State of Nevada

Division of Health Care Financing and Policy

FY 2014-2015 Compliance Review
of
McKesson Technologies, Inc.

March 2015

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FY 2014-2015 Compliance Review Summary
for **McKesson Technologies, Inc.**

Executive Summary

In February 2012, the State of Nevada Department of Health and Human Services, Division of Health Care Financing and Policy (DHCFP) issued a Request for Proposal (RFP) to contract with a Care Management Organization (CMO) to administer care management services to Nevada Comprehensive Care Waiver (NCCW) program enrollees. The NCCW program mandates care management services throughout the State for a subset of high-cost, high-need beneficiaries not served by the existing managed care organizations (MCOs).

The DHCFP awarded a contract to **McKesson Health Solutions**, which later changed its name to **McKesson Technologies, Inc.** (**McKesson**), to serve as the State's CMO. The contract took effect November 12, 2013, and **McKesson** implemented the Nevada Health Care Guidance Program (HCGP) with a program start date of June 1, 2014. The first day of **McKesson**'s operations, however, was Monday June 2, 2014. DHCFP requested its External Quality Review Organization (EQRO), Health Services Advisory Group (HSAG), to conduct an interim assessment of McKesson's compliance with its contract six months after **McKesson**'s CMO operations began in June 2014. The purpose of the fiscal year (FY) 2014-2015 Compliance Review was to verify that **McKesson** had operationalized key elements of the program once services commenced. HSAG conducted an on-site compliance review of **McKesson**'s HCGP on December 10–11, 2014.

HSAG performed the compliance review in two-phases. Phase I focused on the operational structure of key areas of the program and consisted of a desk review of documentation. Phase II of the compliance review consisted of a two-day on-site review, which occurred on December 10–11, 2014 in the **McKesson** Carson City, Nevada office.

Two months prior to the on-site review, HSAG submitted a data request to **McKesson** to provide HSAG with program information and data files used for the desk review and on-site review. HSAG reviewed all documentation submitted by **McKesson** prior to the on-site review, which included:

- **Questionnaire** – used to collect additional information about **McKesson**'s operational structure, number and type of staff designated to the Nevada HCGP, and enrollment counts by risk category, as well as the number and types of care management interventions that occurred during the review period (June 1 – October 31, 2014)
- **Completed compliance review standards tool** – wherein **McKesson** listed all of the documents and information it offered as evidence of compliance with each element for each of the 12 standards reviewed
- **Care management data file** – using the file layout specified by HSAG, **McKesson** listed the demographic information, dates of enrollment, dates of assessment, date the treatment plans were developed, and primary and secondary diagnoses of each individual who had been enrolled and assessed for care management services as of October 31, 2014

- **Grievance data file** – using the file layout specified by HSAG, **McKesson** listed all of the grievances filed by enrollees as of October 31, 2014

For the purposes of this report, HSAG uses the following definitions:

- **Enrolled person** – a person who meets the eligibility criteria for the program and has been identified through **McKesson**'s risk stratification process as someone who would benefit from the HCGP
- **Served person** – a person who meets the eligibility criteria, is enrolled in the HCGP, and has completed a health risk assessment and care management plan with a **McKesson** care manager

McKesson's completed Questionnaire showed that 39,543 persons were enrolled in the program as of October 31, 2014. The care management file submitted by **McKesson** showed that of the 39,543 persons enrolled in the program, **McKesson** completed an assessment and a care management plan for 1,828 persons, or 4.6 percent of the enrolled population. Of the 1,828 persons served, **McKesson** stratified enrollees into the following care management categories: 83 persons in complex care (4.5 percent), 451 in the high category (24.7 percent), 738 in the moderate category (40.4 percent), and 556 in the low category (30.4 percent).

The on-site compliance review included a review of 12 standards, which were based on the requirements of **McKesson**'s contract with the DHCFP. Some of the elements contained in each standard were part of the readiness review; however, most the elements contained in the standards could not be assessed prior to the program start date, which is why they were included in the compliance review. Table 1 below lists each of the standards reviewed.

Table 1—Compliance Review Standards

Standard	Standard Name
I	Stratification of Enrollees
II	Care Management Teams
III	Care Planning
IV	Mental Health Care Management Services
V	Health Education Materials
VI	Nurse Triage and Call Services
VII	Emergency Department Redirection
VIII	Stakeholder Outreach and Education
IX	Feedback to PCPs
X	Provider Services
XI	Care Transitions
XII	Operational Structure and Reporting

Overall, **McKesson** received a composite score of 84.6 percent. Of the 12 standards reviewed, **McKesson** met all of the elements for the following 5 standards: Care Management Teams, Mental Health Care Management Services, Health Education Materials, Emergency Department Redirection, and Stakeholder Outreach and Education. **McKesson** received a ***Partially Met*** for one

or more elements contained in 7 of the 12 standards reviewed, which included: Stratification of Enrollees, Care Planning, Nurse Triage and Call Services, Feedback to Primary Care Providers (PCPs), Provider Services, Care Transitions, and Operational Structure and Reporting.

Since care management activities have the potential to positively impact the quality of services as well as health outcomes, enrollees benefit from early identification, enrollment, assessment, and receipt of care management services. HSAG used the care management data file submitted by **McKesson** to calculate the average length of time between the date of enrollment in the program and the date an assessment was performed. During the on-site review, HSAG reviewers discussed with **McKesson** staff the length of time between the date a person was enrolled in the program and the date care needs were assessed. On average, there were 72 days between the date of enrollment and the date of assessment by **McKesson** care managers.

In the case of pregnant enrollees, the pregnancy is time-limited so the window available to provide effective care management interventions during the gestation period is limited. In some cases, more than 110 days passed between the date the pregnant woman was enrolled in the program and the date her needs were assessed. In one of the 20 files reviewed, HSAG reviewers found that the woman was assessed 154 days after being identified and enrolled in the program and she had already given birth by the date of her assessment.

During both the Readiness Review and the Compliance Review, HSAG found the quality of staff proposed for the program to be consistent with contractual requirements. Further, HSAG found that **McKesson** maintained appropriate written descriptions for developing and operating multidisciplinary care management teams. The quantity of staff designated to the program, however, was inconsistent with care manager-to-enrollee ratios proposed by **McKesson**, given the number of persons enrolled in the program (39,543). Based on the anticipated staffing need for the HCGP noted in Table 8 (63.11 FTEs) and the number of staff designated by **McKesson** for the HCGP (24.1 FTEs), the anticipated shortfall in staffing is 39.01 FTEs.

HSAG used the care management enrollment file to select 20 cases to be included in the care management file review. When reviewing care management files, HSAG reviewers noted that **McKesson** documented most of the elements required by its contract with DHCFP. After **McKesson** completed the initial assessment and care management plan, **McKesson's** electronic care management system, VITAL, generated a copy of the care management plan and faxed it to the PCP, in most cases. The elements related to ongoing care management required the CMO to document evidence of ongoing communication with the enrollee and his/her PCP. **McKesson** documented its communication with the enrollee. Although **McKesson** documented an enrollee's noncompliance with the care management plan and **McKesson**'s inability to reach the enrollee after an assessment was performed, the documentation, in many instances, did not show that either concern was communicated to the enrollee's PCP.

HSAG used the grievance file submitted by **McKesson** to select 10 cases to be included in the grievance file review. The results of the grievance file review showed that **McKesson** staff verbally acknowledged receipt of the grievance during the initial call from the enrollee, and staff members with appropriate expertise handled the grievances. HSAG reviewers found that all notes concerning

the investigation and resolution of the grievances were not documented in the grievance files, and many times the grievance file did not contain the date the grievance was resolved.

The complete findings of the compliance review and associated recommendations are contained within the sections that follow and Attachments to this report. To remedy any deficiencies, **McKesson** must submit a corrective action plan (CAP) to the DHCFP **within 21 days of receiving this report**. The DHCFP maintains ultimate authority for approving or disapproving any corrective action strategies proposed by **McKesson** in its submitted CAP.

Background

On April 24, 2012, the State of Nevada Department of Health and Human Services, Division of Health Care Financing and Policy (the DHCFP) submitted to the Centers for Medicare and Medicaid Services (CMS) a Medicaid section 1115 Research and Demonstration proposal entitled the Nevada Comprehensive Care Waiver (NCCW). The NCCW program is a comprehensive demonstration that seeks to improve the value of the Medicaid delivery system and assist the DHCFP in reaching its goal to expand enrollment of a target population into a managed Fee-for-Service (FFS) system.

In February 2012, the DHCFP issued a Request for Proposal (RFP) to contract with a vendor (herein referred to as the "Care Management Organization" or "CMO") to administer care management services to NCCW program enrollees. The NCCW program mandates care management services throughout the State for a subset of high-cost, high-need beneficiaries not served by the existing managed care organizations (MCOs). The CMO supports improved quality of care, which is expected to generate savings/efficiencies for the Medicaid program. Enrollment in the CMO is mandatory for demonstration-eligible, fee-for-service Medicaid beneficiaries with qualifying health conditions. Enrollment in the CMO is optional for the qualifying American Indian/Alaska Native (AI/AN) population. Children's Health Insurance Program (Nevada Check Up) recipients also are excluded from the CMO.

After conducting an evaluation of all proposals, the DHCFP awarded a contract to **McKesson Health Solutions**, which later was changed its name to **McKesson Technologies, Inc.** (**McKesson**). The contract took effect November 12, 2013. **McKesson** implemented the Nevada Health Care Guidance Program (HCGP) with a program start date of June 1, 2014.

Operational Readiness and Compliance Reviews

There are a number of core functions, roles, activities, and responsibilities that are integral to the success of a care management program. To assess the operational readiness of the CMO, DHCFP requested its External Quality Review Organization (EQRO), Health Services Advisory Group (HSAG), to conduct a readiness review of the CMO prior to the CMO enrolling individuals. The purpose of the readiness review was to verify that the CMO had an appropriate operational structure to oversee the coordination of Medicaid services to program participants and meet the structural, operational, and administrative requirements of the contract. HSAG conducted the readiness review in March 2014 and provided feedback to the DHCFP and **McKesson** regarding the types of corrections that were to be made in order to satisfy all requirements of the readiness review. **McKesson** was required to work with DHCFP staff to remediate any areas of concern that were discovered during the readiness review. At the time of the FY 2015 Compliance Review, there were several items that remained outstanding from the FY 2014 Readiness Review that had not been remedied by **McKesson.**

DHCFP requested that HSAG conduct an interim assessment of **McKesson**'s compliance with its contract within six months of **McKesson**'s program start date in June 2014. HSAG conducted a compliance review of **McKesson**'s HCGP December 10–11, 2014. The purpose of the FY 2014–

2015 Compliance Review was to verify that **McKesson** had operationalized key elements of the program once services commenced on June 1, 2014. The FY 2014–2015 Compliance Review enabled HSAG to review elements that could not be reviewed during the March 2014 readiness review because the program had not yet begun. The period of time under review (review period) was June 1, 2014 through October 31, 2014.

Methodology for Conducting the Compliance Review

HSAG performed the FY 2015 Compliance Review in two-phases. Phase I focused on the operational structure of key areas of the program and consisted of a desk review of documentation and information supplied by **McKesson**. Phase II of the compliance review consisted of a two-day on-site review, which occurred December 10–11, 2014 in the **McKesson** Carson City, Nevada office.

On October 8, 2014, HSAG submitted a data request to **McKesson** to provide HSAG with program information and data files so HSAG may prepare for the review. HSAG reviewed all documentation submitted by **McKesson** prior to the on-site review. **McKesson** uploaded the following information to HSAG's secure FTP site by November 7, 2014, which was the required due date:

- **Questionnaire** – used to collect additional information about **McKesson**'s operational structure, number and type of staff designated to the Nevada HCGP, and counts of persons enrolled in the program by risk category, as well as the number and types of care management interventions that occurred during the review period (June 1 – October 31, 2014)
- **Completed compliance review standards tool** – wherein **McKesson** listed the all of the documents it offered as evidence of compliance with each element for each standard
- **Care management data file** – using the file layout specified by HSAG, **McKesson** listed the demographic information, dates of enrollment, dates of assessment, date the treatment plan was developed, and primary and secondary diagnoses of each individual who had been enrolled and assessed for care management services as of October 31, 2014
- **Grievance data file** – using the file layout specified by HSAG, **McKesson** listed all of the grievances filed by enrollees as of October 31, 2014

Phase I Review Tools and Activities

Phase I consisted of a desk-review of **McKesson**'s completed Questionnaire, policies and procedures, reports, guidelines, and other documentation that demonstrated compliance with contractual elements within the Compliance Review Standards tool. The completed Questionnaire allowed HSAG to obtain additional information about **McKesson** and its operational structure. The Questionnaire was not scored.

Review of Compliance with Standards

The **Compliance Review Standards tool** (Attachment A) included 12 standards, which were based on the requirements of **McKesson**'s contract with the DHCFP. Table 2, on the following page, lists each of the standards contained in the Compliance Review Standards tool.

Table 2—Compliance Review Standards	
Standard	Standard Name
I	Stratification of Enrollees
II	Care Management Teams
III	Care Planning
IV	Mental Health Care Management Services
V	Health Education Materials
VI	Nurse Triage and Call Services
VII	Emergency Department Redirection
VIII	Stakeholder Outreach and Education
IX	Feedback to PCPs
X	Provider Services
XI	Care Transitions
XII	Operational Structure and Reporting

HSAG used the Compliance Review Standards tool (Attachment A) to record the findings from the review of **McKesson** documentation and interviews with key staff during the on-site review. Within the review tool, **McKesson** completed the column labeled, *Information Submitted as Evidence by McKesson*, to include all of the documents listed as evidence of compliance for each element. **McKesson** was encouraged to list and submit to HSAG any policies, procedures, reports, monitoring tools, screen prints, copies of emails, or other documentation that provided evidence of the CMO's compliance with the contractually mandated elements. On November 7, 2014, **McKesson** uploaded the completed tool and associated documentation to HSAG's secure FTP site and organized the documents in subfolders labeled according to the corresponding standard.

From the documentation submitted by **McKesson** and interviews conducted with key staff during the on-site review, HSAG scored each element within the Compliance Review Standards tool as either, *Met*, *Partially Met*, or *Not Met*. Any element that was not applicable to **McKesson** at the time of the review was scored as *N/A*, or *Not Applicable*. A composite score was calculated by summing the total possible points and dividing it by the total items scored as *Met* (1.0 point), *Partially Met* (0.5 point), or *Not Met* (0 points).

Care Management Enrollment Statistics

Since care management activities have the potential to positively impact the quality of services as well as health outcomes, enrollees benefit from early identification, enrollment, assessment, and receipt of care management services. HSAG reviewed care management enrollment statistics from a care management file submitted by **McKesson**. From the file, HSAG calculated the total number of days between the date of enrollment into care management and the date the assessment and care management plan were completed for each enrollee. HSAG then averaged the total number of days between the enrollment date and assessment date for all enrollees. HSAG also calculated the average number of days from the enrollment date to the assessment date for enrollees who were pregnant at the time of enrollment.

Care Management Staffing

The number and type of staff designated to a care management program are important to the success of a care management program. Well-trained and qualified staff can assist persons with chronic conditions manage their illnesses and appropriately navigate the healthcare system. Care manager-to-enrollee ratios by risk level help to verify that there are enough care managers to provide care management services to program enrollees. Within its Questionnaire, **McKesson** submitted an organizational chart and a list of the number and type of full-time equivalent (FTE) staffs dedicated to the Nevada HCGP. HSAG reviewed number and type of care management staff dedicated to the Nevada HCGP, who also had direct contact with enrollees during the review period. HSAG calculated the total number of **McKesson** and ValueOptions FTEs that had direct contact with enrollees. ValueOptions serves as a subcontractor to **McKesson** and provides mental health case management services to HCGP enrollees under the direction of **McKesson**.

Checklists

HSAG reviewers also scored each element within **Checklists** that corresponded to two standards within the Compliance Review Standards Tool. The corresponding **Checklists** were:

- **Checklist 1: Transitioning Recipients into Care Management** (Attachment B-1), the information collected using this checklist was recorded in Element 1 of Standard XI: Care Transitions, in the Compliance Review Standards tool.
- **Checklist 2: Required Reports** (Attachment B-2), the information collected using this checklist was recorded in Element 2 of Standard XII: Operational Structure and Reporting, in the Compliance Review Standards tool.

HSAG surveyors used the Checklist to document findings of key elements in the contract related to transitions of care and required reports. HSAG's surveyors scored each applicable element within the tool as either *Yes*, the element was contained within the file, or *No*, the element was not contained in the file. Elements that were not applicable to the CMO were scored as *N/A* and were not included in the denominator of the total score. To obtain a percentage score, HSAG added the total number of elements receiving a *Yes* score and divided it by the total number of applicable elements.

Phase II Review Tools and Activities

Phase II of the review consisted of a two-day on-site review at **McKesson**'s Carson City, Nevada office. During the on-site review, HSAG interviewed key staff to inquire about several items that were incomplete from the desk review of documentation. **McKesson** staff members were given the opportunity to provide additional documentation until the end of the second day of the on-site review to provide evidence of its compliance with a given element. HSAG surveyors assessed the additional information provided by **McKesson** staff and documented the findings in the Compliance Review Standards tool.

While on-site, HSAG reviewers assessed **McKesson**'s application of contractually required care management activities—identification, risk stratification, comprehensive assessments, care plan

development, ongoing care management services, hospital discharge and care transitions, and care monitoring and reassessment—through a review of 20 enrollee care management records. The on-site review also consisted of a review of 10 enrollee grievances and **McKesson**'s processing of each grievance filed.

Care Management File Review

To obtain the list of enrollee records to be included in the review, **McKesson** provided a list of all enrollees in the HCGP who were currently receiving or had received care management services during the review period (June 1, 2014 through October 31, 2014). **McKesson** uploaded the complete list to HSAG on November 7, 2014 using the data file layout specified by HSAG. From the uploaded file, HSAG generated a list of 20 sample cases, plus an oversample of 7 cases, and posted them to the HSAG secure FTP site for **McKesson** to retrieve five business days prior to the on-site review. While on-site, HSAG reviewed all 20 sample cases.

The care management file review tool was organized into five sections. The evaluation elements within each section were required by **McKesson**'s contract with the DHCFP. The five sections were:

- Section I: Enrollee Identification and Risk Stratification
- Section II: Enrollee Assessment
  - Primary care provider (PCP) selection
  - Linking members to community resources
- Section III: Care Plan Development
- Section IV: Ongoing Care Management
  - Care transitions
  - Hospital discharge planning
- Section V: Care Monitoring and Reassessment

Using the **Care Management File Review Tool** (Attachment C), HSAG scored each element as either *Yes*, the element was contained within the file, or *No*, the element was not contained in the file. Elements that were not applicable to the enrollee were scored as *N/A*, and were not included in the denominator of the total score. Elements in Section I were used to collect information about the enrollee and were not scored. For Sections II, III, IV, and V, HSAG surveyors added the number of elements receiving a *Yes* score for the respective Section and divided it by the total number of applicable elements for the same Section.

Grievance File Review

HSAG surveyors also reviewed grievance records during the on-site review. On November 7, 2014, **McKesson** staff uploaded a grievance data file to HSAG's secure FTP site using a data file layout specified by HSAG. HSAG surveyors used the **Grievance File Review Tool** (Attachment D) tool to document findings from a review of **McKesson**'s grievance records. From data provided by **McKesson**, HSAG selected 10 grievance records to review. HSAG's surveyors scored each applicable element within the tool as either *Yes*, the element was contained within the file, or *No*,

the element was not contained in the file. Elements that were not applicable to the enrollee were scored as *N/A*, and were not included in the denominator of the total score. For each component reviewed, HSAG added the number of elements receiving a *Yes* score for the respective component and divided it by the total number of applicable elements for the same component.

Compliance Review Findings

Phase I – Results for Compliance with Standards

Table 3 displays the compliance review results. A total percentage score was calculated by summing the total possible points and dividing it by the total items scored as *Met* (1.0 point), *Partially Met* (0.5 point), or *Not Met* (0 points). Elements that were *N/A* were not included in the denominator of the score.

Table 3—Summary of Results of Compliance with Standards

Standard Number	Standard Name	Total Elements	Applicable Elements	Met	Partially Met	Not Met	N/A
I	Stratification of Enrollees	3	3	2	1	0	0
II	Care Management Teams	2	2	2	0	0	0
III	Care Planning	2	2	1	1	0	0
IV	Mental Health Care Management Services	2	2	2	0	0	0
V	Health Education Materials	1	1	1	0	0	0
VI	Nurse Triage and Call Services	4	4	2	2	0	0
VII	Emergency Department Redirection	3	3	3	0	0	0
VIII	Stakeholder Outreach and Education	2	2	2	0	0	0
IX	Feedback to Primary Care Providers (PCPs)	2	2	1	1	0	0
X	Provider Services	3	2	1	1	0	1
XI	Care Transitions	1	1	0	1	0	0
XII	Operational Structure and Reporting	2	2	1	1	0	0
	Total Elements	**27**	**26**	**18**	**8**	**0**	**1**
	Composite Score	**22/26 84.6%**					

Overall, **McKesson** received a composite score of 84.6 percent. The findings suggest that **McKesson** met most of the required elements evaluated as part of the compliance review. None of the elements were scored *Not Met* and eight elements were scored *Partially Met*.

Of the 12 standards reviewed, **McKesson** met all of the elements for the following standards: Care Management Teams, Mental Health Care Management Services, Health Education Materials, Emergency Department Redirection, and Stakeholder Outreach and Education.

The following standards were identified as opportunities for improvement since **McKesson** received a ***Partially Met*** for one or more elements contained in the standards: Stratification of Enrollees, Care Planning, Nurse Triage and Call Services, Feedback to Primary Care Providers, Provider Services, Care Transitions, and Operational Structure and Reporting. Examples of the areas identified for improvement include, but are not limited to:

- **Face-to-face interactions with enrollees** – **McKesson**'s policy listed the percentage of enrollees that receive a face-to-face contact by stratification of risk: 25 percent of the complex-risk enrollees, 20 percent of the high-risk enrollees, and 15 percent of the moderate-risk

enrollees to receive a face-to-face contact. Documents submitted by **McKesson** indicated that very few face-to-face interventions had been accomplished prior to the on-site review December 10, 2014; therefore, **McKesson** was not in compliance with its own policy.

- **Nurse triage and nurse advice call service lines** – The contract requires that 90 percent of telephone calls are answered within five rings during live voice answering times. **McKesson** submitted reports from June 2014–October 2014 with summary results for telephone calls received during each month. The reports did not list the calls answered within five rings, so the information concerning calls handled within 30 seconds was used for that requirement. **McKesson** met the 90 percent requirement in June and July, but failed to meet the standard in August (80 percent), September (85 percent), and October (88 percent).
- **Nurse triage and nurse advice call service lines** – The contract requires that 90 percent of calls are answered by a live operator in less than two minutes. None of the **McKesson** reports submitted for review contained the information concerning the calls answered by a live operator in less than two minutes.
- **Feedback to PCPs** – The contract requires the CMO to provide feedback on gaps between recommended care and actual care received by the Enrollees attributed to an identified PCP. The case management file review provided evidence that, in many instances, PCPs were notified of gaps of care for enrollees who were empaneled with the PCP; however, there were some cases where the PCP was not notified of the barriers or gaps in care.
- **DHCFP approval of required documents** – There were two documents (Provider Education Plan and Transitioning Beneficiaries Guideline) that required DHCFP approval that had not been approved by the DHCFP. At the time of the on-site review, **McKesson** staff revised the documents to be in compliance with contractual requirements, but had not yet submitted the revised documents to the DHCFP for approval.
- **Monitoring and Reporting** – The contract requires several reports to be developed and used for monthly, quarterly, and annual monitoring. The required reports must be submitted to the DHCFP by the required schedule. Some of the reports met the elements required by the contract. The following reports, however, did not contain all of the contractually required elements: Enrollee Stratification Report, Enrollee Contact Report, Call Center and Nurse Triage Report, Disenrollment Report, Noncompliance Report, Provider Profiling Report, and Grievance, Complaint, and Dispute Resolution Report.

The complete findings that detail the specific elements that were scored *Partially Met*, and their associated recommendations, are found in Attachment A.

Phase I – Care Management Enrollment Statistics

Table 4 shows, by risk category, the number of Medicaid recipients enrolled in the program, the number of persons served (i.e., assessment completed) in the program, the percent of the total enrolled who were served in the program, and the average number of days between date of enrollment and the date the assessment was completed. Risk categories were defined by **McKesson** as Complex (most comprehensive and complex care needs), High (high care needs), Moderate (moderate care needs), and Low (low care needs).

Table 4—Persons Enrolled and Served in the HCGP				
Categories	Number of Persons Enrolled	Number of Persons Served	Percent of Total Enrolled Who were Served	Average Number of Days Between Enrollment and Completed Assessment
Complex (4)	314	83	0.2%	57 days
High (3)	2,282	451	1.1%	69 days
Moderate (2)	4,696	738	1.9%	81 days
Low (1)	32,251	556	1.4%	65 days
Total	**39,543**	**1,828**	**4.6%**	**Average 72 days**

Of the 39,543 persons enrolled in the program, 1,828 (4.6 percent) enrollees were served, where an assessment and care management plan were developed. On average, 72 days passed between the enrollment date and the date the enrollee was assessed by **McKesson** care managers. Persons served in the moderate risk level had assessments completed, on average, 81 days after enrollment in the program. Persons with complex care needs were assessed, on average, more quickly than that of the other risk categories at 57 days between the date of enrollment and the date of assessment.

Table 5 shows the number of enrollees who had an assessment completed within 0–30 days, 31–60 days, 61–90 days, or greater than 90 days after the person was enrolled in the HCGP.

Table 5—Number of Days Between Enrollment and Assessment		
Assessment Completed with X-X Days of Enrollment	Number of Enrollees	Percent of Total Enrollees
0–30 days	427	23%
31–60 days	447	24%
61–90 days	265	14%
Greater than 90 days	689	38%
Total	**1,828**	**100%**

Table 5 shows that less than half of all enrollees had an assessment completed within 60 days, and 38 percent of enrollees had an assessment completed 90 or more days after the being enrolled in the program.

Table 6 on the following page shows the enrollment statistics for pregnant women in each risk category. Table 6 also shows the average number of days between the date of enrollment and the date the assessment was completed.

Table 6—Enrollment for Pregnant Women		
Categories	Number of Pregnant Enrollees	Average Number of Days Between Enrollment and Completed Assessment
Complex (4)	0	N/A
High (3)	13	72 days
Moderate (2)	10	68 days
Low (1)	25	52 days
Total	**48**	**Average 61 days**

As of October 31, 2014, there were a total of 48 pregnant women who had received care management services in the HCGP. Table 6 shows, on average, 61 days passed before a pregnant enrollee was assessed by a **McKesson** care manager. Pregnant enrollees with the highest acuity level (High Risk) were assessed, on average, 72 days after being enrolled in the program. There were multiple instances where more than 110 days lapsed between the enrollment date and assessment date. There was one notable instance where 154 days had passed between the date of enrollment and the date of assessment, and the enrollee already gave birth by the time her care management needs were assessed.

Phase I – McKesson Care Management Staffing Review

Table 7 shows the numbers and types of staff **McKesson** identified for the HCGP that had direct contact with enrollees during the review period. Any positions that were unfilled at the time of the on-site review are noted as "vacant."

Table 7—HCGP Staffing for Staff Working Directly with Enrollees	
McKesson Staff Title	Full-Time Equivalent (FTE) Count
Case Manager	3.0
Care Manager	8.1
Social Worker	2.0
Triage Health Resource Coordinator	As needed based on call volume (Up to 0.03 FTE used for Nevada)
Triage Nurse	As needed based on call volume (Up to 0.5 FTE used for Nevada)
Community Health Worker	2.0
McKesson Total	**15.1**
ValueOptions Staff Title	Full-Time Equivalent (FTE) Count
Case Manager-Mental Health (MH)	1.0
Care Manager-MH	3.0 + 2.0 Vacant
Community Health Worker	2.0 + 1.0 Vacant
Pharmacist	As needed
ValueOptions Total	**6.0 + 3.0 Vacant**
HCGP Total	**21.1 + 3.0 Vacant** **24.1 Total FTEs**

For the HCGP, **McKesson**'s Questionnaire noted that there were 15.1 full-time equivalents (FTEs) for **McKesson** and 9.0 FTEs for ValueOptions. Of the 9.0 total FTEs for ValueOptions, 3 FTE positions were unfilled at the time of the review. Overall, there were 24.1 FTEs designated to the Nevada HCGP.

According to the case management risk stratification levels provided by **McKesson**, 3 percent of the population is considered complex risk, 7 percent of the population is considered high risk, 20 percent of the population is considered moderate risk, and 70 percent of the population is considered low risk. Table 8 shows the stratification of the population using **McKesson**'s case management risk stratification levels for the 39,543 people enrolled in the program at the time of the review. In addition, the table shows the case manager-to-enrollee ratios proposed by **McKesson** for each risk level. For complex risk enrollees, **McKesson** proposed one case manager to 75 enrollees; for high risk, one case manager to 186 enrollees; for moderate risk, one case manager to 244 enrollees; and any available case manager for enrollees in the low risk category. The table also shows the number of case managers anticipated to be needed in order to satisfy the care manger-to-enrollee ratios proposed by **McKesson**. Lastly, the table shows the surplus or deficit of care managers based on number and types of FTEs submitted by **McKesson** in its Questionnaire. A deficit is noted in red text.

Table 8—Number of Care Managers to Maintain Ratios

Case Management (CM) Risk Level	Percent of Population	Max. Number of Members Served by CM Risk Level	Ratio 1 CM to: XX Enrollees	Number of Care Managers to Maintain CM Ratio	Surplus/Deficit of FTEs to Fulfill Ratios
Complex (4)	3%	1,186	75	15.82	**39.01 FTEs**
High Risk (3)	7%	2,768	186	14.88	
Moderate Risk (2)	20%	7,909	244	32.41	
Low Risk (1)	70%	27,680	Low risk Enrollees may interact with any available care manager.	Unknown	
Total	**100%**	**39,543**		**63.11**	

*Note: 63.11 Care Managers (CMs) represents the minimum number of CMs needed to serve 39,543 members based on McKesson's proposed risk stratification and care manager-to-enrollee ratios.

The risk stratification levels and case manager-to-enrollee ratios proposed by **McKesson** suggest that the anticipated number of staff needed to effectively care manage the population was 63.11 FTEs. As shown in Table 7, **McKesson** has designated 24.1 FTEs to have direct contact with enrollees and provide care management services to enrollees of the Nevada HCGP. Based on the anticipated staffing need for the HCGP noted in Table 8 (63.11 FTEs) and the number of staff designated by **McKesson** for the HCGP (24.1 FTEs), the anticipated shortfall in staffing is 39.01 FTEs.

As shown in Table 3, **McKesson** met the contractual requirements reviewed in Standard II: Care Management Teams. The elements for this standard focused on the written descriptions **McKesson** maintained for developing and operating multidisciplinary care management teams and the supervision of those teams. The quality of the types of staff used to operate the care teams was found to be sufficient in both the Readiness Review and the Compliance Review. The quantity of

staff designated to the program, however, is inconsistent with care manager-to-enrollee ratios proposed by **McKesson**, given the number of persons enrolled in the program. This discrepancy was noted in the Readiness Review findings and no evidence was found to indicate that this discrepancy has been remedied.

Phase I – Checklist Results

Table 9 details the findings from the Checklists. To obtain a percentage score for the Checklists, HSAG added the total number of elements receiving a *Yes* score and divided it by the total number of applicable elements.

Table 9—Summary of Results of Checklists

Checklist Number	Checklist Name	Elements	Yes	No	N/A	Percent Compliant
I	Transitioning Recipients into Care Management	12	12	0	0	**12/12 100%**
II	Required Reports	13	5	7	1	**5/12 41.7%**

McKesson scored 100 percent for all elements contained in Checklist I: Transitioning Recipients into Care Management.

For Checklist II: Required Reports, **McKesson** scored 41.7 percent. As shown in Table 3 and detailed in the findings for Standard XII: Operational Structure and Reporting in Attachment A, **McKesson** did not meet most the required elements in Checklist II: Required Reports. In some cases, the same opportunities for improvement were noted in the Readiness Review findings and had not been remedied by at the time of the on-site compliance review. **McKesson** staff were encouraged to review the remediation plan **McKesson** submitted on April 10, 2014 to become familiar with the strategies **McKesson** identified to correct the issues identified during the readiness review. Detailed findings of the Transitioning Recipients into Care Management and Required Reports Checklists may be found in Attachments B-1 and B-2, respectively.

Phase II – Results of Care Management File Review

Table 10 on the following page shows the results of the care management file review. Section I of the care management file review tool contained demographic information and was not scored. Sections II—V of the care management file review were scored. HSAG surveyors added the number of elements receiving a *Yes* score for the respective Section and divided it by the total number of applicable elements for the same Section.

Table 10—Results of Care Management File Review				
Elements	Section II: Enrollee Assessment	Section III: Care Plan Development	Section IV: Ongoing Care Management	Section V: Care Monitoring and Reassessment
Total Number of Elements	440	240	320	60
Total Number of Elements N/A	14	44	176	50
Total Number of Applicable Elements	**426**	**196**	**144**	**10**
Total Elements Contained in File (Yes)	420	171	114	10
Total Elements Not Contained in File (No)	6	25	30	0
Percent of Elements Contained in File	**420/426 98.69%**	**171/196 87.2%**	**114/144 79.2%**	**10/10 100%**

When reviewing care management files, HSAG reviewers noted that **McKesson** documented most of the elements required by its contract with DHCFP. **McKesson** scored a 98.6 percent for Section II: Enrollee Assessment and 87.2 percent for Section III: Care Plan Development. The elements in Section III that were not well documented in the CMO files were related to enrollee goal-setting and tracking the progress toward enrollee goals.

The section of care management requirements that proved to be the most challenging for **McKesson** was Section IV: Ongoing Care Management, which received a score of 79.2 percent. The standards in this section required the CMO to document evidence of ongoing communication with the enrollee and his/her PCP. The care management files showed that communication between **McKesson** staff and enrollees was documented in the enrollees' files. After **McKesson** completed the initial assessment and care management plan, the VITAL system generated a copy of the care management plan and faxed it to the PCP, in most cases. In many cases, however, additional follow-up with the PCP concerning an enrollee's noncompliance with the care plan or **McKesson**'s inability to reach the enrollee was not documented.

Many of the elements in Section IV were not applicable at the time of the review because the elements focused on discharge planning and follow-up after an enrollee was discharged from the hospital. Only two enrollees were hospitalized during the period being reviewed. For Section V: Care Monitoring and Reassessment, many of the enrollees had not been enrolled in care management long enough to warrant a reassessment (within 6 months of the date of the initial assessment); therefore, many of these elements were not applicable at the time the on-site review occurred. **McKesson** scored 100 percent on the 10 elements that were applicable in Section V.

Phase II – Results of Grievance File Review

Table 11 on the following page shows the results of the grievance file review. HSAG reviewed a total of 10 grievance files. For each component reviewed, HSAG added the number of elements receiving a *Yes* score for the respective component and divided it by the total number of applicable elements for the same component.

Table 11—Results of Grievance File Review

Grievance Elements	Provider Obtained Permission to File on Enrollee Behalf	Grievance Acknowledged	Resolved within 30 Days	Appropriate Level of Expertise
Total Number of Elements	10	10	10	10
Number of Applicable Elements	0	10	10	10
Number of Compliant Elements	N/A	10	4	10
Percent Compliant	**N/A**	**10/10 100%**	**4/10 40%**	**10/10 100%**

The results from the grievance file review indicated that **McKesson** staff verbally acknowledged receipt of the grievance during the initial call from the enrollee, and staff members with appropriate expertise handled the grievances. None of the grievances were file by a provider on behalf of an enrollee. All ten files contained the date the grievance was received, but the process undertaken to resolve the grievance was not found in many of the files. Overall the results of the grievance file review showed that all notes concerning the investigation and resolution of the grievances were not documented in the grievance files. **McKesson** did not always notify enrollees of the resolution of the grievance and record the final date of closure in the grievance files.

Conclusions and Recommendations

McKesson received a composite score of 84.6 percent. Of the 12 standards reviewed, **McKesson** met all of the elements for the following 5 standards: Care Management Teams, Mental Health Care Management Services, Health Education Materials, Emergency Department Redirection, and Stakeholder Outreach and Education. **McKesson** received a ***Partially Met*** for one or more elements contained in the remaining 7 of the 12 standards reviewed.

- HSAG recommends that **McKesson** prioritizes improvement efforts to address deficiencies in the following standards: Stratification of Enrollees, Care Planning, Nurse Triage and Call Services, Feedback to PCPs, Provider Services, Care Transitions, and Operational Structure and Reporting. These standards must be addressed in **McKesson**'s Corrective Action Plan, which is described in the section below.

During the on-site review, HSAG reviewers discussed with **McKesson** staff the length of time that passes between a person's enrollment in the program and when the person's care needs are assessed. In the case of pregnant enrollees, the pregnancy is time-limited so the window available to provide effective care management interventions during the gestation period is limited. In some cases, more than 110 days passed between the time the woman was enrolled in the program and when her needs were assessed. In one notable instance, HSAG reviewers found that 154 days had passed between the date of enrollment and the date of assessment for one pregnant woman, and the enrollee already gave birth by the time her care management needs were assessed.

- HSAG recommends that **McKesson** establish a reasonable standard (number of days between enrollment and assessment) to ensure pregnant enrollees' needs are assessed more quickly. **McKesson** should obtain DHCFP's approval of the standard. Further **McKesson** should monitor the standard on an ongoing basis.

During both the Readiness Review and the Compliance Review, HSAG found the quality of staff proposed for the program to be consistent with contractual requirements. Further, HSAG found that **McKesson** maintained appropriate written descriptions for developing and operating multidisciplinary care management teams. The quantity of staff designated to the program, however, was inconsistent with care manager-to-enrollee ratios proposed by **McKesson**, given the number of persons enrolled in the program (39,543). Based on the anticipated staffing need for the HCGP noted in Table 8 (63.11 FTEs) and the number of staff designated by **McKesson** for the HCGP (24.1 FTEs), the anticipated shortfall in staffing is 39.01 FTEs.

- HSAG recommends that **McKesson** evaluate the quantity of staff designated to the Nevada HCGP program and ensure that the staffing ratios proposed for the program are consistent with the number of FTEs designated to the HCGP program, given the number of persons enrolled in the program.

For the checklist review, **McKesson** scored 100 percent for all elements contained in Checklist I: Transitioning Recipients into Care Management. For Checklist II: Required Reports, **McKesson** scored 41.7 percent, which showed that **McKesson** did not meet most the required elements for reporting to DHCFP. In some cases, the same opportunities for improvement were noted in the

Readiness Review findings and had not been remedied by at the time of the on-site compliance review.

- HSAG recommends that **McKesson** review the remediation plan **McKesson** submitted on April 10, 2014 to become familiar with the strategies **McKesson** identified to correct the issues identified during the Readiness Review. Further, **McKesson** should develop the required reports and submit them to DHCFP for approval to ensure that **McKesson**'s proposed format for the reports meets the needs of DHCFP staff for reporting to CMS.

For the care management file review, **McKesson** received a score of 79.2% for Section IV: Ongoing Care Management. The elements in this section require the CMO to document evidence of ongoing communication with the enrollee and his/her PCP. In many cases, additional follow-up with the PCP was not documented.

- HSAG recommends that **McKesson** communicate with each enrollee's identified PCP, document all communication with the PCP in the care management file, and notify the PCP when the enrollee cannot be reached or is not complying with care management goals and objectives.

The results of the grievance file review indicated that all notes concerning the investigation and resolution of the grievances were not documented in the grievance files. Further, the files did not always contain the date the grievance was resolved, and they did not contain notification to the enrollee concerning the resolution of the grievance.

- HSAG recommends that **McKesson** staff record all notes in the grievance files and also notify enrollees when the grievance is resolved. **McKesson** should also record the date the grievance was resolved and closed in the respective grievance file.

Corrective Action

HSAG provided recommendations for each review element that received a score of ***Partially Met***. There were no elements found ***Not Met***. HSAG's findings and recommendations for each of the elements contained for each Standard may be found in Attachment A of this report. To propose its plan to correct any elements that received a score of ***Partially Met***, **McKesson** must use the template provided in Attachment E to submit its Corrective Action Plan (CAP) to the DHCFP and address each of the items that included a recommendation.

In addition to completing the template found in Attachment E, **McKesson** must submit its planned approach to address the recommendations detailed in the Conclusions and Recommendations section above.

McKesson must submit its Corrective Action Plan to the DHCFP **within 21 days of receiving this report**. The DHCFP maintains ultimate authority for approving or disapproving any corrective action strategies proposed by **McKesson** in its submitted CAP.