

Triennial Compliance Assessment  
Of  
**PrimeWest Health System**

Performed under Interagency Agreement for:

**Minnesota**  
Department of Human Services

By

Minnesota Department of Health (MDH)  
Managed Care Systems Section

**Exam Period:**

June 1, 2011 – August 31, 2014

**File Review Period:**

September 1, 2013 – August 31, 2014

**On-site:**

October 20 – 23, 2014

Examiners:

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**Final Summary Report**  
**December 23, 2014**

**Executive Summary**  
**Triennial Compliance Assessment (TCA)**  
**PrimeWest Health System**

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 SFY 2013 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

**Managed Care Organization (MCO)/County Based Purchaser (CBP):** PrimeWest Health System  
**Examination Period:** June 1, 2011 – August 31, 2014  
**Onsite Dates:** October 20 – 24, 2014

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**DHS Triennial Compliance Assessment (TCA)  
TCA Data Collection Grid  
SFY 2014**

**Managed Care Organization (MCO)/County Based Purchaser (CBP):** PrimeWest Health System  
**Examination Period:** June 1, 2011 – August 31, 2014  
**Onsite Dates:** October 20 – 24, 2014

DHS Contractual Element and References	Met/ Not Met	Audit Comments
<p><b>1. QI Program Structure- 2012 Contract Section 7.1.1.</b> 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</p>	Met	Approved by MDH June 30, 2014

DHS Contractual Element and References	Met/ Not Met	Audit Comments
<p><b>2. Accessibility of Providers -2012 MSHO/MS C+ Contract Section 6.1.4(C)(2) and 6.1.5(E)</b></p> <p>A. In accordance with the DHS/MCO managed care contracts for MSHO and MS C+, 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. 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>	<p><b>Met</b></p>	<p>PWH provided excerpts from 3 documents that, read together, briefly describe its strategies for identifying institutionalized enrollees whose needs could be met in the community.</p> <p>PWH could better meet this element by including all the excerpts in one policy/procedure.</p>

DHS Contractual Element and References	Met/ Not Met	Audit Comments
<p><b>3. Utilization Management - 2012 Contract Section 7.1.3</b></p> <p>A. The MCO shall adopt a utilization management structure consistent with state regulations and current NCQA “Standards for Accreditation of Health Plans.”<sup>1</sup> 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> <ul style="list-style-type: none"> <li>i. Choose the appropriate number of relevant types of utilization data, including one type related to behavioral health to monitor.</li> <li>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.</li> <li>iii. Conduct qualitative analysis to determine the cause and effect of all data not within thresholds.</li> <li>iv. Analyze data not within threshold by medical group or practice.</li> <li>v. Take action to address identified problems of under or overutilization and measure the effectiveness of its interventions.<sup>2</sup></li> </ul> <p>B. The following are the 2012 NCQA Standards and Guidelines for the Accreditation of MCOs UM 1-4 and 10-14.</p>	Met	
<p><b>NCQA Standard UM 1: Utilization Management Structure.</b> The organization clearly defines the structures and processes within its utilization management (UM) program and assigns responsibility to appropriate individuals.</p> <ul style="list-style-type: none"> <li>Element A: Written Program Description</li> <li>Element B: Physician Involvement</li> <li>Element C: Behavioral Health Involvement</li> <li>Element D: Annual Evaluation</li> </ul>	Met	<p>Met through NCQA. Accreditation audit</p> <p>NCQA conducted a survey of PWH Medicaid products. During the survey, NCQA reviewed policies/procedures, but did not review files or HEDIS data. Therefore, PrimeWest received an “Interim Accreditation” effective July 1, 2014 through January 14, 2016. PrimeWest earned 100% of all possible points in the NCQA survey of policies/procedures. Therefore, consistent with MDH/DHS practice with NCQA accredited MCOs, these contract provisions are “Met through NCQA.”</p>

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

<b>DHS Contractual Element and References</b>	<b>Met/ Not Met</b>	<b>Audit Comments</b>
<p><b>NCQA Standard UM 2: Clinical Criteria for UM Decision</b> To make utilization decisions, the organization uses written criteria based on sound clinical evidence and specifies procedures for appropriately applying the criteria.</p> <p>(a) Element A: UM Criteria (b) Element B: Availability of Criteria (c) Element C: Consistency in Applying Criteria</p>	<b>Met</b>	Met through NCQA Accreditation audit
<p><b>NCQA Standard UM 3: Communication Services</b> The organization provides access to staff for members and practitioners seeking information about the UM process and the authorization of care.</p> <p>(a) Element A: Access to Staff</p>	<b>Met</b>	Met through NCQA Accreditation audit
<p><b>NCQA Standard UM 4: Appropriate Professionals</b> Qualified licensed health professionals assess the clinical information used to support UM decisions.</p> <p>(a) Element D: Practitioner Review of BH Denials (b) Element F: Affirmative Statement About Incentives</p>	<b>Met</b>	Met through NCQA Accreditation audit
<p><b>NCQA Standard UM 10: Evaluation of New Technology</b> 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>(a) Element A: Written Process (b) Element B: Description of the Evaluation Process (c) Element C: Implementation of New Technology</p>	<b>Met</b>	Met through NCQA Accreditation audit
<p><b>NCQA Standard UM 11: Satisfaction with the UM Process</b> The organization evaluates member and practitioner satisfaction with the UM process.</p> <p>(a) Element A: Assessing Satisfaction with UM Process.</p>	<b>Met</b>	Met through NCQA Accreditation audit

DHS Contractual Element and References	Met/ Not Met	Audit Comments
<p><b>NCQA Standard UM 12: Emergency Services.</b> 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>	Met	Met through NCQA Accreditation audit
<p><b>NCQA Standard UM 13: Procedures for Pharmaceutical Management.</b> 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	Met through NCQA Accreditation audit
<p><b>NCQA Standard UM 14: Triage and Referral to Behavioral Health.</b> 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>	Met	Met through NCQA Accreditation audit

DHS Contractual Element and References	Met/ Not Met	Audit Comments
<p><b>4. Special Health Care Needs 2012 Contract Section 7.1.4 (A-C)<sup>3,4</sup></b> 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"> <li>A. Mechanisms to identify persons with special health care needs,</li> <li>B. Assessment of enrollees identified, (Senior and SNBC Contract – care plan) and</li> <li>C. Access to specialists</li> </ul>	<p><b>Met</b></p>	

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3 42 CFR 438.208 (c)(1-4)

4 MSHO, MSC+ Contract section 7.1.4 A, C;

DHS Contractual Element and References	Met/ Not Met	Audit Comments
<p><b>5. Practice Guidelines -2012 Contract Section 7.1.5</b><sup>5,6</sup>.</p> <p>A. The MCO shall adopt preventive and chronic disease practice guidelines appropriate for children, adolescents, prenatal care, young adults, adults, and seniors age 65 and older, and, as appropriate, for people with disabilities populations.</p> <p>i. <b><u>Adoption of practice guidelines.</u></b> The MCO shall adopt guidelines based on:</p> <ul style="list-style-type: none"> <li>• Valid and reliable clinical evidence or a consensus of Health Care Professionals in the particular field</li> <li>• Consideration of the needs of the MCO enrollees</li> <li>• Guidelines being adopted in consultation with contracting Health Care Professionals</li> <li>• Guidelines being reviewed and updated periodically as appropriate.</li> </ul> <p>ii. <b><u>Dissemination of guidelines.</u></b> MCO ensures guidelines are disseminated: to all affected Providers; and to enrollees and potential enrollees upon request</p> <p>iii. <b><u>Application of guidelines.</u></b> MCO ensures guidelines are applied to decisions for:</p> <ul style="list-style-type: none"> <li>• Utilization management</li> <li>• Enrollee education</li> <li>• Coverage of services</li> <li>• Other areas to which there is application and consistency with the guidelines.</li> </ul>	<p><b>Met</b></p>	<p>PWH monitors clinics that consistently follow (or do not follow) PWH practice guidelines. As a result of the monitoring, PWH implemented a quality-driven alternative reimbursement strategy with some providers. (Explained in their ARCH report.) Providers report data through MN Community Measurement at the medical group/clinic level.</p>

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5 42 CFR 438.236

6 MSHO/MS+ Contract section 7.2 A-C

DHS Contractual Element and References	Met/ Not Met	Audit Comments
<p><b>6. Annual Quality Assessment and Performance Improvement Program Evaluation- 2012Contract Sections 7.1.8</b> <sup>7,8</sup></p> <p>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:</p> <ul style="list-style-type: none"> <li>i. Review the impact and effectiveness of the MCO’s quality assessment and performance improvement program</li> <li>ii. Include performance on standardized measures (example: HEDIS®) and</li> <li>iii. Include MCO’s performance improvement projects.</li> </ul> <p>B. <b>NCQA QI 1, Element B:</b> There is an annual written evaluation of the QI Program that includes:</p> <ul style="list-style-type: none"> <li>i. A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service</li> <li>ii. A trending of measures to assess performance in the quality and safety of clinical care and quality of services</li> <li>iii. Analysis of the results of QI initiatives, including barrier analysis</li> <li>iv. Evaluation of the overall effectiveness of the QI program, including progress toward influencing network-wide-safe clinical practices</li> </ul>	<p><b>Met</b></p>	

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7 42 CFR 438.240(e)

8 MSHO/MS C+ Contract Section 7.2.4 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
<p><b>7. Performance Improvement Projects -2012 Contract Section 7.2<sup>9,10,11</sup></b></p> <p>A. <b>Interim Project Reports.</b> By December 1<sup>st</sup> 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. <b>Completed (Final) Project Reports:</b> 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><b>Met</b></p>	<p>Interim:  Colorectal CA Screening – 2012, 2013 – Dated December 1  Post-DISCHARGE Member Follow-up – 2012, 2013 – December 1  LDL SCREENING AMONG Members with Diabetes – November 27  HPV Vaccination for Males – 2013- December 1</p> <p>Completed:  HPV Female Adolescents  ASA Therapy  Diabetes BP</p>

9 42 CFR 438.240 (d)(2)

10 MSHO/MS+ Contract section 7.3

11 CMS Protocols, Conduction Performance Improvement Projects, Activity 10

DHS Contractual Element and References	Met/ Not Met	Audit Comments
<p><b>8. Disease Management -2012 Contract Section 7. 3<sup>12</sup></b> The MCO shall make available a Disease Management Program for its Enrollees with:</p> <ul style="list-style-type: none"> <li>A. Diabetes</li> <li>B. Asthma</li> <li>C. Heart Disease</li> </ul> <p><b>Standards</b> -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><b>Diabetes:</b></p>	<b>Met</b>	NCQA 100% compliance
B. Program Content		
C. Identifying Members for DM Programs		
D. Frequency of Member Identification		
E. Providing Members With Information		
F. Interventions Based on Stratification		
G. Eligible Member Participation		
H. Informing and Educating Practitioners		
I. Integrating Member Information		
J. Satisfaction With Disease Management		
K. Measuring Effectiveness		
<b>Asthma:</b>		
B. Program Content		
C. Identifying Members for DM Programs		
D. Frequency of Member Identification		

<sup>12</sup> MSHO/ MSC+ Contract section 7.4, requires only diabetes and hearth DM programs; SNBC Contract section 7.2.9

DHS Contractual Element and References	Met/ Not Met	Audit Comments
E. Providing Members With Information		
F. Interventions Based on Stratification		
G. Eligible Member Participation		
H. Informing and Educating Practitioners		
I. Integrating Member Information		
J. Satisfaction With Disease Management		
K. Measuring Effectiveness		
<b>Heart Disease:</b>		
B. Program Content		
C. Identifying Members for DM Programs		
D. Frequency of Member Identification		
E. Providing Members With Information		
F. Interventions Based on Stratification		
G. Eligible Member Participation		
H. Informing and Educating Practitioners		
I. Integrating Member Information		
J. Satisfaction With Disease Management		
K. Measuring Effectiveness		

DHS Contractual Element and References	Met/ Not Met	Audit Comments
<p><b>9. Advance Directives Compliance - 2012 Contract Section 16</b><sup>13,14</sup></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"> <li>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.</li> <li>ii. Written policies of the MCO respecting the implementation of the right; and</li> <li>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;</li> <li>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).</li> </ul> <p>B. <b>Providers.</b> 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.</p> <p>C. <b>Treatment.</b> To not condition treatment or otherwise discriminate on the basis of whether an individual has executed an advance directive.</p> <p>D. To comply with State law, whether statutory or recognized by the</p>	<p><b>Met</b></p>	<p>PWH’s goal is that all enrollees will have an advance directive and meets this requirement by including the measure on the medical record review audit tool. Annually provider compliance is measured and reported in the medical record review report.</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;

<b>DHS Contractual Element and References</b>	<b>Met/ Not Met</b>	<b>Audit Comments</b>
<p>courts of the State on Advance Directives, including Laws of Minnesota 1998, Chapter 399, §38.</p> <p>E. 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><b>10. Validation of MCO Care Plan Audits for MSHO and MSC+ <sup>15</sup>.</b> MDH will collect information for DHS to monitor MCO Care Plan Audit activities as outlined in the DHS/MCO MSHO/MSC+ 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. 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><b>Met</b></p>	<p>MDH found no errors in the EW Care Plan file sample. In one initial assessment, the plan's last assessment was in July 2013; an initial assessment occurred in October (new to PWH); the reassessment occurred in June 2014. In addition, the signatures on the initial assessment (new to PWH) were from June 2013.</p> <p>DHS informs us that an assessment has to be done within a year "of the last assessment. " Reassessment can be done early as there could be a good reason such as change of condition. If that is the case, a reassessment is not due until one year from that last assessment. Health plans may try to keep the initial assessment date intact and if that is the case, may reassess when that one year comes up.</p> <p>The plan needs to be careful doing assessment early especially when PCA is involved because a person's assessment is to last a full year and if an early assessment would result in reduction of hours, they would need to continue the higher level of services through the whole year of the assessment. To state there is not a prohibition to conducting reassessments early is not completely accurate. There has to be a request for a reassessment or change in condition.</p> <p>If a new care plan or CSP is created based on an assessment, a new signature is required. If there were no changes to the CSP or care plan, then the existing signed care plan is the care plan of record.</p> <p>The file did not include PCA services. Since MDH is unsure if the CSP lead to any change in services, we did not have any finding regarding the file. However, MDH includes the caution raised by DHS in the TCA.</p> <p><i>DHS Comment: DHS (Aging waiver staff) has not defined "annually" so there is not a definition in the contract. However, Aging staff are now indicting reassessments need to be done every 366 days. This more closely aligns with Medicare's 365 definitions. It is expected this changes will be incorporated into an updated care plan audit document.</i></p>

<sup>15</sup> Pursuant to MSHO/MSC+ 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><b>11. Information System.</b> <sup>16, 17</sup> 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><b>Met</b></p>	<p>HEDIS Audit Reports submitted for review for years:</p> <ol style="list-style-type: none"> <li>1. 2011 MetaStar</li> <li>2. 2012 Metastar</li> <li>3. 2013 MetaStar</li> </ol> <p>PrimeWest Health submitted measures were prepared according to HEDIS Technical Specifications.</p>

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16 Families and Children, and Seniors  
17 42 CFR 438.242

DHS Contractual Element and References	Met/ Not Met	Audit Comments
<p><b>12 A. Subcontractors.</b> <sup>18</sup> <b>Written Agreement; Disclosures.</b> 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 CMS. All contracts must include:</p> <p>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:</p> <ol style="list-style-type: none"> <li>(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;</li> <li>(2) A statement as to whether any Person with an Ownership or Control Interest in the disclosing entity as identified in <a href="#">9.3.1(A)</a> is related (if an individual) to any other Person with an Ownership or Control Interest as spouse, parent, child, or sibling;</li> <li>(3) The name of any other disclosing entity in which a Person with an Ownership or Control Interest in the disclosing entity also has an ownership or control interest; and</li> <li>(4) The name, address, date of birth, and social security number of any managing employee of the disclosing entity.</li> </ol>	<p><b>Met</b></p>	<p>All contracts/delegation agreements reviewed included specific payment arrangements.</p> <p>PWH's "contract package" includes a form with disclosure information as required.</p>

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<sup>18</sup>Families and Children Contract Sections 9.1.3.A, 9.1.3.C

DHS Contractual Element and References	Met/ Not Met	Audit Comments
<p>(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.</p> <p>C. 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.</p>		<p>Policy/procedure and contract so requires</p>
<p><b>Exclusions of Individuals and Entities; Confirming Identity</b><sup>19</sup></p> <p>(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.</p> <p>(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:</p> <ol style="list-style-type: none"> <li>1. Are not excluded from participation in Medicaid under Sections 1128 or 1128A of the Social Security Act; and</li> <li>2. Have not been convicted of a criminal offense related to that</li> </ol>	<p><b>Met</b></p>	<p>PWH conducts background checks on each of its board members and leadership. All providers are credentialed including NPDB, EPLS and the OIG checks.</p> <p>PWH delegates its subcontractors the function of conducting searches.</p>

<sup>19</sup> Families and Children Contract Section 9.3.13

DHS Contractual Element and References	Met/ Not Met	Audit Comments
<p>person's involvement in any program established under Medicare, Medicaid or the programs under Title XX of the Social Security Act.</p> <p>(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.</p> <p>(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.</p> <p>(E) The MCO shall report this information to the STATE within seven (7) days of the date the MCO receives the information</p> <p>(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).</p> <p>(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.</p>		

**Attachment A:  
MDH 2014 EW Care Plan Audit**

Audit Protocol	Protocol Description	Measures	Total # Charts Reviewed		Total # Charts "Met"		2014 Total % Met	Comments
			Initial	Reassessment	Initial	Reassessment		
1	<b>INITIAL HEALTH RISK ASSESSMENT</b> For members new to the MCO or product within the last 12 months	A. Date HRA completed is within 30 calendar days of enrollment date	8		8		100%	
		B. All HRA areas evaluated and documented (in enrollee Comprehensive Care Plan)	8		8		100%	
2	<b>ANNUAL HEALTH RISK ASSESSMENT</b> For members on who have been a member of the MCO for more than 12 months [Only for plans with separate HRA]	HRA is completed is within 12 months of previous HRA (results are included in enrollee Comprehensive Care Plan)		8		8	100%	
3	<b>LONG TERM CARE CONSULTATION – INITIAL</b> If member is new to EW in the past 12 months	A. All (100%) of the fields relevant to the enrollee's program are completed with pertinent information or noted as Not Applicable or Not Needed	8		8		100%	
		B. LTCC was completed timely (and in enrollee Comprehensive Care Plan)	8		8		100%	

4	<b>REASSESSMENT OF EW</b> For members open to EW who have been a member of the MCO for more than 12 months	A. Date re-assessment completed is within 12 months of previous assessment		8		8	100%	
		B. All areas of LTCC have been evaluated and documented (and in enrollee Comprehensive Care Plan)		8		8	100%	
5	<b>COMPREHENSIVE CARE PLAN</b> Includes needs identified in the HRA and/or the LTCC and other sources such as medical records and member and/or family input and all elements of the community support plan.	A. Date Comprehensive Care Plan was completed is within 30 calendar days of completed LTCC (“Complete” defined as the date the plan is ready for signature (may also be noted as “date sent to member”)	8	8	8	8	100%	
		B. If enrollee refused recommended HCBS care or service, then refusal should be noted in the Comprehensive Care Plan according to item IV of the CSP as evidence of a discussion between care planner and enrollee about how to deal with situations when support has been refused, referred to as the <i>personal risk management plan</i>	8	8	8	8	100%	
6	<b>COMPREHENSIVE CARE PLAN SPECIFIC</b>	A. Identification of enrollee needs and concerns, including	8	8	8	8	100%	

	<b>ELEMENTS</b> To achieve an interdisciplinary, holistic, and preventive focus; the Comprehensive Care Plan must include the elements listed:	identification of health and safety risks, and what to do in the event of an emergency, are documented in Comprehensive Care Plan and linked to assessed needs as determined by the completed LTCC						
		B. Goals and target dates (at least, month/year) identified Monitoring of outcomes and achievement dates (at least, month/year) are documented	8	8	8	8	100%	
		C. Outcomes and achievement dates (at least, month/year) are documented	8	8	8	8	100%	
		D. If the enrollee refuses any of the recommended interventions, the Comprehensive Care Plan includes documentation of an informed choice about their care and support	8	8	8	8	100%	
7	<b>FOLLOW-UP PLAN</b> Follow-up plan for contact for preventive care <sup>20</sup> , long-term care and community support,	A. All areas of concern are addressed as identified on the Comprehensive Care Plan as stated in #5 of this	8	8	8	8	100%	

<sup>20</sup> 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.

	medical care, or mental health care <sup>21</sup> , or any other identified concern	protocol B. If an area is noted as a concern then there must be documented goals, interventions, and services for concerns or needs identified [If an area is identified as not a concern, then “Not Needed” and will be excluded from denominator for this item]	8	8	8	8	100%	
8	<b>ANNUAL PREVENTIVE CARE</b>	Documentation in enrollee’s Comprehensive Care Plan that <u>substantiates a conversation was initiated</u> with enrollee about the need for an annual, age–appropriate comprehensive preventive health exam (i.e., Influenza immunization, Pneumococcal immunization, Shingles (Zostavax) immunization, Vision screening, Depression screening (or other mental status review), Assessment of the presence of urinary incontinence, Preventive dental exam	8	8	8	8	100%	
9	<b>ADVANCE DIRECTIVE</b>	Evidence that a discussion was initiated,	8	8	8	8	100%	

<sup>21</sup> Mental health care concerns should include but not be limited to: depression, dementia, and other mental illness.

		enrollee refused to complete, was culturally inappropriate, or AD was completed						
10	<b>ENROLLEE CHOICE</b> Enrollee was given a choice between Home and Community-Based Services (HCBS) and Nursing Home Services (also indicates enrollee involvement in care planning)	A. Choice noted in Section J of LTCC Assessment Form (e-docs #3428) or equivalent document (correlates to Section D of the LTCC Screening Document (e-docs #3427)	8	8	8	8	100%	
		B. Completed and signed care plan summary (and in enrollee Comprehensive Care Plan)	8	8	8	8	100%	
11	<b>CHOICE OF HCBS PROVIDERS</b> Enrollee was given information to enable the enrollee to choose among providers of HCBS	Completed and signed care plan summary (and in enrollee Comprehensive Care Plan)	8	8	8	8	100%	See comments in Summary below
12	<b>HOME AND COMMUNITY BASED SERVICE PLAN</b> A HCBS service plan with these areas completed, including clearly identified and documented links to assessed needs per the results of the LTCC	A. Type of services to be furnished	8	8	8	8	100%	
		B. The amount, frequency and duration of each service	8	8	8	8	100%	
		C. The type of provider furnishing each service including non-paid care givers and other informal community supports or resources	8	8	8	8	100%	
13	<b>CAREGIVER</b>	A. Attached Caregiver	8	8	8	8	100%	

	<b>SUPPORT PLAN</b>	Planning Interview						
	If a primary caregiver is identified in the LTCC,	B. Incorporation of stated caregiver needs in Service Agreement, if applicable	8	8	8	8	100%	

**2013 PWH MSHO/MSC+ Elderly Waiver Care Plan Audit Delegate Summary Report**

<b>Audit Protocol Number</b>	<b>Desired Outcome</b>	<b>Description of Protocol Area</b>	<b>Number of Sampled Care Plans</b>	<b>Number of Reviewed Care Plans for which Area is Applicable</b>	<b>Number of Care Plans with a “Met” Score</b>	<b>Percentage of Care Plans with a “Met” Score</b>	<b>Corrective Action Indicated</b>	<b>Improvement Opportunity</b>
1	Initial Health Risk Assessment	a. Completed within timelines	88	11	11	11	None	None
		b. Results included in CCP	88	11	11	11	None	None
		c. All areas evaluated and documented	110	13	13	12	One	One
2	Annual Health Risk Assessment	a. Completed within timelines	88	0	0	0	N/A	N/A
		b. Results included in CCP	88	0	0	0	N/A	N/A
3	LTCC- Initial (New to EW in past 12 months)	a. LTCC results attached to CCP	88	21	21	21	None	None
		b. All relevant fields completed or “n/a” is doc	88	21	21	21	None	None
		c. Completed timely	88	21	21	21	None	None
4	Annual Reassessment of EW	a. Annual re-assess w/in 12 months of prior assessment or explanation documented	88	72	72	72	None	None
		b. Results of LTCC attached to CCP	88	72	72	72	None	None

		c. All areas evaluated and documented	88	72	72	72	None	None
5	Comprehensive Care Plan	CCP completed w\in 30 days of LTCC or explanation documented	110	110	110	108	One	One
6	Comprehensive Care Plan Specific Elements	a. Needs & Concerns identified	154	154	154	103	Three	Three
		b. Goals/target dates identified	88	88	88	88	None	None
		c. Interventions identified	88	88	88	88	None	None
		d. Monitoring progress towards goals	110	110	110	103	One	One
		e. Outcome/Achievement dates are documented	110	110	110	87	One	One
		f. Doc of informed choice if member refuses recommended interventions	88	26	26	26	None	None
		g. Follow up plan for contact for preventative care, long-term care etc..	176	176	176	121	Four	Four
7	Personal Risk Management Plan	a. Service refusal noted in CCP	88	9	9	9	None	None
		b. Personal risk management plan completed	88	9	9	9	None	None
8	Annual Preventive Health Exam	Annual Preventive health exam conversation initiated	88	88	88	88	None	None
9	Advance Directive	Advanced Directive conversation	88	88	88	88	None	None
10	Enrollee Choice	a. Sec J or equivalent document	88	88	88	88	None	None
		b. Completed & signed Care Plan	88	88	88	88	None	None

		c. Copy of CCP summary	88	88	88	88	None	None
11	Choice of HCBS Providers	a. Completed & signed Care Plan	88	88	88		None	None
		b. Copy of CCP Summary	88	88	88	88	None	None
12	HCBS Plan	a. Type of Services	88	88	88	88	None	None
		b. Amount, Frequency, Duration and Cost	88	88	88	88	None	None
		c. Type of Provider & non-paid/informal	88	88	88	88	None	None
		d. Attempted not complete w/explanation	88	0	0	0	N/A	N/A
13	Caregiver Support Plan	a. Caregiver planning interview/assessment attached	88	24	24	24	None	None
		b. Incorporated into SA, if applicable	88	24	24	24	None	None

**Summary:**

DHS followed the sampling methodology outlined in the audit protocol guidelines and presented the sample lists to MDH. MDH audited eight initial assessment files and eight reassessment files following the *MSHO and MSC+ Elderly Waiver Planning Protocol Care Plan Data Collection Guide*.

The PWH 2013 delegate audit (combined) reviewed a larger file sample. All issues identified were in Protocol # 5 and #6: Completeness of the initial health risk assessment and specific elements of the CCP. PWH indicated if a corrective action was indicated.

MDH found no errors in the EW Care Plan file sample. We found one issue with one initial assessment. In that file, the plan’s last assessment was in July 2013; an initial assessment occurred in October (new to PWH); the reassessment occurred in June 2014. The file did not include PCA services. Since MDH is unsure if the CSP lead to any change in services, we did not have any finding regarding the file. However, MDH includes the caution raised by DHS in the TCA Element 10 text.