DEPARTMENT OF HEALTH

South Country Health Alliance

TRIENNIAL COMPLIANCE ASSESSMENT

Triennial Compliance Assessment

Performed under Interagency Agreement for Minnesota Department of Human Services
Examination Period: June 2019 to February 28, 2022
File Review Period: February 1, 2021, to January 31, 2022
Virtual On-Site: April 25-April 29, 2022
Examiners: Elaine Johnson, RN, BS, CPHQ; Dena Harrell, BA, MPA Tom Major, MA, MDiv.
Report Issue Date: September 14, 2023

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

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

Contents

Triennial Compliance Assessment

Executive Summary

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

TCA Process Overview

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

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

- DHS evaluates information collected by MDH to determine if the MCO has "met" or "not met" contract requirements. The MCO will be provided a Preliminary TCA Report to review DHS' initial "met/not met" determinations. At this point, the MCO has an opportunity to refute erroneous information, but may not submit new or additional documentation. Ample time and opportunities are allowed during the QA Examination to submit documents, policies and procedures, or other information to demonstrate

compliance. The MCO must refute erroneous TCA finding within 30 days. TCA challenges will be sent by the MCO to MDH. MDH will forward the MCO's TCA rebuttal comments to DHS for consideration.

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

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

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

I. Quality Assessment and Performance Improvement Program – 2022 Contract Sections 7.1, 7.1.1, 7.1.2[1]

The Quality Assessment and Performance Improvement Program must be consistent with federal requirements under Title XIX of the Social Security Act, 42 CFR § 438, subpart E, and as required pursuant to Minnesota Statutes, Chapters 62D, 62N, 62Q and 256B and related rules, including Minnesota Rules, parts 4685.1105 through 4685.1130, and applicable NCQA "*Standards and Guidelines for the Accreditation of Health Plans*" as specified in this Contract

TCA Quality Program Structure Data Grid

DHS Contractual Element and References	Met or Not Met	Audit Comments
The MCO must incorporate into its *Quality Assessment and Performance Improvement Program Standards,* the standards as described in 42 CFR 438, Subpart D: *MCO, PIHP and PAHP Standards* and 42 CFR 438, Subpart E: *Quality Measurement and Improvement; External Quality Review*. **A. Subpart D: MCO, PIHP and PAHP Standards** **Access Standards** 42 CFR § 438.206 Availability of Services - • 42 CFR § 438.68 Network Adequacy Standards [42 CFR §438.68(a), (b), (c)] 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 - • • 42 CFR §438.3 Standard Contract Requirements	**Met**	The submitted 2021 and 2022, Written Quality Assurance Plans were reviewed and approved by MDH. Program descriptions contained all required elements as outlined in Minnesota Rules 4685.1110 through 4685.1130 and Federal requirements under 42 CFR §438, subpart E.

1 Families and Children MA, Seniors (MSHO/MSC+), and Special Needs Basic Care (SNBC) Contract Section 7.1 and sub-sections; MSHO/MSC+ Contract Section 7.1 also includes the requirement that the MCO must comply with requirements of "*Quality Framework*," for EW services, including those found in the CMS "*Modifications to Quality Measures and Reporting in 1915(c) Home and Community-Based Waivers*" published in March 2014

DHS Contractual Element and References	Met or Not Met	Audit Comments
Structure and Operations Standards 42 CFR §438.214 Provider Selection 42 CFR §438.224 Confidentiality 42 CFR §438.228 Grievance and Appeal Systems 42 CFR §438.230 Sub-contractual Relationships and Delegation 42 CFR §438.236 Practice Guidelines 42 CFR §438.242 Health Information Systems	**Met**	
Consistent with: **B. Minnesota Rules, parts 4685.1105 through 4685.1130,**	**Met**	
C. Applicable NCQA "*Standards and Guidelines for the Accreditation of Health Plans*" as specified in this Contract	**Met**	

II. Information System – 2022 Contract Section 7.1.3[2, 3]

The MCO must operate an information system that supports initial and ongoing operations and quality assessment and performance improvement programs.

Information System Data Grid

DHS Contractual Element and References	Met or Not Met	Audit Comments
A. The MCO must maintain a health information system that collects, analyzes, integrates, and reports data and can achieve the following objectives: B. Collect data on Enrollee and Provider characteristics, and on services furnished to Enrollees; C. Ensure that data received from Providers is accurate and complete by: (1) Verifying the accuracy and timeliness of reported data; (2) Screening or editing the data for completeness, logic, and consistency; and (3) Collecting service information in standardized formats to the extent feasible and appropriate. D. Make all collected data available to the STATE and CMS upon request. E. Must implement Application Programming Interfaces (e.g. Enrollee Data API; Provider Directory API; Payer-to-Payer Data Exchange) according to the Implementation Guides and other CMS guidance. 4	Met	**HEDIS Audit Reports submitted for review for years:** 2021 Attest Health Care Advisors 2020 Attest Health Care Advisors 2019 Attest Health Care Advisors Final Audit Statement includes: *South Country Health Alliance's submitted measures were prepared according to the HEDIS Technical Specifications and present fairly, in all material respects, the organization's performance with respect to these specifications.*

2 Families and Children MA, Seniors and SNBC Contract Section 7.1.3 and its sub-sections

3 [Families and Children MA: SSA 1904(r)(1); Seniors, SNBC: SSA §1903(r)(7)]; 42 CFR §438.242; APIs: 42 CFR §§431.60 and 431.70

4 CMS guidance: *https://www.cms.gov/Regulations-and-Guidance/Guidance/Interoperability/index.*

DHS Contractual Element and References	Met or Not Met	Audit Comments
As a proxy measure, during each of the past three years, all MCO MDH annual HEDIS performance measures have been certified reportable by an NCQA HEDIS audit.		

III. Utilization Management - 2022 Contract Section 7.1.4

The MCO shall adopt a utilization management structure consistent with state and federal regulations and 2022 NCQA "*Standards and Guidelines for the Accreditation of Health Plans*." Pursuant to 42 CFR § 438.330(b)(3), this structure must include an effective mechanism and written description to detect both under- and over-utilization of services.

A. Ensuring Appropriate Utilization

TCA Utilization Management Data Grid for Under/Over Utilization

DHS Contractual Element and References	Met or Not Met	Audit Comments
The MCO shall facilitate the delivery of appropriate care and monitor the impact of its utilization management program to detect and correct potential under and over utilization. The MCO shall submit to the STATE upon request a written report that includes performance measurement data summarizing identified under-utilization and over-utilization of services. The MCO Shall: 1. Choose the appropriate number of relevant types of utilization data, including one type related to behavioral health to monitor.	**Met**	1. Appropriate types of utilization data collected Inpatient Hospital Admissions Inpatient Psych Hospital Admissions Emergency Department Visits MH/SUD Outpatient Utilization Inpatient LOS Telehealth/E-Visits
The MCO Shall: 2. Set thresholds for the selected types of utilization data and annually quantitatively analyze the data against the established thresholds to detect under and overutilization.	**Met**	UM Summary states**:** *Thresholds for selected data are established by the UM Committee or Medical Director based on one or more of the following current data, regional norms, NCQA published thresholds or other published documents.* UM Committee minutes are more specific in that they indicate UM review monitors for excessive variation from the average with a comparison of Family & Children, Seniors and SNBC and control limits of +/-2 standard deviations from average. **Recommendation:** SCHA may want to be more specific in its UM summary to clarify what stimulates further review by the UM committee.

DHS Contractual Element and References	Met or Not Met	Audit Comments
The MCO Shall: 3. Examine possible explanations for all data not within thresholds.	**Met**	
The MCO Shall: 4. Analyze data not within threshold by medical group or practice.	**Met**	
The MCO Shall: 5. Take action to address identified problems of under or overutilization and measure the effectiveness of its interventions.[5]	**Met**	

5 42 CFR 438.330(b)(3)

B. 2022 NCQA Standards and Guidelines UM 1 – 4, 10 – 11; UM 13

The following are the 2022 NCQA Standards and Guidelines for the Accreditation of Health Plans UM 1 – 4 and 10 – 11, and UM 13, effective July 1, 2022.

TCA Utilization Management Data Grid for NCQA Standards

DHS Contractual Element and References	Met or Not Met	Audit Comments
NCQA Standard UM 1: Utilization Management Structure The following are the current NCQA Standards and guidelines for the Accreditation of Health Plans UM 1-4 and 1-13.: The organization clearly defines the structures and processes and assigns responsibility to appropriate individuals.		
Element A: Written Program Description	**Met**	
Element B: Annual Evaluation	**Met**	
NCQA Standard UM 2: Clinical Criteria for UM Decision The organization uses written criteria based on sound clinical evidence and specifies procedures for appropriately applying the criteria.		
Element A: UM Criteria	**Met**	
Element B: Availability of Criteria	**Met**	
Element C: Consistency of Applying Criteria	**Met**	
NCQA Standard UM 3: Communication Services The organization provides access to staff for members and practitioners seeking information about the UM process and the authorization of care. Element A: Access to Staff	**Met**	
NCQA Standard UM 4: Appropriate Professionals		

DHS Contractual Element and References	Met or Not Met	Audit Comments
Qualified Licensed health professionals assess the clinical information used to support UM decisions. Element A: Licensed Health Professionals	**Met**	
Element B: Use of Practitioners for UM Decisions	**Met**	
Element C: Practitioner Review of Non-Behavioral Healthcare Denials	**Met**	
Element D: Practitioner Review of Behavioral Healthcare Denials	**Met**	
Element E: Practitioner Review of Pharmacy Denials	**Met**	
Element F: Use of Board-Certified Consultants	**Met**	
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	**Met**	
Element B: Description of Evaluation Process	**Met**	
NCQA Standard UM 11: Procedures for Pharmaceutical Management The organization ensures that its procedures for pharmaceutical management, if any, promote the clinically appropriate use of pharmaceuticals Element A: Pharmaceutical Management Policies and Procedures	**Met**	
Element B: Pharmaceutical Restrictions/Preferences	**Met**	
Element C: Pharmaceutical Patient Safety Issues	**Met**	

DHS Contractual Element and References	Met or Not Met	Audit Comments
Element D: Reviewing and Updating Procedures	**Met**	
Element E: Considering Exceptions	**Met**	
NCQA Standard UM 13: Delegation of UM If the organization delegates UM activities, there is evidence of oversight of the delegated activities. Element A: Delegation Agreement	**Met**	
Element B: Pre-delegation Evaluation	**Met**	
Element C: Review of the UM Program	**Met**	
Element D: Opportunities for Improvement	**Met**	

IV. Special Health Care Needs – 2022 Contract Section 7.1.5 (1-4)[6, 7]

The MCO must have effective mechanisms to assess the quality and appropriateness of care furnished to Enrollees with special health care needs.

Special Health Care Needs Data Grid

DHS Contractual Element and References	Met or Not Met	Audit Comments
A. Mechanisms to identify persons with special health care needs[8] The MCO must have effective mechanisms to assess the quality and appropriateness of care furnished to Enrollees with special health care needs. If the MCO has in place an alternative mechanism(s) or is proposing a new mechanism(s) that meets or exceeds the requirements of section 7.1.5.1[9], the MCO must submit a written description to the STATE for approval. If the MCO's mechanism(s) have been approved by the STATE and there has been a material change, the MCO must timely submit a revised description to the STATE for approval (see also section 3.11.4)[10] 7.1.5.1 **Mechanism to Identify Persons with Special Health Care Needs**. The MCO must identify Enrollees that may need additional services through method(s) approved by the STATE.	**Met**	

6 42 CFR 438.330 (b)(4)
7 Families and Children MA, Seniors MSHO, MSC+ Contract section 7.1.5 (1-4); SNBC Contract section 7.1.5 (1-4)
8 The definition of special health care needs is different among the three contracts. For MSHO/MSC+ and SNBC, all enrollees are considered to have special health care needs.
9 Section 7.1.5 for Seniors and SNBC contracts; (pursuant to sections 6.1.4, 6.1.5, 6.1.6 of Seniors and 6.1.4, 6.1.5.4 of SNBC contracts)
10 Sections 3.13.5 of the 2022 Seniors and3.14.4 of the 2022 SNBC Contracts

DHS Contractual Element and References	Met or Not Met	Audit Comments
(1) The MCO must analyze claim data for diagnoses and utilization patterns (both under- and over-utilization) to identify Enrollees who may have special health care needs. At a minimum the MCO must quarterly analyze claim data to identify Enrollees eighteen (18) years and older for the following: a. Prevention Quality Indicators as described in the "*Guide to Prevention Quality Indicators: Hospital Admission for Ambulatory Care Sensitive Conditions*" by AHRQ for bacterial pneumonia, dehydration, urinary tract infection, adult asthma, congestive heart failure, hypertension and chronic pulmonary disease; b. Hospital emergency department utilization as determined by the MCO; c. Inpatient utilization stays for the MCO's identified key Minnesota Health Care Program diagnoses or diagnoses clusters; d. Hospital readmission for the same or similar diagnoses as defined by the MCO within a timeframe specified by the MCO; e. Individual Enrollee claims totaling more than one hundred thousand dollars ($100,000) per year; and f. Home Care Services utilization as determined by the MCO.		
(2) In addition to claims data, the MCO may use other methods, such as: 1) health risk assessment surveys. 2) performance measures. 3) medical record reviews. 4) Enrollees receiving PCA services. 5) requests for Service Authorizations; and/or 6) Other methods developed by the MCO or its Network Providers.	Met	
B. Assessment of enrollees identified, (Senior and SNBC Contract – care plan) and 7.1.5.2 **Assessment of Enrollees Identified**. The MCO must implement mechanisms to assess Enrollees identified and monitor the treatment plan set forth by the MCO's treatment team, as applicable. The assessment must utilize appropriate Health Care	Met	

DHS Contractual Element and References	Met or Not Met	Audit Comments
Professionals to identify any ongoing special conditions of the Enrollee that require a course of treatment or regular care monitoring.		
7.1.5.3 **Access to Specialists**. If the assessment determines the need for a course of treatment or regular care monitoring, the MCO must have a mechanism in place to allow Enrollees to directly access a specialist as appropriate for the Enrollee's condition and identified needs. [Minnesota Statutes, §62Q.58]	**Met**	
7.1.5.4 **Annual Reporting to the STATE**. The MCO shall incorporate into, or include as an addendum to, the MCO's Annual Quality Assessment and Performance Improvement Program Evaluation (as required in section 7.1.8) a Special Health Care Needs summary describing efforts to identify Enrollees that may need additional services and the following items: (1) The number of Adults identified in section 7.1.4(A) with special health care needs; (2) The annual number of assessments completed by the MCO or referrals for assessments completed; and (3) If the MCO adds the information in this section as an addendum, the addendum must include an evaluation of items 7.1.5.1 through 7.1.5.3.	**Met**	

V. Practice Guidelines -2022 Contract Section 7.1.6 (1–3) [11]

The MCO shall adopt, disseminate and apply practice guidelines consistent with current NCQA "*Standards and Guidelines for the Accreditation of Health Plans,*" QI 7 Clinical Practice Guidelines.

Practice Guidelines Data Grid

DHS Contractual Element and References	Met or Not Met	Audit Comments
Element A: Adoption of practice guidelines. The MCO shall adopt, disseminate, and apply practice guidelines, as required by 42 CFR §438.236. 7.1.6.1 **Adoption of Practice Guidelines**. The MCO shall adopt guidelines that: 1) are based valid and reliable clinical evidence or a consensus of Health Care Professionals in the particular field; 2) consider the needs of the MCO Enrollees; 3) are adopted in consultation with contracting Health Care Professionals; and 4) are reviewed and updated periodically as appropriate;	**Met**	
7.1.6.2 The MCO shall ensure that guidelines are disseminated to all affected Providers and, upon request, to Enrollees and Potential Enrollees;	**Met**	
7.1.6.3 **Application of Guidelines**. The MCO shall ensure that these guidelines are applied to decisions for utilization management, Enrollee education, coverage of services, and other areas to which there is application and consistency with the guidelines.	**Met**	

11 Families and Children MA, Seniors (MSHO/MSC+), and SNBC Contract Section 7.1.6 and the sub-sections.

VI. Annual Quality Assurance Work Plan – 2022 Contract Section 7.1.7

On or before May 1st of the contract year, The MCO shall provide the STATE with an annual written work plan that details the MCO's proposed quality assurance and performance improvement projects for the year. This report shall follow the guidelines and specifications contained in Minnesota Rules, part 4685.1130, subpart 2, and current NCQA "*Standards and Guidelines for the Accreditation of Health Plans."*

Annual Quality Assurance Work Plan Data Grid

DHS Contractual Element and References	Met or Not Met	Audit Comments
A. The MCO shall provide the STATE with an annual written work plan that details the MCO's proposed quality assurance and performance improvement projects for the year. This report shall follow the guidelines and specifications contained in Minnesota Rules, part 4685.1130, subpart 2, and 2022 NCQA "*Standards and Guidelines for the Accreditation of Health Plans.*" If the MCO chooses to substantively amend, modify or update its work plan at any time during the year, it shall provide the STATE with material amendments, modifications or updates in a timely manner. (*See also section 3.11.4)*[12]	**Met**	
A. Current NCQA "*Standards and Guidelines for the Accreditation of Health Plans.*" **NCQA QI 1, Element B:** An annual work plan that reflects ongoing progress on QI activities throughout the year and addresses: (1) Yearly planned QI activities and objectives for improving: • Quality of clinical care • Safety of clinical care • Quality of service • Members' experience (2) Time frame for each activity's completion (3) Staff members responsible for each activity (4) Monitoring of previously identified issues	**Met**	

12 Sections 3.13.5 of the 2022 Seniors and 3.14.4 of the 2022 SNBC Contracts.

DHS Contractual Element and References	Met or Not Met	Audit Comments
(5) Evaluation of the QI program		

VII. Annual Quality Assessment and Performance Improvement Program Evaluation – 2022 Contract Section 7.1.8 [13] [14]

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

Annual Quality Assessment and Performance Improvement Program Evaluation Data Grid

DHS Contractual Element and References	Met or Not Met	Audit Comments
A. 7.1.8 Annual Quality Assessment and Performance Improvement Program 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: Organization-specific data, CHAPS, HEDIS®) and ii. MCO's performance improvement projects.	**Met**	
NCQA QI 1, Element C: Annual Evaluation The organization conducts an annual written evaluation of the QI program that includes the following information: 1. A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service.	**Met**	

13 42 CFR 438.330(b), (d); Families and Children MA, Seniors and SNBC Contract Section 7.1.8 and the sub-section 7.1.8.1

14 MSHO/MSC+ Contract Section 7.1.8 also includes the requirement that the MCO must include the "*Quality Framework for the Elderly Waiver*" in its Annual Evaluation

DHS Contractual Element and References	Met or Not Met	Audit Comments
2. Trending of measures to assess performance in the quality and safety of clinical care and quality of services.	**Met**	
3. Analysis and evaluation of the overall effectiveness of the QI program and of its progress toward influencing network-wide safe clinical practices.	**Met**	

VIII. Performance Improvement Projects-2022 Contract Section 7.2, 7.2.1(1-2)[15, 16, 17]

The MCO must conduct PIPs designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and Enrollee satisfaction. Projects must comply with 42 CFR § 438.30(b)(1) and (d) and CMS protocol entitled *"CMS External Quality Review (EQR) Protocols, October 2019".* The MCO is encouraged to participate in PIP collaborative initiatives that coordinate PIP topics and designs between MCOs.

Performance Improvement Projects Data Grid

DHS Contractual Element and References	Met or Not Met	Audit Comments
7.2.1 New Performance Improvement Project Proposal. In 2018, the STATE selected the Preventing Chronic Opioid Use topic for the PIP to be conducted over a three-year period (calendar years 2018, 2019, and 2020). The PIP must be consistent with CMS' published protocol entitled "Protocol for Use in Conducting Medicaid External Quality Review Activities: Conducting Performance Improvement Projects," STATE requirements, and include steps one through seven of the CMS protocol.	**Met**	

15 §438.330(b)(1), §438.330(d); Contract Section 7.2 and its sub-sections

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

17 For SNBC contract only: additionally sections 7.2.2 (and its sub-sections) and 7.2.3

DHS Contractual Element and References	Met or Not Met	Audit Comments
7.2.1.1 The MCO shall provide annual PIP progress reports to the STATE. For the 2018-2020 PIPs, the second interim report is due September 1, 2020. **7.2.1.2** For the 2018-2020 PIPs, the final report will be due September 1, 2021.	**Met**	
PIP Proposal and PIP Interim Report Validation Sheets. DHS uses these tools to review and validate MCOs' PIP proposals and annual status reports.	**Met**	

IX. Population Health Management (PHM) - 2022 Contract Section 7.3 (7.3.1-7.3.4)[18]

The MCO shall create and report annually to the STATE a Population Health Management Strategy or any amendment to the original PHM strategy by July, 31 of the contract year, including structure and processes to maintain and improve health care quality, and measures in place to evaluate plan MCO's performance on its process outcomes (for example, clinical care, or Enrollee experience of care). The MCO must inform the STATE within thirty (30) days if the MCO makes a modification to its PHM Strategy, consistent with section 3.11.4, [19]Service Delivery Plan.

Population Health Management Data Grid

DHS Contractual Element and References	Met or Not Met	Audit Comments
7.3.1 **Population Health Management (PHM) Strategy The MCO's PHM Strategy shall be consistent with 2022 NCQA "*Standards and Guidelines for the Accreditation of Health Plans*" pursuant to the 2022 Standards for Population Health Management (PHM).** The MCO must inform the STATE within thirty (30) days if the MCO makes a modification to its PHM Strategy, consistent with section 3.11.4, Service Delivery Plan; and At a minimum, the comprehensive PHM Strategy shall describe: (1) Measurable goals and populations targeted for each of the four areas of focus.	**Met**	**FOCUS 1**: Keeping Members Healthy **Goal** **Increase the number of members, age 18 plus, all products, accessing the Ex-Program services by 0.06% (14 members annually) over three years.** The past performance level for all products was: 2018 (28 members), 2019 (6 members). **Goal** **Increase the number of members, age 18+ on AbilityCare, SingleCare, SharedCare, MSC+ and SeniorCare Complete, utilizing the *BeActive* program by 0.64% (35 members annually) over three years. The past performance level** for all products was: 2018 (141 members)

18 Families and Children MA and Seniors (MSHO/MSC+) contract sections 7.3.1 and 7.3.4 (and its sub-sections); SNBC contract sections 7.3.1, 7.3.2 (and its sub-sections), 7.3.3, 7.3.4, and 7.3.5.

19 Service Delivery Plan: Sections 3.13.5 of the 2022 Seniors and 3.14 of the SNBC Contracts.

DHS Contractual Element and References	Met or Not Met	Audit Comments
(2) Programs and services offered to members for each area of focus; (3) At least one activity that is not direct member intervention (an activity may apply to more than one area of focus); (4) How member programs are coordinated across potential settings, Providers, and levels of care to minimize the confusion for Enrollees being contacted from multiple sources (coordination activities may apply across the continuum of care and to other organization initiatives); and (5) How Enrollees are informed about available PHM programs and services (for example, by interactive contact and/or distribution of materials). (6) How MCO promotes health equity[20] (strategy that describes MCO's commitment to improving health equity and the actions it takes to promote equity in management of member care). A. The PHM Strategy shall include the following areas of focus: a. Keeping Enrollees healthy, b. Managing Enrollees with emerging risk, c. Patient safety or outcomes across settings, and d. Managing multiple chronic illnesses		**FOCUS 2: Managing Members with Emerging Risk** **Goal** Increase the percentage of members, **18-85 years** of age on **products offering care coordination,** who have a diagnosis of hypertension, who have adequately controlled (<140/90 mm Hg) their blood pressure during the year. We would measure this goal successful by improving our **top rate by 3.15% over three years. The past performance level** for all products was: 2017 (64.46%), 2018 (70.91%), 2019 (61.57%) **FOCUS 3: Patient safety or outcomes across settings** **Goal** Increase the percentage of members receiving outpatient mental health services during the year. We would measure this goal successful by improving our **top rate of visits by .56% rate increase over three years. The past performance level** for all products was: 2017 (18.9%), 2018 (20.2%), 2019 (21.5). **Goal** Increase the percentage of members receiving follow-up after hospitalization (specifically for mental illness) within 30 days of discharge. We would measure this goal successful by improving our **top rate of visits by rate increase over three years. The past performance level** for all products was: 2017 (71.57%) 2018 (65.99%) 2019 (67.69%) **Goal** Support members through reducing their Emergency Department (ED) visits related to behavioral health diagnoses, including a diagnosis of depression. We would measure this goal successful by reducing the target populations **rate ED visits by 0.15% annually over three years. The past performance level** for all products was: 2017 (0.086%), 2018 (0.114%) 2019 (3.095%)

20 **Health Equity**: The World Health Organization defines health equity as "the absence of unfair and avoidable or remediable differences in health among population groups defined socially, economically, demographically or geographically."

DHS Contractual Element and References	Met or Not Met	Audit Comments
		FOCUS 4: Managing multiple chronic illnesses **Goal** Increase the percentage of members 18 years of age and older, on PMAP/MNCare products, who were treated **with a newly prescribed anti-depressant medication and who remained on an anti-depressant medication acute phase treatment (at least 84 days).** We would measure this goal successful by improving our top rate of compliance by 4.60% over three years. **The past performance level** for all products was: 2017 (65.99%), 2018 (61.98%), 2019 (60.8%) **Goal** Increase the percentage of members 18 years of age and older, on PMAP/MNCare products, who were treated **with a prescribed anti-depressant medication and who remained on an anti-depressant medication treatment for at least 180 days (continuation phase treatment)** and has at least one other chronic condition**.** We would measure this goal successful by improving our top rate of compliance by 5.07% over three years. **The past performance level** for all products was: 2017 (52.2%), 2018 (46.4%), 2019 (45.9%)
Current NCQA *Standards and Guidelines for the Accreditation of Health Plan* for PHM. B. The following are the 2022 NCQA Standards and Guidelines for the Accreditation of Health Plans Population Health Management (PHM) 1 – 7 and all Factors. **NCQA Standard PHM 1: PHM Strategy** The organization outlines its PHM strategy for meeting the care needs of its member population. **Element A: PHM Strategy Description**	**Met**	**Business Requirements Document** **Population Health Management** Effective 04/12/2021
Element B: Informing Members Factor 1: How members become eligible to participate	**Met**	Members are welcome to self-refer from information they find on our website/Facebook, or they are identified through our reporting (claims) efforts and invited to join a program via telephonic, mailed outreach, or care coordination services.
Factor 2: How to use program services	**Met**	This is defined in program welcome letters to the member

DHS Contractual Element and References	Met or Not Met	Audit Comments
Factor 3: How to opt in or opt out of the program	**Met**	The option to opt-in/out of the program is provided via mailed correspondence/or via phone calls offering the program
NCQA Standard PHM 2: Population Identification. The organization systematically collects, integrates and assesses member data to inform its population health management programs (e.g., documented process, reports, materials). Element A: Data Integration	**Met**	
Element B: Population Assessment	**Met**	
Element C: Activities and Resources	**Met**	
Element D: Segmentation (e.g., population segmentation, risk stratification).	**Met**	
NCQA Standard PHM 3: Delivery System Supports The organization describes how it supports the delivery system, patient-centered medical homes and use of value-based payment arrangements. Element A: Practitioner or Provider Support	**Met**	
Element B: Value-Based Payment Arrangements	**Met**	Nursing Home VBP arrangement (New Ulm Medical Center, Allina and MCHS) – PMPM to support a nurse practitioner to provide care in the nursing facility
NCQA Standard PHM 4: Wellness and Prevention The organization offers wellness services focused on preventing illness and injury, promoting health and productivity, and reducing risk. Element A: Frequency of Health Appraisal Completion	**Met**	
Element B: Topics of Self-Management Tools Factor 1: Healthy weight (BMI) maintenance	**Met**	

DHS Contractual Element and References	Met or Not Met	Audit Comments
Factor 2: Smoking and tobacco use cessation Factor 3: Encouraging physical activity Factor 4: Eating healthy Factor 5: Managing stress Factor 6: Avoiding at-risk drinking Factor 7: Identifying depressive symptoms		
NCQA Standard PHM 5: *Complex Case Management* The organization coordinates services for its highest risk members with complex conditions and helps them access needed resources. Element A: Access to Case Management	**Met**	**established Standard Operating Procedure** Complex Case Management (CM 21) Policy reviewed for PHM 5
Element B: Case Management Systems	**Met**	
Element C: Case Management Process	**Met**	
Element D: Initial Assessment	**Met**	
Element E: Case Management: Ongoing Management	**Met**	
NCQA Standard PHM 6: PHM Impact[21] The organization annually measures the effectiveness of its PHM Strategy and has a systematic process to evaluate whether it has achieved its goals and to gain insights into area needing improvement. The organization uses results from the PHM Impact analysis to annually identify opportunities for improvement. Element A: Measuring Effectiveness Factor 1: Quantitative results for relevant clinical, cost/utilization and experience measure (not CHAPS) Factor 2: Comparison of results with a benchmark or goal	**Met**	

21 A comprehensive analysis of the impact of its PHM strategy in consecutive years

DHS Contractual Element and References	Met or Not Met	Audit Comments
Factor 3: Interpretation of results / actions		
Element B: **Improvement and Action**	**Met**	
NCQA Standard PHM 7: *Delegation of PHM* If the organization delegates PHM activities, there is evidence of oversight of the delegated activities. Element A: Delegation Agreement	**N/A**	The organization has a Delegation Agreement with partner counties. These agreements include oversight of the Population Health Management function of assessing (providing assessments) to our senior and disability populations (SeniorCare Complete, MSC+, SNBC**).**
Element B: Pre-delegation Evaluation	**N/A**	
Element C: Review of the PHM Program	**N/A**	
Element D: Opportunities for Improvement	**N/A**	
7.3.2 PHM Reporting: 7.3.2.1: The MCO shall annually describe its methodology for segmenting or stratifying its Enrollee population, including the subsets to which Enrollees are assigned (for example, high risk pregnancy) and provide to the STATE a report specifying the following: (1) Number of Enrollees in each category and (2) Number of programs or services for which these Enrollees are eligible; and	**N/A**	REVIEWED DHS REPORT Population Health Management Impact Analysis
7.3.2.2: The MCO shall annually report to the STATE a comprehensive analysis of the impact of its PHM strategy that includes at least the following factors: (1) Quantitative results for relevant: a. Clinical measures (outcome or process measures); b. Cost of care or utilization measures; and *c.* Enrollee experience measures (for example, complaints or Enrollee feedback, using focus group or a satisfaction survey).	**Met**	
(2) Comparison of results, including with a benchmark or goal;	**N/A**	

DHS Contractual Element and References	Met or Not Met	Audit Comments
(3) Interpretation of results, including interpretation of measures; and	**N/A**	
(4) The Impact Analysis report is due by July, 31 of the contract year.	**N/A**	
7.3.3 If the MCO chooses to delegate its PHM activities, the MCO shall provide to the STATE a comprehensive description of the structure and mechanism to oversee delegated PHM activities. This report is due July 31 of the contract year and must be completed again at any time the MCO changes any of its PHM delegations. **7.3.4** The MCO shall continue to offer case management services to the most complex, highest risk Enrollees.	**N/A**	

X. Advance Directives Compliance - 2022 Contract Section Article 14 (14.1-14.5)[22, 23]

The MCO agrees to provide all Enrollees at the time of enrollment a written description of applicable State law on Advance Directives and the following:

Advance Directives Compliance Data Grid

22 Families and Children MA, MSHO/MSC+ and SNBC Contract Article 14, sections 14.1 – 14.5.
23 Pursuant to 42 U.S.C. 1396a(a)(57) and (58), 42 C.F.R. 489.100-104 and 42 CFR §438.3(j); (referring to 42 C.F.R. 422.128)

DHS Contractual Element and References	Met or Not Met	Audit Comments
1. Enrollee Information. 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;	**Met**	
B. Written policies of the MCO respecting the implementation of the right;	**Met**	
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; and	**Met**	
D. Information that complaints concerning noncompliance with the Advance Directive requirement may be filed with the State survey and certification agency (i.e. Minnesota Department of Health), pursuant to 42 CFR 422.128 as required in 42 FR 438.(3)(i).	**Met**	
2. Providers Documentation. To require MCO's Primary Care Providers; hospitals, critical access hospitals, skilled nursing facilities, nursing facilities, home health agencies, providers of home health care (and for Medicaid purposes, providers of personal care services), and hospices to ensure that it has been documented in the enrollee's medical records whether or not an individual has executed an Advance Directive.	**Met**	See table below for compliance
3. Treatment. To not condition treatment or otherwise discriminate on the basis of whether an individual has executed an advance directive.	**Met**	
4. Compliance with State Law. To comply with State law, whether statutory or recognized by the courts of the State on Advance Directives, including Minnesota Statutes Chapters 145B and 145C.	**Met**	
5. Education. To provide, individually or with others, education for MCO staff, providers, and the community on Advance Directives.	**Met**	

Primary Care Medical Record Review Follow-up from 2020 completed in 2021

Total Primary Care Providers re-evaluated	2020 Section E Advance Directives	2020 Section E Advance Directives re-evaluated 2021	Decrease from 2020 results re-evaluated in 2021
10	**31%**	**24%**	**7%**

XI. Validation of MCO Care Plan Audits for MSHO and MSC+: Article 6, Seniors Contract Sections 7.1.5.4, 7.8.3, 7.8.4)[24]

MDH will collect information for DHS to monitor MCO Care Plan Audit activities as outlined in the DHS/MCO MSHO/MSC+ Contract.

Validation of MSHO and MSC Care Plan Audits Data Grid

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

24 Pursuant to MSHO/MSC+ 2021 Contract Sections Article 6 (6.1.4, 6.1.5), 7.1.5.4, 7.8.3, and 7.8.4

XII. Subcontractors (Including Pharmacy Benefit Managers) – 2022 Contract Sections 9.2 (and its subsections) and 9.5.4 [25]

1. Written Agreement; Disclosures

All subcontracts must be current, in writing, fully executed, 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:

Written Agreement and Disclosures Data Grid

DHS Contractual Element and References	Met or Not Met	Audit Comments
A. Disclosure of Ownership and Management Information (Subcontractors). In order to assure compliance with 42 CFR § 455.104, the MCO, before entering into or renewing a contract with a subcontractor, must request the following information: (1) The name, address, date of birth, social security number (in the case of an individual), and tax identification number (in the case of a corporation) of each Person, with an Ownership or Control Interest in the disclosing entity or in any subcontractor in which the disclosing entity has direct or indirect ownership of five percent (5%) or more. The address for corporate entities	**Met**	

25 Families and Children MA, Seniors and SNBC Contract Sections 9.2 (and subsections) and 9.5.4 (Families and Children MA); 9.5.2 (Seniors and SNBC) Contracts

DHS Contractual Element and References	Met or Not Met	Audit Comments
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 9.5.1.1 is related (if an individual) to any other Person with an Ownership or Control Interest as spouse, parent, child, or sibling;	**Met**	
(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;	**Met**	
(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 9.5.4 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. The letter should identify all databases that were included in the review. A data certification pursuant to section 11.6 is required with this assurance; and	**Met**	
(7) Upon request, subcontractors must report to the MCO information related to business transactions. Subcontractors must be able to submit this information to the MCO within fifteen (15) days of the date of a written request from the STATE or CMS. The MCO must report the information to the STATE within ten (10) days of the MCO's receipt from the subcontractor.	**Met**	
B. Written Agreements: All subcontracts must be current, in writing, fully executed, 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:	**Met**	

DHS Contractual Element and References	Met or Not Met	Audit Comments
1.MCO subcontracts that include delegation of program integrity responsibilities must require Subcontractors to comply with program integrity obligations under state and federal law and sections 9.4.1 [26]and 9.2.1.1 of this contract. If an MCO engages with a subcontractor and does not delegate its program integrity responsibilities to the subcontractor, the MCO shall remain responsible for all program integrity responsibilities under state and federal law and section 9.4.1.1 with respect to the Subcontractor's services.		
2. Current and fully executed agreements for all subcontractors, including bargaining groups, must be maintained for all administrative services that are expensed to MHCP. Subcontractor agreements determined to be material, as defined by the STATE, must be in the form of a written instrument or electronic document containing the elements of offer, acceptance, consideration, payment terms, scope, duration of the contract, and how the subcontractor services relate to MHCP. [Minnesota Statutes, §256B.69, subd. 5a]	**Met**	
3. Upon request, the STATE shall have access to all subcontractor documentation under this section.	**Met**	
4. Nothing in this section shall allow release of information that is nonpublic data pursuant to section Minnesota Statutes, §13.02.	**Met**	

26 SNBC contract sections 9.9.1 and 9.9.1

2. Exclusions of Individuals and Entities; Confirming Identity – 2022 Contract Sections 9.5.1 , 9.2.5, and Article 15 (15.1)[27] [28]

Exclusion of Individuals Data Grid

DHS Contractual Element and References	Met or Not Met	Audit Comments
(A) Exclusions of Individuals and Entities; Confirming Identity (1) 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, or an affiliate upon contract execution or renewal and credentialing, through routine checks of state and Federal databases. The databases to be checked are the Social Security Administration's Death Master File and the National Plan and Provider Enumeration System (NPPES), and the Excluded Provider Lists maintained by the STATE.	**Met**	
(2) 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), and the Excluded Provider Lists maintained by the STATE, 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 by the STATE nor under §§ 1128 or 1128A of the Social Security Act; and	**Met**	

27 Families and Children, Seniors and SNBC Contract Sections 9.10.1 (and subsections); 9.3.6; Article 15 (15.1)

28 42 CFR §438.610 referring to 48 CFR §2.101; 42 CFR §455.436; Minnesota Statutes, §256B.064, subd. 3

DHS Contractual Element and References	Met or Not Met	Audit Comments
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. [42 CFR §§455.436; 438.602(d); 438.610]		
(3) 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**	
(4) 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 services program, or that have been excluded from participation in Medicaid under §§ 1128 or 1128A of the Social Security Act.	**Met**	
(5) The MCO shall report any excluded Provider to the STATE within seven (7) days of the date the MCO receives the information, or determines that a Network Provider, Person with an Ownership or Control Interest of a Network Provider, agent or managing Employee of the MCO, Subcontractor or affiliate has become excluded or the MCO has inadvertently contracted with an excluded Provider.	**Met**	
(6) In addition to complying with the provisions of section 9.4, 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**	
(B) The MCO shall ensure that its Subcontractors that provide Priority Services have in place a written Business Continuity Plan (BCP) that complies with the requirements of **Article. 15.**	**Met**	

Attachment A: MDH 2022 Elderly Waiver (EW) Care Plan Audit

Audit Protocol	Product Description	2022 MDH Audit Initial Charts Met	2022 MDH Audit Reassessment Charts Met	2022 MDH Audit Total % Charts Met	2021 Total SCHA Audit 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%	
2 **ANNUAL HEALTH RISK ASSESSMENT**	Been a member of the MCO for > 12 months [Only for plans with separate HRA]	8/8	8/8	100%	
3 **LONG TERM CARE CONSULTATION – INITIAL**	If member is new to EW in the past 12 months, an LTCC assessment completed within required timelines.	8/8	N/A	100%	
4 **REASSESSMENT OF EW**	For members open to EW who have been a member of the MCO for more than 12 months, an LTCC completed within 365 days or prior assessment.	N/A	8/8	100%	
5 **PERSON-CENTERED PLANNING**	Opportunities for choice in the person's current environment are described	8/8	8/8	100%	
PERSON-CENTERED PLANNING	Current rituals and routines are described (quality, predictability, preferences)	8/8	8/8	100%	
PERSON-CENTERED PLANNING	Social, leisure, or religious activities the person wants to participate in are described. The person's decision about employment/volunteer opportunities has been documented	8/8	8/8	100%	

Audit Protocol	Product Description	2022 MDH Audit Initial Charts Met	2022 MDH Audit Reassessment Charts Met	2022 MDH Audit Total % Charts Met	2021 Total SCHA Audit Charts % Met
6 **COMPREHENSIVE CARE PLAN-TIMELINESS**	CCP is completed and sent to member with 30 calendar days of the date of a completed LTCC.	8/8	8/8	100%	
7 **COMPREHENSIVE CARE PLAN-IDENTIFIED NEEDS**	The CCP must have an interdisciplinary, holistic, and preventive focus. Enrollee's identified needs and concerns related to primary care, acute care, long-term care, mental and behavioral health, and social service needs and concerns are addressed. The need for services essential to the health and safety of the enrollee is documented. If essential services are included in the plan, a back-up plan for provision of essential services. There is a plan for community-wide disasters, such as weather-related conditions.	8/8	8/8	100%	
8 **COMPREHENSIVE CARE PLAN**	The enrollee's goals or skills to be achieved are included in the plan, related to enrollee's preferences and how enrollee wants to live their life. Goals and skills are clearly described, action steps describing what needs to be done to assist the person, plan for monitoring progress, target dates and outcome/achievement dates.	8/8	8/8	100%	
9 **COMPEREHENSIVE CARE PLAN-Choice**	Enrollee was given a choice between Home and Community-Based Services (HCBS) and Nursing Home Services (also indicates enrollee involvement in care planning). Information to enable choice among providers of HCBS.	8/8	8/8	100%	

Audit Protocol	Product Description	2022 MDH Audit Initial Charts Met	2022 MDH Audit Reassessment Charts Met	2022 MDH Audit Total % Charts Met	2021 Total SCHA Audit Charts % Met
10 **COMPREHENSIVE CARE PLAN-Safety Plan/Personal Risk Management Plan**	Identification of enrollee needs and concerns, including identification of health and safety risks, and what to do in the event of an emergency Goals and target dates identified Interventions identified Monitoring of outcomes and achievement dates are documented	8/8	8/8	100%	
11 **COMPREHENSIVE CARE PLAN-Informal and Formal Services**	Coordinated Services and Support Plan developed and contains at a minimum the type of services to be furnished, the amount, frequency, duration and cost of each service and the type of provider furnishing each service including non-paid caregivers and other informal community supports or resources	8/8	8/8	100%	
12 **CAREGIVER SUPPORT PLAN**	If a primary caregiver is identified in the LTCC. If interview completed then caregiver needs and supports incorporated into the care plan	8/8	8/8	100%	
13 **HOUSING AND TRANSITION**	For people who have been identified as having a transition, the enrollee has a transition plan to support housing choice. The LTCC assessment items relate to housing choices and support, and if enrollee indicates they want assistance in exploring housing options the transition plan reflects a goal, steps to be taken and potential barriers	8/8	8/8	100%	
14 **COMMUNICATIONS OF CARE PLAN/SUMMARY-Physician**	Evidence of care coordinator communication of care plan elements with Primary Care Physician (PCP)	8/8	8/8	100%	
15	The support plan is signed and dated by the enrollee or authorized representative	8/8	8/8	100%	

Audit Protocol	Product Description	2022 MDH Audit Initial Charts Met	2022 MDH Audit Reassessment Charts Met	2022 MDH Audit Total % Charts Met	2021 Total SCHA Audit Charts % Met
COMMUNICATION OF CARE PLAN/SUMMARY-Enrollee					
16 **COMPREHENSIVE CARE PLAN-Enrollee Requests for Updates**	The plan includes a method for the individual to request updates to the plan, as needed	8/8	8/8	100%	
17 **CARE COORDINATOR FOLLOW-UP PLAN**	Follow-up plan for contact plan related to identified concerns or needs, and plan is implemented	8/8	8/8	100%	
18 **ANNUAL PREVENTIVE HEALTH EXAM**	Documentation in enrollee's Comprehensive Care Plan substantiates a conversation was initiated	8/8	8/8	100%	
19 **ADVANCE DIRECTIVE**	Evidence that a discussion was initiated, enrollee refused to complete, was culturally inappropriate, or AD was completed	8/8	8/8	100%	
20 **APPEAL RIGHTS**	Appeal rights information provided to member	8/8	8/8	100%	
21 **DATA PRIVACY**	Data privacy information provided to member	8/8	8/8	100%	

Summary:

MDH received the EW audit sample lists from DHS per audit protocol. MDH reviewed 8 initial EW audits and 8 re-assessments. MDH EW Care Plan audit data span was the year 2022. SCHA EW audit results data span was from 1/1/2020 to 12/31/2020. MDH results showed 100% on all EW Care Plan Audit elements.