

Final Summary Report

TRIENNIAL COMPLIANCE ASSESSMENT

UCare

Performed under Interagency Agreement for Minnesota Department of Human Services

Exam Period: July 1, 2013 to November 30, 2015

File Review Period: December 1, 2014 to November 30, 2015

On-Site: March 14-18, 2016

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Triennial Compliance Assessment

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Executive Summary

Triennial Compliance Assessment (TCA)

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

TCA Process Overview

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

- The first step in the process is the collection and validation of the compliance information by MDH. MDH's desk review and on-site QA Examination includes the collection and validation of information on supplemental federal and public program compliance requirements. To facilitate this process the MCO is asked to provide documents as requested by MDH.
- DHS evaluates information collected by MDH to determine if the MCO has "met" or "not met" Contract requirements. The MCO will be furnished a Preliminary TCA Report to review DHS' initial "met/not met" determinations. At this point, the MCO has an opportunity to refute erroneous information but may not submit new or additional documentation. Ample time and opportunities are allowed during the QA Examination to submit documents, policies and procedures, or other information to demonstrate compliance. The MCO must refute erroneous TCA finding within 30 days. TCA challenges will be sent by the MCO to MDH. MDH will forward the MCO's TCA rebuttal comments to DHS for consideration.
- Before making a final determination on "not-met" compliance issues, DHS will consider TCA rebuttal comments by the MCO. DHS will then prepare a final TCA Report that will be sent to MDH and attached to the final QA Examination Report. As a result of attaching the final TCA Report to the QA Examination Report, greater public transparency will be achieved by not separating compliance information and requiring interested stakeholder to query two state agencies for managed care compliance information.
- The MCO will submit to MDH a corrective action plan (CAP) to correct not-met determinations. The MCO TCA CAP must be submitted to MDH within 30 days. If the MCO fails to submit a CAP, and/or address contractual obligation compliance failures, then financial penalties will be assessed.
- Follow-up on the MCO TCA CAP activities to address not-met issues by MDH. During the on-site MDH Mid-cycle QA Exam, MDH will follow-up on TCA not-met issues to ensure the MCO has corrected all issues addressed in the TCA Corrective Action Plan. CAP follow-up findings will be submitted to DHS for review and appropriate action will be initiated by DHS if needed.

DHS Triennial Compliance Assessment (TCA)
TCA Data Collection Grid
SFY 2016

Managed Care Organization (MCO)/County Based Purchaser (CBP): UCare

Examination Period: July 1, 2014 to November 30, 2015

Onsite Dates: March 14-18, 2016

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DHS Contractual Element and References	Met/ Not Met	Audit Comments
<p>1. QI Program Structure- 2015 Contract Section 7.1.1 The MCO must incorporate into its quality assessment and improvement program the standards as described in 42 CFR 438, Subpart D (access, structure and operations, and measurement and improvement).</p> <p><u>Access Standards</u> 42 CFR § 438.206 Availability of Services 42 CFR § 438.207 Assurances of Adequate Capacity and Services 42 CFR § 438.208 Coordination and Continuity of Care 42 CFR § 438.210 Coverage and Authorization of Services</p> <p><u>Structure and Operations Standards</u> 42 CFR § 438.214 Provider Selection 42 CFR § 438.218 Enrollee Information 42 CFR § 438.224 Confidentiality and Accuracy of Enrollee Records 42 CFR § 438.226 Enrollment and Disenrollment 42 CFR § 438.228 Grievance Systems 42 CFR § 438.230 Subcontractual Relationships and Delegation</p> <p><u>Measurement Improvement Standards</u> 42 CFR § 438.236 Practice Guidelines 42 CFR § 438.240 Quality Assessment and Performance Improvement Program 42 CFR § 438.242 Health Information System</p>	<p>Met</p>	<p>Approved by MDH June 2015</p>

DHS Contractual Element and References	Met/ Not Met	Audit Comments
<p>2. Accessibility of Providers -2015 MSHO/MSC+ Contract Section 6.1.4(C)(2) and 6.1.5(E)</p> <p>In accordance with the DHS/MCO managed care contracts for MSHO and MSC+, the MCO must demonstrate that it offers a range of choice among Waiver providers such that there is evidence of procedures for ensuring access to an adequate range of waiver and nursing facility services and for providing appropriate choices among nursing facilities and/or waiver services to meet the individual need as of Enrollees who are found to require a Nursing Facility Level of Care. 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. For purposes of this section, the word “assisting” includes, but is not limited to, discharge planning and care management responsibilities described in section 6.1.4(A)(2)</p>	<p>Met</p>	

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

DHS Contractual Element and References	Met/ Not Met	Audit Comments
<p>NCQA Standard UM 12: Emergency Services</p> <p>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>	Per NCQA	
<p>NCQA Standard UM 13: Procedures for Pharmaceutical Management</p> <p>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</p> <p>Element B: Pharmaceutical Restrictions/Preferences</p> <p>Element C: Pharmaceutical Patient Safety Issues</p> <p>Element D: Reviewing and Updating Procedures</p> <p>Element E: Considering Exceptions</p>	Per NCQA	
<p>NCQA Standard UM 14: Triage and Referral to Behavioral Health</p> <p>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.</p> <p><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>	Per NCQA	

DHS Contractual Element and References	Met/ Not Met	Audit Comments
<p>4. Special Health Care Needs 2015 Contract Section 7.1.4 A-C^{3, 4}</p> <p>The MCO must have effective mechanisms to assess the quality and appropriateness of care furnished to Enrollees with special health care needs.</p> <ul style="list-style-type: none"> A. Mechanisms to identify persons with special health care needs, B. Assessment of enrollees identified, (Senior and SNBC Contract – care plan) and C. Access to specialists 	Met	

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

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

DHS Contractual Element and References	Met/ Not Met	Audit Comments
<p>5. Practice Guidelines -2015 Contract Section 7.1.5^{5,6},</p> <p>A. The MCO shall adopt, disseminate and apply practice guidelines consistent with current NCQA “Standards and Guidelines for the Accreditation of Health Plans” QI 9 Clinical Practice Guidelines.</p> <p>i. <u>Adoption of practice guidelines.</u> The MCO shall adopt guidelines based on:</p> <ul style="list-style-type: none"> • Valid and reliable clinical evidence or a consensus of Health Care Professionals in the particular field • Consideration of the needs of the MCO enrollees • Guidelines being adopted in consultation with contracting Health Care Professionals • Guidelines being reviewed and updated periodically as appropriate. <p>ii. <u>Dissemination of guidelines.</u> MCO ensures guidelines are disseminated:</p> <ul style="list-style-type: none"> • To all affected Providers • To enrollees and potential enrollees upon request <p>iii. <u>Application of guidelines.</u> MCO ensures guidelines are applied to decisions for:</p> <ul style="list-style-type: none"> • Utilization management • Enrollee education • Coverage of services • Other areas to which there is application and consistency with the guidelines. 	<p>Met</p>	<p>UCare’s practice guidelines included in its evaluation included:</p> <ul style="list-style-type: none"> • Asthma, Diagnosis and Management • Diabetes, Type 2 Diagnosis and Management • Heart Failure in Adults • Obesity, Prevention and Management • Prenatal Care, Routine • Preventive Services for Adults • Preventive Services for Children and Adolescents • Prenatal Care <p>Guideline report in annual Quality Evaluation</p> <p>Utilizing admin data, results showed improvement in compliance in most guidelines tracked. UCare conducted a variety of activities aimed at improving provider and member compliance with guidelines through member and provider education, outreach, case management, and incentives</p> <ul style="list-style-type: none"> • In many areas UCare produces monthly action lists for providers that contain member information identifying who is and is not compliant with regard to the various measures identified as targets for that particular year’s Stars activities (including diabetes care measures). • Hold monthly meetings /discussions with providers to introduce measures and discuss improvement strategies. The intent is to positively impact member outcomes by helping providers identify those members that have not received the necessary testing/screenings/care based on the information available. UCare, and/or the provider, develop interventions such as call campaigns to educate members and encourage them to visit their medical provider for care and treatment.

⁵ 42 CFR 438.236

⁶ MSHO/MS+ Contract section 7.1.5 A-C; SNBC Contract section 7.1.5A-C

DHS Contractual Element and References	Met/ Not Met	Audit Comments
<p>6. Annual Quality Assessment and Performance Improvement Program Evaluation- 2015 Contract Sections 7.1.8 ^{7,8}</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"> i. Review the impact and effectiveness of the MCO’s quality assessment and performance improvement program ii. Include performance on standardized measures (example: HEDIS®) and iii. Include MCO’s performance improvement projects. <p>B. NCQA QI 1, Element B: There is an annual written evaluation of the QI Program that includes:</p> <ul style="list-style-type: none"> i. A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service ii. A trending of measures to assess performance in the quality and safety of clinical care and quality of services iii. Analysis and evaluation of the overall effectiveness of the QI program, including progress toward influencing network-wide-safe clinical practices 	<p>Met</p>	<p>Excellent summary of overall quality program and activities with recognition of “priority areas” in coming year. Good summary and use of tables in PIP projects and pointing out what member populations the PIP applied to</p>

⁷ 42 CFR 438.240(e)

⁸ MSHO/MSC+ Contract Section 7.1.8 also includes the requirement that the MCO must include the “Quality Framework for the Elderly” in its Annual Evaluation

DHS Contractual Element and References	Met/ Not Met	Audit Comments																																																												
<p>7. Performance Improvement Projects-2015 Contract Section 7.2^{9,10,11} The MCO must conduct PIPs designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and Enrollee satisfaction. Projects must comply with 42 CFR § 438.240(b)(1) and (d) and CMS protocol entitled <i>“Protocol for Use in Conducting Medicaid External Quality Review Activities: Conducting Performance Improvement Projects.”</i> The MCO is encouraged to participate in PIP collaborative initiatives that coordinate PIP topics and designs between MCOs.</p> <p>7.2.1 New Performance Improvement Project Proposal The STATE will select the topic for the new PIP to be conducted over the next three years (calendar years 2015, 2016 and 2017) and implemented by the end of the first quarter of calendar year 2015. The PIP must be consistent with CMS’ published protocol entitled <i>“Protocol for Use in Conducting Medicaid External Quality Review Activities: Conducting Performance Improvement Projects”</i>, STATE requirements, and include steps one through seven of the CMS protocol.</p> <p>A. 7.2.2 Annual PIP Status. Annual PIP Status Reports. The MCO shall submit by December 1st in calendar years 2015 and 2016, a written PIP status report in a format defined by the STATE.</p> <p>B. 7.2.3 Final Project Reports: Upon completion of the PIP the MCO shall submit to the STATE for review and approval a final written report by September 1st, 2018, in a format defined by the STATE.</p>	Met	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 35%;">PIPs/QIPs</th> <th style="width: 10%;">Final</th> <th style="width: 10%;">Interim</th> <th style="width: 10%;">New</th> <th style="width: 35%;">Products</th> </tr> </thead> <tbody> <tr> <td>2010 PIP Diabetes Management</td> <td style="text-align: center;">X</td> <td></td> <td></td> <td>MSHO, MSC+, SNBC, PMAP, MnCare</td> </tr> <tr> <td>2011 Collaborative PIP Colorectal CA Screening*</td> <td style="text-align: center;">X (closed 2013)</td> <td></td> <td></td> <td>PMAP, MnCare</td> </tr> <tr> <td>2011 Internal PIP Colorectal CA Screening*</td> <td style="text-align: center;">X (closed 2013)</td> <td></td> <td></td> <td>MSHO, MSC+, SNBC</td> </tr> <tr> <td>2012 Internal PIP Breast Cancer Screening*</td> <td style="text-align: center;">X (closed 2013)</td> <td></td> <td></td> <td>MSHO, MSC+, SNBC</td> </tr> <tr> <td>2012 PIP Emergency Department*</td> <td style="text-align: center;">X (closed 2013)</td> <td></td> <td></td> <td>PMAP, MnCare</td> </tr> <tr> <td>2013 PIP Chlamydia*</td> <td style="text-align: center;">X (closed 2013)</td> <td></td> <td></td> <td>PMAP, MnCare</td> </tr> <tr> <td>2013 PIP Readmissions*</td> <td style="text-align: center;">X (closed 2013)</td> <td></td> <td></td> <td>SNBC</td> </tr> <tr> <td>2013 QIP Readmissions</td> <td style="text-align: center;">X (closed 2015)</td> <td></td> <td></td> <td>MSHO, MSC+</td> </tr> <tr> <td>2015 PIP Increasing F/U After Hospitalization</td> <td></td> <td style="text-align: center;">X</td> <td></td> <td>SNBC</td> </tr> <tr> <td>2015 PIP Reducing Disparities in Antidepressant Med Mngt</td> <td></td> <td style="text-align: center;">X</td> <td></td> <td>PMAP, MnCare</td> </tr> <tr> <td>2016 QIP Antidepressant Med Mngt</td> <td></td> <td></td> <td style="text-align: center;">X</td> <td>MSHO, MSC+</td> </tr> </tbody> </table> <p>The above summarizes PIP/QIP activities since last exam in 2013. Reviewed reports and discussed PIP status of the following current PIP projects:</p> <ul style="list-style-type: none"> • Increasing Follow-up after Hospitalization • Reducing Disparities in Antidepressant Management 	PIPs/QIPs	Final	Interim	New	Products	2010 PIP Diabetes Management	X			MSHO, MSC+, SNBC, PMAP, MnCare	2011 Collaborative PIP Colorectal CA Screening*	X (closed 2013)			PMAP, MnCare	2011 Internal PIP Colorectal CA Screening*	X (closed 2013)			MSHO, MSC+, SNBC	2012 Internal PIP Breast Cancer Screening*	X (closed 2013)			MSHO, MSC+, SNBC	2012 PIP Emergency Department*	X (closed 2013)			PMAP, MnCare	2013 PIP Chlamydia*	X (closed 2013)			PMAP, MnCare	2013 PIP Readmissions*	X (closed 2013)			SNBC	2013 QIP Readmissions	X (closed 2015)			MSHO, MSC+	2015 PIP Increasing F/U After Hospitalization		X		SNBC	2015 PIP Reducing Disparities in Antidepressant Med Mngt		X		PMAP, MnCare	2016 QIP Antidepressant Med Mngt			X	MSHO, MSC+
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9 42 CFR 438.240 (d)(2)

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

11 CMS Protocols, Conduction Performance Improvement Projects, Activity 10

DHS Contractual Element and References	Met/ Not Met	Audit Comments
<p>8. Disease Management -2015 Contract Section 7. 3¹² The MCO shall make available a Disease Management Program for its Enrollees with:</p> <ul style="list-style-type: none"> A. Diabetes B. Asthma C. Heart Disease <p>Standards -The MCO’s Disease Management Program shall be consistent current NCQA <i>“Standards and Guidelines for the Accreditation of Health Plans”</i> – QI Standard Disease Management</p> <p>Waiver of Disease Management Program Requirement. If the MCO is able to demonstrate that a Disease Management Program is: 1) not effective based upon Provider satisfaction, and is unable to achieve meaningful outcomes; or 2) will have a negative financial return on investment, the MCO may request that the STATE waive this requirement for the remainder of the Contract Year.</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>Met per NCQA 100%</p>	<p>100% utilizing 2013 NCQA Standards and Guidelines Accredited for Medicare and Marketplace HMO. Disease Management covered Asthma, Diabetes and Heart Disease.</p>

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

DHS Contractual Element and References	Met/ Not Met	Audit Comments																																			
<p>9. Advance Directives Compliance – 2015 Contract Section 16^{13,14}</p> <p>A. The MCO agrees to provide all Enrollees at the time of enrollment a written description of applicable State law on Advance Directives and the following:</p> <ul style="list-style-type: none"> a. Information regarding the enrollee’s right to accept or refuse medical or surgical treatment; and to execute a living will, durable power of attorney for health care decisions, or other advance directive. b. Written policies of the MCO respecting the implementation of the right; and c. Updated or revised changes in State law as soon as possible, but no later than 90 days after the effective date of the change; d. Information that complaints concerning noncompliance with the Advance Directive requirement may be filed with the State survey and certification agency (i.e. Minnesota Department of Health), pursuant to 42 CFR 422.128 as required in 42 CFR 438.6(i). <p>B. Providers. To require MCO’s providers to ensure that it has been documented in the enrollee’s medical records whether or not an individual has executed an Advance Directive.</p> <p>C. Treatment. To not condition treatment or otherwise discriminate on the basis of whether an individual has executed an advance directive.</p> <p>D. Compliance with State Law. To comply with State law, whether statutory or recognized by the courts of the State on Advance Directives, including Minnesota Statutes Chapters 145B and 145C.</p> <p>Education. To provide, individually or with others, education for MCO</p>	<p>Met</p>	<table border="1" data-bbox="1136 212 1738 548"> <thead> <tr> <th colspan="3">Results Total Member Charts Reviewed</th> <th colspan="2">% Compliant by Age Range</th> </tr> <tr> <th>Age Range</th> <th>2014</th> <th>2013</th> <th>2014</th> <th>2013</th> </tr> </thead> <tbody> <tr> <td>18-30</td> <td>125</td> <td>99</td> <td>3.2%</td> <td>3.0%</td> </tr> <tr> <td>31-50</td> <td>314</td> <td>260</td> <td>7.0%</td> <td>7.3%</td> </tr> <tr> <td>51- 64</td> <td>444</td> <td>359</td> <td>13.3%</td> <td>15.6%</td> </tr> <tr> <td>65 & over</td> <td>1,132</td> <td>1,171</td> <td>25.7%</td> <td>21.4%</td> </tr> <tr> <td></td> <td>2,015</td> <td>1889</td> <td>18.7%</td> <td>17.4%</td> </tr> </tbody> </table> <p>Results of Advance Directive audit by age (from 2014 Annual Evaluation)</p> <p>UCare identified advance directives by medical group/provider by age range to determine which providers need to be educated about the importance of having an advance directive or discussion being documented in the medical record. Based on 11 care systems or provider practice groups, 58% improved their compliance rate over last year. An action plan for continued improvement was put in place for the coming year.</p>	Results Total Member Charts Reviewed			% Compliant by Age Range		Age Range	2014	2013	2014	2013	18-30	125	99	3.2%	3.0%	31-50	314	260	7.0%	7.3%	51- 64	444	359	13.3%	15.6%	65 & over	1,132	1,171	25.7%	21.4%		2,015	1889	18.7%	17.4%
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13 42 C.F.R. 489.100. Pursuant to 42 U.S.C. 1396a(a)(57) and (58) and 42 C.F.R. 489.100-104
14 MSC/MSC+ Contract Article 16; SNBC Contract Article 16

DHS Contractual Element and References	Met/ Not Met	Audit Comments
staff, providers and the community on Advance Directives.		

DHS Contractual Element and References	Met/ Not Met	Audit Comments
<p>10. Validation of MCO Care Plan Audits for MSHO, MSC+,¹⁵ MDH will collect information for DHS to monitor MCO Care Plan Audit activities as outlined in the DHS/MCO MSHO/MS C+ 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>Met</p>	<p>MDH findings indicated UCare scored 100% on all the Care Plan Audit elements with UCare scoring greater than 95% on all protocol elements except for four of the 16.</p> <p>UCare requires a CAP on all elements less than 95%. CAPS are monitored by the Delegation Oversight Specialist. The county has to do two months or more of self-audits depending on the risk criteria for the deficiencies and get 100% on those CAP elements. Numerous methodologies are utilized for county feedback/updates/follow-up including quarterly webinar training, face-to-face training and newsletters.</p> <p>[See Tables at end of the Summary Report]</p>

¹⁵ Pursuant to MSHO/MS C+ 2015 Contract sections 6.1.4(A)(2), 6.1.4(A)(3), 6.1.4(A)(4), 6.1.5(B)(4), 6.1.5(B)(5), 7.8.3

DHS Contractual Element and References	Met/ Not Met	Audit Comments
<p>11. Information System.^{16, 17} The MCO must operate an information system that supports initial and ongoing operations and quality assessment and performance improvement programs. The MCO must maintain a health information system that collects, analyzes, integrates, and reports data. During each of the past three years, all MCO MDH annual HEDIS performance measures have been certified reportable by an NCQA HEDIS audit.</p>	<p>Met</p>	<p>NCQA HEDIS audits as follows:</p> <p>2013 - Advent Advisory Group (All products)-</p> <ul style="list-style-type: none"> • <i>In our opinion, UCare’s submitted measures were prepared according to the HEDIS 2013 Technical Specifications and present fairly, in all material respects, the organization’s performance with respect to these specifications.</i> <p>2014 – Advent Advisory Group (all products)</p> <ul style="list-style-type: none"> • <i>In our opinion, UCare’s submitted measures were prepared according to the eHEDIS 2014 Technical Specifications and present fairly, in all material respects, the organization’s performance with respect to these specifications.</i> <p>2015 – Advent Advisory Group (Medicaid)</p> <ul style="list-style-type: none"> • <i>In our opinion, UCare’s submitted measures were prepared according to the HEDIS 2015 Technical Specifications and present fairly, in all material respects, the organization’s performance with respect to these specifications.</i>

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

DHS Contractual Element and References	Met/ Not Met	Audit Comments
<p>12. 9.3.1 Written Agreement; Disclosures.¹⁸ All subcontracts must be in writing and must include a specific description of payment arrangements. All subcontracts are subject to STATE and CMS review and approval, upon request by the STATE and/or CMS. Payment arrangements must be available for review by the STATE and/or CMS. All contracts must include:</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> <ul style="list-style-type: none"> (1) The name, address, date of birth, social security number (in the case of an individual), and tax identification number (in the case of a corporation) of each Person, with an Ownership or Control Interest in the disclosing entity or in any subcontractor in which the disclosing entity has direct or indirect ownership of five percent (5%) or more. The address for corporate entities must include primary business address, every business location and P.O. Box address; (2) A statement as to whether any Person with an Ownership or Control Interest in the disclosing entity as identified in 9.3.1(A) is related (if an individual) to any other Person with an Ownership or Control Interest as spouse, parent, child, or sibling; (3) The name of any other disclosing entity in which a Person with an Ownership Control Interest in the disclosing entity also has an ownership or control interest; and 	<p>Met</p>	

DHS Contractual Element and References	Met/ Not Met	Audit Comments
<p>(4) The name, address, date of birth, and social security number of any managing employee of the disclosing entity.</p> <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>B. 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.</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>9.3.13 Exclusions of Individuals and Entities; Confirming Identity. 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</p>	<p>Met</p> <p>Not Met</p>	<p><u>Part C.</u> UCare references a sample delegate agreement on pages 4 and 7 the following statements, "...(Sub-contractor) agrees that the services and Delegated Activities it provides under this Agreement shall conform to the applicable provisions of the DHS contract, the CMS contract, and the Exchange agreements...." (page 4); "(Sub-contractor) agrees to furnish UCare with any reports or data concerning the specific services or delegated activities performed by (sub-contractor) described in this agreement...as mutually agreed...except such reports that are required to be provided for UCare compliance with the DHS contract, the CMS contract, the Exchange Agreements or for federal or state audits do not need mutual agreement."</p> <p>UCare must indicate the time frames in the agreement to ensure that UCare and the delegate know by quick reference that there are indeed timeframes.</p>

DHS Contractual Element and References	Met/ Not Met	Audit Comments
<p>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> <p>(1) Are not excluded from participation in Medicaid under Sections 1128 or 1128A of the Social Security Act; and</p> <p>(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.</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>Met</p> <p>Met</p> <p>Met</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>	<p>Met</p> <p>Met</p> <p>Met</p>	
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Audit Protocol		Protocol Description	Measures	Total # Charts Reviewed		Total # Charts "Met"		MDH 2016 % Met	Comments
				Initial	Reassess	Initial	Reassess		
1	INITIAL HEALTH RISK ASSESSMENT 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	N/A	8	N/A	100%		
		B. All HRA areas evaluated and documented (in enrollee Comprehensive Care Plan)	8	N/A	8	N/A	100%		
2	ANNUAL HEALTH RISK ASSESSMENT Been a member of the MCO for > 12 months [Only for plans with separate HRA]	HRA is completed is within 12 months of previous HRA (results are in CCP)	N/A	N/A	N/A	N/A			
3	LONG TERM CARE CONSULTATION – INITIAL 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 info or noted as Not Applicable or Not Needed	8	N/A	8	N/A	100%		
		B. LTCC was completed timely (and in enrollee CCP)	8	N/A	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	A. Date re-assessment completed is within 12 months of previous assessment	N/A	8	N/A	8	100%		
		B. All areas of LTCC have been evaluated and documented (and in CCP)	N/A	8	N/A	8	100%		
5	COMPREHENSIVE CARE PLAN Includes needs identified in the HRA and/or the LTCC and other sources	A. Date CCP completed is within 30 calendar days of completed LTCC	8	8	8	8	100%		

Audit Protocol	Protocol Description	Measures	Total # Charts Reviewed		Total # Charts "Met"		MDH 2016 % Met	Comments
			Initial	Reassess	Initial	Reassess		
6	COMPREHENSIVE CARE PLAN SPECIFIC ELEMENTS	A. Identification of enrollee needs and concerns, including ID of health and safety risks, what to do in the event of an emergency, are in CCP (from LTCC)	8	8	8	8	100%	
		B. Goals and target dates (at least, month/year) identified	8	8	8	8	100%	
		C. Outcomes and achievement dates (at least, month/year) are documented	8	8	8	8	100%	
7	FOLLOW-UP PLAN Follow-up plan for contact for preventive care ¹⁹ , long-term care and community support, medical care, or mental health care ²⁰ , or any other identified concern	A. All areas of concern are addressed as identified on the Comprehensive Care Plan as stated in #5 of this protocol	8	8	8	8	100%	
		B. If an area is noted as a concern then documented goals, interventions, and services [If an area is identified as "Not Needed" or NA is excluded from denominator]	8	8	8	8	100%	
8	ANNUAL PREVENTIVE CARE	Documentation in enrollee's Comprehensive Care Plan that <u>substantiates a conversation was initiated</u>	8	8	8	8	100%	
9	ADVANCE DIRECTIVE	Evidence that a discussion was initiated, enrollee refused to complete, was culturally inappropriate, or AD was completed	8	8	8	8	100%	

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

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

Audit Protocol	Protocol Description	Measures	Total # Charts Reviewed		Total # Charts "Met"		MDH 2016 % Met	Comments
			Initial	Reassess	Initial	Reassess		
10	ENROLLEE CHOICE Enrollee was given a choice between Home and Community-Based Services (HCBS) and Nursing Home Services (also indicates enrollee involvement in care planning)	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 CCP)	8	8	8	8	100%	
11	CHOICE OF HCBS PROVIDERS Information to enable choice among providers of HCBS	Completed and signed care plan summary (in CCP)	8	8	8	8	100%	
12	HOME AND COMMUNITY BASED SERVICE PLAN 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	CAREGIVER SUPPORT PLAN If a primary caregiver is identified in the LTCC,	A. Attached Caregiver Planning Interview	3	0	3	0	100%	
		B. Incorporation of stated caregiver needs in Service Agreement, if applicable	8	8	8	8	100%	
14	APPEAL RIGHTS Appeal rights information provided to member.	Acknowledgement on signed care plan or other signed documentation in file	8	8	8	8	100%	

Audit Protocol		Protocol Description	Measures	Total # Charts Reviewed		Total # Charts "Met"		MDH 2016 % Met	Comments
				Initial	Reassess	Initial	Reassess		
15	DATA PRIVACY Data privacy information provided to member	Acknowledgement on signed care plan or other signed documentation in file	8	8	8	8	100%		

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 data period for Care Plan Audit files was December 1, 2014 through November 30, 2015. File review indicated UCare scored 100% on all elements. Care giver interviews continue to be low, only 3 of the 16 files reviewed had care giver interviews. This is common among all plans.

Attachment B: Comparison of UCare 2015 Care Plan Audit to MDH 2016 and be included in the TOC.

Audit Protocol Number	Desired Outcome	Description of Protocol Area	UCare 2015 % Met	MDH 2016 % Met
1	Initial Health Risk Assessment	a. Completed within timelines	93%	100%
		b. Results included in CCP	93%	100%
		c. All areas evaluated and documented	90%	100%
2	Annual Health Risk Assessment [Only for plans with separate HRA]	a. Complete within timelines	N/A	100%
		b. Results included in CCP	N/A	100%
3	LTCC Assessment- Initial (New to EW in past 12 months)	a. LTCC results attached to CCP	97%	100%
		b. All relevant fields completed or "n/a" is doc'd	94%	100%
		c. Completed timely	94%	100%
4	Annual Reassessment of EW	a. Annual re-assess w/in 365 days of previous assessment or explanation documented	97%	100%
		b. Results of LTCC attached to CCP	100%	100%
		c. All areas of the LTCC have been evaluated and documented	100%	100%
5	Comprehensive Care Plan	CCP completed w\in 30 calendar days of LTCC and explanation documented	97%	100%
6	Comprehensive Care Plan Specific Elements	a. Needs & Concerns identified	97%	100%
		b. Health and safety risks identified and plans for addressing these risks	97%	100%
		c. Documentation of services essential to health and safety	97%	100%
		d. If applicable, back-up plan for essential services	97%	100%
		e. Plan for community-wide disasters	97%	100%
		f. Goals and target dates	97%	100%
		g. Interventions identified	97%	100%
		h. Monitoring progress toward goals	97%	100%

Audit Protocol Number	Desired Outcome	Description of Protocol Area	UCare 2015 % Met	MDH 2016 % Met
		i. Outcomes and achievement dates are documented	94%	100%
		j. Care plan signed by member or authorized rep..	97%	100%
		k. Care Coordinator has documented their plan for follow-up with the member.	98%	100%
7	Communication of Care Plan / Summary	Evidence of Care Coordinator communication of Care Plan elements with Primary Care Physician (PCP)	97%	100%
8	Personal Risk Management Plan	a. HCBS service refusal noted in CCP	64%	NO REFUSALS
		b. Personal risk management plan completed	64%	NO REFUSALS
9	Annual Preventive Health Exam	Annual Preventive health exam conversation initiated	97%	100%
10	Advance Directive	Advanced Directive conversation	97%	100%
11	Enrollee Choice	a. LTCC Section J or equivalent document	96%	100%
		b. Completed & signed Care Plan	96%	100%
		c. Copy of CCP summary	96%	100%
12	Choice of HCBS Providers	a. Completed & signed Care Plan	97%	100%
		b. Copy of CCP Summary	97%	100%
13	Community Support Plan – Community Services and Supports Section	a. Type of Services	97%	100%
		b. Amount, Frequency, Duration and Cost	97%	100%
		c. Type of Provider & non-paid/informal	97%	100%
		d. Attempted not complete w/explanation	N/A	N/A
14	Caregiver Support Plan	a. Caregiver planning interview/ assessment attached	91%	100%
		b. Caregiver needs incorporated into SA, if applicable	44%	100%
15	Appeal Rights	Completed and signed care plan or other signed documentation in enrollee file.	98%	100%

Audit Protocol Number	Desired Outcome	Description of Protocol Area	UCare 2015 % Met	MDH 2016 % Met
16	Data Privacy	Completed and signed care plan or other signed documentation in enrollee file.	98%	100%

Summary:

MDH findings indicated UCare scored 100% on all the Care Plan Audit elements with UCare scoring greater than 95% on all protocol elements except for four of the 16.

UCare requires a CAP on all elements less than 95%. CAPS are monitored by the Delegation Oversight Specialist. The county has to do two months or more of self-audits depending on the risk criteria for the deficiencies and get 100% on those CAP elements. Numerous methodologies are utilized for county feedback/updates/follow-up including quarterly webinar training, face-to-face training and newsletters.