Hennepin Health

TRIENNIAL COMPLIANCE ASSESSMENT

Triennial Compliance Assessment

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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 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 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. QI Program Structure - 2019 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)

TCA Quality Program Structure Data Grid

DHS Contractual Element and References	Met or Not Met	Audit Comments
Written Quality Assurance Plan (Quality Program Description)	**Met**	2018 and 2019, Quality Management Programs were approved.
Access Standards 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	**Met**	
Structure and Operations Standards 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 sub contractual Relationships and Delegation	**Met**	
Measurement Improvement Standards 42 CFR § 438.236 Practice Guidelines 42 CFR § 438.240 Quality Assessment and Performance Improvement Program 42 CFR § 438.242 Health Information System	**Met**	

II. Information System – 2019 Contract Section 7.1.3 [1, 2]

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
The MCO must maintain a health information system that collects, analyzes, integrates, and reports data. During each of the past three years, all MCO MDH annual HEDIS performance measures have been certified reportable by an NCQA HEDIS audit.	Met	HEDIS Compliance audits reviewed as follows: 2017 – Metastar 2018 – Metastar 2019 - Metastar Reports state: *"In our opinion, Hennepin Health submitted measures were prepared according to the HEDIS Technical Specifications and presents fairly, in all material respects, the organization's performance with respect to these specifications."*

1 Families and Children, Seniors and SNBC Contract Section 7.1.3I

2 42 CFR 438.242

III. Utilization Management - 2019 Contract Section 7.1.4

The MCO shall adopt a utilization management structure consistent with state regulations and federal regulations and current NCQA "Standards for Accreditation of Health Plans."[3] 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.

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: i. Choose the appropriate number of relevant types of utilization data, including one type related to behavioral health to monitor.	**Met**	2018 clinical indicators; • Inpatient admissions - behavioral health/chemical dependency (BH/CD) and medical • 30-day inpatient readmissions - BH/CD and medical • ED visits - BH/CD and medical • Annual dental visits
The MCO Shall: ii. Set thresholds for the selected types of utilization data and annually quantitatively analyze the data against the established thresholds to detect under and overutilization.	**Met**	Thresholds set by Hennepin Health trend activity
The MCO Shall:		

3 2019 *Standards and Guidelines for the Accreditation of Health Plans*, effective July 1, 2019

DHS Contractual Element and References	Met or Not Met	Audit Comments
iii. Examine possible explanations for all data not within thresholds.	**Met**	
The MCO Shall: iv. Analyze data not within threshold by medical group or practice.	**Met**	
The MCO Shall: v. Take action to address identified problems of under or overutilization and measure the effectiveness of its interventions.[4]4	**Met**	Examples of initiatives to address over/under utilization: 1. The Dental Coordinator in the QM Department initiated focus study to address underutilization of PMAP/MNCare dental services, for members ages one through 20 years old. There was an approximate five percent increase in dental utilization among this group compared to 2017. 2. Pilot project to address over-utilization trend for members diagnosed with schizophrenia. Extensive analysis done to determine demographics and possible causes for readmits.

4 42 CFR 438.330(b)(3)

B. 2019 NCQA Standards and Guidelines UM 1 – 4, 10 – 12; QI 4

The following are the 2019 NCQA Standards and Guidelines for the Accreditation of Health Plans UM 1 – 4 and 10 – 12, and QI 4.

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 organization clearly defines the structures and processes within its utilization management (UM) program and assigns responsibility to appropriate individuals.		Hennepin Health may want to reference applicable policies in its UM plan for reference, for example New Technology Assessment, Delegation Management, etc**. (Recommendation)**
Element A: Written Program Description	**Not Met**	Hennepin Health does not specify in its UM Program Description its plan for UM delegation. For example, 1) Hennepin Health delegates dental UM to Delta Dental 2) Clarify its PBM role in UM.
Element B: Physician Involvement	**Met**	
Element C: Behavioral Healthcare Practitioner Involvement	**Met**	
Element D: Annual Evaluation	**Met**	Included in the QA Annual Evaluation
NCQA Standard UM 2: Clinical Criteria for UM Decision To make utilization decisions, the organization uses written criteria based on sound clinical evidence and specifies procedures for appropriately applying the criteria.	**Met**	
Element A: UM Criteria	**Met**	
Element B: Availability of Criteria	**Met**	
Element C: Consistency of Applying Criteria	**Met**	
NCQA Standard UM 3: Communication Services	**Met**	

DHS Contractual Element and References	Met or Not Met	Audit Comments
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		
NCQA Standard UM 4: Appropriate Professionals Qualified Licensed health professionals assess the clinical information used to support UM decisions. Element D: Practitioner Review of Behavioral Healthcare Denials	**Met**	
Element G: Affirmative Statement About Incentives	**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 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: Policies and Procedures	**Met**	
Element B: Pharmaceutical Restrictions/Preferences	**Met**	
Element C: Pharmaceutical Patient Safety Issues	**Met**	
Element D: Reviewing and Updating Procedures	**Met**	
Element E: Considering Exceptions	**Met**	

DHS Contractual Element and References	Met or Not Met	Audit Comments
NCQA Standard UM 12: Delegation of UM The organization remains responsible for and has appropriate structures and mechanisms to oversee delegated UM activities.	**Met**	Appropriate delegation oversight of UM was performed by Hennepin Health for Delta Dental consistent with standards. However, as indicated previously, UM delegation is not included in the UM plan.
NCQA Standard QI 4: Member Experience The organization monitors member experience with its services and identifies areas of potential improvement. Element G: Assessing experience with the UM process	**Met**	

IV. Special Health Care Needs - 2019 Contract Section 7.1.5 A-D[5, 6]

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, B. Assessment of enrollees identified, (F&C/MNCare and SNBC Contract – care plan) and C. Access to specialists D. Annual Reporting to the State	**Not Met**	B. Hennepin Health provided three policy and/or procedures describing the Special Health Care Needs program and complex case management services, in addition to a Special Health Care Needs Report. Specifically, they provided a description of how they assess and monitor the Special Needs Basic Care (SNBC) member population, however, there was no similar nor sufficient description of how enrollees are assessed and monitored on the treatment plan for the Prepaid Medical Assistance Program (PMAP) nor MNCare member populations. Hennepin Health must have a written process for all their member populations on how they are assessed and monitored on an ongoing basis in the special health care needs program. **(NOT MET)** In addition, Hennepin Health stated during onsite discussions that the most effective way to engage their members is to assign case managers when identified members are in the emergency room or admitted to the hospital. MDH recommends that any effective process used to engage members in the special health care needs program be included in their policy and/or procedures and also discussed as part of their strategies and analyses in the Special Health Care Needs report. **(MANDATORY IMPROVEMENT)** D. The Special Health Care Needs Report incorporated within the *2018 Quality Program Evaluation* did not provide the required annual data of number of

5 42 CFR 438.330 (b)(4)

6 MSHO, MSC+ Contract section 7.1.5 A, C; SNBC Contract section 7.1.5

		adults assessed or referred nor a summary evaluating the methodology and efforts for identifying an assessing those members. **(NOT MET)**

V. Practice Guidelines -2019 Contract Section 7.1.6[7, 8]

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 guidelines based on scientific evidence or professional standards for at least two medical and two behavioral conditions; and • Update the guidelines at least every two years • Distribute the guidelines to the appropriate practitioners	**Met**	2018 Practice Guidelines adopted from ICSI, USPTF: 1. Medical Preventive Services in Adults 2. Diabetes Management 3. Medication Management for People with Asthma 4. Childhood Immunization Status 5. Immunizations for Adolescents 6. Prenatal and Postpartum Care 7. Follow-up care After Hospitalization for Mental Illness 8. Depression, Major, in Adults in Primary Care 9. Alcohol and Other Drug Dependence
Element B: Adoption of preventive health guidelines. MCO shall adopt preventive health guidelines based on scientific evidence or professional standards for members of all ages; and • Update the guidelines at least every two years; • Distribute the guidelines to the appropriate practitioners.	**Met**	
Element C: Relation to DM Programs. MCO shall base its disease management programs on two of the organizations clinical practice guidelines.	**Met**	

7 42 CFR 438.340 (b) (1)

8 MSHO/MSC+ Contract section 7.1.5 A-C; SNBC Contract section 7.1.6A-C

VI. Annual Quality Assurance Work Plan – 2019 Contract Section 7.1.9

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. Annual written work plan shall follow the guidelines and specifications contained in Minnesota Rules, part 4685.1130, subpart 2, and	**Met**	
B. Current NCQA "*Standards and Guidelines for the Accreditation of Health Plans.*" **NCQA QI, Element A:** 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 (5) Evaluation of the QI program	**Met**	2018 and 2019 Work Plans reviewed. 2019 Work Plan is comprehensive, in that it specifies delegated entities and functions, improvement projects and focus studies, population management, and other mandated DHS quality activities are represented.

VII. Annual Quality Assessment and Performance Improvement Program Evaluation – 2019 Contract Section 7.1.8[9,10]

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
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: HEDIS®) and ii. MCO's performance improvement projects.	**Met**	
NCQA QI 1, Element B: 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. 2. Trending of measures to assess performance in the quality and safety of clinical care and quality of services.	**Met**	

9 42 CFR 438.330(b), (d)

10 MSCHO/MSC+ Contract Section 7.18 requires that the MCO, in conducting its annual quality evaluation, assure consistency with the "Quality Framework for the Elderly Waiver" and current NCQA "Standards and Guidelines for the Accreditation of Health Plans."

DHS Contractual Element and References	Met or Not Met	Audit Comments
3. Analysis and evaluation of the overall effectiveness of the QI program and of its progress toward influencing network-wide safe clinical practices.		

VIII. Performance Improvement Projects-2019 Contract Section 7.2[11, 12, 13, 14,15]

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 *"Protocol for Use in Conducting Medicaid External Quality Review Activities: Conducting Performance Improvement Projects."* The MCO is encouraged to participate in PIP collaborative initiatives that coordinate PIP topics and designs between MCOs.

Performance Improvement Projects Data Grid

DHS Contractual Element and References	Met or Not Met	Audit Comments
7.2.1 Final PIP Report. Upon completion of the 2015 PIP the MCO shall submit to the STATE for review and approval a final written report by September 1, 2018, in a format defined by the STATE.	**Met**	2015 – 2017 Performance Improvement Project Final – The Reduction of Racial Disparities in the Management of Depression Discussion of outcomes and lessons learned
7.2.1 New Performance Improvement Project Proposal. The STATE will select the topic for the PIP to be conducted over the next three years (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	**Met**	Reviewed 2017 new project submission – Reducing Chronic Opioid Use Discussion of status of project

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11 42 CFR 438.330 (b)(1), 42 CFR 438.330(d)

12 MSHO/MSC+ Contract section 7.2; SNBC Contract section 7.2

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

14 42 CFR 438.330(b)(1), 438.330(d)

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

DHS Contractual Element and References	Met or Not Met	Audit Comments
requirements, and include steps one through seven of the CMS protocol.		
PIP Proposal and PIP Interim Report Validation Sheets. DHS uses these tools to review and validate MCOs' PIP proposals and annual status reports.	**NA**	None submitted for review

IX. Population Health Management - 2019 Contract Section 7.4

Population Health Management (PHM). The MCO shall create and report to the STATE a Population Health Management Strategy 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 plan for transition to PHM is due March 1, 2019, and must be updated within thirty (30) days if the MCO makes a modification to its PHM Strategy, consistent with section 3.11.3, Service Delivery Plan.

Population Health Management Data Grid

DHS Contractual Element and References	Met or Not Met	Audit Comments
7.4.1. The MCO's PHM Strategy shall be consistent with current NCQA "Standards and Guidelines for the Accreditation of Health Plans" pursuant to the current Standards for Population Health Management (PHM). A. At a minimum, the comprehensive PHM Strategy shall describe: 1) Measurable goals and populations targeted for each of the four areas of focus; 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 areas 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). B. The PHM Strategy shall include the following areas of focus: **1) Keeping Enrollees healthy,** 2) Managing Enrollees with emerging risk, 3) Patient safety or outcomes across settings, and	**Met**	Began program formally in March 2019 Strategies and goals for the following: 1) Keeping enrollees healthy – Dental Program 2) Managing Enrollees with emerging risk – Native and African American Women High Risk Pregnancy Support – being developed with a part of the reinvestment pot of money (available only to HH partner organizations) 3) Focus on patient safety or outcomes across settings a. Safety - Decreasing Opioid Use – PIP Project b. Managing outcomes - Inpatient coordination of care services for the homeless 4) Managing multiple chronic illnesses – Complex Care Management program in place

DHS Contractual Element and References	Met or Not Met	Audit Comments
4) Managing multiple chronic illnesses. Reference: NCQA PHM 1: PHM Strategy		
7.4.2. PHM Reporting 7.4.2.1 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. Reference: NCQA PHM 2: Population ID	**NA**	Population assessment areas are included in plan
7.4.2.2 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). 2) Comparison of results, including with a benchmark or goal; 3) Interpretation of results, including interpretation of measures. Reference: NCQA PHM 6: PHM Impact	**NA**	
7.4.3 The MCO shall report to the STATE "impact analysis outcomes" (for example, opportunities for improvement, or a plan to act on an identified opportunity for improvement) in the following Contract years. Reference: NCQA PHM 6B: Improvement and Action	**NA**	NA – Program just initiated
7.4.4 If the MCO chooses to delegate its PHM activities, the MCO shall provide to the STATE a comprehensive description of the	**NA**	NA – No delegation

DHS Contractual Element and References	Met or Not Met	Audit Comments
structure and mechanisms to oversee delegated PHM activities. This report is due March 1, 2019, and must be completed again at any time the MCO changes any of its PHM delegations Reference: NCQA PHM 7: Delegation of PHM		
7.4.5 The MCO shall continue to offer case management services to the most complex, highest-risk Enrollees. Reference: NCQA PHM 5: Complex Case Management	**Met**	
Reference NCQA 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 A. Practitioner or Provider Support a. Sharing data b. Offering evidence-based decision making aides c. Providing practice transformation support to primary Providing practice transformation support to primary care practitioners d. Providing comparative quality information on selected specialties e. Providing comparative pricing information on selected services f. One additional activity to support practitioners or providers in achieving PHM goals. B. Value-based payment Arrangements (e.g. P4P)	**Met**	In plan
Reference NCQA PHM 4: Wellness and Prevention The organization offers wellness services focused on preventing illness and injury, promoting health and productivity and reducing risk A. Frequency of Health Appraisal (HA) Completion (annually) B. Topics of self-management tools	**Met**	

X. Advance Directives Compliance - 2019 Contract Section 16[16, 17]

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:

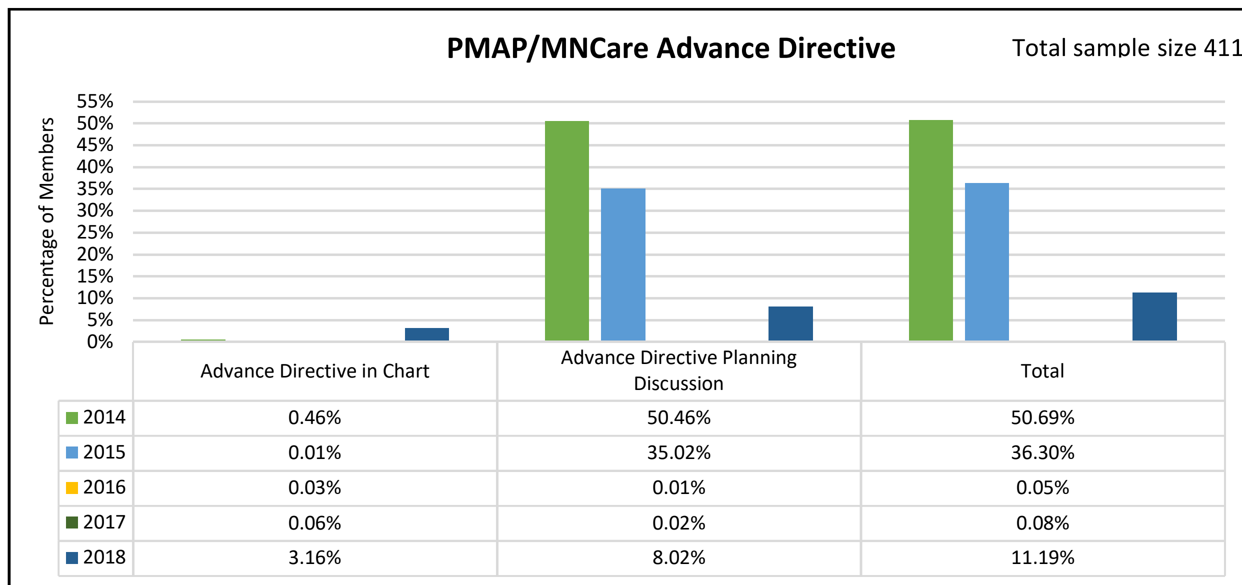
Advance Directives Compliance Data Grid

DHS Contractual Element and References	Met or Not Met	Audit Comments
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 FR 438.6(i).	**Met** **Met** **Met** **Met**	
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.	**Met**	Hennepin Health – PMAP/MNCare Advanced Directive (AD) data in 2018 • Evidence of Advance Directive in Chart: 3.16 % • Evidence of Advanced Care Planning Discussions 8.02% • Combined rate of advance directive presence or discussion: 11.19% **(See Graph below for trending of AD)**

16 Pursuant to 42 U.S.C. 1396a(a)(57) and (58) and 42 C.F.R. 489.100-104 and 42 C.F.R. 422.128

17 MSC/MSC+ Contract Article 16; SNBC Contract Article 16

DHS Contractual Element and References	Met or Not Met	Audit Comments
Treatment. To not condition treatment or otherwise discriminate on the basis of whether an individual has executed an advance directive.		
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**	
Education. To provide, individually or with others, education for MCO staff, providers and the community on Advance Directives.	**Met**	Improvements in EHRs were made to include a designated location for this information. EHRs also have a prompt for providers to discuss advance directives with members (for example, every five years). Cultural barriers frequently noted as a factor in noncompliance with advance directive requirements.



	Advance Directive in Chart	Advance Directive Planning Discussion	Total
2014	0.46%	50.46%	50.69%
2015	0.01%	35.02%	36.30%
2016	0.03%	0.01%	0.05%
2017	0.06%	0.02%	0.08%
2018	3.16%	8.02%	11.19%

Data Source: Epic EHR Audit 2018

XI. Subcontractors-2019 Contract Sections 9.3.1 and 9.3.16 (F&C), and 9.3.1 and 9.3.22 (MSHO/MSC+)[18]

A. Written Agreement; Disclosures

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.

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 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	**Met**	Hennepin Health submitted an example of a delegated contract, policies and/or procedures as well as all required evidence of documents that demonstrate compliance with the DHS Subcontractors contractual requirements.

18 Families and Children Contract Sections 9.3.1A

DHS Contractual Element and References	Met or Not Met	Audit Comments
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 The name, address, date of birth, and social security number of any managing employee of the disclosing entity. (4) The name, address, date of birth and social security number of any managing employee of the disclosing entity. (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. (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.		
B. 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.	**Met**	

B. Exclusions of Individuals and Entities; Confirming Identity[19]

Exclusion of Individuals Data Grid

DHS Contractual Element and References	Met or Not Met	Audit Comments
A. Pursuant to 42 CFR § 455.436, the MCO must confirm the identity and determine the exclusion status of Providers and any Person with an Ownership or Control Interest or who is an agent or managing employee of the MCO or its subcontractors through routine checks of Federal databases, including the Social Security Administration's Death Master File and the National Plan and Provider Enumeration System (NPPES), and also upon contract execution or renewal, and credentialing.	**Met**	
B. The MCO and its subcontractors must search monthly, and upon contract execution or renewal, and credentialing, the OIG List of Excluded Individuals/Entities (LEIE) and the Excluded Parties List System (EPLS, within the HHS System for Awards Management) database (and may search the Medicare Exclusion Database), for any Providers, agents, Persons with an Ownership or Control Interest, and Managing Employees to verify that these persons: (1) Are not excluded from participation in Medicaid under Sections 1128 or 1128A of the Social Security Act; and (2) Have not been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the programs under Title XX of the Social Security Act.	**Met**	
C. The MCO must require subcontractors to assure to the MCO that no agreements exist with an excluded entity or individual for the provision of items or services related to the MCO's obligation under this Contract.	**Met**	
D. The MCO shall require all subcontractors to report to the MCO within five (5) days any information regarding individuals or entities specified	**Met**	

19 Families and Children Contract Section 9.3.16, Seniors and SNBC Contract Sections 9.3.22 and 9.3.23

DHS Contractual Element and References	Met or Not Met	Audit Comments
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.		
E. The MCO shall this information to the STATE within seven (7) days of the date the MCO receives the information	**Met**	
F. In addition to complying with the provisions of section 9.9, the MCO shall not enter into any subcontract that is prohibited, in whole or in part, under § 4707(a) of the Balanced Budget Act of 1997 or under Minnesota Statutes, § 62J.71.	**Met**	