Minnesota Department of Health
Compliance Monitoring Division
Managed Care Systems Section

Final Report

Sanford Health Plan of Minnesota

Quality Assurance Examination
For the Period: March 1, 2011 to January 31, 2014

Final Issue Date:
July 30, 2014

Examiners
Elaine Johnson, RN, BS, CPHQ
Susan Margot, MA
Minnesota Department of Health
Executive Summary

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

To address recommendations, Sanford should:

None

To address mandatory improvement, Sanford must:

Revise its Express Scripts Inc. (ESI) delegation agreement to include Sanford’s specific expectations for claims processing (reconciliation of invoices, timeliness and accuracy of claims payment, etc.), including the reports to be submitted, the frequency, what oversight is performed and the outcome of the oversight.

Revise its policy/procedures to provide a definition of quality of care complaints, clearly state who performs the investigation, any other entity’s role and Sanford’s role in the investigation, who makes the determination that the quality of care allegations are substantiated or unsubstantiated, who determines what intervention is appropriate and who oversees the implementation of the intervention regardless if the quality of care allegations are substantiated or not.

Revise its complaint system policy/procedure to state that it will inform the complainant of the right to submit the complaint in writing and offer assistance, including completing the complaint form and sending it for signature; and define external review for adverse determinations, clinical and non-clinical.

Revise its complaint and appeal policy/procedure to fully describe its internal appeal process for all types of clinical and non-clinical appeals, and to accurately state the enrollee’s rights to external review upon appeal.

Revise the appeal filing form to state that if the person filing the appeal is someone other than the patient or attending health care professional then patient signature authorization is required.
To address deficiencies, Sanford and its delegates must:

Revise it policy/procedure to state that oral complaints must be resolved within 10 calendar days of receipt and must implement the revised procedure to ensure oral complaints are resolved within the correct timeline.

Revise the appeal rights notice to include:
- The right to appeal must be available to the enrollee and to the attending health care professional.
- For expedited appeals the organization must ensure that the enrollee and the attending health care professional have an opportunity to appeal the determination over the telephone.
- Establish procedures for appeals to be made either in writing or by telephone.

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.

Darcy Miner, Director
Compliance Monitoring Division
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I. Introduction

A. History:
Sanford Health Plan is a not-for-profit, community-based HMO that began operations on January 1, 1998. Health services are provided to large and small groups in North Dakota, South Dakota, Iowa and in Minnesota, by Sanford Health Plan of Minnesota. Originally called Sioux Valley Health Plan, it changed its name in March 2007 to acknowledge the gift of Denny T. Sanford to the Sioux Valley Hospital & Health System. Sanford’s Minnesota HMO is a risk-bearing product that provides benefits for in-network services with higher cost sharing for out-of-network services. Extensive care management services are available.

In November 2009, Sanford Health Plan’s parent organization Sanford Health merged with Fargo, ND-based MeritCare launching a new organization: Sanford Health-MeritCare, now called Sanford Health.

Sanford Health Plan of Minnesota is currently licensed in 36 western Minnesota counties. For Minnesota, Sanford Health Plan has outlined a service area expansion for an additional 10 counties to align Sanford Health Plan’s service area with Sanford Health Plan’s provider region.

B. Membership:
Sanford Health Plan’s self-reported Minnesota enrollment as of December 31, 2013 consisted of the following:

<table>
<thead>
<tr>
<th>Product</th>
<th>Enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fully Insured Commercial</td>
<td>422</td>
</tr>
<tr>
<td>Large Group</td>
<td>422</td>
</tr>
<tr>
<td>Small Employer Group</td>
<td>15</td>
</tr>
<tr>
<td>Individual</td>
<td>NA</td>
</tr>
<tr>
<td>Medicare</td>
<td>NA</td>
</tr>
<tr>
<td>Medicare Advantage</td>
<td>NA</td>
</tr>
<tr>
<td>Medicare Cost</td>
<td>NA</td>
</tr>
<tr>
<td>Total</td>
<td>437</td>
</tr>
</tbody>
</table>

C. Onsite Examinations Dates: March 10, 2014 to March 14, 2014

D. Examination Period: March 1, 2011 to January 31, 2014
   Opening Date: December 31, 2013

E. National Committee for Quality Assurance (NCQA): Sanford Health Plan is accredited by NCQA based on 2013 standards. The Minnesota Department of Health (MDH) evaluated and used results of the NCQA review in one of three ways:
   1. If NCQA standards do not exist or are not as stringent as Minnesota law, the accreditation results will not be used in the MDH examination process [No NCQA checkbox].
2. If the NCQA standard was the same or more stringent than Minnesota law and the health plan was accredited with 100% of the possible points then the NCQA results were accepted as meeting Minnesota requirements [NCQA ☒] unless evidence existed indicating further investigation was warranted [NCQA ☐].

3. 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 then 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 quality assurance examination, covering 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 indicate a plan’s overall operation is compliant with an applicable law.

II. Quality Program Administration

Minneso wa Rules, Part 4685.1110. Program

<table>
<thead>
<tr>
<th>Subp.</th>
<th>Written Quality Assurance Plan</th>
<th>Met ☒</th>
<th>Not Met ☐</th>
<th>NCQA ☐</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subp.</td>
<td>Documentation of Responsibility</td>
<td>Met ☒</td>
<td>Not Met ☐</td>
<td>NCQA ☐</td>
</tr>
<tr>
<td>Subp.</td>
<td>Appointed Entity</td>
<td>Met ☒</td>
<td>Not Met ☐</td>
<td>NCQA ☐</td>
</tr>
<tr>
<td>Subp.</td>
<td>Physician Participation</td>
<td>Met ☒</td>
<td>Not Met ☐</td>
<td>NCQA ☐</td>
</tr>
<tr>
<td>Subp.</td>
<td>Staff Resources</td>
<td>Met ☐</td>
<td>Not Met ☐</td>
<td>NCQA ☒</td>
</tr>
<tr>
<td>Subp.</td>
<td>Delegated Activities</td>
<td>Met ☑</td>
<td>Not Met ☒</td>
<td>NCQA ☐</td>
</tr>
<tr>
<td>Subp.</td>
<td>Information System</td>
<td>Met ☐</td>
<td>Not Met ☐</td>
<td>NCQA ☒</td>
</tr>
<tr>
<td>Subp.</td>
<td>Program Evaluation</td>
<td>Met ☒</td>
<td>Not Met ☐</td>
<td>NCQA ☐</td>
</tr>
<tr>
<td>Subp.</td>
<td>Complaints</td>
<td>Met ☐</td>
<td>Not Met ☐</td>
<td>NCQA ☒</td>
</tr>
<tr>
<td>Subp.</td>
<td>Utilization Review</td>
<td>Met ☒</td>
<td>Not Met ☐</td>
<td>NCQA ☐</td>
</tr>
<tr>
<td>Subp.</td>
<td>Provider Selection and Credentialing</td>
<td>Met ☐</td>
<td>Not Met ☐</td>
<td>NCQA ☒</td>
</tr>
<tr>
<td>Subp.</td>
<td>Qualifications</td>
<td>Met ☐</td>
<td>Not Met ☐</td>
<td>NCQA ☒</td>
</tr>
<tr>
<td>Subp.</td>
<td>Medical Records</td>
<td>Met ☒</td>
<td>Not Met ☐</td>
<td>NCQA ☐</td>
</tr>
</tbody>
</table>

Subp. 6. Minnesota Rules, part 4685.1110, subpart 6, states that the HMO must develop and implement review and reporting requirements to assure that the delegated entity performs all delegated activities. The standards established by NCQA for delegation are considered the community standard and, as such, were used for the purposes of this examination. The following delegated entities and functions were reviewed:
### Delegated Entities and Functions

<table>
<thead>
<tr>
<th>Entity</th>
<th>UM Appeals</th>
<th>QM Complaints/Grievances</th>
<th>Cred Claims</th>
<th>Network Coord</th>
<th>Care Coord</th>
</tr>
</thead>
<tbody>
<tr>
<td>Express Scripts</td>
<td>Approvals only</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

Health plans must review delegate reports at least semiannually. Sanford Health Plan delegates claims processing and payment among other functions. While the delegation agreement with Express Scripts, Inc. (ESI) and the Annual Delegation Scorecard identify claims processing and adjudication as a delegated function, the documentation does not state what oversight of the claims functions was performed. Documentation verified that Sanford performs reconciliation of ESI claims twice monthly. Sanford must revise its delegation agreement to include Sanford’s specific expectations for claims processing (reconciliation of invoices, timeliness and accuracy of claims payment, etc.), including the reports to be submitted, the frequency, what oversight is performed and the outcome of the oversight. **(Mandatory Improvement #1)**

**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. Sanford Health Plan received no quality of care complaints in the file period. MDH reviewed policy/procedures Medical Management Program, MM-49 and Monitoring Policy, PR-24. Read together, these policy/procedures address most of MDH expectations for quality of care complaints. Sanford Health Plan can better serve its enrollees by making the following revisions to its policy/procedures:

- Provide a definition of quality of care to guide identification of quality of care complaints. MDH considers quality to include technical competence and appropriateness of care, communication and behavior, facilities and environment, coordination of care and health plan administration.
- Clearly state who performs the investigation. If the investigation is performed by another entity, such as University of South Dakota, clearly state the entity’s role and Sanford Health Plan’s role in the investigation, who makes the determination that the quality of care allegations are substantiated or unsubstantiated, who determines what intervention is appropriate and who oversees the implementation of the intervention. **(Mandatory Improvement #2)**

### Minnesota Rules, Part 4685.1115. Activities

<table>
<thead>
<tr>
<th>Subp.</th>
<th>Activity</th>
<th>Met</th>
<th>Not Met</th>
<th>NCQA</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Ongoing Quality Evaluation</td>
<td>☒</td>
<td>☐</td>
<td>☒ NCQA</td>
</tr>
<tr>
<td>2</td>
<td>Scope</td>
<td>☒</td>
<td>☐</td>
<td>☒ NCQA</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Subp.</th>
<th>Activity</th>
<th>Met</th>
<th>Not Met</th>
<th>NCQA</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Problem Identification</td>
<td>☒</td>
<td>☐</td>
<td>☒ NCQA</td>
</tr>
<tr>
<td>2</td>
<td>Problem Selection</td>
<td>☒</td>
<td>☐</td>
<td>☒ NCQA</td>
</tr>
<tr>
<td>3</td>
<td>Corrective Action</td>
<td>☒</td>
<td>☐</td>
<td>☒ NCQA</td>
</tr>
</tbody>
</table>
Thank you for submitting to MDH Sanford Health Plan’s annual *Quality Improvement Program Evaluation*. It consisted of two evaluations, one for its clinical activities and the other for service and member satisfaction activities. The evaluations were concise, effectively displayed data over time and had excellent summaries of its improvement activities as well as a comprehensive summary of the overall effectiveness of its quality improvement program.

### Minnesota Rules, Part 4685.1125. Focus Study Steps

<table>
<thead>
<tr>
<th>Subp.</th>
<th>Focus Study Steps</th>
<th>Met</th>
<th>Not Met</th>
<th>NCQA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subp. 1</td>
<td>Focused Studies</td>
<td>☒</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Subp. 2</td>
<td>Topic Identification and Selection</td>
<td>☒</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Subp. 3</td>
<td>Study</td>
<td>☒</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Subp. 4</td>
<td>Corrective Action</td>
<td>☒</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Subp. 5</td>
<td>Other Studies</td>
<td>☒</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Sanford Health Plan currently has six quality improvement activities. MDH commends Sanford for the significant improvements made in many of its improvement activities, particularly its adolescent health initiatives.

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

<table>
<thead>
<tr>
<th>Subd. 1</th>
<th>Written Plan</th>
<th>Met</th>
<th>Not Met</th>
<th>NCQA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subd. 2</td>
<td>Work Plan</td>
<td>☐</td>
<td>☐</td>
<td>☒</td>
</tr>
</tbody>
</table>

### III. Complaints Systems

MDH examined Sanford Health Plan’s fully-insured commercial complaint system under Minnesota Statutes, chapter 62Q. MDH reviewed a total of five Complaint System files.

<table>
<thead>
<tr>
<th>Complaint System File Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complaint Files (Oral and Written)</td>
</tr>
<tr>
<td>Non-Clinical Appeal</td>
</tr>
<tr>
<td>Total # Reviewed</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Subd. 1</th>
<th>Establishment</th>
<th>Met</th>
<th>Not Met</th>
<th>NCQA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subd. 2</td>
<td>Procedures for Filing a Complaint</td>
<td>☐</td>
<td>☐</td>
<td>☒</td>
</tr>
</tbody>
</table>
Subd. 3. Notification of Complaint Decisions ☒Met ☐Not Met

Subd. 1. Minnesota Statutes, section 62Q.69, subdivision 1, states a plan must establish and maintain an internal complaint resolution process that meets the requirements of this section to provide for the resolution of a complaint initiated by a complainant. The following revisions must be made to the complaint system policy/procedure:

- Minnesota Statutes, section 62Q.69, subdivision 2, further states the plan must inform the complainant that the complaint may be submitted in writing and must offer to provide the complainant with any assistance needed to submit a written complaint, including an offer to complete the complaint form and promptly mail the completed form to the complainant for signature. At the complainant’s request, the plan must provide the assistance requested. Sanford policy/procedure states it will “provide a complaint form to the complainant, which must be completed and returned to the Member Services Department for further consideration. Upon request, Member Services will provide assistance in submitting the complaint form.” Sanford’s policy/procedure does not offer assistance in submitting the form, including completing and sending it for signature. It requires the enrollee to request assistance. Sanford must revise its policy/procedure to state that it will inform the complainant of the right to submit the complaint in writing and offer assistance, including completing the complaint form and sending it for signature.

- Minnesota Statutes, section 62Q.73, subdivision 3, describes the external review process available for an adverse determination whether clinical or non-clinical. Sanford policy/procedure, MM-49 (page 36), states an external review is requested for a medical necessity final determination. The policy/procedure must be revised to define external review for adverse determinations, clinical or non-clinical.

(Mandatory Improvement #3)

Subd. 2 (a). Minnesota Statutes, section 62Q.69, subdivision 2 (a), states the oral complaint must be resolved “within 10 days of receiving the complaint.” Sanford’s policy/procedure, MM-49, page 36, B, 1, Oral Complaints, states, “within ten (10) business days of receipt.” In Minnesota Statutes, days are counted in calendar days, unless otherwise stated. In addition, one of the five complaints reviewed was an oral complaint. The complaint was resolved in more than 10 calendar days (12). The policy/procedure must be corrected to state the correct timeline and Sanford must implement the correct timeline. (Deficiency #1)

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

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

Subd. 1. Minnesota Statutes, section 62Q.70, states the plan must establish an internal appeal process for reviewing its complaint decision.
• The policy/procedure, MM-49 (pages 38-40) describes a pre-service clinical appeal or a post-service claim appeal. If Sanford uses the pre- and post-service claim categories, it must address all elements of Minnesota Statutes, section 62Q.70 appeals and chapter 62M appeals. The policy/procedure must address pre- and post-service clinical appeals as well as pre- and post-service non-clinical appeals. Sanford must revise its policy/procedure to describe its internal appeal process for all types of clinical and non-clinical appeals.

• MM 49, pages 40-41 Item G, 1, states “If your complaint is denied based on our medical necessity criteria, you have the right to request an External Review upon receiving notice of our decision on your complaint.” A UM appeal is not a “complaint.” Minnesota law states for group health plans that an external review must be offered when a complaint decision relating to a health care service or claim has been appealed in accordance with section 62Q.70 and the appeal decision is partially or wholly adverse to the complainant or any initial determination not to certify that has been appealed in accordance with section 62M.06 and the appeal did not reverse the initial determination. [Emphasis added.] (Note: includes changes effective January 1, 2014.) Sanford must revise its policy/procedure MM-49 to state the enrollee’s rights to external review upon appeal. (Mandatory Improvement #4)

Minnesota Statutes, Section 62Q.71. Notice to Enrollees
☒ Met ☐ Not Met

Minnesota Statutes, Section 62Q.73. External Review of Adverse Determinations
Subd. 3. Right to External Review ☒ 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

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

Minnesota Statutes, Section 62Q.55. Emergency Services  
 ☒ Met  ☐ Not Met

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
V. Utilization Review

<table>
<thead>
<tr>
<th>UM System File Review</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>File Source</strong></td>
</tr>
<tr>
<td>UM Denial Files</td>
</tr>
<tr>
<td>Clinical Appeal Files</td>
</tr>
<tr>
<td><strong>Total</strong></td>
</tr>
</tbody>
</table>

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

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 right to submit 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

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
   Procedures for appeals to be made in writing or by telephone ☒Met ☐Not Met
   (a) Appeal resolution notice timeline ☒Met ☐Not Met
   (b) Documentation requirements ☒Met ☐Not Met
   (c) Review by a different physician ☐Met ☐Not Met ☒NCQA
   (d) Time limit in which to appeal ☒Met ☐Not Met
   (e) Unsuccessful appeal to reverse determination ☐Met ☐Not Met ☒NCQA
   (f) Same or similar specialty review ☒Met ☐Not Met
(g) Notice of rights to external review ☒Met ☐Not Met ☒NCQA
Subd. 4. Notification to Claims Administrator ☒Met ☐Not Met

In the three utilization denial files the appeal rights notice did not contain the following:
• Minnesota Statutes, section 62M.06, subdivision 1, states the right to appeal must be available to the enrollee and to the attending health care professional.
• Minnesota Statutes, section 62M.06, subdivision 2, states that for expedited appeals the organization must ensure that the enrollee and the attending health care professional have an opportunity to appeal the determination over the telephone.
• Minnesota Statutes, section 62M.06, subdivision 3, states the utilization review organization must establish procedures for appeals to be made either in writing or by telephone.

The appeal rights notice must be revised to include all of the above. (Deficiency #2)

In addition, the appeal filing form found in all three files indicate a patient signature is needed if any person other than the patient is filling out the form. As stated in Minnesota Statutes, section 62M.06, subdivision 1, the right to appeal must be available to the enrollee and to the attending health care professional. No patient authorization is required if the attending health care professional is appealing. In one of the appeals reviewed, the attending physician appealed, however the plan did not require patient authorization. The appeal filing form must be revised to state that if the person filing the appeal is someone other than the patient or attending health care professional then the patient signature authorization is required. (Mandatory Improvement #5)

Minnesota Statutes, Section 62M.08. Confidentiality ☐Met ☐Not Met ☒NCQA

Minnesota Statutes, Section 62M.09. Staff and Program Qualifications
Subd. 1. Staff Criteria ☐Met ☐Not Met ☒NCQA
Subd. 2. Licensure Requirements ☐Met ☐Not Met ☒NCQA
Subd. 3. Physician Reviewer Involvement ☒Met ☐Not Met ☐NCQA
Subd. 3a. Mental Health and Substance Abuse Review ☒Met ☐Not Met
Subd. 4. Dentist Plan Reviews ☐Met ☐Not Met ☒NCQA
Subd. 4a. Chiropractic Reviews ☐Met ☐Not Met ☒NCQA
Subd. 5. Written Clinical Criteria ☐Met ☐Not Met ☒NCQA
Subd. 6. Physician Consultants ☐Met ☐Not Met ☒NCQA
Subd. 7. Training for Program Staff ☐Met ☐Not Met ☒NCQA
Subd. 8. Quality Assessment Program ☒Met ☐Not Met ☐NCQA

Minnesota Statutes, Section 62M.11. Complaints to Commerce or Health ☒Met ☐Not Met
VI. Recommendations

None

VII. Mandatory Improvements

1. To comply with Minnesota Rules, 4685.1110, subpart 6, Sanford must revise its ESI delegation agreement to include Sanford’s specific expectations for claims processing (reconciliation of invoices, timeliness and accuracy of claims payment, etc.), including the reports to be submitted, the frequency, what oversight is performed and the outcome of the oversight.

2. To comply with Minnesota Rules, part 4685.1110, subpart 9, Sanford must revise its policies/procedures as follows:
   - Provide a definition of quality of care to guide identification of quality of care complaints. MDH considers quality to include technical competence and appropriateness of care, communication and behavior, facilities and environment, coordination of care and health plan administration.
   - Clearly state who performs the investigation. If the investigation is performed by another entity, such as University of South Dakota, clearly state the entity’s role and Sanford’s role in the investigation, who makes the determination that the quality of care allegations are substantiated or unsubstantiated, who determines what intervention is appropriate and who oversees the implementation of the intervention.

3. To comply with Minnesota Statutes, section 62Q.69, subdivision 1, Sanford must revise its complaint system policy/procedure as follows:
   - State that it will inform the complainant of the right to submit the complaint in writing and offer assistance, including completing the complaint form and sending it for signature.
   - Define external review for adverse determinations, clinical or non-clinical.

4. To comply with Minnesota Statutes, section 62Q.70, Sanford must revise its complaint and appeal policy/procedure to:
   - Fully describe its internal appeal process for all types of clinical and non-clinical appeals, and
   - Accurately state the enrollee’s rights to external review upon appeal.

5. To comply with Minnesota Statutes, section 62M.06, subdivision 1, Sanford must revise its appeal filing form to state that if the person filing the appeal is someone other than the patient or attending health care professional, a patient signature authorization is required.
VIII. Deficiencies

1. To comply with Minnesota Statutes, section 62Q.69, subdivision 2(a), Sanford must revise its policy/procedure to state that oral complaints must be resolved within 10 calendar days of receipt and must implement the revised procedure to ensure oral complaints are resolved within the correct timeline.

2. To comply with Minnesota Statutes, section 62M.06, subdivisions 1, 2 and 3, Sanford must revise its appeal rights notice to include:
   - The right to appeal must be available to the enrollee and to the attending health care professional.
   - For expedited appeal the enrollee and the attending health care professional must have an opportunity to appeal the determination over the telephone.
   - The organization must establish procedures for appeals to be made either in writing or by telephone.