Minnesota Department of Health

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:
April 1, 2013 through September 30, 2015

File Review Period:
October 1, 2014 though August 31, 2015

On-site:
November 16 through November 20, 2015

Examiners:
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## Final Summary Report

February 25, 2016

**Executive Summary**
**Triennial Compliance Assessment (TCA)**

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 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 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 2015**

**Managed Care Organization (MCO)/County Based Purchaser (CBP): Blue Plus**
**Examination Period: April 1, 2013 through September 30, 2015**
**File Review Dates: October 1, 2013 through August 31, 2015**
**Onsite Dates: November16-20, 2015**

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| DHS Contractual Element and References | Met/ Not Met | Audit Comments |
|---|---|---|
| **1. QI Program Structure**- 2015 Contract Section 7.1.1<br>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).<br><br><u>Access Standards</u><br>42 CFR § 438.206 Availability of Services<br>42 CFR § 438.207 Assurances of Adequate Capacity and Services<br>42 CFR § 438.208 Coordination and Continuity of Care<br>42 CFR § 438.210 Coverage and Authorization of Services<br><u>Structure and Operations Standards</u><br>42 CFR § 438.214 Provider Selection<br>42 CFR § 438.218 Enrollee Information<br>42 CFR § 438.224 Confidentiality and Accuracy of Enrollee Records<br>42 CFR § 438.226 Enrollment and Disenrollment<br>42 CFR § 438.228 Grievance Systems<br>42 CFR § 438.230 Subcontractual Relationships and Delegation<br><br><u>Measurement Improvement Standards</u><br>42 CFR § 438.236 Practice Guidelines<br>42 CFR § 438.240 Quality Assessment and Performance Improvement Program<br>42 CFR § 438.242 Health Information System | **Met** | Approved by MDH |

| DHS Contractual Element and References | Met/ Not Met | Audit Comments |
|---|---|---|
| **2. Accessibility of Providers -2015 MSHO/MSC+ Contract Section 6.1.4(C)(2) and 6.1.5(E)**<br>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. For purposes of this section, the word "assisting" includes, but is not limited to, discharge planning and care management responsibilities described in section 6.1.4 (A)(2). | **Met** | |

| DHS Contractual Element and References | Met/ Not Met | Audit Comments |
|---|---|---|
| **3. Utilization Management - 2015 Contract Section 7.1.3**<br><br>A. The MCO shall adopt a utilization management structure consistent with state regulations and federal 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:<br>i. Choose the appropriate number of relevant types of utilization data, including one type related to behavioral health to monitor.<br>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.<br>iii. Examine possible explanations for all data not within thresholds.<br>iv. Analyze data not within threshold by medical group or practice.<br>v. Take action to address identified problems of under or overutilization and measure the effectiveness of its interventions. [2]<br><br>B. The following are the 2014 NCQA Standards and Guidelines for the Accreditation of MCOs UM 1-4 and 10-14.<br><br>**NCQA Standard UM 1: Utilization Management Structure**<br>The organization clearly defines the structures and processes within its utilization management (UM) program and assigns responsibility to appropriate individuals.<br><br>Element A: Written Program Description<br>Element B: Physician Involvement<br>Element C: Behavioral Healthcare Practitioner Involvement<br>Element D: Annual Evaluation | **Met**<br><br>**Per NCQA @100%**<br><br>**Met** | Appropriate Utilization Report indicates areas of focus have been:<br>Residential CD<br>Residential Eating Disorders<br>Early Episode (help newly diagnosed with severe mental illness to manage symptoms)<br>Skilled Nursing Home<br>Anesthesia Claims for GI procedures<br>Pharmacy UM<br>ED Utilization<br>Access Mgmt. (for restricted recipients)<br>Improving transitions post-hospital (PIP)<br>Chlamydia Screening (PIP)<br>Medicaid Member Rewards (increase preventive care)<br>Gaps in Care Outreach (Care Coordinators)<br>Post-Partum Visit Improvement<br><br>Report gave a summary of improvement initiatives and outcomes/effectiveness |

1 2014 *Standards and Guidelines for the Accreditation of Health Plans*, effective July 1, 2014
2 42 CFR 438. 240(b)(3)

| DHS Contractual Element and References | Met/ Not Met | Audit Comments |
|---|---|---|
| **NCQA Standard UM 2: Clinical Criteria for UM Decision**<br>To make utilization decisions, the organization uses written criteria based on sound clinical evidence and specifies procedures for appropriately applying the criteria.<br><br>Element A: UM Criteria<br>Element B: Availability of Criteria<br>Element C: Consistency of Applying Criteria | **Per NCQA 100%** | |
| **NCQA Standard UM 3: Communication Services**<br>The organization provides access to staff for members and practitioners seeking information about the UM process and the authorization of care.<br><br>Element A: Access to Staff | **PER NCQA 100%** | |
| **NCQA Standard UM 4: Appropriate Professionals**<br>Qualified Licensed health professionals assess the clinical information used to support UM decisions.<br><br>Element D: Practitioner Review of Behavioral Healthcare Denials<br>Element F: Affirmative Statement About Incentives | **PER NCQA 100%** | |
| **NCQA Standard UM 10: Evaluation of New Technology**<br>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.<br><br>Element A: Written Process<br>Element B: Description of Evaluation Process | **PER NCQA 100%** | |
| **NCQA Standard UM 11: Experience with UM Process**<br>The organization evaluates member and practitioner satisfaction with the UM process.<br><br>Element A: Assessing Experience with UM Process | **PER NCQA 100%** | |

| DHS Contractual Element and References | Met/ Not Met | Audit Comments |
|---|---|---|
| **NCQA Standard UM 12: Emergency Services**<br>The organization provides, arranges for or otherwise facilitates all needed emergency services, including appropriate coverage of costs.<br><br>Element A: Policies and Procedures | **PER NCQA 100%** | |
| **NCQA Standard UM 13: Procedures for Pharmaceutical Management**<br>The organization ensures that its procedures for pharmaceutical management, if any, promote the clinically appropriate use of pharmaceuticals<br><br>Element A: Policies and Procedures<br>Element B: Pharmaceutical Restrictions/Preferences<br>Element C: Pharmaceutical Patient Safety Issues<br>Element D: Reviewing and Updating Procedures<br>Element E: Considering Exceptions | **PER NCQA 100%** | |
| **NCQA Standard UM 14: Triage and Referral to Behavioral Health**<br>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*<br><br>Element A: Triage and Referral Protocols | **N/A** | |

| DHS Contractual Element and References | Met/ Not Met | Audit Comments |
|---|---|---|
| **4. Special Health Care Needs 2015 Contract Section 7.1.4 A-C**[3, 4]<br>The MCO must have effective mechanisms to assess the quality and appropriateness of care furnished to Enrollees with special health care needs.<br>A. Mechanisms to identify persons with special health care needs,<br><br>B. Assessment of enrollees identified, (Senior and SNBC Contract – care plan) and<br><br>C. Access to specialists | **Met** | |

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

| DHS Contractual Element and References | Met/ Not Met | Audit Comments |
|---|---|---|
| **5. Practice Guidelines -2015 Contract Section 7.1.5**[5,6,]<br>A. The MCO shall adopt, disseminate and apply practice guidelines consistent with current NCQA "*Standards and Guidelines for the Accreditation of Health Plans*" QI 9 Clinical Practice Guidelines.<br>i. **Adoption of practice guidelines**. The MCO shall adopt guidelines based on:<br>• Valid and reliable clinical evidence or a consensus of Health Care Professionals in the particular field<br>• Consideration of the needs of the MCO enrollees<br>• Guidelines being adopted in consultation with contracting Health Care Professionals<br>• Guidelines being reviewed and updated periodically as appropriate.<br>ii. **Dissemination of guidelines.** MCO ensures guidelines are disseminated:<br>• To all affected Providers<br>• To enrollees and potential enrollees upon request<br>iii. **Application of guidelines**. MCO ensures guidelines are applied to decisions for:<br>• Utilization management<br>• Enrollee education<br>• Coverage of services<br>• Other areas to which there is application and consistency with the guidelines. | **Met** | |

5 42 CFR 438.236
6 MSHO/MSC+ Contract section 7.1.5 A-C; SNBC Contract section 7.1.5A-C

| DHS Contractual Element and References | Met/ Not Met | Audit Comments |
|---|---|---|
| **6. Annual Quality Assessment and Performance Improvement Program Evaluation- 2015 Contract Sections 7.1.8** [7,8] | **Met** | **Recommendation from MDH QA Report:** The quality evaluation (2014 Quality Improvement Program Evaluation) is a comprehensive document however it is not clear what products, whether commercial or a Minnesota Health Care Program, are referred to when summarizing quality projects and focus studies |
| A. The MCO must conduct an annual quality assessment and performance improvement program evaluation consistent with state and federal regulations and current NCQA "Standards for Accreditation of Health Plans". This evaluation must: | **Met** | |
| i. Review the impact and effectiveness of the MCO's quality assessment and performance improvement program<br>ii. Include performance on standardized measures (example: HEDIS®) and<br>iii. Include MCO's performance improvement projects. | | |
| B. NCQA QI 1, Element B: There is an annual written evaluation of the QI Program that includes: | **Met** | |
| i. A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service<br>ii. A trending of measures to assess performance in the quality and safety of clinical care and quality of services<br>iii. Analysis and evaluation of the overall effectiveness of the QI program, including progress toward influencing network-wide-safe clinical practices | | The annual evaluation (2014 Quality Improvement Evaluation) had an excellent evaluation of the overall effectiveness of the program and included potential areas for improvement in 2015. |

7 42 CFR 438.240(e)

8 MSHO/MSC+ Contract Section 7.1.8 also includes the requirement that the MCO must include the "Quality Framework for the Elderly" in its Annual Evaluation

| DHS Contractual Element and References | Met/ Not Met | Audit Comments |
|---|---|---|
| **7. Performance Improvement Projects-2015 Contract Section 7.2[9],[10,11]**<br>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 § 438.240(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.<br><br>The STATE will select the topic for the new PIP to be conducted over the next three years (calendar years 2015, 2016 and 2017) and implemented by the end of the first quarter of calendar year 2015. The PIP must be consistent with CMS' published protocol entitled *"Protocol for Use in Conducting Medicaid External Quality Review Activities: Conducting Performance Improvement Projects"*, STATE requirements, and include steps one through seven of the CMS protocol.<br><br>A. Annual PIP Status.<br><br>Annual PIP Status Reports. The MCO shall submit by December 1st in calendar years 2015 and 2016, a written PIP status report in a format defined by the STATE.<br><br>B. Completed (Final) Project Reports:<br><br>Upon completion of the PIP the MCO shall submit to the STATE for review and approval a final written report by September 1st, 2018, in a format defined by the STATE. | **Met** | 2015 PIPs include:<br>*Reducing Racial and Ethnic Disparities in the Management of Depression*<br>*Improving Transitions Post Hospitalization*<br><br>2014 PIPs include:<br>*Improving Transitions Post-hospital*<br><br>Interim reports reviewed for:<br>• *Colorectal Cancer Screening* (2011). 2013 Interim Report submitted November 22, 2013.<br>• *Transitions of Care: Improved Post-Discharge Follow-Up Care* (2011). 2013 Interim Report submitted November 27, 2013.<br>• *Reducing Non-Urgent Emergency Department Use in the F&C-MA/MinnesotaCare Populations: A Partnership with the Minnesota Head Start Association* (2012). 2013 Interim Report submitted November 25, 2013.<br>• *Increasing Use of Spirometry Testing for the Diagnosis of COPD in the MSHO/MSC+/SNBC Populations* (2012). 2013 Interim Report submitted November 26, 2013.<br>• *Chlamydia Screening in Women* (2013). 2013 Interim report submitted December 1, 2013.<br>*Due to language in the 2014 contracts, the MCOs were not required to submit additional reports for PIPs not completed by January 1, 2014.<br><br>Completed/Retired<br>*BP Control for Diabetes*<br>*Reducing Asthma Related Emergency Department Visits in the Public Programs Populations* |

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

| DHS Contractual Element and References | Met/ Not Met | Audit Comments |
|---|---|---|
| **8. Disease Management -2015 Contract Section 7. 3[12]**<br>The MCO shall make available a Disease Management Program for its Enrollees with:<br>A. Diabetes<br>B. Asthma<br>C. Heart Disease<br><br>**Standards -**The MCO's Disease Management Program shall be consistent current NCQA "*Standards and Guidelines for the Accreditation of Health Plans*" – QI Standard Disease Management<br><br>Waiver of Disease Management Program Requirement. If the MCO is able to demonstrate that a Disease Management Program is: 1) not effective based upon Provider satisfaction, and is unable to achieve meaningful outcomes; or 2) will have a negative financial return on investment, the MCO may request that the STATE waive this requirement for the remainder of the Contract Year.<br><br>If the MCO's Diabetes, Asthma, and Heart Disease Management Programs have achieved 100% compliance during the most recent NCQA Accreditation Audit of QI Standards- Disease Management, the MCO will not need to further demonstrate compliance. | **Met** | Blue Plus achieved 100% on its 2014 NCQA accreditation and included diabetes, asthma and heart disease in its disease management program and analysis. |

12 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/ Not Met | Audit Comments |
|---|---|---|
| **9. Advance Directives Compliance – 2015 Contract Section 16**[13,14]<br><br>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:<br>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.<br>ii. Written policies of the MCO respecting the implementation of the right; and<br>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;<br>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).<br><br>B. **Providers.** To require MCO's providers to ensure that it has been documented in the enrollee's medical records whether or not an individual has executed an Advance Directive.<br><br>C. **Treatment.** To not condition treatment or otherwise discriminate on the basis of whether an individual has executed an advance directive.<br><br>D. **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.<br><br>**Education.** To provide, individually or with others, education for MCO staff, providers and the community on Advance Directives. | **Met** | |

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; SNBC Contract Article 16

| DHS Contractual Element and References | Met/ Not Met | Audit Comments |
|---|---|---|
| **10. Validation of MCO Care Plan Audits for MSHO, MSC+,**[15] MDH will collect information for DHS to monitor MCO Care Plan Audit activities as outlined in the DHS/MCO MSHO/MSC+ Contract.<br><br>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 and when applicable the MnDHO 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.<br><br>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.<br><br>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.<br><br>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** | MDH audit showed that in one initial file the LTCC was not done within timelines and had no explanation and in one initial file the CCP took longer than 30 days. All other areas scored 100%. (See Attachment A.)<br><br>The following was observed by MDH:<br>• It was not always possible to determine why the member was considered "initial" and verify timelines. Blue Plus was able to provide additional information on those files that were not clear.<br>• When a LTCC was used for multiple reassessments, it was difficult to determine if every question was completed or if the necessary signature was present for the appropriate year.<br>• MDH audit continues to show few caregiver interviews/assessments were done across all plans.<br><br>Blue Plus does an excellent job in overseeing the counties and entities performing Care Coordination as a Blue Plus delegate. In all categories, MDH audit scores were better than the aggregate Blue Plus scores, probably due to the education and CAPs oversight done by Blue Plus. Changes were made to the Care Pare Plan in response to the Blue Plus findings. (See Attachment B.) |

15 Pursuant to MSHO/MSC+ 2015 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), 7.8.3

| DHS Contractual Element and References | Met/ Not Met | Audit Comments |
|---|---|---|
| **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. 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** | Blue Plus provided certification letters for 2013, 2014 and 2015 from Attest. |

16 Families and Children, Seniors and SNBC Contract Section 7.1.2
17 42 CFR 438.242

| DHS Contractual Element and References | Met/ Not Met | Audit Comments |
|---|---|---|
| **12. Written Agreement; Disclosures.**[18] 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. All contracts must include: | **Met** | |
| (A) Disclosure of Ownership and Management Information (Subcontractors). In order to assure compliance with 42 CFR § 455.104, the MCO, before entering into or renewing a contract with a subcontractor, must request the following information: (1) The name, address, date of birth, social security number (in the case of an individual), and tax identification number (in the case of a corporation) of each Person, with an Ownership or Control Interest in the disclosing entity or in any subcontractor in which the disclosing entity has direct or indirect ownership of five percent (5%) or more. The address for corporate entities must include primary business address, every business location and P.O. Box address; (2) A statement as to whether any Person with an Ownership or Control Interest in the disclosing entity as identified in 9.3.1(A) is related (if an 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 | **Met** | |

18 Families and Children, Seniors and SNBC Contract Sections 9.3.1.A and C

| DHS Contractual Element and References | Met/ Not Met | Audit Comments |
|---|---|---|
| (4) The name, address, date of birth, and social security number of any managing employee of the disclosing entity.<br><br>(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. | | |
| (B) 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** | |
| (C) 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** | |
| **Exclusions of Individuals and Entities; Confirming Identity. 19** 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 | **Met** | |

19 Families and Children, Seniors and SNBC Contract Sections 9.3.13

| DHS Contractual Element and References | Met/ Not Met | Audit Comments |
|---|---|---|
| National Plan and Provider Enumeration System (NPPES), and also upon contract execution or renewal, and credentialing. | | |
| (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: | **Met** | |
| (1) Are not excluded from participation in Medicaid under Sections 1128 or 1128A of the Social Security Act; and | | |
| (2) Have not been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the programs under Title XX of the Social Security Act. | | |
| (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** | |

**Attachment A: MDH 2015 EW Care Plan Audit**

| Audit Protocol | Protocol Description | Measures | Total # Charts Reviewed | | Total # Charts "Met" | | 2015 Total % Met | Comments |
|---|---|---|---|---|---|---|---|---|
| | | | Initial | Reassessment | Initial | Reassessment | | |
| | | | | | | | | |
| 1 | **INITIAL HEALTH RISK ASSESSMENT** | a. Completed within timelines | 15 | N/A | 14 | N/A | 95.65% | |
| | | b. Results included in CCP | 15 | N/A | 15 | N/A | 100% | |
| 2 | **ANNUAL HEALTH RISK ASSESSMENT** [Only for plans with separate HRA] | HRA is completed is within 12 months of previous HRA | N/A | N/A | N/A | N/A | N/A | Blue Plus uses the LTCC as its Health Risk Assessments |
| 3 | **LONG TERM CARE CONSULTATION – INITIAL** If member is new to EW in the past 12 months | A. LTCC results attached to CCP | 2 | N/A | 2 | N/A | 100% | |
| | | All (100%) of the fields relevant are completed or noted as | 2 | N/A | 2 | N/A | 100% | |
| | | B. LTCC was completed timely (and in enrollee Comprehensive Care Plan) | 2 | N/A | 2 | N/A | 100% | |

| Audit Protocol | Protocol Description | Measures | Total # Charts Reviewed | | Total # Charts "Met" | | 2015 Total % Met | Comments |
|---|---|---|---|---|---|---|---|---|
| | | | Initial | Reassessment | Initial | Reassessment | | |
| | | | | | | | | |
| 4 | **REASSESSMENT OF EW** For members open to EW who have been a member of the MCO for more than 12 months | A. Date re-assess w/in 12 months of previous assessment or explanation | N/A | 8 | N/A | 8 | 100% | |
| | | B. All areas of LTCC have been evaluated and documented (and in enrollee Comprehensive Care Plan) | N/A | 8 | N/A | 8 | 100% | |
| | | C. Results of LTCC attached to CCP. | N/A | 8 | N/A | 8 | 100% | |
| 5 | **COMPREHENSIVE CARE PLAN** | A. CCP completed w\in 30 days of LTCC or explanation documented | 15 | 8 | 8 | 14 | 95.65% | |
| 6 | **COMPREHENSIVE CARE PLAN SPECIFIC ELEMENTS** | A. Identification of enrollee needs and concerns, including identification of | 15 | 8 | 8 | 8 | 100% | |

| Audit Protocol | Protocol Description | Measures | Total # Charts Reviewed | | Total # Charts "Met" | | 2015 Total % Met | Comments |
|---|---|---|---|---|---|---|---|---|
| | | | Initial | Reassessment | Initial | Reassessment | | |
| | | | | | | | | |
| | | B. health and safety risks, and what to do in the event of an emergency, and linked to assessed needs as determined by the completed LTCC | 15 | 8 | 15 | 8 | 100% | |
| | | C. Documentation of services essential to health and safety | 15 | 8 | 15 | 8 | 100% | |
| | | D. If applicable, backup plan for essential services | 15 | 8 | 15 | 8 | 100% | |
| | | E. Plan for communitywide disasters | 15 | 8 | 15 | 8 | 100% | |
| | | F. Goals and target dates | 15 | 8 | 15 | 8 | 100% | |
| | | G. Interventions identified | 15 | 8 | 15 | 8 | 100% | |
| | | H. Monitoring progress towards | 15 | 8 | 15 | 8 | 100% | |

| Audit Protocol | Protocol Description | Measures | Total # Charts Reviewed | | Total # Charts "Met" | | 2015 Total % Met | Comments |
|---|---|---|---|---|---|---|---|---|
| | | | Initial | Reassessment | Initial | Reassessment | | |
| | | | | | | | | |
| | | I. Outcomes and achievement dates are documented | 15 | 8 | 15 | 8 | 100% | |
| | | J. CCP signed by member or authorized representative | 15 | 8 | 15 | 8 | 100% | |
| | | K. Follow up for contact for preventive care, long term care, etc. (informed choice) | 15 | 8 | 15 | 8 | 100% | |
| 7 | **Personal Risk Management Plan** | A. HCBS service refusal noted in CCP | 0 | 0 | 0 | 0 | N/A | |
| | | B. Personal risk management plan completed | 0 | 0 | 0 | 0 | N/A | |
| 8 | **ANNUAL PREVENTIVE CARE** | Documentation in enrollee's CCP that substantiates a conversation was initiated | 15 | 8 | 15 | 8 | 100% | |

| Audit Protocol | Protocol Description | Measures | Total # Charts Reviewed | | Total # Charts "Met" | | 2015 Total % Met | Comments |
|---|---|---|---|---|---|---|---|---|
| | | | Initial | Reassessment | Initial | Reassessment | | |
| | | | | | | | | |
| 9 | **ADVANCE DIRECTIVE** | Evidence that a discussion was initiated, enrollee refused to complete, was culturally inappropriate, or AD was completed | 15 | 8 | 15 | 8 | 100% | |
| 10 | **ENROLLEE CHOICE** Enrollee was given a choice between Home and Community-Based Services (HCBS) and Nursing Home | A. Choice noted in Section J of LTCC Assessment Form (e-docs #3428) or equivalent document (correlates to Section D of the LTCC Screening Document (e-docs #3427) | 15 | 8 | 15 | 8 | 100% | |
| | | B. Completed and signed care plan summary | 15 | 8 | 15 | 8 | 100% | |
| | | C. Copy of CCP summary | 15 | 8 | 15 | 8 | 100% | |
| 11 | **CHOICE OF HCBS PROVIDERS** | A. Completed and signed care plan summary | 15 | 8 | 15 | 8 | 100% | |

| Audit Protocol | Protocol Description | Measures | Total # Charts Reviewed | | Total # Charts "Met" | | 2015 Total % Met | Comments |
|---|---|---|---|---|---|---|---|---|
| | | | Initial | Reassessment | Initial | Reassessment | | |
| | | | | | | | | |
| | | B. Copy of CCP summary | 15 | 8 | 15 | 8 | 100% | |
| 12 | **HOME AND COMMUNITY BASED SERVICE PLAN** A HCBS service plan with these areas completed, including clearly identified and documented links to assessed needs per the results of the LTCC | A. Type of services | 15 | 8 | 15 | 8 | 100% | |
| | | B. The amount, frequency, duration and cost of each service | 15 | 8 | 15 | 8 | 100% | |
| | | C. The type of provider furnishing each service including non-paid/informal care givers | 15 | 8 | 15 | 8 | 100% | |
| | | D. Attempted not complete w/explanation | 0 | 0 | 0 | 0 | 0 | |
| 13 | **CAREGIVER SUPPORT PLAN** If a primary caregiver is identified in the LTCC, | A. Attached Caregiver Interview/assessment attached | 1 | 4 | 1 | 4 | 100% | |
| | | B. Incorporation of stated caregiver needs in Service Agreement, if applicable | 1 | 0 | 1 | 0 | 100% | |

| Audit Protocol | Protocol Description | Measures | Total # Charts Reviewed | | Total # Charts "Met" | | 2015 Total % Met | Comments |
|---|---|---|---|---|---|---|---|---|
| | | | Initial | Reassessment | Initial | Reassessment | | |
| | | | | | | | | |
| 14 | **APPEAL RIGHTS** Appeal rights information provided to member. | Signed care plan or other signed documentation in file | 15 | 8 | 15 | 8 | 100% | |
| 15 | **DATA PRIVACY** Data privacy information provided to member | Signed care plan or other signed documentation in file | 15 | 8 | 15 | 8 | 100% | |

## Summary:

DHS followed the sampling methodology outlined in the audit protocol guidelines and presented the sample lists to MDH. MDH audited 15 initial assessment files and eight reassessment files following the *MSHO and MSC+ Elderly Waiver Planning Protocol Care Plan Data Collection Guide*. MDH audit showed that in one initial file the LTCC was not done within timelines and had no explanation and one initial file the CCP took longer than 30 days. All other areas scored 100%.

The following was observed by MDH:

- It was not always possible to determine why the member was considered "initial" and verify timelines. Blue Plus was able to provide additional information on those files that were not clear.
- When a LTCC was used for multiple reassessments, it was difficult to determine if every question was completed or if the necessary signature was present for the appropriate year.
- MDH audit continues to show few caregiver interviews/assessments were done across all plans.

**Attachment B: Comparison of Blue Plus's 2014 Care Plan Audit to MDH's 2015 Results**

| Audit Protocol # | Desired Outcome | Description of Protocol Area | Blue Plus 2014 # Met/ #Reviewed | Blue Plus 2014 % Met | MDH 2015 #Met/ #Reviewed | MDH 2015 % Met |
|---|---|---|---|---|---|---|
| 1 | Initial Health Risk Assessment | a. Completed within timelines | 44/57 | 77.19% | 22/23 | 96.65% |
| | | b. Results included in CCP | 38/38 | 100% | 23/23 | 100% |
| | | c. All areas evaluated and documented | 38/38 | 100 | 23/23 | 100% |
| 2 | Annual Health Risk Assessment | Blue Plus uses the LTCC as our Health Risk Assessment; see Desired Outcome #4 for results | N/A | N/A | N/A | N/A |
| 3 | LTCC- Initial (New to EW in past 12 months) | a. LTCC results attached to CCP | 1/1 | 100% | 2/2 | 100% |
| | | b. All relevant fields completed or "n/a" is doc'd | 1/1 | 100% | 2/2 | 100% |
| | | c. Completed timely | 1/1 | 100 | 2/2 | 100% |
| 4 | Annual Reassessment of EW | a. Annual re-assess w/in 12 months of prior assessment or explanation documented | 420/421 | 99.76% | 8/8 | 100% |
| | | b. Results of LTCC attached to CCP | 415/415 | 100% | 8/8 | 100% |
| | | c. All areas evaluated and documented | 499/531 | 93.97% | 8/8 | 100% |
| 5 | Comprehensive Care Plan | CCP completed w\in 30 days of LTCC or explanation documented | 470/476 | 98.74% | 22/23 | 95.65% |
| 6 | Comprehensive Care Plan Specific Elements | a. Needs & Concerns identified | 456/456 | 100% | 23/23 | 100% |
| | | b. Health and safety risks identified and plans for addressing these risks | 456/456 | 100% | 23/23 | 100% |
| | | c. Documentation of services essential to health and safety | 315/318 | 99.06% | 23/23 | 100% |
| | | d. If applicable, back-up plan for essential services | 328/338 | 97.04% | 23/23 | 100% |
| | | e. Plan for community-wide disasters | 501/561 | 89.30% | 23/23 | 100% |
| | | f. Goals and target dates | 497/506 | 98.22% | 23/23 | 100% |

| Audit Protocol # | Desired Outcome | Description of Protocol Area | Blue Plus 2014 # Met/ #Reviewed | Blue Plus 2014 % Met | MDH 2015 #Met/ #Reviewed | MDH 2015 % Met |
|---|---|---|---|---|---|---|
| | | g. Interventions identified | 456/456 | 100% | 23/23 | 100% |
| | | h. Monitoring progress toward goals | 550/591 | 93.06% | 23/23 | 100% |
| | | i. Outcomes and achievement dates are documented | 625/745 | 83.89% | 23/23 | 100% |
| | | j. Care Plan signed by member or authorized representative | 450/455 | 98.90% | 23/23 | 100% |
| | | k. Follow up plan for contact for preventive care, long term care, etc. | 470/474 | 99.16% | 23/23 | 100% |
| 7 | Personal Risk Management Plan | a. HCBS service refusal noted in CCP | 56/56 | 100% | 23/23 | 100% |
| | | b. Personal risk management plan completed | 54/56 | 96.43% | 23/23 | 100% |
| 8 | Annual Preventive Health Exam | Annual Preventive health exam conversation initiated | 456/456 | 100% | 23/23 | 100% |
| 9 | Advance Directive | Advanced Directive conversation | 455/456 | 99.78% | 23/23 | 100% |
| 10 | Enrollee Choice | a. LTCC Section J or equivalent document | 456/456 | 100 | 23/23 | 100% |
| | | b. Completed & signed Care Plan | 491/496 | 98.99% | 23/23 | 100% |
| | | c. Copy of CCP summary | 489/496 | 98.59% | 23/23 | 100% |
| 11 | Choice of HCBS Providers | a. Completed & signed Care Plan | 489/496 | 98.59% | 23/23 | 100% |
| | | b. Copy of CCP Summary | 490/496 | 98.79% | 23/23 | 100% |
| 12 | Community Support Plan – Community Services and Supports Section | a. Type of Services | 473/474 | 99.79% | 23/23 | 100% |
| | | b. Amount, Frequency, Duration and Cost | 472/473 | 99.79% | 23/23 | 100% |
| | | c. Type of Provider & non-paid/informal | 473/474 | 99.79% | 23/23 | 100% |
| | | d. Attempted not complete w/explanation | 0 | 0 | 0 | 0 |
| 13 | Caregiver Support Plan | a. Caregiver planning interview/assessment attached | 113/116 | 97.41% | 1/1 | 100% |

| Audit Protocol # | Desired Outcome | Description of Protocol Area | Blue Plus 2014 # Met/ #Reviewed | Blue Plus 2014 % Met | MDH 2015 #Met/ #Reviewed | MDH 2015 % Met |
|---|---|---|---|---|---|---|
| | | b. Caregiver needs incorporated into SA, if applicable | 81/84 | 96.43% | 1/1 | 100% |
| 14 | Appeal Rights | Signed care plan or other signed documentation in enrollee file | 279/445 | 62.07% | 23/23 | 100% |
| 15 | Data Privacy | Signed care plan or other signed documentation in enrollee file | 327/443 | 73.81% | 23/23 | 100% |

Attachment B Table displays a summary of Blue Plus aggregated Care Plan Audit results from 2014 (audit timeframe in 2014 was March 1, 2013 through February 28, 2014) in comparison to MDH audit results (sample files between 9/1/2014 and 08/31/2015).

In all categories, MDH audit scores were better than the aggregate Blue Plus scores, probably due to the education and CAPs oversight done by Blue Plus.

A total of 57 of the 59 delegates provided care coordination to Blue Plus EW enrollees during this audit period; two care systems provided care coordination only to members residing in a nursing facility. All delegates not meeting the 95% threshold for any data element were required to do a Corrective Action Plan (CAP) including root-cause analysis, interventions, outcome measures, and timelines for completion/correction. Each delegate was also required to formally notify Blue Plus of the completion of all action steps, including supporting documentation if needed, documented in their CAP. All action steps were to be completed no later than three months from the date Blue Plus accepted the delegate's CAP response.

Thirty-two of the 57 delegates who provide EW services met all of the standard EW audit protocol elements at or better than the 95% target. The remaining 25 delegates submitted a CAP related to the EW Care Plan Audit. This is an improvement from 2013.

Blue Plus identified the following areas of improvement:

- HRA requirements and timelines when a member is new to a Blue Plus product and/or new to Blue Plus.
- Plan for community-wide disasters
- Member goal monitoring/outcome dates
- Appeal Rights and Data Privacy – These elements were new this year and were audited for informational use only

Changes were made to the Care Plan as a result of the Blue Plus findings.