HealthPartners

Triennial Compliance Assessment

FINAL SUMMARY REPORT

DEPARTMENT OF HEALTH

Triennial Compliance Assessment

Performed under Interagency Agreement for Minnesota Department of Human Services
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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 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 - 2017 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)	**Met**	Approved by MDH. Contains all the requirements of Minnesota Rule, part 4685.1110, subparts 1 through 13 and 42 CFR 438, subpart D.
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 Improvement Program 42 CFR § 438.242 Health Information System	**Met**	

II. Information System – 2017 Contract Section 7.1.2 [1, 2]

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 for review for years:** 2015 - Attest Health Care Advisors 2016 - Attest Health Care Advisors 2017 - Attest Health Care Advisors HealthPartners' 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.

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

2 42 CFR 438.242

III. Utilization Management - 2017 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."[3] 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**	Utilization types monitored included: • Behavioral health (Mental and Chemical)inpatient admission rate (admits, ALOS, Days) • Hospital admissions and readmissions • Outpatient • ER Utilization • Pharmacy high cost medications
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 included withhold goals set by DHS and internal trends over time

3 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
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**	Drilldown analysis done on thresholds that were exceeded, for example looking at ALOS and 30 and 60 day re-admission per acute psych facility
The MCO Shall: v. Take action to address identified problems of under or overutilization and measure the effectiveness of its interventions.	**Met**	Actions taken for measures outside of thresholds, for example, • Increasing MTM • Formation of admissions workgroup to analyze gaps, particularly In specific regions identified • Progression of Care Inpatient Behavioral Health Steering Committee continues to closely monitor opportunities to improve care delivery efficiency

B. 2017 NCQA Standards and Guidelines UM 1 – 4, 10 – 12; QI 4

The following are the 2017 NCQA Standards and Guidelines for the Accreditation of Health Plans UM 1 – 4 and 10 – 12, and QI 4.

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.	**Met per NCQA**	HealthPartners scored 100% in its accreditation for Commercial HMO/POS/PPO combined product by NCQA based on 2017 standards
Element A: Written Program Description	**Met per NCQA**	
Element B: Physician Involvement	**Met per NCQA**	
Element C: Behavioral Healthcare Practitioner Involvement	**Met per NCQA**	
Element D: Annual Evaluation	**Met per 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.		
Element A: UM Criteria	**Met per NCQA**	

DHS Contractual Element and References	Met or Not Met	Audit Comments
Element B: Availability of Criteria	**Met per NCQA**	
Element C: Consistency of Applying Criteria	**Met per 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	**Met per 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	**Met per NCQA**	
Element G: Affirmative Statement About Incentives	**Met per 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	**Met per NCQA**	
Element B: Description of Evaluation Process	**Met per NCQA**	
NCQA Standard UM 11: Procedures for Pharmaceutical Management	**Met per NCQA**	

DHS Contractual Element and References	Met or Not Met	Audit Comments
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	**Met per NCQA**	
Element C: Pharmaceutical Patient Safety Issues	**Met per NCQA**	
Element D: Reviewing and Updating Procedures	**Met per NCQA**	
Element E: Considering Exceptions	**Met per NCQA**	
NCQA Standard UM 12: 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 per NCQA**	
Element B: Supervision and Oversight	**Met per NCQA**	
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 per NCQA**	

IV. Special Health Care Needs - 2017 Contract Section 7.1.4 A-C[4, 5]

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 D. Annual Reporting to the State	**Met**	HealthPartners has multiple special health care needs programs for both commercial and Minnesota Health Care Program enrollees. They include enrollees for both chronic conditions and also those that have a mental health diagnosis and are at high risk for hospitalization. HealthPartners analyzes monthly reports from DHS to identify enrollees for their MSHO, MSC+ and SNBC, and utilizes special algorithms performed semi-monthly to identify enrollees for the High Risk Behavioral Health Care management program, and Complex Case Management. HealthPartners reports that in 2016 they identified 956 eligible Medicaid members to be assessed for the SHCN program. These members are triggered by having a high risk condition. Of the 956 identified members, 57% were assessed and about 2% are newly identified for the SHCN program.

4 42 CFR 438.330 (b)(4)

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

V. Practice Guidelines -2017 Contract Section 7.1.5[6, 7]

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 guidelines based on scientific evidence or professional standards for at least two medical and two behavioral conditions; and • Update the guidelines at least every two years • Distribute the guidelines to the appropriate practitioners	**Met**	HealthPartners adopts ICSI guidelines and they include over 40 guidelines in their program.
Element B: Adoption of preventive health guidelines. MCO shall adopt preventive health guidelines based on scientific evidence or professional standards for members of all ages; and • Update the guidelines at least every two years; • Distribute the guidelines to the appropriate practitioners.	**Met**	**Recommendation**: HealthPartners shall consider describing ***how*** Practice Guidelines are selected including how Utilization Management trends are considered, how enrollee needs are considered, and how sources help guide decisions.
Element C: Relation to DM Programs. MCO shall base its disease management programs on two of the organizations clinical practice guidelines.	**Met**	

6 42 CFR 438.340 (b) (1)

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

VI. Annual Quality Assurance Work Plan – 2017 Contract Section 7.1.7[8,9]

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.*"

DHS Contractual Element and References	Met or Not Met	Audit Comments
A. Annual written work plan 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.*	**Not Met**	Mandatory Improvement on MDH Exam: Minnesota Rules, part 4685.1130, subpart 2. B, states the work plan must describe the proposed focus studies to be conducted in the following year. HealthPartners listed as focus studies/improvement initiatives in its 2017 Work Plan as Antidepressant Medication Management (AMM), Medication Therapy Management (MTM) for MSHO, and Colorectal Cancer Screening. MTM is mentioned only briefly in conjunction with withhold and Colorectal is not in the work plan. For 2016, HealthPartners indicated focus studies were AMM, Asthma Action Plan and Chlamydia. Again, not all were included in the 2016 work plan. HealthPartners must identify and describe its focus studies/improvement initiatives in the annual work plan. MDH noted however, that all focus studies/improvement initiatives in both 2016 and 2017 were included in the annual evaluations.

8 42 CFR 438.3302)

9 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
B. Current NCQA "*Standards and Guidelines for the Accreditation of Health Plans.*" **NCQA QI, Element A:** 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**	Recommendation; HealthPartners should include in the annual work plan and annual evaluation those DHS mandated quality activities as outlined in the contract, such as Special Health Care Needs.

VII. Evaluation – 2017 Contract Section 7.1.8[10, 11]

Annual Quality Assessment and Performance Improvement Program Evaluation Data Grid

DHS Contractual Element and References	Met or Not Met	Audit Comments
7.1.7 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 ii. MCO's performance improvement projects.	**Met**	Recommendation on MDH Exam: HealthPartners' annual evaluation gives a thorough summary of its quality activities. It is not always clear in the summary of the performance improvement projects and focus studies as to which plan populations are included in the project. HealthPartners should clearly indicate in the annual evaluation what population(s) were involved in the individual improvement activities.
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.	**Met**	Excellent Executive Summary that outlines the successes and barriers and evaluates overall program for effectiveness. Consolidated the utilization management program into the annual evaluation.

10 42 CFR 438.330(b), (d)

11 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."

VIII. Performance Improvement Projects-2017 Contract Section 7.2, 7.2.1, and 7.2.2[12, 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 Final PIP Report. Upon completion of the 2015 PIP the MCO shall submit to the STATE for review and approval a final written report by September 1, 2018, in a format defined by the STATE.	**Met**	Reviewed and Discussed; Antidepressant Medication Management – ending in 2018
7.2.1 New Performance Improvement Project Proposal. The STATE will select the topic for the PIP to be conducted over the next three years (calendar years 2018, 2019 and 2020). The PIP must be consistent with CMS' published protocol entitled	**Met**	Reviewed and discussed New Project – Reducing Opioid Use

12 42 CFR 438.330 (b)(1), 42 CFR 438.330(d)

13 MSHO/MSC+ Contract section 7.2; SNBC Contract section 7.2.6

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

DHS Contractual Element and References	Met or Not Met	Audit Comments
"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.		
PIP Proposal and PIP Interim Report Validation Sheets. DHS uses these tools to review and validate MCOs' PIP proposals and annual status reports.	**Met**	

IX. Disease Management - 2017 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.	**Met** **NA**	HealthPartners scored 100% on NCQA Disease Management for Diabetes and Asthma. HealthPartners submitted disease management materials for Heart Disease which meet all NCQA requirements and all three are summarized in the annual evaluation.
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**	
Element F: Eligible Member Active Participation	**Met**	

DHS Contractual Element and References	Met or Not Met	Audit Comments
Element G: Informing and Educating Practitioners	**Met**	
Element H: Integrating Member Information	**Met**	
Element I:Experience with Disease Management	**Met**	
Element J: Measuring Effectiveness	**Met**	

X. Advance Directives Compliance - 2017 Contract Section 16[15, 16]

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** **Met** **Met** **Met**	To determine compliance with contractual elements requiring dissemination of information about advance directives to enrollees , MDH reviewed HealthPartners' webpages welcoming members to their plan and providing orientation and a policy and procedure describing, inter alia, where enrollees can obtain information about health care directives. MDH also reviewed a total of five policies and procedures that address how HealthPartners implements enrollees advance directives for treatment decisions when they are incapacitated. These policies and procedures list information that HealthPartners must provide upon member enrollment and provide information on where complaints may be filed.
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**	HealthPartners submitted a "Member Protections" addendum to a provider contract, a policy and procedure on health care directives, and a Medical Records Standard to show compliance with contractual

15 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

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

DHS Contractual Element and References	Met or Not Met	Audit Comments
		requirements regarding documentation of whether or not an individual has executed an advance directive.
Treatment. To not condition treatment or otherwise discriminate on the basis of whether an individual has executed an advance directive.	**Met**	HealthPartners submitted a "Member Protections" addendum to a provider contract, two policies and procedures on health care directives to show compliance with the contractual prohibition on conditioning treatment or otherwise discriminating on the basis of execution of an advance directive.
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**	Health care directive policies and procedures and an addendum to the provider contract show compliance with state law on advance directives.
Education. To provide, individually or with others, education for MCO staff, providers and the community on Advance Directives.	**Met**	HealthPartners provides education on advance directives, as shown by three separate documents showing training protocols for staff and support of an end of life course open to the public.

XI. Validation of MCO Care Plan Audits for MSHO, MSC[17] - 2017 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. 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	DHS followed the sampling methodology outlined in the audit protocol guidelines and presented the sample lists to MDH. MDH audited eight initial files and eight reassessment files.

17 Pursuant to MSHO/MSC+ 2017 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), 7.1.4D, 7.8.3 and 7.3.7.

XII. Subcontractors-2017 Contract Sections 9.3.1 and 9.3.16 (F&C), and 9.3.1 and 9.3.22 (MSHO/MSC+)

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:		MDH reviewed subcontracts with Polk and Norman Counties and a subcontract with Independent Lifestyles, Inc. (ILI)
(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**	While DOB and SS# were not in the ILI contract, ILI supplied this information in a form completed prior to contracting.
(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**	ILI also supplied information as to whether a person with an ownership or control interest had a parent with an ownership or control interest in a form completed prior to contracting.
(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	**Met**	

DHS Contractual Element and References	Met or Not Met	Audit Comments
or control interest; and The name, address, date of birth, and social security number of any managing employee of the disclosing entity. (4) The name, address, date of birth and social security number of any managing employee of the disclosing entity. (5) For the purposes of section 9.3, subcontractor means an individual, agency, or organization to which a disclosing entity has contracted, or is a person with an employment, consulting or other arrangement with the MCO for the provision of items and services that are significant and material to the MCO's obligations under its contract with the STATE. (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** **Met** **Met**	ILI supplied required information about managing employees in a form completed prior to contracting.
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**	

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) 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**	This requirements is included in the state public programs addendum.

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**	The Adverse Actions Report is run on the 11th of each month and reported on the 15th of each month.
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 2018 EW Care Plan Audit

Data in the last column, "2017 HP's Audit Total Charts % Met" are from Health Partners' September 2017: MSHO and MSC+ Elderly Waiver and Non-Elderly Wavier Care Plan Audit Report, completed by Health Partners' Internal Audit Department.

Audit Protocol	Product Description	2017 MDH Audit Initial Charts Met	2017 MDH Audit Reassessment Charts Met	2017 MDH Audit Total % Charts Met	2016 HP's Audit 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%	100%
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%	N/A
3 **LONG TERM CARE CONSULTATION – INITIAL**	If member is new to EW in the past 12 months	8/8	n/a	100%	N/A
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%	100%
5 **COMPREHENSIVE CARE PLAN**	Includes needs identified in the HRA and/or the LTCC and other sources	8/8	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	8/8	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 HP's Audit Total Charts % Met
	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 Outcomes and achievement dates documented				
7 **FOLLOW-UP PLAN**	Follow-up plan for contact for preventive care[18], long-term care and community support, medical care, or mental health	8/8	8/8	100%	100%

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

Audit Protocol	Product Description	2017 MDH Audit Initial Charts Met	2017 MDH Audit Reassessment Charts Met	2017 MDH Audit Total % Charts Met	2016 HP's Audit Total Charts % Met
	care[19], or any other identified concern				
8 **COMMUNICATION OF CARE PLAN/SUMMARY**	Evidence of care coordinator communication of care plan elements with Primary Care Physician (PCP)	8/8	8/8	100%	100%
9 **PERSONAL RISK MANAGEMENT PLAN**	Required if enrollee refused recommended HCBS	8/8	8/8	100%	100%
10 **ANNUAL PREVENTIVE CARE**	Documentation in enrollee's Comprehensive Care Plan that substantiates a conversation was initiated	8/8	8/8	100%	100%
11 **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%
12 **ENROLLEE CHOICE**	Enrollee was given a choice between Home and Community-Based Services (HCBS) and Nursing Home Services	8/8	8/8	100%	100%

[19] 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 HP's Audit Total Charts % Met
	(also indicates enrollee involvement in care planning)				
13 **CHOICE OF HCBS PROVIDERS**	Information to enable choice among providers of HCBS	8/8	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	8/8	8/8	100%	100%
15 **CAREGIVER SUPPORT PLAN**	If a primary caregiver is identified in the LTCC	2/2	3/3	100%	100%
16 **APPEAL RIGHTS**	Appeal rights information provided to member	8/8	8/8	100%	100%
17 **DATA PRIVACY**	Data privacy information provided to member	8/8	8/8	100%	100%
18 **PERSON-CENTERED PLANNING**	Opportunities for choice in the person's current environment are described	8/8	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 HP's Audit Total Charts % Met
PERSON-CENTERED PLANNING	Current rituals and routines are described (quality, predictability, preferences)	8/8	8/8	100%	100%
PERSON-CENTERED PLANNING	Social, leisure, or religious activities the person wants to participate in are described	8/8	8/8	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	8/8	8/8	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	8/8	8/8	100%	100%
PERSON-CENTERED PLANNING	The plan includes a method for the individual to request updates to the plan, as needed	8/8	8/8	100%	100%
PERSON-CENTERED PLANNING	The plan records the alternative home and community-based settings and services that were considered by the individual	8/8	8/8	100%	100%
PERSON-CENTERED PLANNING	The plan is distributed to the individual and	8/8	8/8	100%	n/a

Audit Protocol	Product Description	2017 MDH Audit Initial Charts Met	2017 MDH Audit Reassessment Charts Met	2017 MDH Audit Total % Charts Met	2016 HP's Audit Total Charts % Met
	other people involved in the plan				
PERSON-CENTERED PLANNING	The person's decision about employment/volunteer opportunities has been documented	8/8	8/8	100%	n/a
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	n/a
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	0/0	0/0	NA	n/a

Audit Protocol	Product Description	2017 MDH Audit Initial Charts Met	2017 MDH Audit Reassessment Charts Met	2017 MDH Audit Total % Charts Met	2016 HP's Audit Total Charts % Met
	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				

Summary:

Care plan sampling done by DHS.
MDH reviewed 8 initial assessments and 8 reassessments using 2016 Care Plan Audit Protocol. MDH found 100% compliance on all audit protocols. Comparison done to HealthPartners 2017 EW Care Plan Audit with a scope of the audit including MSHO and MSC+ EW enrollees who had care plans developed within 12 months ending May 31, 2017.