

Minnesota Department of Health  
Compliance Monitoring Division  
Managed Care Systems Section



**Blue Plus**  
**Final Report**

Quality Assurance Examination  
For the period:  
March 1, 2007 to April 30, 2010

*Final Issue Date:*  
January 19, 2011

Examiners:  
Elaine Johnson, RN, BS, CPHQ  
Susan Margot, M.A.

**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. 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. “Mandatory Improvements” are required corrections that must be made to noncompliant policies, documents or procedures where evidence of actual compliance is found in relevant files 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:**

Require their delegate to prepare a corrective action plan for each issue, including a root cause analysis, the interventions, the necessary tasks, the responsible person and a timetable for resolution.

Consider developing an overall delegation oversight policy/procedure to provide consistency in its oversight process.

Include the PTI, Delta Dental and specialist timely availability analysis in its annual *Practitioner Access and Availability Analysis Report*.

**To address mandatory improvements, Blue Plus must:**

Annually approve its delegate’s UM program.

Revise its complaint policy/procedures to include the following:

- Any written complaint will receive a written response as required in Minnesota Statutes, section 62Q.69, subdivision 3(a)
- The policy/procedure for using extensions in complaint resolution as provided for in Minnesota Statutes, section 62Q.69, subdivision 3(a).

Include appeal rights with provider UM denial notifications (DTRs).

Revise its internal appeals and state fair hearing policy/procedure to include the following:

- 8.4.5 (G). The MCO must provide the enrollee, and his or her representative, an opportunity, before and during the appeals process, to examine the enrollee’s case file, including medical records, and any other documents and records considered during the appeal process.

- 8.4.5 (I). The MCO must not take punitive action against a provider who requests an expedited resolution or supports an enrollee’s appeal.
- 8.4.6. If an enrollee appeals a decision from a previous appeal on the same issue, and the MCO decides to hear it, for purposes of the timeframes for resolution, this will be considered a new appeal.
- 8.4.8. If a decision by an MCO is reversed by the appeal process, the MCO:
  - Must comply with the appeal decision promptly and as expeditiously as enrollee’s health condition requires: and
  - Must pay for any services the enrollee already received that are the subject of the appeal.
- In the course of a State Fair Hearing, an enrollee may request an expert medical opinion be arranged by the external review entity pursuant to Minnesota Statutes, § 62Q.73, subdivision 2. The MCO must participate in the external review process in accordance with this section and must comply with the process as specified in Minnesota Statutes, § 62Q.73, subdivision 6(a).

Revise policies/procedures to state specific factors the health plan must consider in determining coverage for emergency services.

Revise policy/procedure to state the following:

- Blue Plus will give notice of the right to continue care and that Blue Plus must provide services under the stated conditions when requested.
- Describe the process for coverage determinations for enrollees receiving culturally appropriate services or non-English communication when there is not another provider in the enrollee’s geographic area.
- Describe how criteria will be used and how continuity of care will be provided if the enrollee’s request is denied.

Revise policy/procedure to state that it will not deny or limit coverage of a service the enrollee has already received solely for lack of prior authorization.

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

Review the counties’ grievance policies/procedures and review an adequate sample of oral grievance files to do appropriate oversight of the grievance process.

Include evidence of ongoing monitoring and the evaluation of that data in the annual evaluation.

Submit modifications to the quality assurance plan to the Minnesota Department of Health.

Inform the complainant who believes the outcome of an oral complaint is adverse, that the complaint may be submitted in writing and Blue Plus must offer any assistance needed to submit a written complaint, including the offer to complete the form and mail it to the complainant for signature.

Advise the complainant of the right to the external review process, and must ensure the enrollee is directed to the Commissioner of Health for external review. (This part of the deficiency is a repeat deficiency from the 2007 Quality Assurance Examination.)

For oral grievances, offer a written form and assistance, document enrollee satisfaction, and inform the enrollee of options for further assistance through the Managed Care Ombudsman and/or MDH.

Provide notice of utilization management denials within ten business days.

Send a written notification of denial to the attending healthcare professional and enrollee, including when the denial is due to lack of information.

Include the State's Notice of Rights with the notification of the resolution of an appeal and include in the appeal notification the qualifications of the reviewer in MHCP-MC appeals in which the denial is upheld.

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.

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Darcy Miner, Director  
Compliance Monitoring Division

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Date

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## I. Introduction

### A. History:

Blue Plus of Minnesota is a nonprofit health maintenance organization and fully owned subsidiary of Blue Cross and Blue Shield of Minnesota (Blue Cross). Blue Plus was incorporated as HMO Minnesota in 1974, serving the Twin Cities metropolitan area and other major population areas. In the late 1980's, Blue Plus added a significant out-state presence. Blue Plus contracts with a variety of medical groups and integrated care systems. Blue Plus does not contract directly with individual primary care physicians (PCPs). Members choose a primary care clinic (PCC) when they enroll in Blue Plus. Some contracting PCCs are single-site entities, 843 PCCs contract with Blue Plus. Most contracting PCCs conduct fee-for-service business and contract with other HMOs. An independent board, consisting of 40 percent member-elected directors, oversees Blue Plus. Prime Therapeutics, the pharmacy benefits manager, is a subsidiary of Blue Plus.

B. Membership: Blue Plus self-reported enrollment as of December 31, 2009 consisted of the following:

<b>Product</b>	<b>Enrollment</b>
<i><b>Fully insured Commercial</b></i>	
Large Group	10,695
Small Employer Group	6,615
Individual	329
<i><b>Minnesota Health Care Programs-Managed Care (MHCP-MC)</b></i>	
Families & Children (PMAP/MSC+)	65,908
MinnesotaCare	45,293
Minnesota Senior Health Options (MSHO)	10,062
Special Needs Basic Care (SNBC)	1,384
<i><b>Total</b></i>	<b>140,286</b>

C. Onsite Examination Dates: July 12, 2010 to July 16, 2010

D. Examination Period: March 1, 2007 to April 30, 2010

File Review Period: May 1, 2009 to April 30, 2010

E. National Committee for Quality Assurance (NCQA): Blue Plus is accredited by NCQA based on 2008 standards. The Minnesota Department of Health (MDH) evaluated and used results of the NCQA review in one of three ways.

- If NCQA standards do not exist or are not as stringent as Minnesota law, the review results will not be used for evaluation [no NCQA box].
- If the NCQA review was the same or more stringent than Minnesota law and the health plan was accredited with 100% of the possible points, the NCQA review result was accepted as meeting Minnesota requirements [NCQA] unless evidence existed indicating further investigation was warranted [NCQA].

- c. If the NCQA standard was the same or more stringent than Minnesota law, but the review resulted in less than 100% of the possible points on NCQA’s score sheet or as an identified opportunity for improvement, MDH conducted its own examination.
- F. 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.
- G. Performance Standard: For each instance of non-compliance with applicable law or rule identified during the course of the quality assurance examination, which 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 had sufficient evidence obtained through: 1) file review; 2) policies and procedures; and 3) interviews that a plan’s overall operation is compliant with an applicable law.

**II. Quality Program Administration**

**Minnesota Rules, Part 4685.1110. Program**

Subp. 1.	Written Quality Assurance Plan	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met	<input type="checkbox"/> NCQA
Subp. 2.	Documentation of Responsibility	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met	<input type="checkbox"/> NCQA
Subp. 3.	Appointed Entity	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met	<input type="checkbox"/> NCQA
Subp. 4.	Physician Participation	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met	<input type="checkbox"/> NCQA
Subp. 5.	Staff Resources	<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	<input checked="" type="checkbox"/> NCQA
Subp. 6.	Delegated Activities	<input type="checkbox"/> Met	<input checked="" type="checkbox"/> Not Met	<input type="checkbox"/> NCQA <sup>1</sup>
Subp. 7.	Information System	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met	<input type="checkbox"/> NCQA
Subp. 8.	Program Evaluation	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met	<input type="checkbox"/> NCQA
Subp. 9.	Complaints	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met	
Subp. 10.	Utilization Review	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met	
Subp. 11.	Provider Selection and Credentialing	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met	<input checked="" type="checkbox"/> NCQA
Subp. 12.	Qualifications	<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	<input checked="" type="checkbox"/> NCQA
Subp. 13.	Medical Records	<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	<input checked="" type="checkbox"/> NCQA

Subp. 6. 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 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:

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<sup>1</sup> NCQA delegation standards are equivalent to Minnesota law for credentialing and quality improvement functions only.

Delegated Entities and Functions								
	UM	UM Appeals	QM	Complaints/ Grievances	Cred	Claims	Network	Care Coord
PrimeTherapeutics (PTI)	X approvals					X	X	
Delta Dental	X	X		X			X	
Wadena County				X (oral)				X
Pipestone County				X (oral)				X

PrimeTherapeutics (PTI) Under contract with Blue Plus, PTI approves prior authorizations and formulary exceptions. Potential denials are forwarded to Blue Plus for physician review. It was PTI's custom to send a copy of the denied request to the Blue Plus Customer Service Center (CSC) in the belief that the denial would likely be appealed. It was necessary for CSC to investigate the form, since it was not clear why the request form was sent. In addition, the clinical appeal file sample included two files in which Blue Plus Medical Directors upheld appeals. However, during the Blue Plus review process, PTI received additional information and overturned the original denial. CSC meets with PTI on a regular basis (every two to three weeks) to review problems. The project group has a charter and maintains minutes. However, as of the May, 2010 meeting, PTI continued to have issues in its business processes. Blue Plus may also address these issues via a delegation oversight process that would require their delegate to prepare a corrective action plan for each issue, including root cause analysis, the interventions, necessary tasks, the responsible person and a timetable for resolution. **(Recommendation #1)**

Delta Dental provides the utilization management, claims, network, and grievance and appeal functions for the MHCP-MC enrollee dental services. In its delegation oversight, Blue Plus was unable to provide documentation that it had approved Delta Dental's UM program. However, meeting minutes indicate UM and UM reports from Delta are reviewed on a regular basis by the Integrated Health Management Committee. In addition, the Delta UM program plan and UM policies/procedures were reviewed during the annual evaluation. While evidence exists of conscientious UM delegation oversight, Blue Plus should specifically indicate in meeting minutes or other documentation that its delegate's UM program plan was approved by Blue Plus. **(Mandatory Improvement #1)**

Blue Plus contracts with 57 counties to provide care coordination services and to conduct the oral grievance process for elderly waiver services. The annual oversight audit of the counties for the review of grievances includes a signed attestation by the county that the grievance process policy is in compliance and one oral grievance file is reviewed by Blue Plus. This is insufficient oversight of the grievance process. To assure that the counties are compliant with the oral grievance process, Blue Plus must review the counties' grievance policies for inclusion of accurate grievance system standards as described in 42 CFR §438, subpart F (contract article 8). In addition, an adequate sample of oral grievance files must be reviewed. The methodology for file sampling should be the same as used with other delegate file reviews. **(Deficiency #1)** To provide consistency in the delegation oversight process, Blue Plus may want to develop an overall delegation oversight policy/procedure. **(Recommendation #2)**

Subd. 9. Minnesota Rules, part 4685.1110, subpart 9, states the quality program must conduct ongoing evaluation of enrollee complaints related to quality of care. A total of 10 quality of care complaint and grievance files were reviewed as follows:

<b>Quality of Care File Review</b>	
<b>QOC File Source</b>	<b># Reviewed</b>
<i>Complaint Files</i>	2
<i>Grievance Files</i>	8
<b>Total</b>	<b>10</b>

**Minnesota Rules, Part 4685.1115. Activities**

- Subp. 1. Ongoing Quality Evaluation Met Not Met NCQA
- Subp. 2. Scope Met Not Met NCQA

**Minnesota Rules, Part 4685.1120. Quality Evaluation Steps**

- Subp. 1. Problem Identification Met Not Met NCQA
- Subp. 2. Problem Selection Met Not Met NCQA
- Subp. 3. Corrective Action Met Not Met NCQA
- Subp. 4. Evaluation of Corrective Action Met Not Met NCQA

Subp. 1. Minnesota Rules, part 4685.1120, subpart 1, states that the HMO shall identify the existence of actual or potential quality problems or identify opportunities for improving care through ongoing monitoring and the evaluation of that data. The 2009 *Quality Improvement Program Evaluation* was very comprehensive except for the following: In the monitoring section of the program evaluation, there was no inclusion of data or an evaluation of that data in the areas of credentialing, hypertension, and member satisfaction with behavioral health.

**(Deficiency #2)**

**Minnesota Rules, Part 4685.1125. Focused Study Steps**

- Subp. 1. Focused Studies Met Not Met
- Subp. 2. Topic Identification and Selection Met Not Met
- Subp. 3. Study Met Not Met
- Subp. 4. Corrective Action Met Not Met
- Subp. 5. Other Studies Met Not Met

**Minnesota Rules, Part 4685.1130. Filed Written Plan and Work Plan**

- Subp. 1. Written Plan Met Not Met  
 Subp. 2. Work Plan Met Not Met NCQA  
 Subp. 3. Amendments to Plan Met Not Met

Subp. 3. Minnesota Rules, part 4685.1130, subpart 3, states that the HMO may change its written quality assurance plan by filing notice with the commissioner 30 days before modifying its quality assurance program or activities. Blue Plus annually revises its written quality assurance plan; however no written quality assurance plans have been filed with MDH since 2006. (Deficiency #3)

**III. Complaints and Grievance Systems**

**Complaint System**

MDH examined the Blue Plus fully-insured commercial complaint system under Minnesota Statutes, chapter 62Q.

MDH reviewed a total of 38 Complaints System files:

<b>Complaint System File Review</b>	
<b>Complaint and Appeal File Source</b>	<b># Reviewed</b>
<i>Complaint Files (Oral and Written)</i>	31
<i>Non-Clinical Appeal Files</i>	(All) 6
<b>Total</b>	<b>37</b>

(Quality of Care Complaints were reviewed as part of Quality Program Administration)

**Minnesota Statutes, Section 62Q.69. Complaint Resolution**

- Subd. 1. Establishment Met Not Met  
 Subd. 2. Procedures for filing a complaint Met Not Met  
 Subd. 3. Notification of Complaint Decisions Met Not Met

Subd. 1. Minnesota Statutes, section 62Q.69, subdivision 1, states the health plan must establish and maintain a complaint resolution process. MDH found the policy/procedures compliant with law with the following exceptions:

- Minnesota Statutes, section 62Q.69, subdivision 3(a), states the health plan must notify the complainant in writing of its decision within 30 days of receiving a written complaint. Blue Plus policy/procedure, *Complaint Process*, page 2 states if further action or response

is required, CSC will notify the member by telephone or in writing of the response. Blue Plus procedure must state that any written complaint will receive a written response.

- Minnesota Statutes, section 62Q.69, subdivision 3(a), also states that the health plan may take an additional 14 days to resolve a complaint. Blue Plus policies/procedures did not include the option to take additional days. In file review, MDH found two files that requested extensions on the resolution of a complaint. These extensions were correctly executed. However, if Blue Plus no longer uses extensions, Blue Plus should state that information in policies/procedures, or, if Blue Plus uses extensions, it should include extensions in its policies/procedures.

**(Mandatory Improvement #2)**

Subd. 2(a). Minnesota Statutes, section 62Q.69, subdivision 2(a), states that if the complainant believes the outcome of an oral complaint is adverse, the health plan must inform the complainant that the complaint may be submitted in writing and must offer any assistance needed to submit a written complaint, including the offer to complete the form and mail it to the complainant for signature. Five commercial complaints in the file sample were oral. Four of the files did not document an offer of assistance. **(Deficiency #4)**

**Minnesota Statutes, Section 62Q.70. Appeal of the Complaint Decision**

Subd. 1.	Establishment	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subd. 2.	Procedures for Filing an Appeal	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subd. 3.	Notification of Appeal Decisions	<input type="checkbox"/> Met	<input checked="" type="checkbox"/> Not Met

Subd. 3(a). Minnesota Statutes, section 62Q.70, subdivision 3(a), states the health plan must give the complainant written notice of the appeal decision and all key findings within 30 days of the receipt of the written appeal. One file exceeded the 30 day timeline.

Subd. 3(b). Minnesota Statutes, section 62Q.70, subdivision 3(b), states if the appeal decision is partially or wholly adverse to the complainant, the notice must advise the complainant of the right to the external review process and the procedure for initiating the external process. Eight clinical appeal files did not notify the enrollee of the right to external review. Blue Plus states that it discovered the problem while preparing for the MDH examination and put a corrective action in place.

In addition, in five initial UM denial files the notification letter directed the enrollee to the Commissioner of Commerce rather than the Commissioner of Health for external review. This part of the deficiency is a repeat deficiency from the 2007 Quality Assurance Examination. [Also see Minnesota Statutes, sections 62Q.73 and 62M.06, subdivision 3(g)] **(Deficiency #5)**

**Minnesota Statutes, Section 62Q.71. Notice to Enrollees**

Met Not Met

**Minnesota Rules, Part 4685.1900. Records of Complaints**

- Subp. 1. Record Requirements Met Not Met  
 Subp. 2. Log of Complaints Met Not Met

**Minnesota Statutes, Section 62Q.73. External Review of Adverse Determinations**

- Subd. 3. Right to external review Met Not Met

Minnesota Statutes, section 62Q.73, subdivision 3 states if the enrollee has received an adverse determination, the enrollee may submit a written request for external review. Notification of the right must accompany the notice of denial. Eight clinical appeal files did not notify the enrollee of the right to external review.

In addition, five initial UM denial files, the notification letter directed the enrollee to the Commissioner of Commerce rather than the Commissioner of Health for external review. This part of the deficiency is a repeat deficiency from the 2007 Quality Assurance Examination. **(Deficiency #5)** [Also see Minnesota Statutes, sections 62Q.70, subdivision 3(b) and 62M.06, subdivision 3(g).]

**Grievance System**

MDH examined Blue Plus’s Minnesota Health Care Programs-Managed Care (MHCP-MC) grievance system for compliance with the federal law (42 CFR 438, subpart F) and the DHS 2009 Model Contract, Article 8.

MDH reviewed a total of 86 grievance system files:

<b>Grievance System File Review</b>	
<b>File Source</b>	<b># Reviewed</b>
<b><i>Grievance</i></b>	
Blue Plus	30
Delta Dental	8
<b><i>Non Clinical Appeals</i></b>	
Blue Plus	10
Delta Dental	8
<b><i>Clinical Appeals</i></b>	
Blue Plus	11
Delta Dental	8
<b><i>State Fair Hearings</i></b>	
Blue Plus	10

Delta Dental	1
<b>Total</b>	<b>86</b>

**Section 8.1. §438.402 General Requirements**

Sec. 8.1.1. Components of Grievance System Met Not Met

**Section 8.2. §438.408 Internal Grievance Process Requirements**

Sec. 8.2.1. §438.402 (b) Filing Requirements Met Not Met

Sec. 8.2.2. §438.408 (b)(1) Timeframe for Resolution of Grievances  
Met Not Met

Sec. 8.2.3. §438.408 (c) Timeframe for Extension of Resolution of Grievances  
Met Not Met

Sec. 8.2.4. §438.406 Handling of Grievances

- (A) §438.406 (a)(2) Written Acknowledgement Met Not Met
- (B) §438.416 Log of Grievances Met Not Met
- (C) §438.402 (b)(3) Oral or Written Grievances Met Not Met
- (D) §438.406 (a)(1) Reasonable Assistance Met Not Met
- (E) §438.406 (a)(3)(i) Individual Making Decision Met Not Met
- (F) §438.406 (a)(3)(ii) Appropriate Clinical Expertise Met Not Met

Sec. 8.2.5. §438.408 (d)(1) Notice of Disposition of a Grievance.

- (A) §438.408 (d)(1) Oral Grievances Met Not Met
- (B) §438.408 (d)(1) Written Grievance Met Not Met

42 CFR 438.408(b)(1) (contract section 8.2.2.) states that oral grievances must be resolved within 10 days of receipt. There was one oral grievance that was greater than the 10 day time line (20 days).

42 CFR 438.408(d)(1) (contract section 8.2.5) states if the oral resolution, as determined by the enrollee, is partially or wholly adverse to the enrollee, or the grievance is not resolved to the satisfaction of the enrollee, the MCO must inform the enrollee that the grievance may be submitted in writing and must offer to provide any assistance needed with the written grievance. In four oral grievance files the enrollee was not offered a written form and assistance. In these files, documentation was unclear if the enrollee was satisfied with the resolution. In addition, in six files, the enrollee was not informed of options for further assistance through the Managed Care Ombudsman and/or MDH. **(Deficiency #6)**

42 CFR 438.408(d)(1) (contract section 8.2.5.) states, in pertinent part, that when a grievance is filed in writing, the written notice must include options for further review through the Managed Care Ombudsman and/or MDH. In one written grievance the written notice did not contain the options for further review.

**Section 8.3. §438.404 DTR Notice of Action to Enrollees**

Sec. 8.3.1.	General requirements	<input type="checkbox"/> Met	<input checked="" type="checkbox"/> Not Met
Sec. 8.3.2.	§438.404 (c) Timing of DTR Notice		
(A)	§438.210 (c) Previously Authorized Services	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
(B)	§438.404 (c)(2) Denials of Payment	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
(C)	§438.210 (c) Standard Authorizations	<input type="checkbox"/> Met	<input checked="" type="checkbox"/> Not Met
(D)	§438.210 (d)(2)(i) Expedited Authorizations	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
(E)	§438.210 (d)(1) Extensions of Time	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
(F)	§438.210 (d) Delay in Authorizations	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Sec. 8.2.3.	§438.420 (b) Continuation of Benefits Pending Decision	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met

42 CFR 438.404 (contract section 8.3.1 (C)) states the MCO must notify the provider of the action and of the right to appeal a DTR. For denial of payment the notification may be through provider contracts, provider manuals or other forms of direct communication. Delta Dental sends an EOB and a letter advising the provider of the denial. The appeal rights are included in the provider manual. This practice has been approved in the past by MDH for both denials of payment and UM denials. After clarification from DHS, it was determined that for denials of payment only, appeal rights can be through the provider manual. In the case of UM denials, appeal rights need to be included with the denial notification since the provider can appeal on behalf of the enrollee. None of the 30 UM denial files reviewed included provider appeal rights. **(Mandatory Improvement #3)**

42 CFR 438.210(c) (contract section 8.3.2 (C)) states, in pertinent part, for standard authorizations that deny or limit services, the MCO must provide the notice to the provider, enrollee and hospital, in writing within 10 business days following receipt of the request. In six MHCP-MC UM denial files and one commercial UM denial, the time frame for the notice was greater than 10 business days (20 to 50 days). Blue Plus must provide notice of the denial within 10 business days. **(Deficiency #7)** This is a repeat deficiency. (See previous Quality Assurance Examination, dated November 19, 2007) [Also see MS § 62M.05, subdivision 3a(a)]

In one file the DTR was dated four days before the Medical Director denial. This was a process issue with a part time Behavioral Health Medical Director. Blue Plus now has a full time Medical Director for Behavioral Health. The MCO must provide notification of a denial by telephone or fax within one business day after making the determination.

In one file (Delta Dental) the telephone notification exceeded one business day.

In two Delta Dental UM files involving lack of information, a DTR was issued advising the enrollee the service was denied due to lack of information. When the requested information came in, the service was again denied, however, a second DTR was not sent to the enrollee. **(Deficiency #8)** This was discovered while preparing for the MDH examination and Delta Dental has put a corrective action plan in place. [Also see Minnesota Statutes, section 62M.05, subdivision 3a(c)]

**Section 8.4. §438.408**

**Internal Appeals Process Requirements**

- Sec. 8.4.1. §438.402 (b) Filing Requirements Met Not Met
- Sec. 8.4.2. §438.408 (b)(2) Timeframe for Resolution of Standard Appeals  
Met Not Met
- Sec. 8.4.3 §438.408 (b) Timeframe for Resolution of Expedited Appeals  
(A) §438.408 (b)(3) Expedited Resolution of Oral and Written Appeals  
Met Not Met  
(B) §438.410 (c) Expedited Resolution Denied Met Not Met  
(C) §438.410 (a) Expedited Appeal by Telephone  
Met Not Met
- Sec. 8.4.4. §438.408 (c) Timeframe for Extension of Resolution of Appeals  
Met Not Met
- Sec. 8.4.5. §438.406 Handling of Appeals  
(A) §438.406 (b)(1) Oral Inquiries Met Not Met  
(B) §438.406 (a)(2) Written Acknowledgement Met Not Met  
(C) §438.406 (a)(1) Reasonable Assistance Met Not Met  
(D) §438.406 (a)(3) Individual Making Decision Met Not Met  
(E) §438.406 (a)(3) Appropriate Clinical Expertise  
[See Minnesota Statutes, sections 62M.06, subd. 3(f) and 62M.09]  
(F) §438.406 (b)(2) Opportunity to Present Evidence  
Met Not Met  
(G) §438.406 (b)(3) Opportunity to Examine the Case File  
Met Not Met  
(H) §438.406 (b)(4) Parties to the Appeal Met Not Met  
(I) §438.410(b) Prohibition of Punitive Action Met Not Met
- Sec. 8.4.6. Subsequent Appeals Met Not Met
- Sec. 8.4.7. §438.408 (d)(2) and (e) Notice of Resolution of Appeals  
(A) §438.408 (d)(2) and (e) Written Notice Content Met Not Met  
(B) §438.210 (c) Appeals of UM Decisions Met Not Met  
(C) §438.210 (c) and .408(d)(2)(ii) Telephone Notification of Expedited Appeals  
Met Not Met  
[Also see Minnesota Statutes, section 62M.06, subd. 2]
- Sec. 8.4.8. §438.424 Reversed Appeal Resolutions  
Met Not Met

§438.408 (d)(2) and (e) (contract section 8.4.7), states, in pertinent part, the State’s Notice of Rights must be included with the notice of resolution of an appeal. In the 16 clinical and non-clinical appeal files reviewed in which the denial was upheld upon appeal, the state Notice of Rights was not included.

Additionally, the DHS contract states the Grievance/Appeal system must meet the requirements of Minnesota Statutes, section 62M.06. Minnesota Statutes, section 62M.06, subdivision 3(e), states, in pertinent part, that when a denial determination is upheld upon appeal, the notification must contain the qualifications of the reviewers, including any license, certification, or specialty designation. In seven MHCP-MC files in which the denial was upheld upon appeal, the appeal notification did not contain the qualifications of the reviewer. These issues were noted by Blue Plus when preparing the files for MDH review. A corrective action plan was developed in response.

**(Deficiency #9)** [Also refer to Minnesota Statutes, section 62M.06, subdivision 3(e)].

Sections 8.4.5 (G) and (I), 8.4.6, and 8.4.8 were not specifically spelled out in the appeals policy entitled *Written and Oral Appeals for Blue Plus Government Programs*. Even though Blue Plus included links and references to the DHS contract sections relating to the appeals process, all the appeals process requirements should be included in the policy/procedure to ensure an accurate and complete process. Missing elements include:

- 8.4.5 (G). The MCO must provide the enrollee, and his or her representative, an opportunity, before and during the appeals process, to examine the enrollee’s case file, including medical records, and any other documents and records considered during the appeal process.
- 8.4.5 (I). The MCO must not take punitive action against a provider who requests an expedited resolution or supports an enrollee’s appeal
- 8.4.6 If an enrollee appeals a decision from a previous appeal on the same issue, and the MCO decides to hear it, for purposes of the timeframes for resolution, this will be considered a new appeal.
- 8.4.8. If a decision by an MCO is reversed by the appeal process, the MCO:
  - Must comply with the appeal decision promptly and as expeditiously as enrollee’s health condition requires: and
  - Must pay for any services the enrollee already received that are the subject of the appeal.

**(Mandatory Improvement #4)**

**Section 8.5. §438.416 (c) Maintenance of Grievance and Appeal Records**

Met Not Met

**Section 8.9. §438.408 (f) State Fair Hearings**

Section 8.9.2. §438.408 (f) Standard Hearing Decisions Met Not Met

Section 8.9.5. §438.420 Continuation of Benefits Pending Resolution of State Fair Hearing Met Not Met

Section 8.9.6. §438.424 Compliance with State Fair Hearing Resolution Met Not Met

Section 8.9.8 External Review Participation Met Not Met

42 CFR 438.408 (contract section 8.9.8) states that in the course of a State Fair Hearing, an Enrollee may request an expert medical opinion be arranged by the external review entity pursuant to Minnesota Statutes, § 62Q.73, subdivision 2. The MCO must participate in the external review process in accordance with this section and must comply with the process as specified in Minnesota Statutes, § 62Q.73, subdivision 6(a). This was not included in the policy *Written and Oral Appeals for Blue Plus Government Programs*. **(Mandatory Improvement #4)**

**Minnesota Rules, Part 4685.1900. Records of Complaints**

- Subp. 1. Record Requirements Met Not Met
- Subp. 2. Log of Complaints (§438.416 (a)) Met Not Met

**IV. Access and Availability**

**Minnesota Statutes, Section 62D.124. Geographic Accessibility**

- Subd. 1. Primary Care; Mental Health Services; General Hospital Services Met Not Met
- Subd. 2. Other Health Services Met Not Met
- Subd. 3. Exception Met Not Met

Blue Plus annually prepares an excellent *Practitioner Access and Availability Analysis Report*. Blue Plus prepares separate reports of the PTI pharmacy network and the Delta Dental network (for MHCP-MC enrollees). In addition, Blue Plus analyzes timely availability of high volume specialty practitioners. These separate reports and analysis are not a part of the annual *Practitioner Access and Availability Analysis Report*. Including the PTI, Delta Dental and specialist timely availability analysis will provide a more comprehensive picture of Blue Plus networks. **(Recommendation #3)**

**Minnesota Rules, Part 4685.1010. Availability and Accessibility**

- Subp. 2. Basic Services Met Not Met
- Subp. 5. Coordination of Care Met Not Met
- Subp. 6. Timely Access to Health Care Services Met Not Met
- Subp. 7. Emergency Services Met Not Met

Subp. 7. Minnesota Rules, part 4685.1010, subpart 7, and Minnesota Statutes, section 62Q.55, state specific factors the health plan must consider in determining coverage for emergency services. These factors are not included in policy/procedure UM 308, *Emergency Services—Commercial Business*. **(Mandatory Improvement #5)**

**Minnesota Statutes, Section 62Q.55. Emergency Services**

Met Not Met

(See Minnesota Rules, part 4685.1010, subpart 7)

**Minnesota Statutes, Section 62Q.121. Licensure of Medical Directors**

Met Not Met

**Minnesota Statutes, Section 62Q.527. Coverage of Nonformulary Drugs for Mental Illness and Emotional Disturbance**

Subd. 2. Required Coverage for Anti-psychotic Drugs

Met Not Met

Subd. 3. Continuing Care

Met Not Met

Subd. 4. Exception to formulary

Met Not Met

**Minnesota Statutes, Section 62Q.535. Coverage for Court-Ordered Mental Health Services**

Subd. 1. Mental health services

Met Not Met

Subd. 2. Coverage required

Met Not Met

**Minnesota Statutes, Section 62Q.56. Continuity of Care**

Subd. 1. Change in health care provider; general notification

Met Not Met

Subd. 1a. Change in health care provider; termination not for cause

Met Not Met

Subd. 1b. Change in health care provider; termination for cause

Met Not Met

Subd. 2. Change in health plans

Met Not Met

Subd. 2a. Limitations

Met Not Met

Subd. 2b. Request for authorization

Met Not Met

Subd. 3. Disclosures

Met Not Met

Subds. 1a, 2 and 2b. Minnesota Statutes, section 62Q.56, subdivision 1a, states in pertinent part, if a provider contract was terminated not for cause, the plan must give the provider and all affected enrollees notice of the right to continue care with the provider. Subdivisions 1a and 2 also state that if the provider contract was terminated not for cause or the enrollee is subject to a change in health plan, the health plan must provide, upon request, authorization to receive services that are otherwise covered under the terms of the health plan through the enrollee's

current provider for up to 120 days if the enrollee is engaged in a current course of treatment for one or more of the stated conditions. Blue Plus policy/procedure *Transition/Continuity of Care*, UMSP 220, states that “new members or members whose physician has terminated with BCBSMN are eligible for consideration of COC/TOC.” Blue Plus policy/procedure must state that it will give notice of the right to continue care and that Blue Plus is required to provide services under the stated conditions when requested.

*Transition/Continuity of Care* does not describe its process for coverage determinations for enrollees receiving culturally appropriate services or non-English communication when there is not another provider in the enrollee’s geographic area.

Finally, Minnesota Statutes, section 62Q.56, subdivision 2b, states that the plan must explain the criteria used if the request for continuity of care is denied or, if approved, explain how transition or continuity of care will be provided. *Transition/Continuity of Care* does not state that it will explain either the criteria used or how continuity of care will be provided.

**(Mandatory Improvement #6)**

**V. Utilization Review**

UM System File Review		# Reviewed
<b>File Source</b>		
<i>UM Denial Files</i>		
Commercial		31
MHCP-MC	Blue Plus	30
	Delta Dental	30
	<i>Subtotal</i>	<i>91</i>
<i>Clinical Appeal Files</i>		
Commercial		29
MHCP-MC	Blue Plus	11
	Delta Dental	8
	<i>Subtotal</i>	<i>48</i>
	<b>Total</b>	<b>139</b>

**Minnesota Statutes, Section 62M.04. Standards for Utilization Review Performance**

- Subd. 1. Responsibility on Obtaining Certification Met Not Met
- Subd. 2. Information upon which Utilization Review is Conducted Met Not Met
- Subd. 3. Data Elements Met Not Met
- Subd. 4. Additional Information Met Not Met
- Subd. 5. Sharing of Information Met Not Met

**Minnesota Statutes, Section 62M.05. Procedures for Review Determination**

- Subd. 1. Written Procedures Met Not Met
- Subd. 2. Concurrent Review Met Not Met NCQA
- Subd. 3. Notification of Determinations Met Not Met
- Subd. 3a. Standard Review Determination
  - (a) Initial determination to certify (10 business days) Met Not Met NCQA
  - (b) Initial determination to certify (telephone notification) Met Not Met
  - (c) Initial determination not to certify Met Not Met
  - (d) Initial determination not to certify (notice of rights to internal appeal) Met Not Met NCQA
- Subd. 3b. Expedited Review Determination Met Not Met NCQA
- Subd. 4. Failure to Provide Necessary Information Met Not Met
- Subd. 5. Notifications to Claims Administrator Met Not Met

Subd. 3a(a). Minnesota Statutes, section 62M.05, subdivision 3a(a), states an initial utilization review determination must be communicated within ten business days. In one commercial denial and six MHCP-MC denials (total of seven), the response exceeded ten business days (taking 20 to 50 calendar days). **(Deficiency #7)** This is a repeat deficiency. (See previous Quality Assurance Examination, dated November 19, 2007) [Also see 42 CFR 438.210(c) (contract section 8.3.2(C))]

Subd. 3a(b). Minnesota Statutes, section 62M.05, subdivision 3a(b), states that when an initial determination is made not to certify, verbal notification by telephone or fax must be provided within one working day after making the determination to the attending healthcare professional. In one file (Delta Dental) the notification took longer than one working day. [Also see 42 CFR 438.210(c) (contract section 8.3.2 (C))]

Subd. 3a(c). Minnesota Statutes, section 62M.05, subdivision 3a(c), states in pertinent part, when an initial determination is made not to certify, written notification must be sent to the attending health care professional and enrollee, the reason may include, among other things, lack of information. In two Delta Dental MHCP-MC UM files involving lack of information, a DTR was issued advising the enrollee the service was denied due to lack of information. When the requested information came in, the service was again denied, however, a second DTR was not sent to the enrollee. **(Deficiency #8)** This was discovered by Delta Dental while preparing for the MDH examination and a corrective action plan has been initiated. [Also see 42 CFR 438.210(c) (contract section 8.3.2(C))]

**Minnesota Statutes, Section 62M.06. Appeals of Determinations not to Certify**

- Subd. 1. Procedures for Appeal Met Not Met
- Subd. 2. Expedited Appeal Met Not Met
- Subd. 3. Standard Appeal
  - (a) Appeal resolution notice timeline Met Not Met

- |  |   |   |  |
|--|---|---|--|
| (b) Documentation requirements                   | <input checked="" type="checkbox"/> Met | <input type="checkbox"/> Not Met            |  |
| (c) Review by a different physician              | <input type="checkbox"/> Met            | <input type="checkbox"/> Not Met            | <input checked="" type="checkbox"/> NCQA |
| (d) Time limit in which to appeal                | <input checked="" type="checkbox"/> Met | <input type="checkbox"/> Not Met            |  |
| (e) Unsuccessful appeal to reverse determination | <input type="checkbox"/> Met            | <input checked="" type="checkbox"/> Not Met | <input type="checkbox"/> NCQA            |
| (f) Same or similar specialty review             | <input checked="" type="checkbox"/> Met | <input type="checkbox"/> Not Met            |  |
| (g) Notice of rights to External Review          | <input type="checkbox"/> Met            | <input checked="" type="checkbox"/> Not Met | <input type="checkbox"/> NCQA            |
| Subd. 4. Notifications to Claims Administrator   | <input checked="" type="checkbox"/> Met | <input type="checkbox"/> Not Met            |  |

Subd. 3(a). Minnesota Statutes, section 62M.06, subdivision 3(a), states the health plan must give written notice of the determination within 30 days of the receipt of the written appeal. One file exceeded the 30 day timeline. [Also see 62Q.70, subdivision 3(a)]

Subd. 3(e). Minnesota Statutes, section 62M.06, subdivision 3(e), states, in pertinent part, that when a denial determination is upheld upon appeal, the notification must contain the qualifications of the reviewers, including any license, certification, or specialty designation. This was included in the notifications of all the commercial clinical appeals files. However, in seven MHCP-MC files in which the denial was upheld upon appeal, the appeal notification did not contain the qualifications of the reviewer. **(Deficiency #9)** [Also see 42 CFR 438.408 (contract section 8.4)]

Subd. 3(g). Minnesota Statutes, section 62M.06, subdivision 3(g), states if the initial determination is not reversed on appeal, the plan must include in its notice the right to submit the appeal to external review. In file review, eight commercial clinical appeals did not notify the enrollee of the right to external review.

In addition, in five initial UM denial files the notification letter directed the enrollee to the Commissioner of Commerce rather than the Commissioner of Health for external review. This part of the deficiency is a repeat deficiency from the 2007 Quality Assurance Examination. [Also see Minnesota Statutes, section 62Q.70, subdivision 3(b) and 62Q.73] **(Deficiency #5)**

**Minnesota Statutes, Section 62M.08. Confidentiality**

Met Not Met NCQA

**Minnesota Statutes, Section 62M.09. Staff and Program Qualifications**

- |  |   |                                  |  |
|--|---|----------------------------------|--|
| Subd. 1. Staff Criteria                            | <input type="checkbox"/> Met            | <input type="checkbox"/> Not Met | <input checked="" type="checkbox"/> NCQA |
| Subd. 2. Licensure Requirement                     | <input type="checkbox"/> Met            | <input type="checkbox"/> Not Met | <input checked="" type="checkbox"/> NCQA |
| Subd. 3. Physician Reviewer Involvement            | <input type="checkbox"/> Met            | <input type="checkbox"/> Not Met | <input checked="" type="checkbox"/> NCQA |
| Subd. 3a. Mental Health and Substance Abuse Review | <input checked="" type="checkbox"/> Met | <input type="checkbox"/> Not Met |  |
| Subd. 4. Dentist Plan Reviews                      | <input type="checkbox"/> Met            | <input type="checkbox"/> Not Met | <input checked="" type="checkbox"/> NCQA |
| Subd. 4a. Chiropractic Reviews                     | <input type="checkbox"/> Met            | <input type="checkbox"/> Not Met | <input checked="" type="checkbox"/> NCQA |
| Subd. 5. Written Clinical Criteria                 | <input type="checkbox"/> Met            | <input type="checkbox"/> Not Met | <input checked="" type="checkbox"/> NCQA |

Subd. 6.	Physician Consultants	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met	<input type="checkbox"/> NCQA
Subd. 7.	Training for Program Staff	<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	<input checked="" type="checkbox"/> NCQA
Subd. 8.	Quality Assessment Program	<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	<input checked="" type="checkbox"/> NCQA

**Minnesota Statutes, Section 62M.10. Accessibility and on-site Review Procedures**

Subd. 1.	Toll-free Number	<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	<input checked="" type="checkbox"/> NCQA
Subd. 2.	Reviews during Normal Business Hours	<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	<input checked="" type="checkbox"/> NCQA
Subd. 7.	Availability of Criteria	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met	

**Minnesota Statutes, Section 62M.12. Prohibition on Inappropriate Incentives**

Met Not Met NCQA

**Minnesota Statutes, Section 62D.12. Prohibited Practices**

Subd. 19.	Coverage of service	<input type="checkbox"/> Met	<input checked="" type="checkbox"/> Not Met
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Subd. 19. Minnesota Statutes, section 62D.12, subdivision 19, states the health plan may not deny or limit coverage of a service the enrollee has already received solely for lack of prior authorization. Blue Plus policies/procedures did not include this statement. **(Mandatory Improvement #7)**

**VI. Recommendations**

1. To better comply with Minnesota Rules, part 4685.1110, subpart 6, Blue Plus should require their delegate to prepare a corrective action plan for each issue, including a root cause analysis, the interventions, the necessary tasks, the responsible person and a timetable for resolution
2. To better comply with Minnesota Rules, part 4685.1110, subpart 6, consider developing an overall delegation oversight policy/procedure to provide consistency in its oversight process.
3. To better comply with Minnesota Statutes, section 62D.124, Blue Plus should include the PTI, Delta Dental and specialist timely availability analysis in its annual *Practitioner Access and Availability Analysis Report*.

## VII. Mandatory Improvements

1. To comply with Minnesota Rules, part 4685.1110, subpart 6, Blue Plus must annually approve its delegate's UM program.
2. To comply with Minnesota Statutes, section 62Q.69, subdivision 1, Blue Plus must revise its complaint policy/procedures to include the following:
  - Any written complaint will receive a written response as required in Minnesota Statutes, section 62Q.69, subdivision 3(a).
  - The policy/procedure for using extensions in complaint resolution as provided for in Minnesota Statutes, section 62Q.69, subdivision 3(a).
3. To comply with 42 CFR 438.404 (contract section 8.3.1 (C)), Blue Plus and its delegates must include appeal rights with provider UM denial notifications (DTRs).
4. To comply with 42 CFR 438.404 regarding the internal appeals process, Blue Plus must revise its internal appeals and state fair hearing policy/procedure to include the following:
  - 8.4.5 (G). The MCO must provide the enrollee, and his or her representative, an opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records considered during the appeal process.
  - 8.4.5 (I). The MCO must not take punitive action against a provider who requests an expedited resolution or supports an enrollee's appeal.
  - 8.4.6. If an enrollee appeals a decision from a previous appeal on the same issue, and the MCO decides to hear it, for purposes of the timeframes for resolution, this will be considered a new appeal.
  - 8.4.8. If a decision by an MCO is reversed by the appeal process, the MCO:
    - Must comply with the appeal decision promptly and as expeditiously as enrollee's health condition requires; and
    - Must pay for any services the enrollee already received that are the subject of the appeal.
  - In the course of a State Fair Hearing, an enrollee may request an expert medical opinion be arranged by the external review entity pursuant to Minnesota Statutes, § 62Q.73, subdivision 2. The MCO must participate in the external review process in accordance with this section and must comply with the process as specified in Minnesota Statutes, § 62Q.73, subdivision 6(a).
5. To comply with Minnesota Rules, part 4685.1010, subpart 7, and Minnesota Statutes, section 62Q.55, Blue Plus policies/procedures must be revised to state specific factors the health plan must consider in determining coverage for emergency services.
6. To comply with Minnesota Statutes, section 62Q.56, Blue Plus policy/procedure must be revised to state the following:
  - Blue Plus will give notice of the right to continue care and that Blue Plus must provide services under the stated conditions when requested .

- Describe the process for coverage determinations for enrollees receiving culturally appropriate services or non-English communication when there is not another provider in the enrollee's geographic area.
  - Describe how criteria will be used and how continuity of care will be provided if the enrollee's request is denied.
7. To comply with Minnesota Statutes, section 62D.12, subdivision 19, Blue Plus policy/procedure should state that it will not deny or limit coverage of a service the enrollee has already received solely for lack of prior authorization.

## **VIII. Deficiencies**

1. To comply with Minnesota Rules, part 4685.1110, subpart 6, Blue Plus must review the counties' grievance policies/procedures and review an adequate sample of oral grievance files to do appropriate oversight of the grievance process.
2. To comply with Minnesota Rules, part 4685.1120, subpart 1, Blue Plus must include evidence of ongoing monitoring and the evaluation of that data in the annual evaluation.
3. To comply with Minnesota Rules, part 4685.1130, subpart 3, Blue Plus must submit modifications to the quality assurance plan to the Minnesota Department of Health.
4. To comply with Minnesota Statutes, section 62Q.69, subdivision 2(a), Blue Plus must inform the complainant who believes the outcome of an oral complaint is adverse, that the complaint may be submitted in writing and Blue Plus must offer any assistance needed to submit a written complaint, including the offer to complete the form and mail it to the complainant for signature.
5. To comply with Minnesota Statutes, sections 62Q.70, subdivision 3(b), section 62Q.73, subdivision 3, and 62M.06, subdivision 3(g), Blue Plus must advise the complainant of the right to the external review process, and must ensure the enrollee is directed to the Commissioner of Health for external review. (The second part of the deficiency is a repeat deficiency from the 2007 Quality Assurance Examination.)
6. To comply with 42 CFR 438.408(d)(1) (contract section 8.2.5), Blue Plus must, for oral grievances, offer a written form and assistance, document enrollee satisfaction, and inform the enrollee of options for further assistance through the Managed Care Ombudsman and/or MDH.
7. To comply with 42 CFR 438.210(c) (contract section 8.3.2 (C)) and Minnesota Statutes, section 62M.05, subdivision 3a(a), Blue Plus must provide notice of utilization management denials within ten business days. (This deficiency is a repeat deficiency from the 2007 Quality Assurance Examination.)

8. To comply with 42 CFR 438.210(C) (contract section 8.3.2 (C)) and Minnesota Statutes, section 62M.05, subdivision 3a(c), Blue Plus must send a written notification of denial to the attending healthcare professional and enrollee, including when the denial is due to lack of information.
9. To comply with 42 CFR 438.408 (d)(2) and (e) (contract section 8.4.7) and Minnesota Statutes, section 62M.06, subdivision, 3(e), Blue Plus must include the State's Notice of Rights with the notification of the resolution of an appeal and must include in the appeal notification the qualifications of the reviewer in MHCP-MC appeals in which the denial is upheld.