DEPARTMENT OF HEALTH

Medica Health Plans

TRIENNIAL COMPLIANCE ASSESSMENT

Triennial Compliance Assessment

Performed under Interagency Agreement for Minnesota Department of Human Services
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Contents

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 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 issues, 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 - 2020 Contract Section 7.1.1 (1-2)[1,2]

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) 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**	MDH reviewed and approved Medica's 2019 and 2020 Quality Improvement Program Descriptions. They contained all requirements as laid out in Minnesota Rule 465.1110, federal requirements as described in 42 CFR §438, subpart E and applicable NCQA standards and guidelines.
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	**Met**	

1 Seniors (MSHO/MSC+), and Special Needs Basic Care (SNBC) Contract Section 7.1 and sub-sections; MSHO/MSC+ Contract Section 7.1 also includes the requirement that the MCO must comply with requirements of "*Quality Framework*," for EW services, including those found in the CMS "*Modifications to Quality Measures and Reporting in 1915(c) Home and Community-Based Waivers*" published in March 2014

2 Note: *DHS understands the impact of the outbreak on health plan reporting and accreditation efforts and therefore asks the MDH auditors to take that into consideration when performing TCA audits which cover the time impacted by the COVID-19 outbreak.. DHS is implementing the exception for March 1-September1, 2020 timeframe*

DHS Contractual Element and References	Met or Not Met	Audit Comments
42 CFR § 438.228 Grievance Systems 42 CFR § 438.230 sub contractual Relationships and Delegation		
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**	

II. Information System – 2020 Contract Section 7.1.3[3, 4]

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	**HEDIS Audit Reports submitted and reviewed for:** 2018 - ATTEST Healthcare Advisors 2019 - ATTEST Healthcare Advisors 2020 - ATTEST Healthcare Advisors Audit reports attest the following: "In our opinion, Medica Health Plans' submitted measures were prepared according to the HEDIS Technical Specifications and present fairly, in all material respects, the organization's performance with respect to these specifications"

3 Seniors and SNBC Contract Section 7.1.3

4 42 CFR 438.242; SSA 1904(r)(1)

III. Utilization Management - 2020 Contract Section 7.1.4

The MCO shall adopt a utilization management structure consistent with state regulations and federal regulations and current NCQA "Standards for Accreditation of Health Plans."[5] 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**	On an annual basis, Medica reviews for the potential of over or underutilization by product. Medica has chosen the following HEDIS utilization metrics to monitor: 2020 measures as identified in Work Plan are: • PSA (Prostate-specific antigen) non-recommended screening • Ambulatory Care – ER Visits • IPU (Inpatient Utilization) – Inpatient Discharges /1000 mbrs • IPU – Days/1000 mbrs • IPU – Inpatient ALOS • PCR (Plan All-Cause Readmissions) – Readmissions • PA (Prior authorization) frequency by medical treatment and financial return • Any item where Medica scored below the NCQA HEDIS 50th percentile or above the DHS withhold target requires action on the part of Medica to improve.

5 2020 *Standards and Guidelines for the Accreditation of Health Plans*, effective July 1, 2020

DHS Contractual Element and References	Met or Not Met	Audit Comments
		Medica Behavioral Health (MBH) assesses quality through the continuous monitoring of key performance indicators Highlights of 2019 include: 1. Re-hospitalization a. Aggregate Re-Hospitalization Rate Comparison (Lines of Business Commercial, Medicaid, Medicare) – Goal met b. Commercial Re-Hospitalization (Combined Mental Health & Substance Use) – Goal Met c. Medicaid Substance Use Re-Hospitalization (SNBC, MSC+) – Goal Not Met In 2019 the Re-Hospitalization rate for substance use did not met the performance goal of 16%. The SU Re-Hospitalization rate was 20.0% (6/30). d. Medicaid Mental Health Re-Hospitalization (SNBC, MSC+) – Goal Not Met In 2019 the Re-Hospitalization rate for Mental Health did not met the performance goal of 16%. The MH Re-Hospitalization rate was 17.8% (72/404). 2. Referrals - Between Behavioral Health and Medica Health Programs a. Improvements in referral numbers across products
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.	**Met**	Thresholds: MSHO HEDIS
The MCO Shall: iii. Examine possible explanations for all data not within thresholds.	**Met**	
The MCO Shall: iv. Analyze data not within threshold by medical group or practice.	**Met**	

DHS Contractual Element and References	Met or Not Met	Audit Comments
The MCO Shall: v. Take action to address identified problems of under or overutilization and measure the effectiveness of its interventions.[6]	**Met**	Analysis was done on all measures not meeting goal/threshold and actions taken

6 42 CFR 438.330(b)(3)

B. 2020 NCQA Standards and Guidelines UM 1 – 4, 10 – 11; UM 13

The following are the 2020 NCQA Standards and Guidelines for the Accreditation of Health Plans UM 1 – 4 and 10 – 11, and UM 13.

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.	**Per NCQA 100%**	Medica scored 100% on UM elements utilizing *2019 NCQA Standards and Guidelines for the Accreditation of Health Plans*
Element A: Written Program Description	**Per NCQA 100%**	
Element B: Annual Evaluation	**Per NCQA 100%**	
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.	**Per NCQA 100%**	
Element A: UM Criteria	**Per NCQA 100%**	
Element B: Availability of Criteria	**Per NCQA 100%**	
Element C: Consistency of Applying Criteria	**Per NCQA 100%**	

DHS Contractual Element and References	Met or Not Met	Audit Comments
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	**Per NCQA 100%**	
NCQA Standard UM 4: Appropriate Professionals Qualified Licensed health professionals assess the clinical information used to support UM decisions. Element A: Licensed Health Professionals	**Per NCQA 100%**	
Element B: Use of Practitioners for UM Decisions	**Per NCQA 100%**	
Element C: Practitioner Review of Non-Behavioral Healthcare Denials	**Per NCQA 100%**	
Element D: Practitioner Review of Behavioral Healthcare Denials	**Per NCQA 100%**	
Element E: Practitioner Review of Pharmacy Denials	**Per NCQA 100%**	
Element F: Use of Board-Certified Consultants	**Per NCQA 100%**	
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	**Per NCQA 100%**	

DHS Contractual Element and References	Met or Not Met	Audit Comments
Element B: Description of Evaluation Process	**Per NCQA 100%**	
NCQA Standard UM 11: Procedures for Pharmaceutical Management The organization ensures that its procedures for pharmaceutical management, if any, promote the clinically appropriate use of pharmaceuticals Element A: Pharmaceutical Management Policies and Procedures	**Per NCQA 100%**	
Element B: Pharmaceutical Restrictions/Preferences	**Per NCQA 100%**	
Element C: Pharmaceutical Patient Safety Issues	**Per NCQA 100%**	
Element D: Reviewing and Updating Procedures	**Per NCQA 100%**	
Element E: Considering Exceptions	**Per NCQA 100%**	
NCQA Standard UM 13: Delegation of UM If the organization delegates UM activities, there is evidence of oversight of the delegated activities. Element A: Delegation Agreement	**Per NCQA 100%**	
Element B: Pre-delegation Evaluation	**Per NCQA 100%**	
Element C: Review of the UM Program	**Per NCQA 100%**	

DHS Contractual Element and References	Met or Not Met	Audit Comments
Element D: Opportunities for Improvement	**Per NCQA 100%**	

IV. Special Health Care Needs - 2020 Contract Section 7.1.5 (1-4)[7, 8]

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[9] The MCO must have effective mechanisms to assess the quality and appropriateness of care furnished to Enrollees with special health care needs. If the MCO has in place an alternative mechanism(s), or is proposing a new mechanism(s) that meets or exceeds the requirements of section 7.1.5.1, the MCO must submit a written description to the STATE for approval. If the MCO's mechanism(s) have been approved by the STATE and there has been a material change, the MCO must timely submit a revised description to the STATE for approval (see also section 3.11.4).	**Met**	Medica products include MSHO, SNBC, and MSC+; all patients are considered special health care needs.

7 42 CFR 438.330 (b)(4)

8 MSHO, MSC+ Contract section 7.1.5 (1-4); SNBC Contract section 7.1.5 (1-4)

9 The definition of special health care needs is different among the three contracts. For MSHO/MSC+ and SNBC, all enrollees are considered to have special health care needs

7.1.5.1 **Mechanism to Identify Persons with Special Health Care Needs**. The MCO must identify Enrollees that may need additional services through method(s) approved by the STATE. (1) The MCO must analyze claim data for diagnoses and utilization patterns (both under- and over-utilization) to identify Enrollees who may have special health care needs. At a minimum the MCO must quarterly analyze claim data to identify Enrollees eighteen (18) years and older for the following: a. Prevention Quality Indicators as described in the "*Guide to Prevention Quality Indicators: Hospital Admission for Ambulatory Care Sensitive Conditions*" by AHRQ for bacterial pneumonia, dehydration, urinary tract infection, adult asthma, congestive heart failure, hypertension and chronic pulmonary disease; b. Hospital emergency department utilization as determined by the MCO; c. Inpatient utilization stays for the MCO's identified key Minnesota Health Care Program diagnoses or diagnoses clusters; d. Hospital readmission for the same or similar diagnoses as defined by the MCO within a timeframe specified by the MCO; e. Individual Enrollee claims totaling more than one hundred thousand dollars ($100,000) per year; and f. Home Care Services utilization as determined by the MCO.		
(2) In addition to claims data, the MCO may use other methods, such as: 1) health risk assessment surveys; 2) performance measures; 3) medical record reviews; 4) Enrollees receiving PCA services; 5) requests for Service Authorizations; and/or 6) Other methods developed by the MCO or its Network Providers.	**Met**	

B. Assessment of enrollees identified, (Senior and SNBC Contract – care plan) and 7.1.5.2 **Assessment of Enrollees Identified**. The MCO must implement mechanisms to assess Enrollees identified and monitor the treatment plan set forth by the MCO's treatment team, as applicable. The assessment must utilize appropriate Health Care Professionals to identify any ongoing special conditions of the Enrollee that require a course of treatment or regular care monitoring.	**Met**	
7.1.5.3 **Access to Specialists**. If the assessment determines the need for a course of treatment or regular care monitoring, the MCO must have a mechanism in place to allow Enrollees to directly access a specialist as appropriate for the Enrollee's condition and identified needs. [Minnesota Statutes, §62Q.58]	**Met**	
7.1.5.4 Annual Reporting to the STATE. The MCO shall incorporate into, or include as an addendum to, the MCO's Annual Quality Assessment and Performance Improvement Program Evaluation (as required in section 7.1.8) a Special Health Care Needs summary describing efforts to identify Enrollees that may need additional services and the following items: **(1) The number of Adults identified in section 7.1.4(A) with special health care needs;** **(2) The annual number of assessments completed by the MCO or referrals for assessments completed; and** **(3) If the MCO adds the information in this section as an addendum, the addendum must include an evaluation of items 7.1.5.1 through 7.1.5.3.**	**Met**	

V. Practice Guidelines -2020 Contract Section 7.1.6 (1–2) [10]

The MCO shall adopt, disseminate and apply practice guidelines consistent with current NCQA "*Standards and Guidelines for the Accreditation of Health Plans,*" QI 7 Clinical Practice Guidelines.

Practice Guidelines Data Grid

DHS Contractual Element and References	Met or Not Met	Audit Comments
Element A: Adoption of practice guidelines. The MCO shall adopt, disseminate and apply practice guidelines, as required by 42 CFR §438.236. 7.1.6.1 **Adoption of Practice Guidelines**. The MCO shall adopt guidelines that: 1) are based valid and reliable clinical evidence or a consensus of Health Care Professionals in the particular field; 2) consider the needs of the MCO Enrollees; 3) are adopted in consultation with contracting Health Care Professionals; and 4) are reviewed and updated periodically as appropriate;	**Met**	Policies are reviewed and updated by the Medica Medical Policy Committee. Some of the Practice Guidelines reviewed and updated (as of Oct. 2019) include: • Asthma (NIH/NHLBI) • Cervical Cancer Screening (USPSTF) • Cholesterol Management (American College of Cardiology, American Heart Association Task Force on Clinical Practice Guidelines) • Chronic Obstructive Lung Disease (Global Initiative for Chronic Obstructive Lung Disease) • Depression/Major Depressive Disorder (USPSTF) • Obesity (AHA/ACC/TOS Prevention Guidelines • Substance Use Disorder (American Society of Addiction Medicine Practice Guideline)

10 MSHO/MSC+ Contract section 7.1.6 (1 - 2); SNBC Contract section 7.1.6 (1–2)

DHS Contractual Element and References	Met or Not Met	Audit Comments
7.1.6.2 The MCO shall ensure that guidelines are disseminated to all affected Providers and, upon request, to Enrollees and Potential Enrollees;	**Met**	
7.1.6.3 **Application of Guidelines**. The MCO shall ensure that these guidelines are applied to decisions for utilization management, Enrollee education, coverage of services, and other areas to which there is application and consistency with the guidelines.	**Met**	Providers are reminded and informed of practice guidelines through monthly *Medica Connections* newsletter, and in Medical Policy updates. Members are informed through member handbooks, and resource guides specific to each plan.

VI. Annual Quality Assurance Work Plan – 2020 Contract Section 7.1.7

The MCO shall provide the STATE with an annual written work plan that details the MCO's proposed quality assurance and performance improvement projects for the year. This report shall follow the guidelines and specifications contained in Minnesota Rules, part 4685.1130, subpart 2, and current NCQA "*Standards and Guidelines for the Accreditation of Health Plans.*"

Annual Quality Assurance Work Plan Data Grid

DHS Contractual Element and References	Met or Not Met	Audit Comments
A. The MCO shall provide the STATE with an annual written work plan that details the MCO's proposed quality assurance and performance improvement projects for the year. This report shall follow the guidelines and specifications contained in Minnesota Rules, part 4685.1130, subpart 2, and 2020 NCQA "*Standards and Guidelines for the Accreditation of Health Plans.*" If the MCO chooses to substantively amend, modify or update its work plan at any time during the year, it shall provide the STATE with material amendments, modifications or updates in a timely manner. (*See also section 3.11.4); and*	**Met**	Reviewed 2019 and 2020 Quality Work Plans
A. Current NCQA "*Standards and Guidelines for the Accreditation of Health Plans.*" **NCQA QI 1, Element B:** An annual work plan that reflects ongoing progress on QI activities throughout the year and addresses: (1) Yearly planned QI activities and objectives for improving: • Quality of clinical care • Safety of clinical care • Quality of service • Members' experience (2) Time frame for each activity's completion (3) Staff members responsible for each activity (4) Monitoring of previously identified issues (5) Evaluation of the QI program	**Met**	

VII. Annual Quality Assessment and Performance Improvement Program Evaluation – 2020 Contract Section 7.1.8[11, 12]

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
A. 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: Organization-specific data, CHAPS, HEDIS®) and ii. MCO's performance improvement projects.	**Met**	Comprehensive and informative document
NCQA QI 1, Element C: 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.	**Met**	

11 42 CFR 438.330(b), (d); Seniors (MSHO/MSC+) and SNBC Contract Section 7.1.8

12 MSHO/MSC+ Contract Section 7.1.8 also includes the requirement that the MCO must include the "*Quality Framework for the Elderly Waiver*" in its Annual Evaluation

DHS Contractual Element and References	Met or Not Met	Audit Comments
2. Trending of measures to assess performance in the quality and safety of clinical care and quality of services.	**Met**	
3. Analysis and evaluation of the overall effectiveness of the QI program and of its progress toward influencing network-wide safe clinical practices.	**Met**	Excellent evaluation of the effectiveness of the overall QI program

VIII. Performance Improvement Projects-2020 Contract Section 7.2, 7.2.1(1-2)[13, 14]

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 § 438.30(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. In 2018, the STATE selected the Preventing Chronic Opioid Use topic for the PIP to be conducted over a three year period (calendar years 2018, 2019, and 2020). 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**	2018 SNBC and MSHO PIP – Reducing Opioid Use
7.2.1.1 The MCO shall provide annual PIP progress reports to the STATE. For the 2018-2020 PIPs, the second interim report is due September 1, 2020.	**Met**	Interim reports reviewed **See Table below for Performance Targets/Rates**

13 42 CFR 438.330 (b)(1), 42 CFR 438.330(d); MSHO/MSC+ Contract section 7.2, 7.2.1 (1-2); SNBC Contract section 7.2, 7.2.1 (1-2)

14 CMS Protocols, EQR Protocol 3: Validating Performance Improvement Projects

DHS Contractual Element and References	Met or Not Met	Audit Comments
7.2.1.2 For the 2018-2020 PIPs, the final report will be due September 1, 2021.	**NA**	
PIP Proposal and PIP Interim Report Validation Sheets. DHS uses these tools to review and validate MCOs' PIP proposals and annual status reports.	**Not submitted to MDH for review**	Plan identified data issues as follows: • The MCOs have been unable to mimic the rates that DHS has provided. DHS has elected not to share the member level data with the MCOs, so the MCOs can only theorize that the barriers for us to produce valid rates. • Specifications for the NCU measure changed after the project start date, which also made it difficult to closely replicate the DHS rates based on the specifications

Also reviewed

2016 Improving Antidepressant Medication Management in the Senior Population, Final Report submitted to DHS 8/30/18

2015 Follow-Up After Hospitalization for Mental Illness (ENDED 12/31/17)

Performance Targets for PIP: Reduce chronic opioid use in the MSHO and SNBC Population

Product	Measures	Target	Actual	Time Period
MSHO	Improvement over baseline rate (19.3%) of seniors prescribed opioids who become new chronic opioid users	< 19.3%	Medica data 14.4% DHS data 33.1%	2019 1st Qtr
SNBC	Improvement over baseline rate (6.6%) of members prescribed opioids who become new chronic opioid users	< 6.6%	Medica data 6.2% DHS data 7.5%	2019 2nd Qtr

IX. Population Health Management (PHM) - 2020 Contract Section 7.3 (1-5)[15]

Population Health Management Program. The MCO shall create and report annually to the STATE a Population Health Management Strategy or any amendment to the original PHM strategy by July, 31 of the contract year, including structure and processes to maintain and improve health care quality, and measures in place to evaluate plan MCO's performance on its process outcomes (for example, clinical care, or Enrollee experience of care). The plan must be updated within thirty (30) days if the MCO makes a modification to its PHM Strategy, consistent with section 3.11.3, Service Delivery Plan.

Population Health Management Data Grid

DHS Contractual Element and References	Met or Not Met	Audit Comments
7.3.1 **Population Health Management (PHM) Strategy**. The MCO's PHM Strategy[16] or any amendment[17] to the original PHM strategy by July 31 of the contract year, including structure and processes to maintain and improve health care quality, and measures in place to evaluate MCO's performance on its process outcomes (for example, clinical care, or Enrollee experience of care). The MCO must inform the STATE within thirty (30) days if the MCO makes a modification to	**Met**	PHM strategy includes the following areas: 1) Keeping Enrollees healthy, (KHM) a. Establish a baseline engagement rate of members accessing Ovia (health pregnancy program) with target of 10% eligible mbrs 2020 b. Increase the number of members who complete an initial Health Risk Assessment within each product by 5%.

15 MSHO/MSC+ Contract Section 7.3, requires only diabetes and heart disease DM programs, SNBC Contract Section 7.2.6

16 For MCOs who are in their first year of PHM in 2020

17 For MCOs who are in their second year of PHM in 2020 and making amendments in their PHM Strategies, after conducting an impact analysis

DHS Contractual Element and References	Met or Not Met	Audit Comments
its PHM Strategy, consistent with section 3.11.4, Service Delivery Plan; and MCO shall be consistent with current NCQA "Standards and Guidelines for the Accreditation of Health Plans" pursuant to the current Standards for Population Health Management (PHM). At a minimum, the comprehensive PHM Strategy shall describe: (1) Measurable goals and populations targeted for each of the four areas of focus; (2) Programs and services offered to members for each area of focus; (3) At least one activity that is not direct member intervention (an activity may apply to more than one areas of focus); (4) How member programs are coordinated across potential settings, Providers, and levels of care to minimize the confusion for Enrollees being contacted from multiple sources (coordination activities may apply across the continuum of care and to other organization initiatives); and (5) How Enrollees are informed about available PHM programs and services (for example, by interactive contact and/or distribution of materials). A. The PHM Strategy shall include the following areas of focus: a. Keeping Enrollees healthy, b. Managing Enrollees with emerging risk, c. Patient safety or outcomes across settings, and d. Managing multiple chronic illnesses		c. Establish baseline engagement metric for Healthy Living by Medica through Active Health. Show measurable improvement over previous vendor 2) Managing Enrollees with emerging risk, (MER) a. Evaluate a strategy to slow progression of chronic kidney disease, increase home dialysis rates, and decrease hospitalizations for CKD related conditions with a vendor partner to launch in 2020. b. Engage Active Health Management in establishing improved reporting to include outcome measures for their Diabetes, Asthma and Heart Disease programs. 3) Patient safety or outcomes across settings, (PSO) a. Decrease member readmission rates by 3% compared to the previous year. b. Decrease all-cause readmissions for ACO population by 4%. c. Increase the percentage of members who receive a complete medication review during participation in the Case Management Transitions of Care program from a 2019 baseline of 53.3 % to 75% by the 4th quarter of 2020. d. Decrease emergency department utilization. Goal is to reduce ED utilization from year to year in our focus ACOs by 5% or more e. Create process to ensure that 100% of members across all lines of business accessing Medication Assisted Therapy who do not already have a care coordinator are offered case management services 4) Managing multiple chronic illnesses. (MMC) a. 95% of complex case management assessments are initiated within 30 days of identification and completed within 60 days of identification unless there is a documented reason explaining why the timeline would not be met. b. Improve assessment and care planning documentation to meet NCQA standards as measured by audit with 90% accuracy. c. Decrease the number of members who are identified as Care Level 1 in the ECC quarterly report by 3% over 2019 baseline d. Establish a Medical/Behavioral Health Integrated team at Medica by 3rd quarter of 2020

DHS Contractual Element and References	Met or Not Met	Audit Comments
Current NCQA *Standards and Guidelines for the Accreditation of Health Plan* for PHM. **NCQA Standard PHM 1: PHM Strategy** The organization outlines its PHM strategy for meeting the care needs of its member population. **Element A: PHM Strategy Description** (1) Measurable goals and populations targeted for each of the four areas of focus;	**Met**	Excellent strategy integrating Population Health Management into improvement efforts.
(2) Programs and services offered to members for each area of focus;	**Met**	
(3) At least one activity that is not direct member intervention (an activity may apply to more than one areas of focus);	**Met**	
(4) How member programs are coordinated across potential settings, Providers, and levels of care to minimize the confusion for Enrollees being contacted from multiple sources (coordination activities may apply across the continuum of care and to other organization initiatives); and	**Met**	
(5) How Enrollees are informed about available PHM programs and services (for example, by interactive contact and/or distribution of materials).	**Met**	
Element B: Informing Members Factor 1: How members become eligible to participate	**Met**	
Factor 2: How to use program services	**Met**	

DHS Contractual Element and References	Met or Not Met	Audit Comments
Factor 3: How to opt in or opt out of the program	**Met**	
NCQA Standard PHM 2: Population Identification. The organization systematically collects, integrates and assesses member data to inform its population health management programs (e.g. documented process, reports, materials). Element A: Data Integration	**Met**	
Element B: Population Assessment	**Met**	
Element C: Activities and Resources	**Met**	
Element D: Segmentation	**Met**	
NCQA Standard PHM 3: Delivery System Supports The organization describes how it supports the delivery system, patient-centered medical homes and use of value-based payment arrangements. Element A: Practitioner or Provider Support	**Met**	
Element B: Value-Based Payment Arrangements	**Met**	
NCQA Standard PHM 4: Wellness and Prevention The organization offers wellness services focused on preventing illness and injury, promoting health and productivity and reducing risk. Element A: Frequency of Health Appraisal Completion	**Met**	
Element B: Topics of Self-Management Tools Factor 1: Healthy weight (BMI) maintenance Factor 2: Smoking and tobacco use cessation Factor 3: Encouraging physical activity Factor 4: Eating healthy	**Met**	

DHS Contractual Element and References	Met or Not Met	Audit Comments
Factor 5: Managing stress Factor 6: Avoiding at-risk drinking Factor 7: Identifying depressive symptoms		
NCQA Standard PHM 5: *Complex Case Management* The organization coordinates services for its highest risk members with complex conditions and helps them access needed resources. Element A: Access to Case Management	**Met**	
Element B: Case Management Systems	**Met**	
Element C: Case Management Process	**Met**	
Element D: Initial Assessment	**Met**	
Element E: Case Management: Ongoing Management	**Met**	
NCQA Standard PHM 6: PHM Impact[18] If the organization annually measures the effectiveness of its PHM Strategy. Element A: Measuring Effectiveness Factor 1: Quantitative results for relevant clinical, cost/utilization and experience measure (not CHAPS) Factor 2: Comparison of results with a benchmark or goal Factor 3: Interpretation of results / actions	**Met**	Some Effectiveness Measures thus far for 2019 include: **KMH 2019-1. Increase member engagement in healthy behaviors by increasing engagement with Redbrick platform.** • At the end of the year the overall engagement rate is at 8%. **KMH 2019-2. Increase member engagement in healthy behaviors by increasing engagement in the Healthy Living by Medica program**. • The volume of programs completed rose from 2618 through all of 2018 to 6840 through July of 2019, the last month in which data are available. This is almost a 500% increase. Year-end data is pending and is expected by the end of February.

18 A comprehensive analysis of the impact of its PHM strategy in consecutive years

DHS Contractual Element and References	Met or Not Met	Audit Comments
		KMH 2019-3. Increase the number of members completing a Health Risk Assessment • **SNBC** Baseline: 48% 2019 Overall: 49.4% • **MSHO:** Baseline: 77.3% 2019 Overall: 83% • **MSC+** Baseline: 57% 2019 Overall: 63.4% **KMH 2019-4. Establish baseline metrics for ACO partners with quality metrics in their 2018 value-based contracts for the following HEDIS measures: breast cancer screening, colorectal cancer screening and diabetes HbA1c control <8.** • Completed. New contract language has been developed and implemented with our ACO partners. **MER 2019-1. Establish baseline metric for members engaging with ActiveHealth nurses for diabetes management to measure the number of members who have at least one session with a certified diabetes educator.** • For 2019, 90 members have completed a session with a Certified Diabetes Educator (CDE). **MER 2019-2. Evaluate the effect of appropriate use of asthma controller medication on avoidable inpatient admissions and ER visits. Pilot with a single ACO; evaluate feasibility of expansion to all ACOs.** • 18 members were found to be on rescue medications but not controller medications. • Inpatient admission rates for those not on a controller were found to be 207.9 admits per 1000 compared to 84.4 admits per 1000 for those on a controller medication. • Readmission rates for those not on a controller medication were 29.7 per 1000 members compared to 11.8 per 1000 for those who were.

DHS Contractual Element and References	Met or Not Met	Audit Comments
		• Emergency department admissions were 67.3 admits per 1000 for members not on a controller and 346.2 for members who were. **PSO 2019-1. Increase the volume of engaged members who participate in the Welcome Home call program.** 2018 – Total participants 803 or ave 69/mo 3019 – Total Participants 1922 or ave 160/mo **PSO 2019-2. Decrease member 30-day readmission rate as measured through the Daily Admissions Report.** **SNBC:** Baseline: 15% 2019 YTD: 10.1% **MSHO:** Baseline: 15.58% 2019 YTD: 16.0% **MSC+** Baseline**:** 4.1% 2019 YTD: 6.6% **PSO 2019-3. Reduce all-cause readmissions for high-risk ACO population.** Rates decrease by 16% to 25% **MMC 2019-1. Initiate complex case management assessments within 30 days of identification and complete within 60 days of identification (unless exceptional circumstances apply).** 62% to 90% 30-day target 98% to 100% 60-day target **MMC 2019-2. Decrease the number of members moving from Enhanced Care Coordination care level 2 to care level 1 in the second half of 2019.** For third quarter, 161 members moved from care level 2 to care level 1.
Element B: **Improvement and Action**	**Met**	Done in report along with Key Activities/Accomplishments, Findings and Analysis and Next Steps for each measure
NCQA Standard PHM 7: *Delegation of PHM*	**Met**	Delegated PHM Activities are identified

DHS Contractual Element and References	Met or Not Met	Audit Comments
If the organization delegates PHM activities, there is evidence of oversight of the delegated activities. Element A: Delegation Agreement		ActiveHealth Management – Disease Management Virgin Pulse – member identification and outreach Care Coordination - delegates include Counties
Element B: Pre-delegation Evaluation	**Met**	
Element C: Review of the PHM Program	**Met**	
Element D: Opportunities for Improvement	**Met**	
7.3.2 PHM Reporting: **7.3.2.1: The MCO shall annually describe its methodology for segmenting or stratifying its Enrollee population, including the subsets to which Enrollees are assigned (for example, high risk pregnancy) and provide to the STATE a report specifying the following:** **(1) Number of Enrollees in each category and** **(2) Number of programs or services for which these Enrollees are eligible; and**	**Met**	
7.3.2.2: The MCO shall annually report to the STATE a comprehensive analysis of the impact of its PHM strategy that includes at least the following factors: (1) **Quantitative results for relevant:** a. Clinical measures (outcome or process measures); b. Cost of care or utilization measures; and *c.* Enrollee experience measures (for example, complaints or Enrollee feedback, using focus group or a satisfaction survey).	**Met**	2019 Report reviewed
(2) Comparison of results, including with a benchmark or goal;	**Met**	

DHS Contractual Element and References	Met or Not Met	Audit Comments
(3) Interpretation of results, including interpretation of measures; and	**Met**	**Challenges Identified:** 2019 was a learning year for Medica. Identifying the correct meeting structure, learning to work cross-segment, understanding what population health means at Medica have each been areas of challenge that we have addressed. In 2019 we tended to approach population health as an entity on to itself. We have learned that population health is most effective when integrated into our normal business processes. **Next Steps** In 2020 encouraging business segment leaders to continue to use population assessment as a basis for decisions about programming to meet member needs as well as to address trends in condition prevalence and medical expense. Making an effort to assure that the effectiveness measures we select for our population health work tie more directly into other improvement efforts and that we either use established metrics or have confidence that we can measure the results of our work in an accurate and consistent manner.
(4) The Impact Analysis report is due by July, 31 of the contract year.	**Met**	

X. Advance Directives Compliance - 2020 Contract Section 14 (14.1-14.5)[19, 20]

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
1. Enrollee Information. 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: 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;	**Met**	
B. Written policies of the MCO respecting the implementation of the right;	**Met**	
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; and	**Met**	
D. Information that complaints concerning noncompliance	**Met**	

19 MSC/MSC+ Contract Article 16; SNBC Contract Article 14, Sections 14.1-14.5

20 Pursuant to 42 U.S.C. 1396a(a)(57) and (58) and 42 C.F.R. 489.100-104 and 42 C.F.R. 422.128

DHS Contractual Element and References	Met or Not Met	Audit Comments
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).		
2. Providers Documentation. To require MCO's Primary Care Providers; hospitals, critical access hospitals, skilled nursing facilities, nursing facilities, home health agencies, providers of home health care (and for Medicaid purposes, providers of personal care services), and hospices to ensure that it has been documented in the enrollee's medical records whether or not an individual has executed an Advance Directive.	**Met**	**See Tables below**
3. Treatment. To not condition treatment or otherwise discriminate on the basis of whether an individual has executed an advance directive.	**Met**	
4. 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**	
5. Education. To provide, individually or with others, education for MCO staff, providers and the community on Advance Directives.	**Met**	

Advance Directive or Advance Care Planning

Ages 18 - 64	**2019**	**2018**	**2017**	**2016**
Evidence in med record that patient does or does not have advance Directive	18%	23%	22%	35%
If no Advance Directive, evidence of Advance Care Planning discussion	4%	6%	2%	7%
Ages 65 - 80	**2019**	**2018**	**2017**	**2016**
Evidence in med record that patient does or does not have advance Directive	85%	89%	45%	69%
If no Advance Directive, evidence of Advance Care Planning discussion	32%	55%	29%	34%

XI. Validation of MCO Care Plan Audits for MSHO, MSC+ - 2020 Article 6 (Seniors Contract Sections 7.1.4, 7.8.3, and 9.4.1)[21]

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. 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 a total of 22 EW care plan files. See attachment A for details on those findings.

21 Pursuant to MSHO/MSC+ 2019 Contract Sections 6.1.4-6.1.5, 7.8.3 and 9.4.1

XII. Subcontractors-2020 Contract Sections 9.3 (and subsections) and 9.10.4[22]

1. Written Agreement; Disclosures

All subcontracts must be current, in writing, fully executed, 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. All contracts must include:

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	**Met**	

22 Seniors, SNBC Contract Sections 9.3 (and sub-sections), 9.10.4

DHS Contractual Element and References	Met or Not Met	Audit Comments
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 9.10.1.1is related (if an individual) to any other Person with an Ownership or Control Interest as spouse, parent, child, or sibling;	**Met**	
(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;	**Met**	
(4) The name, address, date of birth, and social security number of any managing employee of the disclosing entity;	**Met**	
(5) For the purposes of section 9.10, 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;	**Met**	
(6) **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. The letter should identify all databases that were included in the review. A data certification pursuant to section 11.6 is required with this assurance; and	**Met**	
(7) Upon request, subcontractors must report to the MCO information related to business transactions. 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**	
B. Written Agreements: All subcontracts must be current, in writing, fully executed, 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	**Met**	

DHS Contractual Element and References	Met or Not Met	Audit Comments
and/or CMS. Payment arrangements must be available for review by the STATE and/or CMS. All contracts must include: 1. MCO subcontracts that include delegation of program integrity responsibilities must require Subcontractors to comply with program integrity obligations under state and federal law and section 9.9.1 of this contract. If an MCO engages with a subcontractor and does not delegate its program integrity responsibilities to the subcontractor, the MCO shall remain responsible for all program integrity responsibilities under state and federal law and section 9.9.1.1 with respect to the Subcontractor's services.		
2. Current and fully executed agreements for all subcontractors, including bargaining groups, must be maintained for all administrative services that are expensed to MHCP. Subcontractor agreements determined to be material, as defined by the STATE, must be in the form of a written instrument or electronic document containing the elements of offer, acceptance, consideration, payment terms, scope, duration of the contract, and how the subcontractor services relate to MHCP.	**Met**	
3. Upon request, the STATE shall have access to all subcontractor documentation under this section.	**Met**	
4. Nothing in this section shall allow release of information that is nonpublic data pursuant to section Minnesota Statutes, §13.02.	**Met**	

2. Exclusions of Individuals and Entities; Confirming Identity – 2020 Contract Sections 9.10.1, 9.3.6, and Article 15 (15.1)[23] [24]

Exclusion of Individuals Data Grid

DHS Contractual Element and References	Met or Not Met	Audit Comments
(A) Exclusions of Individuals and Entities; Confirming Identity (1) 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, or an affiliate[25], upon contract execution or renewal and credentialing, through routine checks of state and Federal databases. The databases to be checked are the Social Security Administration's Death Master File and the National Plan and Provider Enumeration System (NPPES), and the Excluded Provider Lists maintained by the STATE.	**Met**	
(2) 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), and the Excluded Provider Lists maintained by the STATE, for any	**Met**	

23 Seniors and SNBC Contract Sections 9.10.1 (and subsections); 9.3.6; Article 15 (15.1)

24 42 CFR §438.610 referring to 48 CFR §2.101; 42 CFR §455.436; Minnesota Statutes, §256B.064, subd. 3

DHS Contractual Element and References	Met or Not Met	Audit Comments
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 by the STATE nor under §§ 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. [42 CFR §§455.436; 438.602(d); 438.610]	**Met**	
(3) 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**	
(4) 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 services program, or that have been excluded from participation in Medicaid under §§ 1128 or 1128A of the Social Security Act.	**Met**	
(5) The MCO shall report any excluded Provider to the STATE within seven (7) days of the date the MCO receives the information, or determines that a Network Provider, Person with an Ownership or Control Interest of a Network Provider, agent or managing Employee of the MCO, Subcontractor or affiliate has become excluded or the MCO has inadvertently contracted with an excluded Provider.	**Met**	
(6) 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	**Met**	

DHS Contractual Element and References	Met or Not Met	Audit Comments
part, under § 4707(a) of the Balanced Budget Act of 1997 or under Minnesota Statutes, § 62J.71.		
(B) The MCO shall ensure that its Subcontractors that provide Priority Services have in place a written Business Continuity Plan (BCP) that complies with the requirements of **Article. 15.**	**Met**	

Attachment A: MDH 2020 EW Care Plan Audit

Audit Protocol	Product Description	2020 MDH Audit Initial Charts Met	2020 MDH Audit Reassessment Charts Met	2020 MDH Audit Total % Charts Met	2019 Medica Health Plans Total Charts % Met
1 **INITIAL HEALTH RISK ASSESSMENT**	For members new to the MCO or product within the last 12 months	8/8	N/A	100%	94.6%
2 **ANNUAL HEALTH RISK ASSESSMENT**	Been a member of the MCO for > 12 months [Only for plans with separate HRA]	N/A	8/8	100%	98.6%
3 **LONG TERM CARE CONSULTATION – INITIAL**	If member is new to EW in the past 12 months, an LTCC assessment completed within required timelines.	8/8	NA	100%	100%
4 **REASSESSMENT OF EW**	For members open to EW who have been a member of the MCO for more than 12 months, an LTCC completed within 365 days or prior assessment.	N/A	8/8	100%	10%
5 **PERSON-CENTERED PLANNING**	Opportunities for choice in the person's current environment are described	8/8	8/8	100%	99.3%
PERSON-CENTERED PLANNING	Current rituals and routines are described (quality, predictability, preferences)	8/8	8/8	100%	81.9%

Audit Protocol	Product Description	2020 MDH Audit Initial Charts Met	2020 MDH Audit Reassessment Charts Met	2020 MDH Audit Total % Charts Met	2019 Medica Health Plans Total Charts % Met
PERSON-CENTERED PLANNING	Social, leisure, or religious activities the person wants to participate in are described. The person's decision about employment/volunteer opportunities has been documented	8/8	8/8	100%	95.7%
6 **COMPREHENSIVE CARE PLAN-TIMELINESS**	CCP is completed and sent to member with 30 calendar days of the date of a completed LTCC.	8/8	8/8	100%	98.1%
7 **COMPREHENSIVE CARE PLAN-IDENTIFIED NEEDS**	The CCP must have an interdisciplinary, holistic, and preventive focus. Enrollee's identified needs and concerns related to primary care, acute care, long-term care, mental and behavioral health, and social service needs and concerns are addressed. The need for services essential to the health and safety of the enrollee is documented. If essential services are included in the plan, a back-up plan for provision of essential services. There is a plan for community-wide disasters, such as weather-related conditions.	8/8	8/8	100%	99.4%
8 **COMPREHENSIVE CARE PLAN**	The enrollee's goals or skills to be achieved are included in the plan, related to enrollee's preferences and how enrollee wants to live their life. Goals and skills are clearly described, action steps describing what needs to be done to assist the person, plan for monitoring progress, target dates and outcome/achievement dates.	8/8	8/8	100%	100%

Audit Protocol	Product Description	2020 MDH Audit Initial Charts Met	2020 MDH Audit Reassessment Charts Met	2020 MDH Audit Total % Charts Met	2019 Medica Health Plans Total Charts % Met
9 **COMPEREHENSIVE CARE PLAN-Choice**	Enrollee was given a choice between Home and Community-Based Services (HCBS) and Nursing Home Services (also indicates enrollee involvement in care planning). Information to enable choice among providers of HCBS.	8/8	8/8	100%	99.3%
10 **COMPREHENSIVE CARE PLAN-Safety Plan/Personal Risk Management Plan**	Identification of enrollee needs and concerns, including identification of health and safety risks, and what to do in the event of an emergency Goals and target dates identified Interventions identified Monitoring of outcomes and achievement dates are documented	8/8	8/8	100%	100%
11 **COMPREHENSIVE CARE PLAN-Informal and Formal Services**	Coordinated Services and Support Plan developed and contains at a minimum the type of services to be furnished, the amount, frequency, duration and cost of each service and the type of provider furnishing each service including non-paid caregivers and other informal community supports or resources	8/8	8/8	100%	90.5%
12 **CAREGIVER SUPPORT PLAN**	If a primary caregiver is identified in the LTCC. If interview completed then caregiver needs and supports incorporated into the care plan	1/1	3/3	100%	100%

Audit Protocol	Product Description	2020 MDH Audit Initial Charts Met	2020 MDH Audit Reassessment Charts Met	2020 MDH Audit Total % Charts Met	2019 Medica Health Plans Total Charts % Met
13 **HOUSING AND TRANSITION**	For people who have been identified as having a transition, the enrollee has a transition plan to support housing choice. The LTCC assessment items relate to housing choices and support, and if enrollee indicates they want assistance in exploring housing options the transition plan reflects a goal, steps to be taken and potential barriers	0/0	0/0/	n/a	100%
14 **COMMUNICATIONS OF CARE PLAN/SUMMARY-Physician**	Evidence of care coordinator communication of care plan elements with Primary Care Physician (PCP)	8/8	8/8	100%	95.1%
15 **COMMUNICATION OF CARE PLAN/SUMMARY-Enrollee**	The support plan is signed and dated by the enrollee or authorized representative	14/15	8/8	95.6%	100%
16 **COMPREHENSIVE CARE PLAN-Enrollee Requests for Updates**	The plan includes a method for the individual to request updates to the plan, as needed	8/8	8/8	100%	100%
17 **CARE COORDINATOR FOLLOW-UP PLAN**	Follow-up plan for contact plan related to identified concerns or needs, and plan is implemented	8/8	8/8	100%	99.5%

Audit Protocol	Product Description	2020 MDH Audit Initial Charts Met	2020 MDH Audit Reassessment Charts Met	2020 MDH Audit Total % Charts Met	2019 Medica Health Plans Total Charts % Met
18 **ANNUAL PREVENTIVE HEALTH EXAM**	Documentation in enrollee's Comprehensive Care Plan substantiates a conversation was initiated	8/8	8/8	100%	100%
19 **ADVANCE DIRECTIVE**	Evidence that a discussion was initiated, enrollee refused to complete, was culturally inappropriate, or AD was completed	8/8	8/8	100%	100%
20 **APPEAL RIGHTS**	Appeal rights information provided to member	14/15	8/8	95.6%	99.6%
21 **DATA PRIVACY**	Data privacy information provided to member	14/15	8/8	95.6%	99.6%

Summary:

MDH received a random sample of 40 Elderly Waiver (EW) clients on MSHO or MSC+ enrolled in Medica Health Plans for the time period 01/01/2019-12/31/2019 from DHS per audit protocol. MDH reviewed 8 initial EW care plan files except in the areas of appeal rights and data privacy notifications in which 15 files were reviewed; and 8 re-assessments. MDH results were consistent with Medica Health Plans' audit findings. Medica Health Plans requires a 100% compliance threshold in their care plan audit review for annual reassessments being completed within 12 months of the CCP being completed and sent to member within 30 days and that enrollee choices were offered. Medica Health Plans requires a 95% threshold for all other elements. If a delegate does not meet a threshold then a corrective action plan is completed within 30 days after receiving notification. Delegates are notified of approval or the need for any additional information. MDH found one care initial care plan that did not contain a signed CCP in which the delegate attempted to unsuccessfully follow-up to receive the signed CCP. The 2019 Medica Health Plans audit also indicated this element was below their threshold at 99.6%.