

**Minnesota Department of Health
Health Policy and Systems Compliance Division
Managed Care Systems Section**



**Final Report
HealthPartners and Group Health, Inc.
Quality Assurance Examination
For the period
January 1, 2001 – December 31, 2002**

Examiners:

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Minnesota Department of Health Executive Summary

The Minnesota Department of Health (MDH) conducted a Quality Assurance Examination of HealthPartners to determine if it is operating in accordance with Minnesota law. All findings apply equally to Group Health, Inc. Overall, HealthPartners' performance in adhering to the requirements of Minnesota Statutes and Rules is commendable. HealthPartners fully complied with Minnesota Statutes and Rules in most of the areas of the Quality Assurance Examination except in the areas outlined in the "Deficiencies" and "Recommendations" sections of this report.

For deficiencies, HealthPartners failed to comply with Minnesota law in the following areas:

- HealthPartners must revise its policy for court-ordered care to clearly indicate that medical necessity review is not required for payment authorization for court-ordered mental health services.
- HealthPartners must issue written denials with appeal rights for pharmaceutical requests to members. Pharmaceutical and continuity of care medical determinations must be conducted within 10 business days of the request.
- HealthPartners must provide specialty review of utilization review appeals when warranted.
- HealthPartners must provide physician review of pharmaceutical denials on the initial utilization review determination.
- HealthPartners must change the coverage criteria language for rehabilitative therapies to remain consistent with the MDH rehabilitative stipulation and order.

Recommendations consist of:

- HealthPartners should concurrently evaluate enrollee access to timely health services and should evaluate how provider contracting changes may affect timeliness of access to care for enrollees in all regulated products and networks.
- HealthPartners should develop written exceptions to the prior authorization requirements when circumstances beyond the control of the provider result in a failure to conduct prior authorization.
- HealthPartners should assure that electronic utilization review documentation identifies the patient information that is used for medical necessity determinations.

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

David J. Giese, Director
Health Policy and Systems Compliance Division

Date

I. Introduction	4
II. Quality Program Administration	5
Minnesota Rules, part 4685.1110. Program	5
Minnesota Rules, part 4685.1115. Activities	5
Minnesota Rules, part 4685.1120. Quality Evaluation Steps	5
Minnesota Rules, part 4685.1125. Focused Study Steps	6
Minnesota Rules, part 4685.1130. Filed Written Plan and Work Plan	6
III. Complaints	6
Minnesota Statutes, section 62Q.69. Complaint Resolution	6
Minnesota Statutes, section 62Q.70. Appeal of the Complaint Decision.....	7
Minnesota Statutes, section 62Q.71. Notice to Enrollees	8
Minnesota Rules, part 4685.1900. Records of Complaints	8
Minnesota Statutes, section 62Q.73. External Review of Adverse Determinations.....	8
IV. Access and Availability	8
Minnesota Statutes, section 62D.124. Geographic Accessibility.....	8
Minnesota Rules, part 4685.1010. Availability and Accessibility	9
Minnesota Statutes, section 62Q.14. Open Access to Family Planning.....	9
Minnesota Statutes, section 62Q.23 (c). General Services (Equal Access to Chiropractic, Optometric, and Nursing Services).....	9
Minnesota Statutes, section 62Q.52. Direct Access to Obstetric and Gynecologic Services	10
Minnesota Statutes, section 62Q.56. Continuity of Care	10
Minnesota Statutes, section 62Q.527. Coverage of Nonformulary Drugs for Mental Illness and Emotional Disturbance.....	10
Minnesota Statutes, section 62Q.535. Coverage for Court-Ordered Mental Health Services	11
Minnesota Statutes, section 62Q.58. Access to Specialty Care	11
V. Utilization Review	11
Minnesota Statutes, section 62D.12. Coverage of Services	11
Minnesota Statutes, section 62M.04. Standards for Utilization Review Performance	12
Minnesota Statutes, section 62M.05. Procedures for Review Determination.....	12
Minnesota Statutes, section 62M.06. Appeals of Determinations not to Certify	13
Minnesota Statutes, section 62M.07. Prior Authorization of Services	14
Minnesota Statutes, section 62M.08. Confidentiality.....	14
Minnesota Statutes, section 62M.09. Staff and Program Qualifications.....	14
Minnesota Statutes, section 62M.10. Accessibility and on-site Review Procedures.....	15
Minnesota Statutes, section 62M.11. Complaints to Commerce or Health.....	15
Minnesota Statutes, section 62M.12. Prohibition on Inappropriate Incentives.....	15
VI. Habilitative Therapies Follow-up	15
VII. Participating Entity Visits	16
VIII. Deficiencies	16
IX. Recommendations	17

I. Introduction

- A. History: HealthPartners, Inc. is a nonprofit Minnesota corporation and the parent company of a family of corporations known as HealthPartners. The parent corporation consists of 18 affiliated organizations including HealthPartners Medical Group and Clinics, RiverWay Clinics, HealthPartners Central Minnesota Clinics, HealthPartners Dental Group and Clinics, Regions Hospital, Regions Hospital Foundation, HealthPartners Research Foundation, HealthPartners Institute for Medical Education, and Group Health, Inc. (a separately licensed health maintenance organization), Midwest Assurance Company (a stock company) and HealthPartners Administrators, Inc. (a registered third-party administrator). It provides services through a network of owned and contracted medical and dental centers, physician groups, hospitals, and related healthcare providers located primarily in the Minneapolis-Saint Paul metropolitan area.
- B. Membership: Based on the enrollment report submitted to the Department of Health on July 1, 2003, HealthPartners, Inc. health maintenance organization membership, as of December 31, 2002, consisted of the following fully insured populations:

HealthPartners, Inc.	Enrollment
Fully insured Commercial	327,406
Prepaid Medical Assistance Program	31,556
MinnesotaCare	17,547
General Assistance Medical Care	3,392
Medicare Cost	17,105
Total	397,006

Group Health, Inc.	Enrollment
Fully insured Commercial	26,578
Medicare + Choice	17,066
Total	43,644

- C. Onsite Dates: March 3 – 20, 2003
- D. Examination Period: January 1, 2001 – December 31, 2002
- E. Participating Entities Visits: Eight participating entities in HealthPartners' network were selected for site visits. In addition, six participating entities were interviewed by phone. All visits were conducted based on potential findings identified at the health plan. For details, please refer to Section VII.
- F. NCQA Accreditation: HealthPartners was NCQA accredited on May 20, 2002, for its commercial HMO/POS and Medicare HMO products. HealthPartners has not sought and is not accredited for Prepaid Medical Assistance, General Assistance Medical Care and MinnesotaCare.

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, the review result was utilized [NCQA] unless evidence existed from internal or external sources indicating further investigation was warranted[NCQA]. If the NCQA standard was the same or more stringent than Minnesota law, but the review resulted in a reduction in possible points on NCQA's score sheet or as an identified opportunity for improvement, MDH conducted its own examination.

II. Quality Program Administration

Minnesota Rules, part 4685.1110. Program.

Subp. 1. Written Quality Assurance Plan	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input checked="" type="checkbox"/> NCQA
Subp. 2. Documentation of Responsibility	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input checked="" type="checkbox"/> NCQA
Subp. 3. Appointed Entity	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input checked="" type="checkbox"/> NCQA
Subp. 4. Physician Participation	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input checked="" type="checkbox"/> NCQA
Subp. 5. Staff Resources	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input checked="" type="checkbox"/> NCQA
Subp. 6. Delegated Activities	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input checked="" type="checkbox"/> NCQA
Subp. 7. Information System	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input checked="" type="checkbox"/> NCQA
Subp. 8. Program Evaluation	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input checked="" type="checkbox"/> NCQA
Subp. 9. Complaints	<input checked="" type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> NCQA
Subp. 10. Utilization Review	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input checked="" type="checkbox"/> NCQA
Subp. 11. Provider Selection and Credentialing	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input checked="" type="checkbox"/> NCQA
Subp. 12. Qualifications	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input checked="" type="checkbox"/> NCQA
Subp. 13. Medical Records	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input checked="" type="checkbox"/> NCQA

Findings:

NCQA review results were accepted for Minnesota Rules, part 4685.1110. Seventeen quality-of-care complaint cases were reviewed for verification of compliance with subpart 9, all cases in the sample were public program enrollees.

Minnesota Rules, part 4685.1115. Activities

Subp. 1. Ongoing Quality Evaluation	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input checked="" type="checkbox"/> NCQA
Subp. 2. Scope	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input checked="" type="checkbox"/> NCQA

NCQA review results were accepted for Minnesota Rules, part 4685.1115.

Minnesota Rules, part 4685.1120. Quality Evaluation Steps

Subp. 1. Problem Identification	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input checked="" type="checkbox"/> NCQA
Subp. 2. Problem Selection	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input checked="" type="checkbox"/> NCQA
Subp. 3. Corrective Action	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input checked="" type="checkbox"/> NCQA
Subp. 4. Evaluation of Corrective Action	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input checked="" type="checkbox"/> NCQA

NCQA findings were accepted.

Minnesota Rules, part 4685.1125. Focused Study Steps

Subp. 1. Focused Studies	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input checked="" type="checkbox"/> NCQA
Subp. 2. Topic Identification and Selection	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input checked="" type="checkbox"/> NCQA
Subp. 3. Study	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input checked="" type="checkbox"/> NCQA
Subp. 4. Corrective Action	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input checked="" type="checkbox"/> NCQA
Subp. 5. Other Studies	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input checked="" type="checkbox"/> NCQA

NCQA evaluated the following focused studies undertaken by HealthPartners:

1. Diabetes Care
2. Coronary Artery Disease Initiative
3. Appropriate Antidepressant Medication
4. Congestive Heart Failure Initiative
5. Tobacco Control
6. Improving Satisfaction with Appointment Access

These six studies met the criteria for focused studies in Minnesota Rules, part 4685.1125.

Minnesota Rules, part 4685.1130. Filed Written Plan and Work Plan

Subp. 1. Written Plan	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input checked="" type="checkbox"/> NCQA
Subp. 2. Work Plan	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input checked="" type="checkbox"/> NCQA
Subp. 3. Amendments to Plans	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input checked="" type="checkbox"/> NCQA

NCQA's standard for a written work plan was comparable and more stringent than Minnesota Rules, part 4685.1130. NCQA's review was recognized as meeting the requirements of Minnesota Rules, part 4685.1130.

III. Complaints

Minnesota Statutes, section 62Q.69. Complaint Resolution

Subd. 1. Establishment	<input checked="" type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> NCQA
Subd. 2. Procedures for filing a complaint	<input checked="" type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> NCQA
Subd. 3. Notification of Complaint Decisions	<input checked="" type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> NCQA

HealthPartners has an internal complaint system that is consistent with current laws relating to HMOs. The system includes procedures and processes for handling incoming complaints, time frames for reviewing and responding to complaints, recording requirements for handling complaints and enrollee appeal rights. MDH noted, however, that based on interviews with member services staff, there is not a consistent practice of how to apply the ten-day timeframe described in Minnesota Statutes, section 62Q.69, subdivision 2(a).

Pursuant to Minnesota Statutes, a complaint may be submitted either by telephone or in writing. Each telephone call received in the customer service call center is logged into the system and is categorized as an inquiry, a complaint, or a compliment. Minnesota law states that when a complaint is submitted by telephone, and the oral complaint is not resolved to the satisfaction of the complainant within ten days of receiving the complaint, the health plan company must inform the complainant that the complaint may be submitted in writing (Minnesota Statutes, section 62Q.69, subdivision 2(a)). Once a complaint is submitted in writing, the plan has 30 days (plus a potential 14 days) to resolve the complaint according to Minnesota Statutes, section 62Q.69, subdivision 3.

Prior to the examination, a complaint was submitted to the Minnesota Department of Health regarding the way HealthPartners responded to verbal complaints. As the result of an investigation of the complaint, HealthPartners submitted a corrective action plan to MDH in January 2003 to ensure that verbal inquiries and verbal complaints are appropriately transferred to formal complaints when they are not resolved within 10 days. As part of the corrective action plan, HealthPartners indicated that, "If, during the course of the inquiry investigation the [category code of a call] is changed from an inquiry to a complaint, the system timeframe will defer to the date of the initial telephone contact as the complaint start date." If the member was not satisfied within ten days from the date of the initial call, the plan would be required to inform the member of the right to submit the complaint in writing.

During the course of the examination, interviews were conducted of customer service staff including customer service representatives, one customer service trainer, the customer service supervisor, and the call center manager. Each representative defined a complaint, as opposed to an inquiry, to be the point where the member shows any "dissatisfaction." Each representative was asked about the timeframes within which the plan must respond to verbal inquiries and verbal complaints. Based on responses from the representatives, they have between 21 and 30 days to resolve verbal inquiries and 10 days to resolve verbal complaints. One representative stated that if a call was originally categorized as an inquiry, "as long as [she] is still working on an issue, the category of the call is still an inquiry." At least three interviewees indicated that if a call was originally documented as an inquiry, and the same member calls back nine days later expressing dissatisfaction, the category of the call would be changed to a verbal complaint and the ten-day timeframe to resolve the issue would begin at that time.

When comparing the corrective action plan submitted by HealthPartners in January 2003 to the responses given by member services staff during the audit, there is not a consistent practice of how to apply the ten-day timeframe established by Minnesota Statutes, section 62Q.69, subdivision 3. Further training of member services staff regarding this matter is needed. The Department of Health will continue to monitor this corrective action plan to ensure compliance with applicable law, and will address this matter as part of the monitoring process.

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

Subd. 1. Establishment yes no NCQA
Subd. 2. Procedures for Filing an Appeal yes no NCQA

Subd. 3. Notification of Appeal Decisions yes no NCQA

For internal appeals, HealthPartners follows the requirements set forth in this regulation. For DHS initiated appeals, HealthPartners follows the Department of Human Services requirements.

Minnesota Statutes, section 62Q.71. Notice to Enrollees

Member materials contain all the required components. yes no NCQA

Minnesota Rules, part 4685.1900. Records of Complaints

Subp. 1. Record Requirements yes no NCQA
Subp. 2. Log of Complaints yes no

HealthPartners maintains files for written complaints and has an ongoing retrievable log available through its complaint/caller information system. The log is readily accessible to member services staff and other interested and affected staff throughout the organization.

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

Subd. 2. Exception yes no
Subd. 3. Right to external review yes no

HealthPartners provides proper notice to its members of the right to obtain external review.

IV. Access and Availability

Minnesota Statutes, section 62D.124. Geographic Accessibility

Subd. 1. Primary Care; Mental Health Services; General Hospital Services yes no NCQA
Subd. 2. Other Health Services yes no NCQA
Subd. 3. Exception yes no

HealthPartners met NCQA requirements for number and geographic distribution of providers. HealthPartners contracts with a subset of its providers to serve its public program enrollees. HealthPartners terminated Allina Medical Group (statewide) from its public program network effective January 2003. Hutchinson/Dassel care system joined Minnesota Healthcare Network (MHN), which is not part of the HealthPartners public programs provider network. As a result, the public program enrollee network was reduced from two to one clinic in Meeker County, affecting 117 MinnesotaCare enrollees. Furthermore, McLeod County went from one to no clinic within its boundaries, affecting 128 MinnesotaCare enrollees. Minnesota Statutes 62D.124 requires an HMO to have primary care, mental health and general hospital services available to all its enrollees within 30 miles or 30 minutes, whichever is least. HealthPartners provided GeoAccess mapping to show all public program members had the required geographic access,

however, the data included the Hutchinson/Dassel care system that was not in the network serving public program enrollees. By mutual agreement with the Department of Human Services (DHS), HealthPartners continued to be a choice for Meeker and McLeod counties for MinnesotaCare enrollees. HealthPartners must ensure that enrollees in each of its products have geographic access consistent with the standards established by Minnesota Statutes, section 62D.124. HealthPartners therefore must monitor access by product, and must seek a timely exception when it is unable to meet access standards for any of its various health plans. Because of the unique circumstances of the events in Meeker and McLeod counties, the Department is not assessing a deficiency.

Minnesota Rules, part 4685.1010. Availability and Accessibility

- Subp. 2. Basic Services yes no
- Subp. 5. Coordination of Care yes no
- Subp. 6. Timely Access to Health Care Services yes no NCQA

HealthPartners monitors the timely availability of health care services through enrollee complaints and satisfaction surveys. Enrollee complaints are collected and aggregated by clinic and monitored by number of complaints per 1,000 enrollees. Enrollee satisfaction surveys (CAHPS®) are performed annually and aggregated by care system (groups of clinics) for trends. Both methods of monitoring are retrospective and do not assess current availability of timely appointments.

MDH surveyed area network clinics after HealthPartners’ loss of two care systems in Meeker and McLeod counties. HealthPartners did not contact area clinics to assess the impact of network changes on timely availability of services at remaining network clinics. HealthPartners worked with the Department of Human Services to assure that MinnesotaCare members were not auto-assigned by DHS to HealthPartners. MinnesotaCare members were allowed to voluntarily enroll in HealthPartners limited network. Prepaid Medical Assistance and Prepaid General Assistance Medical Care members did not have the option to select HealthPartners. [Recommendation #1]

Minnesota Statutes, section 62Q.121. Licensure of Medical Directors

- yes no

HealthPartners provided evidence of Medical Directors licensure to practice medicine in Minnesota.

Minnesota Statutes, section 62Q.14. Open Access to Family Planning

- yes no

HealthPartners provides open access to family planning services.

Minnesota Statutes, section 62Q.23 (c). General Services (Equal Access to Chiropractic, Optometric, and Nursing Services)

- Subd. 2. Chiropractic Services yes no
- Subd. 3. Optometric Services yes no
- Subd. 3a. Nursing Services yes no

HealthPartners provides equal access to chiropractic, optometric and nursing services within its provider network.

Minnesota Statutes, section 62Q.52. Direct Access to Obstetric and Gynecologic Services

HealthPartners does not require referrals for obstetric and gynecologic services within its network.

Minnesota Statutes, section 62Q.55. Emergency Services yes no

HealthPartners provides for emergency services 24 hours a day and seven days per week.

Minnesota Statutes, section 62Q.56. Continuity of Care

- Subd. 1. Change in health care provider; general notification yes no
- Subd. 1a. Change in health care provider; termination not for cause yes no
- Subd. 1b. Change in health care provider; termination for cause yes no
- Subd. 2. Change in health plans yes no
- Subd. 3. Disclosures yes no

As part of the complaint resolution process, Minnesota Statutes, section 62Q.69 allows for a thirty day (plus a potential 14 day) timeline to resolve written complaints, including benefit determination. However, pursuant to Minnesota Statutes, section 62Q.68, subdivision 2, any grievance requiring a medical determination in its resolution must have the medical determination aspect of the complaint processed under the procedures described in Minnesota Statutes, section 62M. The process under Minnesota Statutes, section 62M, which describes procedures for utilization review of health care, includes shorter time frames and procedures for expedited review.

While requests for continuity or transition of care are reviewed by utilization management staff and by a medical director, a 30-day timeline is applied to these requests. The plan is treating a medical determination under a timeline applicable to a benefit determination. Based on file review, MDH notes that application of the 30-day timeline interfered with the timely provision of health care services. [See findings under 62M.05]

Minnesota Statutes, section 62Q.527. Coverage of Non-formulary Drugs for Mental Illness and Emotional Disturbance

- Subd. 2. Required Coverage for Anti-psychotic Drugs yes no
- Subd. 3. Continuing Care yes no
- Subd. 4. Exception to formulary yes no

Of the 93 claims denied for lack of prior authorization, a sample of 22 (24%) files was investigated. Thirteen out of 22 (59%) files sampled demonstrated denials solely for no prior authorization.

HealthPartners provider contracts state “*referral provider shall be compensated only for Covered Services which have been duly authorized.*” The contract also contains hold harmless language that prevents the providers from seeking recourse against members in such instances.

Interviews indicated that HealthPartners will make an exception and cover services that are not prior authorized in situations beyond the control of the provider, such as eligibility changes. HealthPartners was unable to provide written policies for the exception determinations.

[Recommendation #2]

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

Subd. 1. Responsibility on Obtaining Certification	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input checked="" type="checkbox"/> NCQA
Subd. 2. Information upon which Utilization Review is conducted	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input checked="" type="checkbox"/> NCQA
Subd. 3. Data Elements	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input checked="" type="checkbox"/> NCQA
Subd. 4. Additional Information	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input checked="" type="checkbox"/> NCQA
Subd. 5. Sharing of Information	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input checked="" type="checkbox"/> NCQA

Although NCQA work papers were accepted for compliance with this statute, problematic areas were identified through the examination process. HealthPartners initiated information systems to document utilization review requests and determinations. Minimal medical necessity information was available in the patient electronic file. Information systems need to articulate adequate medical information about the patient or reference paper copies of information that are used to make medical necessity decisions. [Recommendation #3]

Minnesota Statutes, section 62M.05. Procedures for Review Determination

Subd. 1. Written Procedures	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input checked="" type="checkbox"/> NCQA
Subd. 2. Concurrent Review	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input checked="" type="checkbox"/> NCQA
Subd. 3a. Standard Review Determination	<input type="checkbox"/> yes	<input checked="" type="checkbox"/> no	<input type="checkbox"/> NCQA
Subd. 3b. Expedited Review Determination	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input checked="" type="checkbox"/> NCQA
Subd. 4. Failure to Provide Necessary Information	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input checked="" type="checkbox"/> NCQA

Continuity of Care

HealthPartners’ utilization review staff conducts the medical necessity component of continuity of care determinations under a 30-day timeline rather than by the required ten business days statutory timeline defined in Minnesota Statutes 62M.05. Twenty-five files were reviewed for application of continuity of care determinations. Ten files of the sample were audited for timelines. Four out of ten files did not have determinations completed within ten business days. Although no documented adverse medical consequences occurred, in three cases (12%), enrollees required medical care within 30 days of the request. Examples included delivery of an infant, AIDS management and surgery for a blocked artery. Conducting continuity of care determinations with a utilization review timeline of ten business days would have afforded the

providers and patients the right to expedited utilization review and appeal rights. [Deficiency #2]

Pharmacy

As part of the process to evaluate the medical necessity and appropriateness of prescription drugs, physicians request written formulary exception or prior authorization requests. At HealthPartners, these requests are reviewed by a pharmacist for comparison of the patient’s condition and medication request with HealthPartners’ medical coverage criteria that are available on the website. If the medical criteria are not met, the pharmacist provides a written “notice of criteria not being met” (also called “Initial denials” or “Notice of Inquiry”) to the requesting physician. This notice provides the physician with a number to call if they would like physician review of the request. If the prescribing physician requests health plan physician review, the initial determination is made. At this time the enrollee receives the first notification of the denial with appeal rights.

As a result of the pharmacist review and the original request being classified as an inquiry rather than a utilization review request, a delay occurs in physician review, often extending past the ten day state mandated determination timeline. HealthPartners’ process is not consistent with the law. The pharmacist notification of the failure to meet medical criteria represents the initial determination. Placing this step in the process delays the enrollee rights to a written denial and appeal.

Therefore, HealthPartners failed to issue appropriate denial notices with appeal rights to members and their providers for formulary exceptions and/or drug prior authorizations. Of 2,416 denied pharmacy files subject to examination, 58 were reviewed in the sample. Thirty-six percent of the files sampled exceeded the ten-business day utilization review timeline for initial determination. [Deficiency #2] See the table below:

Pharmacy Denials		
Total Number of Pharmacy Denials	Reviewed	
	# (% of all denials)	Timeline > 10 business days
2416 (100%)	58/2416 (2.4%)	21/58 (36.2%)

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

- Subd. 1. Procedures for Appeal yes no NCQA
- Subd. 2. Expedited Appeal yes no NCQA
- Subd. 3. Standard Appeal yes no NCQA

For pharmaceutical formulary exceptions and prior authorization requests, due to pharmacists reviewing initial requests from prescribing physicians, HealthPartners did not consider the initial determination in these cases to be utilization review denials and, therefore, did not treat the subsequent request as utilization appeals under Minnesota Statutes, section 62M.06.

For selected appeals, HealthPartners did not ensure that a physician in the same or a similar specialty as typically manages the medical condition was available to review the case consistent with Minnesota Statutes, section 62M.06, subdivision 3(f). Interviews with managers responsible for pharmacy benefit administration, quality assurance and utilization review indicated that all medical appeals are sent to the same internist for decisions regardless of the nature of the medical condition.

For home health, one denial determination for 16 hours of skilled nursing care for a medically fragile tracheotomy dependent child was appealed by the parents and primary care physician. The appeal file contained evidence that the patient’s pediatric pulmonologist, pediatric otolaryngologist and pediatric surgeon recommended skilled nursing care to meet the patient’s medical needs. Yet HealthPartners’ Member Appeal Committee did not have representation by any specialty providers.

A pediatric endocrinologist, who is likely to have been treating similar cases, would have appropriately reviewed a pharmaceutical appeal for a growth hormone treatment for a small-for-gestational-age child. However, the determination of the appeal was made by an internist.
[Deficiency #3]

Minnesota Statutes, section 62M.07. Prior Authorization of Services

yes no NCQA

HealthPartners demonstrated compliance with this statute based on NCQA review.

Minnesota Statutes, section 62M.08. Confidentiality

yes no NCQA

HealthPartners demonstrated compliance with this statute based on NCQA review.

Minnesota Statutes, section 62M.09. Staff and Program Qualifications

- | | | | |
|--|------------------------------|--|--|
| Subd. 1. Staff Criteria | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input checked="" type="checkbox"/> NCQA |
| Subd. 2. Licensure Requirement | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input checked="" type="checkbox"/> NCQA |
| Subd. 3. Physician Reviewer Involvement | <input type="checkbox"/> yes | <input checked="" type="checkbox"/> no | <input type="checkbox"/> NCQA |
| Subd. 3a. Mental Health and Substance Abuse Review | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input checked="" type="checkbox"/> NCQA |
| Subd. 4. Dentist Plan Reviews | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input checked="" type="checkbox"/> NCQA |
| Subd. 4a. Chiropractic Reviews | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input checked="" type="checkbox"/> NCQA |
| Subd. 5. Written Clinical Criteria | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input checked="" type="checkbox"/> NCQA |
| Subd. 6. Physician Consultants | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input checked="" type="checkbox"/> NCQA |
| Subd. 7. Training for Program Staff | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input checked="" type="checkbox"/> NCQA |
| Subd. 8. Quality Assessment Program | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input checked="" type="checkbox"/> NCQA |

Subpart 3. Of the 58 pharmacy denial files, a physician did not review 12.1% of the files. Pharmacists conducted reviews and provided “Notice of Criteria not being met” denials to providers without physician review. HealthPartners’ failure to use physicians in the appeal process is based on its belief that Minnesota Statutes, section 62M does not apply to pharmacy utilization review. [Deficiency #4]

Pharmacy Denials		
Total Number of Pharmacy Denials	Sample Reviewed # (% of all denials)	Denied without a physician review # (% of sample reviewed)
2416 (100%)	58/2416 (2.4%)	7/58 (12.1%)

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

- Subd. 1. Toll-free Number yes no NCQA
- Subd. 2. Reviews during Normal Business Hours yes no NCQA
- Subd. 3. Identification of On-site Review Staff yes no NCQA
- Subd. 4. On-site Reviews yes no NCQA
- Subd. 5. Oral Requests for Information yes no NCQA
- Subd. 6. Mutual Agreement yes no NCQA
- Subd. 7. Availability of Criteria yes no NCQA

HealthPartners demonstrated compliance with this statute based on NCQA review.

Minnesota Statutes, section 62M.11. Complaints to Commerce or Health

yes no

Information is available to enrollees that meet the provisions of this statute.

Minnesota Statutes, section 62M.12. Prohibition on Inappropriate Incentives

yes no NCQA

HealthPartners does not provide incentives for its staff to deny medically necessary services.

VI. Habilitative Therapies Follow-up

On May 2, 2002, the Minnesota Department of Health and HealthPartners signed a final stipulation and order regarding habilitative therapies. As part of the stipulation, HealthPartners agreed to adopt revised coverage criteria for habilitative occupational and physical therapy and habilitative speech therapy. During the course of the examination, 23 complaint and appeal files and 33 utilization review files were reviewed on site, and various staff were interviewed regarding habilitative therapy coverage criteria. The audit showed that HealthPartners is in

compliance with the stipulation and order except for one issue in the agreement. Specifically, as part of the stipulation and order, HealthPartners had agreed that its coverage criteria would state, in part, “[I]n cases where progress is questioned, the medical director and his or her designee *will* consult with the treating therapist, and/or a Physical or Occupational Therapist when making the coverage determination.” In the current coverage criteria, the word “*will*” has been changed to “*may*.” The use of the word “*may*,” as opposed to “*will*,” changes the nature of the criterion from a mandate to a suggestion, thereby leaving the matter up to the medical director’s discretion. This change in coverage criteria violates both the letter and the spirit of the agreement reached between HealthPartners and MDH. [Deficiency #5]

VII. Participating Entity Visits

MDH’s Quality Assurance Examination team visited eight participating entities and conducted six phone interviews. Phone interviews were conducted with participating and non-participating clinics to assess level of access for public program enrollees. Two physician interviews were conducted to evaluate pharmacy processes. One physician was a second tier physician with few HealthPartners enrollees. Two home care provider site visits resolved potential issues identified from examination and complimented HealthPartners on improvements made in the prior authorization process of home care services for enrollees. One mental health site visit was conducted, as well as visits with three primary care clinics.

VIII. Deficiencies

1. To comply with Minnesota Statutes, section 62Q.535, HealthPartners must revise its policy and procedure for court-ordered care to clearly distinguish the differences in medical necessity and authorization for court-ordered physical services and court-ordered mental health services.
2. To comply with Minnesota Statutes, section 62M.05, subdivision 3a(c) and (d), HealthPartners must issue written denials that include appeal rights for pharmaceutical requests to members and providers. Pharmaceutical and continuity of care medical determinations need to be communicated to members and providers within ten business days of the request.
3. To comply with Minnesota Statutes, section 62M.06, subdivision 3(f), HealthPartners must ensure on a utilization review appeal that a physician in the same or similar specialty as typically manages the medical condition is available and reviews the case.
4. To comply with Minnesota Statutes, section 62M.09, subdivision 3, HealthPartners must provide physician review of initial determinations of pharmaceutical denials.
5. To comply with the stipulation and order adopted by the Minnesota Department of Health on May 2, 2002, regarding habilitative therapies, HealthPartners must use the word “*will*” in place of “*may*” in the coverage criteria for habilitative therapies.

IX. Recommendations

1. HealthPartners should concurrently evaluate enrollee access to timely health services pursuant to Minnesota Rules, part 4685.1010, subp. 6, and shall evaluate how provider contracting changes may affect timeliness of access to care for enrollees in all regulated product and networks.
2. HealthPartners should develop and implement policies that grant exceptions to the written prior authorization process in circumstances where failure to prior authorize is beyond the control of the provider.
3. HealthPartners should assure that electronic documentation used in utilization review pursuant to Minnesota Statutes, section 62M.04, identifies the information that nurses and physicians are utilizing for medical necessity determinations.