Minnesota Department of Health

Triennial Compliance Assessment

Of

Itasca Medical Care

Performed under Interagency Agreement for:

Minnesota
Department of Human Services

By

Minnesota Department of Health (MDH)
Managed Care Systems Section

Exam Period:
August 1, 2012 - July 31, 2015

File Review Period:
August 1, 2014 - July 31, 2015

On-site:
September 28, 2015 - October 2, 2015

Examiners:
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Final Summary Report

December 23, 2015

Executive Summary
Triennial Compliance Assessment (TCA)
Itasca Medical Care

Federal statutes require DHS to conduct on-site assessments of each contracted MCO to ensure they meet minimum contractual standards. Beginning in calendar year 2007, during 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 by to meet federal BBA 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 2013 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 now 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 SFY 2013 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 furnished 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.

DHS Triennial Compliance Assessment (TCA)
TCA Data Collection Grid
SFY 2015

Managed Care Organization (MCO)/County Based Purchaser (CBP): Itasca Medical Care
Examination Period: August 1, 2012-July 31, 2015
Onsite Dates: September 29th-October 2nd, 2015

Contents

DHS Triennial Compliance Assessment (TCA)
TCA Data Collection Grid
SFY 2015

DHS Contractual Element and References	Met/Not Met	Audit Comments
1. QI Program Structure- 2014 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). <u>Access Standards</u> 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 <u>Structure and Operations Standards</u> 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 Subcontractual Relationships and Delegation <u>Measurement Improvement Standards</u> 42 CFR § 438.236 Practice Guidelines 42 CFR § 438.240 Quality Assessment and Performance Improvement Program 42 CFR § 438.242 Health Information System	**Met**	**MDH RECOMMENDATION FROM MDH REPORT:** All the specified elements are included, however the area of utilization management could be expanded upon to include more specifics regarding IMCare's utilization management program and reporting relationships. The quality evaluation section could be revised to include IMCare's quality evaluation focus that includes a trending of measures for the quality activities, an analysis and evaluation of the overall effectiveness of its quality program and to whom does it get reported and approved.

DHS Contractual Element and References	Met/Not Met	Audit Comments
2. Accessibility of Providers -2014 MSHO/MSC+ Contract Section 6.1.4(C)(2) and 6.1.5(E) A. In accordance with the DHS/MCO managed care contracts for MSHO and MSC+, the MCO must demonstrate that it offers a range of choice among Waiver providers such that there is evidence of procedures for ensuring access to an adequate range of waiver and nursing facility services and for providing appropriate choices among nursing facilities and/or waiver services to meet the individual need as of Enrollees who are found to require a Nursing Facility Level of Care. These procedures must also include strategies for identifying Institutionalized Enrollees whose needs could be met as well or better in non-Institutional settings and methods for meeting those needs, and assisting the Institutionalized Enrollee in leaving the Nursing Facility.	**Met**	In the Care Coordination policy there evidence of procedures for ensuring access to an adequate range of waiver and nursing facility services and for providing appropriate choices Strategies for identifying institutional enrollees whose needs could be met as well or better in a non-institutional setting, methods for meeting those needs and assisting enrollee in leaving the facility are present. RECOMMENDATION: IMCare could add more specificity to the policy as far as strategies and methods for of meeting enrollee needs and how IMCare would assist in the transition.

DHS Contractual Element and References	Met/Not Met	Audit Comments
3. Utilization Management - 2014 Contract Section 7.1.3 A. The MCO shall adopt a utilization management structure consistent with state regulations and current NCQA "Standards for Accreditation of Health Plans."[1] 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. 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. iii. Conduct qualitative analysis to determine the cause and effect of all data not within thresholds. iv. Analyze data not within threshold by medical group or practice. v. Take action to address identified problems of under or overutilization and measure the effectiveness of its interventions.[2] B. The following are the 2012 NCQA Standards and Guidelines for the Accreditation of MCOs UM 1-4 and 10-14.	**Met**	i. Types of utilization data include: • Child/Adolescent Access to PCP • Adult access to Ambulatory Care/Preventive Health (22-44 yrs. and 45-64 yrs.) • Well Child Visits • Timeliness of Pre and Post-Partum Care • Inpatient Utilization (Discharges and LOS) • ER Visits • MH Utilization • Identification of ETOH & other Drug dependent Services ii. Goals set based on MN state average and internal trends iii. Analysis performed iv. Analyzed by medical group v. In 2011, IMCare implemented an emergency department focus study (ED FS) in order to reduce ED over utilization. RECOMMENDATION Element A: IMCare could expand upon its explanation of the UM management structure. For example, include explanation of UM Committee, is it incorporated into another committee, who is responsible, who it reports to, what gets reported to the committee, authority of the committee, etc RECOMMENDATION ON MDH REPORT Element D. IMCare includes the annual utilization management summary into the quality annual evaluation where each UM activity is analyzed individually. IMCare may want to reorganize the evaluation to include all the utilization management activities together under one section and include a summary of the overall effectiveness of utilization management program.
NCQA Standard UM 1: Utilization Management	**Met**	

1 2011 *Standards and Guidelines for the Accreditation of Health Plans*, effective July 1, 2011

DHS Contractual Element and References	Met/Not Met	Audit Comments
Structure The organization clearly defines the structures and processes within its utilization management (UM) program and assigns responsibility to appropriate individuals. Element A: Written Program Description Element B: Physician Involvement Element C: Behavioral Health Involvement Element D: Annual Evaluation		
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. Element A: UM Criteria Element B: Availability of Criteria Element C: Consistency of Applying Criteria	**Met**	
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**	
NCQA Standard UM 4: Appropriate Professionals Qualified Licensed health professionals assess the clinical information used to support UM decisions. Element D: Practitioner Review of BH Denials Element F: Affirmative Statement About Incentives	**Met**	

2 42 CFR 438. 240(b)(3)

DHS Contractual Element and References	Met/Not Met	Audit Comments
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 Element B: Description of Evaluation Process Element C: Implementation of New Technology	**Met**	
NCQA Standard UM 11: Satisfaction with UM Process The organization evaluates member and practitioner satisfaction with the UM process. Element A: Assessing Satisfaction with UM Process	**Met**	
NCQA Standard UM 12: 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**	
NCQA Standard UM 13: Procedures for Pharmaceutical Management 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 Element C: Pharmaceutical Patient Safety Issues Element D: Reviewing and Updating Procedures Element F: Availability of Procedures Element G: Considering Exceptions	**Met**	

DHS Contractual Element and References	Met/Not Met	Audit Comments
NCQA Standard UM 14: 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	**N/A**	IMCare does not have a centralizes triage and referral process

DHS Contractual Element and References	Met/Not Met	Audit Comments
4. Special Health Care Needs 2013 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. 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	**Met**	
5. Practice Guidelines - 2014 Contract Section 7.1.5[5,6,] A. The MCO shall adopt preventive and chronic disease practice guidelines appropriate for children, adolescents, prenatal care, young adults, adults, and seniors age 65 and older, and, as appropriate, for people with disabilities populations. 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. ii. **Dissemination of guidelines.** MCO ensures guidelines are disseminated: • To all affected Providers • To enrollees and potential enrollees upon request iii. **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**	IMCare has met this element. RECOMMENDATION: IMCare ensures that enrollees are educated about some of the practice guidelines through provider and nurse education during patient visits, and also through enrollee newsletters. However, MDH recommends that IMCare be more explicit about ensuring that practice guidelines are made available to enrollees who request it such as by outlining more clear strategies for how this is communicated to enrollees. Although education is taught, enrollees may not even know that guidelines are available to them and thus are not requesting them (as indicated through data in the 2014 Practice Guidelines Report).

3 42 CFR 438.208 (c)(1-4)
4 MSHO, MSC+ Contract section 7.1.4 A, C; SNBC Contract section 7.1.4
5 42 CFR 438.236
6 MSHO/MSC+ Contract section 7.2 A-C; SNBC Contract section 7.1.5A-C

DHS Contractual Element and References	Met/Not Met	Audit Comments
6. Annual Quality Assessment and Performance Improvement Program Evaluation - 2014 Contract Sections 7.1.8 [7,8] A. The MCO must conduct an annual quality assessment and performance improvement program evaluation consistent with state and federal regulations and current NCQA "Standards for Accreditation of Health Plans". This 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. Include MCO's performance improvement projects. B. **NCQA QI 1, Element B:** There is an annual written evaluation of the QI Program that includes: i. A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service ii. A trending of measures to assess performance in the quality and safety of clinical care and quality of services iii. Analysis of the results of QI initiatives, including barrier analysis iv. Evaluation of the overall effectiveness of the QI program, including progress toward influencing network-wide-safe clinical practices	**Met**	RECOMMENDATION ON MDH REPORT: IMcare may want to include more tables and or graphs or both to better demonstrate trends and progress over time, especially in summarizing its performance improvement projects. IMCare may also want to reorganize the evaluation to include all the utilization management activities together under one section and include a summary of the overall effectiveness of utilization management program.

7 42 CFR 438.240(e)
8 MSHO/MSC+ Contract Section 7.2.4 also includes the requirement that the MCO must include the "Quality Framework for the Elderly" in its Annual Evaluation

DHS Contractual Element and References	Met/Not Met	Audit Comments
7. Performance Improvement Projects -2014 Contract Section 7.2 [9,10,11] A. Interim Project Reports. By December 1st of each calendar year, the MCO must produce an interim performance improvement project report for each current project. The interim project report must include any changes to the project(s) protocol steps one through seven and steps eight and ten as appropriate. B. Completed (Final) Project Reports: Completed PIP Project Improvements Sustained over Time- Real changes in fundamental system processes result in sustained improvements:	**Met**	A. Interim Reports Reviewed for 2012 and 2013: • Colorectal Cancer Screening (2012 PIP) • HPV for Males • Blood Pressure Control for Members with Diabetes (2010 PIP) Completed/Discontinued PIPs: B. For the 2014 contract year DHS allowed all MCOs to discontinue all current PIPs being conducted that had not been completed as of January 2, 2014 IMCare discontinued: • Blood Pressure Control for Members with Diabetes (2010 PIP) • Improving Quality of Life for Members with Asthma (2011 PIP) • Colorectal Cancer Screening (2012 PIP) • HPV for Males (2013 PIP) Completed: Medication Reconciliation Post Discharge (QIP) The DHS selected topic in the 2014 contract is reduction of Race and Ethnic Disparities in the Management of Depression. The PIP will be conducted over the calendar years 2015, 2016, and 2017.

9 42 CFR 438.240 (d)(2)
10 MSHO/MSC+ Contract section 7.3; SNBC Contract section 7.2
11 CMS Protocols, Conduction Performance Improvement Projects, Activity 10

DHS Contractual Element and References	Met/Not Met	Audit Comments
8. Disease Management - 2014 Contract Section 7. 3[12] The MCO shall make available a Disease Management Program for its Enrollees with: A. Diabetes B. Asthma C. Heart Disease Standards -The MCO's Disease Management Program shall be consistent current NCQA "Standards and Guidelines for the Accreditation of Health Plans" – QI Standard Disease Management If the MCO's Diabetes, Asthma, and Heart Disease Management Programs have achieved 100% compliance during the most recent NCQA Accreditation Audit of QI Standards - Disease Management, the MCO will not need to further demonstrate compliance. **Diabetes**	**Met**	All items under this element are met. RECOMMENDATION: MDH recommends that IMCare not just outline what the programs do, but how they're implemented. For instance, better descriptions for how often and when/where the health assessments are distributed, what interventions are most commonly used for the respective diseases, and what the most frequently used resources are available.
A. Program Content	X	
B. Identifying Members for DM Programs	X	
C. Frequency of Member Identification	X	
D. Providing Members With Information	X	
E. Interventions Based on Stratification	X	
F. Eligible Member Participation	X	
G. Informing and Educating Practitioners	X	
H. Integrating Member Information	X	
I. Satisfaction With Disease Management	X	
J. Measuring Effectiveness	X	

12 MSHO/ MSC+ Contract section 7.4, requires only diabetes and hearth DM programs; SNBC Contract section 7.2.9

DHS Contractual Element and References	Met/Not Met	Audit Comments
Asthma:		
A. Program Content	X	
B. Identifying Members for DM Programs	X	
C. Frequency of Member Identification	X	
D. Providing Members With Information	X	
E. Interventions Based on Stratification	X	
F. Eligible Member Participation	X	
G. Informing and Educating Practitioners	X	
H. Integrating Member Information	X	
I. Satisfaction With Disease Management	X	
J. Measuring Effectiveness	X	
Heart Disease:		
A. Program Content	X	
B. Identifying Members for DM Programs	X	
C. Frequency of Member Identification	X	
D. Providing Members With Information	X	
E. Interventions Based on Stratification	X	
F. Eligible Member Participation	X	
G. Informing and Educating Practitioners	X	
H. Integrating Member Information	X	
I. Satisfaction With Disease Management	X	
J. Measuring Effectiveness	X	

DHS Contractual Element and References	Met/Not Met	Audit Comments
9. Advance Directives Compliance - 2014 Contract Section 16[13,14] A. 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: i. 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. ii. Written policies of the MCO respecting the implementation of the right; and iii. Updated or revised changes in State law as soon as possible, but no later than 90 days after the effective date of the change; iv. 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 CFR 438.6(i). B. 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. C. Treatment. To not condition treatment or otherwise discriminate on the basis of whether an individual has executed an advance directive. D. To comply with State law, whether statutory or recognized by the courts of the State on Advance Directives, including Laws of Minnesota 1998, Chapter 399, §38. E. To provide, individually or with others, education for MCO staff, providers and the community on Advance Directives.	**Met**	

13 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
14 MSC/MSC+ Contract Article 16; SNBC Contract Article 16

DHS Contractual Element and References	Met/Not Met	Audit Comments
10. Validation of MCO Care Plan Audits for MSHO, MSC+[15] MDH will collect information for DHS to monitor MCO Care Plan Audit activities as outlined in the DHS/MCO MSHO/MSC+ Contract. 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 and when applicable the MSHO program. 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. B. 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. C. 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. D. 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.	**Met**	MDH reviewed eight initial assessment files and all contained the required elements. MDH reviewed eight reassessment files and identified one file that didn't document the essential services, back-up plans, and community wide disaster plans for a member. This prompted a review of an additional 12 files for this particular component which yielded no additional finding.

15 Pursuant to MSHO/MSC+ 2011 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)

DHS Contractual Element and References	Met/Not Met	Audit Comments
11. Information System. [16, 17] The MCO must operate an information system that supports initial and ongoing operations and quality assessment and performance improvement programs. 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**	
12. A. Subcontractors. 18 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 CMS. All contracts must include: 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;	**Met**	(see part D on page 19 of this report for more detail on "Not Met")

16 Families and Children, Seniors and SNBC Contract Section 7.1.2
17 42 CFR 438.242
18Families and Children Contract Sections 9.1.3.A, 9.1.3.C

DHS Contractual Element and References	Met/Not Met	Audit Comments
3) The name of any other disclosing entity in which a Person with an Ownership or Control Interest in the disclosing entity also has an ownership or control interest; and 4) The name, address, date of birth, and social security number of any managing employee of the disclosing entity. 5) For the purposes of section 9.3, subcontractor means an individual, agency, or organization to which a disclosing entity has contracted, or is a 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.		
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.	**Met**	
Exclusions of Individuals and Entities; Confirming Identity.[19] (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.	**Met**	
(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	**Met**	

19 Families and Children Contract Section 9.3.13

DHS Contractual Element and References	Met/Not Met	Audit Comments
persons: 1) Are not excluded from participation in Medicaid under Sections 1128 or 1128A of the Social Security Act; and 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.		
(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.	**Met**	
(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 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.	**Not Met**	All items met except for a change needed in IMCare's provider agreement to state that IMCare providers must report to IMCare *within 5 days….* (the current IMCare Provider Agreement states "10 working days").
(E)The MCO shall report this information to the STATE within seven (7) days of the date the MCO receives the information.	**Met**	
(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).	**Met**	
(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.	**Met**	

Attachment A: MDH 2015 EW Care Plan Audit

Audit Protocol	Protocol Description	Measures	Total # Charts Reviewed		Total # Charts "Met"		2015 Total % Met	Comments
			Initial	Reassessment	Initial	Reassessment		
1	**INITIAL HEALTH RISK ASSESSMENT** For members new to the MCO or product within the last 12 months	A. Date HRA completed is within 30 calendar days of enrollment date	8	N/A	8	N/A	100%	
		B. All HRA areas evaluated and documented (in enrollee Comprehensive Care Plan)	8	N/A	8	N/A	100%	
2	**ANNUAL HEALTH RISK ASSESSMENT** For members on who have been a member of the MCO for more than 12 months [Only for plans with separate HRA]	HRA is completed is within 12 months of previous HRA (results are included in enrollee Comprehensive Care Plan)	N/A	8	N/A	8	100%	
3	**LONG TERM CARE CONSULTATION – INITIAL** If member is new to EW in the past 12 months	A. All (100%) of the fields relevant to the enrollee's program are completed with pertinent information or noted as Not Applicable or Not Needed	8	N/A	8	N/A	100%	
		B. LTCC was completed timely (and in enrollee Comprehensive Care Plan)	8	N/A	8	N/A	100%	
4	**REASSESSMENT OF EW**	A. Date re-assessment completed is within 12 months of previous assessment	N/A	8	N/A	8	100%	

Audit Protocol	Protocol Description	Measures	Total # Charts Reviewed		Total # Charts "Met"		2015 Total % Met	Comments
			Initial	Reassessment	Initial	Reassessment		
	For members open to EW who have been a member of the MCO for more than 12 months							
		B. All areas of LTCC have been evaluated and documented (and in enrollee Comprehensive Care Plan)	N/A	8	N/A	8	100%	
5	**COMPREHENSIVE CARE PLAN** Includes needs identified in the HRA and/or the LTCC and other sources such as medical records and member and/or family input and all elements of the community support plan.	A. Date Comprehensive Care Plan was completed is within 30 calendar days of completed LTCC ("Complete" defined as the date the plan is ready for signature (may also be noted as "date sent to member")	8 initial 8 reassessments		8 initial 8 reassessments		100%	
		B. If enrollee refused recommended HCBS care or service, then refusal should be noted in the Comprehensive Care Plan according to item IV of the CSP as evidence of a discussion between care planner and enrollee about how to deal with situations when support has been refused, referred to as the *Personal Risk Management Plan*	8 initial 8 reassessments		8 initial 8 reassessments		100%	
6	**COMPREHENSIVE CARE PLAN SPECIFIC ELEMENTS**	A. Identification of enrollee needs and concerns, including identification of health and safety risks, and what to do in the event of an emergency, are documented	8 initial 20 reassessments		8 initial 19 reassessments		96.4%	

Audit Protocol	Protocol Description	Measures	Total # Charts Reviewed		Total # Charts "Met"		2015 Total % Met	Comments
			Initial	Reassessment	Initial	Reassessment		
	To achieve an interdisciplinary, holistic, and preventive focus; the Comprehensive Care Plan must include the elements listed:	in Comprehensive Care Plan and linked to assessed needs as determined by the completed LTCC						
		B. Goals and target dates (at least, month/year) identified Monitoring of outcomes and achievement dates (at least, month/year) are documented	8 initial 8 reassessments		8 initial 8 reassessments		100%	
		C. Outcomes and achievement dates (at least, month/year) are documented	8 initial 8 reassessments		8 initial 8 reassessments		100%	
		D. If the enrollee refuses any of the recommended interventions, the Comprehensive Care Plan includes documentation of an informed choice about their care and support	8 initial 8 reassessments		8 initial 8 reassessments		100%	
7	**FOLLOW-UP PLAN** Follow-up plan for contact for preventive care[20], long-term care	A. All areas of concern are addressed as identified on the Comprehensive Care Plan as stated in #5 of this protocol	8 initial 8 reassessments		8 initial 8 reassessments		100%	

[20] Preventive care concerns may include but not be limited to: annual physical, immunizations, screening exams such as dementia screening, vision and hearing exams, health care (advance) directive, dental care, tobacco use, and alcohol use.

Audit Protocol	Protocol Description	Measures	Total # Charts Reviewed		Total # Charts "Met"		2015 Total % Met	Comments
			Initial	Reassessment	Initial	Reassessment		
	and community support, medical care, or mental health care[21], or any other identified concern							
		B. If an area is noted as a concern then there must be documented goals, interventions, and services for concerns or needs identified [If an area is identified as not a concern, then "Not Needed" and will be excluded from denominator for this item]	8 initial 8 reassessments		8 initial 8 reassessments		100%	
8	**ANNUAL PREVENTIVE CARE**	Documentation in enrollee's Comprehensive Care Plan that substantiates a conversation was initiated with enrollee about the need for an annual, age–appropriate comprehensive preventive health exam (i.e., Influenza immunization, Pneumococcal immunization, Shingles (Zostavax) immunization, Vision screening, Depression screening (or other mental status review), Assessment of the presence of urinary incontinence, Preventive dental exam	8 initial 8 reassessments		8 initial 8 reassessments		100%	
9	**ADVANCE DIRECTIVE**	Evidence that a discussion was initiated, enrollee refused to complete, was culturally inappropriate, or AD was completed.	8 initial 8 reassessments		8 initial 8 reassessments		100%	

[21] Mental health care concerns should include but not be limited to: depression, dementia, and other mental illness.

Audit Protocol	Protocol Description	Measures	Total # Charts Reviewed		Total # Charts "Met"		2015 Total % Met	Comments
			Initial	Reassessment	Initial	Reassessment		
10	**ENROLLEE CHOICE** Enrollee was given a choice between Home and Community-Based Services (HCBS) and Nursing Home Services (also indicates enrollee involvement in care planning)	A. Choice noted in Section J of LTCC Assessment Form (e-docs #3428) or equivalent document (correlates to Section D of the LTCC Screening Document (e-docs #3427)	8 initial 8 reassessments		8 initial 8 reassessments		100%	
		B. Completed and signed care plan summary (and in enrollee Comprehensive Care Plan)	8 initial 8 reassessments		8 initial 8 reassessments		100%	
11	**CHOICE OF HCBS PROVIDERS** Enrollee was given information to enable the enrollee to choose among providers of HCBS	Completed and signed care plan summary (and in enrollee Comprehensive Care Plan)	8 initial 8 reassessments		8 initial 8 reassessments		100%	
12	**HOME AND COMMUNITY BASED SERVICE PLAN** A HCBS service plan with these areas completed, including clearly identified and documented links to assessed needs per the results of the LTCC	A. Type of services to be furnished	8 initial 8 reassessments		8 initial 8 reassessments		100%	
		B. The amount, frequency and duration of each service	8 initial 8 reassessments		8 initial 8 reassessments		100%	
		C. The type of provider furnishing each service including non-paid care givers and other informal community supports or resources	8 initial 8 reassessments		8 initial 8 reassessments		100%	

Audit Protocol	Protocol Description	Measures	Total # Charts Reviewed		Total # Charts "Met"		2015 Total % Met	Comments
			Initial	Reassessment	Initial	Reassessment		
13	**CAREGIVER SUPPORT PLAN** If a primary caregiver is identified in the LTCC,	A. Attached Caregiver Planning Interview	8 initial 8 reassessments		8 initial 8 reassessments		100%	
		B. Incorporation of stated caregiver needs in Service Agreement, if applicable	8 initial 8 reassessments		8 initial 8 reassessments		100%	
14	**APPEAL RIGHTS** Appeal rights information provided to member.	Acknowledgement on signed care plan or other signed documentation in file	8 initial 8 reassessments		8 initial 8 reassessments		100%	
15	**DATA PRIVACY** Data privacy information provided to member	Acknowledgement on signed care plan or other signed documentation in file	8 initial 8 reassessments		8 initial 8 reassessments		100%	

Summary:

DHS followed the sampling methodology outlined in the audit protocol guidelines and presented the sample lists to MDH. MDH audited 8 initial assessment files and 8 reassessment files following the *MSHO and MSC+ Elderly Waiver Planning Protocol Care Plan Data Collection Guide*.

IMCare is to be commended for incorporating improvements to the Care Plan Assessment with the delegate. In the 2013 delegate report, IMCare found through their own audit that several protocols were below standard. IMCare incorporated a corrective action plan with the delegate and utilized the Collaborative Care Plan to ensure a more efficient care plan assessment process. In 2014, IMCare's care plan audit was fully in compliance. There was only one finding during the MDH care plan audit related to documentation of backup and essential services which prompted a review of an additional 12 files with no additional findings related to this issue. The IMCare care plan audit yielded 100% with no findings.