IMCare News

IMCare

Editor: Juli McNeil 218-327-6145

IMPORTANT INFORMATION ROUTE:

Administration_____
Business Office_____
Nursing Staff_____
Credentialing Staff_____
Providers (Physician, CNP, PA, Dentist)_____

ITASCA MEDICAL CARE
Itasca Resource Center
1219 SE 2nd Avenue
Grand Rapids, MN 55744

Member Service:
218-327-6188

Toll Free:
1-800-843-9536
www.imcare.org

TDD/TTY:
1-800-627-3529 or 711

Meeting Notices

Provider Advisory Subcommittee
Wednesday, February 10, 2021
7:30-9:00 a.m.

P&T Committee
Wednesday, February 17, 2021
7:30-9:00 a.m.

The IMCare Office will be closed on:

Thanksgiving
November 26-27, 2020

Christmas
December 24-25, 2020

New Year's Day
January 1, 2021

Martin Luther King Day
January 18, 2021

Presidents' Day
February 15, 2021

Inside this issue:

Reporting Fraud, Waste & Abuse

IMCare believes it is the responsibility of everyone to report suspected fraud, waste or abuse.
You can report anonymously by calling 1-866-269-0584.

Affirmative Statement

The purpose of IMCare's Prior Authorization process is to review services prior to being rendered to determine if the services are contractually eligible. Prior authorization is recommended for some services to help providers and members avoid unexpected expenses, benefit reductions, or claim denials.

The prior authorization process determines coverage for medically necessary services, supplies, or treatment. IMCare nurses and physicians make decisions based only on:

1. Appropriateness of care and service and existence of coverage.
2. IMCare does not reward physicians or other individuals for issuing denials of coverage or service care.
3. Financial incentives for Utilization Management (UM) decision makers do not encourage decisions that result in underutilization of services.

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Healthcare Directives

A healthcare directive is a written instruction, such as a living will or durable power of attorney, recognized under State law, relating to the provision of health care when the individual is incapacitated.

IMCare providers must:

- Ensure that it has been documented in an IMCare enrollee's medical records whether or not the individual has executed an advance directive.
- Not condition treatment or otherwise discriminate on the basis of whether an individual has executed a healthcare directive.
- Comply with State law on healthcare directives.

IMCare has added "documentation of healthcare directives" to our audit tool that we use for auditing IMCare enrollee's medical records. The auditors may also ask to view your Policies and Procedures as they pertain to healthcare directives.

For more information, refer to 42 CFR 489.100 through 489.104; Laws of Minnesota 1998, Chapter 399, section 38; and, 42 USC 1396a (a)(57).

IMCare Education Sessions Temporarily Canceled

Usually IMCare holds monthly meetings for enrollees to attend to learn how to use their medical identification card, how to get medical care and what services require prior authorization. Due to the coronavirus (COVID-19) and the mandate to social distance, these meetings have been temporarily canceled.

If you have a patient who has questions about their health care coverage with IMCare, please have them contact IMCare Member Services at 218-327-6188 or toll free 1-800-843-9536. They will gladly explain how IMCare works. Information can also be found on our website at www.imcare.org.

Stakeholders Advisory Committee

Do you have patients enrolled in IMCare that have concerns about overall access, services or barriers that affect many IMCare enrollees? The IMCare Stakeholder Advisory Committee meets two times per year, and as needed, to discuss these concerns and look for ways to improve in those areas.

If you know of an enrollee, or someone who represents them, that is interested in participating in this committee, they can email IMCareOffice@co.itasca.mn.us, or call Member Services at 218 327-6188 or toll free 1 800-843-9536. If you have a patient with concerns, but does not wish to join the committee, these concerns can be submitted in writing, by phone or email at any time during the year. Note this meeting focuses on overall issues that affect people on IMCare.

Medical Records Audit Results

Itasca Medical Care (IMCare) audited enrollee medical records to determine if providers were in compliance with regulatory requirements and National Committee for Quality Assurance (NCQA) standards. Additionally, IMCare ensured that medical records were maintained with timely, legible, and accurate documentation of patient information per IMCare's medical record documentation standard.

In 2020, IMCare audited a total of 221 medical records for the 2019 measurement year, with the following breakdown from the following high-volume primary care providers: Grand Itasca Clinic and Hospital, Fairview Hibbing, Fairview Nashwauk, Hibbing Family Medical Center, Essentia Health Deer River, Essentia Health Hibbing, Essentia Health Grand Rapids, and Scenic Rivers Bigfork. Overall, 81.6% of measures were met for the medical record audit, above the goal of 80%.

The audit utilized a structured tool with 34 measures under four categories with the overall scores:

- Record Format: 100%
- Basic Record Content: 77.73%
- Preventative Screening and Service: 76.35%
- Assessment, Plan and Follow-up: 98.25%

Measurements not meeting goal include:

Basic Record Content

- Enrollee demographic data includes preferred language, sex, race, ethnicity, and date of birth - 20.60% (41/99)
- Health Care Directives are documented in the medical record for those 18 years and older - 37.91% (69/182).

Preventive Screening and Services

- Tobacco cessation information was offered to enrollees who responded "yes" to previous question regarding tobacco use. 57.14% (16/28)
- For enrollees age 12 and over, Screening and Brief Intervention (SBI) to identify unhealthy substance use is conducted annually utilizing a standardized tool- 0.01% (1/178). This measure has been historically low, but is not going to require follow up from facilities for this audit cycle due to an error in the audit procedure, resulting in skewed data.

Each facility audited received individual follow-up letters with facility-based results.

If you would like a copy of the audit protocol and/or Health Record Documentation Standards, please contact IMCare.

Early Intensive Developmental and Behavioral Intervention Providers Needed!

According to the Department of Human Services (DHS), Minnesota currently lacks providers who are qualified to diagnose and treat people with Autism and related conditions. The current provider shortage affects all of Minnesota, particularly rural areas. DHS is looking to expand the Early Intensive Developmental and Behavioral Intervention (EIDBI) provider network. EIDBI services offer medically necessary treatment to people under the age of 21 on Medical Assistance (MA) with autism spectrum disorder (ASD) and related conditions. The purpose of the EIDBI benefit is to:

- Educate, train and support parents and families of people with ASD and related conditions
- Promote people's independence and participation in family, school and community life
- Improve long-term outcomes and quality of life for people and their families

EIDBI Provider Enrollment:

- To enroll as an EIDBI provider with MHCP, follow the instructions on the Early Intensive Developmental Behavioral Intervention (EIDBI) Provider Enrollment manual page.

EIDBI Provider Qualifications:

- See the EIDBI Policy Manual Overview of EIDBI Providers for complete provider qualifications.
- To learn more, take the FREE online training for EIDBI 101:
  - bit.ly/EIDBI-Families/
  - bit.ly/EIDBI-Providers
- **FREE online ASD Strategies in Action Training:** Early signs, core symptoms, and strategies to work or interact with people with ASD or related conditions.
  - https://autismcertificationcenter.org/families

How Enrollees Can Access EIDBI Services

EIDBI services are a covered benefit through IMCare. A person is eligible to receive EIDBI services if they meet all of the following criteria:

- Has been diagnosed with ASD or has risk factors for ASD, including but not limited to, prematurity, family history of ASD, presence of associated intellectual disability or language impairment or has been diagnosed with a related condition
- Has had a comprehensive multi-disciplinary evaluation (CMDE) that establishes their medical need for EIDBI services
- Is enrolled in Medical Assistance (MA), MinnesotaCare, Minnesota Tax Equity and Fiscal Responsibility Act (TEFRA) or other qualifying health care programs
- Is younger than age 21.

A CMDE determines eligibility for EIDBI services and can be shared by parents or legal guardians with other providers, educators, doctors, supports and resources.

How do I find a CMDE provider?
Anyone can make a referral to a CMDE provider. Contact providers on the list directly to learn more about their availability and the specific services they offer. To find a list of CMDE providers, go to the Minnesota Health Care Programs (MHCP) Provider Directory.

Follow these steps:

1. In the "Search for a Provider" box, select **"**Autism–Early Intensive Developmental and Behavioral
2. Intervention," then click "Next".
3. In the "Sub Type" field, select CMDE Assessments, then click "Search."

For more information see IMCare Provider Update 2020-34 on the IMCare Website at http://www.imcare.org/373/Provider-Updates

Compliance Program Requirements for First Tier Entities

(42 CFR § 422.503(b)(vi) and 42 CFR § 423.504(b)(vi))

Action You Must Take
An authorized representative from your organization must verify your compliance with the requirements listed above upon initial contracting (within 30 days) with IMCare and annually thereafter (by December 31st) by completing an Attestation of Compliance. To complete the attestation, go to: http://imcare.org/789/Compliance-Requirements

First Tier and Downstream Entities Defined
First Tier Entity – A party that enters into a written arrangement with Itasca Medical Care (IMCare) to provide administrative services or health care services to Medicare and Medical Assistance (Medicaid) eligible members.

Downstream Entity – A party that enters into a written agreement with a First Tier entity for the provision of administrative services or health care services to a Medicare and Medicaid-eligible member.

What are the Compliance Program Requirements?
All IMCare First Tier entities are required to comply with all applicable Federal and State laws and regulations to prevent, detect and correct fraud, waste and abuse and noncompliance in a timely and well-documented manner. Noncompliance may include inaccurate and untimely payment or delivery of items or medical services, complaints from members, illegal activities and unethical behavior. IMCare requires the implementation of a compliance program as a condition of contractual requirements. These requirements include the following:

- Distribute written compliance policies and procedures to workforce
- Distribute code of conduct to workforce
- Provide workforce with General Compliance Training and Fraud, Waste and Abuse training within 90 days of initial hire and annually thereafter
- Maintain a system to receive, respond to and track questions or reports of suspected or detected noncompliance or potential fraud, waste and/or abuse from employees and to IMCare
- Completing Office of Inspector General (OIG) and General Services Administration's System for Award Management (SAM) exclusion screenings
- Reporting and requesting the use of offshore operations
- Monitoring and auditing First Tier, Downstream and related entities that provide administrative or health care services to IMCare members to ensure they comply with all requirements (e.g., training, exclusion screening, etc.) and any applicable laws, rules and regulations
- Operational oversight – conducting internal oversight of the services performed for IMCare to ensure that compliance is maintained with applicable laws, rules and regulations
- Retain documentation of all compliance/training efforts

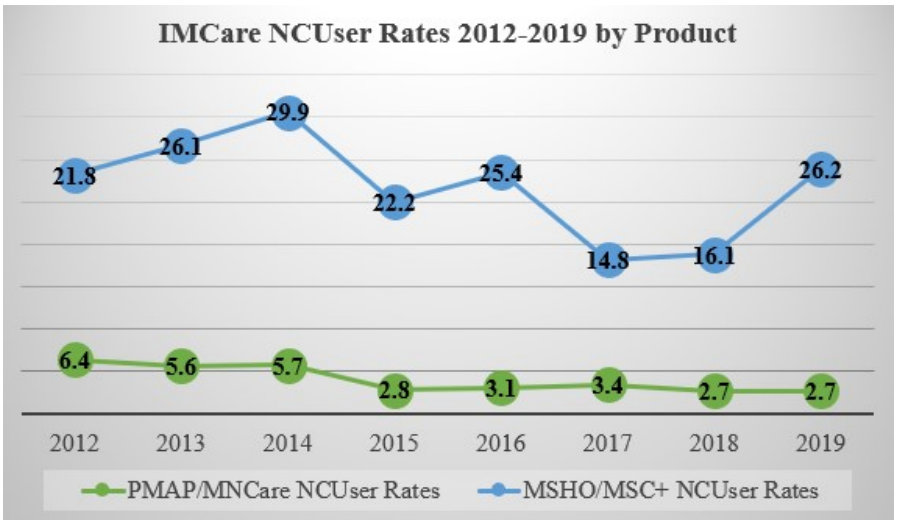
Administrative services include, but are not limited to, the following:

- Member and provider services
- Membership functions
- Utilization Management
- Claims Administration, processing and coverage adjudication
- Pharmacy benefits manager
- Hotline operations
- Bid preparation
- Licensing and credentialing

Documentation Requirements
You must maintain documentation of your compliance according to Federal regulations, which is no less than 10 years. You may be required to produce evidence that you comply with the above requirements. Failure to produce this evidence may result in contractual remedies such as corrective action plan, and up to contract termination.

2018-2020 Itasca Medical Care Opioid Projects

IMCare implemented two different quality projects related to opioids in 2018. Both projects aimed at reducing the number of New Chronic Opioid Users (NCUs), as defined by the Department of Human Services (DHS) Opioid Prescribing Workgroup as individuals who have not filled an opioid for the last 90 days and then fill a 21-day supply (in single or divided fills).



The **Opioid Performance Improvement Project** applies to individual's ages 12-64 enrolled in Itasca Medical Care; those with select cancer diagnosis or on Hospice are excluded. The most recent NCUser rates received from DHS show an IMCare rate of 3.1% (27/883) for 2016 (baseline measurement). The 2019 IMCare NCUser rate was 2.7% (17/640), meeting the goal of an overall decrease in the rate by contract year 2019. IMCare will continue to provide enrollees, providers and pharmacists with education and resources to reduce chronic opioid use, when appropriate. Opioid UM edits in place throughout the course of the project include the following:

- Initial opioid fills are limited to seven days for individuals who have not filled an opioid in the last 90 days
- Opioid fills are limited to 90 Morphine Milligram Equivalents/day based on 30-day supply
- Step Therapy requirement for the use of extended-release opioids; must use immediate release first

The **Opioid Quality Improvement Project** applies to individuals over 65 enrolled in Itasca Medical Care; those with select cancer diagnosis or on Hospice are excluded. The most recent NCUser rates received from DHS show an IMCare rate of of 26.2 % (17/65). The rate increased from the 2018 NCUser rate of 16.1% (10/62). The total number of NCUsers increased by seven enrollees and goal was not met. The OPQIP for the IMCare MSHO/MSC+ 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 Point of Sale Drug Utilization Reports support this conclusion as well. IMCare will continue to provide enrollees, providers and pharmacists with education and resources to reduce chronic opioid use, when appropriate. Additionally, IMCare will continue to utilize different safety monitoring of pharmacy claims to identify areas for improvement and promote safety for enrollees. UM edits at the pharmacy in throughout the course of the project include the following:

- Hard reject at the point of sale for enrollees who have been prescribed opioids with >90 MME/day
- Soft reject (pharmacist can bypass) for duplicate long-acting opioid treatments
- Initial opioid fill limited to seven days for individuals who have not filled an opioid in the last 90 days, this will require PA to bypass.

Opioid Prescribing

Current IMCare Medicaid Formulary opioid utilization management edits include:

- First fill limited to 7 days (opioid naïve for past 90 days)
- 90 morphine milligram equivalent (MME)/day limit
- Required use of immediate-release before extended-release formulations

Prior authorization is required to override these edits. IMCare uses the following resources when reviewing these prior authorization requests:

- Evidence-based practice guidelines
- Minnesota Opioid Prescribing Improvement Program recommendations[1]
- Centers for Disease Control and Prevention (CDC) Guideline for Prescribing Opioids for Chronic Pain[2]

These guidelines include the following recommendations:

- For acute pain (one to four days after a severe injury or a severe medical condition and up to seven days following a major surgical procedure or trauma), the initial prescription should be[1]:
  - Less than 100 MME (total, not per day) of short-acting opioids for most acute pain scenarios.
  - Less than 200 MME total of short-acting opioids following extensive surgical procedures or major traumatic injury, but certain surgical procedures may require more.
- For post-acute pain (between four and 45 days following a severe injury, severe medical condition, or a major surgical procedure or trauma) [1]:
  - Opioids should be prescribed in multiples of seven days, with no more than 200 MME/7 days.
  - Opioid prescribing should be consistent with expected tissue healing, with expected tapering.
  - Avoid prescribing in excess of 700 MME (cumulative) in order to reduce the risk of chronic opioid use and other opioid-related harms.
- For chronic opioid prescribing[2]:
  - Document the anticipated length of use and treatment plan at every visit.
  - Document other medications/modalities for pain management that have been tried.
  - Avoid concurrent controlled substances (e.g., benzodiazepines).
  - Require face-to-face visits at least every 3 months.
  - Document review of the MN Prescription Monitoring Program (PMP) at every visit.
  - Complete random urine drug screens every 3-6 months.
  - Maintain a current chronic pain contract.
  - Carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥50 MME/day.
  - Avoid increasing dosage to ≥90 MME/day.
  - Consider referral to a chronic pain program if >90 MME/day.
  - Consider opioid tapers every 3 months and document outcomes.

Please review and follow these practice guidelines.

[1]https://mn.gov/dhs/opip/
[2]https://www.cdc.gov/drugoverdose/prescribing/guideline.html

Minnesota Provider Screening and Enrollment (MPSE) Portal

The Minnesota Provider Screening and Enrollment (MPSE) portal is a new web-based application that allows providers to submit and manage their Minnesota Health Care Programs (MHCP) provider enrollment records and related requests online. This will eliminate the need for providers to submit paper enrollment requests. It is an easy to use, interactive, on-line tool that streamlines the process and gives you real-time responses. Please see the below links for additional information.

MPSE webpage:
https://mn.gov/dhs/partners-and-providers/policies-procedures/minnesota-health-care-programs/provider/mpse/

MHCP Provider Manual Provider Basics (includes a section on enrollment and Managed Care Organizations):
https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS16_147613

MHCP Provider Manual - Enrollment with MHCP (includes a list of all eligible provider types):
https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=ENROLL-HOME

MPSE Training webpage:
https://mn.gov/dhs/partners-and-providers/training-conferences/minnesota-health-care-programs/provider-training/mpse-portal-training.jsp

MPSE User Manual:
https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=MPSE-HOME

Provider News and Updates (where we post current provider news):
https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/minnesota-health-care-programs/provider-news/

MHCP Provider Call Center (for any questions providers might have about MPSE or MHCP):
https://mn.gov/dhs/partners-and-providers/contact-us/minnesota-health-care-programs/providers/

MN-ITS Log In Page (MPSE Link is located on this page under “MN-ITS Administration”):
https://mn-its.dhs.state.mn.us/GatewayWebUnprotected/index.faces

Billing the IMCare Member

IMCare recently sent a provider update regarding limited instances when it is acceptable to bill an IMCare member. It is available on our website under our Providers & Partners Page. In order to prevent misunderstandings and un-necessary provider write-offs please follow the guidance below.

IMCare allows a limited number of instances when you can bill a member for services you provided. These instances include:

1. Non-covered services (only if you inform the member in writing before you deliver the services that he/she would be responsible for payment) Providers may use the DHS forms listed below to notify members of non-covered services. Providers should complete the form according to the instructions and include the member's signature on the form.
2. Retroactive eligibility
3. EW waiver obligations (may not be billed/charged in advance - must be after the claim adjustment by IMCare)
4. Copays - Federally funded Medical Assistance (Medicaid) members are protected from denial of service based on inability to pay as long as they inform the provider that they are unable to pay the copay. Providers must continue to accept their assertion of inability to pay. Other State-funded Medical Assistance (Medicaid) programs are not affected by the Federal statute.

Non-Covered Services

You may bill a member for non-covered services only when IMCare never covers the services, and only if you inform the member before you deliver the services that he/she will be responsible for payment. Providers should use a written notification form that includes the service in question, the current date and DOS (if different), cost of the services, any other pertinent information, and the member's signature attesting that he/she understands that he/she may be billed. If IMCare normally covers a service, but the member does not meet coverage criteria at the time of the service, the provider cannot charge the member and cannot accept payment from the member.

You should have office procedures in place to prevent misunderstandings about whether or not you properly informed a member about a non-covered service and the cost of the health service.

a. ***Advance Recipient Notice of Non-Covered Service/Item*** **(DHS-3640)** - https://edocs.dhs.state.mn.us/lfserver/Public/DHS-3640-ENG
b. ***Advance Recipient Notice of Non-Covered Prescription*** **(DHS-3641)** - https://edocs.dhs.state.mn.us/lfserver/Public/DHS-3641-ENG

For any questions please contact the
IMCare Compliance Coordinator at 218-327-6183
or by email at IMCareCompliance@co.itasca.mn.us

Claims Timely Filing Requirements Reminder

IMCare requires that claims be submitted correctly and received by IMCare no later than 180 days from the date of service. IMCare does allow Medicare claims to be submitted and received by IMCare no later than 365 days from the date of service, per Medicare rules. Medicare and TPL claims must be received within 180 days of payment resolution with the primary payer.

2020 Behavioral Health Treatment Records 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.

IMCare audited a total of 144 BH records at eleven BH clinics, with an overall average of 78.85%, below the 80% goal. All BH provider clinics audited in 2019 (2018) data, received a post audit letter identifying specific elements not meeting 80% goal, in addition to another copy of the audit tool to review for required standards. Despite this intervention, there were unmet elements in the 2020 audit as well. The audit elements and standards are directly related to statutory, DHS, and National Committee for Quality Assurance (NCQI) criteria. Areas consistently identified as not meeting include:

B. RECORD CONTENT

1. Member demographic data includes preferred language, sex, race, ethnicity, and date of birth

⇒ Member demographic data are documented in a prominent location in each health record and includes the member's preferred language, sex, race, ethnicity, age and date of birth. Documentation also includes whether a member declines to specify race, ethnicity, and/or a preferred language. **This standard applies to clinics using electronic health record (EHR).**

- ◊ 45 CFR 170.207 (f) (g)
- ◊ 45 CFR 170.314 (a) (3)

***If any demographic data is missing, it is unmet.**

C. ASSESSMENT

3. Type of diagnostic assessment is documented. (Brief, standard, and extended diagnostic assessments)

⇒ A description of which type of diagnostic assessment being conducted is documented to include either brief diagnostic assessment, standard diagnostic assessment, extended diagnostic assessment, or adult diagnostic assessment update. This standard applies to all diagnostic assessments.

6. Health history and family health history are documented. (Standard, and extended diagnostic assessments)

⇒ A health history that includes current and/or past major or chronic medical conditions, chemical use, serious accidents, operations, and illnesses. A family health history including physical, chemical, and mental health history is documented. All history of note, that affects member's genetic predisposition to potential physical and mental health issues is documented. This standard applies to standard and extended diagnostic assessments.

2020 Behavioral Health Treatment Records Audit Continued

7. Documentation of current medications, medication allergies and adverse reactions are prominently noted in the mental health record. (Standard, and extended diagnostic assessments)

⇒ Documentation of current medications, the presence of medication allergies, including adverse reactions, consistently and clearly documented in a prominent location of all mental health records. If the member has no medications or known allergies this is also prominently noted in the mental health record. Allergies to environmental allergens, food, pets, etc., noted. This standard applies to standard and extended diagnostic assessments.

9. Cultural influences and their impact on the member are documented. (Brief, standard, and extended diagnostic assessments)

⇒ Cultural influences and their impact on the member are documented. Issues of race, class, social- economic and geographical aspects of the member's life and how they impact current functioning, should be noted. Cultural influences mean historical, geographical, and familial factors that affect assessment and intervention processes. This standard applies to brief, standard and extended diagnostic assessments.

13. Member strengths and resources are documented. (Brief, standard, and extended diagnostic assessments)

⇒ Member strengths and resources, including the extent and quality of social networks, belief systems, and contextual non-personal factors contributing to the member's presenting concerns must be documented in the diagnostic assessment. This standard applies to brief, standard, and extended diagnostic assessments. There should be consideration of member strengths and resources in the development of the treatment plan. The treatment plan notes detail member strengths and resources in achieving treatment plan goals.

14. A clinical summary and provisional clinical hypothesis are documented. (Brief diagnostic assessments)

⇒ There is documentation of a clinical summary that explains the provisional diagnostic hypothesis. The clinical hypothesis may be used to address the member's immediate needs or presenting problems. A provisional diagnostic hypothesis should include aspects of the following that are known at this time: The clinician's formulation of the cause of the client's mental health symptoms, the client's prognosis, and the likely consequences of the symptoms; how the client meets criteria for the diagnosis by describing the client's symptoms, the duration of symptoms, and functional impairment; an analysis of the client's other symptoms, strengths, relationships, life situations, cultural influences, and health concerns and their potential interaction with the diagnosis and formulation of the client's mental health condition; and alternative diagnoses that were considered and ruled out. This standard applies to brief diagnostic assessments only.

*** This Assessment is directly related to the Diagnostic Assessment, and clearly identifies which assessments require this documentation. It is also important to note that any unmet measures within the assessment section (C: Assessment) in future audits may result in further review of diagnostic assessments completed by your agency. Diagnostic assessments not meeting the required DHS components will be reviewed for potential payment takeback. A memo was sent providing education on the topic of diagnostic assessments in June 2018. This is an important issue, aimed at reducing waste and preventing a delay in services for IMCare enrollees.**

Disclosure of Ownership and Control Interest

IMCare Providers must agree to comply with the requirements of 42 CFR § 455.104, which includes:

a) Disclosing entities must provide the following disclosures:
   i) The name and address of any person (individual or corporation) with an ownership or control interest in the disclosing entity. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.
   ii) Date of birth, and Social Security Number (in the case of an individual).
   iii) Other tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has a 5 percent or more interest.
b) Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity has a 5 percent or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child or sibling.
c) The name of any other organization or disclosing entity in which a person with an ownership or control interest in the disclosing entity also has an ownership or control interest.
d) The name, address, date of birth and Social Security Number of any managing employee of the disclosing entity.
e) When the disclosures must be provided:
   i) Upon the provider or disclosing entity submitting the provider application.
   ii) Upon the provider or disclosing entity executing the provider agreement.
   iii) Within 35 days after any change in ownership or the disclosing entity.
f) Consequences for failure to provide required disclosures:
   i) Federal financial participation (FFP) is not available in payments made to a disclosing entity that fails to disclose ownership or control information.

Providers are responsible for disclosing up-to-date information to IMCare when there are changes. The *Ownership and Control Interest Disclosure Statement* form is available at: http://imcare.org/DocumentCenter/View/467/Ownership-and-Control-Interest-Disclosure-Statement-PDF, and can be faxed to 218-327-5545 attention Laura Grover, or emailed to laura.grover@co.itasca.mn.us.

E-Visits

Effective 8/1/2020 IMCare will cover e-visits until the end of the COVID-19 pandemic peacetime emergency, or as determined by the state of Minnesota. E-visits are intended to discuss, diagnose and treat conditions with which the provider is comfortable not seeing the patient face-to-face, and which do not require immediate use of laboratory tests or radiology. E-visits are an in-network benefit. Providers must be contracted with IMCare and are subject to all contract provisions that apply to quality management and oversight.

The e-visit provider is prohibited from billing or charging a fee to the enrollee; no cost-sharing is applicable. For MinnesotaCare, facility fees are not applicable.

For more information on E-visits refer to IMCare Provider Update 2020-33 on the IMCare website http://www.imcare.org/373/Provider-Updates.

Provider Availability & Network Adequacy

IMCare ensures the availability of providers 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).

Primary Care

Goals:

- One Primary Care Provider to every 1000 enrollees.
- One Primary Care Physician with admitting privileges to every 1000 enrollees.
- One Primary Care Provider within 30 miles of enrollee residences.
- One Primary Care Physician with admitting privileges within 30 miles of enrollee residences.
- Preventive Care Visits within three weeks of request.
- Routine Care Visits within two weeks of request.
- Urgent Care Visits within same day or within 24 hours of request.

Outcome:
IMCare meets established primary care access standards and appointment timeframes. Primary care access analysis indicates consistent enrollee access to primary care providers within 30 miles of enrollee residences, however there are nine households that are not within 30 miles of a primary care physician with admitting privileges.

Behavioral Health Care

Goals:

- A ratio of one provider to 2000 enrollees for Substance Use Disorder Providers, Mental Health Advanced Practice Nurses and Psychiatrists.
- A ratio of one provider to 1000 enrollees for Licensed Professional Clinical Counselors, Licensed Psychologists, Licensed Social Workers, and Marriage/Family Therapists.
- A Mental Health Provider, both prescribing and non-prescribing within 30 miles of enrollee residences.
- A Substance Use Provider within 60 miles of enrollee residences.
- A Routine appointment within ten business days for initial visit for routine care.
- Urgent appointment within 48 hours.
- Emergent appointment within six hours for non-life-threatening emergency.
- Follow-up appointment within eight weeks.

Outcome:
IMCare meets all provider/member ratio goals for mental health providers, except for psychiatrists. IMCare meets all appointment availability timelines. IMCare does not meet established availability standards for mental health services. Ten households in northwest Itasca County did not have access to a mental health provider within 30 miles. IMCare meets established SUD access standards for both outpatient and inpatient services. SUD access analysis indicates consistent enrollee access to chemical dependency providers for outpatient and inpatient services within 60 miles of enrollee residences.

Provider Availability & Network Adequacy Continued

Ancillary Service Providers, Pharmacies and Hospitals

Goals:

- A ratio of one provider/facility to every 1000 enrollees for Chiropractor, Dentist, Optometrist, and Pharmacy provider types.
- A ratio of one Hospital to every 2000 Enrollees.
- Chiropractor, Dentist, Optometrist, and Pharmacy within 60 miles of every enrollee residences.
- Hospital within 30 minutes of enrollee residences.
- Routine - within 60 business days.
- Urgent - within 48 hours.

Outcome:
IMCare meets established chiropractic, dental and optometry access standards and appointment availability timeframes. Ancillary Service Providers access analysis indicates consistent enrollee access to these provider types within 60 miles of enrollee residences. IMCare meets established pharmacy access standards. Eight 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.

IMCare Numbers

General IMCare Numbers	Administration
Member Services 218-327-6188	Sarah Anderson, Director, CEO..... 218-327-6789
Fax 218-327-5545	Alexis Martire, UM Director 218-327-6199
Toll Free 1-800-843-9536	Shelley McCauley, Quality Director..... 218-327-6180
TDD.....1-800-627-3529	Celeste Tarbuck, Claims Supervisor..... 218-327-6118
Fraud Hotline.....1-866-269-0584	Dr. Shara Pehl, Medical Director..... 218-327-5520
	Dr. Jeffrey Bolz, Dental Director..... 218-327-5531
Authorization & Medication Reviews Case Management under age 65, Population Health Alpha split by member's last name	**Claims Processing, Other Insurance Provider Relations Alpha split by member's last name**
Peggy Rosik ..... A-C 218-327-5519	Vacant ..... A-D.....218-327-6133
Rachel Kerr ..... D-H 218-327-6728	Annie Caldwell ..... E-H 218-327-5528
Jacqueline Flatley..... I-M 218-327-5533	Billie Fowler ..... I-L.....218-327-6797
Amber Silliman ..... N-R 218-327-6754	Terasa Anderson ..... M-R 218-327-5529
Robbie Hansen ..... S-Z 218-327-5591	Carrie Whitman ..... S-Z.....218-327-5527
Care Coordination age 65 and over Alpha split by member's last name Elderly Waiver Call Public Health - 218-327-2941	IMCare **Itasca Medical Care 1219 SE 2nd Avenue Grand Rapids, MN 55744 www.imcare.org**
Mona Peterson ..... A-Z 218-327-6163	
Vacant..... 218-327-5516	