Medica Health Plans
Triennial Compliance Assessment

SUMMARY REPORT

Performed under Interagency Agreement for Minnesota Department of Human Services
Examination Period: January 1, 2015 – August 31, 2017
File Review Period: July 1, 2016 to August 31, 2017
On-Site: October 2, 2017 – October 6, 2017
Examiners: Elaine Johnson, RN, BS, CPHQ, Anne Kukowski, JD, and Kate Eckroth, MPH
Issue Date: December 6, 2018

Triennial Compliance Assessment

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Executive Summary
Triennial Compliance Assessment (TCA)

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

TCA Process Overview

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

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

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

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

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

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

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

Managed Care Organization (MCO)/County Based Purchaser (CBP): Medica Health Plans
Examination Period: January 1, 2015 – August 31, 2017
Onsite Dates: October 2, 2017 – October 6, 2017

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DEPARTMENT OF HEALTH

DHS Contractual Element and References	Met/ Not Met	Audit Comments
1. QI Program Structure- 2016 Contract Section 7.1.1 The MCO must incorporate into its quality assessment and improvement program the standards as described in 42 CFR 438, Subpart D (access, structure and operations, and measurement and improvement). <u>Access Standards</u> 42 CFR § 438.206 Availability of Services 42 CFR § 438.207 Assurances of Adequate Capacity and Services 42 CFR § 438.208 Coordination and Continuity of Care 42 CFR § 438.210 Coverage and Authorization of Services <u>Structure and Operations Standards</u> 42 CFR § 438.214 Provider Selection 42 CFR § 438.218 Enrollee Information 42 CFR § 438.224 Confidentiality and Accuracy of Enrollee Records 42 CFR § 438.226 Enrollment and Disenrollment 42 CFR § 438.228 Grievance Systems 42 CFR § 438.230 Subcontractual Relationships and Delegation <u>Measurement Improvement Standards</u> 42 CFR § 438.236 Practice Guidelines 42 CFR § 438.240 Quality Assessment and Performance Improvement Program 42 CFR § 438.242 Health Information System	Met	Excellent written QI plan (program description) containing all required element of Minnesota Rule and DHS contract.

DHS Contractual Element and References	Met/ Not Met	Audit Comments
2. Utilization Management - 2016 Contract Section 7.1.3 A. The MCO shall adopt a utilization management structure consistent with state regulations and federal regulations and current NCQA "Standards for Accreditation of Health Plans."[1] The MCO shall facilitate the delivery of appropriate care and monitor the impact of its utilization management program to detect and correct potential under and over utilization. The MCO shall: i. Choose the appropriate number of relevant types of utilization data, including one type related to behavioral health to monitor. ii. Set thresholds for the selected types of utilization data and annually quantitatively analyze the data against the established thresholds to detect under and overutilization. iii. Examine possible explanations for all data not within thresholds. iv. Analyze data not within threshold by medical group or practice. v. Take action to address identified problems of under or overutilization and measure the effectiveness of its interventions. [2] B. The following are the 2016 NCQA Standards and Guidelines for the Accreditation of MCOs UM 1-4 and 10-14. **NCQA Standard UM 1: Utilization Management Structure** The organization clearly defines the structures and processes within its utilization management (UM) program and assigns responsibility to appropriate individuals. Element A: Written Program Description Element B: Physician Involvement Element C: Behavioral Healthcare Practitioner Involvement Element D: Annual Evaluation	**Met** **Per NCQA**	Measures include: • ER Visits • Inpatient Care (Discharges, total days, LOS) • Readmissions • Non-recommended cervical CA screening Adolescent Females • Use of Imaging studies low back pain Thresholds - Compared to internal trend over time and HEDIS all plan average **Recommendation:** Over/under utilization improvement activities should be represented in Medica's annual work plan and in the annual evaluation.

1 2016 *Standards and Guidelines for the Accreditation of Health Plans*, effective July 1, 2016
2 42 CFR 438. 240(b)(3)

DHS Contractual Element and References	Met/ Not Met	Audit Comments
NCQA Standard UM 2: Clinical Criteria for UM Decision To make utilization decisions, the organization uses written criteria based on sound clinical evidence and specifies procedures for appropriately applying the criteria. Element A: UM Criteria Element B: Availability of Criteria Element C: Consistency of Applying Criteria	**Per NCQA 100%**	
NCQA Standard UM 3: Communication Services The organization provides access to staff for members and practitioners seeking information about the UM process and the authorization of care. Element A: Access to Staff	**Per NCQA 100%**	
NCQA Standard UM 4: Appropriate Professionals Qualified Licensed health professionals assess the clinical information used to support UM decisions. Element D: Practitioner Review of Behavioral Healthcare Denials Element F: Affirmative Statement About Incentives	**Per NCQA 100%**	
NCQA Standard UM 10: Evaluation of New Technology The organization evaluates the inclusion of new technologies and the new application of existing technologies in the benefits plan. This includes medical and behavioral health procedures, pharmaceuticals, and devices. Element A: Written Process Element B: Description of Evaluation Process	**Per NCQA 100%**	
NCQA Standard UM 11: Emergency Services The organization provides, arranges for or otherwise facilitates all needed emergency services, including appropriate coverage of costs. Element A: Policies and Procedures	**Per NCQA 100%**	

DHS Contractual Element and References	Met/ Not Met	Audit Comments
NCQA Standard UM 12: Procedures for Pharmaceutical Management The organization ensures that its procedures for pharmaceutical management, if any, promote the clinically appropriate use of pharmaceuticals Element A: Policies and Procedures Element B: Pharmaceutical Restrictions/Preferences Element C: Pharmaceutical Patient Safety Issues Element D: Reviewing and Updating Procedures Element E: Considering Exceptions	**Per NCQA 100%**	
NCQA Standard UM 13: Triage and Referral to Behavioral Health The organization has written standards to ensure that any centralized triage and referral functions for behavioral health services are appropriately implemented, monitored and professionally managed. *This standard applies only to organizations with a centralized triage and referral process for behavioral health, both delegated and non-delegated* Element A: Triage and Referral Protocols	**NA**	
NCQA Standard QI 4: Member Experience The organization monitors member experience with its services and identifies areas of potential improvement. Element G: Assessing experience with the UM process	**Per NCQA 100%**	

DHS Contractual Element and References	Met/ Not Met	Audit Comments
3. Special Health Care Needs - 2016 Contract Section 7.1.4 A-C[3, 4] The MCO must have effective mechanisms to assess the quality and appropriateness of care furnished to Enrollees with special health care needs. A. Mechanisms to identify persons with special health care needs, B. Assessment of enrollees identified, (Senior and SNBC Contract – care plan) and C. Access to specialists	**Met**	Medica has developed a high risk member identification algorithm for its MSC+, MSHO and SNBC population to address any care gaps in their more vulnerable population. Members are stratified into one of four care levels based on data collected by Medica which assesses (for example) inpatient and ER use, pharmacy utilization, and mental health indicators. Each care level has a suggested intervention plan to serve as guidance for care coordinators. This information is generated quarterly and shared with care coordinators. The care coordinators refer to care plans when applicable and follow-up with members as needed via phone or in person to assure that members are receiving adequate services. Medica's SHCN program is robust and collaborative. The SHCN staff at Medica indicate that care coordinators will reach out to Medica when there is need of additional supports for particularly complex cases which often involve an interdisciplinary team. In addition, Medica conducts ongoing claims review that trigger high-risk and when applicable they will work with care coordinators to determine what additional supports are needed.

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

DHS Contractual Element and References	Met/ Not Met	Audit Comments
4. Practice Guidelines -2016 Contract Section 7.1.5[5,6] A. The MCO shall adopt, disseminate and apply practice guidelines consistent with current NCQA "*Standards and Guidelines for the Accreditation of Health Plans*" QI 9 Clinical Practice Guidelines. i. <u>Adoption of practice guidelines</u>. The MCO shall adopt guidelines based on: • Valid and reliable clinical evidence or a consensus of Health Care Professionals in the particular field • Consideration of the needs of the MCO enrollees • Guidelines being adopted in consultation with contracting Health Care Professionals • Guidelines being reviewed and updated periodically as appropriate. ii. <u>Dissemination of guidelines.</u> MCO ensures guidelines are disseminated: • To all affected Providers • To enrollees and potential enrollees upon request iii. <u>Application of guidelines</u>. MCO ensures guidelines are applied to decisions for: • Utilization management • Enrollee education • Coverage of services • Other areas to which there is application and consistency with the guidelines.	Met	ICSI guidelines utilized and readily available to providers Focused on those measures that show the greatest opportunity for improvement: • ADHD, CAD, Asthma, Preventive, Well child visits, Pain Management, Diabetes • Measured and monitored during med record audits and disease management activities

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

DHS Contractual Element and References	Met/ Not Met	Audit Comments
5. Annual Quality Assessment and Performance Improvement Program Evaluation- 2016 Contract Sections 7.1.8 [7,8] A. The MCO must conduct an annual quality assessment and performance improvement program evaluation consistent with state and federal regulations and current NCQA "Standards for Accreditation of Health Plans". This evaluation must: i. Review the impact and effectiveness of the MCO's quality assessment and performance improvement program ii. Include performance on standardized measures (example: HEDIS®) and iii. Include MCO's performance improvement projects. B. NCQA QI 1, Element B: There is an annual written evaluation of the QI Program that includes: i. A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service ii. A trending of measures to assess performance in the quality and safety of clinical care and quality of services iii. Analysis and evaluation of the overall effectiveness of the QI program, including progress toward influencing network-wide-safe clinical practices	Met	Thorough evaluation of the QI program with an excellent summary of effectiveness and outcome review of the 2016 Work Plan.

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

DHS Contractual Element and References	Met/ Not Met	Audit Comments
6. Performance Improvement Projects-2016 Contract Section 7.2[9,10,11] The MCO must conduct PIPs designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and Enrollee satisfaction. Projects must comply with 42 CFR § 438.240(b)(1) and (d) and CMS protocol entitled "*Protocol for Use in Conducting Medicaid External Quality Review Activities: Conducting Performance Improvement Projects*." The MCO is encouraged to participate in PIP collaborative initiatives that coordinate PIP topics and designs between MCOs. 7.2.1 New Performance Improvement Project Proposal The STATE will select the topic for the new PIP to be conducted over the next three years (calendar years 2015, 2016 and 2017) and implemented by the end of the first quarter of calendar year 2015. The PIP must be consistent with CMS' published protocol entitled *"Protocol for Use in Conducting Medicaid External Quality Review Activities: Conducting Performance Improvement Projects"*, STATE requirements, and include steps one through seven of the CMS protocol. A. 7.2.2 Annual PIP Status Reports. The MCO shall submit by December 1st in calendar years 2015 and 2016, a written PIP status report in a format defined by the STATE. B. 7.2.3 Final Project Reports: Upon completion of the PIP the MCO shall submit to the STATE for review and approval a final written report by September 1st, 2018, in a format defined by the STATE. C. PIP Proposal and PIP Interim Report Validation Sheets. DHS uses these tools to review and validate MCOs' PIP proposals and annual status reports.	**Met**	Reviewed and discussed the following; • Racial and Ethnic Disparities in the Management of Depression • Follow-up after Hospitalization Mental Illness (SNBC) • QIP AMM Depression (Seniors) • Improving Transitions Post-Hospital

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

DHS Contractual Element and References	Met/ Not Met	Audit Comments
7. Disease Management -2016 Contract Section 7. 3[12] The MCO shall make available a Disease Management Program for its Enrollees with: A. Diabetes B. Asthma C. Heart Disease Standards -The MCO's Disease Management Program shall be consistent current NCQA "*Standards and Guidelines for the Accreditation of Health Plans*" – QI Standard Disease Management Waiver of Disease Management Program Requirement. If the MCO is able to demonstrate that a Disease Management Program is: 1) not effective based upon Provider satisfaction, and is unable to achieve meaningful outcomes; or 2) will have a negative financial return on investment, the MCO may request that the STATE waive this requirement for the remainder of the Contract Year. If the MCO's Diabetes, Asthma, and Heart Disease Management Programs have achieved 100% compliance during the most recent NCQA Accreditation Audit of QI Standards- Disease Management, the MCO will not need to further demonstrate compliance.	NCQA 100%	

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

<table>
<tr><th>DHS Contractual Element and References</th><th>Met/
Not Met</th><th>Audit Comments</th></tr>
<tr><td>8. Advance Directives Compliance – 2016 Contract Section 16[13,14]

A. The MCO agrees to provide all Enrollees at the time of enrollment a written description of applicable State law on Advance Directives and the following:
a. Information regarding the enrollee's right to accept or refuse medical or surgical treatment; and to execute a living will, durable power of attorney for health care decisions, or other advance directive.
b. Written policies of the MCO respecting the implementation of the right; and
c. Updated or revised changes in State law as soon as possible, but no later than 90 days after the effective date of the change;
d. Information that complaints concerning noncompliance with the Advance Directive requirement may be filed with the State survey and certification agency (i.e. Minnesota Department of Health), pursuant to 42 CFR 422.128 as required in 42 CFR 438.6(i).
B. Providers. To require MCO's providers to ensure that it has been documented in the enrollee's medical records whether or not an individual has executed an Advance Directive.
C. Treatment. To not condition treatment or otherwise discriminate on the basis of whether an individual has executed an advance directive.
D. Compliance with State Law. To comply with State law, whether statutory or recognized by the courts of the State on Advance Directives, including Minnesota Statutes Chapters 145B and 145C.
E. Education. To provide, individually or with others, education for MCO staff, providers and the community on Advance Directives.</td><td>Met</td><td>Med Record Audit: (all products)
Is there evidence in the medical record that the patient does or doesn't have an advance directive?

<table><tr><th></th><th>2015</th><th>2014</th><th>2013</th><th>2012</th><th>2011</th></tr><tr><td>19 – 64 years</td><td>42%</td><td>46%</td><td>41%</td><td>31%</td><td>26%</td></tr><tr><td>65 – 80 years</td><td>38%</td><td>42%</td><td>47%</td><td>na</td><td>na</td></tr></table>
DHS requested to review medical record rates for evidence of advance directives at mid-cycle due to decreasing rates.</td></tr>
</table>

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

DHS Contractual Element and References	Met/ Not Met	Audit Comments
9. Validation of MCO Care Plan Audits for MSHO, MSC+[15] MDH will collect information for DHS to monitor MCO Care Plan Audit activities as outlined in the DHS/MCO MSHO/MSC+ Contract. A. DHS will provide MDH with Data Collection Guide for the random sample of 30 MCO enrollees (plus an over sample of 10 MCO enrollees for missing or unavailable enrollee records) for MSHO and MSC+ program. Of the 40 records sampled, 20 records will be for members new to the MCO within the past 12 months and other 20 records will be for members who have been with the MCO for more than 12 months. B. MDH will request the MCO make available during the MDH QA Examination on-site audit the identified enrollee records. A copy of the data collection instruction sheet, tool and guide will be included with MDH's record request. C. An eight-thirty audit methodology will be used to complete a data collection tool for each file in each sample consistent with the Data Collection Guide. D. Within 60 days of completing the on-site MDH QA Examination, MDH will provide DHS with a brief report summarizing the data collection results, any other appropriate information and the completed data collection tools.	Met	See Attachment A for more detail regarding this element.

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

DHS Contractual Element and References	Met/ Not Met	Audit Comments
10. Information System – 2016 Contract Section 7.1.2[16, 17] The MCO must operate an information system that supports initial and ongoing operations and quality assessment and performance improvement programs. The MCO must maintain a health information system that collects, analyzes, integrates, and reports data. During each of the past three years, all MCO MDH annual HEDIS performance measures have been certified reportable by an NCQA HEDIS audit.	Met	2015 – Attest Health Care Advisors 2016 - Attest Health Care Advisors 2017 - Attest Health Care Advisors Final Audit Statements State; *In our opinion, Medica Health Plans' 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.*

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

DHS Contractual Element and References	Met/ Not Met	Audit Comments
11. 9.3.1 Written Agreement; Disclosures.[18] All subcontracts must be in writing and must include a specific description of payment arrangements. All subcontracts are subject to STATE and CMS review and approval, upon request by the STATE and/or CMS. Payment arrangements must be available for review by the STATE and/or CMS. All contracts must include: A. Disclosure of Ownership and Management Information (Subcontractors). In order to assure compliance with 42 CFR § 455.104, the MCO, before entering into or renewing a contract with a subcontractor, must request the following information: (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; (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; (3) The name of any other disclosing entity in which a Person with an Ownership Control Interest in the disclosing entity also has an ownership or control interest; and	 Met Met Met	Medica maintains a thorough and clear process for ongoing monitoring of subcontractors. Medica submitted evidence to MDH from their subcontractors that assures that Medica is collecting data related to Disclosure of Ownership or Control Interest

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

DHS Contractual Element and References	Met/ Not Met	Audit Comments
(4) The name, address, date of birth, and social security number of any managing employee of the disclosing entity.	Met	
(5) For the purposes of section 9.3, subcontractor means an individual, agency, or organization to which a disclosing entity has contracted, or is a person with an employment, consulting or other arrangement with the MCO for the provision of items and services that are significant and material to the MCO's obligations under its contract with the STATE.	Met	
(6) MCO Disclosure Assurance. The MCO must submit to the STATE by September 1st of the Contract Year a letter of assurance stating that the disclosure of ownership information has been requested of all subcontractors, and reviewed by the MCO prior to MCO and subcontractor contract renewal.	Met	MDH reviewed Medica's letter of assurance to DHS verifying that Medica is requesting subcontractors to submit disclosure of ownership information to Medica prior to contract renewal.
(7) 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.	Not Met	Medica does not have written in a policy and procedure the requirement of Medica to report to the STATE within 10 days any information related to business transactions that was submitted to Medica by a subcontractor. Medica must update their policy and procedure to indicate this reporting requirement.
9.3.16 Exclusions of Individuals and Entities; Confirming Identity. (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	Met	MDH reviewed Medica's documented evidence that they conduct monthly checks against federal databases.

DHS Contractual Element and References	Met/ Not Met	Audit Comments
National Plan and Provider Enumeration System (NPPES), and also upon contract execution or renewal, and credentialing.		
b. The MCO and its subcontractors must search monthly, and upon contract execution or renewal, and credentialing, the OIG List of Excluded Individuals/Entities (LEIE) and the Excluded Parties List System (EPLS, within the HHS System for Awards Management) database (and may search the Medicare Exclusion Database), for any Providers, agents, Persons with an Ownership or Control Interest, and Managing Employees to verify that these persons: (1) Are not excluded from participation in Medicaid under Sections 1128 or 1128A of the Social Security Act; and (2) Have not been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the programs under Title XX of the Social Security Act.	Met	
c. The MCO must require subcontractors to assure to the MCO that no agreements exist with an excluded entity or individual for the provision of items or services related to the MCO's obligation under this Contract.	Met	MDH reviewed evidence of revised Disclosure of Ownership documents sent to Medica from subcontractors. Medica showed evidence that they conduct monthly checks on excluded entities or individuals based in part of any revised disclosure of ownerships from subcontractors.
d. The MCO shall require all subcontractors to report to the MCO within five (5) days any information regarding individuals or entities specified in (A) above, who have been convicted of a criminal offense related to the involvement in any program established under Medicare, Medicaid, the programs under Title XX of the Social Security Act, or that have been excluded from participation in Medicaid under §§ 1128 or 1128A of the Social Security Act.	Met	
e. The MCO shall this information to the STATE within seven (7) days of the date the MCO receives the information	Met	

f. The MCO must also promptly notify the STATE of any action taken on a subcontract under this section, consistent with 42 CFR § 1002.3 (b)(3).	Met	
g. In addition to complying with the provisions of section 9.9, the MCO shall not enter into any subcontract that is prohibited, in whole or in part, under § 4707(a) of the Balanced Budget Act of 1997 or under Minnesota Statutes, § 62J.71.	Met	

Attachment A: MDH 2016 EW Care Plan Audit

Audit Protocol	Product Description	2017 MDH Audit Initial Charts Met	2017 MDH Audit Reassessment Charts Met	2017 MDH Audit Total % Charts Met	2016 Medica 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%	91.4%
2 **ANNUAL HEALTH RISK ASSESSMENT**	Been a member of the MCO for > 12 months [Only for plans with separate HRA]	N/A	N/A		
3 **LONG TERM CARE CONSULTATION – INITIAL**	If member is new to EW in the past 12 months	8/8	N/A	100%	86.4%
4 **REASSESSMENT OF EW**	For members open to EW who have been a member of the MCO for more than 12 months	N/A	14/15	93.3%	82.3%
5 **COMPREHENSIVE CARE PLAN**	Includes needs identified in the HRA and/or the LTCC and other sources	8/8	14/15	93.3%	96.7%
6 **COMPREHENSIVE CARE PLAN SPECIFIC ELEMENTS**	The CCP must have an interdisciplinary, holistic, and preventive focus. To achieve this focus, the Comprehensive Care Plan must include the elements listed below: A. Identification of enrollee needs and concerns, including identification of health and safety risks, and what to do in the event of an emergency B. Goals and target dates identified	8/8	15/15	100%	91.7%

Audit Protocol	Product Description	2017 MDH Audit Initial Charts Met	2017 MDH Audit Reassessment Charts Met	2017 MDH Audit Total % Charts Met	2016 Medica Total Charts % Met
	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[19], long-term care and community support, medical care, or mental health care[20], or any other identified concern	8/8	15/15	100%	97.4%
8 **COMMUNICATION OF CARE PLAN/SUMMARY**	Evidence of care coordinator communication of care plan elements with Primary Care Physician (PCP)	8/8	15/15	100%	98.4%
9 **PERSONAL RISK MANAGEMENT PLAN**	Required if enrollee refused recommended HCBS	8/8	15/15	100%	100%
10 **ANNUAL PREVENTIVE CARE**	Documentation in enrollee's Comprehensive Care Plan that substantiates a conversation was initiated	8/8	15/15	100%	97.7%

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

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

Audit Protocol	Product Description	2017 MDH Audit Initial Charts Met	2017 MDH Audit Reassessment Charts Met	2017 MDH Audit Total % Charts Met	2016 Medica Total Charts % Met
11 **ADVANCE DIRECTIVE**	Evidence that a discussion was initiated, enrollee refused to complete, was culturally inappropriate, or AD was completed	8/8	15/15	100%	97.7%
12 **ENROLLEE CHOICE**	Enrollee was given a choice between Home and Community-Based Services (HCBS) and Nursing Home Services (also indicates enrollee involvement in care planning)	8/8	15/15	100%	99.2%
13 **CHOICE OF HCBS PROVIDERS**	Information to enable choice among providers of HCBS	8/8	15/15	100%	99.2%
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	15/15	100%	97.3%
15 **CAREGIVER SUPPORT PLAN**	If a primary caregiver is identified in the LTCC	2/2	1/1 1 of 15 had caregiver identified	100%	97.0%
16 **APPEAL RIGHTS**	Appeal rights information provided to member	8/8	15/15	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 Medica Total Charts % Met
17 **DATA PRIVACY**	Data privacy information provided to member	8/8	15/15	100%	100%
18 **PERSON-CENTERED PLANNING**	Opportunities for choice in the person's current environment are described	8/8	15/15	100%	100% (New in July 2016)
PERSON-CENTERED PLANNING	Current rituals and routines are described (quality, predictability, preferences)	8/8	15/15	100%	100%
PERSON-CENTERED PLANNING	Social, leisure, or religious activities the person wants to participate in are described	8/8	15/15	100%	98.6%
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	15/15	100%	92.8%
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	15/15	100%	92.8%
PERSON-CENTERED PLANNING	The plan includes a method for the individual to request updates to the plan, as needed	8/8	15/15	100%	98.2%
PERSON-CENTERED PLANNING	The plan records the alternative home and community-based settings and services that were considered by the individual	8/8	15/15	100%	97.7%

Audit Protocol	Product Description	2017 MDH Audit Initial Charts Met	2017 MDH Audit Reassessment Charts Met	2017 MDH Audit Total % Charts Met	2016 Medica Total Charts % Met
PERSON-CENTERED PLANNING	The plan is distributed to the individual and other people involved in the plan	8/8	15/15	100%	100%
PERSON-CENTERED PLANNING	The person decision about employment/volunteer opportunities has been documented	8/8	15/15	100%	100%
PERSON-CENTERED PLANNING	Has the individual chosen a different living arrangement than their current living arrangement? If so, is a plan in place on how to help that individual move to their preferred setting, identifying barriers and steps that need to be taken before the move happens? Present in LTCC, requires revision to CCP	8/8	15/15	100%	100%
PERSON-CENTERED PLANNING	For people who have been identified as having a transition, the following are transition related items: 10.a. The essential elements of the transition summary and follow-up plan has been completed for an individual who has transitioned 10.b. During transition	8/8	15/15	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 Medica Total Charts % Met
	planning, there is evidence that the person was provided information and options to make informed choices that were meaningful to them				

Summary:

MDH reviewed 8 Initial Assessment Care Plans and 15 Reassessment Care Plans. MDH found two issues in the 23 files reviewed both relating to meeting timeline requirements. One of the issues specifically pertained to a reassessment taking longer than 12 months to complete and the other related to delay in completing the Comprehensive Care Plan. In the 2016 care plan audit that Medica conducted which reviewed a total of 246 care plans, the review indicated similar findings to MDH's review with lower results for these two timeline requirements. While MDH consistently found 100% compliance with all other requirements, Medica found issues in some of their files although overall the results were consistently in the 90th percentile and also 100% in most protocols. Medica reviewed more files than MDH which may explain the differences in results however both the MDH and Medica reviews indicated that care plans consistently meet contractual requirements. MDH noted that only 3 of the 23 files reviewed included a completed caregiver assessment which may be an area that Medica wants to emphasize with the care coordinators.