PrimeWest Health

Triennial Compliance Assessment

FINAL SUMMARY REPORT

DEPARTMENT OF HEALTH

Triennial Compliance Assessment

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Triennial Compliance Assessment

Executive Summary

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

TCA Process Overview

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

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

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

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

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

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

I. QI Program Structure - 2016 Contract Section 7.1.1

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

TCA Quality Program Structure Data Grid

DHS Contractual Element and References	Met or Not Met	Audit Comments
Written Quality Assurance Plan (Quality Program Description)	**Comment**	PWH submitted its 2017 PrimeWest Health Quality Improvement Program on April 26, 2017. It was reviewed and approved during the course of the examination and was found to meet all State requirements.
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**	
Structure and Operations Standards 42 CFR § 438.214 Provider Selection 42 CFR § 438.218 Enrollee Information 42 CFR § 438.224 Confidentiality and Accuracy of Enrollee Records 42 CFR § 438.226 Enrollment and Disenrollment 42 CFR § 438.228 Grievance Systems 42 CFR § 438.230 sub contractual Relationships and Delegation	**Met**	
Measurement Improvement Standards 42 CFR § 438.236 Practice Guidelines 42 CFR § 438.240 Quality Assessment and Performance	**Met**	

DHS Contractual Element and References	Met or Not Met	Audit Comments
Improvement Program 42 CFR § 438.242 Health Information System		

II. Utilization Management - 2016 Contract Section 7.1.3

The MCO shall adopt a utilization management structure consistent with state regulations and federal regulations and current NCQA "Standards for Accreditation of Health Plans."[1] Pursuant to 42 CFR §438.330(b)(3), this structure must include an effective mechanism and written description to detect both under and over utilization.

A. Ensuring Appropriate Utilization

TCA Utilization Management Data Grid for Under/Over Utilization

DHS Contractual Element and References	Met or Not Met	Audit Comments
The MCO shall facilitate the delivery of appropriate care and monitor the impact of its utilization management program to detect and correct potential under and over utilization. The MCO Shall:	**Met**	Numerous types of UM data tracked/trended by product including: Acute Inpatient ALOS Plan ALL-Cause Readmissions ACSC Admits (significant decrease)

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

DHS Contractual Element and References	Met or Not Met	Audit Comments
i. Choose the appropriate number of relevant types of utilization data, including one type related to behavioral health to monitor.		ER Visits (decease all products except MSHO) Mental Health Inpatient and Office Visits Chemical Health Inpatient and Office Visits Chiropractic Visits DME HCBS MSHO SNF (decreasing since 2017)
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 set using internal tracking
The MCO Shall: iii. Examine possible explanations for all data not within thresholds.	**Met**	Quantitative and qualitative analysis completed on data not within thresholds
The MCO Shall: iv. Analyze data not within threshold by medical group or practice.	**Met**	
The MCO Shall: v. Take action to address identified problems of under or overutilization and measure the effectiveness of its interventions.	**Met**	Overall utilization summarized in 2016 Annual Evaluation which states *enrollment increased, inpatient care and admissions stabilized, with ALOS increase. Increase due to lifting of prior authorization requirements. Increasingly, medical care is being shifted from the inpatient to the outpatient setting and the number of ambulatory surgeries has increased. Ambulatory care and ER visits have decreased, along with ACSC, which may be due to increased access, education, high-quality care coordination, and disease management programs. Mental health and chemical dependency services have stabilized, as have imaging costs. Pharmacy utilization in the MSHO program has increased and is an ongoing concern due to the number of new medications coming on the market each year and the cost of many of the new medications. Overall utilization continues to be well managed with vigorous monitoring programs in place.*

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

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

TCA Utilization Management Data Grid for NCQA Standards

DHS Contractual Element and References	Met or Not Met	Audit Comments
NCQA Standard UM 1: Utilization Management Structure The organization clearly defines the structures and processes within its utilization management (UM) program and assigns responsibility to appropriate individuals.	**See below.**	See comments for individual elements.
Element A: Written Program Description	**Per 100% NCQA**	
Element B: Physician Involvement	**Per 100% NCQA**	
Element C: Behavioral Healthcare Practitioner Involvement	**Per 100% NCQA**	
Element D: Annual Evaluation	**Per 100% NCQA**	
NCQA Standard UM 2: Clinical Criteria for UM Decision To make utilization decisions, the organization uses written criteria based on sound clinical evidence and specifies procedures for appropriately applying the criteria.	**See below.**	See comments for individual elements.
Element A: UM Criteria	**Per 100% NCQA**	

DHS Contractual Element and References	Met or Not Met	Audit Comments
Element B: Availability of Criteria	**Per 100% NCQA**	
Element C: Consistency of Applying Criteria	**Per 100% NCQA**	
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 100% NCQA**	
NCQA Standard UM 4: Appropriate Professionals Qualified Licensed health professionals assess the clinical information used to support UM decisions. Element D: Practitioner Review of Behavioral Healthcare Denials	**Per 100% NCQA**	
Element F: Affirmative Statement About Incentives	**Per 100% NCQA**	
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 100% NCQA**	
Element B: Description of Evaluation Process	**Per 100% NCQA**	
NCQA Standard UM 11: Emergency Services	**Per 100% NCQA**	

DHS Contractual Element and References	Met or Not Met	Audit Comments
The organization provides, arranges for or otherwise facilitates all needed emergency services, including appropriate coverage of costs. Element A: Policies and Procedures		
NCQA Standard UM 12: 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	**Per 100% NCQA**	
Element B: Pharmaceutical Restrictions/Preferences	**Per 100% NCQA**	
Element C: Pharmaceutical Patient Safety Issues	**Per 100% NCQA**	
Element D: Reviewing and Updating Procedures	**Per 100% NCQA**	
Element E: Considering Exceptions	**Per 100% NCQA**	
NCQA Standard UM 13: Triage and Referral to Behavioral Health The organization has written standards to ensure that any centralized triage and referral functions for behavioral health services are appropriately implemented, monitored and professionally managed. *This standard applies only to organizations with a centralized triage and referral process for behavioral health, both delegated and non-delegated.* Element A: Triage and Referral Protocols	NA	

DHS Contractual Element and References	Met or Not Met	Audit Comments
NCQA Standard QI 4: Member Experience The organization monitors member experience with its services and identifies areas of potential improvement. Element G: Assessing experience with the UM process	**Per 100% NCQA**	

III. Special Health Care Needs - 2016 Contract Section 7.1.4 A-C[2, 3]

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

Special Health Care Needs Data Grid

DHS Contractual Element and References	Met or Not Met	Audit Comments
A. Mechanisms to identify persons with special health care needs, B. Assessment of enrollees identified, (Senior and SNBC Contract – care plan) and C. Access to specialists	**Met**	

2 42 CFR 438.208 (c)(1-4)

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

IV. Practice Guidelines -2016 Contract Section 7.1.5[4, 5]

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

Practice Guidelines Data Grid

DHS Contractual Element and References	Met or Not Met	Audit Comments
i. **Adoption of practice guidelines**. The MCO shall adopt guidelines based on: • Valid and reliable clinical evidence or a consensus of Health Care Professionals in the particular field • Consideration of the needs of the MCO enrollees • Guidelines being adopted in consultation with contracting Health Care Professionals • Guidelines being reviewed and updated periodically as appropriate.	**Met**	PrimeWest Health has adopted guidelines from several organizations including, but not limited to, the American Diabetes Association, the Institute for Clinical Systems Improvement (ICSI), the American Academy of Child and Adolescent Psychiatry and DHS. The 2017 guidelines are as follows: (1) Preventive Care (all age groups—includes screenings and BMI assessment) (2) Immunizations (3) Prenatal Care (4) Comprehensive Diabetes Care (5) Congestive Heart Failure (6) Hypertension (7) Chronic Obstructive Pulmonary Disease (8) Asthma (9) Depression (all age groups) (10) Attention Deficit Hyperactivity Disorder (children and adolescents)

4 42 CFR 438.236

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

DHS Contractual Element and References	Met or Not Met	Audit Comments
		PrimeWest Health reviews guidelines annually. They are reviewed, updated, and approved by the Quality and Care Coordination Committee, the Joint Powers Board, the Utilization Management Committee, and by the Medical Director at least every two years, but more often as needed. PrimeWest Health indicates that the needs of their member population are taken into consideration when updating their guidelines. For instance, they noted a high prevalence of Asthma and Depression in their member population which they noted as critical and thus are part of the adopted guidelines.
ii. **Dissemination of guidelines.** MCO ensures guidelines are disseminated: • To all affected Providers • To enrollees and potential enrollees upon request	Met	Enrollees are made aware of the guidelines through member education, such as in PWH quarterly member newsletters, through patient visits; and wellness camps, such as the child Asthma camp.
ii. **Application of guidelines**. MCO ensures guidelines are applied to decisions for: • Utilization management • Enrollee education • Coverage of services • Other areas to which there is application and consistency with the guidelines.	Met	

V. Annual Quality Assessment and Performance Improvement Program Evaluation – 2016 Contract Section 7.1.8[6,7]

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."

DHS Contractual Element and References	Met or Not Met	Audit Comments
7.1.8 Annual Quality Assessment and Performance Improvement Program Evaluation must: i. Review the impact and effectiveness of the MCO's quality assessment and performance improvement program ii. Include performance on standardized measures (example: HEDIS®) and iii. MCO's performance improvement projects.	**Not Met** **Met** **Met**	i. The annual evaluation should summarize completed and ongoing QI activities outlined in the Program description. Mandatory Disease Management entities of Heart Disease and Asthma are not included. See below.
NCQA QI 1, Element B: Annual Evaluation The organization conducts an annual written evaluation of the QI program that includes the following information: 1. A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service. 2. Trending of measures to assess performance in the quality and safety of clinical care and quality of services. 3. Analysis and evaluation of the overall effectiveness of the QI program and of its progress toward influencing network-wide safe clinical practices.	**Not Met** **Met** **Met**	1. Minnesota Rules, part 4685.1115 states the plan must conduct an evaluation of its quality activities. Minnesota Rules, part 4685.1130 states the plan must have a work plan that gives a detailed description of the quality activities conducted in the following year. The DHS contract (sections 7.1.7 and 7.1.8) reiterates the requirement and further states the work plan and annual evaluation be consistent with NCQA standards. One of the mandated DHS quality activities is a disease management program for enrollees with diabetes, asthma and heart disease (contract section 7.3). PWH's Quality Assurance Plan states "*PrimeWest Health offers DM/CCIPs for members with asthma, chronic*

6 42 CFR 438.330

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

DHS Contractual Element and References	Met or Not Met	Audit Comments
		obstructive pulmonary disease (COPD), depression, diabetes, and high blood pressure (heart disease)". The 2016 and 2017 work plans include disease management, however, the work listed encompasses only Diabetes and Depression. The 2017 Quality Annual Evaluation includes a summary for the disease management activities of diabetes and depression only. Since asthma, diabetes, and heart disease, among other disease entities, are in the Quality Assurance Plan, and Disease Management is included in the work plan, it must include a plan for all three of the mandatory disease entities and a summary of the work and progress of those quality activities must be reflected in the annual evaluation.

VI. Performance Improvement Projects-2016 Contract Section 7.2[8, 9, 10]

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

Performance Improvement Projects Data Grid

DHS Contractual Element and References	Met or Not Met	Audit Comments
7.2.1 New Performance Improvement Project Proposal The STATE will select the topic for the new PIP to be conducted over the next three years (calendar years 2015, 2016 and 2017) and implemented by the end of the first quarter of calendar year 2015. The PIP must be consistent with CMS' published protocol entitled *"Protocol for Use in Conducting Medicaid External Quality Review Activities: Conducting Performance Improvement Projects"*, STATE requirements, and include steps one through seven of the CMS protocol.	**Met**	Validation sheets sheets reviewed and discussed. Indicated small numbers of non-white enrollees
7.2.2 Annual PIP Status Reports. The MCO shall submit by December 1st in calendar years 2015 and 2016, a written PIP status report in a format defined by the STATE.	**Met**	PIP status reports reviewed; SNBC and MSHO QIP – Medication Reconciliation AMM Updates for 2015 and 2016

8 42 CFR 438.240 (d)(2)

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

10 CMS Protocols, Conduction Performance Improvement Projects, Activity 10

DHS Contractual Element and References	Met or Not Met	Audit Comments
7.2.3 Final Project Reports: Upon completion of the PIP the MCO shall submit to the STATE for review and approval a final written report by September 1st, 2018, in a format defined by the STATE.	**NA**	
PIP Proposal and PIP Interim Report Validation Sheets. DHS uses these tools to review and validate MCOs' PIP proposals and annual status reports.	**Met**	Validation sheets reviewed: Drug and Alcohol Screening Using the SBIRT Method Antidepressant medication management with special focus on racial/ethnic disparities

VII. Disease Management - 2016 Contract Section 7.3

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

Disease Management Data Grid

DHS Contractual Element and References	Met or Not Met	Audit Comments
A. Disease Management Program Standards. The MCO's Disease Management Program shall be consistent with current NCQA "Standards and Guidelines for the Accreditation of Health Plans" pursuant to the QI Standard for Disease Management. B. Waiver of Disease Management Program Requirement. If the MCO is able to demonstrate that a Disease Management Program: 1) is not effective based upon Provider satisfaction, and is unable to achieve meaningful outcomes; or 2) would have a negative financial return on investment, then the MCO may request that the STATE waive this requirement for the remainder of the Contract Year.	**See Individual Elements**	
Element A: Program Content	**Met**	
Element B: Identifying Members for DM Programs	**Met**	
Element C: Frequency of Member Identification	**Met**	
Element D: Providing Members with Information	**Met**	
Element E: Interventions Based on Assessment	**Met**	PrimeWest Health utilizes disease-specific assessments that place members in one of three stratification levels. The level determines which interventions will be used with the member.

DHS Contractual Element and References	Met or Not Met	Audit Comments
Element F: Eligible Member Active Participation	**Met**	PrimeWest Health tracks participation rates on an annual basis, but they did not report on historical rates in the 2016 Disease Management report. PWH shall consider including historical rates in the annual Disease Management report to identify where membership is improving or opportunities for improvement. **(Recommendation)**
Element G: Informing and Educating Practitioners	**Met**	
Element H: Integrating Member Information	**Met**	
Element I: Experience with Disease Management	**Not met**	PrimeWest collects member experience and feedback data from members in each of the 5 Disease Management programs. However, the 2016 Disease Management report only analyzed data from 2 Disease Management programs (Depression and Diabetes). PrimeWest must report and analyze member experience data from the 3 required Disease Management programs (Diabetes, Asthma and Heart Disease).
Element J: Measuring Effectiveness	**Not Met**	PrimeWest indicated that during 2016 they revised their entire Disease Management program which included all new performance measures for each of their 5 Disease Management programs. Therefore, the 2016 Disease Management report included all new outcome measures. As such, the data analysis for each measure was limited to verifying if PrimeWest met their goal. The 2015 report and historical data before 2015 for the Disease Management program focused on inpatient hospitalization and emergency room utilization data. There was no written summary analysis of the past data, and there were no identified goals. These measures were discontinued in 2015. PrimeWest must identify goals for each measure in order to effectively analyze their data.

VIII. Advance Directives Compliance - 2016 Contract Section 16[11, 12]

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

Advance Directives Compliance Data Grid

DHS Contractual Element and References	Met or Not Met	Audit Comments
A. Information regarding the enrollee's right to accept or refuse medical or surgical treatment; and to execute a living will, durable power of attorney for health care decisions, or other advance directive. B. Written policies of the MCO respecting the implementation of the right; and C. Updated or revised changes in State law as soon as possible, but no later than 90 days after the effective date of the change; D. Information that complaints concerning noncompliance with the Advance Directive requirement may be filed with the State survey and certification agency (i.e. Minnesota Department of Health), pursuant to 42 CFR 422.128 as required in 42 FR 438.6(i).	**Met**	PrimeWest Health has a process for ensuring that their members, county care coordinators, and providers are regularly reminded about the importance of discussing Health Care Directives during patient visits. New members receive a 17-page packet that includes details about Health Care Directives including their rights, a frequently asked questions page, and a blank Health Care Directives form to share with their provider. In addition, members receive a reminder in the quarterly "PrimeLines" member newsletter about updating or completing their Health Care Directives. Lastly, PrimeWest Health conducts ongoing training to the county care coordinators and internal PrimeWest Health staff. Providers also receive reminders about discussing Health Care Directives with their patients in PrimeWest Health provider newsletters.
Providers. To require MCO's providers to ensure that it has been documented in the enrollee's medical records whether or not an individual has executed an Advance Directive.	**Met**	PrimeWest conducts annual audits to ensure that Health Care directives are being discussed and that this is documented in patient charts. The 2016 care plan audit (following the 8-30 rule) included 30 Elderly Waiver and 30 non-Elderly Waiver care plans from PrimeWest Health's MSC+ and

11 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

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

DHS Contractual Element and References	Met or Not Met	Audit Comments
		HMO SNP members for each of the 13 counties. Review of the charts verified that either a conversation about Health Care Directives occurred and/or that a Health Care Directive is in the patient file. The results of the audit indicated 100% compliance. PrimeWest also conducted a medical record audit for all members over the age of 18 to verify if a Health Care Directive discussion was documented in the medical record. A total of 660 records from 33 primary care clinics were reviewed. The 2016 audit results indicated that 42% of medical records documented a discussion about Health Care Directives and/or that there was one executed. While onsite during MDH exam discussions, PrimeWest Health indicated that the biggest factor predicting which clinics would have higher rates for compliance was whether they had an electronic medical record (EMR) and whether the EMR feature that alerts providers to discuss Health Care Directives was turned on or off. PrimeWest Health also mentioned that providers who participated in their Accountable Rural Community Health (ARCH) program were more likely to document Health Care Directives discussions in medical records. PrimeWest Health explained that this was likely due to the frequent conversations at ARCH meetings with providers which raised awareness to the importance of discussing it.
Treatment. To not condition treatment or otherwise discriminate on the basis of whether an individual has executed an advance directive.	**Met**	
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**	
Education. To provide, individually or with others, education for MCO staff, providers and the community on Advance Directives.	**Met**	

IX. Validation of MCO Care Plan Audits for MSHO, MSC[13, 14] - 2016 Seniors Contract Sections 7.1.4D, 7.8.3, and 9.3.7

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

Validation of MSHO and MSC Care Plan Audits Data Grid

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

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

14 42 CFR 438.242.

X. Information System – 2016 Contract Section 7.1.2 [15, 16]

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	2014 – MetaStar 2015 – MetaStar 2016 – MetaStar *PrimeWest Health submitted measures were prepared according to the HEDIS® Technical Specifications and presents fairly, in all material respects, the organization's performance with respect to these specifications.*

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

16 42 CFR 438.242

XI. Subcontractors-2016 Contract Sections 9.3.1 and 9.3.16

A. Written Agreement; Disclosures

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

Written Agreement and Disclosures Data Grid

DHS Contractual Element and References	Met or Not Met	Audit Comments
A. Disclosure of Ownership and Management Information (Subcontractors). In order to assure compliance with 42 CFR § 455.104, the MCO, before entering into or renewing a contract with a subcontractor, must request the following information:		
(1) The name, address, date of birth, social security number (in the case of an individual), and tax identification number (in the case of a corporation) of each Person, with an Ownership or Control Interest in the disclosing entity or in any subcontractor in which the disclosing entity has direct or indirect ownership of five percent (5%) or more. The address for corporate entities must include primary business address, every business location and P.O. Box address;	**Met**	
(2) A statement as to whether any Person with an Ownership or Control Interest in the disclosing entity as identified in 9.3.1(A) is related (if an individual) to any other Person with an Ownership or Control Interest as spouse, parent, child, or sibling;	**Met**	
(3) The name of any other disclosing entity in which a Person with an Ownership Control Interest in the disclosing entity also has an ownership or control interest; and The name, address, date of birth, and social security number of any managing employee of the disclosing entity.	**Met**	
(4) For the purposes of section 9.3, subcontractor means an individual, agency, or organization to which a disclosing entity has contracted, or is a	**Met**	

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

B. Exclusions of Individuals and Entities; Confirming Identity

Exclusion of Individuals Data Grid

DHS Contractual Element and References	Met or Not Met	Audit Comments
A. Pursuant to 42 CFR § 455.436, the MCO must confirm the identity and determine the exclusion status of Providers and any Person with an Ownership or Control Interest or who is an agent or managing employee of the MCO or its subcontractors through routine checks of Federal databases, including the Social Security Administration's Death Master File and the National Plan and Provider Enumeration System (NPPES), and also upon contract execution or renewal, and credentialing.	**Met**	
B. The MCO and its subcontractors must search monthly, and upon contract execution or renewal, and credentialing, the OIG List of Excluded Individuals/Entities (LEIE) and the Excluded Parties List System (EPLS, within the HHS System for Awards Management) database (and may search the Medicare Exclusion Database), for any Providers, agents, Persons with an Ownership or Control Interest, and Managing Employees to verify that these persons: (1) Are not excluded from participation in Medicaid under Sections 1128 or 1128A of the Social Security Act; and (2) (2)Have not been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the programs under Title XX of the Social Security Act.	**Met**	
C. The MCO must require subcontractors to assure to the MCO that no agreements exist with an excluded entity or individual for the provision of items or services related to the MCO's obligation under this Contract.	**Met**	
D. The MCO shall require all subcontractors to report to the MCO within five (5) days any information regarding individuals or entities specified in (A) above, who have been convicted of a criminal offense related to the involvement in any program established under Medicare, Medicaid, the programs under Title XX of the Social Security Act, or that have been	**Met**	

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

Attachment A: MDH 2016 EW Care Plan Audit

Audit Protocol	Product Description	2017 MDH Audit Initial Charts Met	2017 MDH Audit Reassessment Charts Met	2017 MDH Audit Total % Charts Met	2016 PWH Total Charts % Met
1 **INITIAL HEALTH RISK ASSESSMENT**	For members new to the MCO or product within the last 12 months	10/10	n/a	100%	100%
2 **ANNUAL HEALTH RISK ASSESSMENT**	Been a member of the MCO for > 12 months [Only for plans with separate HRA]	N/A	N/A	N/A	100%
3 **LONG TERM CARE CONSULTATION – INITIAL**	If member is new to EW in the past 12 months	4/4	N/A	100%	100%
4 **REASSESSMENT OF EW**	For members open to EW who have been a member of the MCO for more than 12 months	N/A	8/8	100%	98.8%
5 **COMPREHENSIVE CARE PLAN**	Includes needs identified in the HRA and/or the LTCC and other sources	10/10	8/8	100%	100%
6 **COMPREHENSIVE CARE PLAN SPECIFIC ELEMENTS**	The CCP must have an interdisciplinary, holistic, and preventive focus. To achieve this focus, the Comprehensive Care Plan must include the elements listed below: A. Identification of enrollee needs and concerns, including identification of health and safety risks, and what to do in the event of an emergency B. Goals and target dates identified C. Interventions identified D. Monitoring of outcomes and achievement dates are documented	10/10	8/8	100%	100%

Audit Protocol	Product Description	2017 MDH Audit Initial Charts Met	2017 MDH Audit Reassessment Charts Met	2017 MDH Audit Total % Charts Met	2016 PWH Total Charts % Met
	Outcomes and achievement dates documented				
7 **FOLLOW-UP PLAN**	Follow-up plan for contact for preventive care[17], long-term care and community support, medical care, or mental health care[18], or any other identified concern	10/10	8/8	100%	100%
8 **COMMUNICATION OF CARE PLAN/SUMMARY**	Evidence of care coordinator communication of care plan elements with Primary Care Physician (PCP)	10/10	8/8	100%	100%
9 **PERSONAL RISK MANAGEMENT PLAN**	Required if enrollee refused recommended HCBS	0/0	4/4	100%	100%
10 **ANNUAL PREVENTIVE CARE**	Documentation in enrollee's Comprehensive Care Plan that substantiates a conversation was initiated	10/10	8/8	100%	100%
11 **ADVANCE DIRECTIVE**	Evidence that a discussion was initiated, enrollee refused to complete, was culturally inappropriate, or AD was completed	10/10	8/8	100%	100%
12 **ENROLLEE CHOICE**	Enrollee was given a choice between Home and Community-Based Services (HCBS) and Nursing Home Services (also	10/10	8/8	100%	100%

[17] 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.

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

Audit Protocol	Product Description	2017 MDH Audit Initial Charts Met	2017 MDH Audit Reassessment Charts Met	2017 MDH Audit Total % Charts Met	2016 PWH Total Charts % Met
	indicates enrollee involvement in care planning)				
13 **CHOICE OF HCBS PROVIDERS**	Information to enable choice among providers of HCBS	10/10	8/8	100%	100%
14 **COORDINATED SERVICES AND SUPPORT PLAN**	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	10/10	8/8	100%	100%
15 **CAREGIVER SUPPORT PLAN**	If a primary caregiver is identified in the LTCC	0/0 No caregiver interviews in Initial assessments	2/2	100%	100%
16 **APPEAL RIGHTS**	Appeal rights information provided to member	10/10	8/8	100%	100%
17 **DATA PRIVACY**	Data privacy information provided to member	10/10	8/8	100%	100%
18 **PERSON-CENTERED PLANNING**	Opportunities for choice in the person's current environment are described	3/3	0/0	100%	100% (New in July 2016 3 files reviewed after this date, all having person-centered planning)
PERSON-CENTERED PLANNING	Current rituals and routines are described (quality, predictability, preferences)	3/3	0/0	100%	100%

Audit Protocol	Product Description	2017 MDH Audit Initial Charts Met	2017 MDH Audit Reassessment Charts Met	2017 MDH Audit Total % Charts Met	2016 PWH Total Charts % Met
PERSON-CENTERED PLANNING	Social, leisure, or religious activities the person wants to participate in are described	3/3	0/0	100%	100%
PERSON-CENTERED PLANNING	Goals or skills to be achieved are described and are related to the person's preferences and how the person wants to live their life	3/3	0/0	100%	100%
PERSON-CENTERED PLANNING	Action steps describing what needs to be done to assist the person to achieve the goals or skills are documented	3/3	0/0	100%	100%
PERSON-CENTERED PLANNING	The plan includes a method for the individual to request updates to the plan, as needed	3/3	0/0	100%	100%
PERSON-CENTERED PLANNING	The plan records the alternative home and community-based settings and services that were considered by the individual	3/3	0/0	100%	100%
PERSON-CENTERED PLANNING	The plan is distributed to the individual and other people involved in the plan	3/3	0/0	100%	100%
PERSON-CENTERED PLANNING	The person decision about employment/volunteer opportunities has been documented	3/3	0/0	100%	100%
PERSON-CENTERED PLANNING	Has the individual chosen a different living arrangement than their current living arrangement? If so, is a plan in place on how to help that individual move to their preferred setting, identifying barriers and steps that need to be taken before the move happens? Present in LTCC, requires revision to CCP	N/A	N/A	N/A	100%

Audit Protocol	Product Description	2017 MDH Audit Initial Charts Met	2017 MDH Audit Reassessment Charts Met	2017 MDH Audit Total % Charts Met	2016 PWH Total Charts % Met
PERSON-CENTERED PLANNING	For people who have been identified as having a transition, the following are transition related items: 10.a. The essential elements of the transition summary and follow-up plan has been completed for an individual who has transitioned 10.b. During transition planning, there is evidence that the person was provided information and options to make informed choices that were meaningful to them	N/A	N/A	N/A	100%

Summary:

During the onsite review for the TCA exam, MDH reviewed a total 18 care plans (10 initial assessments and 8 reassessments). All charts were 100% in compliance with the audit protocol. Three files contained the new Person-centered Planning protocols (implemented in July of 2016) and were in compliance. In comparison, PrimeWest Health reviewed a total of 110 care plans for 2016 from 13 counties and found one delegate to be deficient in protocol number 4 related to the annual reassessment of care plans and timeliness and care plan completion. PrimeWest Health's threshold is 100% thus a corrective action plan was implemented. PrimeWest indicated they would conduct continued monitoring until the delegate is in full compliance.