



---

## **Blue Plus**

**QUALITY ASSURANCE EXAMINATION - 2025**

## **Blue Plus 2025 Quality Assurance Examination Report**

For the Period: July 1, 2021 – September 30, 2024

Examiners: Dena Harrell, BA, MPA; Brenda Sorvig, BA, MHI; Mary Timm, BS

Issue Date: April 15, 2026

Minnesota Department of Health

Managed Care Systems Section

PO Box 64975

St. Paul, MN 55164-0975

[health.mcs@state.mn.us](mailto:health.mcs@state.mn.us)

[www.health.state.mn.us](http://www.health.state.mn.us)

## MINNESOTA DEPARTMENT OF HEALTH EXECUTIVE SUMMARY

The Minnesota Department of Health (MDH) conducted a Quality Assurance Examination of Blue Plus to determine whether it is operating in accordance with Minnesota Law. Our mission is to protect, maintain and improve the health of all Minnesotans. MDH has found that Blue Plus is compliant with Minnesota and Federal law, except in the areas outlined in the “Deficiencies” and “Mandatory Improvements” sections of this report. Deficiencies are violations of law. Mandatory Improvements are required corrections that must be made to non-compliant policies, documents or procedures where evidence of actual compliance is found or where the file sample did not include any instances of the specific issue of concern. The “Recommendations” listed are areas where, although compliant with law, MDH identified improvement opportunities.

**To address recommendations, Blue Plus should:**

1. Incorporate into its workflow process for oral complaints that staff confirm with the enrollee whether they were satisfied with the outcome of the complaint.
2. Ensure that during pre-service reviews, all requests for records are attempted at least twice through phone call or fax and that the DTR Notice of Action provide clear language explaining to enrollees the accurate steps that the health plan took in their attempts to obtain records.

**To address mandatory improvements, Blue Plus and its delegates must:**

None identified.

**To address deficiencies, Blue Plus and its delegates must:**

1. Review its Quality of Care Complaint processes to ensure that notification timelines are met in all quality of care investigations.
2. Notify Enrollees with oral grievance resolution that if the resolution is partially or wholly adverse or not resolved to the satisfaction of the Enrollee, the grievance may be submitted in writing, and the MCO must offer to provide any assistance needed to submit a written grievance.

This report including these deficiencies, mandatory improvements and recommendations is approved and adopted by the Minnesota Commissioner of Health pursuant to authority in Minnesota Statutes, chapter 62D.



---

Diane Rydrych, Director  
Health Policy Division

04/15/2026

Date

# Contents

I.	Introduction.....	7
II.	Quality Program Administration .....	9
	Delegated Activities.....	9
	Activities .....	10
	Quality Evaluation Steps.....	10
	Focused Study Steps.....	10
	Filed Written Plan and Work Plan .....	11
	Provider Selection and Credentialing.....	11
	Requirements For Timely Provider Credentialing .....	12
	Enrollee Advisory Body.....	12
III.	Quality of Care Grievances and Complaints.....	13
	Quality of Care Complaints.....	13
IV.	Complaint Systems .....	14
	Complaint Systems .....	14
	Definitions .....	14
	Complaint Resolution .....	14
	Appeal of the Complaint Decision.....	15
	Notice to Enrollees .....	15
	Record Keeping; Reporting.....	16
	External Review of Adverse Determinations.....	16
V.	Grievance Systems.....	17
	Grievance Systems.....	17
	Internal Grievance Process Requirements .....	18
	DTR Notice of Action to Enrollees .....	19
	Internal Appeals Process Requirements.....	20
	State Appeals.....	21

VI. Access and Availability..... 22

    Geographic Accessibility..... 22

    Licensure of Medical Directors..... 22

    Essential Community Providers..... 22

    Availability and Accessibility..... 22

    Coverage of Nonformulary Drugs for Mental Illness and Emotional Disturbance..... 23

    Mental Health Coverage; Medically Necessary Care ..... 23

    Coverage for Court-Ordered Mental Health Services ..... 23

    Emergency Services..... 23

    Consumer Protections Against Balance Billing..... 24

    Continuity of Care..... 24

VII. Utilization Review..... 25

    Scope ..... 25

    Definitions ..... 25

    Standards for Utilization Review Performance ..... 26

    Procedures for Review Determination..... 26

    Appeals of Adverse Determinations..... 26

    Prior Authorization of Services..... 27

    Confidentiality ..... 27

    Staff and Program Qualifications ..... 28

    Accessibility and On-site Review Procedures: Availability of Criteria ..... 28

    Complaints to Commerce or Health..... 28

    Prohibition of Inappropriate Incentives ..... 29

    Continuity of Care: Prior Authorizations ..... 29

    Annual Posting on Website; Prior Authorizations..... 29

    Annual Report to Commissioner of Health; Prior Authorization..... 29

    Prohibited Practices..... 30

    Reconstructive surgery (reviewed only if applicable files)..... 30

VIII. Summary of Findings ..... 31

    Recommendations..... 31

    Mandatory Improvements ..... 31

    Deficiencies..... 31

# I. Introduction

1. History:

Founded in 1974, Blue Plus, a subsidiary of Blue Cross and Blue Shield of Minnesota (Blue Cross), is a Minnesota nonprofit licensed health maintenance organization (HMO) that offers health plans and networks throughout Minnesota to individuals and groups through contracted networks of health care providers. Aware Integrated, Inc., a Minnesota nonprofit corporation, is the parent holding company of Blue Cross. The Blue Plus Board of Directors, consisting of forty percent enrollee elected directors, oversees Blue Plus. In addition to offering a range of commercial products, Blue Plus currently contracts with both the Centers for Medicare & Medicaid Services (CMS) and the Minnesota Department of Human Services (DHS) to provide the benefits of both Medicare and the Minnesota Medical Assistance (Medicaid) program to enrollees. This program is also known as the Minnesota Senior Health Options (MSHO) program. Blue Plus also contracts with DHS to deliver and administer Minnesota Senior Care Plus and also contracts with DHS to deliver and administer MinnesotaCare and the Prepaid Medical Assistance Program (PMAP). In addition, Blue Plus offers small group and individual plans in Minnesota’s fully insured commercial market.

2. Membership: Blue Plus self-reported Minnesota enrollment as of September 2024 consisted of the following:

### Self-Reported Enrollment

	Product	Enrollment
<b>Fully Insured Commercial</b>	Large Group	0
	Small Employer Group	8,129
	Individual	57,603
<b>Minnesota Health Care Programs – Managed Care (MHCP-MC)</b>	Families & Children	281,629
	MinnesotaCare	29,265
	Minnesota Senior Care (MSC+)	4,328
	Minnesota Senior Health Options (MSHO)	10,003
	Special Needs Basic Care	0
	<b>Total</b>	<b>390,957</b>

3. Virtual Examination Dates: February 3 – February 12, 2025

4. Examination Period: July 1, 2021 – September 30, 2024  
 File Review Period: October 1, 2023 – September 30, 2024  
 Opening Date: November 18, 2024

5. National Committee for Quality Assurance (**NCQA**): Blue Plus is accredited by NCQA for its Commercial, Exchange, and Medicaid products based on 2024 standards. The Minnesota Department of Health (MDH) evaluated and used results of the NCQA review in one of three ways:

1. If NCQA standards do not exist or are not as stringent as Minnesota law, the accreditation results were not used in the MDH examination process and “No NCQA” is marked in the table cell.

2. If the NCQA standard was the same or more stringent than Minnesota law and the health plan was accredited with 100% of the possible points, the NCQA results were accepted as meeting Minnesota requirements (“NCQA Met” is marked in the NCQA Column) unless evidence existed indicating further investigation was warranted (“NCQA Not Met” is marked in the NCQA column)
3. If the NCQA standard was the same or more stringent than Minnesota law, but the health plan was accredited with less than 100% of the possible points or MDH identified an opportunity for improvement, MDH conducted its own examination.
6. Sampling Methodology: Due to the small sample sizes and the methodology used for sample selection for the quality assurance examination, the results cannot be extrapolated as an overall deficiency rate for the health plan.
7. Performance Standard: For each instance of non-compliance with applicable law or rule identified during the quality assurance examination, that covers a three-year audit period, the health plan is cited with a deficiency. A deficiency will not be based solely on one outlier file if MDH has sufficient evidence that a plan’s overall operation is compliant with an applicable law. Sufficient evidence may be obtained through: 1) file review; 2) policies and procedures; and 3) interviews.

## II. Quality Program Administration

### Minnesota Rules, Part 4685.1110

Subject	Met or Not Met	NCQA
Subpart 1. Written Quality Assurance Plan	Met	No NCQA
Subpart 2. Documentation of Responsibility	Met	
Subpart 3. Appointed Entity	Met	
Subpart 4. Physician Participation	Met	
Subpart 5. Staff Resources	Met	
Subpart 6. Delegated Activities	Met	
Subpart 7. Information System	Met	
Subpart 8. Program Evaluation	Met	
Subpart 9. Complaints	Met	No NCQA
Subpart 10. Utilization Review	Met	No NCQA
Subpart 11. Provider Selection and Credentialing Also refer to 62Q.097	Met	
Subpart 12. Qualifications	Met	
Subpart 13. Medical Records	Met	No NCQA

### Delegated Activities

Minnesota Rules, part 4685.1110, subpart 6, states the HMO must develop and implement review and reporting requirements to assure that the delegated entity performs all delegated activities. The standards and processes established by the National Committee for Quality Assurance (NCQA) for delegation are considered the community standard and, as such, were used for the purposes of this examination. The following delegated entities and functions were reviewed.

### Delegated Entities and Functions

Entity	UM	QOC	Complaints/ Grievances	Appeals	Cred	Claims	Disease Mgmt	Network	Care Coord
Amerigroup (through 12/31/2023)	X		X (MHCP)	X (MHCP)		X	X		X
Delta Dental of Minnesota	X	X	X (MHCP)	X (MHCP)	X	X		X	
Doctor on Demand					X				
EviCore Healthcare	X			X (Commercial)					
Genevieve									X

Entity	UM	QOC	Complaints/ Grievances	Appeals	Cred	Claims	Disease Mgmt	Network	Care Coord
Horizon Public Health									X
North Memorial Health					X				
Prime Therapeutics LLC	X	X	X (MHCP)	X	X	X		X	

Review of Blue Plus’s delegation oversight indicated an appropriate process consistent with standards as set forth in the *2024 NCQA Standards and Guidelines for the Accreditation of Health Plans*.

## Activities

### Minnesota Rules, Part 4685.1115

Subject	Met or Not Met
Subpart 1. Ongoing Quality Evaluation	Met
Subpart 2. Scope	Met

## Quality Evaluation Steps

### Minnesota Rules, Part 4685.1120

Subject	Met or Not Met
Subpart 1. Problem Identification	Met
Subpart 2. Problem Selection	Met
Subpart 3. Corrective Action	Met
Subpart 4. Evaluation of Corrective Action	Met

## Focused Study Steps

### Minnesota Rules, Part 4685.1125

Subject	Met or Not Met
Subpart 1. Focused Studies	Met
Subpart 2. Topic Identification and Selections	Met
Subpart 3. Study	Met
Subpart 4. Corrective Action	Met
Subpart 5. Other Studies	Met

## Filed Written Plan and Work Plan

### Minnesota Rules, Part 4685.1130

Subject	Met or Not Met	N/A
Subpart 1. Written Plan	Met	
Subpart 2. Work Plan	Met	
Subpart 3. Amendments to Plan		N/A

Minnesota Rules, Part 4685.1130, subpart 1 and subpart 3 states, the health maintenance organization shall file its written quality assurance plan with the commissioner and may change its written quality assurance plan by filing notice with the commissioner for approval. During the examination period, MDH reviewed and approved Blue Plus’s 2023 and 2024 Quality Program Description submissions, having met all requirements as outlined in Minnesota Rule 4685.1110.

### Provider Selection and Credentialing

Minnesota Rules, part 4685.1110, subpart 11, states the plan must have policies and procedures for provider selection, credentialing and recredentialing that, at a minimum, are consistent with community standards. MDH recognizes the community standard to be NCQA. Blue Plus scored 100% on all 2024 NCQA Credentialing/recredentialing standards and has therefore met Minnesota requirements.

MDH reviewed a total of 24 initial credentialing files as indicated in the following table:

### Credentialing File Review

File Source	Provider Type	# Reviewed
Initial – Blue Plus	<i>Allied</i>	4
	<i>Physician</i>	4
<b>Subtotal</b>		<b>8</b>
Initial – Doctor on Demand	<i>Allied</i>	4
	<i>Physician</i>	4
<b>Subtotal</b>		<b>8</b>
Initial – North Memorial Health	<i>Allied</i>	4
	<i>Physician</i>	4
<b>Subtotal</b>		<b>8</b>
<b>Total</b>		<b>24</b>

## Requirements For Timely Provider Credentialing

### Minnesota Statutes, Section 62Q.097

Subdivision	Subject	Met or Not Met
<b>Subd. 1.</b>	Definitions	Met
<b>Subd. 2.</b> Time limit for credentialing determination	(1) If application is clean and if clinic/facility requests, notify of date by which determination on app.	Met
	(2) If app determined not to be clean, inform provider of deficiencies/missing information within three business days	Met
	(3) Make determination on clean app within 45 days after receiving clean app	Met
	(4) Health plan allowed 30 additional days to investigate any quality or safety concerns.	Met

## Enrollee Advisory Body

### Minnesota Statutes, Section 62D.06, Subdivision 2

Subject	Met or Not Met
<b>Subd. 2</b> Enrollee Input. Governing body shall establish a mechanism to afford the enrollees an opportunity to express their opinions in matters of policy and operation.	Met

### III. Quality of Care Grievances and Complaints

MDH reviewed a total of 3 quality of care complaint system files.

#### Quality of Care File Review

File Source	# Reviewed
<i>Quality of Care</i>	
<i>Commercial Complaints</i>	3
<b>Total</b>	<b>3</b>

#### Quality of Care Complaints

#### Minnesota Statutes, Section 62D.115 (Commercial Only)

Subject	Met or Not Met
<b>Subd. 1.</b> Definition	Met
<b>Subd. 2.</b> Quality of Care Investigations	Not Met

#### Finding: Quality of Care Complaints (Repeat Deficiency)

MN Statute, 62Q.69, Subd. 2(b), states that upon receipt of a written complaint, the health plan company must notify the complainant within 10 (ten) business days that the complaint was received, unless the complaint is resolved to the satisfaction of the complainant within the ten business days. MDH reviewed a total of 3 Quality of Care Complaint files and found that 2 of the files reviewed were not compliant with the 10-business day requirement of notifying the enrollee that the complaint was received. Due to peer protection confidentiality of Quality of Care Complaints process described in MN Statute 62D.115, Subd. 2(c,1), enrollees are not notified of the outcome of the complaint, but the health plan still must notify the enrollee within 10 business days that the complaint was received and will be further investigated as a Quality of Care Complaint. MDH identified this finding as Deficiency #1 during the 2021 QA Exam of Blue Plus, therefore this will be a Repeat Deficiency.

Therefore, MDH finds that Blue Plus must review its Quality of Care Complaint processes to ensure that notification timelines are met in all quality of care investigations, pursuant to MN Statutes, § 62D.115, Subd. 2 and § 62Q.69, Subd. 2. **(Deficiency #1).**

## IV. Complaint Systems

### Complaint Systems

MDH examined Blue Plus’s fully insured commercial Complaint System for compliance with complaint resolution requirements of Minnesota Statutes, Chapter 62Q.

MDH reviewed a total of 24 Complaint System files.

#### Complaint System File Review

File Source	Complaint Type	# Reviewed
Complaint Files	<i>Blue Plus Written</i>	2
	<i>Blue Plus Oral</i>	14
	<b>Subtotal</b>	<b>16</b>
Non-Clinical Appeals	<i>All Types</i>	8
	<b>Subtotal</b>	<b>8</b>
	<b>Total</b>	<b>24</b>

### Definitions

#### Minnesota Statutes, Section 62Q.68

Subject	Met or Not Met
Subd. 2. Complaint	Met
Subd. 3. Complainant	Met

### Complaint Resolution

#### Minnesota Statutes, Section 62Q.69

Subject	Met or Not Met
Subd. 1. Establishment	Met
Subd. 2. Procedures for Filing a Complaint	Met
Subd. 3. Notification of Complaint Decisions	Met

## Finding: Procedures for Filing a Complaint

MN Statutes 62Q.69 Subd. 2, states that if a complaint is submitted orally and the resolution of the complaint, as determined by the complainant, is partially or wholly adverse to the complainant, or the oral complaint is not resolved to the satisfaction of the complainant, by the health plan company within ten days of receiving the complaint, the health plan company must inform the complainant that the complaint may be submitted in writing. The health plan company must also offer to provide the complainant with any assistance needed to submit a written complaint, including an offer to complete the complaint form for a complaint that was previously submitted orally and promptly mail the completed form to the complainant for the complainant's signature. Upon file review for oral complaints, MDH was unable to determine if Blue Plus staff was confirming with the enrollee if they were satisfied with the outcome of their complaint. Blue Plus states their policy is to offer enrollees the complaint form and assistance completing the complaint form for all grievance phone calls, regardless of whether the enrollee is satisfied or dissatisfied at the end of the call.

MDH recommends that Blue Plus incorporate into its workflow process for oral complaints for Blue Plus staff to confirm with the enrollee whether they were satisfied with the outcome of the complaint, consistent with MN Statute 62Q.69, Subd. 2. **(Recommendation #1)**

## Appeal of the Complaint Decision

### Minnesota Statutes, Section 62Q.70

Subject	Met or Not Met
Subd. 1. Establishment	Met
Subd. 2. Procedures for Filing an Appeal	Met
Subd. 3. Notification of Appeal Decisions	Met

## Notice to Enrollees

### Minnesota Statutes, Section 62Q.71

Subject	Met or Not Met
62Q.71. Notice to Enrollees	Met

## Record Keeping; Reporting

### Minnesota Statutes, Section 62Q.72

Subject	Met or Not Met
Subd. 1. Record Keeping	Met

## External Review of Adverse Determinations

### Minnesota Statutes, Section 62Q.73

Subject	Met or Not Met
Subd. 3. Right to External Review	Met

## V. Grievance Systems

### Grievance Systems

MDH examined Blue Plus’s Minnesota Health Care Programs Managed Care Programs – Managed Care (MHCP-MC) Grievance System for compliance with the federal law (42 CFR 438, subpart F) and the DHS 2024 Contract, Article 8.

MDH reviewed a total of 199 Grievance System files.

#### Grievance System File Review

File Source	Complaint Type	# Reviewed
<b>Grievances</b>	<i>Blue Plus Oral</i>	30
	<i>Blue Plus Written</i>	0
	<i>Amerigroup Oral</i>	30
	<i>Amerigroup Written</i>	1
	<i>Delta Dental Oral</i>	7
	<i>Delta Dental Written</i>	1
	<i>Prime Therapeutics Oral</i>	8
	<i>Prime Therapeutics Written</i>	0
	<b>Subtotal</b>	<b>77</b>
<b>DTRs</b>	<i>Blue Plus</i>	8
	<b>Subtotal</b>	<b>8</b>
<b>Clinical and Non-Clinical Appeals</b>	<i>Blue Plus Oral</i>	17
	<i>Blue Plus Written</i>	13
	<i>Amerigroup Oral</i>	3
	<i>Amerigroup Written</i>	27
	<i>Delta Dental Oral</i>	4
	<i>Delta Dental Written</i>	4
	<i>Prime Therapeutics Oral</i>	0
	<i>Prime Therapeutics Written</i>	30
	<b>Subtotal</b>	<b>98</b>
<b>State Fair Hearing</b>	<i>Blue Plus</i>	8
	<i>Delta Dental</i>	8
	<b>Subtotal</b>	<b>16</b>
<b>Total</b>		<b>199</b>

## General Requirements

### DHS Contract, Section 8.1, 42 CFR §438.402

Contract Section	42 CFR	Subject	Met or Not Met
8.1.	§438.402	General Requirements: Sec. 8.1.1 Components of Grievance System	Met

## Internal Grievance Process Requirements

### DHS Contract, Section 8.2, 42CFR §438.408

Topic	Contract Section	42 CFR	Subject	Met or Not Met
	8.2.1.	§438.402 (c)	Filing Requirements	Met
	8.2.2.	§438.408 (b)(1), (d)(1)	Timeframe for Resolution of Grievances	Met
	8.2.3.	§438.408 (c)	Timeframe for Extension of Resolution of Grievances	Met
Handling of Grievances (Section 8.2.4, 42CFR §438.406)	8.2.4.1	§438.406 (b)(1)	Written Acknowledgement	Met
	8.2.4.2	§438.416	Log of Grievances	Met
	8.2.4.3	§438.402 (c)(3)	Oral or Written Grievances	Met
	8.2.4.4	§438.406 (a)	Reasonable Assistance	Met
	8.2.4.5	§438.406 (b)(2)(i)	Individual Making Decision	Met
	8.2.4.6	§438.406 (b)(2)(ii)	Appropriate Clinical Expertise	Met
Notice of Disposition of a Grievance (Section 8.2.5., 42CFR §438.408 (d)(1))	8.2.5.1	§438.404 (b) §438.406 (a)	Oral Grievances	Not Met
	8.2.5.2	§438.404 (a), (b)	Written Grievances	Met

### Finding: Notice of Disposition of a Grievance; Oral Grievances

The Minnesota Department of Human Services (DHS) Contract for Prepaid Medical Assistance and MinnesotaCare with Blue Plus states in section 8.2.5.1 that if the oral grievance resolution (as determined by the Enrollee) is partially or wholly adverse or not resolved to the satisfaction of the Enrollee, the MCO must inform the Enrollee that the grievance may be submitted in writing and must also offer to provide any assistance needed to submit the grievance in writing. Upon file review of Amerigroup oral grievances, MDH found in 6 of 8 files that it was not clear whether Enrollees were satisfied with the outcome of the grievance resolution, since Amerigroup sent resolution letters for all grievances. The resolution letters did not inform the Enrollee that if they determine the resolution to be partially or wholly adverse and/or they are not

satisfied with the outcome, that the grievance may be submitted in writing with the offer of the MCO to provide any assistance needed with submitting a written grievance. MDH reviewed an additional 22 files and found 6 additional files to be noncompliant, for a total of 12 noncompliant files.

Therefore, MDH finds that Blue Plus and its delegates must notify Enrollees with oral grievance resolutions that if the resolution is partially or wholly adverse or not resolved to the satisfaction of the Enrollee, the grievance may be submitted in writing, and the MCO must offer to provide any assistance needed to submit a written grievance, pursuant to 42 CFR §438.404 (b), §438.406 (a) and DHS Contract, section 8.2.5.1. **(Deficiency #2)**

## DTR Notice of Action to Enrollees

### DHS Contract, Section 8.3, 42CFR §438.10, §438.404

Contract Section	42 CFR	Subject	Met or Not Met
8.3.1.	§438.10(c), (d) §438.402(c) §438.404(b)	General Requirements	Met
8.3.2	§438.402 (c), §438.404 (b)	Content of DTR Notice of Action	Met
8.3.2.1	§438.404	Notice to Provider	Met
8.3.3.	§438.404 (c)	Timing of DTR Notice	Met
8.3.3.1	§431.211	Previously Authorized Services	Met
8.3.3.2	§438.404 (c)(2)	Denials of Payment	Met
8.3.3.3	§438.210 (c)(d)	Standard Authorizations (1) <i>As expeditiously as the enrollee's health condition requires</i>	Met
		Standard Authorizations (2) <i>To the attending health care professional and hospital by telephone or fax within one working day after making the determination</i>	Met
		Standard Authorizations (3) <i>To the provider, enrollee and hospital, in writing, and must include the process to initiate an appeal, within ten (10) business days following receipt of the request for the service, unless the MCO receives an extension of the resolution period</i>	Met
8.3.3.4	§438.210 (d)(2)(i)	Expedited Authorizations	Met
8.3.3.5	§438.210 (d)(1)	Extensions of Time	Met
8.3.3.6	§438.210(d)(3) and 42 USC 1396r-8(d)(5)	Covered Outpatient Drug Decisions	Met
8.3.3.7	§438.210 (d)(1)	Delay in Authorizations	Met

## Finding: Content of DTR Notice of Action

The Minnesota Department of Human Services (DHS) Contract for Prepaid Medical Assistance and MinnesotaCare with Blue Plus states in section 8.3.2 that the content of the DTR Notice of Action must include a clear detailed description in plain language of the reasons for the action. Upon file review, MDH found one DTR file in which Blue Plus was unsuccessful in their attempt to request records for further review. There was only one fax attempt to request records even though Blue Plus states their best practice for pre-service reviews is to attempt at least twice through phone call or fax. In addition, the DTR Notice of Action rationale did not clearly state the steps that were taken by the MCO in their attempt to obtain records but instead stated they “looked at the records” and “did not get the information they needed.”

MDH recommends that during pre-service requests, Blue Plus ensures it follows best practice in which all requests for records are attempted at least twice through phone call or fax and that the DTR Notice of Action provide clear language explaining to enrollees the accurate steps that the health plan took in their attempts to obtain records. **(Recommendation #2)**

## Internal Appeals Process Requirements

### DHS Contract, Section 8.4, 42CFR §438.404

Topic	Contract Section	42 CFR	Subject	Met or Not Met
MCO Appeals Process Requirements	8.4.1.	§438.402 (b)	One Level of Appeal	Met
	8.4.2.	§438.408 (b)	Filing Requirements	Met
Timeframe for Resolution of Appeals	8.4.3.1	§438.408 (b)(2)	Standard Appeals	Met
	8.4.3.2	§438.408 (b)(3)	Expedited Appeals	Met
	8.4.3.3	§438.408 (c)(3)	Deemed Exhaustion	Met
	8.4.4.	§438.408 (c)	Timeframe for Extension of Resolution of Appeals and Expedited Appeals	Met
Handling of Appeals	8.4.5.1	§438.406 (b)(3)	Oral Inquiries	Met
	8.4.5.2	§438.406 (b)(1)	Written Acknowledgment	Met
	8.4.5.3	§438.406 (a)	Reasonable Assistance	Met
	8.4.5.4	§438.406 (b)(2)	Individual Making Decision	Met
	8.4.5.5	§438.406 (b)(2)	Appropriate Clinical Expertise	Met
	8.4.5.6	§438.406 (b)(4)	Opportunity to Present Evidence	Met
	8.4.5.7	§438.406 (b)(5)	Opportunity to Examine the Care File	Met
	8.4.5.8	§438.406 (b)(6)	Parties to the Appeal	Met
	8.4.5.9	§438.410 (b)	Prohibition of Punitive Action Subsequent Appeals	Met
	8.4.6.		Subsequent Appeals	Met
Notifying Enrollees and Providers of	8.4.7.1	§438.408 (d)(2) and (e)	Written Notice Content	*
	8.4.7.2	§438.210 (c)	Appeals of UM Decisions	Met

Topic	Contract Section	42 CFR	Subject	Met or Not Met
Resolution of Appeal	8.4.7.3	§438.410 (c) and .408 (d)(2)(ii)	Telephone Notification of Expedited Appeals	Met
	8.4.7.4	§438.408 (d)(2) and (e)	Notification Requirements if Appeal Unsuccessful	Met
Reversed Appeal Resolutions	8.4.8.1	§438.424	Authorize or Provide the Disputed Services	Met
	8.4.8.2	§438.424	Payment for any Services Enrollee Already Received	Met
Continuation of Benefits Pending Appeal or State Appeal	8.5.1	§438.420 (b)	Continuation of Benefits Pending Resolution of Appeal	Met
	8.5.2	§438.420 (b)	Continuation of Benefits Pending Resolution of State Appeal	Met
	8.5.3	§438.420 (d)	Upheld Appeal Resolutions	Met
	<b>8.6.</b>	<b>§438.416</b>	<b>Maintenance of Grievance and Appeal Records</b>	Met

\*DHS Contract Section 8.4.7.1 to be reviewed at Blue Plus’s mid-cycle review.

## State Appeals

### DHS Contract, Section 8.8, 42CFR §438.416 (c)

Topic	Contract Section	42 CFR	Subject	Met or Not Met
	<b>8.8.2.</b>	<b>§438.408 (f)(2)</b>	<b>Standard Hearing Decisions</b>	Met
	<b>8.8.3.</b>	<b>§431.250</b>	<b>Costs of State Fair Hearing</b>	Met
	<b>8.8.4.</b>	<b>§431.250</b>	<b>Expedited Hearing Decisions</b>	Met
Compliance with State Appeal Resolution	8.8.5.1.	§438.424	Compliance with Decisions	Met
	8.8.5.2.	§438.424(a)	MCO’s Responsibility for Payment of Services	Met
	8.8.5.3.	§438.424(b)	Upheld State Fair Hearing Resolutions	Met
	<b>8.8.7.</b>	<b>§438.48(f)</b>	<b>External Review or Medical Review Participation</b>	Met
	<b>8.8.8.</b>	<b>§431.245</b>	<b>Judicial Review</b>	Met

## VI. Access and Availability

### Geographic Accessibility

#### Minnesota Statutes, Section 62D.124

Subject	Met or Not Met
<b>Subd. 1.</b> Primary Care, Mental Health Services, General Hospital Services	Met
<b>Subd. 2.</b> Other Health Services	Met
<b>Subd. 3.</b> Waiver	Met
<b>Subd. 6.</b> Provider Network Notifications	Met

### Licensure of Medical Directors

#### Minnesota Statutes, Section 62Q.121

Subject	Met or Not Met
<b>62Q.121.</b> Licensure of Medical Directors	Met

### Essential Community Providers

#### Minnesota Statutes, Section 62Q.19

Subject	Met or Not Met
<b>Subd. 3.</b> Health Plan Company Affiliation	Met

### Availability and Accessibility

#### Minnesota Rules, Part 4685.1010

Subject	Met or Not Met
<b>Subpart 2.</b> Basic Services	Met
<b>Subpart 5.</b> Coordination of Care	Met
<b>Subpart 6.</b> Timely Access to Health Care Services	Met
<b>Subpart 7.</b> Access to Emergency Care	Met

## Coverage of Nonformulary Drugs for Mental Illness and Emotional Disturbance

### Minnesota Statutes, Section 62Q.527.

Subject	Met or Not Met
Subd. 2. Required Coverage for Anti-psychotic Drugs	Met
Subd. 3. Continuing Care	Met
Subd. 4. Exception to Formulary	Met

## Mental Health Coverage; Medically Necessary Care

### Minnesota Statutes, Section 62Q.53

Subject	Met
Subd. 1. Requirement	Met
Subd. 2. Minimum Definition	Met

## Coverage for Court-Ordered Mental Health Services

### Minnesota Statutes, Section 62Q.535

Subject	Met or Not Met
Subd. 2. Coverage required	Met

## Emergency Services

### Minnesota Statutes, Section 62Q.55

Subject	Met or Not Met
Subd. 1. Access to Emergency Services	Met
Subd. 2. Emergency Medical Condition	Met
Subd. 3. Emergency Services	Met
Subd. 4. Stabilize	Met
Subd. 5. Coverage Restrictions or Limitations	Met

## Consumer Protections Against Balance Billing

### Minnesota Statutes, Section 62Q.556

Subject	Met or Not Met
<b>Subd. 1.</b> Nonparticipating Provider Balance Billing Prohibition	Met
<b>Subd. 2.</b> Cost-sharing Requirements and Independent Dispute Resolution	Met

## Continuity of Care

### Minnesota Statutes, Section 62Q.56

Subject	Met or Not Met	N/A
<b>Subd. 1.</b> Change in health care provider, general notification	Met	
<b>Subd. 1a.</b> Change in health care provider, termination not for cause	Met	
<b>Subd. 1b.</b> Change in health care provider, termination for cause	Met	
<b>Subd. 2.</b> Change in health plans (applies to group, continuation and conversion coverage)	Met	

## VII. Utilization Review

MDH examined Blue Plus’s commercial Utilization Review (UR) System under Minnesota Statutes, chapter 62M. A total of **39** UR files were reviewed.

### Commercial UR System File Review

File Type	File Source	# Reviewed
Commercial <b>UM Denial Files</b>	Blue Plus	8
	Evicore Healthcare	8
	Prime Therapeutics	7
	<b>Subtotal</b>	<b>23</b>
Commercial <b>Clinical Appeal Files</b>	Blue Plus	8
	Evicore Healthcare	8
	<b>Subtotal</b>	<b>16</b>
<b>Total</b>		<b>39</b>

### Scope

#### Minnesota Statutes, Section 62M.01

Subject	Met or Not Met
<b>Subd. 3.</b> Scope	Met

### Definitions

#### Minnesota Statutes, Section 62M.02

Subject	Met or Not Met
<b>Subd. 1a – 18, 20</b> Definitions	Met

## Standards for Utilization Review Performance

### Minnesota Statutes, Section 62M.04

Subject	Met or Not Met	NCQA
<b>Subd. 1.</b> Responsibility for Obtaining Certification	Met	
<b>Subd. 2.</b> Information Upon Which Utilization Review is Conducted		NCQA Met

## Procedures for Review Determination

### Minnesota Statutes, Section 62M.05

Subject	Met or Not Met	NCQA
<b>Subd. 1.</b> Written Procedures	Met	
<b>Subd. 2.</b> Concurrent Review		NCQA Met
<b>Subd. 3.</b> Notification of Adverse Determinations and Authorizations	Met	
<b>Subd. 3a.</b> Standard Review Determination	Met	
<b>Subd. 3a.(a)</b> <i>Initial determination to certify or not (5 business days)</i>	Met	
<b>Subd. 3a.(b)</b> <i>Initial determination to certify (telephone notification)</i>	Met	
<b>Subd. 3a.(c)</b> <i>Initial determination not to certify (notice within 1 working day)</i>	Met	
<b>Subd. 3a.(d)</b> <i>Initial determination not to certify (notice of right to appeal)</i>	Met	
<b>Subd. 3b.</b> Expedited Review Determination	Met	
<b>Subd. 4.</b> Failure to Provide Necessary Information	Met	
<b>Subd. 5.</b> Notifications to Claims Administrator	Met	

## Appeals of Adverse Determinations

### Minnesota Statutes, Section 62M.06

Subject	Met or Not Met
<b>Subd. 1.</b> Procedures for Appeal	Met
<b>Subd. 2.</b> Expedited Appeal	Met
<b>Subd. 3.</b> Standard Appeal (a) <i>Procedures for appeals written and telephone</i>	Met
<b>Subd. 3.</b> Standard Appeal (b) <i>Appeal resolution notice timeline</i>	Met
<b>Subd. 3.</b> Standard Appeal (c) <i>Documentation requirements</i>	Met

Subject	Met or Not Met
<b>Subd. 3.</b> Standard Appeal <i>(d) Review by a different physician</i>	Met
<b>Subd. 3.</b> Standard Appeal <i>(e) Defined time period in which to file appeal</i>	Met
<b>Subd. 3.</b> Standard Appeal <i>(f) Unsuccessful appeal to reverse determination</i>	Met
<b>Subd. 3.</b> Standard Appeal <i>(g) Same or similar specialty review</i>	Met
<b>Subd. 3.</b> Standard Appeal <i>(h) Notice of rights to external review</i>	Met
<b>Subd. 4.</b> Notifications to Claims Administrator	Met

## Prior Authorization of Services

### Minnesota Statutes, Section 62M.07

Subject	Met or Not Met
<b>Subd. 1.</b> Written Standards	Met
<b>Subd. 2.</b> Prior Authorization of Certain Services Prohibited	Met
<b>Subd. 3.</b> Retrospective Revocation or Limitation of Prior Authorization	Met
<b>Subd. 4.</b> Submission of Prior Authorization Requests	Met

## Confidentiality

### Minnesota Statutes, Section 62M.08

Subject	Met or Not Met
<b>Subd. 1.</b> Written Procedures to Ensure Confidentiality	Met
<b>Subd. 2.</b> Summary Data	Met

## Staff and Program Qualifications

### Minnesota Statutes, Section 62M.09

Subject	Met or Not Met	NCQA
<b>Subd. 1.</b> Staff Criteria		NCQA Met
<b>Subd. 2.</b> Licensure Requirements		NCQA Met
<b>Subd. 3.</b> Physician Reviewer; Adverse Determinations	Met	
<b>Subd. 3a.</b> Mental Health and Substance Abuse Review	Met	No NCQA
<b>Subd. 4.</b> Dentist Plan Reviews		NCQA Met
<b>Subd. 4a.</b> Chiropractic Reviews		NCQA Met
<b>Subd. 5.</b> Written Clinical Criteria		NCQA Met
<b>Subd. 6.</b> Physician Consultants		NCQA Met
<b>Subd. 7.</b> Training for Program Staff		NCQA Met
<b>Subd. 8.</b> Quality Assessment Program		NCQA Met

## Accessibility and On-site Review Procedures: Availability of Criteria

### Minnesota Statutes, Section 62M.10

Subdivision	Subject	Met or Not Met
<b>Subd. 7.</b> Availability of Criteria	<i>(a) Utilization Review Determinations other than Prior Authorization</i>	Met
	<i>(b) Prior Authorization Determinations: Current Requirement &amp; Restrictions; Posting on Public Website</i>	Met
<b>Subd. 8.</b> Notice; New Prior Authorization Requirements or Restrictions; Change to Existing Requirement or Restriction	<i>(a) New or Amended Prior Authorization Requirement or Restriction; Posting on Public Website</i>	Met
	<i>(b) Notice to Health Care Professionals within 45 Days before Implementation</i>	Met

## Complaints to Commerce or Health

### Minnesota Statutes, Section 62M.11

Subject	Met or Not Met
<b>62M.11</b> Complaints to Commerce or Health	Met

## Prohibition of Inappropriate Incentives

### Minnesota Statutes, Section 62M.12

Subject	Met or Not Met	NCQA
62M.12 Prohibition of Inappropriate Incentives	Met	

## Continuity of Care: Prior Authorizations

### Minnesota Statutes, Section 62M.17

Subject	Met or Not Met
Subd. 1. Compliance with Prior Authorization Approved by Previous Utilization Review Organization; Change in Health Plan Company	Met
Subd. 2. Effect of Change in Prior Authorization Clinical Criteria	Met

## Annual Posting on Website; Prior Authorizations

### Minnesota Statutes, Section 62M.18

Subject	Met or Not Met
62M.18 Annual Posting on Website; Prior Authorizations	Met

## Annual Report to Commissioner of Health; Prior Authorization

### Minnesota Statutes, Section 62M.19

Subject	Met or Not Met
62M.18 Annual Report to Commissioner of Health; Prior Authorization	Met

## Prohibited Practices

### Minnesota Statutes, Section 62D.12

Subject	Met or Not Met
Subd. 19. Coverage of Service	Met

## Reconstructive surgery (reviewed only if applicable files)

### Minnesota Statutes, Section 62A.25

Subject	Met or Not Met	N/A
Subd. 1. Scope of Coverage		N/A
Subd. 2. Required Coverage		N/A

## VIII. Summary of Findings

### Recommendations

1. To better comply with Minnesota Statute 62Q.69, Subd. 2, Blue Plus should incorporate into its workflow process for oral complaints that staff confirm with the enrollee whether they were satisfied with the outcome of the complaint.
2. To better comply with the Minnesota Department of Human Services Contract for Prepaid Medical Assistance and MinnesotaCare with Blue Plus, section 8.3.2, Blue Plus should ensure that during pre-service reviews, all requests for records are attempted at least twice through phone call or fax and that the DTR Notice of Action provide clear language explaining to enrollees the accurate steps that the health plan took in their attempts to obtain records.

### Mandatory Improvements

None identified.

### Deficiencies

1. To comply with Minnesota Statutes, 62D.115, Subd. 2 and 62Q.69, Subd. 2, Blue Plus must review its Quality of Care Complaint processes to ensure that notification timelines are met in all quality of care investigations.
2. To comply with 42 CFR §438.404 (b), §438.406 (a) and the Minnesota Department of Human Services Contract for Prepaid Medical Assistance and MinnesotaCare, section 8.2.5.1, Blue Plus must notify Enrollees with oral grievance resolutions that if the resolution is partially or wholly adverse or not resolved to the satisfaction of the Enrollee, the grievance may be submitted in writing, and the MCO must offer to provide any assistance needed to submit a written grievance.