# UCare

# Triennial Compliance Assessment

FINAL SUMMARY REPORT

DEPARTMENT OF HEALTH

## Triennial Compliance Assessment

Performed under Interagency Agreement for Minnesota Department of Human Services
Examination Period: December 1, 2015 – February 28, 2018
File Review Period: For Delta and Magellan Files - November 1, 2017 to March 1, 2018
For UCare and ESI Files – December 1, 2017 to March 1, 2018
On-Site: May 7-11, 2018
Examiners: Elaine Johnson, RN BS, CPHQ; Anne Kukowski, JD, MS; and Kate Eckroth, MPH
Issue Date: February 21, 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 - 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 E (access, structure and operations, and measurement and improvement)

**TCA Quality Program Structure Data Grid**

| | | |
|---|---|---|
| _____ | | |
| Access Standards<br>42 CFR § 438.206 Availability of Services<br>42 CFR § 438.207 Assurances of Adequate Capacity and Services<br>42 CFR § 438.208 Coordination and Continuity of Care<br>42 CFR § 438.210 Coverage and Authorization of Services | **Met** | |
| _____ | | |
| Measurement Improvement Standards<br>42 CFR § 438.236 Practice Guidelines<br>42 CFR § 438.240 Quality Assessment and Performance Improvement Program<br>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 | Reviewed the certified HEDIS audit reports as follows:<br>June 2016 – Advent Advisory Group<br>June 2017 - Advent Advisory Group<br>June 2018 - Advent Advisory Group<br><br>Summary Reports state:<br>*In our opinion, UCare'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 7.1.2I

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.<br>The MCO Shall:<br>i. Choose the appropriate number of relevant types of utilization data, including one type related to behavioral health to monitor. | Met | 2017 Reporting included the following measures:<br>• Inpatient admissions – admits per 1000<br>• Emergency utilization – visits per 1000<br>• Pharmacy utilization – opioid high dosage and multiple providers<br>• Behavioral Health utilization – Initiation and Engagement of alcohol and other drug dependence treatment (IET) |
| The MCO Shall:<br>ii. Set thresholds for the selected types of utilization data | **Met** | Thresholds were deviations from historical trends |

3 2016 *Standards and Guidelines for the Accreditation of Health Plans*, effective July 1, 2017

| | | |
|---|---|---|
| and annually quantitatively analyze the data against the established thresholds to detect under and overutilization. | | |
| The MCO Shall:<br>iii. Examine possible explanations for all data not within thresholds. | **Met** | |
| The MCO Shall:<br>iv. Analyze data not within threshold by medical group or practice. | **Met** | For example, ED utilization data analysis showed upward trends and proposal was made for increased funding for CHW in two clinics as well as further analysis of top ED diagnosis and other measures. |
| The MCO Shall:<br>v. Take action to address identified problems of under or overutilization and measure the effectiveness of its interventions.[4]4 | **Met** | |

4 42 CFR 438.330(b)(3)

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

The following are the 2016 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

| | | |
|---|---|---|
| | | |
| Element A: Written Program Description | **100% NCQA** | |
| | | |
| Element C: Behavioral Healthcare Practitioner Involvement | **100% NCQA** | |
| | | |
| NCQA Standard UM 2: Clinical Criteria for UM Decision<br>To make utilization decisions, the organization uses written criteria based on sound clinical evidence and specifies procedures for appropriately applying the criteria. | **100% NCQA** | |
| Element A: UM Criteria | **100% NCQA** | |

| | | |
|---|---|---|
| Element B: Availability of Criteria | **100%<br>NCQA** | |
| | | |
| NCQA Standard UM 3: Communication Services<br>The organization provides access to staff for members and practitioners seeking information about the UM process and the authorization of care.<br>Element A: Access to Staff | **100%<br>NCQA** | |
| | | |
| Element G: Affirmative Statement About Incentives | **100%<br>NCQA** | |
| | | |
| Element B: Description of Evaluation Process | **100%<br>NCQA** | |
| NCQA Standard UM 11: Procedures for Pharmaceutical Management | **100%<br>NCQA** | |

| | | |
|---|---|---|
| | | |
| | | |
| Element B: Pharmaceutical Restrictions/Preferences | **100%<br>NCQA** | |
| | | |
| Element D: Reviewing and Updating Procedures | **100%<br>NCQA** | |
| | | |
| NCQA Standard UM 12: Triage and Referral to Behavioral Health<br>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.*<br>Element A: Triage and Referral Protocols | **na** | |
| | | |
| NCQA Standard QI 4: Member Experience<br>The organization monitors member experience with its services and identifies areas of potential improvement.<br>Element G: Assessing experience with the UM process | **100%<br>NCQA** | |

# IV. Special Health Care Needs - 2017 Contract Section 7.1.4 A-C[5, 6]

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,<br>B. Assessment of enrollees identified, (Senior and SNBC Contract – care plan) and<br>C. Access to specialists<br>D. Annual Reporting to the State | **Met** | UCare uses a variety of resources to recruit PMAP enrollees into the SHCN programs. This includes internal and external referrals from customer service and/or primary or specialty care providers, readmission reports, or monthly claims data (such as claims on ED usage, high cost claims, or high inpatient length of stay). Members who meet a particular criterion undergo an initial screening by a care manager who determines whether they may benefit from case management. If so, members undergo an initial assessment conducted by an RN. A Plan of Care is developed and ongoing monitoring is done through telephone contact, and revised accordingly as the member's condition changes. Once Plan of Care goals are met or the member declines further case management services then the member case management services are discontinued.<br><br>UCare PMAP adult membership decreased by 96% between 2015 and 2016 (the latest report data available), and 97% in the pediatric PMAP population. This made it difficult to analyze the data due to small sample size. Most of the clinical indicators decreased during 2016. UCare's PMAP membership increased again during the middle of 2017. |

5 42 CFR 438.330 (b)(4)

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

# V. Practice Guidelines -2017 Contract Section 7.1.5[7,8]

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<br>• Update the guidelines at least every two years<br>• Distribute the guidelines to the appropriate practitioners | **Met** | UCare adopts Practice Guidelines from the Institute for Clinical Systems Improvement and American Academy of Child and Adolescent Psychiatry. They are as follows:<br>Asthma<br>Type 2 Diabetes<br>Heart Failure in adults<br>Obesity in adults<br>Prenatal care<br>Preventive services for adults<br>Preventive services for children and adolescents<br>Children and Adolescent ADHD<br>Children and Adolescent Depressive Disorders<br>Major Depressive Disorder<br>Schizophrenia<br>Substance Use Disorders<br><br>Guidelines are reviewed at least every two years by the Quality Improvement Advisory and Credentialing Committee and more often as needed. |

7 42 CFR 438.340 (b) (1)

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

| | | |
|---|---|---|
| **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<br>• Update the guidelines at least every two years;<br>• Distribute the guidelines to the appropriate practitioners. | **Met** | |
| _____ | | |
| **Element D: Performance Measurement.** MCO shall annually measure performance against at least two key aspects of two of the following:<br>• Clinical practice guidelines for chronic or acute conditions; or<br>• Clinical practice guidelines for behavioral health conditions; or<br>• Preventive health guidelines. | **Met** | |

# VI. Annual Quality Assurance Work Plan – 2017 Contract Section 7.1.7

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

## Annual Quality Assurance Work Plan Data Grid

| DHS Contractual Element and References | Met or Not Met | Audit Comments |
|---|---|---|
| A. Annual written work plan shall follow the guidelines and specifications contained in Minnesota Rules, part 4685.1130, subpart 2, and | **Met** | MDH reviewed work plans for the years 2016, 2017, and 2018 work plans. The *2018 Quality Program Work Plan* was a thorough document, describing the quality activities, performance improvement projects (focus studies) and monitoring activities for the coming year. |
| B. Current NCQA "*Standards and Guidelines for the Accreditation of Health Plans.*"<br><br>**NCQA QI, Element A:** An annual work plan that reflects ongoing progress on QI activities throughout the year and addresses:<br>(1) Yearly planned QI activities and objectives for improving:<br>• Quality of clinical care<br>• Safety of clinical care<br>• Quality of service<br>• Members' experience<br>(2) Time frame for each activity's completion<br>(3) Staff members responsible for each activity<br>(4) Monitoring of previously identified issues<br>(5) Evaluation of the QI program | **Met** | The work plan included all NCQA elements as well as all the mandated DHS quality activities as set forth in the DHS contract, Article 7. |

# VII. Annual Quality Assessment and Performance Improvement Program Evaluation – 2017 Contract Section 7.1.8[9, 10]

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<br>The organization conducts an annual written evaluation of the QI program that includes the following information:<br>1. A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service.<br>2. Trending of measures to assess performance in the quality and safety of clinical care and quality of services. | **Met** | |

9 42 CFR 438.330(b), (d)

10 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."

| | | |
|---|---|---|
| 3. Analysis and evaluation of the overall effectiveness of the QI program and of its progress toward influencing network-wide safe clinical practices. | | |

# VIII. Performance Improvement Projects-2017 Contract Section 7.2[11, 12, 13, 14,15]

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. | **N/A** | PIP Interim reports reviewed:<br>Increasing F/U after Hospitalization<br>Reducing Disparities in AMM<br>QIP: AMM |
| **7.2.1 New Performance Improvement Project Proposal.** | **Met** | 2017 Dental Project (SNBC)<br>2018 Opioid Project |

11 42 CFR 438.330 (b)(1), 42 CFR 438.330(d)

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

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

14 42 CFR 438.330(b)(1), 438.330(d)

15 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.<br>DHS uses these tools to review and validate MCOs' PIP proposals and annual status reports. | **Met** | DHS Validation sheet reviewed for Reducing Disparities AMM |

# IX. Disease Management - 2017 Contract Section 7.3[16]

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** | |

16 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** | UCare receives monthly asthma reports based on HEDIS specifications and notifications of daily ER/hospital admissions related to Asthma. |
| | | |
| Element E: Interventions Based on Assessment | **Met** | "At Risk" eligible members received an automated voice response education phone call. "High Risk" members receive in-home visits for an asthma assessment, care management and ongoing asthma education. |
| | | |
| Element G: Informing and Educating Practitioners | **Met** | |
| | | |
| Element I:Experience with Disease Management | **Met** | |
| Element J: Measuring Effectiveness | **Met** | |

**Figure 1: Disease Management Member Participation**

Opt-In Program Participation Rates

| Program | Total Eligible Population | Members Who Opted In | Opt-in Active Participation Rate |
|---|---|---|---|
| High Risk Asthma | 1,060 | 864 | 19% |

Opt-Out Program Participation Rates (UCare for Seniors and Choices population)

| Program | Total Eligible Population | Members Who Opted Out | Opt-out Active Participation Rate |
|---|---|---|---|
| At-Risk Asthma | 4,803 | 2,469 | 49% |

# X. Advance Directives Compliance - 2017 Contract Section 16[17, 18]

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.<br>B. Written policies of the MCO respecting the implementation of the right; and<br>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;<br>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**<br>**Met**<br>**Met**<br>**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. | **Met** | See **Figure 2** below for medical record audit results of compliance with provider documentation. |

17 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

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

| | | |
|---|---|---|
| | | |
| **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** | UCare's community newsletters; webpages; question and answer document; and provider newsletters, bulletin, and manual evidence UCare's efforts to educate all relevant parties about advance directives. |

**Figure 2: Advance Directive Medical Record Audit Results**

| Product | 2015 | 2016 | 2017 |
|---|---|---|---|
| Connect | 26.7% d=232 | 17.4% d=327 | 26.7% d=329 |
| MSHO | 56.5% d=504 | 83.2% d=411 | 87.3% d=411 |
| PMAP | 12.4% d=307 | 11.1% d=369 | 13.1% d=191 |
| UCare Choices | NA | 10.8% d=120 | 10.8% d=142 |
| Total | 32.7% d=1364 | 27.0% d=1550 | 44.2% d=1522 |

# XI. Validation of MCO Care Plan Audits for MSHO, MSC[19] - 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.<br>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.<br>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.<br>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 | |

19 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 9.3.7.

# XII. Subcontractors-2017 Contract Sections 9.3.1 and 9.3.16 (F&C), and 9.3.1 and 9.3.22 (MSHO/MSC+)[20]

## 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.

To evaluate UCare's compliance with DHS contract provisions relating to subcontracting, MDH reviewed UCare subcontracts with Delta Dental and Express Scripts (ESI), and UCare's own policies, procedures, instructions, checklists and forms pertaining subcontracting.

**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 | **Met** | |

20 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[21]

## 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:<br>(1) Are not excluded from participation in Medicaid under Sections 1128 or 1128A of the Social Security Act; and<br>(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** | |

21 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** | |

# XIII. Attachment A: MDH 2018 EW Care Plan Audit

Data in the last column, "2017 UCare Total Charts %" are from combined results from UCare's 2017 MSHO and MSC+ Rate Cell Audit Tool for Roseau County and UCare's 2017 MSHO and MSC+ Rate Cell Audit Tool.

| Audit Protocol | Product Description | 2018 MDH Audit Initial Charts Met | 2018 MDH Audit Reassessment Charts Met | 2018 MDH Audit Total % Charts Met | 2017 UCare Total Charts % Met |
|---|---|---|---|---|---|
| 1<br><br>**INITIAL HEALTH RISK ASSESSMENT** | For members new to the MCO or product within the last 12 months | 8/8 | N/A | 100% | 96.4% |
| 2<br><br>**ANNUAL HEALTH RISK ASSESSMENT** | Been a member of the MCO for > 12 months [Only for plans with separate HRA] | N/A | N/A | N/A | N/A |
| 3<br><br>**LONG TERM CARE CONSULTATION – INITIAL** | If member is new to EW in the past 12 months, an LTCC assessment completed within required timelines. | 8/8 | N/A | 100% | |
| 4<br><br>**REASSESSMENT OF EW** | For members open to EW who have been a member of the MCO for more than 12 months, an LTCC completed within 365 days or prior assessment. | N/A | 8/8 | 100% | 97.2% |
| 5<br><br>**PERSON-CENTERED PLANNING** | Opportunities for choice in the person's current environment are described | 8/8 | 8/8 | 100% | 100% |
| **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. The person's decision about | 8/8 | 8/8 | 100% | 100% |

| Audit Protocol | Product Description | 2018 MDH Audit Initial Charts Met | 2018 MDH Audit Reassessment Charts Met | 2018 MDH Audit Total % Charts Met | 2017 UCare Total Charts % Met |
|---|---|---|---|---|---|
| | employment/volunteer opportunities has been documented | | | | |
| 6<br><br>**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% | 100% |
| 7<br><br>**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% |
| 8<br><br>**COMPREHENSIVE CARE PLAN** | The enrollee's goals or skills to be achieved are included in the plan, related to enrollee's preferences and how enrollee wants to live their life. Goals and skills are clearly described, action steps describing what needs to be done to assist the person, plan for monitoring progress, target dates and outcome/achievement dates. | 8/8 | 8/8 | 100% | 97.7% |
| 9<br><br>**COMPEREHENSIVE CARE PLAN-Choice** | Enrollee was given a choice between Home and Community-Based Services (HCBS) and Nursing Home Services (also | 8/8 | 8/8 | 100% | 99.7% |

| Audit Protocol | Product Description | 2018 MDH Audit Initial Charts Met | 2018 MDH Audit Reassessment Charts Met | 2018 MDH Audit Total % Charts Met | 2017 UCare Total Charts % Met |
|---|---|---|---|---|---|
| | indicates enrollee involvement in care planning).<br><br>Information to enable choice among providers of HCBS. | | | | |
| 10<br><br>**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<br>Goals and target dates identified<br>Interventions identified<br>Monitoring of outcomes and achievement dates are documented | 8/8 | 8/8 | 100% | 100% |
| 11<br><br>**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% | 99.7% |
| 12<br><br>**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 | 5/5 | 100% | 66.7% |
| 13<br><br>**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 | 1/1 | 8/8 | 100% | 100% |

| Audit Protocol | Product Description | 2018 MDH Audit Initial Charts Met | 2018 MDH Audit Reassessment Charts Met | 2018 MDH Audit Total % Charts Met | 2017 UCare Total Charts % Met |
|---|---|---|---|---|---|
| | enrollee indicates they want assistance in exploring housing options the transition plan reflects a goal, steps to be taken and potential barriers | | | | |
| 14<br><br>**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% |
| 15<br><br>**COMMUNICATION OF CARE PLAN/SUMMARY-Enrollee** | The support plan is signed and dated by the enrollee or authorized representative | 8/8 | 8/8 | 100% | 99.7% |
| 16<br><br>**COMPREHENSIVE CARE PLAN-Enrollee Requests for Updates** | The plan includes a method for the individual to request updates to the plan, as needed | 8/8 | 8/8 | 100% | 100% |
| **17**<br><br>**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% |
| **18**<br><br>**ANNUAL PREVENTIVE HEALTH EXAM** | Documentation in enrollee's Comprehensive Care Plan that substantiates a conversation was initiated | 8/8 | 8/8 | 100% | 100% |
| **19** | Evidence that a discussion was initiated, enrollee refused to complete, was | 8/8 | 8/8 | 100% | 100% |

| Audit Protocol | Product Description | 2018 MDH Audit Initial Charts Met | 2018 MDH Audit Reassessment Charts Met | 2018 MDH Audit Total % Charts Met | 2017 UCare Total Charts % Met |
|---|---|---|---|---|---|
| **ADVANCE DIRECTIVE** | culturally inappropriate, or AD was completed | | | | |
| **20**<br><br>**APPEAL RIGHTS** | Appeal rights information provided to member | 8/8 | 8/8 | 100% | 99.7% |
| **21**<br><br>**DATA PRIVACY** | Data privacy information provided to member | 8/8 | 8/8 | 100% | 99.7% |

## Summary:

MDH reviewed 8 initial assessments and 8 reassessments using 2017 Care Plan Audit Protocol. MDH found 100% compliance on all audit protocols. MDH's audit results were compared to UCare's 2017 EW Care Plan Audit of 354 files. UCare found more issues, but total "met" charts were consistently 97% or higher with the exception of Audit Protocol #12-Caregiver Assessment Plan. UCare's review indicated that just 66% of the charts met this protocol which is substantially lower than MDH's findings of 100%.