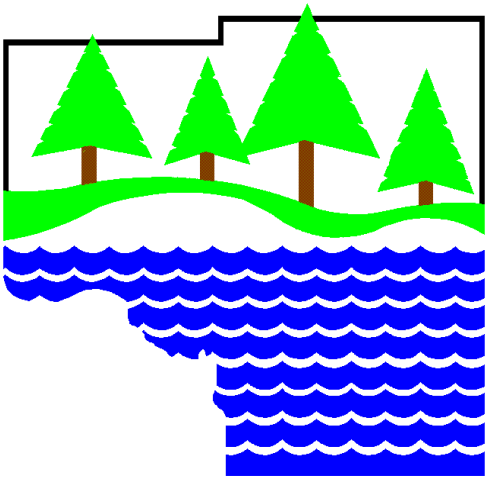

2019 ITASCA MEDICAL CARE PROGRAM EVALUATION

Approved by:
IMCare QI/UM Committee: 03/18/2020
Itasca County Board of Commissioners: 03/24/20

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 2019 QI/UM activities.

In 2019 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 2019. Throughout 2019, 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 2019, to improve enrollee access to appropriate care. IMCare worked extensively to enhance the way in which grievance and appeals are identified and addressed. This initiative began in 2018, but was a work in progress throughout 2019.

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 Improvement Utilization Management Director/s 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.

2019 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.

2019 HEDIS – Medicaid

IMCare performed well in several 2019 HEDIS measures. Although breast and cervical cancer screening measures remained below the MN state average, improvements were seen in PMAP breast cancer screening and MNCare cervical cancer screening rates. A network facility that serves the largest volume of IMCare enrollees has 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. In addition, IMCare plans to continue global enrollee education and individual enrollee preventative screening reminders. As a result, an increase in these measures in future HEDIS audits is anticipated.

Figure 1: 2017-2019 Breast Cancer Screening- PMAP/MNCare

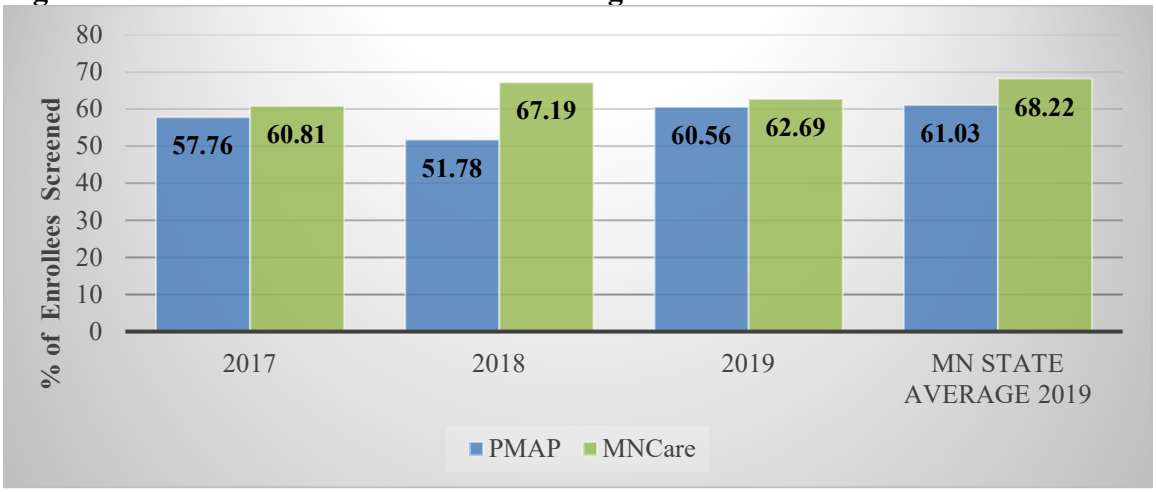
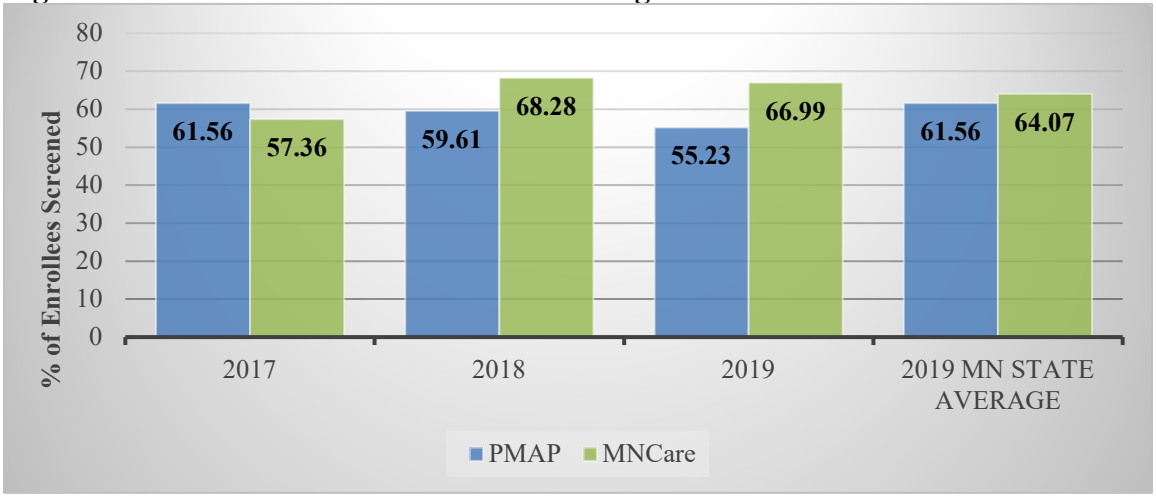


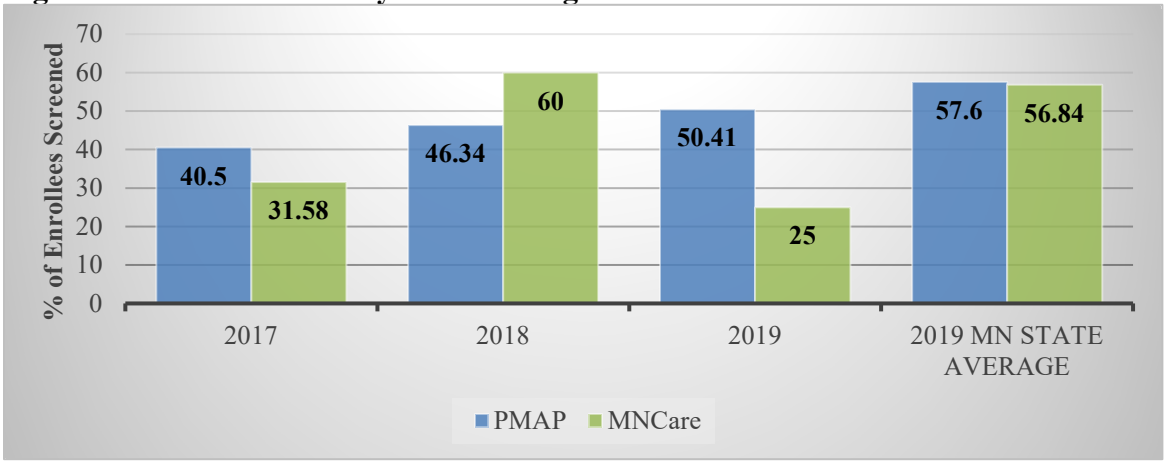
Figure 2: 2017-2019 Cervical Cancer Screening- PMAP/MNCare



Chlamydia Screening

Chlamydia testing remained below goal for both populations in 2019, but has shown steady improvement in the PMAP population since 2017. MNCare had 4/16 enrollees complete screening.

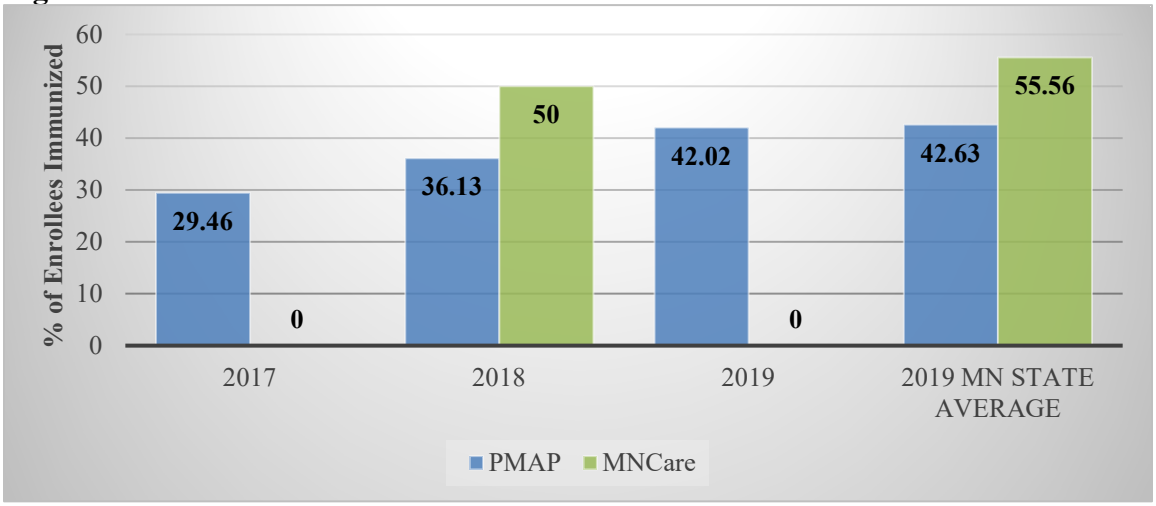
Figure 3: 2017-2019 Chlamydia Screening PMAP/MNCare



Childhood Immunizations (CIS)

Although PMAP Childhood Immunization Combo 10 rate did not meet goal in 2019, it has shown steady improvement from year to year. Due to low enrollee population in MNCare, this measurement is not reported in 2019. Data from 2018 reflects 1 out of 2 enrollees for this measurement.

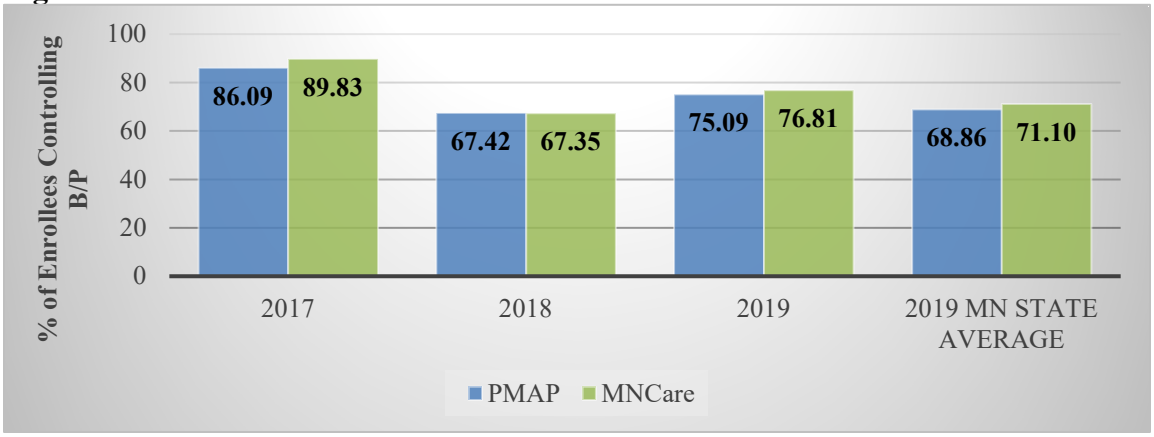
Figure 4: 2017-2019 Childhood Immunizations PMAP/MNCare



Controlling Blood Pressure (CBP)

In 2019, IMCare exceeded goals for blood pressure control for enrollees with and without diabetes.

Figure 5: 2017-2019 HEDIS Blood Pressure Control Rates for Enrollees 18-65



2019 HEDIS -MSHO

HEDIS measurement specification changes for 2019 are reflected in Measurement M1 (Controlling High Blood Pressure), which no longer has a different threshold for patients with diabetes. In addition, patients needed at least two visits with diagnosis of hypertension in the measurement year and/or year before to be included in the measure. Measurements M2-M4(Comprehensive Diabetes Care) were changed for 2019 to add exclusions for enrollees with advanced illness and frailty. Measurement M4 (medical attention for nephropathy), while still below goal, represents a 5.7% increase from 2018. Enrollees exceeded the state average for HbA1c testing and diabetic eye exams. While the Nephropathy measurement was not above the state average, the percentage of enrollees receiving this test has risen each year to just below the state average. The medication reconciliation post-discharge (MRP) measure has increased each year, and is well above the state average

Figure 6: 2019 HEDIS Measurement Methodology

Measurement Methodology	Data Source
M1. Percentage of enrollees 65–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) (CBP) *Note: For HEDIS 2017 and 2018, control was defined as <140/90 mm Hg for enrollees with diabetes and <150/90 mm Hg for enrollees without diabetes.	Hybrid HEDIS Data
M2. Percentage of enrollees 65–75 years of age with diabetes (type 1 and type 2) who had Hemoglobin A1c (HbA1c) testing (CDC) *Note: For HEDIS 2019 CDC measures, advanced illness and frailty exclusions were added.	Hybrid HEDIS Data
M3. Percentage of enrollees 65–75 years of age with diabetes (type 1 and type 2) who had an eye exam (retinal) performed (CDC)	Hybrid HEDIS Data
M4. Percentage of enrollees 65-75 years of age with diabetes (type 1 and type 2) who had medical attention for nephropathy (screening/monitoring test or evidence of nephropathy) (CDC)	Hybrid HEDIS Data

Figure 6: 2019 HEDIS Measurement Methodology Continued

Measurement Methodology	Data Source
M5. The percentage of discharges from January 1–December 1 of the measurement year for enrollees 65 years of age and older for whom medications were reconciled the date of discharge through 30 days after discharge (31 total days) (MRP).	Hybrid HEDIS Data

Figure 7: 2017-2019 HEDIS M1-Blood Pressure Control (CBP)

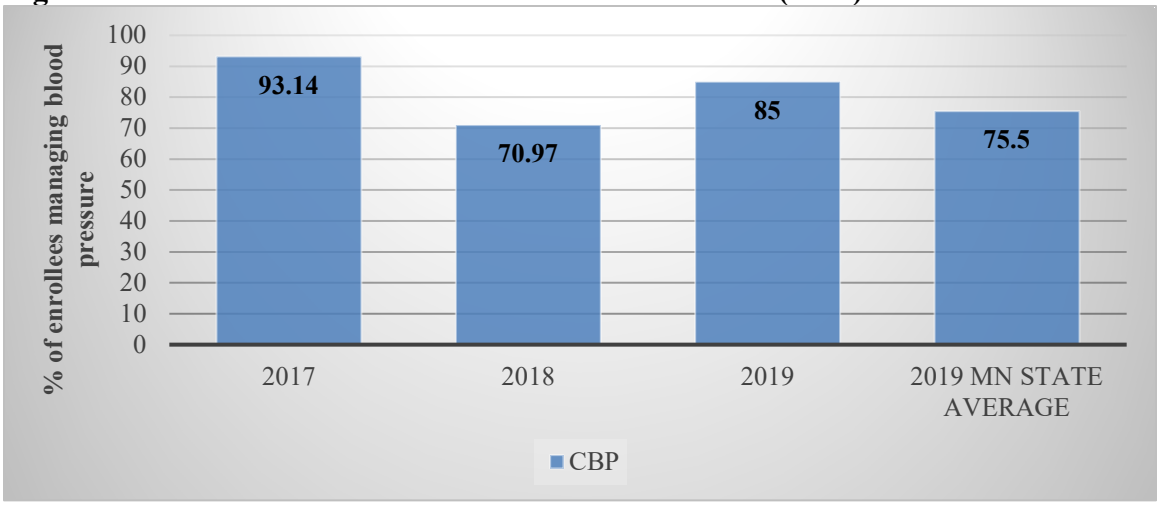


Figure 8: 2017-2019 Senior HEDIS Comprehensive Diabetes Care (CDC)

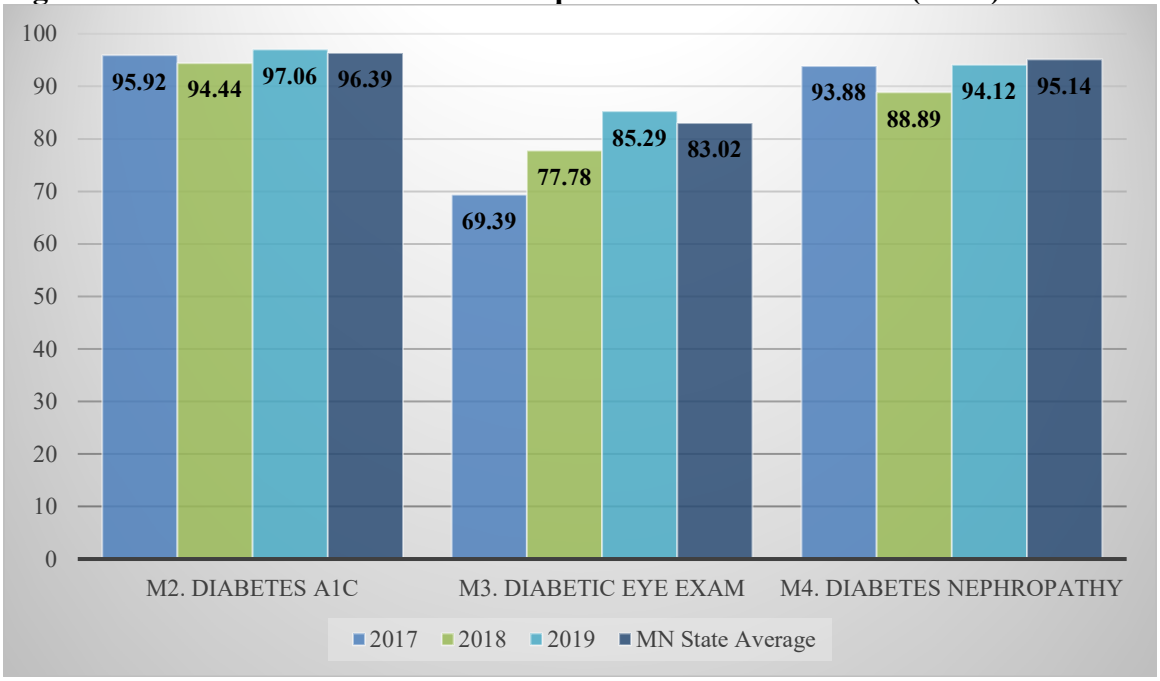
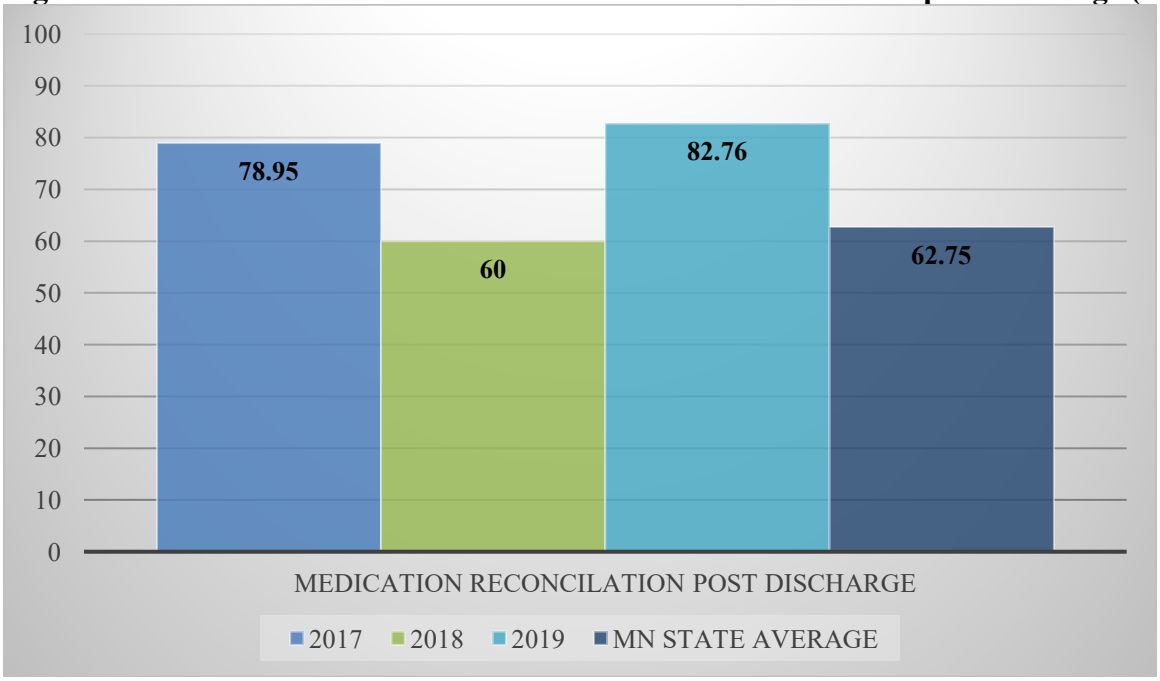


Figure 9: 2017-2019 Seniors HEDIS M5- Medication reconciliation post-discharge (MRP)



Performance Improvement Projects

2018-2020 Opioid Prescribing Improvement Project (OPIP)

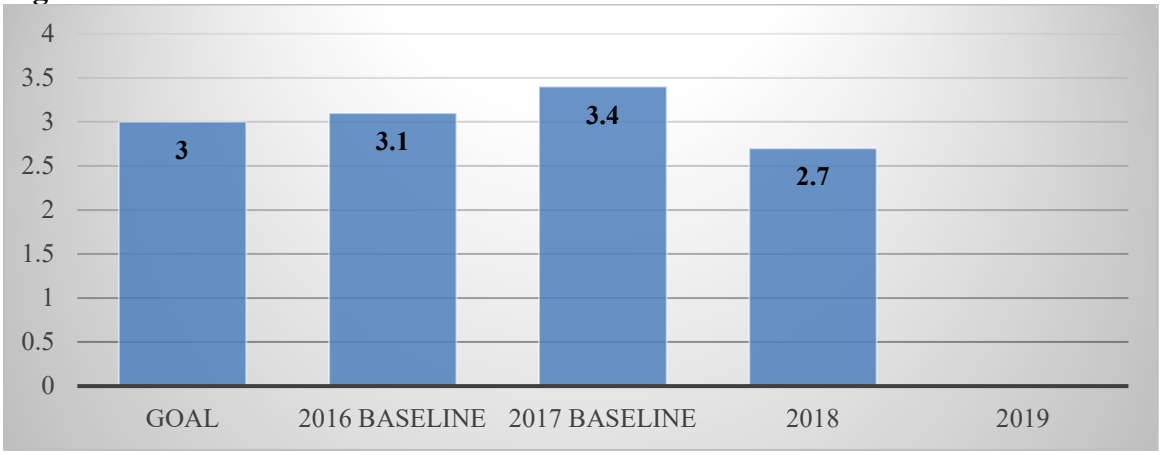
The Opioid Prescribing Improvement Project (OPIP) was designed to decrease the number of New Chronic Users (NCUsers) of opioid pain medications in the study population by the end of CY2019, and sustain the improvement through CY2020. The OPIP is required by and defined in the 2019 DHS Families & Children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

In 2019, IMCare carried out numerous interventions aimed at reducing the number of new chronic opioid users. The most impactful was in the IMCare pharmacy claims system, continued programming of 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 CDC recommendations for Prescribing Opioids for Chronic Pain, and 2018-2020 IMCare Opioid Project Updates. Global enrollee education was provided via newsletter regarding alternative therapies for the treatment of chronic pain, over-the-counter and prescription drug disposal, information regarding chronic pain self-management workshops in the area , opioid dependence/withdrawal information, treatment resources and 2018-2020 IMCare Opioid Projects. Managed Care Nurses (MCN) were provided education by the IMCare Medical Director regarding how to process opioid drug authorizations based on opioid UM edits. Lastly, the IMCare Pharmacy Director, in collaboration with University of Minnesota School of

Pharmacy, provided education regarding Medication Assisted Therapy (MAT) to Itasca County employees on 07/09/2019.

The goal of this OPIP is to decrease the IMCare NCUsers rate (as defined by DHS) to 3.0. The baseline rate (2016 NCUsers Rate) was 3.1. The 2017 rate for the Medicaid population was 3.4, with a decreasing rate of 2.7 in 2018. The 2019 NCUsers rate has not been provided by DHS to date but has an anticipated release date of April 2020. 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)

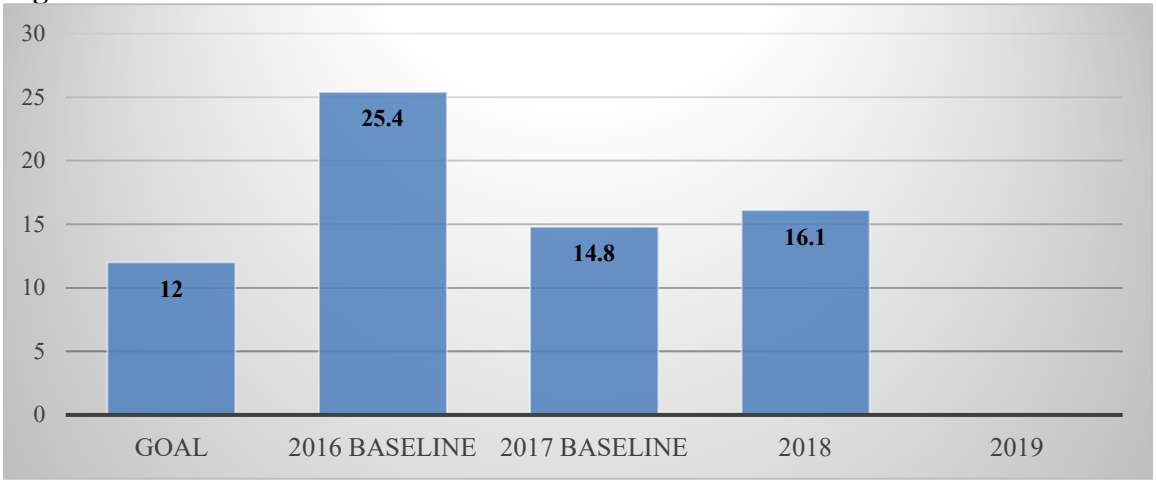
As per the 2019 *Contract For Minnesota Senior Health Options and Minnesota Senior Care Plus Services with Itasca Medical Care*, Section 7.2.1.1, "The STATE and MCOs selected the topic for the PIP to be conducted over a three-year period (calendar years 2018, 2019, and 2020). Topics should address the full spectrum of clinical and nonclinical areas associated with the MCO and not consistently eliminate any particular subset of Enrollees or topics when viewed over multiple years. The PIP must be consistent with CMS' published protocol entitled "*Protocol for Use in Conducting Medicaid External Quality Review Activities: Conducting Performance Improvement Projects*," STATE requirements, and include steps one through seven of the CMS protocol." DHS selected the 2018-2020 Quality Improvement Project topic, hereafter referred to as the Opioid Prescribing Quality Improvement Project (OPQIP). IMCare implemented the OPQIP for its Minnesota Senior Health Options (MSHO) and Minnesota Senior Care Plus Services (MSC+) populations on January 1, 2018. The OPQIP is designed to decrease the number of New Chronic Users (NCUsers) of opioid pain medications in the study population by the end of CY2019, and sustain this improvement through CY2020.

In 2019, IMCare carried out numerous interventions aimed at reducing the number of new chronic opioid users in the senior population. The IMCare pharmacy claims system continued

programming of soft rejects, requiring pharmacist intervention to bypass the following items, cumulative opioid quantity limits exceeding 90 morphine milligram equivalents (MME)/day for all cumulative opioids, four or more opioid prescribers in 30 days, or four or more pharmacies used to obtain opioids in 30 days. Global provider education was provided via newsletter regarding CDC recommendations for Prescribing Opioids for Chronic Pain, and 2018-2020 IMCare Opioid Project Updates. Global enrollee education was provided via newsletter regarding alternative therapies for the treatment of chronic pain, over the counter and prescription drug disposal, information regarding chronic pain self-management workshops in the area, opioid dependence/withdrawal information, treatment resources and 2018-2020 IMCare Opioid Projects. Managed Care Nurses were provided education by the IMCare Medical Director regarding how to process opioid drug +5authorizations based on opioid UM edits. The IMCare Pharmacy Director, in collaboration with University of Minnesota School of Pharmacy, provided education regarding Medication Assisted Therapy (MAT) to Itasca County employees on 07/09/2019. In addition, senior care coordinators and elderly waiver case managers were provided an update regarding the OPQIP at the Stakeholders Advisory Committee meeting on 04/03/2019.3 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 with a slight increase in 2018 to 16.1. In 2018 the rate increase may be attributed to the decrease in denominator, as the overall number of NCUsers decreased by two. The 2019 NCUsers rate has not been provided by DHS to date but has an anticipated release date of April 2020. While it is difficult to fully evaluate the effectiveness of the current opioid interventions without the 2019 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 2019. Individual enrollee/caregiver education and CM regarding appropriate use of the ED and network clinic/urgent care options was administered by an IMCare MCN or senior care coordinator throughout 2019. When appropriate, Restricted Recipient Program (RRP) enrollee education/warning/placement occurred throughout 2019. The IMCare Spring/Summer 2019 provider newsletter included the following: 2018 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 2019.

Medicaid ED utilization relative to enrollment decreased 9.86% from 2018 to 2019, meeting goal. Of the 193 Medicaid enrollees identified through the ED FS in 2019, 17 received individualized written education regarding their ED use; two received case management; four received RRP warning letters; and one was enrolled in the RRP. Even though the number of interventions decreased from previous years, they may have been timelier than in previous years, contributing to the decrease in ED utilization.

The top five primary diagnoses for ED visits by Medicaid enrollees identified by the ED FS in 2019 included:

1. Acute upper respiratory infection, unspecified (J06.9)
2. Other chest pain (R07.89)
3. Nausea with vomiting, unspecified (R11.2)
4. Suicidal ideations (R45.851)
5. Generalized abdominal pain (R10.84)

Senior ED utilization relative to enrollment increased significantly from 2018 to 2019 (26.67%), as did the number of seniors identified by the ED FS (53 in 2019, compared to 34 in 2018). In 2019, the top five primary diagnoses for this population included:

1. Chronic obstructive pulmonary disease w (acute) exacerbation (J44.1)
2. Pneumonia, unspecified organism (J18.1 & J18.9)
3. Urinary tract infection, site not specified (N39.0)
4. Unspecified atrial flutter (I48.92)
5. Chest pain, unspecified (R07.9)

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

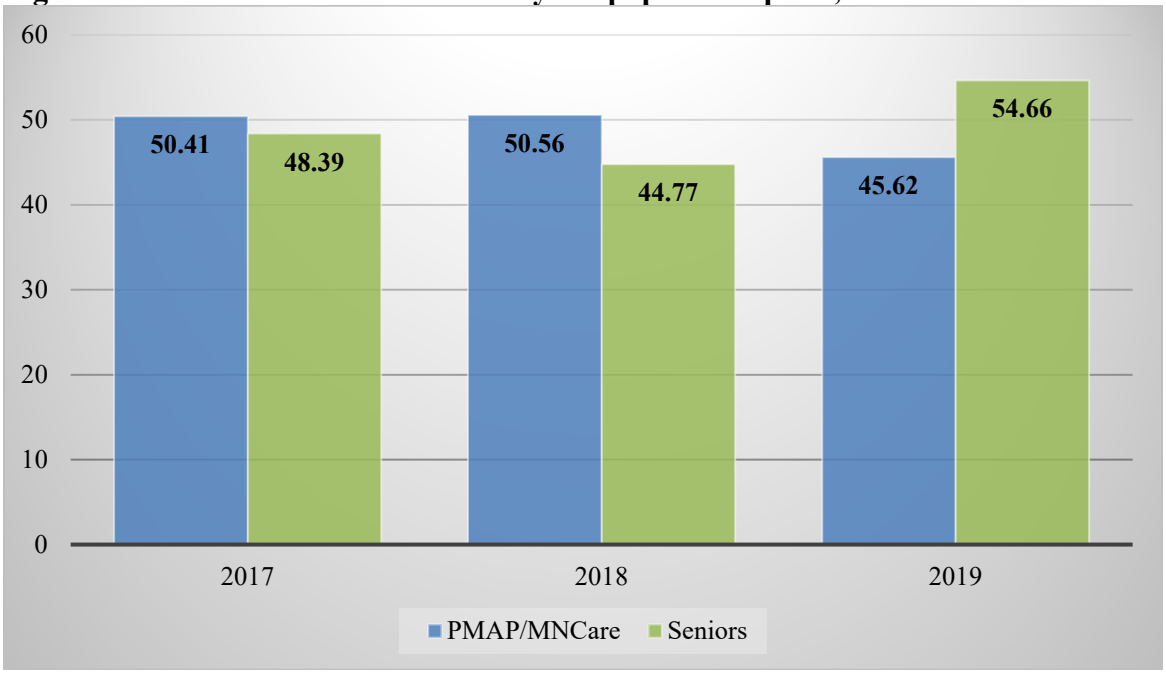


Figure 13: 2017-2019 PMAP/MNCare ED FS Results

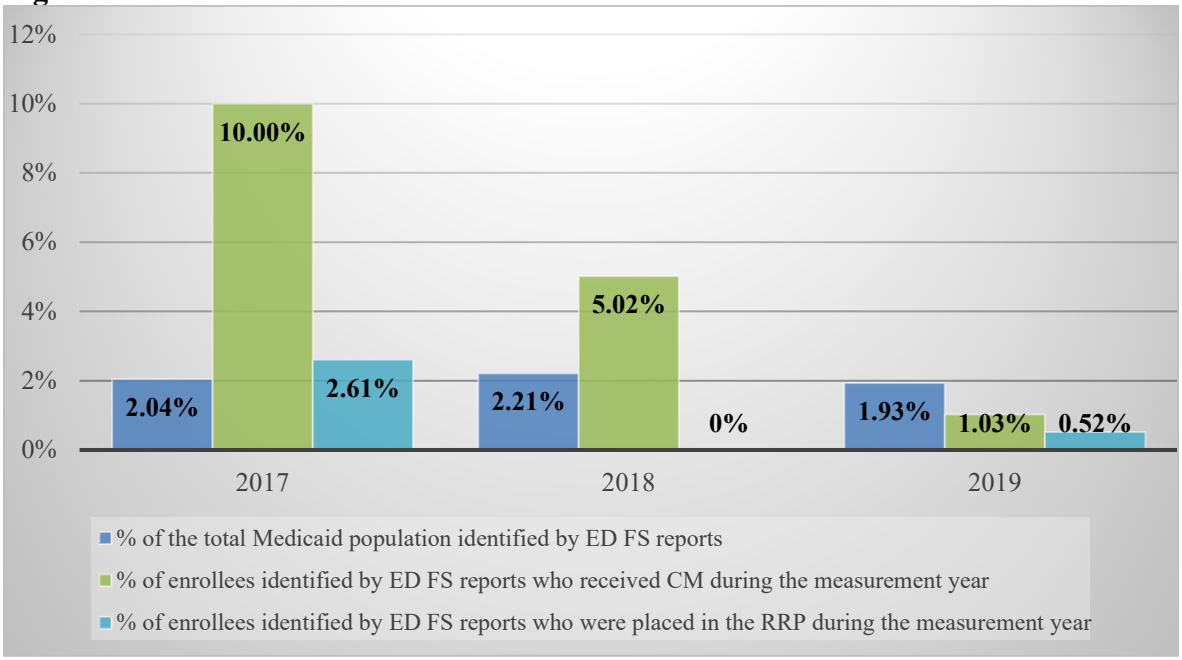
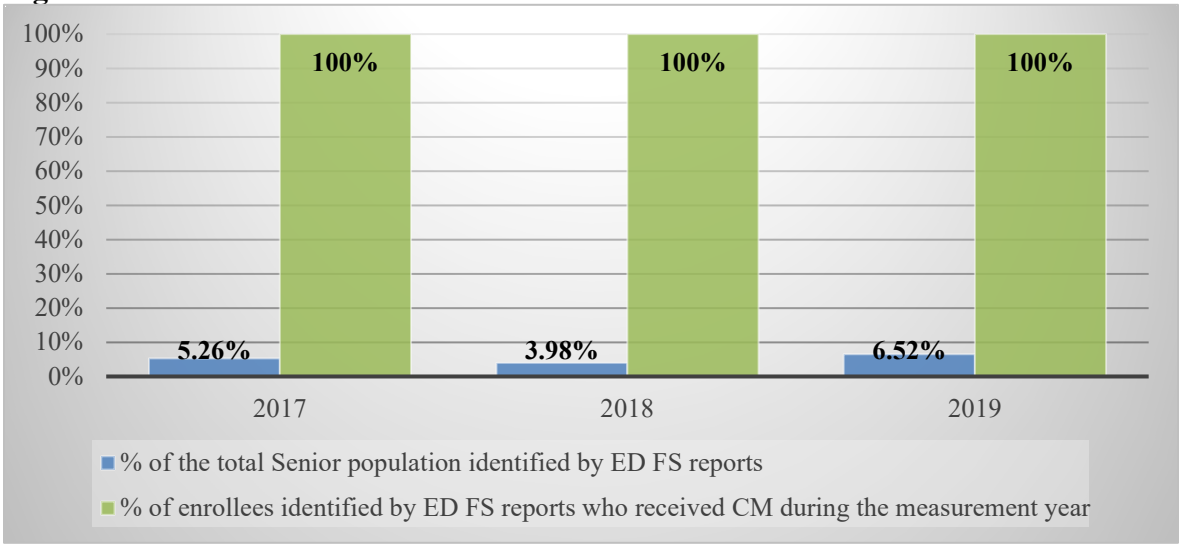


Figure 14: 2017-2019 Seniors ED FS Results



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.

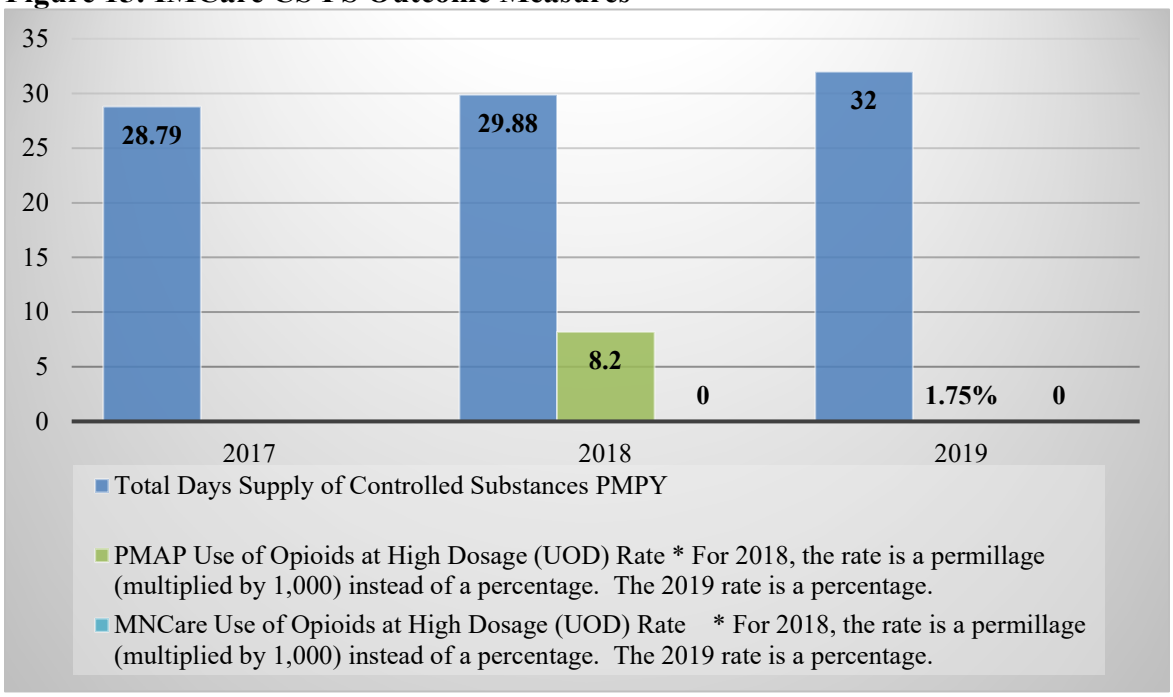
IMCare had a number of interventions to reduce inappropriate controlled substance use in 2019. Global provider education was provided via newsletter regarding CDC recommendations for Prescribing Opioids for Chronic Pain, and 2018-2020 IMCare Opioid Project Updates. Global enrollee education was provided via newsletter regarding alternative therapies for the treatment of chronic pain, over the counter and prescription drug disposal, information regarding chronic pain self-management workshops in the area, opioid dependence/withdrawal information, treatment resources. The CVS/Caremark Safety and Monitoring Solutions (SMS) and Enhanced Safety and Monitoring Solution (ESMS) programs were administered by CVS/Caremark for IMCare throughout 2019. Additionally, individual enrollee education/CM regarding CS use and the potential dangers of using multiple providers/pharmacies for CS prescriptions was administered by an IMCare MCN throughout 2019. When appropriate, Restricted Recipient Program (RRP) enrollee education/warning/placement occurred throughout 2019. The IMCare spring/summer 2019 provider newsletter included the following: 2018 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 2019. 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 2019. IMCare also continued to allow enrollees to receive out-of-network methadone treatment with no prior authorization throughout 2019. IMCare's availability of network providers who offered in-network buprenorphine treatment for

opioid dependence doubled 2019, and this increased rates of treatment significantly. This reduced barriers for enrollees to receive treatment related to Opioid Use Disorders, it is unknown whether this directly contributed to the opioid use rates throughout 2019.

CVS Health SMS program interventions were more robust in 2019 than in 2018, resulting in decreased use of controlled substances (four enrollees) and multiple pharmacies/prescribers to obtain controlled substances (21 enrollees). In 2019, IMCare identified 176 enrollees through the CS FS, increased from 163 enrollees in 2018. Six enrollees received individualized written education regarding their CS fills, four received an RRP warning letter, and two were enrolled in the RRP. The decreases in the number of enrollees who received CM and RRP warning letters in 2019 may be associated with the existing OPIP, including point-of-sale rejects which require prior authorization to bypass. As a result, MCNs interacted with enrollees and providers prospectively, potentially reducing inappropriate utilization of opioids.
The number of enrollees receiving methadone treatment for opioid use disorder increased slightly from 2018 to 2019, but the number of enrollees utilizing buprenorphine drugs nearly doubled. Two network practitioners began prescribing buprenorphine in October of 2017. Prior to that, enrollees would have to travel to be seen by out-of-network practitioners.

The total days-supply (TDS) of controlled substances (DEA schedules II-V) dispensed to Medicaid enrollees decreased 1.28% from 2018 to 2019, meeting goal. The TDS of buprenorphine drugs had the largest increase from 2018 to 2019 (117%), with a 20% decrease in the TDS of all other opioids (Figure 1). In addition, IMCare performed well in the Use of Opioids at High Dosages (UOD) HEDIS measure in 2019. The TDS of stimulants, benzodiazepines and hypnotics showed little change from previous years.

Figure 15: IMCare CS FS Outcome Measures

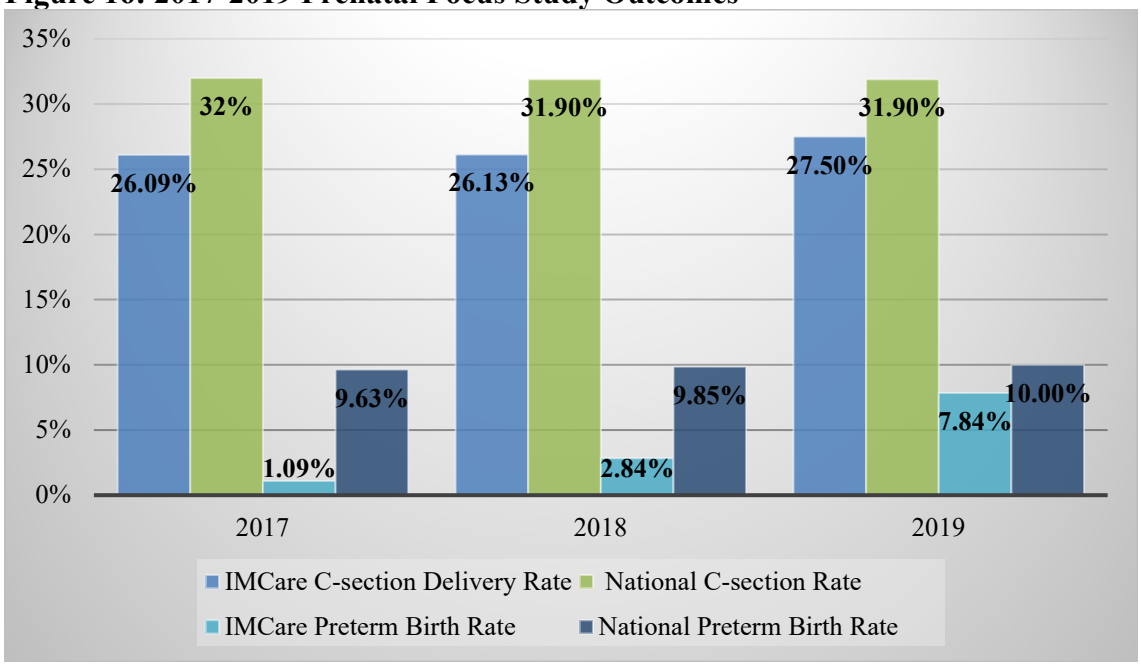


Prenatal Initiative Focus Study

A prenatal focus study, referred to as *A Healthy Pregnancy* program, was developed in 2007, in collaboration with Itasca County Public Health's Maternal-Child Health Division. This program is for at-risk IMCare pregnant enrollees. The Minnesota Health Care Program (MHCP) Provider Manual states, "At-risk is used to describe a pregnant woman who requires additional prenatal care services because of factors that increase the probability of a preterm delivery, a low birth weight infant, or a poor birth outcome." The program includes prenatal education and support and is free to pregnant enrollees. A pregnancy congratulatory letter is sent to each eligible pregnant enrollee. The letter encourages her to seek early prenatal care and informs her about the program and who she can contact for additional information. After enrollment in the program, each pregnant enrollee is matched to a Maternal Child Public Health Nurse (MCH) with the *Prenatal and Healthy Beginnings* program. The education provided through the program follows the *MHCP Provider Manual* guidelines for enhanced services. Topics include information about normal body changes in pregnancy, fetal development, self-care, pregnancy danger warning signs, preventing preterm labor, review of signs and symptoms of preterm labor, lifestyle and parenting support, breastfeeding, and labor and delivery education. Postpartum education is also included in *A Healthy Pregnancy* program, providing education and support to new mothers. It is the intent of IMCare and 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.

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: 2017-2019 Prenatal Focus Study Outcomes



Special Health Care Needs
Medicaid Special Health Care Needs
IMCare identified enrollees with special health care needs. Enrollees were identified through regular analysis of claims, hospital admissions and utilization management information. Enrollees identified are 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 Prepaid Medical Assistance Program (PMAP) and MinnesotaCare (MNCare) enrollees ages 18-64 years old 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

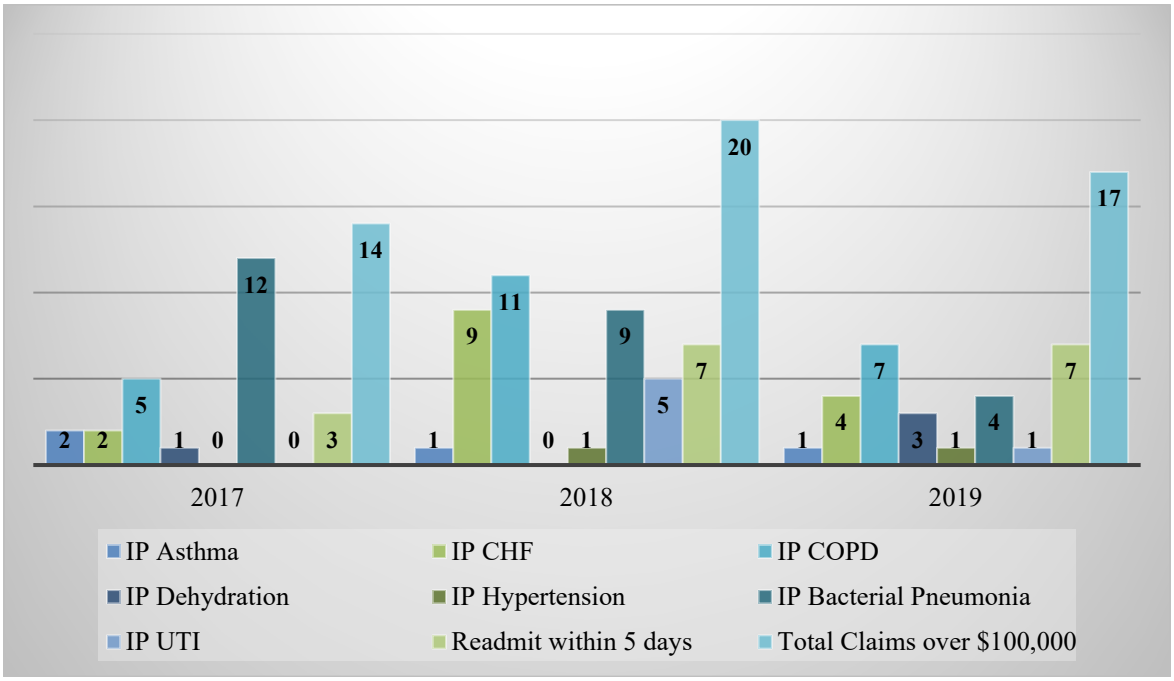
total claims exceeding $100,000

In 2019, 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, including: bacterial pneumonia, dehydration, urinary tract infection, adult asthma, congestive heart failure, hypertension and chronic pulmonary disease.

Enrollment policies through the State of Minnesota shifted in 2018, 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.

The number of enrollees with four or more ED visits was relatively static from 2017 to 2018, but a significant decrease was noted in 2019. IMCare MCNs reviewed ED visits reports monthly and contacted 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 was suspected, IMCare investigated further and took appropriate action (e.g., enrollee placement in the Restricted Recipient Program). Enrollment in complex case management (CCM) and disease management (DM) collectively decreased overall from 2018. Readmission within five days for same or similar diagnosis remained stable from 2018. IMCare MCNs continue to monitor and identify preventable readmissions quarterly and work to identify ways to prevent reoccurrence. Total Claims Exceeding $100,000 decreased in 2019. Many of these claims are identified as enrollees being treated for malignancy (7), mental health treatment (2), and also disorders of the blood (3), which required costly ongoing care.

Figure 17: 2017-2019 Number of Medicaid Enrollees with the Specified Special Health Care Needs



Seniors (MSHO and MSC+) Special Health Care Needs

IMCare assesses the quality and timeliness of case management/care coordination provided to seniors through the annual audit of case management/care coordination record documentation.

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

Public Health (PH) provides care coordination/case management for IMCare MSHO and MSC+ Enrollees who, through their assessment, have been determined to meet Nursing Facility Level of Care criteria and so qualify for Home and Community-Based Services (HCBS) under the Elderly Waiver (EW). In addition, IMCare Care Coordinators manage care for the CW and SNF populations. The assessment process for all Enrollees includes information to improve health care delivery and promote positive health outcomes.

IMCare has an active program to reach out to all Community Well (CW) and Skilled Nursing Facility (SNF) Enrollees aged 65 years and older. A nursing facility assessment is completed within 30 days of enrollment for all SNF enrollees. If CW Enrollees agree to a face-to-face visit, IMCare care coordinators/case managers complete a comprehensive health assessment within 30 days of enrollment. Reassessments are offered annually, within 364 days of the previous assessment, or more frequently if indicated by the Enrollee's comprehensive care plan or a

change in condition. The HRA or LTCC assessment tool is used to complete the comprehensive health assessment for CW enrollees. These tools assess Enrollee health status including condition-specific issues, supports and services needed based on strengths, choices and preferences in life domain areas, documentation of clinical health history and medications, activities of daily living (ADL) and instrumental activities of daily living (IADL), mental health status and cognitive functioning, life planning activities, evaluation of visual and hearing needs, preferences and limitations, evaluation of 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 works with Enrollees during a transition. The transition process utilizes the Eric A. Coleman conceptual model, "Four Pillars", thereby improving quality of care and preventing readmissions. During the transition process, when CW and EW Enrollees discharge to their usual care setting, the Enrollee's Care Coordinator/Case Manager contacts them to determine if they have a follow-up appointment scheduled, if they have transportation to their appointment, if they know the signs/symptoms to report to the provider, if they have knowledge of their medications and how to take them, and if they have and/or utilize a personal health record. If the Enrollee needs help in any of these areas, the Care Coordinator/Case Manager assists them.

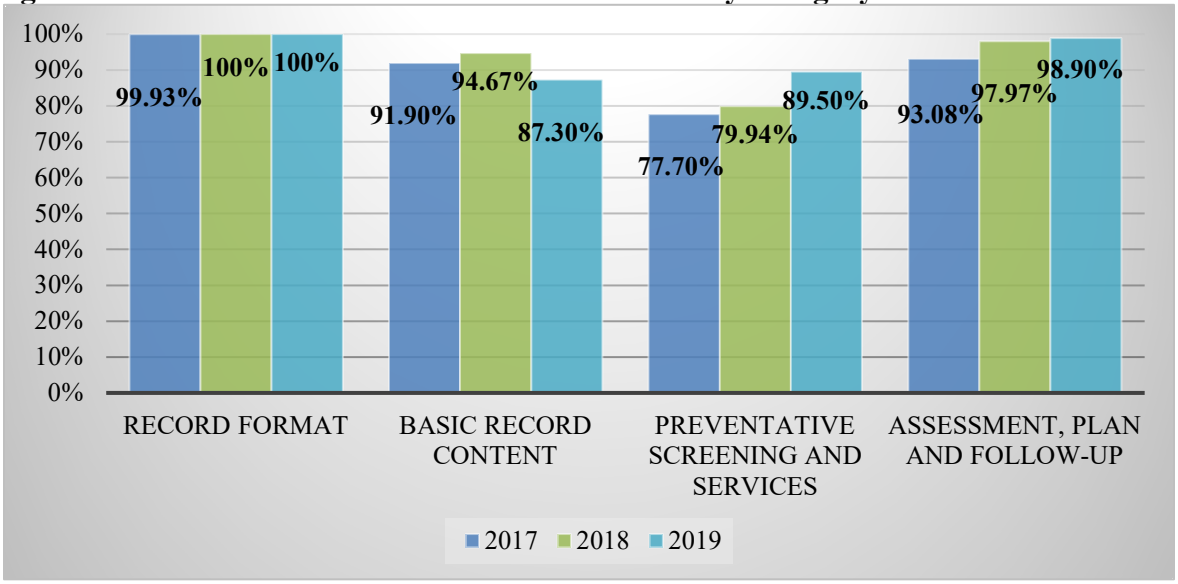
Record Audits

Medical Record Audit

Itasca Medical Care (IMCare) annually audits enrollee medical records to determine provider compliance with regulatory requirements and National Committee for Quality Assurance (NCQA) standards. Additionally, IMCare ensures that medical records are maintained with timely, legible and accurate documentation of patient information per IMCare' s medical record documentation standards. IMCare audited a total of 223 medical records, with 97.5% of measures met, for the medical record audit, which is above the goal of 80%.

Most measures increased or remained the same. Health Care Directives present in the medical record for those eighteen and older decreased by 8.5%, with 80% of providers not meeting goal. Past medical history for enrollees under the age of 18 decreased by 41.27%. 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 53.3% increase from the previous year.

Figure 18: 2017-2019 Medical Record Audit Results by Category



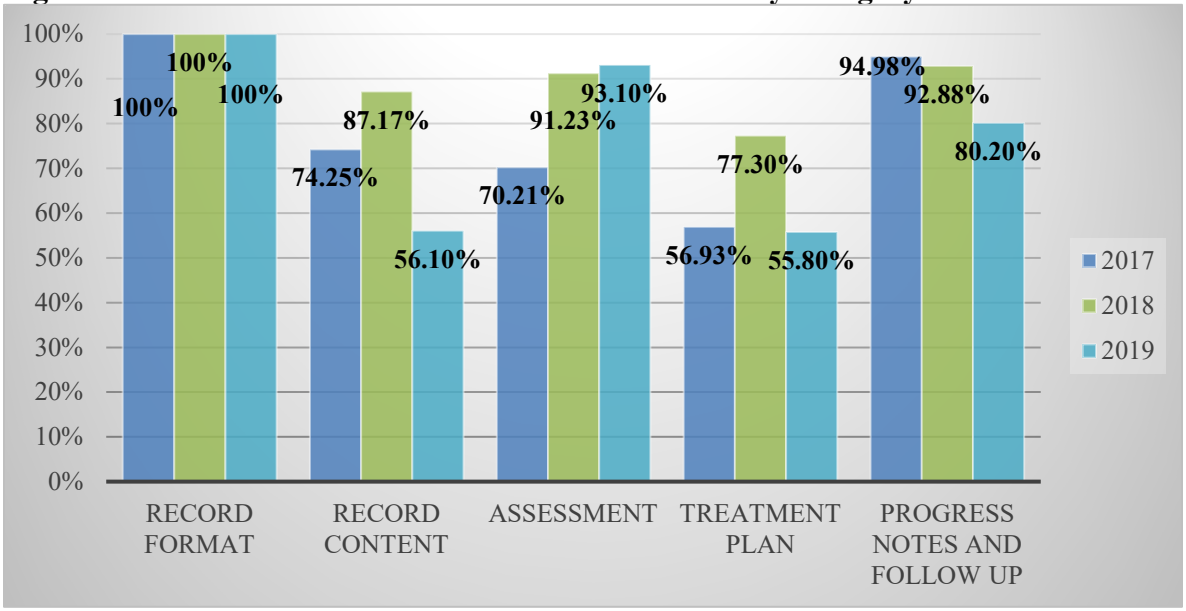
Behavioral Health Treatment Record Audit

Itasca Medical Care (IMCare) conducts annual behavioral health (BH) treatment records audits to determine if providers are documenting important elements of behavioral health treatment according to regulatory requirements and National Committee for Quality Assurance (NCQA) standards in the assessment and treatment plan, progress notes, and follow-up of IMCare enrollees. Additionally, IMCare assures that behavioral health treatment records are maintained with timely, legible and accurate documentation of patient information per IMCare' s behavioral health treatment record documentation standards. The treatment record may be paper, electronic (EHR) or consist of both.

IMCare audited 11 Behavioral Health Providers for a total of 177 behavioral health records. There were minor changes to the audit protocol from the previous year, which may account for some of the change in results as providers were not aware of the expectation during the measurement year. Two measurements were removed from the previous 2018 audit protocol, and additional changes were made to one measurement.

Overall, most measures met the 80% goal, and two that did not meet goal demonstrated an increase from the previous audit. Record Format indicated 100% compliance, Record Content, Treatment Plan, Progress Note and Follow up sections had averages below 80%. The Treatment Plan section had a new measure this year with performance less than 80%. Behavioral Health providers were provided with the tool guide and recommended areas for improvement.

Figure 19: 2017-2019 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).

2019 Interventions**:**

- Quarterly *Timeliness of Credentialing and Recredentialing* reports were reviewed/approved by the IMCare PAC throughout 2019 to assure compliance with the required timeframes.
- A draft of the *2018 Timeliness of Credentialing Appointments Report* was reviewed/approved by the IMCare PAC on 02/13/19.
- The final *2018 Timeliness of Credentialing Appointments Report* was reviewed/approved by the IMCare External QI/UM Committee on 03/20/19.
- Initial appointment and reappointment credentialing/recredentialing checklists were updated throughout the year when indicated.

In 2019, IMCare processed all initial credentialing and recredentialing applications within the required timeframes. No extensions to the timeframes were requested/granted.

Organizational Provider Credentialing

In 2019, 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 credentials organizational providers at the time of initial contracting and at least every 36 months thereafter, to ensure that the provider is in good standing with federal/state regulatory bodies and has been reviewed/approved by an appropriate accrediting body (Policy and Procedure 1.08.11). 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).

2019 Interventions**:**

- A draft of the *2018 Organizational Provider Credentialing Report* was reviewed by the IMCare Provider Advisory Subcommittee (PAC) on 02/13/19.
- The final *2018 Organizational Provider Credentialing Report* was reviewed/approved by the IMCare External QI/UM Committee on 03/20/19.
- Quarterly credentialing reports, including organizational provider credentialing/ recredentialing information, were reviewed/approved by the IMCare PAC throughout 2019.
- 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 recredentialing is completed on a 36-month cycle. The 15 organizational providers recredentialed in 2019 met all required elements.

Site Visit Audit

In 2019, IMCare followed the National Committee for Quality Assurance (NCQA) standards to ensure a consistent, thorough credentialing process that meets community standards and current contractual and legal requirements. IMCare conducts 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 are 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).

2019 Interventions:

- A draft of the *2018 Site Visit Audit Report* was reviewed/approved by the IMCare Provider Advisory Subcommittee (PAC) on 02/13/19.
- The final *2018 Site Visit Audit Report* was reviewed/approved by the IMCare External QI/UM Committee on 03/20/19.
- Quarterly credentialing reports, including office site visit audit results, were reviewed/approved by the IMCare PAC throughout 2019.
- 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 2019 met goal. Providers received a letter explaining their audit results and encouraging correction of any deficiencies.

Credentialing File Audit
In accordance with NCQA standards, IMCare completed 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.

2019 Interventions:

- A draft of the *2018 Credentials File Audit Report* was reviewed by the IMCare Provider Advisory Subcommittee (PAC) on 02/13/19. PAC suggestions were incorporated into the final report.
- The final *2018 Credentials File Audit Report* was reviewed/approved by the IMCare External QI/UM Committee on 03/20/19.
- Initial appointment and reappointment credentialing/recredentialing checklists were updated throughout the year as needed.

The IMCare QI/UM Director audited a random sample of ten individual practitioner credentialing files with initial credentialing (five) or recredentialing (five) completed in 2019. All of the measures met the 100% goal.

Provider Service 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 2019, 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 2019 and Fall/Winter 2019 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 a decrease of 8.5% in percentage of charts including documentation in medical 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 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 2018-2019, IMCare identified potential gaps in the accessibility of primary care, specialty care, behavioral health care and ancillary service providers by analysis and comparison of IMCare ensured access to providers for minority and special needs populations by conducting cultural, ethnic, racial and linguistic needs assessments of all enrollees at enrollment (and additionally as needed) through Health Screening Surveys and Long-Term Care Consultations (LTCC). IMCare also received and reviewed a monthly list of enrollees identified as having potential cultural, ethnic, racial and linguistic needs from DHS. The IMCare Provider Directory included the languages spoken at each of the primary care clinics. American Indians were able to utilize tribal and Indian Health Services clinics, in addition to network providers, without prior authorization by IMCare.
- IMCare complied with the Mental Health Parity and Addiction Equity Act (MHPAEA, Pub.L. 110-343) making it easier for enrollees with mental health and substance use disorders to get the care they need by prohibiting certain discriminatory practices that limit coverage for behavioral health treatment and services.
- A reminder system was utilized to facilitate timely reporting of clinic grievances by providers. Each provider was emailed/faxed/mailed a copy of the report and a reminder one to two weeks prior to the deadline dates. A follow-up reminder was emailed/faxed/ phoned if IMCare still had not received the form after the due date.
- The 2018 Access and Availability Report was reviewed/approved by the IMCare Provider Advisory Subcommittee (PAC) on 11/14/2018 and the External Quality Improvement/Utilization Management (QI/UM) Committee on 12/19/2018.
- The 2017 Clinic Grievance Report was reviewed/approved by the PAC on 02/14/2018 and the External QI/UM Committee on 03/21/2018.
- The 2017 Credentials File Audit Report was reviewed/approved by the PAC on 02/14/2018 and the External QI/UM Committee on 03/21/2018.
- The 2017 Site Visit Audit Report was reviewed/approved by the PAC on 02/14/2018 and the External QI/UM Committee on 03/21/2018.

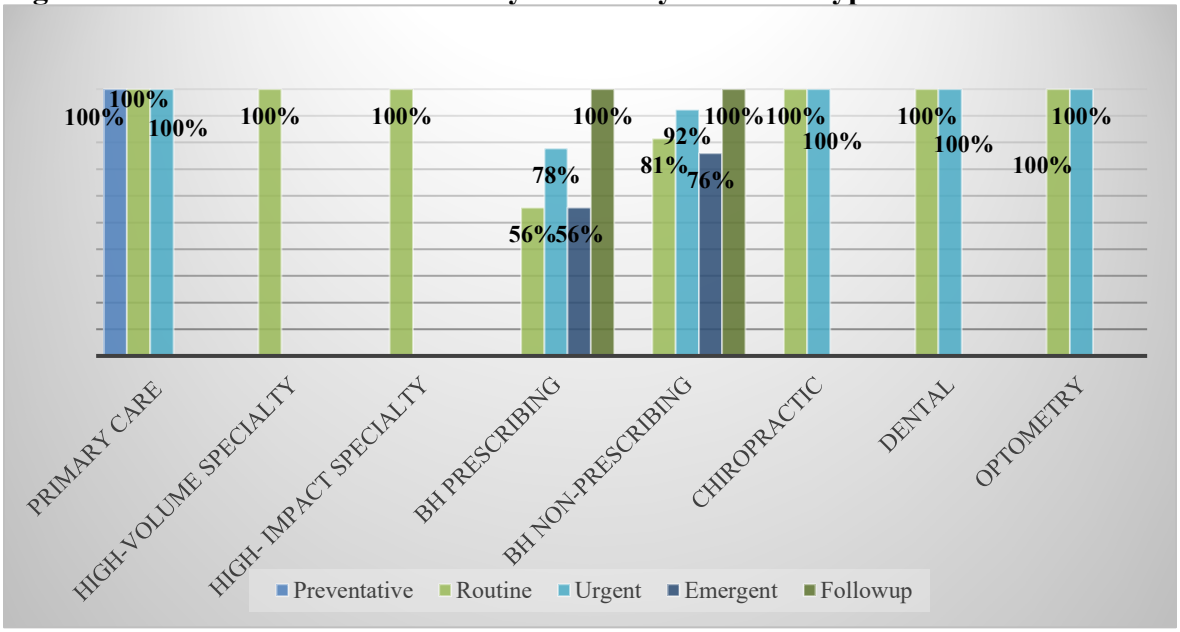
During the study period, IMCare met goal for most accessibility measurements and provider types outside of behavioral health providers. Both prescribing and non-prescribing behavioral health provider were below goal in routine, urgent and emergent visits. IMCare conducted individual follow up with the providers who did not meet the standards and requested a response on how they intended to become in compliance with the standards. Overall IMCare maintained an adequate care network as it relates to provider accessibility. 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. IMCare entertains all individual behavioral health practitioner requests for credentialing and all providers who can meet NCQA credentialing standards are added to the IMCare network. Furthermore, the Itasca County Crisis Response Team provides around-the-clock urgent/emergent behavioral health care to Itasca County residents. Network urgent care facilities and emergency departments also ensure accessibility of urgent/emergent care.

Analysis of enrollee grievances revealed no grievances related to cultural/ethnic/racial/linguistic enrollee needs or accessibility of IMCare providers during the study period.

Figure 20: 2019 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.

2018-2019 Interventions:

- IMCare ensured provider availability for minority and special needs populations by conducting cultural, ethnic, racial and linguistic needs assessments of all enrollees at enrollment (and additionally as needed) through Health Screening Surveys and Long-Term Care Consultations (LTCC). IMCare also received and reviewed a monthly list of enrollees identified as having potential cultural, ethnic, racial and linguistic needs from DHS. The IMCare Provider Directory included the languages spoken at each of the

primary care clinics. American Indians were able to utilize tribal and Indian Health Services clinics, in addition to network providers, without prior authorization by IMCare.

- The 2018 Provider Availability and Network Adequacy Report was reviewed/approved by the IMCare Provider Advisory Subcommittee (PAC) on 11/14/2018 and the External Quality Improvement/Utilization Management (QI/UM) Committee on 12/19/2018.
- The 2017 Clinic Grievance Report was reviewed/approved by the PAC on 02/14/2018 and the External QI/UM Committee on 03/21/2018.

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

IMCare met goal for nearly all behavioral health provider to enrollee ratios, but not geographic availability measures. All psychiatrists in the IMCare service area are IMCare network providers; however, there is a long-standing national and rural shortage of this provider type. IMCare allows enrollees to see psychiatrists at the nearest out-of-network tertiary care center without a referral or prior authorization and has participated in local recruitment efforts. During the study period, eight households in northwest Itasca County did not have access to a mental health provider within 30 miles. A recent increase in telemedicine mental health services has improved enrollee access to these services, which would not be reflected on the current GeoAccess map. IMCare network facilities provide medical stabilization for enrollees requiring mental health and chemical dependency assessment/admission, when necessary. In addition, the Itasca County Crisis Response Team provides around-the-clock urgent/emergent behavioral health care to Itasca County residents.

Nearly all ancillary service provider, pharmacy and hospital measures met goal for the study period. Eleven households in northwest Itasca County 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.

In July 2018, IMCare implemented a tracking system for authorizations to allow for retroactive review of in and out-of-network requests by provider specialty. Per review of this data, enrollees are utilizing services out-of-network for two specialty types in which access standards are not met, including orthopedic surgery and mental health services/psychiatry. The ratio of enrollees seeking care out-of-network remains quite low in comparison to total enrollment.

IMCare completed a quantitative and qualitative analysis, by product line, of enrollee DTRs, grievances and appeals data related to network adequacy and experience. During the study period, there were only six denials based on the out-of-network status of the provider, when a

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

Enrollee Experience

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

An external vendor, as delegated by DHS and Centers for Medicare & Medicaid Services (CMS), conducted the survey and compiled a report for all public Managed Care Organizations (MCOs). The standardized survey instrument used was the CAHPS.

CAHPS results in 2019 were based on a combined MCO enrollee sample for the MNCare and MSC+ population due to inclusion criteria. It is also important to note that Minnesota state averages were lower than in previous years. With that being said, the differences in the analytical approach from the current vendor, Health Survey Advisory Group (HSAG), and previous vendor, DataStat, are due to case-mix adjustment. DataStat case-mix adjusted their rates using age and self-reported health status, while HSAG did not conduct any case-mix adjustment on the results. To calculate results, HSAG used the raw CAHPS data files that were provided by DHS and generated all of the results presented in the summary report. HSAG did not use the results from the previous vendor reports. Therefore, there may be differences in the trending data when viewing DataStat's reports in years 2017 and 2018. HSAG follows NCQA specifications and guidelines when calculating CAHPS results and NCQA does not recommend case-mix adjustment of CAHPS results

Samples for each of IMCare's memberships were generated as outlined below.

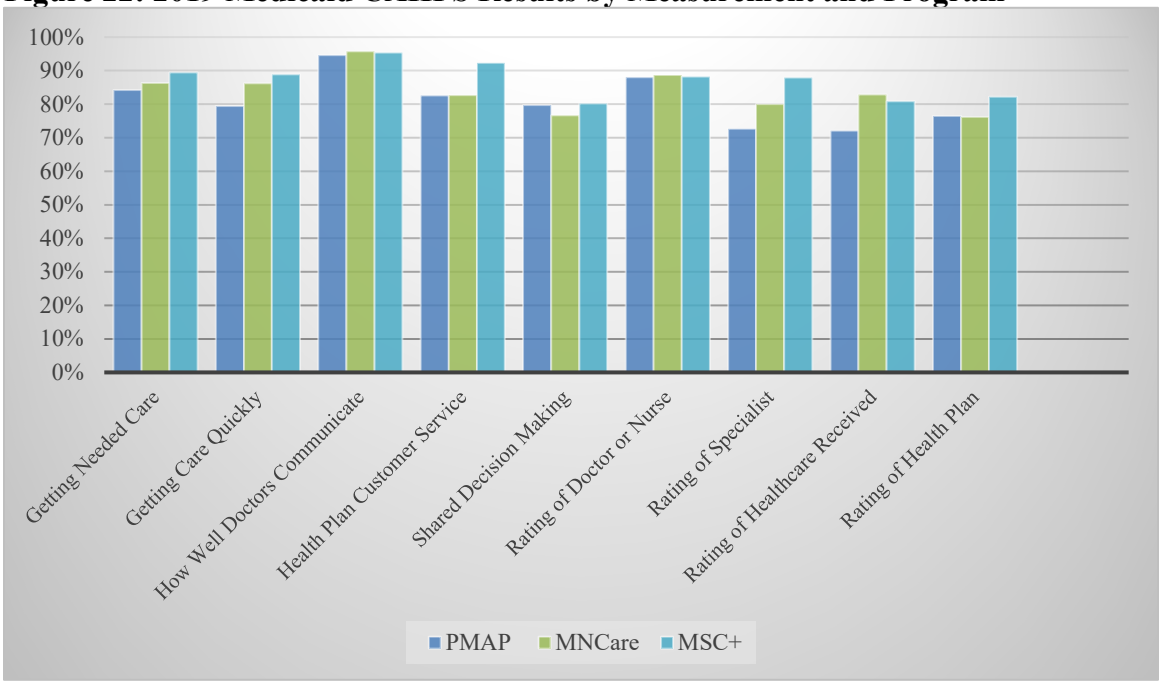
- **Prepaid Medical Assistance Program (PMAP):** A random sample of 1,350 eligible IMCare enrollees, ages 18-64 years, was used.
- **MinnesotaCare (MNCare):** IMCare data was combined with PrimeWest Health, Hennepin Health and South Country Health Alliance, for a total sample size of 1,350 enrollees.
- **Minnesota Senior Care Plus (MSC+):** IMCare data was combined with PrimeWest Health and South Country Health Alliance, for a total sample size of 1,200 enrollees.
-

Figure 21: 2019 CAHPS Survey Completion Rate

	Eligible Sample Size	# of Enrollees who Completed the Survey	Survey Completion Rate
PMAP	1350	130	9.63%
MNCare	1350*	185*	13.7%
MSC+	1200*	253*	21/1%

* Combined Sample

Figure 22: 2019 Medicaid CAHPS Results by Measurement and Program



In 2019, six of nine PMAP goals were not met, with two of them meeting in 2018. 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, which are handled by the Itasca County Financial Assistance Department. IMCare has limited ability to influence change in the customer service experience that enrollees receive from this entity.

In 2019, four of nine MNCare combined sample measures were not met. However, IMCare met or exceeded all goals in 2018. Nearly all MSC+ combined sample results met goal in 2019. The only unmet goal, Shared Decision Making, was met by IMCare in 2018. It is difficult to interpret these results given the combined samples for these populations in 2019.

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

Senior Enrollee Satisfaction with Care Coordination Survey

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.

Six-hundred sixty-nine total surveys were sent in 2019.The total number of respondents were 199, with 144 being IMCare Community Well or Nursing Home, and 55 being Elderly Waiver

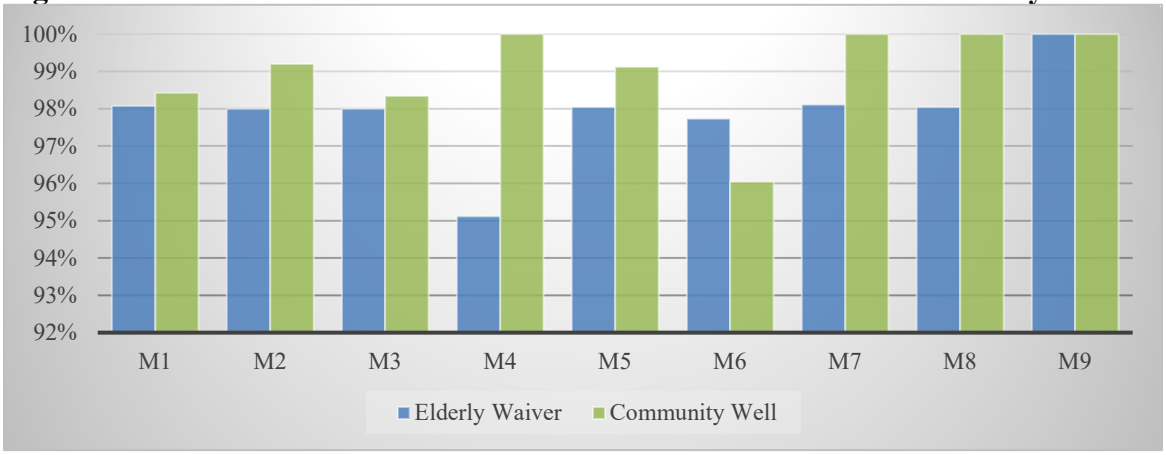
enrollees. The overall response rate was 29.74%, down from 34.95% in 2018. Interventions included additional education regarding Care Coordination services was provided to enrollees via the enrollee newsletter. Returned surveys were separated by Elderly Waiver and IMCare care coordination to identify specific opportunities for improvement for enrollees.

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. The number of enrollees that answered NA/Does Not Apply, especially on questions M4 an M6 warrants that changes need to be made to the questions. It also indicates that the surveys should be tailored to the different populations. For example, with M4, community-well enrollees are often not receiving services, or are not eligible for enhanced services beyond their benefit package, therefore, there may be confusion surrounding that question. The IMCare Nursing Home enrollees were also an outlier and many of them answered NA/Does Not Apply to all the survey questions. All goals were met or exceeded for this population.

Figure 23: 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 24: 2019 Senior Enrollee Satisfaction with Care Coordination Survey Results



Enrollee Education Sessions

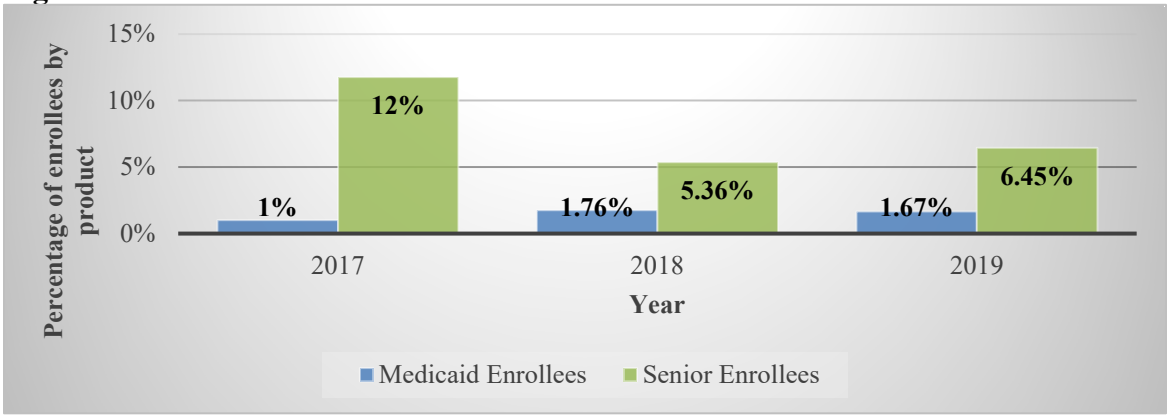
IMCare provides monthly enrollee education. Enrollees new to IMCare are notified in writing of the monthly education sessions when they receive their new IMCare medical cards. The purpose of the education is for enrollees to understand how to use their IMCare medical card, review of the Enrollee Handbook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

2019 Interventions:

- Written notification of monthly enrollee education was sent to individuals who were newly enrolled during 2019.
- 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 2019, IMCare saw a slight increase in the number of new enrollees in the Medicaid population. The increase in the denominator resulted in a slight decrease in the rate of participation, however there were more overall participants than the previous year. The MSHO population had a slight increase in rate of participation but was likely due to the decrease in the number of new enrollees in that population during the measurement year. 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 contribute 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 25: 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.

2019 Interventions:

- IMCare Director, QI/UM Director and Compliance Officer met with to First Call for Help (FCFH) during 2019 to discuss opportunities for improvement and communicated via email on an ongoing basis.
- IMCare QI/UM Director/s conducted routine monitoring of Prairie Fyre to review call abandonment rates and followed up with staff accordingly.
- 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 uses the CMS benchmark for internal monitoring. IMCare's internal rate of abandonment is 1.66%, which is below the CMS benchmark. IMCare's disconnect rate for Part C and Part D Beneficiary Customer Services Center calls (IMCare) met goal, coming in below the 5% benchmark at 3.13%. The Pharmacy Customer Services Center (CVS Caremark) calls, had a disconnect rate of 7.81%, during first quarter of 2019, not meeting the goal of 5% or less. IMCare transitioned the Pharmacy Helpdesk Call Number to IMCare Enrollee Services line during second quarter of 2019 and the disconnect rate for the remainder of the year showed improvement, coming in at 1.88% abandonment rate, well below the goal of 5% or less. 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. Most abandoned calls were LEP calls which occurred after IMCare business hours, however FCFH did demonstrate year-to-year improvements of abandonment rates. 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 utilizes volunteers. It is questionable whether each volunteer has been given adequate training regarding IMCare processes and that may be the cause for the higher abandonment rates in the identified areas. IMCare had some turn-over during the measurement year which may have impacted the ability of the CSR to answer the call prior to going to voicemail.

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.

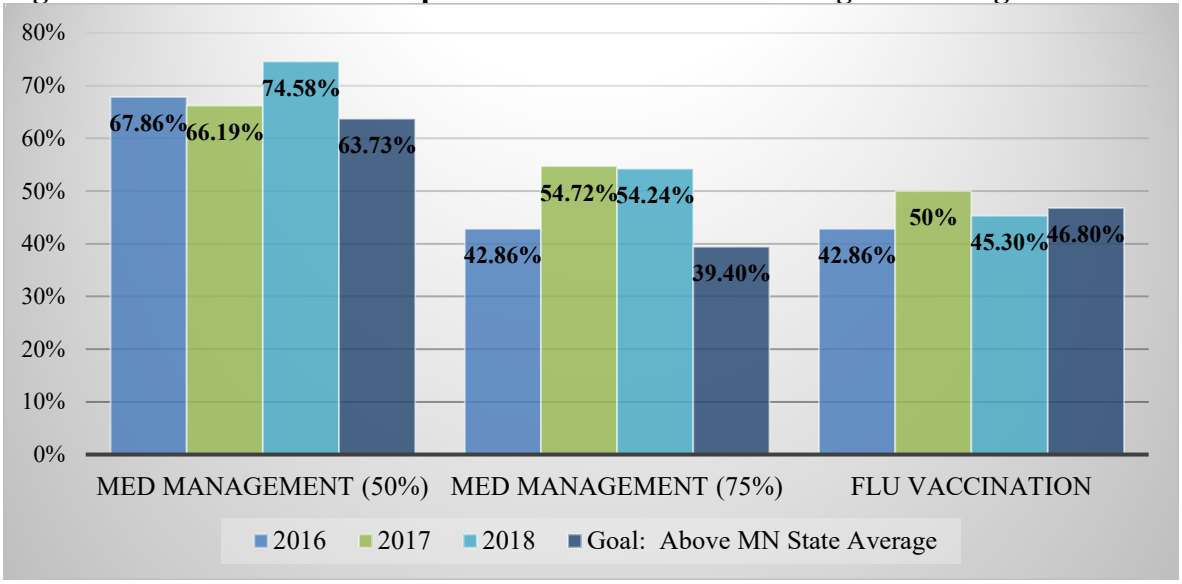
Disease Management
In 2019, the IMCare Ways to Wellness program continued to assist enrollees with managing their chronic health conditions to include asthma, diabetes, heart failure and/or hypertension. Some of these enrollees may have had one or more of the listed chronic conditions. These enrollees received quarterly educational mailings and/or nurse phone calls depending on stratification levels post disease-specific assessment.

Claims data, provider documentation submitted with authorization requests, emergency department utilization monthly reports, health screening surveys and care coordinator assessments were utilized to identify enrollees who may benefit from the Ways to Wellness program. IMCare also received referrals from clinics, hospitals, case managers and self-referrals for possible participation in the program.

Figure 26: Asthma Disease Management Program Measurements

Measurement	Data Source
M1. Medication Management - The percentage of IMCare enrollees 5–64 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 5-64 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 27: Year-To-Year Comparison Asthma Disease Management Program Results

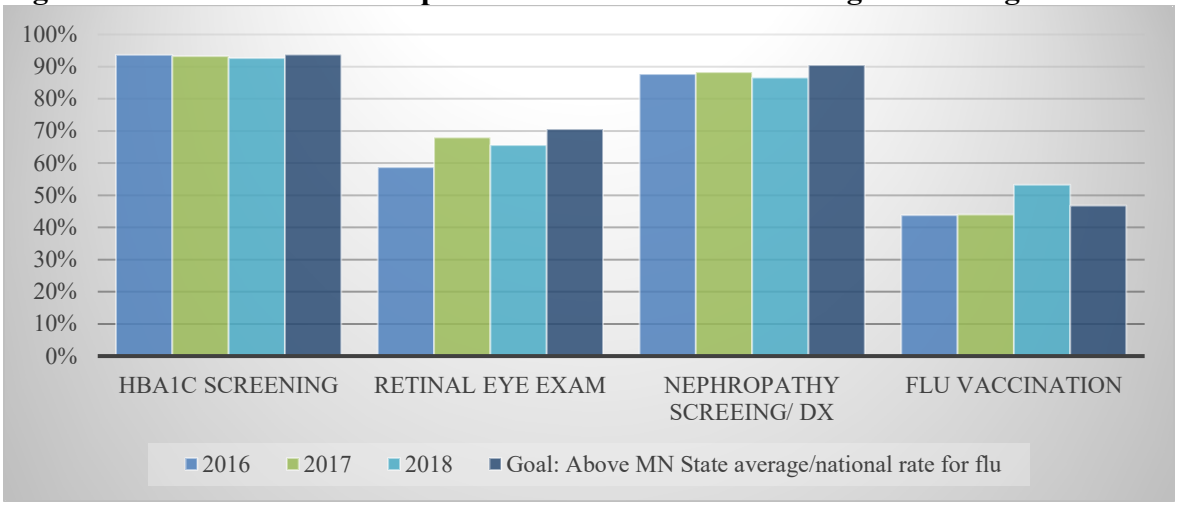


The percentage of IMCare enrollees 5–64 years of age during the measurement year who were identified as having persistent asthma and remained on an asthma controller medication for at least 50% and 75% of their treatment period exceeded the established goals. IMCare remained just below the National rate for influenza vaccinations for this population. Claims from clinic/hospitals, pharmacies, and Minnesota Immunization Information Connection (MIIC) data were utilized to obtain data. Utilization of the 2018 MIIC data captured additional information on enrollee vaccination status. 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 2018 Enrollee Newsletter.

Figure 28: 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 29: Year-To-Year Comparison Diabetes Disease Management Program Results



Enrollee's with diabetes were automatically enrolled in disease management; enrollees could opt out when contacted to complete Diabetes Assessment. In 2018, IMCare did not meet the established goals for HgbA1C screenings, retinal eye exams or nephropathy screenings. For 2019, IMCare did a secondary review at the eye care clinics, if the eye exam data was not available in the primary care record. IMCare was above the National average for flu vaccinations. 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. An annual reminder was included in the Fall 2019 Enrollee Newsletter.

Figure 30: 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 had at least one inpatient stay with the primary diagnosis of congestive heart failure (CHF) during the measurement year.	Enrollee Report
M2. 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 31: Year-To-Year Comparison Heart Failure Disease Management Program Results

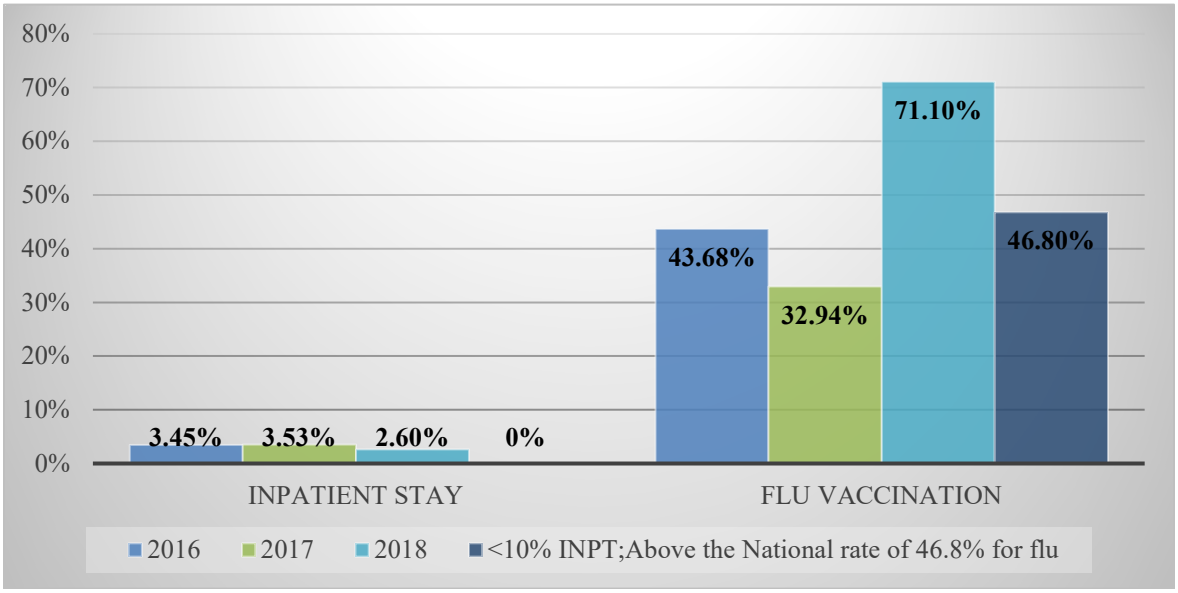
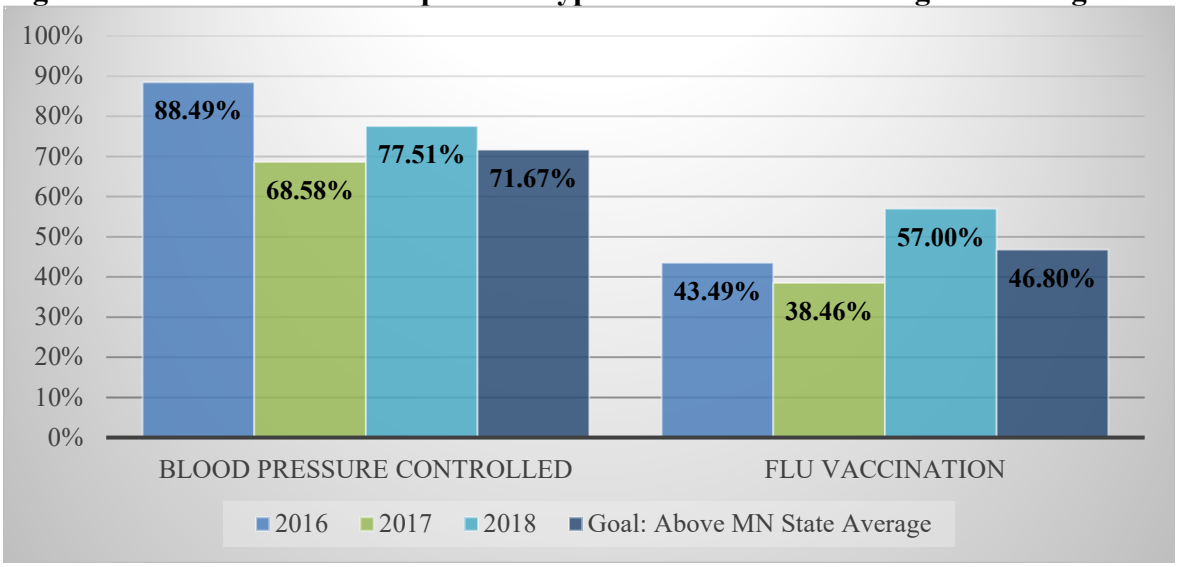


Figure 32: Hypertension Disease Management Program Measurements

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 enrollees enrolled in the IMCare Disease Management program for hypertension who received an influenza vaccination during the measurement year.	Claims

Figure 33: Year-To-Year Comparison Hypertension Disease Management Program Results



The Flu Vaccination goal was met; IMCare utilized medical and pharmacy claims data in addition to MIIC for the measurement. 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 2019 Enrollee Newsletter.

Adoption of Practice Guidelines

The adoption, dissemination and application of clinical practice guidelines are required by 2019 Families and Children and Seniors Contracts with the Department of Human Services (DHS). Per Article 7.1.5 of the 2019 DHS 'Families and Children', "The MCO shall adopt, disseminate and apply practice guidelines, as required by 42 CFR 438.236. Per Article 7.1.6 of the 2019 Seniors contracts, "The MCO shall adopt preventive and chronic disease practice guidelines appropriate for Enrollees age sixty-five (65) and older, consistent with accepted geriatric practices." The MCO shall adopt, disseminate and apply practice guidelines that meet the following requirements under 42 CFR 438.26:

1. Are based on valid and reliable clinical evidence or a consensus of practitioners in the particular field.
2. Consider the needs of the MCO's enrollees
3. Are adopted in consultation with contracted health care professionals
4. Are reviewed and updated periodically as appropriate.

2019 CLINICAL PRACTICE GUIDELINES:

- Type 2 Diabetes Mellitus - 'Overview of Medical Care in Adults with Diabetes Mellitus' UpToDate (www.uptodate.com) October 2018
- Preventive Care in Adults: Recommendations-UpToDate (www.uptodate.com), June 2018
- Geriatric Health Maintenance-UpToDate (www.uptodate.com), August 2018
- Screening Tests in Children and Adolescents-UpToDate (www.uptodate.com), January 2019
- Guidelines for Adolescent Preventive Services-UpToDate (www.uptodate.com) June 2018
- Prenatal Care: Initial Assessment-UpToDate (www.uptodate.com) December 2018 and Prenatal Care: Second and Third Trimesters-UpToDate (www.uptodate.com) October 2018

Continuity and Coordination of Care

2019 MSHO/MSC+ Transitions Report

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

IMCare's contracted providers are required to notify IMCare of planned and unplanned transitions of care within one business day of the transition. Care Coordinators (CC) are required to complete specific tasks related to the transition within one business day of the provider

notification. The goal of these tasks is to reduce hospital readmissions and improve enrollee outcomes by providing consistent enrollee support during the transition.

IMCare assesses and ensures that proper notification of transitions is received, and proper follow-up care is given to Minnesota Senior Health Options (MSHO) and Minnesota Senior Care (MSC+) 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 2019, letters were sent to providers reminding them of the requirements as stated in the IMCare Provider Manual, Inpatient Hospital Notification and Authorization (Chapter 13) as follows:

- Notify IMCare of all emergency and non-emergency hospital inpatient admissions within 24 hours of the admission, or for admissions occurring during a weekend or holiday, by the end of the following business day.
    - Failure to notify IMCare may result in denial or delay in payment of claims
- Make information related to the admission available to IMCare during the course of an enrollee's hospitalization.
- Make information regarding the time and date of discharge and information regarding the treatment provided to the enrollee available to IMCare within the next working day following a enrollee's 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.

In the most recent study period, the total number of transitions changed slightly over 2017, from 505 transitions to 522 transitions, an increase of 3.3%. Five measurements did not meet goal for 2018. Three of those measurements demonstrated a significant increase over 2017, and the remaining two measurements had minor decreases.

In 2018, IMCare had determined that our enrollee transition process would be better served by a direct audit of the Transition of Care Logs (TOC). This audit has not yet been implemented but will be completed within the next six months. A random selection of TOC Logs for each CC will be pulled from CTD and examined thoroughly for timeliness, completeness, and proper documentation. This will allow for direct feedback to CCs using real examples. IMCare will then be better able to identify areas for improvement as well as areas where the process is working well. This will translate into an excellent training opportunity for all CCs.

Finally, the following interventions will be continued:

- IMCare will provide CC training on the transition process, the importance of each task, and required documentation.
- IMCare will consider requesting network provider's policies and procedures on transitions to ensure the policy includes notification within one business day of an unplanned transition.
- IMCare CCs will continue to attend the monthly MCO Care Coordination Workgroup meetings to exchange ideas and learn from other health plans.
- Yearly MOC training will be conducted with IMCare delegates.
- IMCare will continue to develop relationships and communicate transition needs and requirements to facility discharge planners/social workers.

IMCare recognizes that the timely completion of all transition tasks will result in better quality of care for its enrollees and will continue to work toward meeting its goals in this area.

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 were thirteen categories that were assessed as part of the oversight process. Assessment was done through review of each categorical material set which, in total included over 20 reports and policy and procedure documents as listed in the attachments section below. 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 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 1,7 (Establishing a Pharmacy Network/Maintaining Point of Sale Claims Processing).

Minnesota Department of Human Services (DHS) Memorandum of Agreement
MSHO is a program for dual-eligible enrollees, who must be eligible for Medicare and Medicaid to voluntarily enroll in MSHO. Due to the need to be eligible for both programs, IMCare contracts with DHS to enroll individuals through CMS and the state eligibility program. DHS is responsible for performing all enrollment functions, including required notices, and submitting a file to IMCare for systems upload. IMCare performs monthly random audits on DHS enrollment files to ensure that all CMS requirements are met and documented as needed. Overall, DHS is not meeting the IMCare standards regarding their delegated responsibilities and IMCare is working to implement a corrective action plan with DHS.

Itasca County Public Health Provider Participation Agreement
IMCare contracts with Itasca County Public Health, as their one and only delegate to provide care coordination and case management services to enrollees over the age of 65 utilizing EW services. IMCare monitors the timeliness and comprehensiveness of enrollee care plans, MN Choices assessments 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.

2019 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 2019, IMCare utilized the following policies and guidelines when making UM authorization decisions:

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

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

Medicaid Under and Over Utilization
Ensuring appropriate utilization of services is required as per Article 7.1.4 of the 2019 DHS Families and Children contract, "The MCO shall adopt a utilization management structure consistent with state and federal regulations and current NCQA "*Standards and Guidelines for the Accreditation of Health Plans*." Pursuant to 42 CFR § 438.330(b)(3), "this structure must include an effective mechanism and written description to detect both under- and over-utilization of services.

2018 Interventions:

- Enrollee newsletters were sent out in spring and fall of 2018. Article topics included information about preventative wellness visits and screening, vaccines, chronic medical

conditions, alternative pain management, cancer screenings, dental visits, opioid abuse, transportation information, and depression medication management.
- Calls were made to all Medicaid-eligible enrollees to inform them of dental benefits.
- Individual letters were sent out for well child reminders, mammograms, flu shot information, colonoscopy, and cervical screenings.

IMCare HEDIS utilization measures have been static over the past three years, with less than five percent variability from year-to-year, except for Follow-Up After Emergency Department Visit for Mental Illness which had a 11.92% increase. IMCare's PMAP preventive care in children measure rates were below the MN state average rates, besides in Children and Adolescents' Access to PCP and Well-Child Visits 3rd-6th years of life. All preventative care in children goals were met for the MNCare population, with the exception of Children and Adolescents' Access to PCP, this appears to have a large shift. However, this appears to be related to the small denominator that accompanies it. 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 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 the DHS has placed on dental access in the 2018 Families and Children and Seniors contracts, IMCare implemented several new dental interventions, including calls to all enrollees to promote dental care, which will likely show continued increase in HEDIS 2020 ADV rates.

Mental Health Utilization (MPT) goal was unmet for the PMAP & MNCare population, as it was above the MN state average and had continued year-to-year increase in utilization. However, in contrast, the MNCare & PMAP populations met the goal for Identification of Alcohol and Other Drug Services (IAD). 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 measurement table, these measures apply to different age groups. IMCare met the FUM goal by a with a large increase in the PMAP population, however, did not meet the goal for the MNCare population probably due to the low denominator in calculation. 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 three 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 continued upward trends of IAD rates as well.

The focus on SUD reform will hopefully help increase the follow-up visit rates, by raising awareness of services and increasing referrals out of the ED in the future.

Figure 34: 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 35: 2017-2019 PMAP Under & Over Utilization HEDIS Results

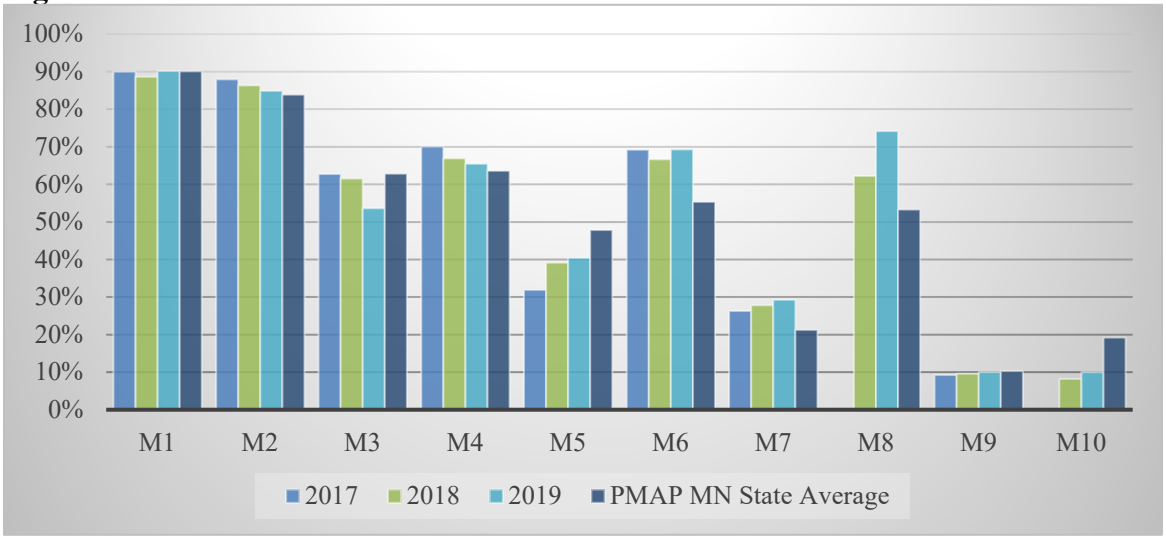
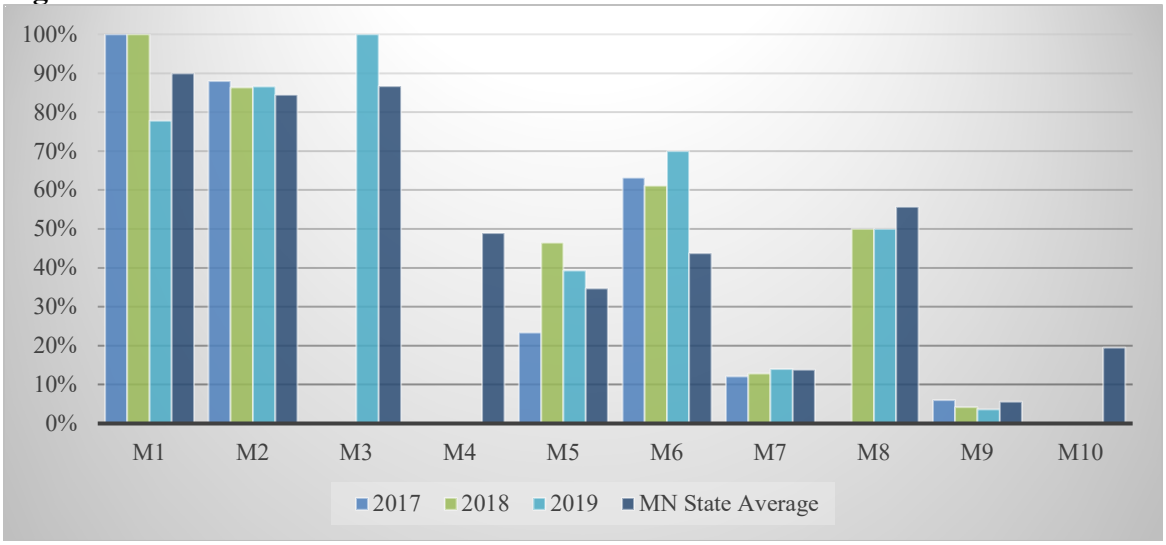


Figure 36: 2017-2019 MNCare Under & Over Utilization HEDIS Results



**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 2019 DHS Seniors contract, "The MCO shall adopt a utilization management structure consistent with state and federal regulations and current NCQA "*Standards and Guidelines for the Accreditation of Health Plans*." Pursuant to 42 CFR § 330(b)(3), this structure must include an effective mechanism and written description to detect both under- and over-utilization of services.

2018 Interventions:

- IMCare continued the Emergency Department (ED) Focus Study. ED Utilization reports were run quarterly and reviewed by Managed Care nurses; Senior Care Coordinators were also forwarded these reports as indicated. IMCare Managed Care 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 June 2018 enrollee newsletter.
- Enrollee education regarding disease management and care coordination was included in the June 2018 and December 2018 enrollee newsletter.
- MSHO enrollees who agreed to have a MNChoices or Health Risk Assessment (HRA) were screened for substance use and depression and educated on the importance of preventative care.
- Enrollee education regarding colorectal screening was included in the December 2018 newsletter.
  The 2018 Medicare Under and Over Utilization Report was reviewed/approved by the IMCare Provider Advisory Subcommittee (PAC) on 11/14/2018 and the IMCare External QI/UM Committee on 12/19/2018.

IMCare had year-to-year improvements in a majority of measures. Inpatient Utilization (IPU): Discharges increased from last year and remains above the state average; in contrast the average number of days per hospital stay was below the state average, meeting goal. It is not clear what factors are contributing to an increase in the rate of inpatient hospitalizations, outside of a decrease in senior enrollment during the measurement year, resulting in smaller denominators and an aging population with more comorbidities. Both Emergency Department Visits (AMB), and Outpatient Visits are up from 2018, leaving the goal unmet. Emergency Department Visit rates are similar to data reported in 2017, to the contrary Outpatient Visits appear to be on an upward trend. Mental Health Utilization (MPT), was up 2.5% from 2018, but continues to meet goal and fall just below the state average. Colorectal Cancer Screening (COL) is below the state average but had slight improvement from 2018 to 2019. Transitions of Care, (TRC), with four measurable components, was a new measure, last year for HEDIS 2018. IMCare continues to perform well above the state average in all TRC 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 37: 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
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 Medicare-eligible enrollees who obtained outpatient mental health services during the measurement.	HEDIS Data
M7. Percentage of Medicare-eligible enrollees who obtained outpatient alcohol and other drug services during the measurement.	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 38: Medicare Under and Over Utilization HEDIS Measurement Methodology

Measurement	Goal	2017	2018	2019	Status
M1. Adults' Access (AAP) 65+ years	Above MN State Avg. of 98.33%	96.59%	97.68%	98.47%	Goal met.
M2. Inpatient Utilization General Hospital/Acute Care (IPU): **Discharges/1,000 Enrollee Years**	Below MN State Avg.* of 410.82	416.53	466.92	493.70	Goal not met.

Figure 38: Medicare Under and Over Utilization HEDIS Measurement Methodology Continued

Measurement	Goal	2017	2018	2019	Status
M3. Inpatient Utilization **General Hospital/Acute Care (IPU):Avg Days**	Below MN State Avg.* of 4.60	3.83	4.48	4.51	Goal met.
M4. Ambulatory Outpatient Visits/1,000 Enrollee Years (AMB)	Below MN State Avg. of 11935.30	11,886.15	12,715.34	12,729.43	Goal not met.
M5. Emergency Department Visits/1,000 Enrollee Months (AMB)	Below MN State Avg. of 668.48	678.56	581.78	678.28	Goal not met.
M6. Mental Health Utilization/1,000 Enrollee Months (MPT)	Below MN State Avg. of 14.72%	11.16%	11.50%	14.01%	Goal met.
M7. Identification of Alcohol and Other Drug (IAD) Dependence Services/ 1,000 Enrollee Months	Below MN State Avg. of 5.74%	5.00%	6.32%	6.00%	Goal not met.
M8. Colorectal Cancer Screening (COL)	Above MN State Avg. of 68.74%	57.89%	59.81%	60.82%	Goal not met.
M9. Transitions of Care (TRC): **Notification of Inpatient Admission**	Above MN State Avg. of 37.45%	NR	46.15%	66.67%	Goal met.

Figure 38: Medicare Under and Over Utilization HEDIS Measurement Methodology Continued

Measurement	Goal	2017	2018	2019	Status
M10. Transitions of Care (TRC): Receipt of Discharge Information	Above MN State Avg. of 22.12%	NR	43.08%	59.77%	Goal met.
M11. Transitions of Care (TRC): Patient Engagement After Inpatient Discharge	Above MN State Avg. of 83.17%	NR	90.77%	90.80%	Goal met.
M12. Transitions of Care (TRC): Medication Reconciliation Post-Discharge	Above MN State Avg. of 60.88%	NR	61.54%	82.76%	Goal met.

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 2018 results were evaluated in 2019.

2018 Interventions:

- Throughout 2018, IMCare authorization requirements were communicated to providers via multiple provider updates. IMCare followed regulatory requirements regarding the process for and timeliness of authorization review.
- 2018 Utilization Management Criteria resources were reviewed/approved by the IMCare Provider Advisory Subcommittee (PAC) on 02/14/18 and by the IMCare QI/UM Committee on 03/21/18.

- Throughout 2018, 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 2018 provider newsletter.
- IMCare network provider education regarding the IMCare Disease Management Program and the process for referral was included in the Fall 2018 provider newsletter.
- IMCare network providers were educated about the 2018 formularies via provider updates throughout 2018.
- In 2018, 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 2018, IMCare followed NCQA guidelines for credentialing individual practitioners and organizational providers.
  The 2018 IMCare Provider Satisfaction Survey Report was reviewed and approved by PAC on 05/9/18 and the QI/UM Committee on 06/20/18.

The 2019 Provider Satisfaction Survey had a response rate of 21%. The overall provider satisfaction rate was impressive at 94%, although it did show a decrease from 100% in 2018. All but one 2019 survey question measurement exceeded goal. Variations in individual measurements are difficult to interpret due to relatively small denominators; however, IMCare continues to show a high level of provider satisfaction. Dissatisfaction is evident with Behavioral Health providers, specifically surrounding reimbursement. IMCare has followed DHS fee schedules; therefore, this directly correlates to DHS rate reductions.

Figure 39: 2017- 2019 Provider Satisfaction Survey Response Rate by Provider Type

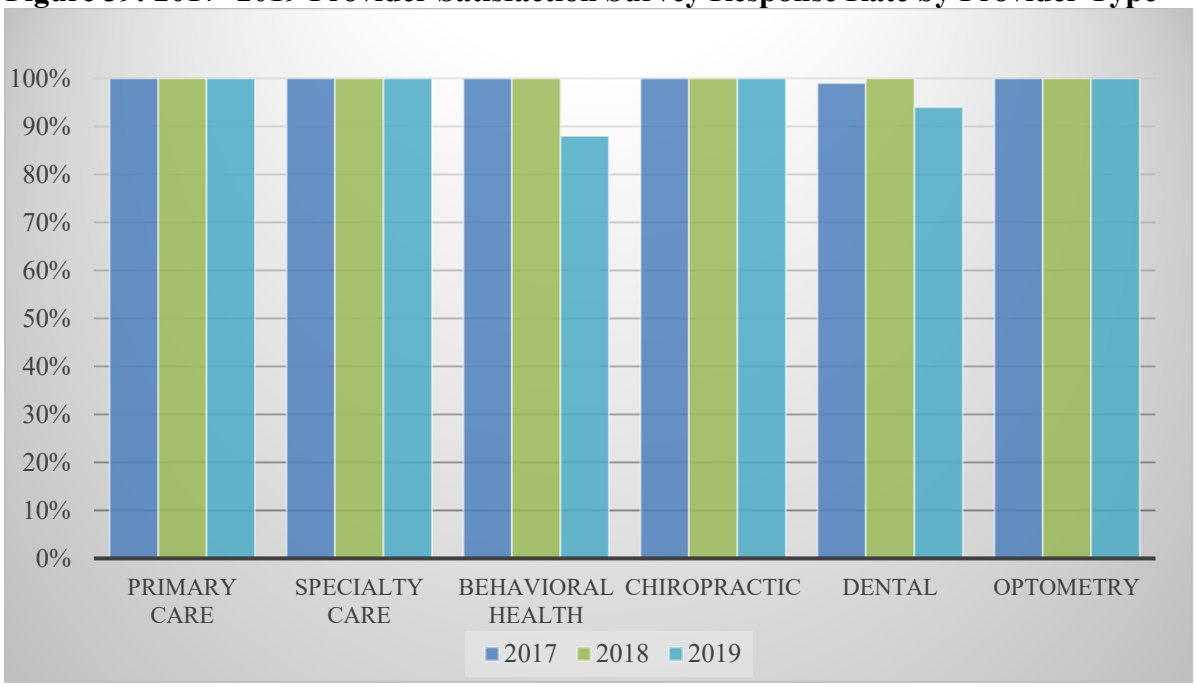
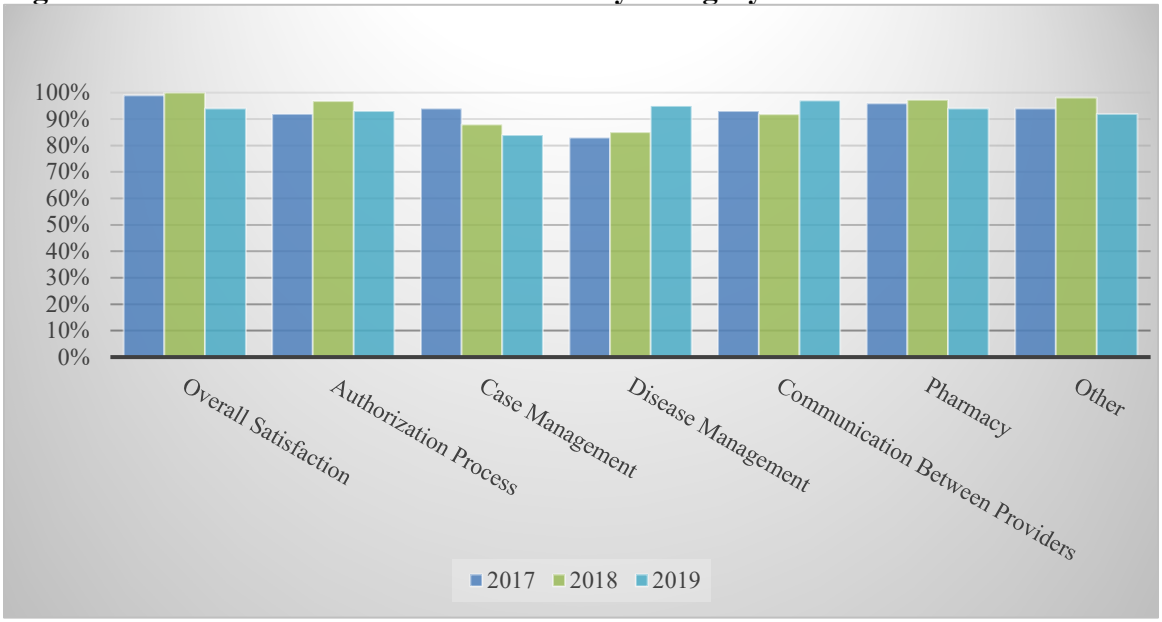


Figure 40: 2017-2019 Provider Satisfaction by Category



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 QI/UM Director/s monitor incoming communication and involve UM staff and the Medical Director as necessary.
- Staff can send outbound communication regarding UM inquiries during normal business hours and after hours as necessary.
- Staff identify themselves by name, title and organization name when initiating or returning calls regarding UM issues. IMCare provides a toll-free number and staff are available to accept collect calls regarding UM issues.
- IMCare offers 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 2019 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 2019, 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 QI/UM Director/s and Contract Compliance Officer daily. IMCare met all timelines for UM decisions in 2019.

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 2019.

Clinical Information and Interrater Reliability
The IMCare QI/UM 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 (M1)
- Reviewer request of information per policy (M2)
- Case handled within established standards (M3)
- Correct criteria set/policy used (M4)
- Nurse/physician apply criteria correctly (M5)
- Health care professional contacted by phone or fax within one working day (M6)

2019 Interventions:

- 2019 Utilization Management Criteria were reviewed/approved by the Provider Advisory Subcommittee (PAC) on 02/13/2019 and the External QI/UM Committee on 03/18/2019.
- InterQual criteria updates were loaded into CaseTrakker (authorization review system) as they became available, throughout 2019.
- CVS/Caremark drug criteria sets were updated in January of 2019, and as they became available thereafter.
- Monthly Utilization Management Operations Workgroup (UM Ops) were held 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 audited a total of 115 determinations with the following breakdown: Managed Care Nurses were audited on 90 determinations; Medical Director and Physician Consultant were audited on 25 determinations. In each measure, the Medical Director and Physician Consultant maintained the goal of 100%. The Managed Care Nurses met one of the six goals. The unmet areas ranged from 95.56% to 98.89%. The measure with the most discrepancies was application of criteria. There were fewer number of files reviewed as there were Managed Care Nurses vacancies throughout 2019, this resulted in more weighted shifts in the data.

Figure 41. 2017 – 2019 Managed Care Nurse Interrater Reliability Audit Results

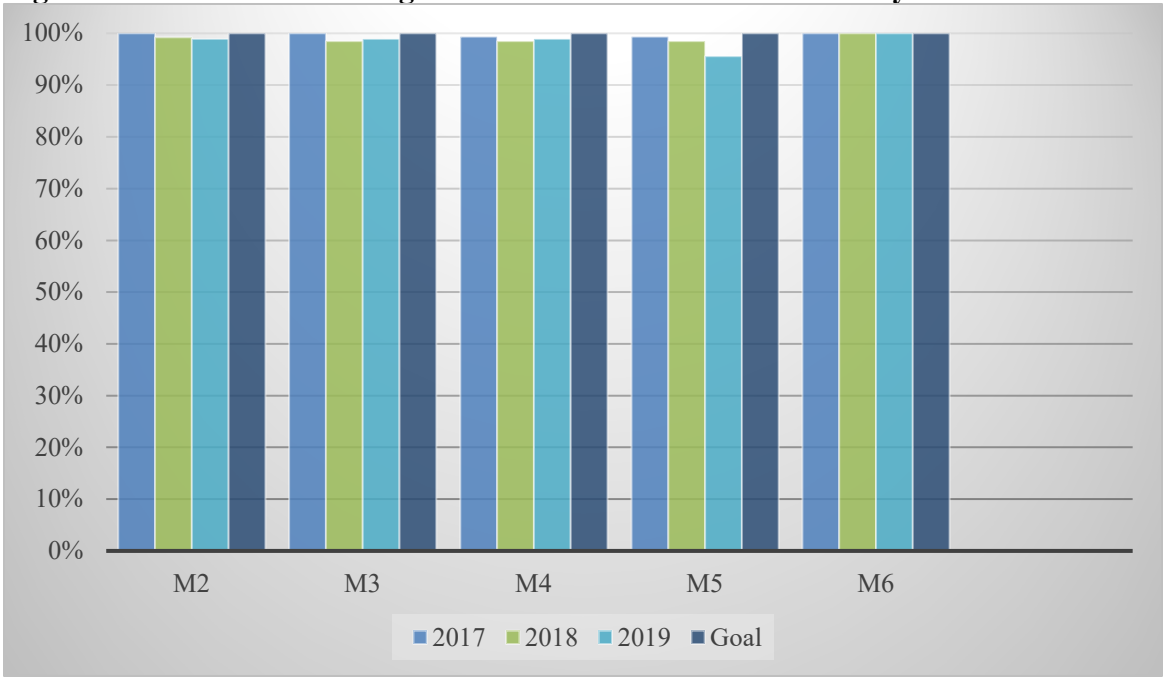
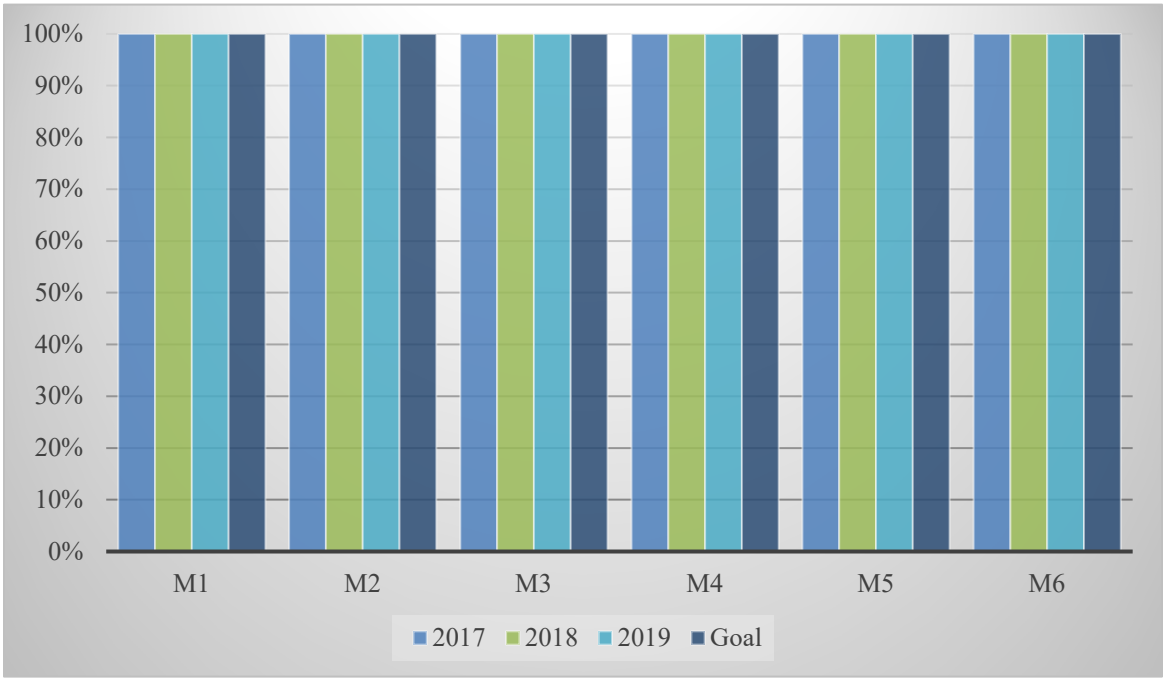


Figure 42. 2017-2019 Medical Director/Physician Consultant Interrater Reliability Audit Results



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

2019 Interventions:

- The Managed Care Nurses worked proactively with practitioners/practitioner staff on authorization requests to minimize lack of information denials.
- The 2018 DTR Report was reviewed/approved by the IMCare Provider Advisory Subcommittee (PAC) on 02/13/19 and the IMCare External Quality Improvement/Utilization Management (QI/UM) Committee on 03/20/19.
- Collaborated with DHS via DHS/MCO workgroup to address service code mapping. Purpose was to align all MCO's service code reporting.

In 2019, IMCare sent 543 DTR Notices of action. Consistent with previous years, a majority of the DTRs were for Service Authorization (86.9%). 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 Managed Care 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.

2019 Interventions:

- A weekly internal Appeals and Grievances Workgroup (Internal AG) continued to monitor, review, discuss and analyze appeal documentation and processes as needed
- An Enrollee Appeal and Grievance Form was developed and approved by MN DHS to facilitate enrollees putting their appeal in writing if they choose
- Advance Recipient Notice (ARN) provider update was developed and sent to all network providers on 02/04/2019, placed on provider portal Healthx and the ARN was placed on the IMCare website. The ARN notifies an enrollee when a provider is going to provide a service that is not covered and may be billed to the enrollee
- Continue to update the prior authorization list to streamline the process, and remove select authorization requirements
- Collaborated with DHS and claims vendor to identify mis-identification of service categories and update systems as necessary
- The 2018 Appeal Report was reviewed/approved by the IMCare Provider Advisory Subcommittee(PAC) on 02/13/19 and the IMCare External Quality Improvement/Utilization Management(QI/UM) Committee on 03/20/19.

In 2019, IMCare received 40 appeals due to billing & financial issues and 5 appeals related to services and/or benefits. Categories of service were:

- Restricted Recipient (1)
- Chiropractic (2)
- Dental (2)
- Emergency Room (2)
- Hospital (2)
- Mental Health (5)
- Pharmacy (1)
- Professional Medical Services (27)
- Transportation – Ambulance (2)
- Urgent Care (1)

Five Service Appeals
Provider appealed on behalf of an enrollee. The denial was for a medication that prohibited use of the medication per lifestyle choices. Provider submitted additional documentation and denial was overturned.

Enrollee appeal was due to an enrollee being placed in the restricted recipient program for mis-use of emergency room services. The enrollee's letter was considered by IMCare Medical Director along with initial documentation used for placement. The denial was upheld.

Provider appeal was for a denial of a procedure due to provider documentation not meeting continuity of care, IMCare access standards, free choice, or out of network criteria coverage. Additional documentation was provided showing the enrollee had previously established care

with provider prior to IMCare coverage and given the nature of the procedure the denial was overturned.

Provider appeal was due to a denial of an injection for failure of enrollee to complete course of physical therapy per InterQual criteria. Provider submitted documentation of completed physical therapy. The denial was overturned.

Enrollee appeal was due to a denial for no authorization for an out of network provider visit. No additional information was provided by enrollee. The denial was upheld.

IMCare participated in an MDH QA & TCA exam August 2018. This audit resulted in a deficiency in our Appeals and Grievance system. IMCare drafted a corrective action plan that was accepted by MDH in January 2019. IMCare collaborated with the DHS Ombudsman's office until DHS was satisfied with IMCare's appeal and grievance processes. IMCare took a number of actions to solidify their appeals and grievance identification and documentation in 2019 including establishing an internal appeal and grievance committee that reviews enrollee and provider contacts for missed appeal and grievance opportunities. Stated by both MDH and DHS it was determined that IMCare was previously addressing enrollee and provider issues but not documenting as appeals and grievances. IMCare is on trend for 2019 with other health plans in numbers of appeals and grievances.

IMCare has a thorough utilization review process that is reviewed regularly and adjusted as needed. An IMCare MCN 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 MCN 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, within compliance of the DHS PDL and management procedures. Pharmaceutical management procedures are communicated to providers via direct mail, e-mail, fax, and the IMCare website.

In 2019, Pharmaceutical and Pharmaceutical Management procedures were communicated to enrollees and prescribing practitioners. This information included co-payment information, prior authorization requirements, limits on refills, doses or prescriptions, use of generic substitutions, and covered pharmaceuticals. All information was available on the IMCare website as well.

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.

Contact Information

If you have questions or comments about any information contained in this report, please contact the IMCare QI/UM Director/s, Alexis Martire, at (218)327-6199, (800)843-9536 ext. 2199 email to alexis.martire@co.itasca.mn.us or Shelley McCauley, at (218)327-6180, (800-843-9536, ext. 2180 email shelley.mccauley@co.itasca.mn.us.