



Blue Plus

TRIENNIAL COMPLIANCE ASSESSMENT – 2025

Triennial Compliance Assessment

Performed under Interagency Agreement for Minnesota Department of Human Services

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Overview

Collection of DHS Supplemental Triennial Compliance Assessment (TCA) Information

Federal regulations require the Department of Human Services (DHS) to conduct triennial on-site contract compliance validation assessments of each contracted Managed Care Organization (MCO)¹. Through an Inter-Agency Agreement (IAA) Minnesota Department of Health (MDH) collects on-site supplemental compliance information for DHS to meet federal requirements. The on-site validation and collection of information by MDH during their Quality Assurance Examination (QA Exam) effectively reduces the MCO's public programs regulatory oversight burden.

The QA Exam, as well as the Triennial Compliance Assessment (TCA) Audit, for DHS, are conducted by MDH. A QA Exam assesses MCO compliance with MN Law/MN Rule and a TCA Audit assesses MCO's compliance with the MCO-DHS Contract(s). Both QA Exams and TCA Audits, occur at least every three years with a mid-cycle review in approximate 18 months after the on-site full QA Exam if needed. Mid-cycle reviews check MCO progress towards their Corrective Action Plans (CAPs).

During a QA Exam, MDH verifies MCO compliance with (i) Minnesota Statutes and Rules, (ii) Applicable Federal Law, and (iii) Community Standards as per National Committee for Quality Assurance (NCQA) guidelines. The MDH QA Exam includes the following four exam modules: Module (I): Quality Program Administration, Module (II): Complaint and Grievances System, Module (III): Access-Availability/Continuity of Care Module, and (IV) Utilization Management. Below is a brief overview of each QA Exam module:

¹ MCO: Managed Care Organization (MCO) means health plan, providing services to Medicaid Beneficiaries within the areas served by the plan.

Module 1: Quality Assurance or Quality Program Administration module verifies compliance with (a) Minnesota Rules, parts 4685.1110 – 1130, (b) Delegation, which includes NCQA guidelines as community standards and reviewing contracts, (c) Credentialing/Re-credentialing, as per NCQA guidelines, and (d) Quality of Care, as per Minnesota statutes §62D.08 and §62D.115.

Module II: Grievance and Appeals System module verifies: (a) Complaint and Appeal System as per MS §62Q.69-§62Q.73, (b) Grievance and Appeal System as per 42 CFR §438.228, (c) State Monitoring requirements as per 42 CFR §438.228, (d) Information requirement as per 42 CFR §438.10 (ix) (A)(B)(C)(D), (e) Enrollee Rights as per 42 CFR §438.100, and (f) Section 8.0 of the DHS Contract (for MHCP – Managed Care enrollees). Data collected encompasses State Appeals and quarterly reports from MCOs on the number of Grievances, Appeals, Denials, Terminations, and Reductions (DTR) of all health care service deliverables, State Fair Hearings, and State Appeals.

Module III: Access-Availability/Continuity of Care verifies (a) Geographic Accessibility, Network Adequacy as per MS §62k.10, MS §62D.124, (b) Availability and Accessibility, Provider Refusal to Continue Care, Inappropriate Utilization as per MR, part 4685.1010, (c) Essential Community Providers (ECPs) as per MS §62Q.19, (d) Emergency Services as per MS §62Q.55, (e) Coverage for Court-ordered Mental Health Services as per MS §62Q.535, (f) Coverage of Non-formulary Drugs for Mental Illness and Emotional Disturbance, and (g) Continuity of Care as per MS §62Q.56.

Module IV: Utilization Review (UR) or Utilization Management (UM) module verifies standards for Utilization Review (UR) determinations, denials, appeals, staff/program qualifications, complaints to MDH, etc., as per MS §62M.04. – §62M.11.

During a TCA Exam, MDH gathers MCO-DHS contract compliance information on pre-defined TCA elements, which include selected DHS contracts sections, such as the following: (1) QI Program Structure, (2) Information Systems, (3) UM – Over/Under Utilization and NCQA Elements 1-5 and 10-13, and QI 4, (4) Special Health Care Needs, (5) Practice Guidelines, (6) QI Work Plans, (7) Annual Evaluation, (8) PIPs, (9) Population Health Management, (10) Advance Directives, (11) Care Plan Audit for MSHO / MSC+, and (12) Subcontractors / Disclosures and Confirming Identity.

Note that regulatory areas overlap between the QA Exam (MDH and DHS) and the TCA Audit (DHS Only). Examples include, pieces of Quality portion, Grievances and Appeals System, Credentialing / Re-credentialing, Delegation, UM, etc. Overlapping areas covered in the QA Exam are not stated in the TCA Info Pack or the TCA Data Collection Grid. For example, Network Adequacy, Credentialing/Re-credentialing, Grievances and Appeals system, some portions of NCQA's guidelines on QI and UM, etc. are covered under QA Exam. Selected NCQA guidelines, which are not covered during QA Exam, are referred to in DHS contracts and thus part of the TCA Info Pack. For example, NCQA standards related to Population Health Management and Clinical Practice Guidelines are part of the TCA

Audit only. MDH deems certain NCQA standards in the MDH QA Exam when NCQA is equivalent to MN State Laws / MN Rules or when NCQA is more stringent than MN State Law / MN Rules. MDH does not deem NCQA standards for TCA elements as that is determined by DHS. MDH reviews the TCA UM over/under utilization element for health plans since that is not an NCQA standard. The UM elements 1-13 are reviewed when the health plan is not NCQA accredited or when the health plan did not receive a 100% NCQA UM score.

Collection of Supplemental TCA Information

DHS and MDH collaborate to streamline the TCA process and reduce unnecessary burden to the MCOs wherever possible. When a TCA Corrective Action Plan (CAP) is needed, the MCO will submit the TCA CAP to MDH and follow the same MDH CAP submission timelines. The final QA Examination Report and the final TCA Report are published and distributed together to facilitate greater public transparency and simplify the accessibility of information on state managed care compliance activities. Below is an overview of the TCA process steps:

1. MDH collects and validates compliance information from the MCO and DHS. MDH's desk review and on-site QA Exam include the collection and validation of information on supplemental federal and public program compliance requirements.
2. DHS evaluates information collected by MDH to determine if the MCO has "met" or "not met" Contract requirements. MDH sends the Preliminary TCA Report to the MCO 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. DHS will consider MCO rebuttal comments before making a final determination on not-met items.
3. If necessary, the MCO submits a CAP to correct not-met determinations. The MCO will submit a TCA CAP to MDH within 30 days to correct identified non-compliance issues. If the MCO fails to submit a CAP, and/or address contractual obligation compliance failures, then financial penalties will be assessed.
4. MDH follows up on the approved CAP activities to monitor progress toward correcting not-met TCA issues. During the mid-cycle QA Exam on-site, MDH will follow-up on TCA not-met issues to ensure the MCO has corrected all issues addressed in

the TCA CAP. CAP follow-up findings will be submitted to DHS for review and appropriate action will be initiated by DHS if needed.

MDH QA Exam and EQR Reporting

When MDH publishes the final QA Examination Report, DHS will evaluate reported deficiencies, mandatory improvements, recommendations and the MCO proposed CAP. If DHS determines the MCO breached the DHS/MCO Contract and, if the proposed MDH corrective actions fail to adequately address Contract requirements, the MCO will be requested to submit a separate corrective plan to DHS outlining how the breach will be cured. This process completes the DHS' federal TCA oversight obligations as required by 42 CFR § 438.358 (b).

MDH QA Exam, DHS' TCA process, and other DHS oversight activities along with information from other sources will be used by the External Quality Review Organization (EQRO) to generate a detailed annual technical report (ATR) of MCO compliance with federal and state quality, timeliness and access to care requirements as required under 42 CFR § 438.364(a).

The MCO should not confuse these separate activities with one another, each have their own authority under state or federal regulations. The contract between the MCO and DHS is the integration of federal, state and purchaser's requirements to ensure the quality of care and services provided to public program managed care enrollees.

MSHO/MSC+ Care Plan Data Collection Guide

Since July 1, 2009, MDH has been collecting information on Elderly Waiver Care Planning Audit, required by the DHS/MCO Minnesota Senior Health Options (MSHO) / Minnesota Senior Care Plus (MSC+) Contract. The MSHO/MSH+ contract is generally referred to as the "Seniors" contract. A Care Plan Audit Protocol is developed each year for use by the MCOs. The seventeen elements included in the Care Plan Audit Protocol are as follows:

1. Enrollee Assessment
2. Comprehensive Care Plan
3. Comprehensive Care Plan – Assessed Needs Addressed

4. Comprehensive Care Plan – Goals
5. Comprehensive Care Plan – Choice
6. Comprehensive Care Plan – Safety/Person Risk Management
7. Comprehensive Care Plan – Informal and Formal Services
8. Comprehensive Care Plan – Caregiver Support
9. Comprehensive Care Plan – Housing and Transition
10. Communication of Care Plan/Summary – Physician
11. Communication of Care Plan/Summary – Enrollee and Providers
12. Comprehensive Care Plan – Enrollee Request for Updates
13. Care Coordinator Follow-up Plan
14. Annual Preventive Health Exam
15. Advance Directive
16. Appeal Rights
17. Data Privacy

I. Quality Assessment and Performance Improvement Program – 2024 Contract Sections 7.1^{2,3,4}, 7.1.1, 7.1.2

A. The MCO shall provide an ongoing quality assessment and performance improvement program for the services it furnishes to all Enrollees, ensuring the delivery of quality health care. The Quality Assessment and Performance Improvement Program must be consistent with federal requirements under Title XIX of the Social Security Act, 42 CFR § 438, subpart E, and as required pursuant to Minnesota Statutes, Chapters 62D, 62N, 62Q and 256B and related rules, including Minnesota Rules, parts 4685.1105 through 4685.1130, 9506.0400, subp. 5, and applicable NCQA “Standards and Guidelines for the Accreditation of Health Plans” as specified in 2024 Contract.

TCA Quality Program Structure Data Grid

DHS Contractual Element and References	Met or Not Met	Audit Comments
<p>B. Scope and Standards: The MCO must incorporate into its quality assessment and improvement program the standards as described in 42 CFR § 438, Subpart E, (Quality Measurement and Improvement; External Quality Review). At least annually, the MCO must assess program standards to determine the quality and appropriateness of care and services furnished to all Enrollees. This assessment must include monitoring and</p>	<p>Met</p>	<p>2024-2026: Healthy Start Performance Improvement Project Proposal-Submitted.</p>

2 Families and Children MA, Seniors (MSHO/MS C+), and Special Needs Basic Care (SNBC) Contracts Sections 7.1 and sub-sections.

3 MSHO/MS C+ and SNBC Contracts Section 7.1 also include the requirements that the MCO must comply with requirements of “Quality Framework,” for EW services, including those found in the CMS “Modifications to Quality Measures and Reporting in 1915(c) Home and Community-Based Waivers” published in March 2014; MCO shall participate as requested in the STATE’s HCBS Settings Transition Plan to assure that LTSS will be delivered in settings consistent with 42 CFR §441.301(c)(4); and MCO must participate in efforts by the State to prevent, detect, and remediate critical incidents (consistent with assuring beneficiary health and welfare per 42 CFR §§441.302 and 441.730(a)), based on the requirements on the State for home and community-based waiver programs per 42 CFR §441.302(h).

4 For MSHO and SNBC SNP Enrollees, the Quality Assessment and Performance Improvement Program must also meet the quality review requirements for Medicare Advantage contractors specified in Title XVIII, §1852(e) of the SSA (42 USC §1395w-22) and the implementing regulations at 42 CFR §§422.152 through 158.

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DHS Contractual Element and References	Met or Not Met	Audit Comments
<p>evaluation of compliance with STATE and Centers for Medicare and Medicaid Services (CMS) standards and performance measurement.</p>		
<p>C. Accreditation Status: The MCO must inform the State whether it has been accredited by a private independent accrediting entity through an annual report due August 1 of the contract year, in a format determined by the STATE. If the MCO holds an accreditation, the MCO must authorize the private independent accrediting entity to provide the state a copy of its most recent accreditation review, including accreditation status, survey type, and level; accreditation results, including recommended actions or improvements, corrective action plans, and summaries of findings; and expiration date of the accreditation. The report is due in conjunction with the Triennial Compliance Audit conducted by the state as provided in the protocols provided for the Triennial Compliance Examination. [42 CFR §438.332].</p>	<p>Met</p>	

II. Information System – 2024 Contract Section 7.1.3⁵

DHS Contractual Element and References	Met or Not Met	Audit Comments
<p>A. The MCO must maintain a health information system that collects, analyzes, integrates, and reports data and can achieve the following objectives:</p> <p>(1) Collect data on Enrollee and Provider characteristics, and on services furnished to Enrollees;</p> <p>(2) Ensure that data received from Providers is accurate and complete by:</p> <ul style="list-style-type: none"> (a) Verifying the accuracy and timeliness of reported data; (b) Screening or editing the data for completeness, logic, and consistency; and (c) Collecting service information in standardized formats to the extent feasible and appropriate. <p>(3) Make all collected data available to the STATE and CMS upon request.</p> <p>(4) The MCO must implement Application Programming Interfaces (APIs) that permit retrieval of data through the use of common technologies to:</p> <ul style="list-style-type: none"> (a) Provide adjudicated claims and encounter data, with clinical data if the MCO maintains clinical data, and information about covered outpatient drugs. (b) Provide prior authorization information. (c) Provide a provider directory accessible through the MCO’s web site. (d) Provide payer-to-payer data exchange, and patient, provider, and payer application programming interfaces (APIs) (effective when required by CMS; see final rule CMS-0057 at the following website: 	<p>Met</p>	<p>Reviewed 2021, 2022, 2023 HEDIS Compliance Audits Reports from an NCQA certified HEDIS auditor showing all MCO MDH annual HEDIS performance measures have been certified reportable.</p>

5 §438.242 Health information systems, Contract Section 7.1.3; [Families and Children MA: SSA §1904(r)(1); Seniors, SNBC; [SSA §1903(r)(7)] 42 CFR §438.242; APIs: 42 CFR §§431.60 and 431.70; §438.10(h)(1) and (2); [42 CFR 438.62(b)(1)(vi)].
 CMS guidance on: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Interoperability/index>; <https://www.cms.gov/Regulations-and-Guidance/Guidance/Interoperability/index>.

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DHS Contractual Element and References	Met or Not Met	Audit Comments
<p>https://www.federalregister.gov/documents/2024/02/08/2024-00895/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-advancing-interoperability for details)</p> <p>(e) The MCO shall implement the requirements of this section in accordance with the Implementation Guides (IGs) and other relevant materials listed in the CMS guidance at https://www.cms.gov/Regulations-and-Guidance/Guidance/Interoperability/index.</p>		

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

III. Review Utilization Management - 2024 Contract Section 7.1.4 (7.1.4.1-7.1.4.2)⁶

The MCO shall adopt a utilization management structure consistent with state and federal regulations and 2024 NCQA “Standards and Guidelines for the Accreditation of Health Plans.” 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 of services.

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 of services. The MCO shall submit to the STATE upon request a written report that includes performance measurement data summarizing identified under-utilization and over-utilization of services. The MCO Shall:		
1. Choose the appropriate number of relevant types of utilization data, including one type related to behavioral health to monitor.	Met	
2. 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	

⁶ 42 CFR § 438.330(b)(3).

DHS Contractual Element and References	Met or Not Met	Audit Comments
3. Examine possible explanations for all data not within thresholds.	Met	
4. Analyze data not within threshold by medical group or practice.	Met	
5. Take action to address identified problems of under or overutilization and measure the effectiveness of its interventions.	Met	

B. 2024 NCQA Standards and Guidelines UM 1 – 5, 10 – 11; UM 13

The following are the 2024 NCQA Standards and Guidelines for the Accreditation of Health Plans UM 1 – 5, 10 – 11, and UM 13, effective July 1, 2024.

TCA Utilization Management Data Grid for NCQA Standards

DHS Contractual Element and References	Met or Not Met	Audit Comments
The following are the current NCQA Standards and guidelines for the Accreditation of Health Plans UM 1-5, 10-11, and 13:		
<p>NCQA Standard UM 1: Utilization Management Structure</p> <p>The organization’s UM program has clearly defined structures and processes and assigns responsibility to appropriate individuals.</p>	Met	
<p>Element A: Written Program Description</p> <p>The organization’s UM program description must include the following:</p> <ul style="list-style-type: none"> 5. The program scope and process used to determine benefit coverage and medical necessity. 6. Information sources used to determine benefit coverage and medical necessity. 	Met	

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DHS Contractual Element and References	Met or Not Met	Audit Comments
Element B: Annual Evaluation	Met	
<p>NCQA Standard UM 2: Clinical Criteria for UM Decision</p> <p>The organization uses written criteria based on sound clinical evidence to make utilization decisions and specifies procedures for appropriately applying the criteria.</p>	Met	
<p>Element A: UM Criteria</p> <p>The organization:</p> <ol style="list-style-type: none"> 1. Has written UM decision-making criteria that are objective and based on medical evidence. 2. Has written policies for applying the criteria based on individual needs. 3. Has written policies for applying the criteria based on an assessment of the local delivery system. 4. Involves appropriate practitioners in developing, adopting, and reviewing criteria. 5. Annually reviews the UM criteria and the procedures for applying them and updates the criteria when appropriate. 	Met	
Element B: Availability of Criteria	Met	
<p>Element C: Consistency of Applying Criteria</p> <p>At least annually, the organization:</p> <ol style="list-style-type: none"> 1. Evaluates the consistency with which health care professionals involved in UM apply criteria in decision making 2. Acts on opportunities to improve consistency, if applicable. 	Met	
<p>NCQA Standard UM 3: Communication Services</p> <p>The organization provides access to staff for members and practitioners seeking information about the UM process and the authorization of care.</p>	Met	
Element A: Access to Staff	Met	
NCQA Standard UM 4: Appropriate Professionals	Met	

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DHS Contractual Element and References	Met or Not Met	Audit Comments
Qualified Licensed health professionals assess the clinical information used to support UM decisions.		
Element A: Licensed Health Professionals	Met	
Element B: Use of Practitioners for UM Decisions	Met	
Element C: Practitioner Review of Non-Behavioral Healthcare Denials	Met	
Element D: Practitioner Review of Behavioral Healthcare Denials	Met	
Element E: Practitioner Review of Pharmacy Denials	Met	
Element F: Use of Board-Certified Consultants	Met	
NCQA Standard UM 5: Timeliness of UM Decisions The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of the situation.	Met	
Element A: Notification of Nonbehavioral Healthcare Decisions	Met	
Element B: Notification of Behavioral Healthcare Decisions	Met	
Element C: Notification of Pharmacy Decisions	Met	
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, including medical and behavioral health procedures, pharmaceuticals, and devices.	Met	
Element A: Written Process	Met	
Element B: Description of the Evaluation Process	Met	
NCQA Standard UM 11: Procedures for Pharmaceutical Management	Met	

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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: Pharmaceutical Management Procedures	Met	
Element B: Pharmaceutical Restrictions/Preferences	Met	
Element C: Pharmaceutical Patient Safety Issues	Met	
Element D: Reviewing and Updating Procedures	Met	
Element E: Considering Exceptions	Met	
NCQA Standard UM 13: Delegation of UM If the organization delegates UM activities, there is evidence of oversight of the delegated activities.	Met	
Element A: Delegation Agreement	Met	
Element B: Pre-delegation Evaluation	Met	
Element C: Review of the UM Program	Met	
Element D: Opportunities for Improvement	Met	

IV. Special Health Care Needs – 2024 Contract Section 7.1.5 (7.1.5.1-7.1.5.4)^{7,8}

The MCO must have effective mechanisms to assess the quality and appropriateness of care furnished to Enrollees with special health care needs.⁹

Special Health Care Needs Data Grid

DHS Contractual Element and References	Met or Not Met	Audit Comments
<p>A. Mechanisms to identify persons with special health care needs</p> <p>The MCO must have effective mechanisms to assess the quality and appropriateness of care furnished to Enrollees with special health care needs. If the MCO has in place an alternative mechanism(s) or is proposing a new mechanism(s) that meets or exceeds the requirements of section 7.1.5.1¹⁰, the MCO must submit a written description to the STATE for approval. If the MCO’s mechanism(s) have been approved by the STATE and there has been a material change, the MCO must timely submit a revised description to the STATE for approval (see also section 3.11.4)¹¹</p>	<p>Met</p>	<p>2024: Blue Plus resumed in-house Special Health Care Needs, Case Management, and Disease Management services (from subcontractor Amerigroup Partnership Plan).</p>

7 42 CFR 438.330 (b)(4).

8 Families and Children MA, Seniors (MSHO/MSC+), and SNBC Contract Section 7.1.5 and the sub-sections.

9 The definition of special health care needs is different among the three contracts. For MSHO/MSC+ and SNBC, all enrollees are considered to have special health care needs.

10 Section 7.1.5 for Seniors and SNBC contracts; (pursuant to sections 6.1.4, 6.1.5, 6.1.6 of Seniors and 6.1.4, 6.1.5.4 of SNBC contracts).

11 Sections 3.13.5 of the 2024 Seniors and 3.14.4 of the 2024 SNBC Contracts.

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DHS Contractual Element and References	Met or Not Met	Audit Comments
<p>7.1.5.1 Mechanism to Identify Persons with Special Health Care Needs. The MCO must identify Enrollees that may need additional services through method(s) approved by the STATE.</p> <p>(1) The MCO must analyze claim data for diagnoses and utilization patterns (both under- and over-utilization) to identify Enrollees who may have special health care needs. At a minimum the MCO must quarterly analyze claim data to identify Enrollees eighteen (18) years and older for the following:</p> <ul style="list-style-type: none"> a. Prevention Quality Indicators as described in the <i>“Guide to Prevention Quality Indicators: Hospital Admission for Ambulatory Care Sensitive Conditions”</i> by AHRQ for bacterial pneumonia, dehydration, urinary tract infection, adult asthma, congestive heart failure, hypertension and chronic pulmonary disease; b. Hospital emergency department utilization as determined by the MCO; c. Inpatient utilization stays for the MCO’s identified key Minnesota Health Care Program diagnoses or diagnoses clusters; d. Hospital readmission for the same or similar diagnoses as defined by the MCO within a timeframe specified by the MCO; e. Individual Enrollee claims totaling more than one hundred thousand dollars (\$100,000) per year; and f. Home Care Services utilization as determined by the MCO. 	Met	
<p>(2) In addition to claims data, the MCO may use other methods, such as:</p> <ul style="list-style-type: none"> (1) health risk assessment surveys. (2) performance measures. (3) medical record reviews. (4) Enrollees receiving PCA services. (5) requests for Service Authorizations; and/or (6) Other methods developed by the MCO or its Network Providers. 	Met	
<p>B. Assessment of enrollees identified</p> <p>7.1.5.2 Assessment of Enrollees Identified. The MCO must implement mechanisms to assess Enrollees identified and monitor the treatment plan set forth by the MCO’s treatment team, as</p>	Met	Annual assessments: focus on identification and assessment, care plan creation, and access to specialists.

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DHS Contractual Element and References	Met or Not Met	Audit Comments
applicable. The assessment must utilize appropriate Health Care Professionals to identify any ongoing special conditions of the Enrollee that require a course of treatment or regular care monitoring.		
7.1.5.3 Access to Specialists. If the assessment determines the need for a course of treatment or regular care monitoring, the MCO must have a mechanism in place to allow Enrollees to directly access a specialist as appropriate for the Enrollee’s condition and identified needs. [Minnesota Statutes, §62Q.58]	Met	
<p>7.1.5.4 Annual Reporting to the STATE. The MCO shall incorporate into, or include as an addendum to, the MCO’s Annual Quality Assessment and Performance Improvement Program Evaluation (as required in section 7.1.8) a Special Health Care Needs summary describing efforts to identify Enrollees that may need additional services and the following items:</p> <ul style="list-style-type: none"> (1) The number of persons identified in section 7.1.5.1 with special health care needs. (2) The annual number of assessments completed by the MCO or referrals for assessments completed; and (3) If the MCO adds the information in this section as an addendum, the addendum must include an evaluation of items 7.1.5.1 through 7.1.5.3. 	Met	Reports are generated for each of the six Special Health Care Needs (SHCN) report categories: AHRQ Conditions, Multiple Emergency Room Visits, Top Diagnosis, Top Diagnosis Readmissions, High Dollar Claims, and Home Care Authorizations.

V. Practice Guidelines -2024 Contract Section 7.1.6 (1–3)¹²

The MCO shall adopt, disseminate and apply practice guidelines as required by 42 CFR §438.236.

Practice Guidelines Data Grid

DHS Contractual Element and References	Met or Not Met	Audit Comments
<p>7.1.6.1 Adoption of Practice Guidelines. The MCO shall adopt guidelines that:</p> <ul style="list-style-type: none"> (1) are based valid and reliable clinical evidence or a consensus of Health Care Professionals in the field; 2) consider the needs of the MCO Enrollees; (3) are adopted in consultation with contracting Health Care Professionals; and (4) are reviewed and updated periodically as appropriate. 	Met	
<p>7.1.6.2 Dissemination of Guidelines. The MCO shall ensure that guidelines are disseminated to all affected Providers and, upon request, to Enrollees and Potential Enrollees;</p>	Met	
<p>7.1.6.3 Application of Guidelines. The MCO shall ensure that these guidelines are applied to decisions for utilization management, Enrollee education, coverage of services, and other areas to which there is application and consistency with the guidelines.</p>	Met	

¹² Families and Children MA, Seniors (MSHO/MSC+), and SNBC Contract Section 7.1.6 and the sub-sections.

VI. Annual Quality Assurance Work Plan – 2024 Contract Section 7.1.7 (1-2)¹³

On or before May 1st of the Contract Year, The 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
<p>A. The 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 2024 NCQA “Standards and Guidelines for the Accreditation of Health Plans.” If the MCO chooses to substantively amend, modify or update its work plan at any time during the year, it shall provide the STATE with material <i>amendments, modifications or updates in a timely manner. (See also section 3.11.4)</i>¹⁴</p>	Met	
<p>B. NCQA QI 1: Quality Improvement (QI) Program Structure and Operations: Organization clearly defines its QI Program Structure and Operations (e.g., QI programs, processes, assigned responsibilities, etc.). Element A: Organization’s QI Program description should specify: (1) The QI program structure: The program description includes the following information about the QI structure:</p> <ul style="list-style-type: none"> • The QI program’s functional areas and their responsibilities, • Reporting relationship of QI staff, QI Committee and any subcommittee, • Resources And analytical support, • Delegated QI activities, if organization delegates QI activities, • Collaborative QI activities, if any, 	Met	

¹³ Seniors (MSHO/MSC+) and SNBC Contract Section 7.1.7 and the sub-sections.

¹⁴ Sections 3.13.5 of the 2024 Seniors and 3.14.4 of the 2024 SNBC Contracts.

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DHS Contractual Element and References	Met or Not Met	Audit Comments
<ul style="list-style-type: none"> • Relationship of the QI programs and population health management (PHM) programs, in terms of operations and oversight. (2) The behavioral healthcare aspects of the program. (3) Involvement of a designated physician in the QI program. (4) Involvement of a behavioral healthcare practitioner in the behavioral aspects of the program. (5) Oversight of QI functions of the organization by the QI Committee. <p>Element B: An annual work plan that reflects ongoing progress on QI activities throughout the year and addresses:</p> <ul style="list-style-type: none"> (1) Yearly planned QI activities and objectives for improving: <ul style="list-style-type: none"> • 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 		

VII. Annual Quality Assessment and Performance Improvement Program Evaluation – 2024 Contract Section 7.1.8^{15, 16}

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.” The MCO must submit the written evaluation to the STATE by May 1st of the Contract Year.

Annual Quality Assessment and Performance Improvement Program Evaluation Data Grid

DHS Contractual Element and References	Met or Not Met	Audit Comments
<p>A. 7.1.8 Annual Quality Assessment and Performance Improvement Program Evaluation must:</p> <p>(1) Review the impact and effectiveness of the MCO’s quality assessment and performance improvement program</p> <p>(2) Include performance on standardized measures (example: Organization-specific data, CHAPS, HEDIS®) and MCO’s performance improvement projects.</p>	Met	
<p>B. NCQA QI 1, Element C: Annual Evaluation</p> <p>The organization conducts an annual written evaluation of the QI program that includes the following information:</p> <p>(1) A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service – The annual evaluation should be a (concise) report summarizing all the completed and ongoing QI activities outlined within the QI program description.</p>	Met	

15 42 CFR 438.330(b), (d); Families and Children MA, Seniors and SNBC Contract Section 7.1.8 and the sub-section 7.1.8.1.

16 MSHO/MSC+ Contract Section 7.1.8 also includes the requirement that the MCO must include the “Quality Framework for the Elderly Waiver” in its Annual Evaluation.

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DHS Contractual Element and References	Met or Not Met	Audit Comments
(2) Trending of measures to assess performance in the quality and safety of clinical care and quality of services — The annual evaluation must include trending of QI measures results over time and comparisons against performance objectives defined within the QI program description. The MCO should use charts, graphs or tables, or a combination of these, to display trended data.	Met	
(3) Analysis and evaluation of the overall effectiveness of the QI program and of its progress toward influencing network-wide safe clinical practices. The annual evaluation report must contain the following: (i) The title and description of each QI program initiative, described in the work plan; (ii) (ii) QI program’s major accomplishments; (ii) performance measures, trended over time; (iii) (iii) barriers to achieving objectives, if any; (iv) (iv) recommended interventions for overcoming issues and barriers; (v) (v) whether planned yearly activities were completed and objectives were met; and (vi) (vi) whether QI program will be restructured or changed in the subsequent year.	Met	
C. NCQA MED 7, Element A: Quality Assessment and Performance Improvement Program The organization’s comprehensive quality assessment and performance improvement program includes: 1. Mechanisms to detect underutilization and overutilization. 2. Mechanisms to assess the quality and appropriateness of care provided to members with special health care needs. 3. Mechanisms to assess the quality and appropriateness of care provided to members using long-term services and supports. 4. Participation in efforts to prevent, detect, and remediate critical incidents for members with long-term services and supports needs.	Met	

VIII. Performance Improvement Projects-2024 Contract Section 7.2, 7.2.1(1-3)^{17, 18, 19}

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 “CMS External Quality Review (EQR) Protocols, February 2023.” 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
<p>7.2.1 2024 - 2026 Performance Improvement Project.</p> <p>7.2.1.1 The proposal of the continued PIPs topics, “Healthy Start for Mothers and their Children” (for Families and Children MA contract) and “Comprehensive Diabetes Care” (for Seniors and SNBC contracts) were due October 1, 2023.</p> <p>From January 2024, the PIPs with these topics (e.g., “Healthy Start for Mothers and their Children” (for Families and Children MA contract) and “Addressing the Impact of Behavioral Health Diagnoses on Selected Physical Health Conditions or Diseases” (for Seniors and SNBC contracts) are conducted over a three-year period (calendar years 2024, 2025, and 2026). The PIPs must be consistent with CMS’s published protocol entitled “CMS EXTERNAL QUALITY REVIEW (EQR) PROTOCOLS, February 2023”, as well as STATE requirements, and include steps one through seven of the CMS Protocol. The MCO shall provide annual PIP progress reports to the STATE.</p>	<p>Met</p>	<p>Healthy Start for Mothers and Their Children Performance Improvement Project (PIP): 2023 Interim Report Proposal Final 2024-2026: Healthy Start Performance Improvement Project Proposal MCO: Blue Cross and Blue Shield of Minnesota and Blue Plus (“Blue Plus”)</p>

17 §438.330(b)(1), §438.330(d); Contract Section 7.2 and its sub-sections.

18 CMS Protocols, Protocol 1: Validation of Performance Improvement Projects (PIPs).

19 For Seniors and SNBC contracts: sections 7.2.2 (and its sub-sections); for SNBC contract only: additionally, 7.2.3, and 7.2.4; 42 CFR 438.110 (a).

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DHS Contractual Element and References	Met or Not Met	Audit Comments
<p>7.2.1.2 For the 2024-2026 PIPs, the first interim report is due September 1, 2024, for Families and Children MA contract and September 1, 2025, for Seniors and SNBC contracts.</p>	<p>Met</p>	<p>2024-2026: Healthy Start Performance Improvement Project Proposal-Submitted.</p>
<p>7.2.1.3 If the MCO completed the 2021-2023 PIP in 2023, then the MCO shall submit it to the STATE for review and approval a final written report by September 1, 2024.</p>	<p>Met</p>	

IX. Population Health Management (PHM) - 2024 Contract Section 7.3 (7.3.1-7.3.5)²⁰

The MCO shall create and report annually to the STATE a Population Health Management Strategy or any amendment to the original PHM strategy by July 31 of the contract year, including structure and processes to maintain and improve health care quality, and measures in place to evaluate plan MCO’s performance on its process outcomes (for example, clinical care, or Enrollee experience of care). The MCO must inform the STATE within thirty (30) days if the MCO makes a modification to its PHM Strategy, consistent with section 3.11.4²¹, Service Delivery Plan.

Population Health Management Data Grid

DHS Contractual Element and References	Met or Not Met	Audit Comments
<p>7.3.1, 7.3.2 Population Health Management (PHM) Strategy: The MCO’s PHM Strategy shall be consistent with 2024 NCQA “Standards and Guidelines for the Accreditation of Health Plans” pursuant to the 2024 Standards for Population Health Management (PHM). At a minimum, the comprehensive PHM Strategy shall describe:</p> <ul style="list-style-type: none"> (1) Measurable goals and populations targeted for each of the four areas of focus. (2) Programs and services offered to members for each area of focus; (3) Activities that are not direct member intervention (an activity may apply to more than one area of focus); (4) How member programs are coordinated across potential settings, Providers, and levels of care to minimize the confusion for Enrollees being contacted from multiple sources (coordination activities may apply across the continuum of care and to other organization initiatives); and (5) How Enrollees are informed about available PHM programs and services (for example, MCO may make the information available on its website; by mail, email, text, or other mobile applications; by telephone; or in person). 	<p>Met</p>	<p>NCQA Scores were 100% All must pass were met.</p>

²⁰ Families and Children MA and SNBC contract sections 7.3.1, 7.3.2 (and its sub-sections), 7.3.3 (and its sub-sections), 7.3.4, and 7.3.5; Seniors (MSHO/MSC+) contract sections 7.3.1, 7.3.2 (and its sub-sections), 7.3.3, and 7.3.4.

²¹ Service Delivery Plan: Sections 3.13.5 of the 2024 Seniors and 3.14 of the SNBC Contracts.

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DHS Contractual Element and References	Met or Not Met	Audit Comments
(6) How MCO promotes health equity ²² (strategy that describes MCO’s commitment to improving health equity and the actions it takes to promote equity in management of member care).	Met	
<p>A. The PHM Strategy shall include the following areas of focus:</p> <ul style="list-style-type: none"> a. <i>Keeping Enrollees healthy,</i> b. <i>Managing Enrollees with emerging risk,</i> c. <i>Patient safety or outcomes across settings, and</i> d. <i>Managing multiple chronic illnesses</i> e. <i>Improvements in health equity across disparate populations.</i> 	Met	
<p>B. The following are the 2024 NCQA Standards and Guidelines for the Accreditation of Health Plans Population Health Management (PHM) 1 – 7 and all Factors.</p> <p>NCQA Standard PHM 1: PHM Strategy The organization outlines its PHM strategy for meeting the care needs of its member population.</p>	Met	
Element A: PHM Strategies	Met	
Element B: Informing Members	Met	

²² **Health Equity:** The World Health Organization defines health equity as “the absence of unfair and avoidable or remediable differences in health among population groups defined socially, economically, demographically or geographically.”

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DHS Contractual Element and References	Met or Not Met	Audit Comments
<p>NCQA Standard PHM 2: Population Identification. The organization systematically collects, integrates and assesses member data to identify and inform groups for its population health management programs and determines actionable categories for appropriate intervention (e.g. documented process or infrastructure reports, and materials).</p>		
<p>Element A: Data Integration</p>	Met	
<p>Element B: Population Assessment</p>	Met	
<p>Element C: Activities and Resources</p>	Met	
<p>Element D: Segmentation (e.g., population segmentation, risk stratification).</p>	Met	
<p>NCQA Standard PHM 3: Delivery System Supports The organization describes how it supports the delivery system, patient-centered medical homes, and use of value-based payment arrangements.</p>	Met	
<p>Element A: Practitioner or Provider Support</p>		
<p>Element B: Value-Based Payment Arrangements</p>	Met	
<p>NCQA Standard PHM 4: Wellness and Prevention The organization offers wellness services focused on preventing illness and injury, promoting health and productivity, and reducing risk.</p>	Met	
<p>Element A: Frequency of Health Appraisal Completion (annually)</p>	Met	
<p>Element B: Topics of Self-Management Tools</p>	Met	
<p>NCQA Standard PHM 5: Complex Case Management The organization coordinates services for its highest risk members with complex conditions and helps them access needed resources.</p>	Met	

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DHS Contractual Element and References	Met or Not Met	Audit Comments
Element A: Access to Case Management	Met	
Element B: Case Management Systems	Met	
Element C: Case Management Process	Met	
Element D: Initial Assessment	Met	
Element E: Case Management: Ongoing Management	Met	
<p>NCQA Standard PHM 6: PHM Impact²³ The organization annually measures the effectiveness of its PHM Strategy and has a systematic process to evaluate whether it has achieved its goals and to gain insights into area needing improvement. The organization uses results from the PHM Impact analysis to annually identify opportunities for improvement.</p>	Met	Blue Cross' Quality Program facilitates the completion of the Population Health Strategy as well as the annual evaluation of the measures of effectiveness as referenced in the NCQA Monitored Programs section. The Quality Program also manages the completion of the organization's broader quality program documents, which includes an annual work plan of additional activities related to all population health priority areas.
Element A: Measuring Effectiveness	Met	An overview and details of the programs that are monitored for effectiveness and information related to eligible population and products is included in the overview of NCQA monitored programs section submitted.
Element B: Improvement and Action	Met	
<p>NCQA Standard PHM 7: Delegation of PHM If the organization delegates PHM activities, there is evidence of oversight of the delegated activities.</p>	Met	NCQA Met 100%
Element A: Delegation Agreement	Met	

²³ A comprehensive analysis of the impact of its PHM strategy in consecutive years.

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DHS Contractual Element and References	Met or Not Met	Audit Comments
Element B: Pre-delegation Evaluation	Met	
Element C: Review of the PHM Program	Met	
Element D: Opportunities for Improvement	Met	
<p>7.3.3 PHM Reporting:</p> <p>7.3.3.1 The MCO shall annually describe its methodology for segmenting or stratifying its Enrollee population, including the subsets to which Enrollees are assigned (for example, high risk pregnancy) and provide to the STATE a report specifying the following:</p> <p>(1) Number of Enrollees in each category and</p> <p>(2) Number of programs or services for which these Enrollees are eligible.</p>	Met	
<p>7.3.2.2 The MCO shall annually report to the STATE a comprehensive analysis of the impact of its PHM strategy that includes at least the following factors:</p> <p>(1) Quantitative results for relevant:</p> <p>(a) Clinical measures (outcome or process measures);</p> <p>(b) Cost of care or utilization measures; and</p> <p>(c) Enrollee experience measures (for example, complaints or Enrollee feedback, using focus group or a satisfaction survey).</p>	Met	
Comparison of results, including with a benchmark or goal;	Met	
Interpretation of results, including interpretation of measures; and	Met	
(4) The Impact Analysis report is due by July, 31 of the contract year.	Met	
<p>7.3.4 If the MCO chooses to delegate its PHM activities, the MCO shall provide to the STATE a comprehensive description of the structure and mechanism to oversee delegated PHM activities. This report is due July 31 of the contract year and must be completed again at any time the MCO changes any of its PHM delegations.</p> <p>7.3.5 The MCO shall continue to offer case management services to the most complex, highest risk Enrollees.</p>	Met	

X. Advance Directives Compliance - 2024 Contract Section Article 14 (14.1-14.5)^{24, 25}

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
1. Enrollee Information. 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:		
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 another advance directive;	Met	Advanced Directives information provided to enrollees in the 2021, 2022, 2023, and 2024 F&C, MNCare, MSC+, and MSHO member handbooks.
B. Written policies of the MCO respecting the implementation of the right;	Met	
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; and	Met	
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. (3)(j).	Met	MSHO member handbooks instruct enrollees to file complaint with the Office of Health Facility Complaints at MDH; suggest DHS change instructions for complaints to be filed with Managed Care Systems at MDH to be consistent with instructions in F&C, MNCare, and MSC+ member handbooks.

24 Families and Children MA, MSHO/MSC+ and SNBC Contract Article 14, sections 14.1 – 14.5.

25 Pursuant to 42 U.S.C. 1396a(a)(57) and (58), 42 C.F.R. 489.100-104 and 42 CFR §438.3(j); (referring to 42 C.F.R. 422.128).

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DHS Contractual Element and References	Met or Not Met	Audit Comments
<p>2. Providers Documentation. To require MCO’s Primary Care Providers; hospitals, critical access hospitals, skilled nursing facilities, nursing facilities, home health agencies, providers of home health care (and for Medicaid purposes, providers of personal care services), and hospices to ensure that it has been documented in the enrollee’s medical records whether or not an individual has executed an Advance Directive.</p>	Met	
<p>3. Treatment. To not condition treatment or otherwise discriminate on the basis of whether an individual has executed an advance directive.</p>	Met	
<p>4. 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.</p>	Met	
<p>5. Education. To provide, individually or with others, education for MCO staff, providers, and the community on Advance Directives.</p>	Met	

XI. Validation of MCO Care Plan Audits for MSHO and MSC+: Article 6, Seniors Contract Sections 7.1.5.4, 7.8.3, 7.8.4, 7.8.5²⁶

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

Validation of MSHO and MSC Care Plan Audits Data Grid

DHS Contractual Element and References	Met or Not Met	Audit Comments
<p>A. DHS will provide MDH with Data Collection Guide for the random sample of 30 MCO enrollees (plus an over sample of 10 MCO enrollees for missing or unavailable enrollee records) for MSHO and MSC+ program. Of the 40 records sampled, 20 records will be for members new to the MCO within the past 12 months and other 20 records will be for members who have been with the MCO for more than 12 months.</p> <p>B. MDH will request the MCO make available during the MDH QA Examination on-site audit the identified enrollee records. A copy of the Data Collection Guide and data collection tool will be included with MDH's record request.</p> <p>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.</p> <p>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.</p>	<p>Met</p>	

²⁶ Pursuant to MSHO/MS C+ 2023 Contract Sections Article 6 (6.1.4, 6.1.5), 7.1.5.4, 7.8.3, 7.8.4, and 7.8.5.

XII. Subcontractors²⁷ (Including Pharmacy Benefit Managers) – 2024 Contract Sections 9.2 (and its subsections) and 9.5.4²⁸

1. Written Agreement; Disclosures

All subcontracts must be current, in writing, fully executed, 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:

Written Agreement and Disclosures Data Grid

DHS Contractual Element and References	Met or Not Met	Audit Comments
<p>A. Disclosure of Ownership and Management Information (Subcontractors) 9.5.4. 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:</p>	Met	
<p>(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;</p>	Met	

²⁷ **Subcontractors must not be located outside of the United States.** According to the sections 6.10.1.10 (Families and Children MA); 6.7.1.10 (SNBC); 6.5.1.9 (Seniors) of the contracts, United States includes the fifty states, the District of Columbia, the Commonwealth of Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands. [§1902(a)(80) of the SSA].

²⁸ Families and Children MA, Seniors, and SNBC Contract Sections 9.2 (and subsections) and 9.5.4 (Families and Children MA, Seniors and SNBC Contracts).

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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 9.5.1.1 is related (if an individual) to any other Person with an Ownership or Control Interest as spouse, parent, child, or sibling;	Met	
(3) The name of any other disclosing entity in which a Person with an Ownership or Control Interest in the disclosing entity also has an ownership or control interest;	Met	
(4) The name, address, date of birth, and social security number of any managing employee of the disclosing entity;	Met	
(5) For the purposes of section 9.5.4, 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:	Met	
(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. The letter should identify all databases that were included in the review. A data certification pursuant to section 11.6 is required with this assurance; and	Met	
(7) Upon request, subcontractors must report to the MCO information related to business transactions. 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	
<p>B. Written Agreements [9.2.1 (1-40)] All subcontracts must be current, in writing, fully executed, 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:</p>	Met	
(1) MCO subcontracts that include delegation of program integrity responsibilities must require Subcontractors to comply with program integrity obligations under state and federal law and	Met	

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DHS Contractual Element and References	Met or Not Met	Audit Comments
<p>sections 9.4.1²⁹ and 9.2.1.1 of this contract. If an MCO engages with a subcontractor and does not delegate its program integrity responsibilities to the subcontractor, the MCO shall remain responsible for all program integrity responsibilities under state and federal law and section 9.4.1.1 with respect to the Subcontractor’s services.</p>		
<p>(2) Current and fully executed agreements for all subcontractors, including bargaining groups, must be maintained for all administrative services that are expensed to MHCP. Subcontractor agreements determined to be material, as defined by the STATE, must be in the form of a written instrument or electronic document containing the elements of offer, acceptance, consideration, payment terms, scope, duration of the contract, and how the subcontractor services relate to MHCP. [Minnesota Statutes, §256B.69, subd. 5a]</p>	Met	
<p>(3) Upon request, the STATE shall have access to all subcontractor documentation under this section.</p>	Met	
<p>(4) Nothing in this section shall allow release of information that is nonpublic data pursuant to section Minnesota Statutes, §13.02.</p>	Met	

²⁹ SNBC and Seniors (MSHO) contract sections 9.9.1, 9.9.2, and 9.9.3.

2. Exclusions of Individuals and Entities; Confirming Identity – 2024 Contract Sections 9.5.1³⁰ (1-4), 9.2.3, 9.2.4, 9.2.5³¹ and Article 15 (15.1)

Exclusion of Individuals and Entities Data Grid

DHS Contractual Element and References	Met or Not Met	Audit Comments
<p>A. Exclusions of Individuals and Entities; Confirming Identity</p> <p>(1) 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, or an affiliate upon contract execution or renewal and credentialing, through routine checks of state and Federal databases. The databases to be checked are the Social Security Administration's Death Master File and the National Plan and Provider Enumeration System (NPPES), and the Excluded Provider Lists maintained by the STATE.</p>	Met	
<p>(2) 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), and the Excluded Provider Lists maintained by the STATE, for any Providers, agents, Persons with an Ownership or Control Interest and Managing Employees to verify that these persons:</p>	Met	
<p>(1) Are not excluded from participation in Medicaid by the STATE nor under §§ 1128 or 1128A of the Social Security Act; and</p>	Met	
<p>(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. [42 CFR §§455.436; 438.602(d); 438.610]</p>	Met	

30 42 CFR §438.610 referring to 48 CFR §2.101; 42 CFR §455.436; Minnesota Statutes, §256B.064, subd. 3.

31 Seniors and SNBC contracts sections 9.2.4, 9.2.5 (and subsections), 9.2.6, and 9.2.7.

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DHS Contractual Element and References	Met or Not Met	Audit Comments
(3) 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	
(4) The MCO shall require all Subcontractors to report to the MCO within five (5) days any information regarding individuals or entities specified in section 9.5.1.1, who have been convicted of a criminal offense related to the involvement in any program established under Medicare, Medicaid, the programs under Title XX services program, or that have been excluded from participation in Medicaid under §§ 1128 or 1128A of the Social Security Act.	Met	
(5) The MCO shall report any excluded Provider to the STATE within seven (7) days of the date the MCO receives the information, or determines that a Network Provider, Person with an Ownership or Control Interest of a Network Provider, agent or managing Employee of the MCO, Subcontractor or affiliate has become excluded or the MCO has inadvertently contracted with an excluded Provider.	Met	
(6) In addition to complying with the provisions of section 9.4, 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	
B. The MCO shall ensure that its Subcontractors that provide Priority Services have in place a written Business Continuity Plan (BCP) that complies with the requirements of Article. 15.	Met	

Attachment A: MDH 2023 Elderly Waiver (EW) Care Plan Audit

Audit Protocol	Product Description	2023 MDH Audit Initial Charts Met	2023 MDH Audit Reassessment Charts Met	2023 MDH Audit Total % Charts Met
1 ENROLLEE ASSESSMENT	All enrollees will receive a complete assessment as applicable within required timelines.	4/4	4/4	100%
1.1 Timeliness	a. Initial LTCC/HRA completed within 30 calendar days of enrollment or b. Reassessment was completed within 365 days of previous LTCC assessment or c. LTCC/HRA completed within 20 calendar days of member request.	4/4	4/4	100%
2 COMPREHENSIVE CARE PLAN - Timeliness	Enrollees receive a completed Comprehensive Care Plan (CCP) within 30 calendar days of a completed LTCC/MnCHOICES Assessment.	4/4	4/4	100%
3 COMPREHENSIVE CARE PLAN – Assessed Needs Addressed	The Comprehensive Care Plan (CCP) addresses all enrollee assessed needs and preferences, and reflects a person-centered interdisciplinary, holistic and preventive focus.	4/4	4/4	100%
4 COMPREHENSIVE CARE PLAN – Goals	The enrollee’s goals or skills to be achieved are included in plan, are related to the enrollee’s preferences and how the enrollee wants to live their life, and there is a plan to achieve their goals.	4/4	4/4	100%
5 COMPREHENSIVE CARE PLAN – Choice	The enrollee is provided information related to, and makes informed choices about, long-term care services and providers.	4/4	4/4	100%
6 COMPREHENSIVE CARE PLAN - Safety Plan /	The enrollee has been assessed for risk and has a plan to address identified safety issues relating to risks, rights and choice.	4/4	3/4	87.5%

BLUE PLUS TRIENNIAL COMPLIANCE ASSESSMENT REPORT

Audit Protocol	Product Description	2023 MDH Audit Initial Charts Met	2023 MDH Audit Reassessment Charts Met	2023 MDH Audit Total % Charts Met
Personal Risk Management Plan				
7 COMPREHENSIVE CARE PLAN – Informal and Formal Services	The enrollee receives a description of their formal and informal services that contains all required elements.	4/4	4/4	100%
8 COMPREHENSIVE CARE PLAN – Caregiver Support	Informal caregivers are identified and supported in the plan.	4/4	4/4	100%
9 COMPREHENSIVE CARE PLAN – Housing and Transition	The enrollee has a transition plan to support housing choice.	4/4	N/A	100%
10 COMMUNICATION OF CARE PLAN/ SUMMARY - Physician	The enrollee’s primary care physician receives a Care Plan Summary.	4/4	4/4	100%
11 COMMUNICATION OF CARE PLAN/SUMMARY - Enrollee and Providers	The support plan is signed and dated and disseminated to all relevant parties.	4/4	4/4	100%

BLUE PLUS TRIENNIAL COMPLIANCE ASSESSMENT REPORT

Audit Protocol	Product Description	2023 MDH Audit Initial Charts Met	2023 MDH Audit Reassessment Charts Met	2023 MDH Audit Total % Charts Met
12 COMPREHENSIVE CARE PLAN – Enrollee Requests for Updates	The care plan includes a method for the individual to request updates to the plan, as needed.	4/4	4/4	100%
13 CARE COORDINATOR FOLLOW-UP PLAN	Enrollees have a care coordinator follow-up or contact plan related to identified concerns or needs, and the plan is implemented.	4/4	4/4	100%
14 ANNUAL PREVENTIVE HEALTH EXAM	Enrollee engages in conversation about the need for an annual, age–appropriate comprehensive preventive health exam with care coordinator.	4/4	4/4	100%
15 ADVANCE DIRECTIVE	Enrollee has opportunity for annual discussion about and/or completion of an Advance Directive	4/4	4/4	100%
16 APPEAL RIGHTS	Enrollee receives information about their appeal rights.	4/4	4/4	100%
17 DATA PRIVACY	Enrollee receives information about data privacy.	4/4	4/4	100%

Summary:

MDH received the EW audit sample lists from DHS per audit protocol. MDH reviewed 4 initial EW audits and 4 re-assessments.