DEPARTMENT OF HEALTH

Blue Plus

TRIENNIAL COMPLIANCE ASSESSMENT

Triennial Compliance Assessment

Performed under Interagency Agreement for Minnesota Department of Human Services
Examination Period: December 1, 2015– July 1, 2018
File Review Period: July 1, 2017 – June 30, 2018
On-Site: October 8– 12, 2018
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Final Report Issue Date: April 23, 2019

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As requested by Minnesota Statute 3.197: This report cost approximately $125.00 to prepare, including staff time, printing and mailing expenses.

Contents

Triennial Compliance Assessment

Executive Summary

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

TCA Process Overview

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

- The first step in the process is the collection and validation of the compliance information by MDH. MDH's desk review and on-site QA Examination includes the collection and validation of information on supplemental federal and public program compliance requirements. To facilitate this process the MCO is asked to provide documents as requested by MDH.
- DHS evaluates information collected by MDH to determine if the MCO has "met" or "not met" contract requirements. The MCO will be provided a Preliminary TCA Report to review DHS' initial "met/not met" determinations. At this point, the MCO has an

opportunity to refute erroneous information, but may not submit new or additional documentation. Ample time and opportunities are allowed during the QA Examination to submit documents, policies and procedures, or other information to demonstrate compliance. The MCO must refute erroneous TCA finding within 30 days. TCA challenges will be sent by the MCO to MDH. MDH will forward the MCO's TCA rebuttal comments to DHS for consideration.

- Before making a final determination on "not-met" compliance issues, DHS will consider TCA rebuttal comments by the MCO. DHS will then prepare a final TCA Report that will be sent to MDH and attached to the final QA Examination Report. As a result of attaching the final TCA Report to the QA Examination Report, greater public transparency will be achieved by not separating compliance information and requiring interested stakeholder to query two state agencies for managed care compliance information.

- The MCO will submit to MDH a corrective action plan (CAP) to correct not-met determinations. The MCO TCA CAP must be submitted to MDH within 30 days. If the MCO fails to submit a CAP, and/or address contractual obligation compliance issues, then financial penalties will be assessed.

- Follow-up on the MCO TCA CAP activities to address not-met issues by MDH. During the on-site MDH Mid-cycle QA Exam, MDH will follow-up on TCA not-met issues to ensure the MCO has corrected all issues addressed in the TCA Corrective Action Plan. CAP follow-up findings will be submitted to DHS for review and appropriate action will be initiated by DHS if needed.

I. QI Program Structure - 2017 Contract Section 7.1.1

The MCO must incorporate into its quality assessment and improvement program the standards as described in 42 CFR 438, Subpart D (access, structure and operations, and measurement and improvement)

TCA Quality Program Structure Data Grid

DHS Contractual Element and References	Met or Not Met	Audit Comments
Written Quality Assurance Plan (Quality Program Description)	**Met**	Blue Plus's written quality assurance plan was submitted and approved by MDH in both 2017 and 2018. The plans contained all required elements of Minnesota Rule 4685.1110, 42 CFR 438, subpart D, and applicable NCQA standards.
Access Standards 42 CFR § 438.206 Availability of Services 42 CFR § 438.207 Assurances of Adequate Capacity and Services 42 CFR § 438.208 Coordination and Continuity of Care 42 CFR § 438.210 Coverage and Authorization of Services	**Met**	
Structure and Operations Standards 42 CFR § 438.214 Provider Selection 42 CFR § 438.218 Enrollee Information 42 CFR § 438.224 Confidentiality and Accuracy of Enrollee Records 42 CFR § 438.226 Enrollment and Disenrollment 42 CFR § 438.228 Grievance Systems 42 CFR § 438.230 sub contractual Relationships and Delegation	**Met**	
Measurement Improvement Standards 42 CFR § 438.236 Practice Guidelines 42 CFR § 438.240 Quality Assessment and Performance Improvement Program 42 CFR § 438.242 Health Information System	**Met**	

II. Information System – 2017 Contract Section 7.1.2 [1, 2]

The MCO must operate an information system that supports initial and ongoing operations and quality assessment and performance improvement programs.

Information System Data Grid

DHS Contractual Element and References	Met or Not Met	Audit Comments
The MCO must maintain a health information system that collects, analyzes, integrates, and reports data. During each of the past three years, all MCO MDH annual HEDIS performance measures have been certified reportable by an NCQA HEDIS audit.	Met	Certified HEDIS auditor reports as follows were reviewed: 2016 – ATTEST Health Care Advisors 2017 – ATTEST Health Care Advisors 2018 - ATTEST Health Care Advisors Reports state; *In our opinion, Blue Cross and Blue Shield of Minnesota's submitted measures were prepared according to HEDIS technical specifications and present fairly, in all material respects, the organization's performance with respect to the specifications.*

1 Families and Children, Seniors and SNBC Contract Section 7.1.2I

2 42 CFR 438.242

III. Utilization Management - 2017 Contract Section 7.1.3

The MCO shall adopt a utilization management structure consistent with state regulations and federal regulations and current NCQA "Standards for Accreditation of Health Plans."[3] Pursuant to 42 CFR §438.330(b)(3), this structure must include an effective mechanism and written description to detect both under and over utilization.

A. Ensuring Appropriate Utilization

TCA Utilization Management Data Grid for Under/Over Utilization

DHS Contractual Element and References	Met or Not Met	Audit Comments
The MCO shall facilitate the delivery of appropriate care and monitor the impact of its utilization management program to detect and correct potential under and over utilization. The MCO Shall: i. Choose the appropriate number of relevant types of utilization data, including one type related to behavioral health to monitor.	**Met**	Types of utilization data include, but not limited to: PMPM COST OF Inpatient Outpatient Professional Behavioral Health Prescription Drugs Inpatient Admits LOS Outpatient Services/100 members

3 2016 *Standards and Guidelines for the Accreditation of Health Plans*, effective July 1, 2017

DHS Contractual Element and References	Met or Not Met	Audit Comments
		Professional Services/member Rx drugs/member Cost per unit Total Medical Diagnostics Mental Illness Congenital Anomalies Neoplasms
The MCO Shall: ii. Set thresholds for the selected types of utilization data and annually quantitatively analyze the data against the established thresholds to detect under and overutilization.	**Met**	Thresholds utilized are tracking/trending own data over time. Reviewed on quarterly basis.
The MCO Shall: iii. Examine possible explanations for all data not within thresholds.	**Met**	Analysis done. For example, • Determined key drivers of mental illness, congenital anomalies and Neoplasms. • Behavioral Health was only area to trend up driven primarily by increase in Facility Inpt MH and CD. • Significant decreases in Interpreter services and PCA
The MCO Shall: iv. Analyze data not within threshold by medical group or practice.	**Met**	
The MCO Shall: v. Take action to address identified problems of under or overutilization and measure the effectiveness of its	**Met**	Some examples are: • Deep dive into Readmissions • Pharmacy Utilization Program • Access Management (Restricted Recipient)

DHS Contractual Element and References	Met or Not Met	Audit Comments
interventions.[4]4		

4 42 CFR 438.330(b)(3)

B. 2017 NCQA Standards and Guidelines UM 1 – 4, 10 – 12; QI 4

The following are the 2017 NCQA Standards and Guidelines for the Accreditation of Health Plans UM 1 – 4 and 10 – 12, and QI 4.

TCA Utilization Management Data Grid for NCQA Standards

DHS Contractual Element and References	Met or Not Met	Audit Comments
NCQA Standard UM 1: Utilization Management Structure The organization clearly defines the structures and processes within its utilization management (UM) program and assigns responsibility to appropriate individuals.	**Met**	**Blue Plus scored 100% in its NCQA Accreditation for its Commercial HMO/POS/PPO Combined, Marketplace PPO and Medicaid HMO products based on 2017 utilization management standards**.
Element A: Written Program Description	**Met per NCQA**	
Element B: Physician Involvement	**Met per NCQA**	
Element C: Behavioral Healthcare Practitioner Involvement	**Met per NCQA**	
Element D: Annual Evaluation	**Met per NCQA**	
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	**Met per NCQA**	

DHS Contractual Element and References	Met or Not Met	Audit Comments
Element B: Availability of Criteria	**Met per NCQA**	
Element C: Consistency of Applying Criteria	**Met per NCQA**	
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 per NCQA**	
NCQA Standard UM 4: Appropriate Professionals Qualified Licensed health professionals assess the clinical information used to support UM decisions. Element D: Practitioner Review of Behavioral Healthcare Denials	**Met per NCQA**	
Element G: Affirmative Statement About Incentives	**Met per NCQA**	
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	**Met per NCQA**	
Element B: Description of Evaluation Process	**Met per NCQA**	
NCQA Standard UM 11: Procedures for Pharmaceutical Management	**Met per NCQA**	

DHS Contractual Element and References	Met or Not Met	Audit Comments
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	**Met per NCQA**	
Element C: Pharmaceutical Patient Safety Issues	**Met per NCQA**	
Element D: Reviewing and Updating Procedures	**Met per NCQA**	
Element E: Considering Exceptions	**Met per NCQA**	
NCQA Standard UM 12: 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 per NCQA**	
Element B: Supervision and Oversight	**Met per NCQA**	
NCQA Standard QI 4: Member Experience The organization monitors member experience with its services and identifies areas of potential improvement. Element G: Assessing experience with the UM process	**Met per NCQA**	

IV. Special Health Care Needs - 2017 Contract Section 7.1.4 A-C[5, 6]

The MCO must have effective mechanisms to assess the quality and appropriateness of care furnished to Enrollees with special health care needs.

Special Health Care Needs Data Grid

DHS Contractual Element and References	Met or Not Met	Audit Comments
A. Mechanisms to identify persons with special health care needs, B. Assessment of enrollees identified, (Senior and SNBC Contract – care plan) and C. Access to specialists D. Annual Reporting to the State	**Met**	PMAP, MNCare, and MSHO members with special health care needs are identified via rules and algorithms using monthly analysis of claims data for special health care need "triggers," health risk assessment surveys, performance measures, medical record reviews, receipt of PCA services, and requests for service authorizations. A coaching program was initiated in October 2015 and is designed to identify and engage members at their most vulnerable point, to involve a care team, coordinate with providers, and support the member to improve their health and well-being. A health coach contacts identified as having special needs and performs an assessment. If the member is amenable, the coach engages them in creating an individual care plan. Clinicians may refer members to a number of services (e.g. transportation, CD or MI, food assistance, caregiver assistance, medication management). Referrals are monitored monthly. PMAP, MinnesotaCare, MSC+, and MSHO are all open access, so that members enrolled in these products may see any Blue Plus network provider without a referral.

5 42 CFR 438.330 (b)(4)

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

V. Practice Guidelines -2017 Contract Section 7.1.5[7, 8]

The MCO shall adopt, disseminate and apply practice guidelines consistent with current NCQA "*Standards and Guidelines for the Accreditation of Health Plans,*" QI 7 Clinical Practice Guidelines.

Practice Guidelines Data Grid

DHS Contractual Element and References	Met or Not Met	Audit Comments
Element A: Adoption of practice guidelines. The MCO shall adopt guidelines based on scientific evidence or professional standards for at least two medical and two behavioral conditions; and • Update the guidelines at least every two years • Distribute the guidelines to the appropriate practitioners	**Met**	Guidelines as follows: ADHD – AAP (professional standard resource) Depression – APA, ICSI Diabetes - ADA Asthma – NHLBI (National Heart, Lung Blood Institute) Heart Failure - AHA Hypertension Osteoporosis – NOF (National Osteoporosis Foundation) Preventive Services - USPSTF • Annual review. Reviewed by Sr Medical Director of Quality and Provider Relations with final approval by Quality Management Committee • Posted on Web site and included in Provider Policy and Procedure Manual
Element B: Adoption of preventive health guidelines. MCO shall adopt preventive health guidelines based on scientific evidence or professional standards for members of all ages; and	**Met**	Preventive Services for Adults – USPSTF Children and Adolescents

7 42 CFR 438.340 (b) (1)

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

DHS Contractual Element and References	Met or Not Met	Audit Comments
• Update the guidelines at least every two years; • Distribute the guidelines to the appropriate practitioners.		Routine Prenatal Care
Element C: Relation to DM Programs. MCO shall base its disease management programs on two of the organizations clinical practice guidelines.	**Met**	

VI. Annual Quality Assurance Work Plan – 2017 Contract Section 7.1.7

Tthe MCO shall provide the STATE with an annual written work plan that details the MCO's proposed quality assurance and performance improvement projects for the year. This report shall follow the guidelines and specifications contained in Minnesota Rules, part 4685.1130, subpart 2, and current NCQA "*Standards and Guidelines for the Accreditation of Health Plans.*"

Annual Quality Assurance Work Plan Data Grid

DHS Contractual Element and References	Met or Not Met	Audit Comments
A. Annual written work plan shall follow the guidelines and specifications contained in Minnesota Rules, part 4685.1130, subpart 2, and	**Met**	Annual work plans from 2016 and 2017 meets requirements of Minnesota Rule, NCQA and DHS.
B. Current NCQA "*Standards and Guidelines for the Accreditation of Health Plans.*" **NCQA QI, Element A:** An annual work plan that reflects ongoing progress on QI activities throughout the year and addresses: (1) Yearly planned QI activities and objectives for improving: • Quality of clinical care • Safety of clinical care • Quality of service • Members' experience (2) Time frame for each activity's completion (3) Staff members responsible for each activity (4) Monitoring of previously identified issues (5) Evaluation of the QI program	**Met**	

VII. Annual Quality Assessment and Performance Improvement Program Evaluation – 2017 Contract Section 7.1.8[9, 10]

The MCO must conduct an annual quality assessment and performance improvement program evaluation consistent with state and federal regulations and current NCQA "Standards and Guidelines for the Accreditation of Health Plans."

Annual Quality Assessment and Performance Improvement Program Evaluation Data Grid

DHS Contractual Element and References	Met or Not Met	Audit Comments
7.1.7 Annual Quality Assessment and Performance Improvement Program Evaluation must: i. Review the impact and effectiveness of the MCO's quality assessment and performance improvement program ii. Include performance on standardized measures (example: HEDIS®) and ii. MCO's performance improvement projects.	**Met**	
NCQA QI 1, Element B: Annual Evaluation The organization conducts an annual written evaluation of the QI program that includes the following information: 1. A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service. 2. Trending of measures to assess performance in the quality and safety of clinical care and quality of services.	**Met**	

9 42 CFR 438.330(b), (d)

10 MSCHO/MSC+ Contract Section 7.1.8 requires that the MCO, in conducting its annual quality evaluation, assure consistency with the "Quality Framework for the Elderly Waiver" and current NCQA "Standards and Guidelines for the Accreditation of Health Plans."

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

VIII. Performance Improvement Projects-2017 Contract Section 7.2[11, 12, 13, 14,15]

The MCO must conduct PIPs designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and Enrollee satisfaction. Projects must comply with 42 CFR § 438.30(b)(1) and (d) and CMS protocol entitled "*Protocol for Use in Conducting Medicaid External Quality Review Activities: Conducting Performance Improvement Projects*." The MCO is encouraged to participate in PIP collaborative initiatives that coordinate PIP topics and designs between MCOs.

Performance Improvement Projects Data Grid

DHS Contractual Element and References	Met or Not Met	Audit Comments
7.2.1 Final PIP Report. Upon completion of the 2015 PIP the MCO shall submit to the STATE for review and approval a final written report by September 1, 2018, in a format defined by the STATE.	**Met**	Reviewed final PIP report on Reducing Race and Ethnic Disparities in Management of Depression submitted on August 29, 2018
7.2.1 New Performance Improvement Project Proposal. The STATE will select the topic for the PIP to be conducted over the next three years (calendar years 2018, 2019 and 2020). The PIP must be consistent with CMS' published protocol entitled	**Met**	Reviewed and discussed PIP proposal – Reducing Chronic Opioid Use, collaborative project for PMAP, MNCare, and SNBC with HealthPartners, Hennepin Health, UCare

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

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

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

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

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

DHS Contractual Element and References	Met or Not Met	Audit Comments
"Protocol for Use in Conducting Medicaid External Quality Review Activities: Conducting Performance Improvement Projects", STATE requirements, and include steps one through seven of the CMS protocol.		
PIP Proposal and PIP Interim Report Validation Sheets. DHS uses these tools to review and validate MCOs' PIP proposals and annual status reports.	**Met**	Interim Report Validation sheets reviewed for Race/Ethnic disparities Depression

IX. Disease Management - 2017 Contract Section 7.3[16]

Disease Management Program. The MCO shall make available a Disease Management Program for its enrollees with diabetes, asthma and heart disease. The MCO may request the state to approve an alternative Disease Management Program topic other than diabetes, asthma or heart disease. The MCO must submit to the state appropriate justification for the MCO's request.

Disease Management Data Grid

DHS Contractual Element and References	Met or Not Met	Audit Comments
A. Disease Management Program Standards. The MCO's Disease Management Program shall be consistent with current NCQA "Standards and Guidelines for the Accreditation of Health Plans" pursuant to the QI Standard for Disease Management. B. Waiver of Disease Management Program Requirement. If the MCO is able to demonstrate that a Disease Management Program: 1) is not effective based upon Provider satisfaction, and is unable to achieve meaningful outcomes; or 2) would have a negative financial return on investment, then the MCO may request that the STATE waive this requirement for the remainder of the Contract Year.	**Not Met**	Blue Plus is NCQA accredited 100% for their Medicaid HMO product for Asthma and Diabetes Disease Management programs. MDH reviewed only the Heart Disease program.
Element A: Program Content	**Met**	
Element B: Identifying Members for DM Programs	**Met**	

16 MSHO/MSC+ Contract Section 7.3, requires only diabetes and heart disease DM programs, SNBC Contract Section 7.2.6

DHS Contractual Element and References	Met or Not Met	Audit Comments
Element C: Frequency of Member Identification	**Met**	
Element D: Providing Members with Information	**Met**	
Element E: Interventions Based on Assessment	**Met**	
Element F: Eligible Member Active Participation	Not Met	During onsite discussions, Blue Plus stated they have not collected data or analyzed member participation data for their Heart Disease program.
Element G: Informing and Educating Practitioners	**Met**	
Element H: Integrating Member Information	**Met**	
Element I:Experience with Disease Management	**Met**	
Element J: Measuring Effectiveness	**Not Met**	Blue Plus does not have a measure that is specific to assessing members in their Heart Disease program. During onsite discussions, Blue Plus stated that they measure effectiveness of their Heart Disease program using HEDIS measures that overlap with other Disease Management programs. Blue Plus stated that they do not measure and analyze effectiveness of the Heart Disease program with the same rigor as they do for Asthma and Diabetes Disease Management programs.

X. Advance Directives Compliance - 2017 Contract Section 16[17, 18]

The MCO agrees to provide all Enrollees at the time of enrollment a written description of applicable State law on Advance Directives and the following:

Advance Directives Compliance Data Grid

DHS Contractual Element and References	Met or Not Met	Audit Comments
A. Information regarding the enrollee's right to accept or refuse medical or surgical treatment; and to execute a living will, durable power of attorney for health care decisions, or other advance directive. B. Written policies of the MCO respecting the implementation of the right; and C. Updated or revised changes in State law as soon as possible, but no later than 90 days after the effective date of the change; D. Information that complaints concerning noncompliance with the Advance Directive requirement may be filed with the State survey and certification agency (i.e. Minnesota Department of Health), pursuant to 42 CFR 422.128 as required in 42 FR 438.6(i).	**Met**	
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**	A total of 954 medical records from MSHO, PMAP and MNCare were audited for CY 2016. Of those, 40% contained an Advance Directive or was discussed during a medical visit. See the chart below for a breakdown by product. The percentage of MHCP enrollees that contain

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

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

DHS Contractual Element and References	Met or Not Met	Audit Comments
		the Advance Directive discussion or have one present in the medical chart is very low in 2016 at just 4%. Blue Plus acknowledged that it is low and that it needs improvement. They commented that competing priorities in the doctor's office may be a reason for why the proportion is low.
Treatment. To not condition treatment or otherwise discriminate on the basis of whether an individual has executed an advance directive.	**Met**	
Compliance with State Law. To comply with State law, whether statutory or recognized by the courts of the State on Advance Directives, including Minnesota Statutes Chapters 145B and 145C.	**Met**	
Education. To provide, individually or with others, education for MCO staff, providers and the community on Advance Directives.	**Met**	

	Total Members in Sample	Advance Directive Discussed or Present During CY 2016	Advance Directive Discussed or Present During CY 2015
MHSO (Medicare/Medicare Eligible)	411	369 (90%)	66%
MHCP (MNCare and PMAP)	543	17 (3%)	4%
Total	**954**	**386 (40%)**	**30%**

XI. Validation of MCO Care Plan Audits for MSHO, MSC[19] - 2017 Seniors Contract Sections 7.1.4D, 7.8.3, and 9.3.7

MDH will collect information for DHS to monitor MCO Care Plan Audit activities as outlined in the DHS/MCO MSHO/MSC+ Contract.

Validation of MSHO and MSC Care Plan Audits Data Grid

DHS Contractual Element and References	Met or Not Met	Audit Comments
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	

19 Pursuant to MSHO/MSC+ 2017 Contract sections 6.1.4(A)(2), 6.1.4(A)(3), 6.1.4(A)(4), 6.1.5(B)(4), 6.1.5(B)(5), 7.1.4D, 7.8.3 and 9.3.7.

XII. Subcontractors-2017 Contract Sections 9.3.1 and 9.3.16 (F&C), and 9.3.1 and 9.3.22 (MSHO/MSC+)[20]

A. Written Agreement; Disclosures

All subcontracts must be in writing and must include a specific description of payment arrangements. All subcontracts are subject to STATE and CMS review and approval, upon request by the STATE and/or CMS. Payment arrangements must be available for review by the STATE and/or CMS.

Written Agreement and Disclosures Data Grid

DHS Contractual Element and References	Met or Not Met	Audit Comments
A. Disclosure of Ownership and Management Information (Subcontractors). In order to assure compliance with 42 CFR § 455.104, the MCO, before entering into or renewing a contract with a subcontractor, must request the following information:		MDH reviewed an annual letter of assurance and a template for disclosure of ownership and management information, business transactions and exclusions.
(1) The name, address, date of birth, social security number (in the case of an individual), and tax identification number (in the case of a corporation) of each Person, with an Ownership or Control Interest in the disclosing entity or in any subcontractor in which the disclosing entity has direct or indirect ownership of five percent (5%) or more. The address for corporate entities must include primary business address, every business location and P.O. Box address;	**Met**	All requirements of the DHS contract regarding disclosure of ownership and business dealings were met.

20 Families and Children Contract Sections 9.3.1A

DHS Contractual Element and References	Met or Not Met	Audit Comments
(2) A statement as to whether any Person with an Ownership or Control Interest in the disclosing entity as identified in 9.3.1(A) is related (if an individual) to any other Person with an Ownership or Control Interest as spouse, parent, child, or sibling; (3) The name of any other disclosing entity in which a Person with an Ownership Control Interest in the disclosing entity also has an ownership or control interest; and The name, address, date of birth, and social security number of any managing employee of the disclosing entity. (4) The name, address, date of birth and social security number of any managing employee of the disclosing entity. (5) For the purposes of section 9.3, subcontractor means an individual, agency, or organization to which a disclosing entity has contracted, or is a person with an employment, consulting or other arrangement with the MCO for the provision of items and services that are significant and material to the MCO's obligations under its contract with the STATE. (6) MCO Disclosure Assurance. The MCO must submit to the STATE by September 1st of the Contract Year a letter of assurance stating that the disclosure of ownership information has been requested of all subcontractors, and reviewed by the MCO prior to MCO and subcontractor contract renewal.	**Met** **Met** **Met** **Met** **Met**	
B. Upon request, subcontractors must report to the MCO information related to business transactions in accordance with 42 CFR §455.105(b). Subcontractors must be able to submit this information to the MCO within fifteen (15) days of the date of a written request from the STATE or CMS. The MCO must report the information to the STATE within ten (10) days of the MCO's receipt from the subcontractor.	**Met**	

B. Exclusions of Individuals and Entities; Confirming Identity[21]

Exclusion of Individuals Data Grid

DHS Contractual Element and References	Met or Not Met	Audit Comments
A. Pursuant to 42 CFR § 455.436, the MCO must confirm the identity and determine the exclusion status of Providers and any Person with an Ownership or Control Interest or who is an agent or managing employee of the MCO or its subcontractors through routine checks of Federal databases, including the Social Security Administration's Death Master File and the National Plan and Provider Enumeration System (NPPES), and also upon contract execution or renewal, and credentialing.	**Met**	Submitted documents, including an annual letter of assurance, the MCO's Exclusionary Scan Policy; and a master service agreement, showed compliance with DHS contract requirements regarding identification and exclusion of certain individuals and entities. Blue Plus's 2017 attestation letter documents monthly reviews of the Social Security Administration's Death Master File and the National Plan and Provider Enumeration System (NPPES) to determine each vendor's status. However, Blue Plus's exclusionary scan policy does not include the Social Security Administration's Death Master File or the NPPES among the sources it enumerates for routine checking. We recommended that the policy to augmented to comply with practice.
B. The MCO and its subcontractors must search monthly, and upon contract execution or renewal, and credentialing, the OIG List of Excluded Individuals/Entities (LEIE) and the Excluded Parties List System (EPLS, within the HHS System for Awards Management) database (and may search the Medicare Exclusion Database), for any Providers, agents, Persons with an Ownership or Control Interest, and Managing Employees to verify that these persons: (1) Are not excluded from participation in Medicaid under Sections 1128 or 1128A of the Social Security Act; and	**Met**	

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

DHS Contractual Element and References	Met or Not Met	Audit Comments
(2) Have not been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the programs under Title XX of the Social Security Act.		
C. The MCO must require subcontractors to assure to the MCO that no agreements exist with an excluded entity or individual for the provision of items or services related to the MCO's obligation under this Contract.	**Met**	
D. The MCO shall require all subcontractors to report to the MCO within five (5) days any information regarding individuals or entities specified in (A) above, who have been convicted of a criminal offense related to the involvement in any program established under Medicare, Medicaid, the programs under Title XX of the Social Security Act, or that have been excluded from participation in Medicaid under §§ 1128 or 1128A of the Social Security Act.	**Met**	
E. The MCO shall this information to the STATE within seven (7) days of the date the MCO receives the information	**Met**	
F. In addition to complying with the provisions of section 9.9, the MCO shall not enter into any subcontract that is prohibited, in whole or in part, under § 4707(a) of the Balanced Budget Act of 1997 or under Minnesota Statutes, § 62J.71.	**Met**	

XIII. Attachment A: MDH 2018 EW Care Plan Audit

Audit Protocol	Product Description	2018 MDH Audit Initial Charts Met	2018 MDH Audit Reassessment Charts Met	2018 MDH Audit Total % Charts Met	2018 Blue Plus Total Charts % Met
1 **INITIAL HEALTH RISK ASSESSMENT**	For members new to the MCO or product within the last 12 months	15/15	N/A	100%	94.3%
2 **ANNUAL HEALTH RISK ASSESSMENT**	Been a member of the MCO for > 12 months [Only for plans with separate HRA]	N/A	NA	NA	n/a
3 **LONG TERM CARE CONSULTATION – INITIAL**	If member is new to EW in the past 12 months, an LTCC assessment completed within required timelines.	15/15	NA	100%	100%
4 **REASSESSMENT OF EW**	For members open to EW who have been a member of the MCO for more than 12 months, an LTCC completed within 365 days or prior assessment.	N/A	8/8	100%	86.9%
5 **PERSON-CENTERED PLANNING**	Opportunities for choice in the person's current environment are described	15/15	8/8	100%	96.7%

Audit Protocol	Product Description	2018 MDH Audit Initial Charts Met	2018 MDH Audit Reassessment Charts Met	2018 MDH Audit Total % Charts Met	2018 Blue Plus Total Charts % Met
PERSON-CENTERED PLANNING	Current rituals and routines are described (quality, predictability, preferences)	15/15	8/8	100%	97.2%
PERSON-CENTERED PLANNING	Social, leisure, or religious activities the person wants to participate in are described. The person's decision about employment/volunteer opportunities has been documented	15/15	8/8	100%	92.5%
6 **COMPREHENSIVE CARE PLAN-TIMELINESS**	CCP is completed and sent to member with 30 calendar days of the date of a completed LTCC.	13/15	8/8	91.3%	97.7%
7 **COMPREHENSIVE CARE PLAN-IDENTIFIED NEEDS**	The CCP must have an interdisciplinary, holistic, and preventive focus. Enrollee's identified needs and concerns related to primary care, acute care, long-term care, mental and behavioral health, and social service needs and concerns are addressed. The need	15/15	8/8	100%	98.4%

Audit Protocol	Product Description	2018 MDH Audit Initial Charts Met	2018 MDH Audit Reassessment Charts Met	2018 MDH Audit Total % Charts Met	2018 Blue Plus Total Charts % Met
	for services essential to the health and safety of the enrollee is documented. If essential services are included in the plan, a back-up plan for provision of essential services. There is a plan for community-wide disasters, such as weather-related conditions.				
8 **COMPREHENSIVE CARE PLAN**	The enrollee's goals or skills to be achieved are included in the plan, related to enrollee's preferences and how enrollee wants to live their life. Goals and skills are clearly described, action steps describing what needs to be done to assist the person, plan for monitoring progress, target dates and outcome/achievement dates.	15/15	8/8	100%	90.3%
9	Enrollee was given a choice between Home and Community-Based	15/15	8/8	100%	98.6%

Audit Protocol	Product Description	2018 MDH Audit Initial Charts Met	2018 MDH Audit Reassessment Charts Met	2018 MDH Audit Total % Charts Met	2018 Blue Plus Total Charts % Met
COMPEREHENSIVE CARE PLAN-Choice	Services (HCBS) and Nursing Home Services (also indicates enrollee involvement in care planning). Information to enable choice among providers of HCBS.				
10 **COMPREHENSIVE CARE PLAN-Safety Plan/Personal Risk Management Plan**	Identification of enrollee needs and concerns, including identification of health and safety risks, and what to do in the event of an emergency Goals and target dates identified Interventions identified Monitoring of outcomes and achievement dates are documented	15/15	8/8	100%	99.4%
11 **COMPREHENSIVE CARE PLAN-Informal and Formal Services**	Coordinated Services and Support Plan developed and contains at a minimum the type of services to be furnished, the amount, frequency,	15/15	8/8	100%	99.8%

Audit Protocol	Product Description	2018 MDH Audit Initial Charts Met	2018 MDH Audit Reassessment Charts Met	2018 MDH Audit Total % Charts Met	2018 Blue Plus Total Charts % Met
	duration and cost of each service and the type of provider furnishing each service including non-paid caregivers and other informal community supports or resources				
12 **CAREGIVER SUPPORT PLAN**	If a primary caregiver is identified in the LTCC. If interview completed then caregiver needs and supports incorporated into the care plan	3/3	8/8	100%	91.7%
13 **HOUSING AND TRANSITION**	For people who have been identified as having a transition, the enrollee has a transition plan to support housing choice. The LTCC assessment items relate to housing choices and support, and if enrollee indicates they want assistance in exploring housing options the transition plan reflects a goal, steps to be taken and potential barriers	1/1	8/8	100%	99.0%

Audit Protocol	Product Description	2018 MDH Audit Initial Charts Met	2018 MDH Audit Reassessment Charts Met	2018 MDH Audit Total % Charts Met	2018 Blue Plus Total Charts % Met
14 **COMMUNICATIONS OF CARE PLAN/SUMMARY-Physician**	Evidence of care coordinator communication of care plan elements with Primary Care Physician (PCP)	14/15	8/8	95.7%	99.8%
15 **COMMUNICATION OF CARE PLAN/SUMMARY-Enrollee**	The support plan is signed and dated by the enrollee or authorized representative	14/15	8/8	95.7%	98.6%
16 **COMPREHENSIVE CARE PLAN-Enrollee Requests for Updates**	The plan includes a method for the individual to request updates to the plan, as needed	15/15	8/8	100%	99.8% (New in July 2016)
17 **CARE COORDINATOR FOLLOW-UP PLAN**	Follow-up plan for contact plan related to identified concerns or needs, and plan is implemented	15/15	8/8	100%	99.8%
18 **ANNUAL PREVENTIVE HEALTH EXAM**	Documentation in enrollee's Comprehensive Care Plan substantiates a conversation was initiated	15/15	8/8	100%	99.8%
19	Evidence that a discussion was	14/15	8/8	95.7%	99.8%

Audit Protocol	Product Description	2018 MDH Audit Initial Charts Met	2018 MDH Audit Reassessment Charts Met	2018 MDH Audit Total % Charts Met	2018 Blue Plus Total Charts % Met
ADVANCE DIRECTIVE	initiated, enrollee refused to complete, was culturally inappropriate, or AD was completed				
20 **APPEAL RIGHTS**	Appeal rights information provided to member	15/15	8/8	100%	98.6%
21 **DATA PRIVACY**	Data privacy information provided to member	15/15	8/8	100%	98.7%

Summary:

MDH received the EW audit sample lists from DHS per audit protocol. MDH reviewed fifteen initial EW audits and eight re-assessments. One initial EW file within the first eight reviewed did not contain evidence of an advance directive discussion; for two other files, the CCP was not completed and sent within 30 days of the LTCC. Therefore, fifteen files were reviewed. No additional files lacked an advance directive discussion. However, one of the additional files reviewed both lacked evidence that the care plan was communicated to the PCP and did not include the enrollee's signature on the care plan.

Blue Plus conducted audits from March through September of 2018. Blue Plus's EW audit results showed scores of less than 100% in nineteen of the twenty one protocols. Blue Plus used a 95% threshold for deficiencies. Scores dipped below 95% for five protocols: 1, initial health risk assessment; 4, reassessment of EW; 5, person centered planning; 8, comprehensive care plan; and 12, caregiver support plan. MDH conducted its audit in October of 2018. MDH's audit resulted in scores of less than 100% for the areas of: 6, comprehensive care plan, timeliness; 14, communications of care plan - physician; 15 communications of care plan - enrollee; and 16, advance directives. Only protocol 6 was below 95%. However, Blue Plus's audit included more files than MDH's audit.

Blue Plus followed up on the audit results with findings, mandatory improvements, and recommendations and had counties complete corrective action plans for findings and recommendations. Person centered planning became effective July 1, 2017, so this area was not required to be included in Blue Plus's corrective action plans for the counties.