Final Summary Report

TRIENNIAL COMPLIANCE ASSESSMENT

South Country Health Alliance

Performed under Interagency Agreement for Minnesota Department of Human Services
Examination Period: May 1, 2013 to February 29, 2016
File Review Period: March 1, 2015 to February 29, 2016
On-Site: May 16-20, 2016
Examiners: Elaine Johnson, RN, BS, CPHQ and Kate Eckroth, MPH
Final Issue Date: August 29, 2016

MDH Minnesota Department *of* Health
MANAGED CARE SYSTEMS

Triennial Compliance Assessment

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As requested by Minnesota Statute 3.197: This report cost approximately $125.00 to prepare, including staff time, printing and mailing expenses.

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Executive Summary
Triennial Compliance Assessment (TCA)

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

TCA Process Overview

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

- The first step in the process is the collection and validation of the compliance information by MDH. MDH's desk review and on-site QA Examination includes the collection and validation of information on supplemental federal and public program compliance requirements. To facilitate this process the MCO is asked to provide documents as requested by MDH.

- DHS evaluates information collected by MDH to determine if the MCO has "met" or "not met" Contract requirements. The MCO will be furnished a Preliminary TCA Report to review DHS' initial "met/not met" determinations. At this point, the MCO has an opportunity to refute erroneous information but may not submit new or additional documentation. Ample time and opportunities are allowed during the QA Examination to submit documents, policies and procedures, or other information to demonstrate compliance. The MCO must refute erroneous TCA finding within 30 days. TCA challenges will be sent by the MCO to MDH. MDH will forward the MCO's TCA rebuttal comments to DHS for consideration.

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

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

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

DHS Triennial Compliance Assessment (TCA)
TCA Data Collection Grid
SFY 2017

Managed Care Organization (MCO)/County Based Purchaser (CBP): South Country Health Alliance (SCHA)
Examination Period: May 1, 2013 to February 29, 2016
Onsite Dates: May 16-20, 2016

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DHS Contractual Element and References	Met/ Not Met	Audit Comments

1. 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). <u>Access Standards</u> 42 CFR § 438.206 Availability of Services 42 CFR § 438.207 Assurances of Adequate Capacity and Services 42 CFR § 438.208 Coordination and Continuity of Care 42 CFR § 438.210 Coverage and Authorization of Services <u>Structure and Operations Standards</u> 42 CFR § 438.214 Provider Selection 42 CFR § 438.218 Enrollee Information 42 CFR § 438.224 Confidentiality and Accuracy of Enrollee Records 42 CFR § 438.226 Enrollment and Disenrollment 42 CFR § 438.228 Grievance Systems 42 CFR § 438.230 Subcontractual Relationships and Delegation <u>Measurement Improvement Standards</u> 42 CFR § 438.236 Practice Guidelines 42 CFR § 438.240 Quality Assessment and Performance Improvement Program 42 CFR § 438.242 Health Information System	Met	SCHA's 2015 was approved by MDH in June 2015 and the 2016 Quality Program Description was approved in May of 2016. <u>Access Standards</u>: **Recommendation From MDH Report:** Minnesota Statutes, Section 62D.124 (as cited in contract section 6.13) outlines the accessibility requirements for primary, mental health, hospital and specialty services to provide timely access within the standards. SCHA submitted geo access mapping that showed accessibility of providers within the statutory parameters. A summary of its access to care is included in the 2015 Quality Evaluation which provides a synopsis of SCHA's network access and appointment availability including its delegates. However, SCHA could provide a more in-depth analysis of the geo-access maps, identify gaps, if any, in its network and explain why it continued to "expand its contracted provider network" by 10% and in what areas. SCHA should include in its network adequacy summary a more in-depth analysis of its geo mapping results of provider types, identify gaps, and steps taken to remedy those gaps. <u>Measurement and Improvement Standards</u> **Deficiency pertaining to Quality Delegation from MDH Report under Minnesota Rules, part 4685.1110, subpart 6,** which states the HMO must develop and implement review and reporting requirements to assure that the delegated entity performs all delegated activities. • In SCHA's oversight of Perform RX in performing the credentialing function, no evidence was submitted showing oversight of pharmacy credentialing processes as spelled out in the delegation agreement. • SCHA did not provide evidence of adequate oversight of its delegates' utilization management (UM) appeal rights notice. DHS Contract states plans will utilize the appeal rights notice that is approved by the State. Review of all the delegates' files that performed UM revealed that the appeal rights notices utilized were outdated as follows: ➢ DentaQuest appeals rights were dated 2010 and the DTRs were dated 2011 ➢ Perform RX appeal rights were dated 2012 ➢ Health Solutions appeals rights were from 2012 and had the wrong label (labeled as Medicare) SCHA recognized the use of outdated appeal rights on the part of DentaQuest

DHS Contractual Element and References	Met/ Not Met	Audit Comments
		in February 2016 and instituted a change March 11, 2016. However, the issue was not corrected until after the MDH examination was opened. The outdated appeal rights notice utilized by Perform Rx and Mayo Health Solutions were not addressed.

DHS Contractual Element and References	Met/ Not Met	Audit Comments
2. Utilization Management - 2016 Contract Section 7.1.3 A. 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] The MCO shall facilitate the delivery of appropriate care and monitor the impact of its utilization management program to detect and correct potential under and over utilization. The MCO shall: i. Choose the appropriate number of relevant types of utilization data, including one type related to behavioral health to monitor. ii. Set thresholds for the selected types of utilization data and annually quantitatively analyze the data against the established thresholds to detect under and overutilization. iii. Examine possible explanations for all data not within thresholds. iv. Analyze data not within threshold by medical group or practice. v. Take action to address identified problems of under or overutilization and measure the effectiveness of its interventions. [2] B. The following are the 2016 NCQA Standards and Guidelines for the Accreditation of MCOs UM 1-4 and 10-14.	Met	Data from SCHA over and under-utilization reports indicate that utilization measures fell within SCHA-designated thresholds during CY 2014. SCHA identified trends and observations in ER, Mental Health/Chemical Dependency, Primary Care and inpatient measures with explanations of some of the trends including shifts due to seasonal changes and Medicaid expansion.
NCQA Standard UM 1: Utilization Management Structure The organization clearly defines the structures and processes within its utilization management (UM) program and assigns responsibility to appropriate individuals. Element A: Written Program Description Element B: Physician Involvement Element C: Behavioral Healthcare Practitioner Involvement Element D: Annual Evaluation	Met	SCHA delegates UM functions to Mayo Health Solutions, Perform Rx, DentaQuest and Clinical Resource Group (Chiropractic).

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

DHS Contractual Element and References	Met/ Not Met	Audit Comments
NCQA Standard UM 2: Clinical Criteria for UM Decision To make utilization decisions, the organization uses written criteria based on sound clinical evidence and specifies procedures for appropriately applying the criteria. Element A: UM Criteria Element B: Availability of Criteria Element C: Consistency of Applying Criteria	Met	**UM Deficiency finding from MDH Report:** In the 8 Mayo Health Solution files, 8 Perform Rx files, and 14 DentaQuest files, the appeal rights forms approved by DHS were outdated. SCHA indicated that all 30 of each of the delegate files contained outdated appeal right forms. To comply with: • 42 CFR §438.210(c) (Contract section 8.3.1) • 42 CFR §438.408 (d)(2) (Contract section 8.4.7(A)), • Minnesota Statute 62M.05, subdivision 3a(d)., and • Minnesota Statute 62M.06, subdivision 1a. SCHA must ensure that all DTR notices and clinical appeals that are wholly or partially unfavorable to the enrollee include the most recently approved DHS appeal rights form. Enrollees must have the most current information of their appeal rights including the process for internal appeals and State Fair Hearings.
NCQA Standard UM 3: Communication Services The organization provides access to staff for members and practitioners seeking information about the UM process and the authorization of care. Element A: Access to Staff	Met	
NCQA Standard UM 4: Appropriate Professionals Qualified Licensed health professionals assess the clinical information used to support UM decisions. Element D: Practitioner Review of Behavioral Healthcare Denials Element F: Affirmative Statement About Incentives	Met	
NCQA Standard UM 10: Evaluation of New Technology The organization evaluates the inclusion of new technologies and the new application of existing technologies in the benefits plan. This includes medical and behavioral health procedures, pharmaceuticals, and devices. Element A: Written Process Element B: Description of Evaluation Process	Met	
NCQA Standard UM 11: Emergency Services The organization provides, arranges for or otherwise facilitates all needed emergency services, including appropriate coverage of costs. Element A: Policies and Procedures	Met	

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

DHS Contractual Element and References	Met/ Not Met	Audit Comments
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 Element B: Pharmaceutical Restrictions/Preferences Element C: Pharmaceutical Patient Safety Issues Element D: Reviewing and Updating Procedures Element E: Considering Exceptions	Met	
NCQA Standard UM 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	Met	
NCQA Standard QI 4: Member Experience The organization monitors member experience with its services and identifies areas of potential improvement. Element G: Assessing experience with the UM process	Met	

DHS Contractual Element and References	Met/ Not Met	Audit Comments
3. Special Health Care Needs - 2016 Contract Section 7.1.4 A-C[3, 4] The MCO must have effective mechanisms to assess the quality and appropriateness of care furnished to Enrollees with special health care needs. 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	During the examination period Mayo Health Solutions performed this function for SCHA. In 2015, South Country purchased and implemented a new case management information system called TruCare by Casenet, Inc. as well as hired staff and developed policies and processes for the case management program. A Case Management Supervisor was hired in the summer of 2015. The program was officially transitioned from Health Solutions in January 2016.

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

DHS Contractual Element and References	Met/ Not Met	Audit Comments
4. Practice Guidelines -2016 Contract Section 7.1.5[5,6,] A. 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. i. <u>Adoption of practice guidelines</u>. The MCO shall adopt guidelines based on: • Valid and reliable clinical evidence or a consensus of Health Care Professionals in the particular field • Consideration of the needs of the MCO enrollees • Guidelines being adopted in consultation with contracting Health Care Professionals • Guidelines being reviewed and updated periodically as appropriate. ii. <u>Dissemination of guidelines.</u> MCO ensures guidelines are disseminated: • To all affected Providers • To enrollees and potential enrollees upon request iii. <u>Application of guidelines</u>. 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	• Preventive Services for Adults • Preventive Services for Children • Prenatal, Routine Care • Diabetes, Type 2 Management • Asthma, Diagnosis and Management • Hypertension Diagnosis and Treatment • Adult Depression • Children & Adolescents with Attention-Deficit / Hyperactivity Disorder SCHA utilizes ICSI as a primary source for guidelines. Practice Guidelines are printed in newsletters and shared with enrollees during practitioner visits, health promotion and QI project materials.

5 42 CFR 438.236
6 MSHO/MSC+ Contract section 7.1.5 A-C; SNBC Contract section 7.1.5A-C

DHS Contractual Element and References	Met/ Not Met	Audit Comments
5. Annual Quality Assessment and Performance Improvement Program Evaluation- 2016 Contract Sections 7.1.8 [7,8] A. The MCO must conduct an annual quality assessment and performance improvement program evaluation consistent with state and federal regulations and current NCQA "Standards for Accreditation of Health Plans". This evaluation must: i. Review the impact and effectiveness of the MCO's quality assessment and performance improvement program ii. Include performance on standardized measures (example: HEDIS®) and iii. Include MCO's performance improvement projects. B. NCQA QI 1, Element B: There is an annual written evaluation of the QI Program that includes: i. A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service ii. A trending of measures to assess performance in the quality and safety of clinical care and quality of services iii. Analysis and evaluation of the overall effectiveness of the QI program, including progress toward influencing network-wide-safe clinical practices	Met	The evaluation has: • A summary of the overall effectiveness of its quality program and focus areas identified for the following year • An analysis of its HEDIS and CAHPS data and what activities/programs it has in place to address • Summarizes status of improvement projects • Good use of tables to exemplify trending of measures and progress over time • As indicated on the MDH QA Report, MDH recommended a summary of the status of its network and the identification of any gaps and what is being done about those gaps rather than just include the geo-access maps.

7 42 CFR 438.240(e)
8 MSHO/MSC+ Contract Section 7.1.8 also includes the requirement that the MCO must include the "Quality Framework for the Elderly" in its Annual Evaluation

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

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

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

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.

A. 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.
B. 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.
C. PIP Proposal and PIP Interim Report Validation Sheets.
DHS uses these tools to review and validate MCOs' PIP proposals and annual status reports.

</td><td>

Met

Met

NA

Met

</td><td>

Current PIPs, QIPs AND Focus studies for SCHA

<table>
<tr><th colspan="3">2014</th></tr>
<tr><th>Project Type</th><th>Project Focus</th><th>Target Populations</th></tr>
<tr><td>QIP</td><td>Medication Reconciliation Post-Hospital Discharge</td><td>Seniors / SNBC</td></tr>
<tr><td>Focused Study</td><td>Infant Well-Child Visits</td><td>F&C</td></tr>
<tr><td>Focused Study</td><td>3-6 Year Well-Child Visits</td><td>F&C</td></tr>
<tr><td colspan="3">NOTE: Existing PIPs were terminated as a result of DHS Contract changes</td></tr>
</table>

<table>
<tr><th colspan="3">2015</th></tr>
<tr><th>Project Type</th><th>Project Focus</th><th>Target Populations</th></tr>
<tr><td>PIP</td><td>Anti-Depressant Medication Mngt</td><td>F&C</td></tr>
<tr><td>QIP</td><td>Medication Reconciliation Post-Hospital Discharge</td><td>Seniors / SNBC</td></tr>
<tr><td>Focused Study</td><td>Dental Access</td><td>F&C / Seniors / SNBC</td></tr>
</table>

Reviewed Interim PIP status reports for Medication Management Post-Hospitalization (QIP) and Anti-Depressant Management (PIP) initiated in 2015.

Discussed PIPS/QIPS with SCHA staff and reviewed validation sheets.

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

<table>
<tr><th>DHS Contractual Element and References</th><th>Met/
Not Met</th><th>Audit Comments</th></tr>
<tr><td>7. Disease Management -2016 Contract Section 7. 3[12]

The MCO shall make available a Disease Management Program for its Enrollees with:
A. Diabetes
B. Asthma
C. Heart Disease

Standards -The MCO's Disease Management Program shall be consistent current NCQA "Standards and Guidelines for the Accreditation of Health Plans" – QI Standard Disease Management

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

If the MCO's Diabetes, Asthma, and Heart Disease Management Programs have achieved 100% compliance during the most recent NCQA Accreditation Audit of QI Standards- Disease Management, the MCO will not need to further demonstrate compliance.</td><td>Met</td><td>SCHA has opt-in DM programs entitled Step Up! For Better Health that include Diabetes, Heart Disease, and Adult and Child Asthma consistent with NCQA guidelines. Outcome measures are:
• Hospitalizations: Each program participant will have less than 2 hospitalizations in the 6 months following enrollment in the program.
• Emergency Department Use: Each program participant will have less than 2 ED visits in the 6 months following program enrollment.
In 2015, results were as follows:
<table><tr><th colspan="5">2015 SCHA DM Program Results</th></tr><tr><th>Program</th><th># Eligible</th><th># Opt-in</th><th>Participation Rate</th><th>Outcome Measures
1. Hospitalizations: less than 2 hospitalizations in the 6 mo following enrollment
2. Ed Use: less than 2 ED visits in the 6 mo following enrollment.</th></tr><tr><td>CHF</td><td>116</td><td>29</td><td>25%</td><td>1. 0 members
2. 0 members</td></tr><tr><td>Diabetes</td><td>628</td><td>112</td><td>18%</td><td>1. 1 member
2. 0 members</td></tr><tr><td>Adult Asthma</td><td>586</td><td>28</td><td>5%</td><td>1. 1 member
2. 0 members</td></tr><tr><td>Child Asthma</td><td>444</td><td>20</td><td>5%</td><td>1. 0 members
2. 0 members</td></tr></table>Moving forward, SCHA is exploring ways to increase enrollment and improve the DM program model.</td></tr>
</table>

12 MSHO/ MSC+ Contract section 7.3, requires only diabetes and heart disease DM programs; SNBC Contract section 7.2.6

DHS Contractual Element and References	Met/ Not Met	Audit Comments
8. Advance Directives Compliance – 2016 Contract Section 16[13,14] A. The MCO agrees to provide all Enrollees at the time of enrollment a written description of applicable State law on Advance Directives and the following: 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 CFR 438.6(i). B. Providers. To require MCO's providers to ensure that it has been documented in the enrollee's medical records whether or not an individual has executed an Advance Directive. C. Treatment. To not condition treatment or otherwise discriminate on the basis of whether an individual has executed an advance directive. D. 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	SCHA improved compliance with Advance Directives documented in Primary Care Clinic medical records increasing compliance rates from 41% in 2014 to 92% in 2015. This likely improved through more provider education at lower performing clinics during 2014. During discussions while onsite, SCHA said that implementation of EMR systems at clinics has helped improve compliance as well. SCHA compliance audits indicated that within Behavioral Health Clinics the rates improved from 61% in 2014 to 71% in 2015.

13 42 C.F.R. 489.100. Pursuant to 42 U.S.C. 1396a(a)(57) and (58) and 42 C.F.R. 489.100-104
14 MSC/MSC+ Contract Article 16; SNBC Contract Article 16

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

DHS Contractual Element and References	Met/ Not Met	Audit Comments
9. Validation of MCO Care Plan Audits for MSHO, MSC+,[15,] MDH will collect information for DHS to monitor MCO Care Plan Audit activities as outlined in the DHS/MCO MSHO/MSC+ Contract. A. DHS will provide MDH with Data Collection Guide for the random sample of 30 MCO enrollees (plus an over sample of 10 MCO enrollees for missing or unavailable enrollee records) for MSHO and MSC+ program. 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	See Attachment A and B for more detail regarding this element.

15 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

DHS Contractual Element and References	Met/ Not Met	Audit Comments
10. Information System – 2016 Contract Section 7.1.2[16, 17] The MCO must operate an information system that supports initial and ongoing operations and quality assessment and performance improvement programs. The MCO must maintain a health information system that collects, analyzes, integrates, and reports data. During each of the past three years, all MCO MDH annual HEDIS performance measures have been certified reportable by an NCQA HEDIS audit.	Met	Final Audit Reports reviewed included: 1. 2013 – MetaStar Inc. 2. 2014 – ATTEST Health Care Advisors Final Audit Reports stated: *In our opinion, South Country Health Alliance's 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.* MetaStar noted in its report under Strengths that "*All staff members have a quality improvement attitude. Process improvements are made with the goal of being both efficient and effective".*

16 Families and Children, Seniors and SNBC Contract Section 7.1.2
17 42 CFR 438.242

DHS Contractual Element and References	Met/ Not Met	Audit Comments
11. 9.3.1 Written Agreement; Disclosures.[18]	Met	
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. All contracts must include:		
A. Disclosure of Ownership and Management Information (Subcontractors). In order to assure compliance with 42 CFR § 455.104, the MCO, before entering into or renewing a contract with a subcontractor, must request the following information:	Met	
(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	Met	

18 Families and Children, Seniors and SNBC Contract Sections 9.3.1.A and C

DHS Contractual Element and References	Met/ Not Met	Audit Comments
(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 9.3, subcontractor means an individual, agency, or organization to which a disclosing entity has contracted, or is a person with an employment, consulting or other arrangement with the MCO for the provision of items and services that are significant and material to the MCO's obligations under its contract with the STATE.	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.	Met	
B. 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	
9.3.16 Exclusions of Individuals and Entities; Confirming Identity. 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	Met	

DHS Contractual Element and References	Met/ Not Met	Audit Comments
National Plan and Provider Enumeration System (NPPES), and also upon contract execution or renewal, and credentialing.		
b. The MCO and its subcontractors must search monthly, and upon contract execution or renewal, and credentialing, the OIG List of Excluded Individuals/Entities (LEIE) and the Excluded Parties List System (EPLS, within the HHS System for Awards Management) database (and may search the Medicare Exclusion Database), for any Providers, agents, Persons with an Ownership or Control Interest, and Managing Employees to verify that these persons: (1) Are not excluded from participation in Medicaid under Sections 1128 or 1128A of the Social Security Act; 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.	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 excluded from participation in Medicaid under §§ 1128 or 1128A of the Social Security Act.	Met	
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	Protocol Description	Measures	Total # Charts Reviewed		Total # Charts "Met"		MDH 2016 % Met	Comments
			Initial	Reassess	Initial	Reassess		
1	INITIAL HEALTH RISK ASSESSMENT For members new to the MCO or product within the last 12 months	A. Date HRA completed is within 30 calendar days of enrollment date	8	n/a	8	n/a	100%	
		B. All HRA areas evaluated and documented (in enrollee Comprehensive Care Plan)	8	n/a	8	n/a	100%	
2	ANNUAL HEALTH RISK ASSESSMENT Been a member of the MCO for > 12 months [Only for plans with separate HRA]	HRA is completed is within 12 months of previous HRA (results are in CCP)	n/a	8	n/a	8	100%	
3	LONG TERM CARE CONSULTATION – INITIAL If member is new to EW in the past 12 months	A. All (100%) of the fields relevant to the enrollee's program are completed with pertinent info or noted as Not Applicable or Not Needed	8	n/a	8	n/a	100%	
		B. LTCC was completed timely (and in enrollee CCP)	8	n/a	8	n/a	100%	
4	REASSESSMENT OF EW For members open to EW who have been a member of the MCO for more than 12 months	A. Date re-assessment completed is within 12 months of previous assessment	n/a	8	n/a	8	100%	
		B. All areas of LTCC have been evaluated and documented (and in CCP)	n/a	8	n/a	8	100%	

Audit Protocol	Protocol Description	Measures	Total # Charts Reviewed		Total # Charts "Met"		MDH 2016 % Met	Comments
			Initial	Reassess	Initial	Reassess		
5	COMPREHENSIVE CARE PLAN Includes needs identified in the HRA and/or the LTCC and other sources	A. Date CCP completed is within 30 calendar days of completed LTCC	8	8	8	8	100%	
6	COMPREHENSIVE CARE PLAN SPECIFIC ELEMENTS	A. Identification of enrollee needs and concerns, including ID of health and safety risks, what to do in the event of an emergency, are in CCP (from LTCC)	8	8	8	8	100%	
		B. Goals and target dates (at least, month/year) identified	8	8	8	8	100%	
		C. Outcomes and achievement dates (at least, month/year) are documented	8	8	8	8	100%	
7	FOLLOW-UP PLAN Follow-up plan for contact for preventive care[19], long-term care and community support, medical care, or mental health care[20], or any other identified concern	A. All areas of concern are addressed as identified on the Comprehensive Care Plan as stated in #5 of this protocol	8	8	8	8	100%	
		B. If an area is noted as a concern then documented goals, interventions, and services [If an area is identified as "Not Needed" or NA is excluded from denominator]	8	8	8	8	100%	
8	ANNUAL PREVENTIVE CARE	Documentation in enrollee's Comprehensive Care Plan that substantiates a conversation was initiated	8	8	8	8	100%	

[19] 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.
[20] Mental health care concerns should include but not be limited to: depression, dementia, and other mental illness.

Audit Protocol	Protocol Description	Measures	Total # Charts Reviewed		Total # Charts "Met"		MDH 2016 % Met	Comments
			Initial	Reassess	Initial	Reassess		
9	ADVANCE DIRECTIVE	Evidence that a discussion was initiated, enrollee refused to complete, was culturally inappropriate, or AD was completed	8	8	8	8	100%	
10	ENROLLEE CHOICE Enrollee was given a choice between Home and Community-Based Services (HCBS) and Nursing Home Services (also indicates enrollee involvement in care planning)	A. Choice noted in Section J of LTCC Assessment Form (e-docs #3428) or equivalent document (correlates to Section D of the LTCC Screening Document (e-docs #3427)	8	8	8	8	100%	
		B. Completed and signed care plan summary (and in CCP)	8	8	8	8	100%	
11	CHOICE OF HCBS PROVIDERS Information to enable choice among providers of HCBS	Completed and signed care plan summary (in CCP)	8	8	8	8	100%	
12	HOME AND COMMUNITY BASED SERVICE PLAN A HCBS service plan with these areas completed, including clearly identified and documented links to assessed needs per the results of the LTCC	A. Type of services to be furnished	8	8	8	8	100%	
		B. The amount, frequency and duration of each service	8	8	8	8	100%	
		C. The type of provider furnishing each service including non-paid care givers and other informal community supports or resources	8	8	8	8	100%	
13	CAREGIVER SUPPORT PLAN	A. Attached Caregiver Planning Interview	n/a	n/a	n/a	n/a	n/a	No initial caregiver interviews

Audit Protocol	Protocol Description	Measures	Total # Charts Reviewed		Total # Charts "Met"		MDH 2016 % Met	Comments
			Initial	Reassess	Initial	Reassess		
	If a primary caregiver is identified in the LTCC,	B. Incorporation of stated caregiver needs in Service Agreement, if applicable	n/a	2	n/a	2	100%	2 reassessments had caregiver needs addressed in SA but no assessment
14	APPEAL RIGHTS Appeal rights information provided to member.	Acknowledgement on signed care plan or other signed documentation in file	8	8	8	8	100%	
15	DATA PRIVACY Data privacy information provided to member	Acknowledgement on signed care plan or other signed documentation in file	8	8	8	8	100%	

Summary:

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

The most current SCHA audit was conducted in the spring/summer of 2015. The audit assessed 12 delegated entities (counties) who provided services to enrollees in the SeniorCare Complete (MSHO) and the MSC+ Elderly Waiver products. During the MDH onsite exam, examiners looked at 8 initial and 8 reassessment care plans. MDH found no issues with the care plans. The care plans audited were thorough, well-organized and followed-up on at regular intervals. Attachment B below compares the SCHA audit with MDH's audit. A summary of SCHA's audit is written below the table. Overall, SCHA's audit found more issues than MDH's audit. Part of this reason may be due to MDH's smaller care plan sample size, and also because some of the care plan files that MDH reviewed were completed following the release of SCHA's audit results to the delegated counties and thus improvements by the counties may have been implemented immediately.

Attachment B: Comparison of SCHA 2015 Care Plan Audit to MDH 2016

Audit Protocol Number	Desired Outcome	Description of Protocol Area	SCHA 2015 % Met	MDH 2016 % Met
1	Initial Health Risk Assessment	a. Completed within timelines	91%	100%
		b. Results included in CCP	91%	100%
		c. All areas evaluated and documented	71%	100%
2	Annual Health Risk Assessment [Only for plans with separate HRA]	a. Complete within timelines	N/A	N/A
		b. Results included in CCP	N/A	N/A
3	LTCC Assessment- Initial (New to EW in past 12 months)	a. LTCC results attached to CCP	100%	100%
		b. All relevant fields completed or "n/a" is doc'd	89%	100%
		c. Completed timely	80%	100%
4	Annual Reassessment of EW	a. Annual re-assess w/in 365 days of previous assessment or explanation documented	87%	100%
		b. Results of LTCC attached to CCP	99%	100%
		c. All areas of the LTCC have been evaluated and documented	82%	100%
5	Comprehensive Care Plan	CCP completed w\in 30 calendar days of LTCC and explanation documented	76%	100%
6	Comprehensive Care Plan Specific Elements	a. Needs & Concerns identified	64%	100%
		b. Health and safety risks identified and plans for addressing these risks	90%	100%
		c. Documentation of services essential to health and safety	94%	100%
		d. If applicable, back-up plan for essential services	94%	100%
		e. Plan for community-wide disasters	87%	100%
		f. Goals and target dates	85%	100%
		g. Interventions identified	97%	100%
		h. Monitoring progress toward goals	96%	100%

Audit Protocol Number	Desired Outcome	Description of Protocol Area	SCHA 2015 % Met	MDH 2016 % Met
		i. Outcomes and achievement dates are documented	67%	100%
		j. Care plan signed by member or authorized rep..	91%	100%
		k. Care Coordinator has documented their plan for follow-up with the member.	74%	100%
7	Communication of Care Plan / Summary	Evidence of Care Coordinator communication of Care Plan elements with Primary Care Physician (PCP)	99%	100%
8	Personal Risk Management Plan	a. HCBS service refusal noted in CCP	79%	100%
		b. Personal risk management plan completed	57%	100%
9	Annual Preventive Health Exam	Annual Preventive health exam conversation initiated	96%	100%
10	Advance Directive	Advanced Directive conversation	95%	100%
11	Enrollee Choice	a. LTCC Section J or equivalent document	73%	100%
		b. Completed & signed Care Plan	73%	100%
		c. Copy of CCP summary	99%	100%
12	Choice of HCBS Providers	a. Completed & signed Care Plan	73%	100%
		b. Copy of CCP Summary	99%	100%
13	Community Support Plan – Community Services and Supports Section	a. Type of Services	96%	100%
		b. Amount, Frequency, Duration and Cost	96%	100%
		c. Type of Provider & non-paid/informal	96%	100%
		d. Attempted not complete w/explanation	Not provided	100%
14	Caregiver Support Plan	a. Caregiver planning interview/ assessment attached	94%	n/a
		b. Caregiver needs incorporated into SA, if applicable	82%	100%
15	Appeal Rights	Completed and signed care plan or other signed documentation in enrollee file.	91%	100%

Audit Protocol Number	Desired Outcome	Description of Protocol Area	SCHA 2015 % Met	MDH 2016 % Met
16	Data Privacy	Completed and signed care plan or other signed documentation in enrollee file.	73%	100%

Summary:

SCHA noted that overall, delegate performance on care plans has improved from 2014 to 2015. They credit training and education in areas where protocols scored less than 100% for how they improved over the prior year. During training sessions, the health plan ensures they are clear on their expectations for care plan completion. SCHA noted to MDH during onsite interviews that one of the biggest challenges to compliance for care coordinators who conduct care plans is higher turn-over. For this reason, SCHA has emphasized regular communication and ongoing training at each entity to ensure new staff clearly understand the protocols and expectations.