Triennial Compliance Assessment

Of

UCare

Performed under Interagency Agreement for:

Minnesota
Department of Human Services

By

Minnesota Department of Health (MDH)
Managed Care Systems Section

Exam Period: January 1, 2011 through June 30, 2013

File Review Period: July 1, 2012 through June 30, 2013

On-site: September 9, 2013 through September 16, 2013

Examiners:
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Final Summary Report
February 13, 2014

Executive Summary
Triennial Compliance Assessment (TCA)
UCare

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 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 2013

Managed Care Organization (MCO): UCare
Examination Period: January 1, 201111 – June 30, 2013
Onsite Dates: September 9-16, 2013

Table of Contents

DHS Contractual Element and References	Met/ Not Met	Audit Comments
1. QI Program Structure- 2012 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). <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 <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 <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	**Met** **Met** **Met**	UCare 2013 Quality Program Description approved by MDH
2. Accessibility of Providers -2012 MSHO/MSC+ Contract Section 6.1.4(C)(2) and 6.1.5(E) A. In accordance with the DHS/MCO managed care contracts for MSHO and MSC+, the MCO must demonstrate that it offers a range of choice among Waiver providers such that there is evidence of procedures for ensuring access to an adequate range of waiver and nursing facility services and for providing appropriate choices among nursing facilities and/or waiver services to meet the individual need as of Enrollees who are found to require a Nursing Facility Level of Care. 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	**Met**	UCare conducts an excellent ongoing evaluation of EW Waiver (HCBS) services network and annually surveys care coordinators to identify issues across the network and specific county issues. UCare assists counties in resolving access issues with specific services.

DHS Contractual Element and References	Met/ Not Met	Audit Comments
3. Utilization Management - 2012 Contract Section 7.1.3 A. The MCO shall adopt a utilization management structure consistent with state regulations and current NCQA "Standards for Accreditation of Health Plans."[1] The MCO shall facilitate the delivery of appropriate care and monitor the impact of its utilization management program to detect and correct potential under and over utilization. The MCO shall: i. Choose the appropriate number of relevant types of utilization data, including one type related to behavioral health to monitor. ii. Set thresholds for the selected types of utilization data and annually quantitatively analyze the data against the established thresholds to detect under and overutilization.	 **Met** **Met**	Measures included: inpatient hospital utilization, emergency room utilization, generic drug dispensing, long term psychotropic medication use and behavioral health provider visits. All of the utilization data for these categories remained within internal threshold limits for over and under-utilization in 2012. Also reviewed in 2012 on an ad hoc basis were the following utilization types: dental, chiropractic, spine surgery, atypical antipsychotic medication usage in children, therapies (PT, OT, and ST) and swing bed utilization. Improvement initiatives included: • For therapy services, UCare contracted with a therapies utilization review vendor to provide prior authorization services. In addition, the prior authorization threshold was changed from 9 visits to 3 visits prior to requiring plan authorization. This resulted in both a lower utilization rate and cost savings. • A study of swing bed utilization was completed and an intensive utilization review process was initiated as a pilot in April 2012 in a select service area. The goal was to ensure members received care at the most appropriate level and setting. Through the pilot, approximately 50% of requested swing bed admissions were redirected and resulted in a discharge to home, approximately 40% were redirected to a skilled nursing facility, and the remaining members were admitted to a swing bed stay.
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. Element A: Written Program Description Element B: Physician Involvement Element C: Behavioral Health Involvement Element D. Annual Evaluation	 **Met** **Met** **Met** **Met**	

1 2011 *Standards and Guidelines for the Accreditation of Health Plans*, effective July 1, 2011

DHS Contractual Element and References	Met/ Not Met	Audit Comments
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. Element A: UM Criteria Element B: Availability of Criteria Element C: Consistency of Applying Criteria **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** **Met** **Met** **Met**	
NCQA Standard UM 4: Appropriate Professionals Qualified Licensed health professionals assess the clinical information used to support UM decisions. Element D: Practitioner Review of BH Denials Element F: Affirmative Statement About Incentives **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 Element C: Implementation of New Technology	 **Met** **Met** **Met** **Met** **Met**	

DHS Contractual Element and References	Met/ Not Met	Audit Comments
NCQA Standard UM 11: Satisfaction with UM Process The organization evaluates member and practitioner satisfaction with the UM process. Element A: Assessing Satisfaction with UM Process **NCQA Standard UM 12: Emergency Services** The organization provides, arranges for or otherwise facilitates all needed emergency services, including appropriate coverage of costs. Element A: Policies and Procedures	 **Met** **Met**	
NCQA Standard UM 13: Procedures for Pharmaceutical Management The organization ensures that its procedures for pharmaceutical management, if any, promote the clinically appropriate use of pharmaceuticals Element A: Policies and Procedures Element B: Pharmaceutical Restrictions/Preferences Element C: Pharmaceutical Patient Safety Issues Element D: Reviewing and Updating Procedures Element F: Availability of Procedures Element G: Considering Exceptions **NCQA Standard UM 14: Triage and Referral to Behavioral Health** The organization has written standards to ensure that any centralized triage and referral functions for behavioral health services are appropriately implemented, monitored and professionally managed. *This standard applies only to organizations with a centralized triage and referral process for behavioral health, both delegated and non-delegated* Element A: Triage and Referral Protocols	 **Met** **Met** **Met** **Met** **Met** **Met** **N/A**	UCare does not have a centralized triage or referral

DHS Contractual Element and References	Met/ Not Met	Audit Comments
4. Special Health Care Needs 2012 Contract Section 7.1.4 (A-C) [2, 3] The MCO must have effective mechanisms to assess the quality and appropriateness of care furnished to Enrollees with special health care needs. 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** **Met** **Met**	Good reporting/analysis and acts on findings. Also has pediatric (ages 0 to 17) SHCN data. Clinical indicators are: Acute URI, Otis Media, Hospital ED for Acute URI, Fever, GI, Otitis Media, Traumatic Injury Hospital Readmissions within 14 days for similar dx, Paid claims > $50,000, Inpt LOS > 7 days
5. Practice Guidelines -2012 Contract Section 7.1.5[4,5,] A. The MCO shall adopt preventive and chronic disease practice guidelines appropriate for children, adolescents, prenatal care, young adults, adults, and seniors age 65 and older, and, as appropriate, for people with disabilities populations. i. **Adoption of practice guidelines**. The MCO shall adopt guidelines based on: • 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. ii. **Dissemination of guidelines.** MCO ensures guidelines are disseminated: • To all affected Providers • To enrollees and potential enrollees upon request iii. **Application of guidelines**. MCO ensures guidelines are applied to decisions for: • Utilization management • Enrollee education • Coverage of services • Other areas to which there is application and consistency with the guidelines.	**Met** **Met** **Met** **Met** **Met** **Met** **Met**	See table below UCare adopts and disseminates practice guidelines consistent with the QCare Preventive Care Standards on Child and Adolescents immunization, well-child visits, Chlamydia screening, breast cancer screening and cervical cancer screening. UCare has a well-constructed program for developing and reviewing practice guidelines biannually. The guidelines are reviewed by the QIAC Committee. UCare usually adopts ICSI guidelines, however some are supplemented with guidelines from other organizations, i.e., CDC&P. Practice guidelines are available in the on-line provider manual and published in the provider newsletter. Enrollees are provided the guidelines upon request and in newsletters. UCare monitors provider compliance by review of administrative HEDIS data. Analysis looks for opportunities for improvement by clinic. The report provided stated interventions include P4P, however in discussion, UCare staff noted that they are separate programs. UCare's report was comprehensive..

2 42 CFR 438.208 (c)(1-4)
3 MSHO, MSC+ Contract section 7.1.4 A, C; SNBC Contract section 7.1.4
4 42 CFR 438.236

Guideline	Prevention	Chronic	Child	Adol	Prenatal Care	Young Adults	Adult	Disabled	Seniors 65+
Preventive Services for adults—comprehensive: counseling, education and disease screening ICSI+ US Preventive Svs Task Force & CDC&P=> Fluzone for ≥65 years	x					x	x	x	x
Preventive Svs for children & adolescents—comprehensive: C&TC+age related screenings(ie, blood lead) immunizations and dental standards; ICSI & DHS C&TC	x		x	x		x		x	
Prenatal care-Routine: consistent and timely screenings, risk evaluations, counseling, education. ICSI	x			x	x	x	x	x	
Diabetes, Type 2 Dx and Mgmt—Comprehensive and self-mgmt. Adults, prevention, complications and risk factors, nutrition therapy, physical activity, self-mgmt & medication mgmt. ICSI		x				x	x	x	x
Asthma, Dx & Mgmt.—acute & chronic for at-risk ICSI		x	x	x	x	x	x	x	
Obesity, prevention & mgmt.—ICSI + BMI measure at each visit; f/u at 4 weeks vs 12 weeks	x					x	x	x	x

5 MSHO/MSC+ Contract section 7.2 A-C; SNBC Contract section 7.1.5A-C

DHS Contractual Element and References	Met/ Not Met	Audit Comments
6. Annual Quality Assessment and Performance Improvement Program Evaluation- 2013 Contract Sections 7.1.8 [6,7]		
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: 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.	**Met**	
B. **NCQA QI 1, Element B:** There is an annual written evaluation of the QI Program that includes: 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 of the results of QI initiatives, including barrier analysis iv. Evaluation of the overall effectiveness of the QI program, including progress toward influencing network-wide-safe clinical practices	**Met**	

6 42 CFR 438.240(e)
7 MSHO/MSC+ Contract Section 7.2.4 also includes the requirement that the MCO must include the "Quality Framework for the Elderly" in its Annual Evaluation

DHS Contractual Element and References	Met/ Not Met	Audit Comments
7. Performance Improvement Projects -2012 Contract Section 7.2[8.9,10] A. **<u>Interim Project Reports</u>**. By December 1st of each calendar year, the MCO must produce an interim performance improvement project report for each current project. The interim project report must include any changes to the project(s) protocol steps one through seven and steps eight and ten as appropriate.	**Met**	Interim Performance Improvement Project Reports submitted for review: 1. UCare Colorectal Cancer Screening (MSHO, MSC+, SNBC), November 30, 2012 2. Collaborative Colorectal Cancer Screening (Families and Children), November 30, 2013 3. Breast Cancer Screening (MSHO, MSC+, SNBC), December 1, 2012 4. Blood Pressure Control for Members with Diabetes (Collaborative all products), November 30, 2012 5. Reducing Non-Urgent ED Use (collaborative for PMAP, MNCare), November 30, 2012
B. **<u>Completed (Final) Project Reports</u>**: Completed PIP Project Improvements Sustained over Time- Real changes in fundamental system processes result in sustained improvements: i Were PIP intervention strategies sustained following project completion?	**Met**	Completed PIPs: HPV 2011, ASA Therapy in Ischemic Heart Disease and Diabetes 2012, Preventive 2011. **ASA Therapy** –Care Coordinators, on Comprehensive Care Plan, encourage through Disease Management (Diabetes and Heart Disease), member materials and educational materials and resources still available **Preventive Care** – sustained intervention strategies as above **HPV** – Partnerships with schools, shared materials developed with Minnesota Cancer Alliance, MDH, School Nurse Organization, Stratis Health will continue to house educational materials
ii. Has the MCO monitored post PIP improvements?		**ASA** – Monitor through Community Measurement Optimum Diabetes Care Measures **Preventive** – Monitored through Care Plan Audits **HPV** – Claims data and new HEDIS measure

8 42 CFR 438.240 (d)(2)
9 MSHO/MSC+ Contract section 7.3; SNBC Contract section 7.2
10 CMS Protocols, Conduction Performance Improvement Projects, Activity 10

DHS Contractual Element and References	Met/ Not Met	Audit Comments
8. Disease Management -2012 Contract Section 7. 311 The MCO shall make available a Disease Management Program for its Enrollees with: A. Diabetes B. Asthma C. Heart Disease **Standards -**The MCO's Disease Management Program shall be consistent current NCQA "*Standards and Guidelines for the Accreditation of Health Plans*" – QI Standard Disease Management 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.	**Met**	UCare's Disease Management program has the mandatory disease management programs of diabetes, asthma, and heart disease. They changed their vendor in 2010 and have new data methodology that yield some significant results. UCare stratifies by at risk vs. high risk enrollees. Interventions include barrier assessment; education, support and reinforcement of self-management communication with their provider. For example, "at risk" enrollees get interactive voice response phone calls with an Asthma Action Plan and incentives for completion with their physician. High Risk enrollees get Asthma Action Plans and the same incentive plan and they receive a RT case mgmt. and an in-home visit. In 2011, UCare measured the heart failure DM program using a cohort methodology. In 2012, UCare applied this methodology to all 3 DM programs and measured using the NCQA measurement year of July through June. Comparing the measures before and after the interventions. For the Heart Failure Program, UCare measured the number of inpatient admits per 1000 participants and the number of ED visits per 1,000. In a quasi-experimental cohort study, UCare compared each at risk and high risk participant with 1 control group at risk or high risk enrollee who did not receive the interventions. In comparison, UCare found that high risk participants had a 40% reduction in admits, compared to the control group 26%. High Risk participants had a 26% reduction in ED visits compared to non-participants at 21%. At risk participants had a more modest reduction. However the program appears to be effective in reducing the number of admits and ED visits.

11 MSHO/ MSC+ Contract section 7.4, requires only diabetes and hearth DM programs; SNBC Contract section 7.2.9

Disease Management Compliance

Condition	Met/Not Met	Comments UCare changed its reporting dates to align with NCQA, so provided 2011 and 1/1-6/30/12 reporting. Next report will be 7/1/12-6/30/13
Diabetes	**Met**	
B. Program Content	**Met**	
C. Identifying Members for DM Programs	**Met**	
D. Frequency of Member Identification	**Met**	
E. Providing Members With Information	**Met**	
F. Interventions Based on Stratification	**Met**	
G. Eligible Member Participation	**Met**	
H. Informing and Educating Practitioners	**Met**	
I. Integrating Member Information	**Met**	
J. Satisfaction With Disease Management	**Met**	
K. Measuring Effectiveness	**Met**	Uses HEDIS "Comprehensive Diabetes Care Components Track against Medicare National 75th percentile and MN Plan Average. racked 4 measures; MSHO met goal for 2: Eye exam and HbA1c; missed LDL-C Screening by %5; & monitoring Neuropathy by <1%;Medicaid combined missed Neuro by <1%;SNBC met all
Asthma:		
B. Program Content	**Met**	
C. Identifying Members for DM Programs	**Met**	
D. Frequency of Member Identification	**Met**	
E. Providing Members With Information	**Met**	
F. Interventions Based on Stratification	**Met**	
G. Eligible Member Participation	**Met**	
H. Informing and Educating Practitioners	**Met**	
I. Integrating Member Information	**Met**	
J. Satisfaction With Disease Management	**Met**	
K. Measuring Effectiveness	**Met**	Uses HEDIS measure of Use of *Appropriate Medications for People with Asthma*. Compares to MN Plan Average and National 75th percentile Missed 75th percentile for HEDIS by < 1% for both PMAP and Medicaid combined.;
Heart Disease:		
B. Program Content	**Met**	
C. Identifying Members for DM Programs	**Met**	
D. Frequency of Member Identification	**Met**	
E. Providing Members With Information	**Met**	
F. Interventions Based on Stratification	**Met**	
G. Eligible Member Participation	**Met**	

H. Informing and Educating Practitioners	**Met**	
I. Integrating Member Information	**Met**	
J. Satisfaction With Disease Management	**Met**	
K. Measuring Effectiveness	**Met**	**Heart Failure Outcome Measures:** the number of inpatient admits per 1000 participants and the number of ED visits per 1,000. In a "quasi-experimental cohort study," UCare compared each at risk and high risk participant with 1 control group at risk or high risk enrollee who did not receive the interventions. In comparison, UCare found that high risk participants had a 40% reduction in admits, compared to the control group 26%. High Risk participants had a 26% reduction in ED visits compared to non-participants at 21%. At risk participants had a more modest reduction. However the program appears to be effective in reducing the number of admits and ED visits.

Disease Management Program	**Participation Rate 7/2012 – 6/2013**
Asthma	
At Risk	100%
High Risk	20%
Diabetes	
At Risk	100%
High Risk	23%
Heart Failure	83%

DHS Contractual Element and References	Met/ Not Met	Audit Comments
9. Advance Directives Compliance - 2012 Contract Section 1612,13 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: i. Information regarding the enrollee's right to accept or refuse medical or surgical treatment; and to execute a living will, durable power of attorney for health care decisions, or other advance directive. ii. Written policies of the MCO respecting the implementation of the right; and iii. Updated or revised changes in State law as soon as possible, but no later than 90 days after the effective date of the change; iv. Information that complaints concerning noncompliance with the Advance Directive requirement may be filed with the State survey and certification agency (i.e. Minnesota Department of Health), pursuant to 42 CFR 422.128 as required in 42 CFR 438.6(i).	**Met**	UCare documented an improvement in all age groups (18-30; 31-50; 51-up).
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.	**Met**	
C. Treatment. To not condition treatment or otherwise discriminate on the basis of whether an individual has executed an advance directive.	**Met**	
D. To comply with State law, whether statutory or recognized by the courts of the State on Advance Directives, including Laws of Minnesota 1998, Chapter 399, §38.	**Met**	
E. To provide, individually or with others, education for MCO staff, providers and the community on Advance Directives.	**Met**	

12 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
13 MSC/MSC+ Contract Article 16; SNBC Contract Article 16

DHS Contractual Element and References	Met/ Not Met	Audit Comments
10. Validation of MCO Care Plan Audits for MSHO and MSC+[14]. MDH will collect information for DHS to monitor MCO Care Plan Audit activities as outlined in the DHS/MCO MSHO/MSC+) Contract. 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**	UCare requires a CAP from delegates for each element that scores less than 95%. In UCare's 2012 Care Plan Audit, aggregate results showed of the 34 unique elements audited, seven had scores of 95% or greater. MDH audit results showed 100% on all reassessment files and 95% or greater was scored on all the elements. MDH noted that of the 23 files reviewed, there were only four caregiver assessments done. (Refer to Attachment A, Tables 1 and 2 for full audit results).

14 Pursuant to MSHO/MSC+ 2011 Contract sections 6.1.4(A)(2), 6.1.4(A)(3), 6.1.4(A)(4), 6.1.5(B)(4), 6.1.5(B)(5)

DHS Contractual Element and References	Met/ Not Met	Audit Comments
11. Information System. [15, 16] 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.	**Met**	HEDIS Audit Reports submitted for review for years: 1. 2011 – Logiqual Health Management Solutions 2. 2012 – Logiqual Health Management Solutions 3. 2013 – Advent Advisory Group Final Audit Statement: *In our opinion, UCare'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.*

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

Attachment A: **Element 10: EW Care Plan Audit**
Health Plan: UCare
Exam Year: 2013

Table 1

Audit Protocol	Protocol Description	Measures	Total # Charts Reviewed		Total # Charts "Met"		MDH 2013 Total % Met	Comments
			Initial	Reassess	Initial	Reassess		
1	**INITIAL HEALTH RISK ASSESSMENT** For members new to the MCO or product within the last 12 months	Date HRA completed is within 30 calendar days of enrollment date	15	NA	15	NA	15/15 100%	
		All HRA areas evaluated and documented (in enrollee Comprehensive Care Plan)	15	NA	15	NA	15/15 100%	
2	**ANNUAL HEALTH RISK ASSESSMENT** For members on who have been a member of the MCO for more than 12 months [Only for plans with separate HRA]	HRA is completed is within 12 months of previous HRA (results are included in enrollee Comprehensive Care Plan)	NA	NA	NA	NA	NA	UCare uses LTCC for HRA
3	**LONG TERM CARE CONSULTATION – INITIAL** If member is new to EW in the past 12 months	All (100%) of the fields relevant to the enrollee's program are completed with pertinent information or noted as Not Applicable or Not Needed	10	NA	10	NA	10/10 100%	
		LTCC was completed timely (and in enrollee Comprehensive Care Plan)	10	NA	10	NA	10/10 100%	
4	**REASSESSMENT OF EW** For members open to EW who have been a member of	Date re-assessment completed is within 12 months of previous assessment	NA	8	NA	8	8/8 100%	

Audit Protocol	Protocol Description	Measures	Total # Charts Reviewed		Total # Charts "Met"		MDH 2013 Total % Met	Comments
			Initial	Reassess	Initial	Reassess		
	the MCO for more than 12 months	All areas of LTCC have been evaluated and documented (and in enrollee Comprehensive Care Plan)	NA	8	NA	8	8/8 100%	
5	**COMPREHENSIVE CARE PLAN** Includes needs identified in the HRA and/or the LTCC and other sources such as medical records and member and/or family input and all elements of the community support plan.	Date Comprehensive Care Plan was completed is within 30 calendar days of completed LTCC ("Complete" defined as the date the plan is ready for signature (may also be noted as "date sent to member"	15	8	15	8	23/23 100%	
6	**COMPREHENSIVE CARE PLAN SPECIFIC ELEMENTS** To achieve an interdisciplinary, holistic, and preventive focus; the Comprehensive Care Plan must include the elements listed:	Identification of enrollee needs and concerns, including identification of health and safety risks, and what to do in the event of an emergency, are documented in Comprehensive Care Plan and linked to assessed needs as determined by the completed LTCC	15	8	15	8	23/23 100%	
		Goals and target dates (at least, month/year) identified	15	8	14	8	22/23 95.7%	In one file the CCP very sparse (old CCP used) and it did not contain all of the specific CCP elements
		Interventions identified	15	8	14	8	22/23 95.7%	

Audit Protocol	Protocol Description	Measures	Total # Charts Reviewed		Total # Charts "Met"		MDH 2013 Total % Met	Comments
			Initial	Reassess	Initial	Reassess		
		Monitoring progress towards goals	15	8	14	8	22/23 95.7%	
		Outcomes and achievement dates (at least, month/year) are documented	15	8	14	8	22/23 95.7%	
		Documentation of informed choice if member refuses intervention	0	2	0	2	2/2 100%	
		Follow-up plan for contact for preventive care17, long-term care and community support, medical care, or mental health care18, or any other identified concern	15	8	14	8	22/23 95.7%	
7	**PERSONAL RISK MANAGEMENT PLAN**	If refused recommended HCBS care or service, refusal noted in the CCP	0	0	0	0	NA	
		A personal risk management plan is completed as evidence of discussion on how to deal with situations when support refused.	0	0	0	0	NA	
8	**ANNUAL PREVENTIVE CARE**	Documentation in enrollee's Comprehensive Care Plan that substantiates a conversation was	15	8	14	8	22/23 95.7%	

17 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.
18 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 2013 Total % Met	Comments
			Initial	Reassess	Initial	Reassess		
		initiated with enrollee about the need for an annual, age–appropriate comprehensive preventive health exam (i.e., Influenza immunization, Pneumococcal immunization, Shingles (Zostavax) immunization, Vision screening, Depression screening (or other mental status review), Assessment of the presence of urinary incontinence, Preventive dental exam						
9	**ADVANCE DIRECTIVE**	evidence that a discussion was initiated, enrollee refused to complete, was culturally inappropriate, or AD was completed	15	8	14	8	22/23 95.7%	
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)	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)	15	8	15	8	23/23 100%	
		Completed and signed care plan summary (and in enrollee Comprehensive Care Plan)	12	8	12	8	20/20 100%	
11	**CHOICE OF HCBS**	Completed and signed	12	8	12	8	20/20	

Audit Protocol	Protocol Description	Measures	Total # Charts Reviewed		Total # Charts "Met"		MDH 2013 Total % Met	Comments
			Initial	Reassess	Initial	Reassess		
	PROVIDERS Enrollee was given information to enable the enrollee to choose among providers of HCBS	care plan summary (and in enrollee Comprehensive Care Plan)					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	type of services to be furnished	15	8	15	8	23/23 100%	
		the amount, frequency and duration of each service	15	8	15	8	23/23 100%	
		the type of provider furnishing each service including non-paid care givers and other informal community supports or resources	15	8	15	8	23/23 100%	
13	**CAREGIVER SUPPORT PLAN** If a primary caregiver is identified in the LTCC,	Attached Caregiver Planning Interview	1	3	1	3	4/4 100%	
		Incorporation of stated caregiver needs in Service Agreement, if applicable	0	1	0	1	1/1 100%	

Summary:

DHS utilized its sampling methodology to produce the EW care plan sample lists. MDH submitted the sample EW care plan lists to UCare which contained 20 initial assessments and 20 reassessments. MDH reviewed 15 initial assessments and eight reassessments following the *MSHO and MSC+ Elderly Waiver Planning Protocol Care Plan Data Collection Guide*.

UCare requires a CAP from delegates for each element that scores less than 95%. In UCare's 2012 Care Plan Audit, aggregate results showed of the 34 unique elements audited, seven had scores of 95% or greater. (Refer to Table 2). MDH audit results showed 100% on all reassessment files and scored 95% or greater on all the elements.

Table 2: Comparison of UCare Audit Findings from 2012 and MDH Audit Findings from 2013

Audit Protocol #	Desired Outcome	Description of Protocol Area	UCare 2012 # Care Plans with a "Met" score	UCare 2012 % Care Plans with a "Met" score	MDH 2013 # Care Plans w/ "Met" Score	MDH 2013 % Care Plans w/ "Met" Score
1	Initial Health Risk Assessment	a. Completed within timelines	176/230	76.5%	15/15	100%
		b. Results included in CCP	152/178	85.4%	15/15	100%
		c. All areas evaluated and documented	166/202	82.2%	15/15	100%
2	Annual Health Risk Assessment	a. Complete within timelines	0	N/A	0	NA
		b. Results included in CCP	0	N/A	0	NA
3	LTCC- Initial (New to EW in past 12 months)	a. LTCC results attached to CCP	8/8	100.0%	10/10	100%
		b. All relevant fields completed or "n/a" is doc'd	7/8	87.5%	10/10	100%
		c. Completed timely	8/8	100.0%	10/10	100%
4	Annual Reassessment of EW	a. Annual re-assess w/in 12 months of prior assessment or explanation documented	301/303	99.3%	8/8	100%
		b. Results of LTCC attached to CCP	280/282	99.3%	8/8	100%
		c. All areas evaluated and documented	360/403	89.3%	8/8	100%
5	Comprehensive Care Plan	CCP completed w\in 30 days of LTCC or explanation documented	484/506	95.7%	23/23	100%
6	Comprehensive Care Plan Specific Elements	a. Needs & Concerns identified	487/518	94.0%	23/23	100%
		b. Goals/target dates identified	488/518	94.2%	22/23	95.7%
		c. Interventions identified	486/517	94.0%	22/23	95.7%
		d. Monitoring progress towards goals	480/509	94.3%	22/23	95.7%
		e. Outcome/Achievement dates are documented	312/365	85.5%	22/23	95.7%
		f. Doc of informed choice if member refuses recommended interventions	48/64	75.0%	2/2	100%
		g. Follow up plan for contact for preventative care, long-term care etc.	448/466	96.1%	22/23	100%
7	Personal Risk Management Plan	a. HCBS service refusal noted in CCP	29/46	63.0%	0	NA
		b. Personal risk management plan completed	50/70	71.4%	0	NA
8	Annual Preventive Health Exam	Annual Preventive health exam conversation initiated	486/515	94.4%	22/23	95.7%
9	Advance Directive	Advanced Directive conversation	526/546	96.3%	22/23	95.7%
10	Enrollee Choice	a. LTCC Section J or equivalent document	491/526	93.3%	23/23	100%
		b. Completed & signed Care Plan	489/526	93.0%	20/20	100%
		c. Copy of CCP summary	495/533	92.9%	20/20	100%
11	Choice of HCBS Providers	a. Completed & signed Care Plan	464/499	93.0%	20/20	100%
		b. Copy of CCP Summary	494/533	92.7%	20/20	100%

Audit Protocol #	Desired Outcome	Description of Protocol Area	UCare 2012 # Care Plans with a "Met" score	UCare 2012 % Care Plans with a "Met" score	MDH 2013 # Care Plans w/ "Met" Score	MDH 2013 % Care Plans w/ "Met" Score
12	Community Support Plan – Community Services and Supports Section	a. Type of Services	463/495	93.5%	23/23	100%
		b. Amount, Frequency, Duration and Cost	463/495	93.5%	23/23	100%
		c. Type of Provider & non-paid/informal	463/495	93.5%	23/23	100%
		d. Attempted not complete w/explanation	0/0	NA	0	NA
13	Caregiver Support Plan	a. Caregiver planning interview/assessment attached	96/121	79.3%	4/4	100%
		b. Caregiver needs incorporated into SA, if applicable	62/86	72.2%	1/1	100%