Triennial Compliance Assessment

of

Medica Health Plans

Performed under Interagency Agreement for:

Minnesota
Department of Human Services

By

Minnesota Department of Health (MDH)
Managed Care Systems Section

Exam Period:
March 1, 2012 through December 31, 2014

File Review Period:
January 1 through December 31, 2014

On-site:
March 16 through 19, 2015

Examiners:
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Final Report

July 22, 2015

Executive Summary
Triennial Compliance Assessment (TCA)
Medica Health Plans

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): Medica Health Plans
Examination Period: March 1, 2012 through December 31, 2014
Onsite Dates: March 16 through 19, 2015

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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**	

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**	

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 2014 NCQA Standards and Guidelines for the Accreditation of MCOs UM 1-4 and 10-14. **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. Element A: Written Program Description Element B: Physician Involvement Element C: Behavioral Health Involvement Element D: Annual Evaluation	**Met** **Met**	Medica identified (HEDIS) indicators, high and low thresholds, rates for previous 5 years, measurements adjustments, findings, interventions and recommendations for Medicaid enrollees in each product. Medica provided 3rd Quarter (8/21/14) report on Annual rates, findings and notes per MHCP program. Well child care study termed for 2015. PMAP/MNCare included antidepressant medication mgmt. for acute and ongoing treatment (behavioral health). Now focusing on the continuation phase of medication monitoring for at least 12 weeks. They also looked at ER visits, total admits, and 30 day readmits across all products. Trend is lower # of admits, but increased ER visits. Believe on-site nurse reviewers at HCMC, UM and Children's has had a good effect. Changes: Making readmit indicator readmit within 7 days vs. 30 days. Medica moving to Total Cost of Care measures. This may lead to choosing different elements and different measures.

[1] 2014 *Standards and Guidelines for the Accreditation of Health Plans*, effective July 1, 2014
[2] 42 CFR 438. 240(b)(3)

DHS Contractual Element and References	Met/ Not Met	Audit Comments
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 E: Considering Exceptions	**Met**	
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	**Met**	

DHS Contractual Element and References	Met/ Not Met	Audit Comments
4. Special Health Care Needs 2014 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). C. Access to specialists.	**Met**	Medica has worked on improving their recruitment strategies for various SHCN programs. In their "Welcome Home" (transitions in care) program during 2014 they implemented a more aggressive strategy to encourage metro hospitals to reach out to Medica and notify them of an enrollee. Total participation increased from 34 in 2013 to 205 in 2014. The participation rate increased from 34% to 38% (MDH calculated this participation rate). Likewise, in the Integrated Care Coordination program Medica developed more active recruitment strategies called "Feet on the Street" in which care coordinators actively went into communities and knocked on enrollees' doors. The program was able to increase enrollment from 84 enrollees to 111 from 2013 to 2014. The participation rate increased from 22% in 2013 to 28% in 2014 (MDH calculated this participation rate). Overall, Medica states that from 2013 to 2014 they have been able to increase total absolute number of participating members in all of their SHCN programs by 40%. MDH advises Medica to calculate the participation rate in addition to reporting absolute member participation. Medica has done an excellent job of identifying more members who are eligible for their programs, but to fully access how effective their recruitment strategies are they should assess participation rates from year to year.

[3] 42 CFR 438.208 (c)(1-4)
[4] MSHO, MSC+ Contract section 7.1.4 A, C;

DHS Contractual Element and References	Met/ Not Met	Audit Comments
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 ages 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; and 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**	Medica adopts the Institute for Clinical Systems Improvement (ICSI) guidelines and makes them available to both enrollees and providers on Medica's website. Medica adopts guidelines that cover conditions and disease applicable to stages of life as well as relevant to managing population health.

[5] 42 CFR 438.236
[6] MSHO/MSC+ Contract Section 7.1.5 A-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®). 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**	

[7] 42 CFR 438.240(e)

[8] MSHO/MSC+ Contract section 7.1.8 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] The project proposal must be consistent with CMS' published protocol entitled "*Protocol for Use in Conducting Medicaid External Quality Review Activities: Conducting Performance Improvement Projects"* and STATE requirements. The new PIP proposal must include steps one through seven of the CMS protocol. The MCO must submit to the STATE for review and approval a written description of PIP the MCO proposes based on the topic selected by the STATE by September 1, 2014. The proposed PIP must be implemented by the end of the first quarter of calendar year 2015. A. Annual PIP Status Reports. The MCO shall submit by September 1st in calendar years 2015, 2016, and 2017 a written PIP status report in a format defined by the STATE. B. Final PIP Report. 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. C. Current PIPs. The MCO shall submit to the STATE by July 1, 2014, a final PIP status report for those current PIPs being conducted that have not been completed by January 2, 2014.	**Met**	• For the Interim Project reports, Medica sent the Improving Transitions Post-hospitalization for 2013 and 2014. Both were on time and complete. • Chlamydia 2013; intervention focused on systemic changes in clinics which continue • Colon-rectal cancer screening 2011; worked with targeted clinics with diverse population, including a Karen subpopulation, on systematic changes so improvement should be "inherently" sustainable. • Reducing Non-Urgent Emergency Department Use - Head Start 2012. Trained additional staff, which eliminated need for consultants. Makes the program more sustainable and more widely available. • Increasing use of Spirometry Testing for the Diagnosis of COPD in 2012. HEDIS finding indicate they met their goal. Educational resources available on line and clinic/provider intervention have been embedded in their systems. • Transitions of Care: Improved Post Discharge Follow-Up Care 2011. Participating hospitals showed significant improvement; however the final report didn't address sustainability. Medica continues to monitor readmissions as part of its over/under-utilization monitoring.

[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

<table>
<tr><th>DHS Contractual Element and References</th><th>Met/
Not Met</th><th>Audit Comments</th></tr>
<tr><td>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

Waiver of Disease Management Program Requirement. If the MCO is able to demonstrate that a Disease Management Program is: 1) not effective based upon Provider satisfaction, and is unable to achieve meaningful outcomes; or 2) will have a negative financial return on investment, the MCO may request that the STATE waive this requirement for the remainder of the Contract Year.

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.</td><td>Not Met</td><td>Medica received 100% of all NCQA points on QI 8 with the exception of Element B which we reviewed.

This program, while emphasizing health and wellness, does not purposefully engage enrollees with the required diagnoses and doesn’t meet the requirements of DHS Contract Section 7.3.

Medica’s Health and Wellness Program’s purpose is to assist and facilitate individual learning and practicing self-management. Disease Management staff is not “condition-specific.” Therefore, Medica’s Disease Management does not fit into the standard format. NCQA faulted Medica because it did not get lab results from the medical record.

Enrollees are encouraged to find a medical home, however Medica doesn’t monitor the enrollee’s condition in this program.

H&W doesn’t discuss a treatment plan.
The initial interview asks about other health conditions.
The program offers group coaching for lifestyle changes.

<table><tr><th>Health Coaching Approach</th><th>Disease Management Approach</th></tr><tr><td>Person focused</td><td>Disease focused</td></tr><tr><td>Member’s agenda</td><td>Provider or Health Plan’s agenda</td></tr><tr><td>Collaborative</td><td>Prescriptive</td></tr><tr><td>Health behavior change</td><td>Adherence to treatment</td></tr><tr><td>Relationship-based</td><td>Task-based</td></tr><tr><td>In-house, local staff</td><td>Vendored, staff outside of Medica Service Area</td></tr></table></td></tr>
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[12] MSHO/ MSC+ Contract section 7.3, requires only diabetes and heart disease DM programs; SNBC Contract section 7.2.6

Element A: Program Content		Members with all conditions or combinations of conditions are invited to participate in the program, but the top 10 most frequently occurring chronic conditions and combinations include: • Low back pain • Depression • Diabetes, Hyperlipidemia, Hypertension • Arthritis • Hypertension • Hyperlipidemia, Hypertension • Hyperlipidemia • Diabetes, CAD, Hyperlipidemia, Hypertension • Depression, Low Back Pain [Note: Asthma is not among the top 10 conditions]
Element B: Identifying Members for DM Programs		Identification Methodology -The coordinated member identification (CMI) process scans 100% of Medica members on a monthly basis. Claims: The identification algorithms utilize the Johns Hopkins ACGDxRx predictive model to identify members who are predicted to be high risk and high cost in the next year. Certain members (currently very high dollar, high risk, catastrophic, ill members) are identified for Medica's care management programming and sent directly to case management for intervention. The next group of members (are identified for the Health and Wellness Coaching Program) for intervention. Health Assessment: In addition, Medica uses data from the Personal Health Profile (PHP) to identify members for the Health and Wellness Coaching Program. Criteria used for identification includes members who indicate a low level of activation or identify as having a chronic condition. Referrals: Self, provider, employer and other program (Case Management, Treatment Decision Support, EAP, Nurseline, Medica Behavioral Health, Tobacco Cessation, Customer Service, etc.) referrals are accepted into the Health and Wellness Coaching Program.

		The coordinated member identification algorithms are refined regularly so that Medica targets individuals predicted to be high cost in the coming year as well as those most amenable to health behavior change. Criteria used for identification for the Health and Wellness Coaching Program include members who: • Indicate a low level of activation • Identify as having a chronic condition • Are referred by self, provider, employer and other program (Case Management, Treatment Decision Support, EAP, Nurseline, Medica Behavioral Health, Tobacco Cessation, Customer Service, etc.).
Element C: Frequency of Member Identification		Scans 100% of Medica members on a monthly basis.
Element D: Providing Members With Information		Members receive a mailed invitation or personalized letter to participate. Two weeks after the print materials are sent and if the member hasn't already called Medica, health coach place two outbound telephone calls to each member. The outbound calls ask the member if they would like to participate in the program. If the member does not respond to the health coach calls, a letter is sent to the member explaining that we were not able to reach them via the phone and that if they would like to participate, please call the Health and Wellness Coaching Program phone number.
Element E: Interventions Based on Assessment		Catastrophic, ill members are identified for Medica's care management programming and sent directly to case management for intervention. The next group of members are identified for the Health and Wellness Coaching Program for intervention. Once a member has been enrolled in the Active level, they receive an initial assessment (health inventory). This helps the health coach to build a rapport with the member and learn about the member's needs and wants related to their health. In addition, the initial assessment will assess the member's readiness to make lifestyle and behavior changes and their level of self-management knowledge, skills and confidence.

		The Health coach works with the member to identify and prioritize goals and create their individualized health improvement plan with interventions and milestones. Coaching sessions (telephonic and online through e-mail), tailored educational mailings, proactive coordination, referral to services and resources, and subsequent assessments are tailored to the member's health improvement plan. All members receive a workbook that addresses health behavior change, stress management, healthful living tips and several exercises to support the member in their health improvement journey. Upon graduation, members receive a $75 gift card. In order to receive an incentive at program completion, the member needs to: 1. Complete 2-3 scheduled coaching sessions, not including the initial assessment session. 2. Participate in program at Active level for 30 consecutive days. The majority of members graduate from the program after six months. Criteria determining health and wellness coaching completion status are dependent upon program participation level (Active or Self-directed).
Element F: Eligible Member Active Participation		In 2013, almost 49,000 members were identified for the program. Of these members, 14.7% decided to engage with the program. Of the engaged population, 30% completed the program and 10.5% are still participating. Slightly less than 60% disenrolled from the program, which is a decrease from the 2012 level. Medica conducted enrollee surveys, and evaluated its success related to Enrollee satisfaction/confidence in managing their health. They identified participation overall, including who engaged, who completed the program, etc. But Medica did not identify participation rates by condition.
Element G: Informing and Educating Practitioners		Proactively works with the member to establish a health care home and primary care provider, valuable assets in chronic condition/health management. The health coach guides the member in developing the skill-

		set to build and establish a collaborative and effective relationship with their primary care provider and other care providers (doctors, home care, social worker, etc.) that are part of their healthcare support system.
Element H: Integrating Member Information		See below.
Element I: Experience With Disease Management		Reported Quarterly
Element J: Measuring Effectiveness		Comprehensive measures and reporting are available for the Health and Wellness Coaching Program, including: • Operations Reporting: Provides counts and metrics on how many members are participating in the program, and the extent to which program components are being utilized. • Performance Reporting: Rapid cycle metrics on how well the design of the program is matching up to the members' needs. Metrics include goals, clinical variables, demographic data. • Evaluation Reporting: Measures the medical cost savings: Program impact estimated to be -$48 PPPM less for HWC members compared to control group. Clinical improvements; Reduction in numbers of ER, output and input visits per 1,000. (No urgent care visits) Over 71% of all goals were "met" or "partially met" and 6.2% of goals are currently "in progress." The total number of goals decreased from 2012 levels, as did the percentage of "met" goals AND member satisfaction related to the Health & Wellness Coaching Program. **HWC was more impactful for members with certain conditions (diabetes and malignancies)** **Behavioral Coaching has greater financial impact than HCP**

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 and 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. 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**	

15 Pursuant to MSHO/MSC+ 2014 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**	HEDIS Audit Reports certified by Attest Health Care Advisors for years: 1. 2012 Attest 7/1/12 2. 2013 Attest 6/28/2013 3. 2014 Attest 6/27/2014

[16] Families and Children, Seniors and SNBC Contract section 7.1.2
[17] 42 CFR 438.242

DHS Contractual Element and References	Met/ Not Met	Audit Comments
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; (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.	**Met**	Medica performs systematic monitoring of disclosures, delegating the process to subcontractors.

[18] Families and Children Contract Sections 9.3.1.A, 9.1.3.C

DHS Contractual Element and References	Met/ Not Met	Audit Comments
(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.		

DHS Contractual Element and References	Met/ Not Met	Audit Comments
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. (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. 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. (D) The MCO shall require all subcontractors to report to the MCO within five (5) days any information regarding individuals or entities	**Met**	Medica performs systematic monitoring of excluded entities and individuals through its credentialing system.

[19] Families and Children Contract Section 9.3.13

DHS Contractual Element and References	Met/ Not Met	Audit Comments
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. (E) The MCO shall report this information to the STATE within seven (7) days of the date the MCO receives the information. (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). (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.		

Attachment A: MDH 2014 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	15	N/A	14	N/A	93.3%	
		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%	

Audit Protocol	Protocol Description	Measures	Total # Charts Reviewed		Total # Charts "Met"		2015 Total % Met	Comments
			Initial	Reassessment	Initial	Reassessment		
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)	15	N/A	14	n/a	93.3%	
4	**REASSESSMENT OF EW** For members open to EW who have been a member of the MCO for more than 12 months	A. Date re-assessment completed is within 12 months of previous assessment	N/A	8	n/a	8	100%	
		B. All areas of LTCC have been evaluated and documented (and in enrollee Comprehensive Care Plan)	N/A	8	N/A	8	100%	

Audit Protocol	Protocol Description	Measures	Total # Charts Reviewed	Total # Charts "Met"	2015 Total % Met	Comments
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")	23	22	95.6%	
		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*	16	16	100%	
6	**COMPREHENSIVE CARE PLAN SPECIFIC ELEMENTS**	A. Identification of enrollee needs and concerns, including identification of health and	16	16	100%	

Audit Protocol	Protocol Description	Measures	Total # Charts Reviewed	Total # Charts "Met"	2015 Total % Met	Comments
	To achieve an interdisciplinary, holistic, and preventive focus; the Comprehensive Care Plan must include the elements listed:	safety risks, and what to do in the event of an emergency, are documented 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	16	16	100%	
		C. Outcomes and achievement dates (at least, month/year) are documented	16	16	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	16	16	100%	

Audit Protocol	Protocol Description	Measures	Total # Charts Reviewed	Total # Charts "Met"	2015 Total % Met	Comments
7	**FOLLOW-UP PLAN** Follow-up plan for contact for preventive care[20], long-term care and community support, medical care, or mental health care[21], or any other identified concern	A. All areas of concern are addressed as identified on the Comprehensive Care Plan as stated in #5 of this protocol	16	16	100%	
		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]	16	16	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,	16	16	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.
[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
		Pneumococcal immunization, Shingles (Zostavax) immunization, Vision screening, Depression screening (or other mental status review), Assessment of the presence of urinary incontinence, Preventive dental exam				
9	**ADVANCE DIRECTIVE**	Evidence that a discussion was initiated, enrollee refused to complete, was culturally inappropriate, or AD was completed	16	16	100%	
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)	16	16	100%	
		B. Completed and signed care plan summary (and in enrollee Comprehensive Care Plan)	16	16	100%	

Audit Protocol	Protocol Description	Measures	Total # Charts Reviewed	Total # Charts "Met"	2015 Total % Met	Comments
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)	16	16	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	16	16	100%	
		B. The amount, frequency and duration of each service	28	25	89.3%	*
		C. The type of provider furnishing each service including non-paid care givers and other informal community supports or resources	28	25	89.3%	*
13	**CAREGIVER SUPPORT PLAN** If a primary caregiver is identified in the LTCC,	A. Attached Caregiver Planning Interview	16	16	100%	
		B. Incorporation of stated caregiver needs in Service Agreement, if applicable	16	16	100%	

Audit Protocol	Protocol Description	Measures	Total # Charts Reviewed	Total # Charts "Met"	2015 Total % Met	Comments
14	**APPEAL RIGHTS** Appeal rights information provided to member.	Acknowledgement on signed care plan or other signed documentation in file	16	16	100%	
15	**DATA PRIVACY** Data privacy information provided to member	Acknowledgement on signed care plan or other signed documentation in file	16	16	100%	

*Originally, 8 reassessment files were reviewed. Within the eight files, each of two files contained one service required by the enrollee without an associated cost. This resulted in the review of 12 additional reassessment files. Within the additional sample, one file identified one service without an associated cost.

Summary:

DHS followed the sampling methodology outlined in the audit protocol guidelines and presented the sample lists to MDH. MDH audited 15 initial assessment files and 20 reassessment files (but not for every element) following the *MSHO and MSC+ Elderly Waiver Planning Protocol Care Plan Data Collection Guide*.

The Medica 2014 delegate care plan audit report reviewed a significantly larger file sample size than MDH which included only care plans done during 2013. Medica identified files with a score of 95% or lower as needing a corrective action plan from the affected delegates. The issues cited were isolated and no excessive.

Likewise, the MDH care plan audit evaluated files from 2014 and findings indicated two separate issues. Within the *Initial Assessment* file review MDH cited an issue with Protocols #1 and 3: Health Risk Assessment (HRA) and Long Term Care Consultation (LTCC) respectively. One file of the 15 reviewed was outside the 30 day timeline between enrollment and to assessment. Within the *Reassessment File* review MDH found an issue with Protocol #12: Home and Community Based Care Plan. Three files out of the 20 reviewed did not list the total cost for a particular HCBS service.

Comparatively, Medica's care plan audit cited more issues (due to a larger sample size) than the MDH audit. There was no observed pattern between the types of issues found between the two audits.