affirmative Statement was reviewed, included in the Fall/Winter IMCare enrollee newsletter, and distributed with the IMCare privacy notice in all new enrollee and annual EOC mailings.

Timeliness of UM Decisions

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

IMCare utilizes CaseTrakker Dynamo (CTD) to manage authorization requests. CTD has been designed to track timeliness, including a technical denial option. A technical denial occurs when

the set time for review of an authorization has expired. IMCare has never had a technical denial. UM reviewers 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 Quality Director and Contract Compliance Officer daily. IMCare met all timelines for UM decisions in 2018.

Notification of UM Decisions

When an initial determination is made to certify for standard requests, notification is provided promptly by written notification to the provider via facsimile. When an initial determination is made not to certify for standard requests, notification is provided by telephone, and by facsimile to a verified number, or by electronic mail to a secure electronic mailbox within one working day after making the determination to the attending health care professional and hospital if applicable. Written notification must also be sent to the facility as applicable and attending healthcare professional if notification occurred by telephone. Written notification must be sent to the enrollee. An expedited initial determination must be utilized if the attending healthcare professional believes that an expedited determination is warranted. Notification of an expedited initial determination to either certify or not to certify is provided to the facility, the attending healthcare professional, and the enrollee as expeditiously via phone, no later than 72 hours from the initial request. Upon request, IMCare must provide the provider or enrollee with the criteria used to determine the necessity, appropriateness, and efficacy of the health care service, and identify the basis for the criteria. Written notice must also inform the enrollee and the attending healthcare professional of the right to submit and appeal to IMCare and include the procedure for initiating an appeal.

IMCare monitors the timeliness of decision making and of notifications for all requests and calculates the percentage of decisions that adhere to timelines. CTD can be reviewed at any time by generating a search by authorization type and a date span. IMCare monitors timelines daily through frequent review of CTD pending authorization requests. IMCare met all timelines for notification of UM decisions in 2018.

Clinical Information and Interrater Reliability

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

A random sample of cases are reviewed for:

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

2018 Interventions:

- 2018 Utilization Management Criteria were reviewed/approved by the Provider Advisory Subcommittee (PAC) on 02/14/2018 and the External QI/UM Committee on 03/21/2018.
- InterQual criteria updates were loaded into Case Trakker (authorization review system) as they became available, throughout 2018.
- CVS/Caremark drug criteria sets were updated in January of 2018, and as they became available thereafter.
- A monthly Utilization Management Operations Workgroup (UM Ops) was initiated to evaluate, discuss and modify UM criteria and/or processes as needed. Additionally, at the UM Ops Workgroup, education was provided regarding the application of this criteria.

IMCare strives for 100% accuracy of application of adopted clinical criteria. IMCare audited a total of 147 determinations with the following breakdown: QI/UM Nurses were audited on 130 determinations; Medical Director and Physician Consultant were audited on 17 determinations. In each measure, the Medical Director and Physician Consultant maintained the goal of 100%. The QI/UM Nurses met one of the six goals. The unmet areas ranged from 98.46% to 99.33%. The discrepancies applied to two separate determinations done by one reviewer; the reviewer no longer works for IMCare. There were fewer number of files reviewed as there were QI/UM Nurse vacancies throughout 2018, this resulted in more weighted shifts in the data.

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

2018 Interventions:

- The Quality Improvement/Utilization Management (QI/UM) Nurses worked proactively with practitioners/practitioner staff on authorization requests to minimize lack of information denials
- The 2017 DTR Report was reviewed/approved by the IMCare Provider Advisory Subcommittee (PAC) on 02/14/18 and the IMCare External Quality Improvement/Utilization Management (QI/UM) Committee on 03/21/18.

In 2018, IMCare had 2,859 service authorizations. Of these, 123 were for behavioral health services and 2,736 were for non-behavioral health services. This is a decline in behavioral health service authorization requests from previous years, is due to modification of the behavioral health authorization process and enhanced behavioral health access in the IMCare network. There was a total of 29 denials in 2018 (9 Targeted Case Management, 9 Professional Medical Services, 5 Dental, 2 Personal Care Assistant/ Homecare, 2 Lab/ Diagnostic Services) and no partial approvals. There were 1,824 drug authorizations. Of these, 1,068 were approved and four were denied, the remainder of the drug authorizations were withdrawn by provider or cancelled.

In 2018, IMCare sent 579 DTR Notices of action, 550 were Waivered Services Notices. Most of the remaining DTRs were requests for services where the submitted records did not meet coverage criteria, followed by providers not being in network and the service could be provided by an in-network provider. This endorses IMCare' s service and drug authorization requirements.

An enrollee is assessed for eligibility of some services that are consumer driven services (i.e.; EW and Personal Care Assistance (PCA)) and there are services where Itasca County Health and Human Services determines eligibility (i.e. 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 at enrollee request. This inflates reportable DTRs.

IMCare QI/UM Nurses 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, including withdrawal of the request by the practitioner when unable to make a determination. 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 Pharmacy Benefits Manager (PBM).

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

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

In 2018, IMCare received six appeals. Appeals were for services and/or benefits as follows:

- Dental-Implants/Bridges (1)
- DME-Medical Supplies – Equipment (1)
- Home Care – PCA Service (2)
- Home Care – Skilled Nursing Visit (1)
- Professional Medical Services - Lab/Diagnostic(1)

Due to the receipt of additional information through the appeal process and a reassessment, one PCA hour reduction appeal was overturned resulting in approval of the enrollee's request. The other appeal that was overturned was due to other insurance not reported accurately by the enrollee at the time claims were processed. Enrollee provided updated information and her request was approved. The other four appeals were upheld utilizing internal independent physicians. No appeals were sent to Medical Review Institute of America (external review vendor) in 2018.

IMCare transitioned to a new HPCC due to staff turnover in July. IMCare participated in an MDH QA & TCA exam August 2018. This audit resulted in a deficiency in our Appeals and Grievance system. This gives IMCare a great opportunity to review current processes and look for areas for improvement. IMCare is collaborating with the DHS Ombudsman's Office and is in the process of submitting a Corrective Action Plan (CAP) for resolution of the deficiency. Components of the CAP are included in opportunities below. In our initial meeting regarding the MDH audit results, the DHS Ombudsman Office conveyed that appeals (and grievances) are not necessarily a negative for IMCare. Reporting appeals is a way to communicate to our enrollees their rights regarding their healthcare and to report to DHS the valuable ways we help our enrollees resolve issues. Per the DHS Grievances and Appeals Trend Analysis (2015, 2016, 2017 and 1st Qtr. of 2018) provided during the 2018 MDH Audit, the Ombudsman Office views

appeals as a way of evaluating whether enrollees understand and are aware of their right to file an oral or written appeal.

IMCare has a thorough utilization review process that is reviewed regularly and adjusted as needed. An IMCare QI/UM Nurse reviews a request, 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 enrollee 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 to the enrollee and attending healthcare professional provides specific, clear information why the request was denied. This has reduced the number of appeals received, in addition to the number of appeals that result in overturning IMCare' s original decision.

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.

Emergency Services

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

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

Pharmaceutical Management

IMCare has developed and regularly reviews and updates policies and procedures for pharmaceutical management based on sound clinical evidence. Policy and Procedure (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 Pharmacy Benefit Manager (PBM) on the development of the formulary and management procedures. Pharmaceutical management procedures are

communicated to providers via direct mail, e-mail, fax, the IMCare web site, and/or the formulary booklet annually and as needed.

In 2018, Pharmaceutical and Pharmaceutical Management procedures were communicated to enrollees and prescribing practitioners. This information included co-payment information, prior authorization requirements, limits on refills, doses or prescriptions, use of generic substitutions, and covered pharmaceuticals. All information was available on the IMCare web site as well.

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

The IMCare Pharmacy Exceptions P&P 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. The P&P was reviewed in July, 2018.

Contact Information

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