DEPARTMENT OF HEALTH

South Country Health Alliance

TRIENNIAL COMPLIANCE ASSESSMENT

Triennial Compliance Assessment

Performed under Interagency Agreement for Minnesota Department of Human Services
Examination Period: June 1, 2016 to February 28, 2019
File Review Period: March 1, 2018 to February 28, 2019
On-Site: May 20, 2019 to May 24, 2019
Examiners: Elaine Johnson, RN, BS, CPHQ and Kate Eckroth, MPH
Final Report Issue Date: November 5, 2019

Minnesota Department of Health
Managed Care Systems Section
PO Box 64882
St. Paul, MN 55164-0882
651-201-5100
health.mcs@state.mn.us
www.health.state.mn.us

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

Contents

Triennial Compliance Assessment

Executive Summary

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

TCA Process Overview

DHS and MDH collaborated to redesign the 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 - 2018 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

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**	
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 – 2018 Contract Section 7.1.3[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 submitted measures were reviewed by: 2016 – ATTEST Health Care Advisors 2017 - ATTEST Health Care Advisors 2018 - ATTEST Health Care Advisors Summary 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.*

1 Families and Children, Seniors and SNBC Contract Section 7.1.2

2 42 CFR 438.242

III. Utilization Management - 2018 Contract Section 7.1.4

The MCO shall adopt a utilization management structure consistent with state regulations and federal regulations and current NCQA "Standards for Accreditation of Health Plans."[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**	2018 Data types chosen were: Inpatient admit rates Emergency Department Visit Rates Mental Health/Chem Dep Utilization Rates PCP (Outpatient) Utilization Rates In 2019, it appears these same data types are being utilized for over/under utilization. Since UM is new in-house, it would be helpful for baseline data purposes to expand the data types to get a good handle on utilization volumes and types.
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	**Met**	Thresholds for upper and lower run-limits is plus/minus two standard deviations from mean

3 2018 *Standards and Guidelines for the Accreditation of Health Plans*, effective July 1, 2018

overutilization.		
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**	
The MCO Shall: v. Take action to address identified problems of under or overutilization and measure the effectiveness of its interventions.[4]	**Met**	Some examples include: SCHA had P4P agreements with several provider organizations which included ED utilization where quarterly utilization reports were sent to providers. In 2017 had pilot project to increase PCP visits for Ability Care for one specific provider organization. Only modest improvements and pilot dropped.

B. 2018 NCQA Standards and Guidelines UM 1 – 4, 10 – 12; QI 4

The following are the 2018 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.		
Element A: Written Program Description	**Not Met**	UM Program Description dated 12/31/2018 is in the format of a policy. In January, 2019 SCHA undertook a significant change in its UM practice by bringing all of UM in-house. Neither the UM Program Description nor the UM work plan (which was included QA work plan) reflected this significant change. The 2018 UM Summary states in part "*As of 1/1/2019, South Country has transitioned Utilization Management function for medical services in-house and will develop new strategies and tools to monitor and evaluate utilization of benefits and services for members."* Those "new strategies and tools" were not reflected in the 2019 UM documents. The UM Program Description contains the mandated components and usual processes, however, they not specific to SCHA's needs of a new service. For instance, some areas that may be included in a program description or UM plan would be: • ongoing monitoring of new staff for compliance to UM criteria and UM processes; • education needs of UM staff; • collection of process and outcome data to determine timeliness and appropriateness of services; • baseline data for a top-10 high dollar diagnosis;

		• top-10 high volume diagnoses; • assessing current and future prior authorization requirements; • etc. MDH requested and reviewed onsite the UM Committee Charter for the newly formed committee (dated 10.19.2018) and two sets of minutes, dated 10.19.18 and 2.15.2019. The UM committee was to report to the QAC. It is reflected in the QAC minutes that the UM Committee will report to the QAC (minutes from 12.7.2018) UM work plan is included in QA Work plan which is appropriate. However, UM work plan for 2019 does not include the UM committee, utilization data type measures, specific monitoring and evaluation activities, and still states it will "continue to monitor TPA's". It should be specific in that TPAs are now Delta Dental and Perform Rx and the monitoring/oversight of UM functions for those delegates. Additional utilization data types will assist SCHA in determining areas for improvement for UM. UM Committee is reflected in the QA Program Description.
Element B: Physician Involvement	**Met**	
Element C: Behavioral Healthcare Practitioner Involvement	**Met**	
Element D: Annual Evaluation	**Met**	
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.	**Met**	
Element A: UM Criteria	**Met**	
Element B: Availability of Criteria	**Met**	

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**	
Element G: Affirmative Statement About Incentives	**Met**	
Element B: Description of Evaluation Process	**Met**	
NCQA Standard UM 11: Procedures for Pharmaceutical Management The organization ensures that its procedures for pharmaceutical management, if any, promote the clinically appropriate use of pharmaceuticals Element A: Policies and Procedures	**Met**	

Element B: Pharmaceutical Restrictions/Preferences	**Met**	
Element D: Reviewing and Updating Procedures	**Met**	
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 Element B: Supervision and Oversight	NA	

IV. Special Health Care Needs - 2018 Contract Section 7.1.5 A-D[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**	In 2018, SCHA identified 1,416 PMAP and MNCare members based on certain claims triggers such as Pneumonia or readmission or high cost claims. Of those, 1,149 (81%) were referred to various programs for follow-up. For instance, of the cases identified, 54% were referred to a Community Care Connector which is a county-level service program. Of the 1,149 members targeted for referral to SCHA programs, 69 (4.9%) were enrolled in the Complex Case Management Program which is SCHA's Special Health Care needs program for PMAP/MNCare members. See table on the following page for year over year data. Recommendation: SCHA shall include percentages in their enrollment table to better track trends over time.

4 42 CFR 438.330 (b)(4)

5 MSHO, MSC+ Contract section 7.1.4 A-C; SNBC Contract section 7.1.5

Total Number of PMAP and MNCare Members Identified for SHCN Case Management			
	2015	2016	2018
Number of SHCN Identified	1,058	1,392	1,416
Cases targeted for referral to SCHA programs	922	1,181	1,149
Cases Referred to Complex Case Management program	87	476	512
Cases Open to Complex Case Management program	84	114	69
Cases Referred to Community Care Connector (County)	757	655	762
Cases Referred to Disease Management	0	21	26
Cases Referred to Other (restricted, high dollar, reinsurance, Healthy Pathways, etc.)	71	262	228

V. Practice Guidelines -2018 Contract Section 7.1.6[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**	Adopts generally from ICSI, USPSTF, AAFP 1. Preventive Services for Adults 2. Preventive Services for Child/Adol 3. Prenatal Care 4. Type 2 Diabetes 5. Asthma 6. HTN Dx and Tx 7. Depression in Adults 8. Child/Adol with ADHD
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**	Review and update of the Practice Guidelines are done annually by the QA Committee in consultation with health care professionals. Practice Guidelines are disseminated through the Provider Portal of their website as well as some published in the Provider Network News e-newsletter.

6 42 CFR 438.340 (b) (1)

7 MSHO/MSC+ Contract section 7.1.6 A-C; SNBC Contract section 7.1.6A-C

DHS Contractual Element and References	Met or Not Met	Audit Comments
Element C: Relation to DM Programs. MCO shall base its disease management programs on two of the organizations clinical practice guidelines.	**Met**	

VI. Annual Quality Assurance Work Plan – 2018 Contract Section 7.1.8

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

Annual Quality Assurance Work Plan Data Grid

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**	

VII. Annual Quality Assessment and Performance Improvement Program Evaluation – 2018 Contract Section 7.1.9[8,9]

The MCO must conduct an annual quality assessment and performance improvement program evaluation consistent with state and federal regulations and current NCQA "Standards and Guidelines for the Accreditation of Health Plans."

Annual Quality Assessment and Performance Improvement Program Evaluation Data Grid

—		
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.	**Met** **Met**	

8 42 CFR 438.330(b), (d)

9 MSCHO/MSC+ Contract Section 7.1.9 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
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**	SCHA Annual Evaluation of years 2016 and 2017 did not contain an evaluation of the overall effectiveness of the program. It did contain a "Summary of Progress" and barriers and recommendations for each individual project. However, the overall evaluation should include an analysis and evaluation of the QI program and its progress in meeting its goals based on an assessment of performance in all aspects of the program. It should address areas such as: • Adequacy of QI program resources • QI committee structure evaluation of adequacy and membership • Practitioner and leadership involvement in QI program • Need to restructure or change QI program due to organizational, membership, provider, Joint Powers Board, regulatory and other influences.

VIII. Performance Improvement Projects-2018 Contract Section 7.2[10, 11, 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**	Completed: Reducing Racial Disparities in the Management of Depression – Final report reviewed
7.2.1 New Performance Improvement Project Proposal.	**Met**	In-progress: Preventing New Chronic Opioid Users Project reviewed and discussed with SCHA

10 42 CFR 438.330 (b)(1), 42 CFR 438.330(d)

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

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

13 42 CFR 438.330(b)(1), 438.330(d)

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

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 *"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**	Reviewed validation sheets

2018 and 2019 Improvement Project Tables

2018 Improvement Projects		
Project Type	**Project Focus**	**Target Populations**
CCIP/FS	Antidepressant Med Mgmt.	F & C/Seniors/SNBC
FS	Healthy Pathways	F & C/Seniors/SNBC
FS DHS Project	SNBC Dental Access Improvement Project	SNBC
PIP/QIP/FS	Chronic User Opioid	F & C/Seniors/SNBC
2019 Improvement Projects		
Project Type	**Project Focus**	**Target Populations**
CCIP/FS	Annual Diabetic Retinal Exam	MSHO/AbilityCare
PIP/FS	Chronic User Opioid	F & C/Seniors/SNBC
FS DHS Project	SNBC Dental Access Improvement Project	SNBC
FS	Healthy Pathways	F & C/Seniors/SNBC

IX. Disease Management - 2018 Contract Section 7.3[15]

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

Element A: Program Content	**Met**	
Element B: Identifying Members for DM Programs	**Met**	

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

Element C: Frequency of Member Identification	**Met**	
Element E: Interventions Based on Assessment	**Met**	
Element G: Informing and Educating Practitioners	**Met**	
Element I:Experience with Disease Management	**Met**	
Element J: Measuring Effectiveness	**Not Met**	The 2017 NCQA Standards require that the health plan use a relevant process or outcome for measuring effectiveness of their Disease Management programs, and that it be analyzed in comparison with a benchmark or goal. SCHA analyzes Hospitalizations and ED to assess effectiveness for all of their Disease Management programs. The analysis in the Disease Management Program Evaluation does not include any tables or charts to analyze year over year trends. For instance, SCHA full analysis of its data states, "There was one program participant that had two or more hospitalizations or emergency department visits in the six months following program enrollment into one of the *Step Up! For Better Health* programs." This analysis does not adequately assess the effectiveness of its programs. During onsite discussions MDH and SCHA talked about including more robust and relevant measures such a HEDIS measures that assess HbA1C testing and Blood Pressure control. This will better drive and help evaluate the effectiveness of each of their programs.

2018 *Step Up! For Better Health* Program Participants (Opt-In) = 297			
	Total Eligible	**Total Opt-in**	**"Opt-In" %**
Diabetes	760	193	25%
Heart Failure	167	27	16%
Adult Asthma	807	52	6%
Child Asthma	418	25	6%
Total	*2,152*	*297*	*14%*

X. Advance Directives Compliance - 2018 Contract Section 16[16, 17]

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**	
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.	**Not Met**	SCHA indicates the implementation of the electronic medical record over the past few years has improved compliance rates. However, providers have indicated that lack of time during the visit and comfort

16 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

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

		in addressing health care directives have contributed to lower compliance rates. SCHA conducts annual medical record audits of all new clinics as well as any clinic that was below a threshold of 80% (if they were a new clinic) or below 95% (if they are an ongoing clinic). In 2017, 3 of the 4 clinics reviewed were not in compliance with the health care directive requirement. In 2018, 3 of the 3 clinics were not in compliance with the health care directive requirement. MDH noted during onsite discussions the small sample size used to evaluate compliance in medical records. SHCA must add more clinics to increase their sample size in order to conduct a valid and reliable assessment of compliance with this measure.
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**	

XI. Validation of MCO Care Plan Audits for MSHO, MSC[18] - 2018 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	See Attachment A; 2019 MDH EW Care Plan Audit

18 Pursuant to MSHO/MSC+ 2018 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 9.3.7.

XII. Subcontractors-2018 Contract Sections 9.3.1 and 9.3.16 (F&C), and 9.3.1 and 9.3.22 (MSHO/MSC+)[19]

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**	

19 Families and Children Contract Sections 9.3.1A

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[20]

Exclusion of Individuals Data Grid

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**	

20 Families and Children Contract Section 9.3.16, Seniors and SNBC Contract Sections 9.3.22 and 9.3.23

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**	
F. 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 2019 EW Care Plan Audit

Audit Protocol	Product Description	2018 MDH Audit Initial Charts Met	2018 MDH Audit Reassessment Charts Met	2018 MDH Audit Total % Charts Met	2019 SCHA 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% 25/25
2 **ANNUAL HEALTH RISK ASSESSMENT**	Been a member of the MCO for > 12 months [Only for plans with separate HRA]	N/A	NA	NA	n/a
3 **LONG TERM CARE CONSULTATION – INITIAL**	a) If member is new to EW in the past 12 months, an LTCC assessment completed within required timelines. b) 100% items complete	8/8 8/8	NA	100% 100%	a) 100% 25/25 b) 94% 32/34
4 **REASSESSMENT OF EW**	a) For members open to EW who have been a member of the MCO for more than 12 months, an LTCC completed within 365 days or prior assessment. b) 100% items complete	N/A	8/8	100% 100%	a) 100% 69/69 b) 93% 115/124
5 **PERSON-CENTERED PLANNING**	Opportunities for choice in the person's current environment are described	8/8	8/8	100%	100% 95/95

Audit Protocol	Product Description	2018 MDH Audit Initial Charts Met	2018 MDH Audit Reassessment Charts Met	2018 MDH Audit Total % Charts Met	2019 SCHA Total Charts % Met
PERSON-CENTERED PLANNING	Current rituals and routines are described (quality, predictability, preferences)	8/8	8/8	100%	100% 95/95
PERSON-CENTERED PLANNING	Social, leisure, or religious activities the person wants to participate in are described. The person's decision about employment/volunteer opportunities has been documented	8/8	8/8	100%	100% 95/95
6 **COMPREHENSIVE CARE PLAN-TIMELINESS**	CCP is completed and sent to member with 30 calendar days of the date of a completed LTCC.	8/8	8/8	100%	1005 96/96
7 **COMPREHENSIVE CARE PLAN-IDENTIFIED NEEDS**	The CCP must have an interdisciplinary, holistic, and preventive focus. Enrollee's identified needs and concerns related to primary care, acute care, long-term care, mental and behavioral health, and social service needs and concerns are addressed. The need for services essential to the health and safety of the enrollee is documented. If essential services are included in the plan, a back-up plan for provision of essential services. There is a plan for community-wide disasters, such as weather-related conditions.	8/8	8/8	100%	100% 96/96
8 **COMPREHENSIVE CARE PLAN**	The enrollee's goals or skills to be achieved are included in the plan, related to enrollee's preferences and how enrollee wants to live their life. Goals and skills are clearly described, action steps	8/8	8/8	100%	84% 191/228

Audit Protocol	Product Description	2018 MDH Audit Initial Charts Met	2018 MDH Audit Reassessment Charts Met	2018 MDH Audit Total % Charts Met	2019 SCHA Total Charts % Met
	describing what needs to be done to assist the person, plan for monitoring progress, target dates and outcome/achievement dates.				
9 **COMPEREHENSIVE CARE PLAN-Choice**	Enrollee was given a choice between Home and Community-Based Services (HCBS) and Nursing Home Services (also indicates enrollee involvement in care planning). Information to enable choice among providers of HCBS.	8/8	8/8	100%	100% 95/95
10 **COMPREHENSIVE CARE PLAN-Safety Plan/Personal Risk Management Plan**	Identification of enrollee needs and concerns, including identification of health and safety risks, and what to do in the event of an emergency Goals and target dates identified Interventions identified Monitoring of outcomes and achievement dates are documented	8/8	8/8	100%	96% 107/118
11 **COMPREHENSIVE CARE PLAN-Informal and Formal Services**	Coordinated Services and Support Plan developed and contains at a minimum the type of services to be furnished, the amount, frequency, duration and cost of each service and the type of provider furnishing each service including non-paid caregivers and other informal community supports or resources	8/8	8/8	100%	100% 96/96

Audit Protocol	Product Description	2018 MDH Audit Initial Charts Met	2018 MDH Audit Reassessment Charts Met	2018 MDH Audit Total % Charts Met	2019 SCHA Total Charts % Met
12 **CAREGIVER SUPPORT PLAN**	If a primary caregiver is identified in the LTCC. If interview completed then caregiver needs and supports incorporated into the care plan	1/1	2/2	100%	85% 35/41
13 **HOUSING AND TRANSITION**	For people who have been identified as having a transition, the enrollee has a transition plan to support housing choice. The LTCC assessment items relate to housing choices and support, and if enrollee indicates they want assistance in exploring housing options the transition plan reflects a goal, steps to be taken and potential barriers	0/0	0/0	100%	100% 91/91
14 **COMMUNICATIONS OF CARE PLAN/SUMMARY-Physician**	Evidence of care coordinator communication of care plan elements with Primary Care Physician (PCP)	8/8	8/8	100%	100% 96/96
15 **COMMUNICATION OF CARE PLAN/SUMMARY-Enrollee**	The support plan is signed and dated by the enrollee or authorized representative	8/8	8/8	100%	100% 55/55
16 **COMPREHENSIVE CARE PLAN-Enrollee Requests for Updates**	The plan includes a method for the individual to request updates to the plan, as needed	8/8	8/8	100%	99% 95/96

Audit Protocol	Product Description	2018 MDH Audit Initial Charts Met	2018 MDH Audit Reassessment Charts Met	2018 MDH Audit Total % Charts Met	2019 SCHA Total Charts % Met
17 **CARE COORDINATOR FOLLOW-UP PLAN**	Follow-up plan for contact plan related to identified concerns or needs, and plan is implemented	8/8	8/8	100%	100% 96/96
18 **ANNUAL PREVENTIVE HEALTH EXAM**	Documentation in enrollee's Comprehensive Care Plan substantiates a conversation was initiated	8/8	8/8	100%	100% 96/96
19 **ADVANCE DIRECTIVE**	Evidence that a discussion was initiated, enrollee refused to complete, was culturally inappropriate, or AD was completed	8/8	8/8	100%	100% 118/118
20 **APPEAL RIGHTS**	Appeal rights information provided to member	8/8	8/8	100%	100% 117/117
21 **DATA PRIVACY**	Data privacy information provided to member	8/8	8/8	100%	100% 117/117

Summary:

MDH received the EW audit sample lists from DHS per audit protocol. MDH reviewed 8 initial EW audits and 8 re-assessments. MDH EW Care Plan audit data span was the year 2018.
SCHA EW audit results data span was from 1/1/2017 to 12/31/2017 and was comprised of all SCHA counties. Follow up was done by SCHA on all elements not obtaining a 100% score, which were aspects of the Comprehensive Care Plan Goals for which training and bi-monthly audits were done. Caregiver support identification was also addressed. MDH results showed 100% on all EW Care Plan Audit elements.