AUDIT ACTIVITIES GRID

FINANCIAL				
Audit Name	**Auditor**	**Purpose**	**Frequency**	**Availability of Report**
Financial Audit	Minnesota Department of Commerce	The audit is conducted using procedures outlined in the National Association of Insurance Commissioners (NAIC) Examiners hand book. Activities include: • Assessing the health plan's financial condition/stability over a three year period. • Evaluating if there are potential risks that could threaten a plan's financial stability. • Assessing the effectiveness of health plan systems and internal controls in place to review administrative expense detail, analyze payments and review and test work done by external auditors. • Reporting on any deficiencies in processes and procedures. • Reviewing health plan corporate affairs and operations to determine compliance with Minnesota statutes.	The audit is conducted every three years. Financial transactions over the three year period are subject to audit. The Minnesota Department of Health delegates its financial oversight responsibility to the Minnesota Department of Commerce.	The report is publicly available on the Minnesota Department of Health's website.
Annual Financial Statement Audit	Independent audit firm selected by the health plan	• Required by the state. • This audit is a comprehensive examination of a health plan's annual financial statements prepared using Statutory Accounting Principles established by the NAIC and state statute. Some plans also choose to have an audit conducted on its financial statements prepared using Generally Accepted Accounting Principles. The audit is conducted based on nationally established Generally Accepted Auditing Standards, including a rotation of auditors. • This audit determines whether or not the plan's financial statement balances are accurate, complete and valid.	The audit is conducted annually by an independent audit firm selected by the board of the health plan.	The report is filed with the Minnesota Department of Commerce but is not available unless requested. It is available, upon request, directly from the health plan. Audited financial results are also required to be reported annually to health plan enrollees.

FINANCIAL				
Audit Name	**Auditor**	**Purpose**	**Frequency**	**Availability of Report**
Cash flow and investment income audit	CMS, Office of Inspector General (OIG)	• This audit is a review of how the health plan treats investment income as it sets its premium prices and develops bids for Medicare. OIG will use information gathered to write the report commenting on CMS oversight of this portion of the bid process.	The audit is conducted as scheduled.	This audit may be publicly available from CMS upon request, unless exempt from disclosure under federal law. The audit is available directly from the health plan upon request.
CMS Office of Financial Management Transaction and Financial Activity Audit	Audit firm selected by CMS	This audit examines how the health plan spent Medicare money to ensure the plan is in compliance with CMS contract requirements. • Accuracy and compliance with regulations of Prescription Drug Event (PDE) data and other data reported to CMS. • Base year experience reported in the bid filing is accurate and compliant with regulations and instructions. • Adequate internal controls exist over payments made for medical and drug related benefits/services. • Health plan meets solvency requirements to bear the financial risks of potential financial losses in the program and has the ability to pay for services performed.	Each contract with CMS is subject to an audit once every three years.	This audit may be publicly available from CMS upon request, unless exempt from disclosure under federal law. The audit is available directly from the health plan upon request.
MINNESOTA SENIOR HEALTH OPTIONS (MSHO) / SPECIAL NEEDS BASICCARE (SNBC)				
Audit Name	**Auditor**	**Purpose**	**Frequency**	**Availability of Report**
MSHO Audit SNBC Audit	CMS	• The audit ensures a health plan is following all rules and regulations in providing health care coverage for people who qualify for both Medicare and Medicaid.	The audit is conducted as scheduled.	This audit may be publicly available from CMS upon request, unless exempt from disclosure under federal law. The audit is available directly from the health plan upon request.
Structure and Process Audit	CMS	• The audit evaluates care management, member satisfaction, quality improvement, transition management and coordination of Medicare/Medicaid benefits in special needs plans.	The audit is conducted annually.	The audit findings are not public.

QUALITY				
Audit Name	**Auditor**	**Purpose**	**Frequency**	**Availability of Report**
Quality Assurance	Minnesota Department of Health (MDH)	This audit reviews health plan compliance with state law and MDH rules. It ensures the health plan follows all rules around member complaints and grievances, benefit decisions and ensuring the health plan has enough qualified providers to meet their enrollee's needs. • During this audit, MDH also gathers information on behalf of the Minnesota Department of Human Services (DHS) for that agency's Triennial Compliance Assessment (see next row).	The audit is conducted every three years with a review in between years one and three.	The report is publicly available on the Minnesota Department of Health's website.
Triennial Compliance Assessment (TCA)	Minnesota Department of Human Services (DHS) (conducted by MDH)	• This audit is a review of a health plan's compliance with DHS contract and federal requirements for 16 standards, including: service and utilization review, network maintenance and monitoring, quality improvement structure (including Performance Improvement Projects), credentialing, disease management programs, grievances and appeals process, procedures for pharmaceutical management, and compliance with advance directives requirements. If a health plan is not meeting DHS requirements and enrollees weren't receiving care, this audit would show any violations.	The audit is conducted every three years.	Available from the Minnesota Department of Human Services
Care Plan Audit	Department of Human Services (DHS) (conducted by contractor)	• This audit is a review of a health plan's compliance with the DHS contract and verification that MSHO/MSC+ care plan audits are performed by the health plan. It ensures people who coordinate care for MSHO and MSC+ enrollees are doing the work required in the contracts.	The audit is conducted annually.	The audit is available directly from the health plan upon request.

QUALITY				
Audit Name	**Auditor**	**Purpose**	**Frequency**	**Availability of Report**
HEDIS (Healthcare Effectiveness Data and Information Set) Medical Records and Compliance Audit	CMS	• The audit is used for obtaining and submitting quality of care information to CMS and the State. The data is gathered by reviewing randomly selected charts (e.g. blood pressure on the last visit) and information from bills (e.g. how many women had a mammogram.) HEDIS is used by more than 90 percent of America's health plans to measure performance on the quality of care enrollees receive and the enrollee's satisfaction with service. The report reviews 71 components across eight are of care including chronic disease management, wellness and prevention, safety and potential waste, and appropriate care for children and older adults. • A Health plan uses this information to compare its results to local and national health plans. Health plans also examine the data to determine where improvements are needed and if past improvement efforts have been successful. • This also reviews how the health plan gathered the information it used to develop reports that are submitted to HEDIS.	The audit is conducted annually.	This audit may be publicly available from CMS upon request, unless exempt from disclosure under federal law. The audit is available directly from the health plan upon request.
MEDICARE ADVANTAGE				
Audit Name	**Auditor**	**Purpose**	**Frequency**	**Availability of Report**
Parts C & D Program Audit	Centers for Medicare & Medicaid Services (CMS)	• This audit is a review of compliance with Medicare Parts C and D regulations and other applicable CMS standards. The audit is determined by: data, complaints, prior audit/compliance history, experience in Medicare Advantage, low enrollment and Medical Advantage Organizations not recently audited.	This audit is tied to how CMS determines its payments to the health plan based on the level of illness of its members.	This audit may be publicly available from CMS upon request, unless exempt from disclosure under federal law. The audit is available directly from the health plan upon request.

MEDICARE ADVANTAGE				
Audit Name	**Auditor**	**Purpose**	**Frequency**	**Availability of Report**
Risk Adjustment Data Validation (RADV) Audit	CMS	• Part of a health plan's payment from CMS is based on the diagnoses of people enrolled in the health plan. Certain illnesses allow a health plan to be paid more than the base rate. All of the illnesses must be documented in the individuals' medical charts. This audit picks a sample of enrollees and requires the health plan to prove the CMS the individuals have the reported diagnosis. If there are errors (a person is reported to have a diagnosis but the medical chart doesn't include that detail) CMS takes back money. The audit determines an error rate based on the sample. That error rate is then multiplied across all Medicare Advantage enrollees in the health plan to determine how much money the health plan must give back to CMS.	All Medicare Advantage Organizations will have an audit within three years (2009-2011).	This audit may be publicly available from CMS upon request, unless exempt from disclosure under federal law. The audit is available directly from the health plan upon request.
Data Validation Audit	CMS (via vendor contracted by health plan)	• This is a review of past Part C & D data to ensure they are reliable, valid, complete and comparable across plans. Auditors (on behalf of CMS) review the processes for collecting, storing, analyzing and reporting data.	The audit is conducted annually.	This audit may be publicly available from CMS upon request, unless exempt from disclosure under federal law. The audit is available directly from the health plan upon request.
Medicare Advantage Part D Audit	CMS	• This audit is a review of fraud, waste and abuse in Medicare Advantage Organization's Part D program. Typically, these are targeted audits based on complaints.	The audit is conducted as scheduled.	This audit may be publicly available from CMS upon request, unless exempt from disclosure under federal law. The audit is available directly from the health plan upon request.
Bid Submission and Payment Audit	CMS, Office of the Actuary	• This audit ensures that health plan followed all federal rules as it prepared its Medicare Advantage bid, including which costs were included.	One-third of Medicare Advantage Organizations receive this audit annually.	This audit may be publicly available from CMS upon request, unless exempt from disclosure under federal law. The audit is available directly from the health plan upon request.

COMMERCIAL				
Audit Name	**Auditor**	**Purpose**	**Frequency**	**Availability of Report**
Claims Administration Audits	Independent Outside Consulting Firms	• These audits validate the accuracy of claim processing and benefit administration. They typically include a review of a sample of all claims processed on an employer's behalf, but also can include a review of all the operations of the health plan.	This audit is conducted on a regular basis.	Nonpublic
Statement of Auditing Standard (SAS 70) Audits	Independent External Certified Public Accountants	• These audits are designed to provide an independent validation that the health plans have adequate controls and safeguards when they process claims for their customers.	This audit is conducted on a regular basis.	Nonpublic