

Triennial Compliance Assessment

Of

Blue Plus

Performed under Interagency Agreement for:

Minnesota
Department of Human Services

By

Minnesota Department of Health (MDH)
Managed Care Systems Section

Exam Period: May 1, 2010 to March 31, 2013

File Review Period: April 1, 2012 to March 31, 2013

On-site: June 17, 2013 to June 21, 2013

Examiners:

Elaine Johnson, RN, BS, CPHQ
Susan Margot, MA

Final TCA Summary Report
December 31, 2013

Executive Summary
Triennial Compliance Assessment (TCA)
BluePlus

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)/County Based Purchaser (CBP): Blue Plus
Examination Period: May 1, 2010 to March 31, 2013
Onsite Dates: June 17, 2013 to June 21, 2013

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DHS Triennial Compliance Assessment (TCA)
TCA Data Collection Grid
SFY 2013

| DHS Contractual Element and References | Met/ Not Met | Audit Comments |
|---|-------------------|---|
| <p>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).</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>Excellent format. Includes 10 focus areas, high level goals and key outcome measures.</p> |

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| <p>2. Accessibility of Providers -2012 MSHO/MSC+ Contract Section 6.1.4(C)(2) and 6.1.5(E)</p> <p>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</p> | <p>Not Met</p> | <p>Blue Plus does not contract with individual home and community based service providers, but relies on the counties' contracts with vendors. The Blue Plus Coordination of Care Guidelines state the care coordinator must ensure access to an adequate range of choices for each member by helping identify culturally sensitive supports and services. The Blue Plus contract with the counties does not discuss the county EW vendor contract, except to state what should be done if the service is provided outside the county's network. Blue Plus annually surveys each county with two questions regarding how the county ensures EW providers meet the DHS provider standards/requirements and how the county monitors providers and services. The survey doesn't address an adequate range of EW providers or services. No analysis or reporting of the survey results was provided.</p> <p><u>DHS Comment: Blue Plus is expected to develop and have policies and procedures in place for reviewing and acknowledging when network gaps occur.</u></p> <p>Blue Plus Care Coordination Guidelines for enrollees in nursing facilities show an ongoing process for care transitions. Blue Plus monitors for care transition documentation in its annual care plan audits and corrective Action Plans, noting continuing improvement. In MDH care plan evaluation, MDH identified one care plan where the enrollee was moved out of the nursing home to community based EW services with appropriate reviews, notices and follow-up.</p> |
| <p>3. Utilization Management - 2012 Contract Section 7.1.3</p> <p>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:</p> <ol style="list-style-type: none"> 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. | <p>Met</p> | <p>Blue Plus has initiated a new Quality Improvement process. BP provided the 2012 Utilization Management Program Evaluation, of which "Appropriate Utilization" was a section.</p> <p>Thresholds are based on their own trend data and national trend reports.</p> <p>2012 reported on 17 initiatives in various stages of review and implementation. Analysis is highly data driven and focused on particular providers, as appropriate (high volume utilization, select pilot projects, etc.).</p> <p>Along with the data from the Trend Committee, and with the Government Programs Appropriate Utilization Workgroup (GPAUW), Blue Plus participated in a (HMO) collaborative PIP to decrease the number of non-</p> |

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

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| <p>iii. Conduct qualitative analysis to determine the cause and effect of all data not within thresholds.</p> <p>iv. Analyze data not within threshold by medical group or practice.</p> <p>v. Take action to address identified problems of under or overutilization and measure the effectiveness of its interventions. ²</p> <p>B. The following are the 2012 NCQA Standards and Guidelines for the Accreditation of MCOs UM 1-4 and 10-14.</p> <p>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.</p> <p>Element A: Written Program Description Element B: Physician Involvement Element C: Behavioral Health Involvement Element D: Annual Evaluation</p> <p>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.</p> <p>Element A: UM Criteria Element B: Availability of Criteria Element C: Consistency of Applying Criteria</p> <p>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.</p> <p>Element A: Access to Staff</p> <p>NCQA Standard UM 4: Appropriate Professionals. Qualified Licensed health professionals assess the clinical information used to support UM decisions.</p> | <p>Met Thru NCQA</p> <p>Met Thru NCQA</p> <p>Met Thru NCQA</p> <p>Met Thru NCQA</p> | <p>emergent visits to the ED. In collaboration with Minneapolis Head Start and early Head Start, HeadStart teachers were trained to teach children and parents about what to do when they get sick and where to go for care.</p> |
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2 42 CFR 438. 240(b)(3)

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| <p>Element D: Practitioner Review of BH Denials Element F: Affirmative Statement About Incentives</p> | | |
| <p>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.</p> <p>Element A: Written Process Element B: Description of Evaluation Process Element C: Implementation of New Technology</p> | <p>Met Thru NCQA</p> | |
| <p>NCQA Standard UM 11: Satisfaction with UM Process. The organization evaluates member and practitioner satisfaction with the UM process.</p> <p>Element A: Assessing Satisfaction with UM Process</p> | <p>Met Thru NCQA</p> | |
| <p>NCQA Standard UM 12: Emergency Services. 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> | <p>Met</p> | |
| <p>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</p> <p>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</p> | <p>Met Thru NCQA</p> | |
| <p>NCQA Standard UM 14: Triage and Referral to Behavioral Health. The</p> | <p>N/A</p> | <p>BluePlus does not have centralized behavioral health triage</p> |

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| <p>organization has written standards to ensure that any centralized triage and referral functions for behavioral health services are appropriately implemented, monitored and professionally managed. <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 Element B: Clinical Decisions Element C: Supervision and Oversight</p> | | |
| <p>4. Special Health Care Needs 2012 Contract Section 7.1.4 (A-C)^{3, 4} The MCO must have effective mechanisms to assess the quality and appropriateness of care furnished to Enrollees with special health care needs.</p> <p>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</p> | <p>Met</p> | |
| <p>5. Practice Guidelines -2012 Contract Section 7.1.5^{5,6,}</p> <p>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.</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: to all affected Providers; and to enrollees and potential enrollees upon request</p> | <p>Met</p> | |

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

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

5 42 CFR 438.236

6 MSHO/MS+ Contract section 7.2 A-C

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| Diabetes: | | |
| B. Program Content | | |
| C. Identifying Members for DM Programs | | |
| D. Frequency of Member Identification | | |
| E. Providing Members With Information | | |
| F. Interventions Based on Stratification | | |
| G. Eligible Member Participation | | |
| H. Informing and Educating Practitioners | | |
| I. Integrating Member Information | | |
| J. Satisfaction With Disease Management | | |
| K. Measuring Effectiveness | | <p>—HbA1c Poorly controlled (>9.0%) Reported Rate (Adjusted) 31.39; 75th percentile was 35%</p> <p>-- Eye Exams Reported Rate (Adjusted) 81.92; 90th percentile was 60%</p> <p>--Neuropathy Monitoring Reported Rate (Adjusted) 85.41; 75th percentile was 82%</p> <p>--Averaged Rate (3.1874 score)</p> <p>--LDL-C Screening Reported Rate (Adjusted) 84.30; 90th percentile was 81%</p> <p>--HbA1c Testing Reported Rate (Adjusted) 92.71; 90th percentile was 89%</p> |
| Asthma: | | |
| B. Program Content | | |
| C. Identifying Members for DM Programs | | |
| D. Frequency of Member Identification | | |
| E. Providing Members With Information | | |
| F. Interventions Based on Stratification | | |
| G. Eligible Member Participation | | |
| H. Informing and Educating Practitioners | | |
| I. Integrating Member Information | | |
| J. Satisfaction With Disease Management | | |
| K. Measuring Effectiveness | | Use of Appropriate Medications for People with Asthma (combined measure). Reported Rate (Adjusted) 91.73; 75 th percentile was 90% |
| Heart Disease: | | |
| B. Program Content | | |
| C. Identifying Members for DM Programs | | |

| | | |
|---|------------|---|
| D. Frequency of Member Identification | | |
| E. Providing Members With Information | | |
| F. Interventions Based on Stratification | | |
| G. Eligible Member Participation | | |
| H. Informing and Educating Practitioners | | |
| I. Integrating Member Information | | |
| J. Satisfaction With Disease Management | | |
| K. Measuring Effectiveness | | Cholesterol Management for Patients with Cardiovascular Conditions (Screening rate only). Reported Rate (Adjusted) 93.26; 75 th percentile was 87% |
| 9. Advance Directives Compliance - 2012 Contract Section 16 ^{13,14} | Met | |
| <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"> 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). <p>B. Providers. To require MCO’s providers to ensure that it has been</p> | | |

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;

| DHS Contractual Element and References | Met/ Not Met | Audit Comments |
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| 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 | |

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| <p>10. Validation of MCO Care Plan Audits for MSHO and 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> | Met | Comparison of Blue Plus’s 2012 EW Care Plan Audit Aggregate results with MDH’s 2013 Care Plan Audit | | | | | | |
| | | Audit Protocol # | Protocol | Description of Protocol Area | 2012 Blue Plus # of Care Plans with a “Met” score | 2012 Blue Plus % of Care Plans with a “Met” score | 2013 MDH Total # Charts “Met” | MDH 2013 Total % Met |
| | | 1 | Initial Health Risk Assessment | a. Completed within timelines | 64/83 | 77.11% | 13/15 | 86.7% |
| | | | | b. All areas evaluated and documented | 56/61 | 91.80% | 13/15 | 86.7% |
| | | 2 | Annual Health Risk Assessment | a. Complete within timelines b. Results included in CCP | Blue Plus uses LTCC for the HRA | | | |
| 3 | LTCC- Initial (New to EW in | a. Competed timely and attached to CCP | 3/3 | 100% | 2/2 | 100% | | |

¹⁵ Pursuant to MSHO/MS C+ 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 | | | | |
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| 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. | | | past 12 months) | b. All relevant fields completed or "n/a" is doc'd | 3/3 | 100% | 2/2 | 100% |
| 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. | | 4 | Annual Reassessment of EW | a. Annual reassess w/in 12 months of prior assessment or explanation documented | 457/460 | 99.35% | 15/15 | 100% |
| | | | | b. All areas evaluated and documented | 532/566 | 93.99% | 15/15 | 100% |
| | | 5 | Comprehensive Care Plan | CCP completed w/in 30 days of LTCC or explanation documented | 620/644 | 96.27% | 29/30 | 96.7% |
| | | 6 | Comprehensive Care Plan Specific Elements | a. Needs & Concerns identified, including Health and safety risks | 567/589 | 96.26% | 27/30 | 90.0% |
| | | | | b. Goals and target dates | 496/522 | 95.02% | 28/30 | 93.3% |
| | | | | c. Outcomes and achievement dates are documented | 532/741 | 71.79% | 28/30 | 93.3% |
| | | | | d. Follow up plan for contact for preventive care, long term care, etc. | 670/766 | 87.47% | 26/30 | 86.7% |
| | | 7 | Personal Risk Management Plan | a. HCBS service refusal noted in CCP | 24/29 | 82.76% | 3/3 | 100% |
| b. Personal risk management plan completed | 26/37 | | | 70.27% | 3/3 | 100% | | |

| DHS Contractual Element and References | Met/ Not Met | Audit Comments | | | | |
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| | | 8 | Annual Preventive Health Exam | Annual Preventive health exam conversation initiated | 539/545 | 98.90% | 28/30 | 93.3% | | |
| | | 9 | Advance Directive | Advanced Directive conversation | 551/559 | 98.57% | 29/30 | 96.7% | | |
| | | 10 | Enrollee Choice | a. LTCC Section J or equivalent document | 498/501 | 99.40% | 30/30 | 100% | | |
| | | | | b. Completed & signed Care Plan | 570/584 | 97.60% | 28/30 | 93.3% | | |
| | | 11 | Choice of HCBS Providers | Completed & signed Care Plan | 549/562 | 97.69% | 28/30 | 93.3% | | |
| | | 12 | Community Support Plan – Community Services and Supports Section | a. Type of Services | 506/545 | 92.84% | 28/30 | 93.3% | | |
| | | | | b. Amount, Frequency, Duration and Cost | 507/545 | 93.03% | 28/30 | 93.3% | | |
| | | | | c. Type of Provider & non-paid/informal | 507/545 | 93.03% | 28/30 | 93.3% | | |
| | | 13 | Caregiver Support Plan | a. Caregiver planning interview/assessment attached | 121/142 | 85.21% | 1/1 | 100% | | |
| | | | | b. Caregiver needs incorporated into SA, if applicable | 119/140 | 85.00% | 1/1 | 100% | | |
| | | <p>The audit results comparing Blue Plus’s EW Care Plan audit with MDH are very similar. MDH audit showed 100% compliance on all reassessment files. MDH concurs Blue Plus identified areas of ongoing improvement that included:</p> <ul style="list-style-type: none"> Delegates need further training on HRAs. When an enrollee has ongoing care coordination, but is new to a product, a HRA or review of previous HRA needs to be done and within timelines. Goals, outcomes and follow up planning documentation | | | | | | | | |

| DHS Contractual Element and References | Met/ Not Met | Audit Comments |
|--|-------------------|--|
| | | <ul style="list-style-type: none"> • Community Support Plan not included in all files • In the 30 files reviewed by MDH, only one file had a caregiver assessment. [Refer to Attachment A for complete summary]. |
| <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.</p> <p>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>HEDIS Audit Reports submitted for review for years:</p> <ol style="list-style-type: none"> 1. 2010 – Attest Health Care Advisors 2. 2011 - Attest Health Care Advisors 3. 2012 - Attest Health Care Advisors <p>Audit reports state “...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”.</p> |

¹⁶ Families and Children, and Seniors
¹⁷ 42 CFR 438.242

**Attachment A:
Health Plan: Blue Plus
Exam Year: 2013**

Care Plan Audit

| 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 | 13 | NA | 13/15 86.7% | 1 file no HRA update 1 file 58 days |
| | | All HRA areas evaluated and documented (in enrollee Comprehensive Care Plan) | 15 | NA | 13 | NA | 13/15 86.7% | 1 file no HRA 1 file no CCP |
| 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 | Blue Plus 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 | 2 | NA | 2 | NA | 2/2 100% | |
| | | LTCC was completed timely (and in enrollee Comprehensive Care Plan) | 2 | NA | 2 | NA | 2/2 100% | |
| 4 | REASSESSMENT OF EW | Date re-assessment completed is within 12 | NA | 15 | NA | 15 | 15/15 100% | |

| Audit Protocol | Protocol Description | Measures | Total # Charts Reviewed | | Total # Charts "Met" | | MDH 2013 Total % Met | Comments |
|----------------|---|---|-------------------------|----------|----------------------|----------|----------------------|---|
| | | | Initial | Reassess | Initial | Reassess | | |
| | For members open to EW who have been a member of the MCO for more than 12 months | months of previous assessment | | | | | | |
| | | All areas of LTCC have been evaluated and documented (and in enrollee Comprehensive Care Plan) | NA | 15 | NA | 15 | 15/15 100% | |
| 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 | 15 | 14 | 15 | 29/30 96.7% | |
| 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 | 15 | 12 | 15 | 27/30 90.0% | 1 file had no CCP, 1 file used old CCP that did not contain all items, and 1 file had no emergency plan |
| | | Goals and target dates (at | 15 | 15 | 13 | 15 | 28/30 | |

| Audit Protocol | Protocol Description | Measures | Total # Charts Reviewed | | Total # Charts "Met" | | MDH 2013 Total % Met | Comments |
|----------------|--------------------------------------|--|-------------------------|----------|----------------------|----------|----------------------|----------|
| | | | Initial | Reassess | Initial | Reassess | | |
| | | least, month/year) identified Monitoring of outcomes and achievement dates (at least, month/year) are documented | | | | | 93.3% | |
| | | Outcomes and achievement dates (at least, month/year) are documented | 15 | 15 | 13 | 15 | 28/30 93.3% | |
| | | If the enrollee refuses any of the recommended interventions, the Comprehensive Care Plan includes documentation of an informed choice about their care and support | NA | NA | NA | NA | | |
| | | Follow-up plan for contact for preventive care ¹⁸ , long-term care and community support, medical care, or mental health care ¹⁹ , or any other identified concern | 15 | 15 | 11 | 15 | 26/30 86.7 | |
| 7 | PERSONAL RISK MANAGEMENT PLAN | If refused recommended HCBS care or service, | 3 | NA | 3 | NA | 3/3 100% | |

¹⁸ 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.

¹⁹ 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 | | |
| | | refusal noted in the CCP | | | | | | |
| | | A personal risk management plan is completed as evidence of discussion on how to deal with situations when support refused. | 3 | NA | 3 | NA | 3/3 100% | |
| 8 | ANNUAL PREVENTIVE CARE | Documentation in enrollee's Comprehensive Care Plan that <u>substantiates a conversation was initiated</u> 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 | 15 | 15 | 13 | 15 | 28/30 93.3% | 1 initial file had no CCP and 1 initial file used old CCP not containing all elements |

| Audit Protocol | Protocol Description | Measures | Total # Charts Reviewed | | Total # Charts "Met" | | MDH 2013 Total % Met | Comments |
|----------------|---|--|-------------------------|----------|----------------------|----------|----------------------|--|
| | | | Initial | Reassess | Initial | Reassess | | |
| 9 | ADVANCE DIRECTIVE | evidence that a discussion was initiated, enrollee refused to complete, was culturally inappropriate, or AD was completed | 15 | 15 | 14 | 15 | 29/30 96.7% | |
| 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 | 15 | 15 | 15 | 30/30 100% | |
| | | Completed and signed care plan summary (and in enrollee Comprehensive Care Plan) | 15 | 15 | 13 | 15 | 28/30 93.3% | 1 file no CCP and 1 file blank form signed |
| 11 | CHOICE OF HCBS PROVIDERS Enrollee was given information to enable the enrollee to choose among providers of HCBS | Completed and signed care plan summary (and in enrollee Comprehensive Care Plan) | 15 | 15 | 13 | 15 | 28/30 93.3% | |
| 12 | HOME AND COMMUNITY BASED SERVICE PLAN A HCBS service plan with these areas completed, including clearly identified | type of services to be furnished | 15 | 15 | 13 | 15 | 28/30 93.3% | 2 files had no HCBS plan |
| | | the amount, frequency and duration of each service | 15 | 15 | 13 | 15 | 28/30 93.3% | |

| Audit Protocol | Protocol Description | Measures | Total # Charts Reviewed | | Total # Charts "Met" | | MDH 2013 Total % Met | Comments |
|----------------|--|--|-------------------------|----------|----------------------|----------|----------------------|----------|
| | | | Initial | Reassess | Initial | Reassess | | |
| | and documented links to assessed needs per the results of the LTCC | the type of provider furnishing each service including non-paid care givers and other informal community supports or resources | 15 | 15 | 13 | 15 | 28/30 93.3% | |
| 13 | CAREGIVER SUPPORT PLAN If a primary caregiver is identified in the LTCC, | Attached Caregiver Planning Interview | 1 | NA | 1 | NA | 1/1 100% | |
| | | Incorporation of stated caregiver needs in Service Agreement, if applicable | 1 | NA | 1 | NA | 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 Medica, which contained 20 initial assessments and 20 reassessments, of which MDH reviewed 15 of each following the *MSHO and MSC+ Elderly Waiver Planning Protocol Care Plan Data Collection Guide*.

Blue Plus changed its audit policy in March 2011 raising the bar as to what is expected. The delegate must now meet a 95% threshold to obtain a "met score".

If the delegate did not reach 95% a CAP was required. After completing the audit, an exit interview is conducted with agency director/supervisor recognizing improved efforts, areas of concern and suggestions for process improvements. 20 of the 61 delegates met the 95% target. The remaining 41 delegates submitted a CAP.

MDH's audit of Blue Plus's reassessment EW Care Plan files showed 100% compliance. Table 2 shows the comparison between Blue Plus's 2012 EW Care Plan audit and MDH's 2013 audit. The results were very similar. MDH concurs with Blue Plus's assessment of ongoing improvement needs as follows:

- Delegates need further training on HRAs. When an enrollee has ongoing care coordination, but is new to a product, a HRA or review of previous HRA needs to be done and within timelines.
- Goals, outcomes and follow up planning documentation
- Community Support Plan not included in all files
- In the 30 files reviewed by MDH, only one file had a caregiver assessment.

Fall Care Coordinator training covered audit process improvements, transitions of care and Care Coordinator expectations.

Table 2

| Comparison of Blue Plus's 2012 EW Care Plan Audit Aggregate results with MDH's 2013 Care Plan Audit | | | | | | |
|--|---|--|--|--|--------------------------------------|-----------------------------|
| Audit Protocol Number | Desired Outcome | Description of Protocol Area | 2012 Blue Plus # of Care Plans with a "Met" score | 2012 Blue Plus % of Care Plans with a "Met" score | 2013 MDH Total # Charts "Met" | MDH 2013 Total % Met |
| 1 | Initial Health Risk Assessment | a. Completed within timelines | 64/83 | 77.11% | 13/15 | 86.7% |
| | | b. All areas evaluated and documented | 56/61 | 91.80% | 13/15 | 86.7% |
| 2 | Annual Health Risk Assessment | a. Complete within timelines | Blue Plus uses LTCC for the HRA | | | |
| | | b. Results included in CCP | | | | |
| 3 | LTCC- Initial (New to EW in past 12 months) | a. Completed timely and attached to CCP | 3/3 | 100% | 2/2 | 100% |
| | | b. All relevant fields completed or "n/a" is doc'd | 3/3 | 100% | 2/2 | 100% |
| 4 | Annual Reassessment of EW | a. Annual re-assess w/in 12 months of prior assessment or explanation documented | 457/460 | 99.35% | 15/15 | 100% |
| | | b. All areas evaluated and documented | 532/566 | 93.99% | 15/15 | 100% |
| 5 | Comprehensive Care Plan | CCP completed w/in 30 days of LTCC or explanation documented | 620/644 | 96.27% | 29/30 | 96.7% |

| Comparison of Blue Plus's 2012 EW Care Plan Audit Aggregate results with MDH's 2013 Care Plan Audit | | | | | | |
|---|---|---|---|---|-------------------------------|----------------------|
| Audit Protocol Number | Desired Outcome | Description of Protocol Area | 2012 Blue Plus # of Care Plans with a "Met" score | 2012 Blue Plus % of Care Plans with a "Met" score | 2013 MDH Total # Charts "Met" | MDH 2013 Total % Met |
| 6 | Comprehensive Care Plan Specific Elements | a. Needs & Concerns identified, including Health and safety risks | 567/589 | 96.26% | 27/30 | 90.0% |
| | | b. Goals and target dates | 496/522 | 95.02% | 28/30 | 93.3% |
| | | c. Outcomes and achievement dates are documented | 532/741 | 71.79% | 28/30 | 93.3% |
| | | d. Follow up plan for contact for preventive care, long term care, etc. | 670/766 | 87.47% | 26/30 | 86.7% |
| 7 | Personal Risk Management Plan | a. HCBS service refusal noted in CCP | 24/29 | 82.76% | 3/3 | 100% |
| | | b. Personal risk management plan completed | 26/37 | 70.27% | 3/3 | 100% |
| 8 | Annual Preventive Health Exam | Annual Preventive health exam conversation initiated | 539/545 | 98.90% | 28/30 | 93.3% |
| 9 | Advance Directive | Advanced Directive conversation | 551/559 | 98.57% | 29/30 | 96.7% |
| 10 | Enrollee Choice | a. LTCC Section J or equivalent document | 498/501 | 99.40% | 30/30 | 100% |
| | | b. Completed & signed Care Plan | 570/584 | 97.60% | 28/30 | 93.3% |
| 11 | Choice of HCBS Providers | Completed & signed Care Plan | 549/562 | 97.69% | 28/30 | 93.3% |
| 12 | Community Support Plan – Community | a. Type of Services | 506/545 | 92.84% | 28/30 | 93.3% |
| | | b. Amount, Frequency, Duration and Cost | 507/545 | 93.03% | 28/30 | 93.3% |

| Comparison of Blue Plus's 2012 EW Care Plan Audit Aggregate results with MDH' s 2013 Care Plan Audit | | | | | | |
|---|-------------------------------|--|--|--|--------------------------------------|-----------------------------|
| Audit Protocol Number | Desired Outcome | Description of Protocol Area | 2012 Blue Plus # of Care Plans with a "Met" score | 2012 Blue Plus % of Care Plans with a "Met" score | 2013 MDH Total # Charts "Met" | MDH 2013 Total % Met |
| | Services and Supports Section | c. Type of Provider & non-paid/informal | 507/545 | 93.03% | 28/30 | 93.3% |
| 13 | Caregiver Support Plan | a. Caregiver planning interview/assessment attached | 121/142 | 85.21% | 1/1 | 100% |
| | | b. Caregiver needs incorporated into SA, if applicable | 119/140 | 85.00% | 1/1 | 100% |