

Triennial Compliance Assessment

Of

Metropolitan Health Plan

(Includes Hennepin Health)

Performed under Interagency Agreement for:

**Minnesota
Department of Human Services**

By

**Minnesota Department of Health (MDH)
Managed Care Systems Section**

Exam Period:

May 1, 2011 through February 28, 2014

File Review Period: May 12, 2014 through May 16, 2014

On-site:

May 12, 2014 through May 16, 2014

Examiners:

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**Final Summary Report
September 29, 2014**

Executive Summary
Triennial Compliance Assessment (TCA)
Metropolitan Health Plan (MHP) & Hennepin Health

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 2013 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 2014**

Managed Care Organization (MCO)/County Based Purchaser (CBP): Metropolitan Health Plan (MHP) [includes Hennepin Health as a CBP product line]

Examination Period: May 1, 2011 through February 28, 2014

Onsite Dates: May 12, 2014 through May 16, 2014

Table of Contents

1. QI Program Structure- 2013 Contract Section 7.1.1	4
2. Accessibility of Providers -2013 MSHO/MS+ Contract Section 6.1.4(C)(2) and 6.1.5(E).....	5
3. Utilization Management - 2013 Contract Section 7.1.3	6
4. Special Health Care Needs 2013 Contract Section 7.1.4 (A-C)	10
5. Practice Guidelines -2013 Contract Section 7.1.5	11
6. Annual Quality Assessment and Performance Improvement Program Evaluation- 2013 Contract Sections 7.1.8	12
7. Performance Improvement Projects -2013 Contract Section 7.2	13
8. Disease Management -2013 Contract Section 7.3	14
9. Advance Directives Compliance - 2013 Contract Section 16	15
10. Validation of MCO Care Plan Audits for MSHO, MS+	17
11. Information System	18
Attachment A: Element 10 – MSHO/MS+ Elderly Waiver Care Plan Audit	19

DHS Contractual Element and References	Met/ Not Met	Audit Comments
<p>1. QI Program Structure- 2013 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).</p> <p><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</p> <p><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</p> <p><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</p>	Met	Written Quality Program Description approved by MDH 11/12/13

DHS Contractual Element and References	Met/ Not Met	Audit Comments
<p>2. Accessibility of Providers -2013 MSHO/MS C+ Contract Section 6.1.4(C)(2) and 6.1.5(E)</p> <p>A. In accordance with the DHS/MCO managed care contracts for MSHO and MSC+, the MCO must demonstrate that it offers a range of choice among Waiver providers such that there is evidence of procedures for ensuring access to an adequate range of waiver and nursing facility services and for providing appropriate choices among nursing facilities and/or waiver services to meet the individual need as of Enrollees who are found to require a Nursing Facility Level of Care.</p>	Not Met	No evidence of network gaps analysis or interventions were provided to MDH for review. MDH reviewed three document provided by MHP (EW providers enrolled with DHS 2/14; DHS Provider Accessibility Report 9/13; MSHO/SNP CMS provider accessibility report (January -August 2013), none demonstrated evidence of procedures to ensure adequate access.
<p>These procedures must also include strategies for identifying Institutionalized Enrollees whose needs could be met as well or better in non-Institutional settings and methods for meeting those needs, and assisting the Institutionalized Enrollee in leaving the Nursing Facility</p>	Not Met	MHP provided policy/procedure SNP0007, Waivered Services. Page 2 states, Elderly Waiver (EW) services shall also be provided to allow members residing in the nursing facility to return to a community setting. MHP will provide transitional services (see transition of care policy). Policy/Procedure SNP002, Transition of Care Policy, states transition includes support of SNP enrollees through transitions, identify unplanned transitions and reduce unplanned transitions the policy/procedures did not discuss specific strategies to identify institutionalized enrollees whose needs could be met as well or better in the community.

DHS Contractual Element and References	Met/ Not Met	Audit Comments
<p>3. Utilization Management - 2013 Contract Section 7.1.3</p> <p>A. The MCO shall adopt a utilization management structure consistent with state 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:</p> <ol style="list-style-type: none"> 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. Conduct qualitative analysis to determine the cause and effect of 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 <p>B. The following are the 2012 NCQA Standards and Guidelines for the Accreditation of MCOs UM 1-4 and 10-14.</p>	<p>Met</p>	<p>In 2012 the following were used as measures:</p> <ul style="list-style-type: none"> • Ambulatory Care: Emergency department (ED) visits/1,000 member months (HH, MSHO/MSC+, SNBC) • Advance directives (MSHO/MSC+, SNBC) • Follow-up after hospitalization for mental illness (SNBC) • Influenza vaccines (MSHO/MSC+, SNBC) • Preventive care visits (MSHO/MSC+, SNBC) <p>Benchmark goals are laid out for HH, SNBC and MSHO/MSC+.</p> <p>Data is analyzed and actions are taken. 2013 categories were:</p> <ul style="list-style-type: none"> • Ambulatory care: emergency department (ED) visits/1,000 member months • Advance directives • Follow-up after hospitalization for mental illness • Influenza vaccines • Initiation of chemical dependency treatment (HH) <p>MHP uses Community Measurement data to analyze by clinic. Whenever possible analyze by individual provider using claims data.</p>

¹ 2011 *Standards and Guidelines for the Accreditation of Health Plans*, effective July 1, 2011
² 42 CFR 438.240(b)(3)

DHS Contractual Element and References	Met/ Not Met	Audit Comments
<p>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.</p> <p>Element A: Written Program Description Element B: Physician Involvement Element C: Behavioral Health Involvement Element D: Annual Evaluation</p>	Met	<p>UM 2 Staff does inter-rater reliability through a weekly “huddle”. CAP was done On 1/17/14/to increase number of cases to 3 to 5 per week with formal documentation. Documentation includes staff participating, issues/decisions and any follow up required. Staff report “Huddle” very effective in sharing information and consistency. Medical Director comes to the “Huddle” and MD’s do their own IRR. MDH accepted the CAP as it was done prior to opening exam and CAP activities were completed.</p>
<p>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.</p> <p>Element A: UM Criteria Element B: Availability of Criteria Element C: Consistency of Applying Criteria</p>	Met	<p>UM 4 MHP Policy Name – Appropriate Professionals: Licensure of Utilization Management (UM) Staff Policy ID – UMP0004 (PAGE 2) states: E. <i>Denials are reviewed by:</i> 1. <i>Medical denials - a physician must complete a medical review of the service requested.</i> 2. <i>Pharmaceutical denials - a physician must complete a review of the pharmaceutical service denial after the pharmacist has done the original review.</i> 3. <i>Dental denials - a physician or a dentist must complete a review of the dental service requested.</i> 4. <i>Chiropractic denials - physician or a chiropractor must complete a review of the chiropractic service requested.</i> 5. <i>Physical therapy denials - a physician or a physical therapist must complete a review of the physical therapy service requested.</i></p>
<p>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.</p> <p>Element A: Access to Staff</p>	Met	
<p>NCQA Standard UM 4: Appropriate Professionals Qualified Licensed health professionals assess the clinical information used to support UM decisions.</p> <p>Element D: Practitioner Review of BH Denials Element F: Affirmative Statement About Incentives</p>	Not Met	<p>MHP Policy and Procedures reviewed did not indicate that only qualified professionals may deny services. MHP made changes in the policies when MDH was on site but will require further MHP approval.</p> <p>File review indicated no files were denied by a physical therapist. All PT denials were done by the Medical Director.</p> <p>In five pharmacy UM denial files the pharmacist did the denial. A CAP was done on 1/30/14 and a new process implemented on 2/3/14. There is a daily review of all files and in subsequent pharmacy UM denials the Medical Director does the denial after a review by the pharmacist. MDH accepted the CAP as it was completed prior to opening exam and subsequent files were done by MD. CAP is provided to DHS.</p>

DHS Contractual Element and References	Met/ Not Met	Audit Comments
<p>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.</p> <p>Element A: Written Process Element B: Description of Evaluation Process Element C: Implementation of New Technology</p>	Met	The organization has a documented process for recognizing and evaluating technological advances in medical and behavioral healthcare procedures, pharmaceuticals and devices. The organization's procedures include the involvement of behavioral healthcare professionals in the decision making process.
<p>NCQA Standard UM 11: Satisfaction with UM Process The organization evaluates member and practitioner satisfaction with the UM process.</p> <p>Element A: Assessing Satisfaction with UM Process</p>	Not Met	UM 11. MHP discovered when putting together the 2013 annual evaluation that a <u>practitioner satisfaction was not measured in 2013</u> . A Corrective Action Plan was initiated in February 13, 2014. Provider satisfaction with UM program was measured via a provider satisfaction survey in 2014. (MDH provided DHS with the CAP and 2012 Provider Satisfaction Survey Analysis with the other TCA documents.)
<p>NCQA Standard UM 12: Emergency Services The organization provides, arranges for or otherwise facilitates all needed emergency services, including appropriate coverage of costs.</p> <p>Element A: Policies and Procedures</p>	Not Met	UM 12. Policy/procedure UMP0012, page 2 states MHP may deny an emergency room claim based on a lack of information, but it must allow at least 45 days to provide the requested information before denying the claim based on lack of information. MN Statutes, section 62M.05, subdivision 3a(a), states the plan must communicate the initial determination to the provider and enrollee within 10 business days of the request, provided the plan has received all information. DHS contract section, 8.3.2 (E) states, the plan may extend the timeframe by an additional 14 days if justifies the need. Minnesota law does not provide for an extension. This is in UM 12, however nothing in law or contract states the plan must allow at least 45 days to provide the requested information.
<p>NCQA Standard UM 13: Procedures for Pharmaceutical Management The organization ensures that its procedures for pharmaceutical management, if any, promote the clinically appropriate use of pharmaceuticals</p> <p>Element A: Policies and Procedures Element B: Pharmaceutical Restrictions/Preferences Element C: Pharmaceutical Patient Safety Issues Element D: Reviewing and Updating Procedures Element F: Availability of Procedures Element G: Considering Exceptions</p>	Met	

DHS Contractual Element and References	Met/ Not Met	Audit Comments
<p>NCQA Standard UM 14: 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. <i>This standard applies only to organizations with a centralized triage and referral process for behavioral health, both delegated and non-delegated</i></p> <p>Element A: Triage and Referral Protocols</p>	<p>NA</p>	

DHS Contractual Element and References	Met/ Not Met	Audit Comments
<p>4. Special Health Care Needs 2013 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.</p> <ul style="list-style-type: none"> 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 	<p>Met</p>	<p>All members are considered Special Needs. Hennepin Health has Community Health Workers and Navigators to assist members with needs and Care Coordination at PCC. MSHO and MSC+ have Care Coordination Care Plans and care plan audits done</p>

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
<p>7. Performance Improvement Projects -2013 Contract Section 7.2^{9,10,11}</p> <p>A. Interim Project Reports. By December 1st of each calendar year, the MCO must produce an interim performance improvement project report for each current project. The interim project report must include any changes to the project(s) protocol steps one through seven and steps eight and ten as appropriate.</p> <p>B. Completed (Final) Project Reports: Completed PIP Project Improvements Sustained over Time- Real changes in fundamental system processes result in sustained improvements:</p> <p>i Were PIP intervention strategies sustained following project completion?</p> <p>ii. Has the MCO monitored post PIP improvements?</p>	<p>Met</p> <p>Met</p>	<p>Interim Performance Improvement Project Reports submitted for review:</p> <ol style="list-style-type: none"> 1. Transitions of Care – November 27, 2013 2. Annual Preventive and Diagnostic Dental Services – November 29, 2012 November 27, 2013 3. 2013 - HH – Reducing ED Utilization in Adults Through a Collaborative Healthcare Model – November 27, 2013 4. 2013 Reducing Readmissions MSHO/MS+ - November 27, 2013 5. 2013 Reducing Readmissions SNBC – November 13, 2013 <p>Completed projects include;</p> <ol style="list-style-type: none"> 1. Preventive Care Terminated 2011 2. ASA Therapy 2011 3. Transitions of Care – absorbed in Decreasing readmits 4. BP Control in Diabetic Patients <p>Care coordinators, care plan audits, TOC logs</p> <p>HEDIS, Community Measurement</p>

9 42 CFR 438.240 (d)(2)

10 MSHO/MS+ Contract section 7.3; SNBC Contract section 7.2

11 CMS Protocols, Conduction Performance Improvement Projects, Activity 10

DHS Contractual Element and References	Met/ Not Met	Audit Comments
<p>8. Disease Management -2013 Contract Section 7. 312 The MCO shall make available a Disease Management Program for its Enrollees with:</p> <ul style="list-style-type: none"> A. Diabetes B. Asthma C. Heart Disease <p>Standards -The MCO’s Disease Management Program shall be consistent current NCQA “<i>Standards and Guidelines for the Accreditation of Health Plans</i>” – QI Standard Disease Management</p> <p>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.</p>	<p>Not Met</p>	<p>MHP’s disease management program includes Diabetes, Asthma, Heart disease and concurrent diabetes with heart disease. The DM Program is based on phone contact to enrollees with hospitalizations, ED visits, etc. with pertinent diagnoses. Member can receive member education mailings, and/or personal assistance setting goals and learning self-management.</p> <p>MHP did not calculate the participation rate for the disease management programs. MHP provide MDH with the number of enrollees participating in the programs, but did not provide total number of eligible for each program so a rate could be calculated. The 2012 Qual Eval (of 2011 calendar year data) reports in absolute numbers: 9666 total membership, 301 members participated [Asthma=76 CV=127 DM=98] and DMgrs performed 7,608 total member interventions. The report should include the participation rate: the absolute number of participants divided by the number of eligible members.</p> <p>MHP conducted an excellent barrier analysis. Among noted issues:</p> <ul style="list-style-type: none"> • Low rate of literacy in their population. • High rate of homelessness • Transient phone numbers • MNSure does not collect phone numbers • Frequent insecurity of food sources <p>MHP also noted high rate of success at member events doing LDL checks and getting personal advice from Dr. Morgan.</p> <p>MDH noted that given the HH population difficulties, phone contact and educational materials may not be the appropriate strategy for HH enrollees.</p>

DHS Contractual Element and References	Met/ Not Met	Audit Comments
<p>9. Advance Directives Compliance - 2013 Contract Section 16^{13,14}</p> <p>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:</p> <ul style="list-style-type: none"> i. 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. ii. Written policies of the MCO respecting the implementation of the right; and iii. Updated or revised changes in State law as soon as possible, but no later than 90 days after the effective date of the change; iv. 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). <p>B. Providers. To require MCO’s providers to ensure that it has been documented in the enrollee’s medical records</p> <p>C. whether or not an individual has executed an advance directive.</p>	<p>Not Met</p>	<p>MHP provided audits from MSHO, MSC+ care plans and Cornerstone (SNBC) care plans. All audits showed all sampled care plans addressed Advanced Directives. However, no measure of Hennepin Health enrollees was offered. MDH noted that: completion of advanced directives is not part of Hennepin Health’s reporting priorities.</p>

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
<p>D. Treatment. To not condition treatment or otherwise discriminate on the basis of whether an individual has executed an advance directive.</p> <p>E. To comply with State law, whether statutory or recognized by the courts of the State on Advance Directives, including Laws of Minnesota 1998, Chapter 399, §38.</p> <p>F. To provide, individually or with others, education for MCO staff, providers and the community on Advance Directives.</p>		

DHS Contractual Element and References	Met/ Not Met	Audit Comments
<p>10. Validation of MCO Care Plan Audits for MSHO, MSC+¹⁵.</p> <p>MDH will collect information for DHS to monitor MCO Care Plan Audit activities as outlined in the DHS/MCO MSHO/MS+ Contract.</p> <p>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 and when applicable the MnDHO 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.</p> <p>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.</p> <p>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.</p> <p>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.</p>	<p>Met</p>	<p>Of the 40 files from DHS's sample list, MDH audited eight initial care plan files and eight reassessments. All files contained 100% of the required audit protocol areas.</p> <p>MDH noted:</p> <ul style="list-style-type: none"> • In two initial files it was unclear as to why the file was an initial. These files did not contain enough case notes to help determine this. • No files reviewed contained a caregiver interview. • MHP has a good HRA tracking form that clearly spells out the waiver span. <p>Comparison of MHP's 2012 and 2013 EW care plan audits with MDH's 2014 audit showed all areas with 100%.</p> <p>See Attachment A for audit details.</p>

15 Pursuant to MSHO/MS+ 2011 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)

DHS Contractual Element and References	Met/ Not Met	Audit Comments
<p>11. Information System. ^{16, 17} The MCO must operate an information system that supports initial and ongoing operations and quality assessment and performance improvement programs.</p> <p>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.</p>	<p>Met</p>	<p>HEDIS Audit Reports submitted for review for years:</p> <ol style="list-style-type: none"> 1. 2011 - Metastar 2. 2012 - Metastar 3. 2013 - Metastar <p>Final Audit Statements state: “In our opinion, Metropolitan Health Plan 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. “</p>

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

Attachment A: Element 10 – MSHO/MSC+ Elderly Waiver Care Plan Audit

Table 1

Audit Protocol Number	Desired Outcome	Description of Protocol Area	Number of Files Reviewed		Number of Files with a “Met” score		% of Files with “Met” score	Comments
			Initial	Reassessment	Initial	Reassessment		
1	Initial Health Risk Assessment	a. Completed within timelines	8	NA	8	NA	8/8 100%	2 files were >30 days from enrollment but good explanations and follow through
		b. Results included in CCP	8	NA	8	NA	8/8 100%	
		c. All areas evaluated and documented	8	NA	8	NA	8/8 100%	
2	Annual Health Risk Assessment	a. Complete within timelines	HRA is the LTCC				NA	
		b. Results included in CCP						
3	LTCC- Initial (New to EW in past 12 months)	a. LTCC results attached to CCP	4	NA	4	NA	4/4 100%	
		b. All relevant fields completed or “n/a” is doc'd	4	NA	4	NA	4/4 100%	
		c. Completed timely	4	NA	4	NA	4/4 100%	
4	Annual Reassessment of EW	a. Annual re-assess w/in 12 months of prior assessment or explanation documented	NA	8	NA	8	8/8 100%	
		b. Results of LTCC attached to CCP	NA	8	NA	8	8/8 100%	
		c. All areas evaluated and documented	NA	8	NA	8	8/8 100%	

Audit Protocol Number	Desired Outcome	Description of Protocol Area	Number of Files Reviewed		Number of Files with a "Met" score		% of Files with "Met" score	Comments
			Initial	Reassessment	Initial	Reassessment		
5	Comprehensive Care Plan	CCP completed w/in 30 days of LTCC or explanation documented	8	8	8	8	16/16 100%	
6	Comprehensive Care Plan Specific Elements	a. Needs & Concerns identified	8	8	8	8	16/16 100%	
		b. Health and safety risks identified and plans for addressing these risks	8	8	8	8	16/16 100%	
		c. Documentation of services essential to health and safety	8	8	8	8	16/16 100%	
		d. If applicable, back-up plan for essential services	1	5	1	5	6/6 100%	
		e. Plan for community-wide disasters	8	8	8	8	16/16 100%	
		f. Goals and target dates	8	8	8	8	16/16 100%	
		g. Interventions identified	8	8	8	8	16/16 100%	
		h. Monitoring progress toward goals	8	8	8	8	16/16 100%	
		i. Outcomes and achievement dates are documented	8	8	8	8	16/16 100%	
		j. Follow up plan for contact for preventive care, long term care, etc.	8	5	8	5	13/13 100%	

Audit Protocol Number	Desired Outcome	Description of Protocol Area	Number of Files Reviewed		Number of Files with a “Met” score		% of Files with “Met” score	Comments
			Initial	Reassessment	Initial	Reassessment		
7	Personal Risk Management Plan	a. HCBS service refusal noted in CCP	NA	2	NA	2	2/2 100%	
		b. Personal risk management plan completed	NA	2	NA	2	2/2 100%	
8	Annual Preventive Health Exam	Annual Preventive health exam conversation initiated	8	8	8	8	16/16 100%	
9	Advance Directive	Advanced Directive conversation	8	8	8	8	16/16 100%	
10	Enrollee Choice	a. LTCC Section J or equivalent document	8	8	8	8	16/16 100%	
		b. Completed & signed Care Plan	8	8	8	8	16/16 100%	
		c. Copy of CCP summary	8	8	8	8	16/16 100%	
11	Choice of HCBS Providers	a. Completed & signed Care Plan	8	8	8	8	16/16 100%	
		b. Copy of CCP Summary	8	8	8	8	16/16 100%	
12	Community Support Plan – Community Services and Supports Section	a. Type of Services	8	8	8	8	16/16 100%	
		b. Amount, Frequency, Duration and Cost	8	8	8	8	16/16 100%	
		c. Type of Provider & non-paid/informal	8	8	8	8	16/16 100%	
		d. Attempted not complete w/explanation	NA	1	NA	1	1/1 100%	

Audit Protocol Number	Desired Outcome	Description of Protocol Area	Number of Files Reviewed		Number of Files with a “Met” score		% of Files with “Met” score	Comments
			Initial	Reassessment	Initial	Reassessment		
13	Caregiver Support Plan	a. Caregiver planning interview/assessment attached	NA	NA	NA	NA	NA	No caregiver assessments were done on any files in MDH sample
		b. Caregiver needs incorporated into SA, if applicable	NA	NA	NA	NA	NA	

Summary:

DHS utilized its sampling methodology to produce the EW care plan sample lists. MDH submitted the sample EW care plan lists to MHP which contained 20 initial assessments and 20 reassessments. MDH reviewed eight initial assessments and eight reassessments following the *MSHO and MSC+ Elderly Waiver Planning Protocol Care Plan Data Collection Guide*.

MHP scored 100% on all protocol areas (See Table A). In the initial HRA, two files were outside of the 30 day timeline from enrollment to assessment, however very thorough explanations were included. In one file there were problems getting the County to open the waiver (38 days). The care coordinator showed excellent monitoring, follow up and documentation. In the other file the care coordinator entered the data into MMIS but had to wait to get paperwork from the client. In two files it was difficult to determine why the file was an initial. This is an issue when case notes are not included in the file. There were no files in MDH’s sample that included a caregiver interview.

MHP uses a HRA Tracking form which is a great form that clearly spells out the waiver span.

The 2014 MDH audit of MSHO/MS C+ Care Plans was consistent with MHP’s audit results from 2012 and 2013 which is in Table 2 below. MHP consistently scored 100% as evidenced by MDH findings of 100%. Two areas of inconsistency between MHP’s audits and MDH’s are in the areas of #2 HRA and #13 Caregiver Support. The difference in HRA could be due to MHP audit non-EW care plans. Since the HRA is the LTCC, MDH uses #4 Annual Reassessment of EW. The discrepancy in # 13 Caregiver support is probably due to MHP counting all of the files that are looked at rather than just the files that identified and interviewed a caregiver. Both could also be due to differences in auditing practices.

Table 2 Comparison of MHP Audit Findings from 2012 and 2013 AND MDH Audit Findings from 2014

Audit Protocol #	Desired Outcome	Description of Protocol Area	MHP 2012 # and % Care Plans w/ "Met" score	MHP 2013 # and % Care Plans w/ "Met" score	MDH 2014 # and % Care Plans w/ "Met" Score
1	Initial Health Risk Assessment	a. Completed within timelines	12/12 100%	32/32 100%	8/8 100%
		b. Results included in CCP	11/11 100%	32/32 100%	8/8 100%
		c. All areas evaluated and documented	11/11 100%	32/32 100%	8/8 100%
2	Annual Health Risk Assessment	a. Complete within timelines	18/18 100%	52/54 96.2%	NA
		b. Results included in CCP	18/18 100%	54/54 100%	NA
3	LTCC- Initial (New to EW in past 12 months)	a. LTCC results attached to CCP	18/18 100%	32/32 100%	4/4 100%
		b. All relevant fields completed or "n/a" is doc'd	18/18 100%	32/32 100%	4/4 100%
		c. Completed timely	18/18 100%	32/32 100%	4/4 100%
4	Annual Reassessment of EW	a. Annual re-assess w/in 12 months of prior assessment or explanation documented	22/22 100%	32/32 100%	8/8 100%
		b. Results of LTCC attached to CCP	22/22 100%	32/32# and 100%	8/8 100%
		c. All areas evaluated and documented	22/22 100%	32/32 100%	8/8 100%

Audit Protocol #	Desired Outcome	Description of Protocol Area	MHP 2012 # and % Care Plans w/ "Met" score	MHP 2013 # and % Care Plans w/ "Met" score	MDH 2014 # and % Care Plans w/ "Met" Score
5	Comprehensive Care Plan	CCP completed w/in 30 days of LTCC or explanation documented	70/70 100%	32/32 100%	16/16 100%
6	Comprehensive Care Plan Specific Elements	a. Needs & Concerns identified	70/70 100%	32/32 100%	16/16 100%
		b. Goals/target dates identified	70/70 100%	32/32 100%	16/16 100%
		c. Interventions identified	70/70 100%	32/32 100%	16/16 100%
		d. Monitoring progress towards goals	70/70 100%	32/32 100%	6/6 100%
		e. Outcome/Achievement dates are documented	70/70 100%	32/32 100%	16/16 100%
		f. Doc of informed choice if member refuses recommended interventions	70/70 100%	32/32 100%	16/16 100%
		g. Follow up plan for contact for preventative care, long-term care etc.	70/70 100%	32/32 100%	16/16 100%
7	Personal Risk Management Plan	a. HCBS service refusal noted in CCP	70/70 100%	32/32 100%	16/16 100%
		b. Personal risk management plan completed	70/70 100%	32/32 100%	16/16 100%
8	Annual Preventive Health Exam	Annual Preventive health exam conversation initiated	70/70 100%	32/32 100%	16/16 100%

Audit Protocol #	Desired Outcome	Description of Protocol Area	MHP 2012 # and % Care Plans w/ "Met" score	MHP 2013 # and % Care Plans w/ "Met" score	MDH 2014 # and % Care Plans w/ "Met" Score
9	Advance Directive	Advanced Directive conversation	70/70 100%	32/32 100%	16/16 100%
10	Enrollee Choice	a. LTCC Section J or equivalent document	70/70 100%	32/32 100%	16/16 100%
		b. Completed & signed Care Plan	70/70 100%	32/32 100%	16/16 100%
		c. Copy of CCP summary	70/70 100%	32/32 100%	16/16 100%
11	Choice of HCBS Providers	a. Completed & signed Care Plan	70/70 100%	32/32 100%	16/16 100%
		b. Copy of CCP Summary	70/70 100%	32/32 100%	16/16 100%
12	Community Support Plan – Community Services and Supports Section	a. Type of Services	70/70 100%	32/32 100%	16/16 100%
		b. Amount, Frequency, Duration and Cost	70/70 100%	32/32 100%	16/16 100%
		c. Type of Provider & non-paid/informal	70/70 100%	32/32 100%	16/16 100%
		d. Attempted not complete w/explanation	72/72 100%	32/32 100%	1/1 100%
13	Caregiver Support Plan	a. Caregiver planning interview/assessment attached	70/70 100%	32/32 100%	NA
		b. Caregiver needs incorporated into SA, if applicable	70/70 100%	32/32 100%	NA