Hennepin Health

Triennial Compliance Assessment

FINAL SUMMARY REPORT

DEPARTMENT OF HEALTH

Triennial Compliance Assessment

Performed under Interagency Agreement for Minnesota Department of Human Services
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Triennial Compliance Assessment

Executive Summary

Federal statutes require the Department of Human Services (DHS) to conduct on-site assessments of each contracted Managed Care Organization (MCO) to ensure they meet minimum contractual standards. Beginning in calendar year 2007, during the Minnesota Department of Health's (MDH's) managed care licensing examination (MDH QA Examination) MDH began collecting (on-behalf of DHS) on-site supplemental compliance information. This information is needed to meet the federal Balanced Budget Act's external quality review regulations and is used by the External Quality Review Organization (EQRO) along with information from other sources to generate a detailed annual technical report (ATR). The ATR is an evaluation of MCO compliance with federal and state quality, timeliness and access to care requirements. The integration of the MDH QA Examination findings along with supplemental information collected by MDH (triennial compliance assessment- TCA) meets the DHS federal requirement.

TCA Process Overview

DHS and MDH collaborated to redesign the SFY TCA processes, simplifying timelines and corrective action plan submissions, and adding a step to confirm MCO compliance with corrective action plans. The basic operational steps remain the same however; when a TCA corrective action plan is needed, the MCO will submit the TCA Corrective Action Plan to MDH following the MDH corrective action plan submission timelines. When the final QA Examination Report is published, the report will include the final TCA Report. Although the attachment of the final TCA Report to the QA Examination Report is a minor enhancement, this will facilitate greater public transparency and simplify finding information on state managed care compliance activities. Below is an overview of the TCA process steps:

- The first step in the process is the collection and validation of the compliance information by MDH. MDH's desk review and on-site QA Examination includes the collection and validation of information on supplemental federal and public program compliance requirements. To facilitate this process the MCO is asked to provide documents as requested by MDH.
- DHS evaluates information collected by MDH to determine if the MCO has "met" or "not met" Contract requirements. The MCO will be provided a Preliminary TCA Report to review DHS' initial "met/not met" determinations. At this point, the MCO has an

opportunity to refute erroneous information but may not submit new or additional documentation. Ample time and opportunities are allowed during the QA Examination to submit documents, policies and procedures, or other information to demonstrate compliance. The MCO must refute erroneous TCA finding within 30 days. TCA challenges will be sent by the MCO to MDH. MDH will forward the MCO's TCA rebuttal comments to DHS for consideration.

- Before making a final determination on "not-met" compliance issues, DHS will consider TCA rebuttal comments by the MCO. DHS will then prepare a final TCA Report that will be sent to MDH and attached to the final QA Examination Report. As a result of attaching the final TCA Report to the QA Examination Report, greater public transparency will be achieved by not separating compliance information and requiring interested stakeholder to query two state agencies for managed care compliance information.

- The MCO will submit to MDH a corrective action plan (CAP) to correct not-met determinations. The MCO TCA CAP must be submitted to MDH within 30 days. If the MCO fails to submit a CAP, and/or address contractual obligation compliance failures, then financial penalties will be assessed.

- Follow-up on the MCO TCA CAP activities to address not-met issues by MDH. During the on-site MDH Mid-cycle QA Exam, MDH will follow-up on TCA not-met issues to ensure the MCO has corrected all issues addressed in the TCA Corrective Action Plan. CAP follow-up findings will be submitted to DHS for review and appropriate action will be initiated by DHS if needed.

I. QI Program Structure - 2016 Contract Section 7.1.1

The MCO must incorporate into its quality assessment and improvement program the standards as described in 42 CFR 438, Subpart D (access, structure and operations, and measurement and improvement

TCA Quality Program Structure Data Grid

DHS Contractual Element and References	Met or Not Met	Audit Comments
Written Quality Assurance Plan (Quality Program Description)	**Comment**	Minnesota Rules, Part 4685.1130, subpart 3, states that the health plan may change its written quality assurance plan by filing notice with the Commissioner of Health for approval. Hennepin Health has not submitted its written quality improvement plan (Quality Program Description) to MDH for approval since 2013. Hennepin Health staff stated its internal policy states the written plan requirement is to revise it every two years. The written plan was revised in 2016 and approved by the Board in September 2016 but was not submitted to MDH for approval. Nor did Hennepin Health follow its own policy. Hennepin Health is required to submit the written quality plan to MDH for approval when making any revisions. **(MDH Deficiency on Exam)** Given the variability of the health care environment, Hennepin Health should revisit its written quality plan on an annual basis to keep pace with its practice and incorporate identified changes resulting from the evaluation of the overall effectiveness of the quality program **(Recommendation on MDH Exam)** Review of the Hennepin Health Program Description (written quality plan) (dated 2016) contained all the requirements of MR 4685.1100 and 42 CFR 438, Subpart D.
Access Standards 42 CFR § 438.206 Availability of Services 42 CFR § 438.207 Assurances of Adequate Capacity and Services 42 CFR § 438.208 Coordination and Continuity of Care 42 CFR § 438.210 Coverage and Authorization of Services	**Met**	Meets requirements.

DHS Contractual Element and References	Met or Not Met	Audit Comments
Structure and Operations Standards 42 CFR § 438.214 Provider Selection 42 CFR § 438.218 Enrollee Information 42 CFR § 438.224 Confidentiality and Accuracy of Enrollee Records 42 CFR § 438.226 Enrollment and Disenrollment 42 CFR § 438.228 Grievance Systems 42 CFR § 438.230 sub contractual Relationships and Delegation	**Met**	Hennepin Health has a Utilization Management Committee and a credentialing program, that are present in the scope of the Quality Plan; these areas are not represented as part of the quality organizational committee structure. It is unclear where delegation oversight and compliance fit in the structure, if at all. Hennepin Health should evaluate its quality structure description in the written plan so that it accurately represents what is in practice, what works best for the organization and what was represented to MDH verbally. **(Recommendation on MDH exam)**
Measurement Improvement Standards 42 CFR § 438.236 Practice Guidelines 42 CFR § 438.240 Quality Assessment and Performance Improvement Program 42 CFR § 438.242 Health Information System	**Met**	Meets requirements.

II. Utilization Management - 2016 Contract Section 7.1.3

The MCO shall adopt a utilization management structure consistent with state regulations and federal regulations and current NCQA "Standards for Accreditation of Health Plans."[1] 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.

A. Ensuring Appropriate Utilization

TCA Utilization Management Data Grid for Under/Over Utilization

DHS Contractual Element and References	Met or Not Met	Audit Comments
The MCO shall facilitate the delivery of appropriate care and monitor the impact of its utilization management program to detect and correct potential under and over utilization. The MCO Shall: i. Choose the appropriate number of relevant types of utilization data, including one type related to behavioral health to monitor.	**Met**	i . UM 2015 Evaluation cited the following as over/under utilization: • Dental • Durable Medical Equipment (DME) • Inpatient • Outpatient • Pharmacy • Professional • Support Services • Transportation Behavioral Health is embedded in the listed four focus indicators of the categories. Both Hennepin Health and SNBC were evaluated separately in the focus categories, with Behavioral Health evaluated as follows:

1 2016 *Standards and Guidelines for the Accreditation of Health Plans*, effective July 1, 2016

DHS Contractual Element and References	Met or Not Met	Audit Comments
		Inpatient – Includes admissions for mental health and chemical dependency in SNBC population, which are trending downward Outpatient (ED) – SNBC ED costs are up and has been identified as subject of UM Focus Group meetings to investigate Pharmacy – Average PMPM spending for HH is $85.00 compared to $214 for SNBC Support Services – For SNBC, includes mental health case management services, which showed upward spike so HH looking into internal vs external case management services (currently is external)
The MCO Shall: ii. Set thresholds for the selected types of utilization data and annually quantitatively analyze the data against the established thresholds to detect under and overutilization.	**Not Met**	ii. Thresholds were on a separate report that contained only graphs; however, data thresholds were not represented, referred to or utilized in the evaluation of the utilization data in the evaluation report. Report indicated increase/decrease in utilization for categories, but did not indicate if utilization was outside thresholds. There was no indicated of how thresholds were determined.
The MCO Shall: iii. Examine possible explanations for all data not within thresholds.	**Not Met**	iii. Not all categories identified as areas for over/under utilization were addressed in the summary report. The summary report contained explanations for inpatient, ED services (outpatient) pharmacy, and support services. Dental, DME, PCA, SNF, and transportation were in the separate report containing only graphs with the thresholds but no explanation or analysis. However, these categories were included in the Total cost PMPM. The report states "For the purposes of this utilization management evaluation, analysis was completed on four focus indicators that were often the most critically reviewed at the monthly meetings. These four focus indicators were pharmacy, support services, hospital emergency department services and hospital inpatient services." An analysis should be done on all over/under utilization identified areas.
The MCO Shall: iv. Analyze data not within threshold by medical group or practice.	**Not Met**	iv. Data not analyzed by medical group or practice. ED Utilization was identified as an area requiring further investigation to determine the reasons and diagnoses accounting for increased access. Inpatient cost PMPM explanation indicated Chem Dep costs were up 30% and C-section up 154% without further analysis.
The MCO Shall: v. Take action to address identified problems of under or	**Not Met**	v. Actions taken – In relation to hospital inpatient services, the report states "*In 2014, various performance improvement projects were in place to reduce re-*

DHS Contractual Element and References	Met or Not Met	Audit Comments
overutilization and measure the effectiveness of its interventions.		*admissions and improve transition of care, which may have played a role in the reduction of inpatient utilization for 2015".* It would be more thorough to list the various improvement projects that made a difference.

B. 2016 NCQA Standards and Guidelines UM 1 – 4, 10 – 13; QI 4

The following are the 2016 NCQA Standards and Guidelines for the Accreditation of Health Plans UM 1 – 4 and 10 – 13, and QI 4, effective July 1, 2016.

TCA Utilization Management Data Grid for NCQA Standards

DHS Contractual Element and References	Met or Not Met	Audit Comments
NCQA Standard UM 1: Utilization Management Structure The organization clearly defines the structures and processes within its utilization management (UM) program and assigns responsibility to appropriate individuals.	**See below.**	See comments for individual elements.
Element A: Written Program Description	**Not Met**	Element A. Written UM Plan – Not Met due to: Contains the statement for Pharmaceutical Denials – must have pharmacist or physician. Per Minnesota Statutes 62M.09, subd. 3(a), a physician must review all cases in which the organization has concluded that a determination not to certify for clinical reasons is appropriate. A pharmacist cannot do pharmaceutical denials under Minnesota Statutes. Hennepin Health does this correctly in practice. Hennepin Health's policies also are correct.

DHS Contractual Element and References	Met or Not Met	Audit Comments
		Contains NCQA timelines, which in the case of non-urgent pre-service (routine prior auth) are different from MHCP-MC timelines, see NCQA Timeline Table following this table in footnote2. Hennepin Health is not NCQA. The timelines in the plan should be representative of what the plan needs to follow, consistent with Minnesota law.
Element B: Physician Involvement	**Met**	Meets requirements.
Element C: Behavioral Healthcare Practitioner Involvement	**Met**	Meets requirements.
Element D: Annual Evaluation	**Met**	Meets requirements.
NCQA Standard UM 2: Clinical Criteria for UM Decision To make utilization decisions, the organization uses written criteria based on sound clinical evidence and specifies procedures for appropriately applying the criteria.	**See below.**	See comments for individual elements.
Element A: UM Criteria	**Met**	Meets requirements.
Element B: Availability of Criteria	**Met**	Meets requirements.

2 **NCQA Timeline Table**

Requirement	Non Urgent Pre-service	Urgent Pre-service**	Urgent Concurrent	Post Service
NCQA requirement	15 calendar days	72 hours	24 hours	30 calendar days
DHS/MDH requirement	10 business days*	Expedited review 72 hrs.	Not specified	30 days

DHS Contractual Element and References	Met or Not Met	Audit Comments
Element C: Consistency of Applying Criteria	**Met**	Meets requirements.
NCQA Standard UM 3: Communication Services The organization provides access to staff for members and practitioners seeking information about the UM process and the authorization of care. Element A: Access to Staff	**Met**	Meets requirements.
NCQA Standard UM 4: Appropriate Professionals Qualified Licensed health professionals assess the clinical information used to support UM decisions. Element D: Practitioner Review of Behavioral Healthcare Denials	**Met**	Meets requirements.
Element F: Affirmative Statement About Incentives	**Met**	Meets requirements.
NCQA Standard UM 10: Evaluation of New Technology The organization evaluates the inclusion of new technologies and the new application of existing technologies in the benefits plan. This includes medical and behavioral health procedures, pharmaceuticals, and devices. Element A: Written Process	**Met**	Meets requirements.
Element B: Description of Evaluation Process	**Met**	Meets requirements.
NCQA Standard UM 11: Emergency Services The organization provides, arranges for or otherwise facilitates all needed emergency services, including appropriate coverage of costs. Element A: Policies and Procedures	**Met**	Meets requirements.
NCQA Standard UM 12: Procedures for Pharmaceutical Management	**Met**	Meets requirements.

DHS Contractual Element and References	Met or Not Met	Audit Comments
The organization ensures that its procedures for pharmaceutical management, if any, promote the clinically appropriate use of pharmaceuticals Element A: Policies and Procedures		
Element B: Pharmaceutical Restrictions/Preferences	**Met**	Meets requirements.
Element C: Pharmaceutical Patient Safety Issues	**Met**	Meets requirements.
Element D: Reviewing and Updating Procedures	**Met**	Meets requirements.
Element E: Considering Exceptions	**Met**	Meets requirements.
NCQA Standard UM 13: Triage and Referral to Behavioral Health The organization has written standards to ensure that any centralized triage and referral functions for behavioral health services are appropriately implemented, monitored and professionally managed. *This standard applies only to organizations with a centralized triage and referral process for behavioral health, both delegated and non-delegated.* Element A: Triage and Referral Protocols	**Not applicable**	Hennepin Health does not utilize centralized triage and referral for behavioral health services
NCQA Standard QI 4: Member Experience The organization monitors member experience with its services and identifies areas of potential improvement. Element G: Assessing experience with the UM process	**Met**	Meets requirements.

III. Special Health Care Needs - 2016 Contract Section 7.1.4 A-C[3, 4]

The MCO must have effective mechanisms to assess the quality and appropriateness of care furnished to Enrollees with special health care needs.

Special Health Care Needs Data Grid

DHS Contractual Element and References	Met or Not Met	Audit Comments
A. Mechanisms to identify persons with special health care needs, B. Assessment of enrollees identified, (Senior and SNBC Contract – care plan) and C. Access to specialists	**M**et	MDH reviewed several Hennepin Health policy and procedures related to case management and care coordination for all non- Special Needs Basic Care (SNBC) Hennepin Health enrollees and also more specific care management for SNBC enrollees. The 2014 and 2015 "Special Health Care Needs (SHCN)" reports which analyzed and summarized the SHCN program for all Hennepin Health enrollees were also reviewed. Hennepin Health analyzes claims data quarterly for all enrollees over the age of 18, looking for triggers such as high ED utilization, hospital stays with certain diagnoses, or high hospital readmissions. SHCN enrollees are also identified through assessments when care coordinators are involved (such as in the SNBC program). Care Guides in the SNBC program work with enrollees on care plans as well as provide more holistic social services that could potentially remove barriers in health care. The 2015 SHCN data report identified that ED utilization rate per 1,000 has decreased from 2014 to 2015. Hennepin Health acknowledges that it is too soon to note a pattern, but they attribute part of this decrease to implementation of Community Health Worker services in the ED, which helps triage enrollees between urgent care and the ED.

3 42 CFR 438.208 (c)(1-4)

4 MSHO, MSC+ Contract section 7.1.4 A, C; SNBC Contract section 7.1.4

IV. Practice Guidelines -2016 Contract Section 7.1.5[5, 6]

The MCO shall adopt, disseminate and apply practice guidelines consistent with current NCQA "*Standards and Guidelines for the Accreditation of Health Plans,*" QI 9 Clinical Practice Guidelines.

Practice Guidelines Data Grid

DHS Contractual Element and References	Met or Not Met	Audit Comments
i. **Adoption of practice guidelines**. The MCO shall adopt guidelines based on: • Valid and reliable clinical evidence or a consensus of Health Care Professionals in the particular field • Consideration of the needs of the MCO enrollees • Guidelines being adopted in consultation with contracting Health Care Professionals • Guidelines being reviewed and updated periodically as appropriate.	**Met**	Hennepin Health adopts guidelines of the Institute for Clinical Systems Improvement (ICSI), the United States Preventative Services Task Force, and Minnesota Community Measurement. 2017 guidelines are as follows: 1) Preventative services for adults 2) Diabetes management 3) Medication management for people with asthma 4) Childhood immunization status 5) Immunizations for adolescents 6) Prenatal and postpartum care 7) Follow-up after hospitalization for mental illness 8) Major depression in adults in primary care 9) Alcohol and drug dependence
ii. **Dissemination of guidelines.** MCO ensures guidelines are disseminated: • To all affected Providers • To enrollees and potential enrollees upon request	**Met**	Hennepin Health reported that, due to the high mobility of their members and inadequate social supports, traditional mailings (such as newsletters) to all enrollees with practice guideline education was not effective. Hennepin Health has adopted strategies for a greater outreach to enrollees that help disseminate the education. For instance, when members are visiting primary care clinics for preventative services, clinic

5 42 CFR 438.236

6 MSHO/MSC+ Contract section 7.1.5 A-C; SNBC Contract section 7.1.5A-C

DHS Contractual Element and References	Met or Not Met	Audit Comments
		staff communicate education related to healthy pregnancies, well-child check-ups, etc. On a quarterly basis, they also provide education on the TV in the front lobby where members in the waiting room can see it.
ii. **Application of guidelines**. MCO ensures guidelines are applied to decisions for: • Utilization management • Enrollee education • Coverage of services • Other areas to which there is application and consistency with the guidelines.	**Met**	Meets requirements.

V. Annual Quality Assessment and Performance Improvement Program Evaluation – 2016 Contract Section 7.1.8[7,8]

The MCO must conduct an annual quality assessment and performance improvement program evaluation consistent with state and federal regulations and current NCQA "Standards and Guidelines for the Accreditation of Health Plans."

Annual Quality Assessment and Performance Improvement Program Evaluation Data Grid

DHS Contractual Element and References	Met or Not Met	Audit Comments
7.1.8 Annual Quality Assessment and Performance Improvement Program Evaluation must: i. Review the impact and effectiveness of the MCO's quality assessment and performance improvement program ii. Include performance on standardized measures (example: HEDIS®) and iii. MCO's performance improvement projects.	**Not Met** **Met** **Met**	A i. The individual activities are appropriately evaluated; however, the overall quality program was not evaluated to determine its progress in meeting its goals. This overall program evaluation may include an effectiveness summary of areas such as its program resources, QI committee structure, practitioner and/or leadership involvement, or any identified structure or program changes for the subsequent year. Hennepin Health must include in its annual evaluation an evaluation of the overall effectiveness of its quality program. (Mandatory Improvement in MDH Exam) A ii and iii. Hennepin Health's annual evaluation thoroughly addresses the individual activities in the annual work plan, trends data over time and uses graphs and tables to display the data. The evaluation addresses the performance improvement projects, HEDIS, Special Health Care Needs, CAHPS, and Practice Guidelines specified in DHS contract.

7 42 CFR 438.3302)

8 MSCHO/MSC+ Contract Section 7.1.8 requires that the MCO, in conducting its annual quality evaluation, assure consistency with the "Quality Framework for the Elderly Waiver" and current NCQA "Standards and Guidelines for the Accreditation of Health Plans."

DHS Contractual Element and References	Met or Not Met	Audit Comments
NCQA QI 1, Element B: Annual Evaluation The organization conducts an annual written evaluation of the QI program that includes the following information: 1. A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service. 2. Trending of measures to assess performance in the quality and safety of clinical care and quality of services. 3. Analysis and evaluation of the overall effectiveness of the QI program and of its progress toward influencing network wide safe clinical practices.	**Met** **Met** **Not Met**	As described above.

VI. Performance Improvement Projects-2016 Contract Section 7.2[9, 10, 11]

The MCO must conduct PIPs designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and Enrollee satisfaction. Projects must comply with 42 CFR § 438.240(b)(1) and (d) and CMS protocol entitled "*Protocol for Use in Conducting Medicaid External Quality Review Activities: Conducting Performance Improvement Projects*." The MCO is encouraged to participate in PIP collaborative initiatives that coordinate PIP topics and designs between MCOs.

Performance Improvement Projects Data Grid

DHS Contractual Element and References	Met or Not Met	Audit Comments
7.2.1 New Performance Improvement Project Proposal The STATE will select the topic for the new PIP to be conducted over the next three years (calendar years 2015, 2016 and 2017) and implemented by the end of the first quarter of calendar year 2015. 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.	**Met**	Reduction of Racial Disparities in the Management of Depression interim reports and DHS Validation sheets for 2015 and 2016 were reviewed. Timing of HEDIS data is recognized barrier that delays outcome measures and analysis of intervention effectiveness.
7.2.2 Annual PIP Status Reports.	**Met**	Meets requirements.

9 42 CFR 438.240 (d)(2)

10 MSHO/MSC+ Contract section 7.2; SNBC Contract section 7.2

11 CMS Protocols, Conduction Performance Improvement Projects, Activity 10

DHS Contractual Element and References	Met or Not Met	Audit Comments
The MCO shall submit by December 1st in calendar years 2015 and 2016, a written PIP status report in a format defined by the STATE.		
7.2.3 Final Project Reports: Upon completion of the PIP the MCO shall submit to the STATE for review and approval a final written report by September 1st, 2018, in a format defined by the STATE.	**Not applicable**	Not applicable since Final report will be in September 2018.
PIP Proposal and PIP Interim Report Validation Sheets. DHS uses these tools to review and validate MCOs' PIP proposals and annual status reports.	**Met**	Meets requirements.

VII. Disease Management - 2016 Contract Section 7.3

Disease Management Program. The MCO shall make available a Disease Management Program for its enrollees with diabetes, asthma and heart disease. The MCO may request the state to approve an alternative Disease Management Program topic other than diabetes, asthma or heart disease. The MCO must submit to the state appropriate justification for the MCO's request.

Disease Management Data Grid

DHS Contractual Element and References	Met or Not Met	Audit Comments
A. Disease Management Program Standards. The MCO's Disease Management Program shall be consistent with current NCQA "Standards and Guidelines for the Accreditation of Health Plans" pursuant to the QI Standard for Disease Management. B. Waiver of Disease Management Program Requirement. If the MCO is able to demonstrate that a Disease Management Program: 1) is not effective based upon Provider satisfaction, and is unable to achieve meaningful outcomes; or 2) would have a negative financial return on investment, then the MCO may request that the STATE waive this requirement for the remainder of the Contract Year.	**See Individual Elements** **Not Applicable**	A. Hennepin Health has a Disease Management Program that covers diabetes, asthma and heart disease. The Diabetes Management Summary (version 3), Disease Management Patient Services Program Description, Stratification and Patient Interventions (DMP0007), twenty appendices, and three additional policies were used to evaluate the Disease Management Program. B. Not Applicable
Element A: Program Content	**Met**	Meets requirements.
Element B: Identifying Members for DM Programs	**Met**	Meets requirements.
Element C: Frequency of Member Identification	**Met**	Meets requirements.
Element D: Providing Members with Information	**Met**	Meets requirements.
Element E: Interventions Based on Assessment	**Met**	Meets requirements.

DHS Contractual Element and References	Met or Not Met	Audit Comments
Element F: Eligible Member Active Participation	**Not met**	Element F: Eligible Member Active Participation. See the summary report table at footnote 12. The numbers in footnote 10 do not correspond to other eligibility numbers referred to in the report. For example, the report states that in 2015, there 874 members were identified as having asthma and, of these members, there were 185 members who had an emergency room visit. This equates to 21 % of members with asthma had an emergency room visit(s). Hennepin should look at how it calculates total eligible populations for participation and be consistent as far as the measures (e.g.by product or totals). When using other data, identify the source of that data.
Element G: Informing and Educating Practitioners	**Met**	Meets requirements.
Element H: Integrating Member Information	**Met**	Meets requirements.

12 Results of Hennepin Health's active participation rates for 2015

Program	Total eligible population	Members who opted in	Opt-in active participation rate
Cardiovascular	47	37	78.7%
Diabetes	51	10	19.60%
Asthma	54	22	40.74%
Diabetes/cardiovascular	59	40	67.79%

DHS Contractual Element and References	Met or Not Met	Audit Comments
Element I:Experience with Disease Management	**Met**	Element I: Experience with Disease Management Satisfaction was to be measured by Satisfaction Survey and Grievance data. Grievance data was not addressed in report. Low survey response rate - 17 out of 52 surveys returned (3.6%) Report states that one nurse completed survey per the member's request due to the member's impairments. In addition, lower education levels, inability to read, indifference, or the length of the survey may have dissuaded members from completing the form.
Element J: Measuring Effectiveness	**Not Met**	Element J: HEDIS measures for Diabetes are below this table in footnote 13. HEDIS measures for cholesterol rates for Cardiovascular and Diabetes are below this table in footnote 14

13 2015 HEDIS Measures for Diabetes

Comprehensive Diabetes	Cornerstone	Hennepin Health
A1c	93.3%*	91.54%*
LDL	71.03%	68.75%*
Eye Exam	54.87%	60.66%*
Nephropathy	78.46%	87.87%*
BP <140/90	65.13%*	63.97%*

14 HEDIS Measures: Cholesterol Rates for Cardiovascular and Diabetes Programs

DM Program	#Mbrs Participate	Initiative #
Cardiovascular cholesterol rates	110	61
Diabetes cholesterol rates	662	464

DHS Contractual Element and References	Met or Not Met	Audit Comments
		Asthma ED rates; *In 2015, there were 874 members identified as having asthma members and of these members, there were 185 members who had an ED visit. This equates to 21 % of members with asthma had an emergency room visit(s).* Analysis of outcome measures • Should include a comparison with a benchmark or goal. On a separate sheet submitted to MDH, containing only tables, the benchmarks are included in the table for Diabetes measures; however this was not present in the summary report. • Show trend data and analysis of results over time to help determine effectiveness of programs In 2016, efforts were going to be focused on increasing enrollment in the programs. HEDIS measure requirements for Cholesterol changed so outcome measure for Diabetes is changing to Eye exams and Cardiovascular to promote statin therapy.

VIII. Advance Directives Compliance - 2016 Contract Section 16[15, 16]

The MCO agrees to provide all Enrollees at the time of enrollment a written description of applicable State law on Advance Directives and the following:

Advance Directives Compliance Data Grid

DHS Contractual Element and References	Met or Not Met	Audit Comments
A. Information regarding the enrollee's right to accept or refuse medical or surgical treatment; and to execute a living will, durable power of attorney for health care decisions, or other advance directive. B. Written policies of the MCO respecting the implementation of the right; and C. Updated or revised changes in State law as soon as possible, but no later than 90 days after the effective date of the change; D. Information that complaints concerning noncompliance with the Advance Directive requirement may be filed with the State survey and certification agency (i.e. Minnesota Department of Health), pursuant to 42 CFR 422.128 as required in 42 FR 438.6(i).	**Met**	MDH reviewed an Advance Directive policy and procedure and several SNBC-specific survey tools to review how Advance Directives education is disseminated to the enrollees.
Providers. To require MCO's providers to ensure that it has been documented in the enrollee's medical records whether or not an individual has executed an Advance Directive.	**Met**	The "2015 Advanced Directives Audit Results HH and SNBC" report was also reviewed. From this report, the chart included as footnote 15 below this table is the Hennepin Health (HH)-Prepaid Medical Assistance Population 2015 chart audit for Advance Directive provider-

15 42 C.F.R. 489.100. Pursuant to 42 U.S.C. 1396a(a)(57) and (58) and 42 C.F.R. 489.100-104

16 MSC/MSC+ Contract Article 16; SNBC Contract Article 16

DHS Contractual Element and References	Met or Not Met	Audit Comments
		patient discussion documentation in member charts. It also audited for the actual Advance Directive noted in chart 17 The sample size was 432 members in 2014 and 434 members in 2015. The chart indicates a slight drop from 2014 to 2015. HH cited that the drop could be attributed to the inclusion of other non-Hennepin Health clinics in the audit for 2015 that were not included in 2014. Overall, despite no seniors in their member population, HH stated they scored higher than anticipated partially due the complex health care needs of their enrollee population. HH says it is advantageous to have access to the shared EPIC medical record because social workers, in addition to nurses and doctors, can ascertain if Advance Directives have been discussed and continue the conversation with the member outside of medical visits.
Treatment. To not condition treatment or otherwise discriminate on the basis of whether an individual has executed an advance directive.	**Met**	Meets requirements.
Compliance with State Law. To comply with State law, whether statutory or recognized by the courts of the State on Advance Directives, including Minnesota Statutes Chapters 145B and 145C.	**Met**	Meets requirements.

17 **Hennepin Health Advance Directives**

Year	Advance Directive in Chart	Advance Directive Planning Discussion	Total
2014	0.46%	50.46%	50.69%
2015	9.91%	35.02%	36.30%

DHS Contractual Element and References	Met or Not Met	Audit Comments
Education. To provide, individually or with others, education for MCO staff, providers and the community on Advance Directives.	**Met**	Meets requirements.

IX. Validation of MCO Care Plan Audits for MSHO, MSC[18, 19] - 2016 Seniors Contract Sections 7.1.4D, 7.8.3, and 9.3.7

MDH will collect information for DHS to monitor MCO Care Plan Audit activities as outlined in the DHS/MCO MSHO/MSC+ Contract.

Validation of MSHO and MSC Care Plan Audits Data Grid

DHS Contractual Element and References	Met or Not Met	Audit Comments
A. DHS will provide MDH with Data Collection Guide for the random sample of 30 MCO enrollees (plus an over sample of 10 MCO enrollees for missing or unavailable enrollee records) for MSHO and MSC+ program. B. Of the 40 records sampled, 20 records will be for members new to the MCO within the past 12 months and other 20 records will be for members who have been with the MCO for more than 12 months. C. MDH will request the MCO make available during the MDH QA Examination on-site audit the identified enrollee records. A copy of the data collection instruction sheet, tool and guide will be included with MDH's record request. D. An eight-thirty audit methodology will be used to complete a data collection tool for each file in each sample consistent with the Data Collection Guide. Within 60 days of completing the on-site MDH QA Examination, MDH will provide DHS with a brief report summarizing the data collection results, any other appropriate information and the completed data collection tools.	Not applicable	Not applicable to Hennepin Health

18 Pursuant to MSHO/MSC+ 2016 Contract sections 6.1.4(A)(2), 6.1.4(A)(3), 6.1.4(A)(4), 6.1.5(B)(4), 6.1.5(B)(5), 7.8.3.

19 42 CFR 438.242.

X. Information System – 2016 Contract Section 7.1.2 [20, 21]

The MCO must operate an information system that supports initial and ongoing operations and quality assessment and performance improvement programs.

Information System Data Grid

DHS Contractual Element and References	Met or Not Met	Audit Comments
The MCO must maintain a health information system that collects, analyzes, integrates, and reports data. During each of the past three years, all MCO MDH annual HEDIS performance measures have been certified reportable by an NCQA HEDIS audit.	Met	The following HEDIS audit report findings were reviewed: 2014 – MetaStar 2015 – MetaStar 2016 – MetaStar The reports indicated: *In our opinion, Metropolitan Health Plan submitted measures were prepared according to the HEDIS Technical Specifications and presents fairly, in all material respects, the organization's performance with respect to these specifications.*

20 Families and Children, Seniors and SNBC Contract Section 7.1.2I

21 42 CFR 438.242

XI. Subcontractors-2016 Contract Sections 9.3.1 and 9.3.16

A. Written Agreement; Disclosures

All subcontracts must be in writing and must include a specific description of payment arrangements. All subcontracts are subject to STATE and CMS review and approval, upon request by the STATE and/or CMS. Payment arrangements must be available for review by the STATE and/or CMS.

Written Agreement and Disclosures Data Grid

DHS Contractual Element and References	Met or Not Met	Audit Comments
A. Disclosure of Ownership and Management Information (Subcontractors). In order to assure compliance with 42 CFR § 455.104, the MCO, before entering into or renewing a contract with a subcontractor, must request the following information: (1) The name, address, date of birth, social security number (in the case of an individual), and tax identification number (in the case of a corporation) of each Person, with an Ownership or Control Interest in the disclosing entity or in any subcontractor in which the disclosing entity has direct or indirect ownership of five percent (5%) or more. The address for corporate entities must include primary business address, every business location and P.O. Box address; (2) A statement as to whether any Person with an Ownership or Control Interest in the disclosing entity as identified in 9.3.1(A) is related (if an individual) to any other Person with an Ownership or Control Interest as spouse, parent, child, or sibling; (3) The name of any other disclosing entity in which a Person with an Ownership Control Interest in the disclosing entity also has an ownership or control interest; and The name, address, date of birth, and social security number of any managing employee of the disclosing entity. (4) For the purposes of section 9.3, subcontractor means an individual, agency, or organization to which a disclosing entity has contracted, or is a	**Not Met**	Hennepin Health determined in October of 2016 that current elements in TMG, Delta Dental, Navitus and Mental Health Resources subcontracts were either absent or did not adequately address all requirements. HH implemented a corrective action plan to update the subcontracts with the requirements listed in DHS Contract 9.3.1 and 9.3.16 by adding an amendment. The Board committee approved the TMG, Delta Dental and Navitus subcontract amendments on February 21st. No details were provided to indicate revisions were made for the Mental Health Resources subcontract.

DHS Contractual Element and References	Met or Not Met	Audit Comments
person with an employment, consulting or other arrangement with the MCO for the provision of items and services that are significant and material to the MCO's obligations under its contract with the STATE.		
B. MCO Disclosure Assurance. The MCO must submit to the STATE by September 1st of the Contract Year a letter of assurance stating that the disclosure of ownership information has been requested of all subcontractors, and reviewed by the MCO prior to MCO and subcontractor contract renewal.	**Not Met**	See comments above.
C. Upon request, subcontractors must report to the MCO information related to business transactions in accordance with 42 CFR §455.105(b). Subcontractors must be able to submit this information to the MCO within fifteen (15) days of the date of a written request from the STATE or CMS. The MCO must report the information to the STATE within ten (10) days of the MCO's receipt from the subcontractor.	**Not Met**	See comments above.

B. Exclusions of Individuals and Entities; Confirming Identity

Exclusion of Individuals Data Grid

DHS Contractual Element and References	Met or Not Met	Audit Comments
A. Pursuant to 42 CFR § 455.436, the MCO must confirm the identity and determine the exclusion status of Providers and any Person with an Ownership or Control Interest or who is an agent or managing employee of the MCO or its subcontractors through routine checks of Federal databases, including the Social Security Administration's Death Master File and the National Plan and Provider Enumeration System (NPPES), and also upon contract execution or renewal, and credentialing.	**Not Met**	Hennepin Health sent a copy of an email stating that HH does these checks for DHS Contract 9.3.16, parts a and b. An email is not sufficient evidence because it does not include actual documentation that they are routinely doing these checks. HH also sent a completed *Disclosure and Provider Exclusion Search* form to indicate that they receive disclosures from individual providers. This was not sufficient evidence that these checks are being done monthly per DHS Contract 9.3.16 parts, a and b. There was no actual documentation to indicate these are being done monthly on sub-contractors.
B. The MCO and its subcontractors must search monthly, and upon contract execution or renewal, and credentialing, the OIG List of Excluded Individuals/Entities (LEIE) and the Excluded Parties List System (EPLS, within the HHS System for Awards Management) database (and may search the Medicare Exclusion Database), for any Providers, agents, Persons with an Ownership or Control Interest, and Managing Employees to verify that these persons: (1) Are not excluded from participation in Medicaid under Sections 1128 or 1128A of the Social Security Act; and (2) (2)Have not been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the programs under Title XX of the Social Security Act.	**Not Met**	See comments on page 28.
C. The MCO must require subcontractors to assure to the MCO that no agreements exist with an excluded entity or individual for the provision of items or services related to the MCO's obligation under this Contract.	**Not Met**	See comments on page 28.
D. The MCO shall require all subcontractors to report to the MCO within five (5) days any information regarding individuals or entities specified in (A) above, who have been convicted of a criminal offense related to	**Not Met**	Hennepin Health did not supply evidence to assure that subcontractors are notifying HH that no agreements exist with an excluded entity or individual for these provisions.

DHS Contractual Element and References	Met or Not Met	Audit Comments
the involvement in any program established under Medicare, Medicaid, the programs under Title XX of the Social Security Act, or that have been excluded from participation in Medicaid under §§ 1128 or 1128A of the Social Security Act.		
E. The MCO shall this information to the STATE within seven (7) days of the date the MCO receives the information	**Not Met**	See comments on page 28.
F. The MCO must also promptly notify the STATE of any action taken on a subcontract under this section, consistent with 42 CFR § 1002.3 (b)(3).	**Not Met**	See comments on page 28.
G. In addition to complying with the provisions of section 9.9, the MCO shall not enter into any subcontract that is prohibited, in whole or in part, under § 4707(a) of the Balanced Budget Act of 1997 or under Minnesota Statutes, § 62J.71.	**Not Met**	See comments on page 28.