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

Final Report
Itasca Medical Care
Quality Assurance Examination
For the period
October 1, 2003 through April 30, 2006

Examiners:
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Minnesota Department of Health
Executive Summary:

The Minnesota Department of Health (MDH) conducted a Quality Assurance Examination of Itasca Medical Care (IMCare) to determine whether it is operating in accordance with Minnesota law and with the DHS Contract. Based on the Examination, MDH has found IMCare compliant with Minnesota law and the DHS Contract, except in the areas outlined in the “Deficiencies” section of this report. The “Recommendations” listed are areas where, although compliant with law, MDH identified improvement opportunities.

To address deficiencies, IMCare and its delegates must:

Ensure that the governing body review and approve the written quality plan.

Include in vendor delegation contracts the process by which the plan will evaluate the delegated entities’ performance and must, at least annually, evaluate the delegated entities’ performance.

Ensure that data on complaints related to quality of care be reported to and evaluated by the quality assurance program at least quarterly.

Ensure that data from utilization review activities be reported to the quality assurance program for analysis at least quarterly.

Assess and implement ongoing monitoring of the quality, safety, accessibility and medical record keeping practices of office sites where care is delivered in the credentialing process.

Ensure the length of the recredentialing cycle is within the 36-month time frame and must have mechanisms to incorporate ongoing monitoring of practitioner complaints and adverse events into the recredentialing process.

Evaluate the quality of medical and behavioral health organizational providers with which it contracts.

Include in its annual quality program evaluation all activities outlined in its annual work plan and address the specified components.

Include in its annual work plan a detailed description of the proposed quality and monitoring activities and must include the prescribed elements.

Properly identify and categorize all grievances and appeals and provide a written response to all appeals, whether the appeal is submitted to the plan verbally or in writing.

Communicate determinations to the provider and enrollee within ten business days.
To address recommendations, IMCare should:

Clearly specify in its vendor delegation contracts the reports and frequency of reports it expects from its delegates.

Have the approval of the Medical Director’s recredentialing come from its credentialing committee and indicate on the credentialing/recredentialing approval document the date in which the credentialing committee reviewed that provider.

Implement 14-day extensions when a service authorization lacks sufficient information to make a determination.

Revise its Availability of Network policy and procedure to indicate that the enrollee’s travel time to the nearest behavioral health provider is 30 miles or 30 minutes. Annual evaluation of geographic distribution of mental health providers should also be based on the 30 mile or 30 minute standard.

Revise its provider manual to include the requirement that primary care clinics maintain 24-hour, seven day per week availability, including a 24-hour answering service.

Clarify its policy and procedure regarding referrals/prior authorizations to include referrals (as well as standing referrals). In addition, IMCare should revise its Provider Manual to include the recent policy change that prior authorization to certain specialty providers is no longer required.

Revise its continuity of care policy and procedure to encompass relevant policy and procedures such as who will identify affected enrollees with special needs, the criteria to be used to determine the need for continuity of care and how the criteria will be applied, as described in other policies and procedures.

Include the enrollee and provider right to request the criteria and the source of the criteria used to make the determination not to certify in its DTR.

Document the due date for information necessary to make pre-service determinations in its records and in its notice to the enrollee and provider.

Document the written clinical criteria used when making utilization review determinations in its records and in the notice to the enrollee and the provider.

Implement its inter-rater reliability consistent with its 2006 Quality Work Plan.
This report including these deficiencies and recommendation is approved and adopted by the Minnesota Commissioner of Health pursuant to authority in Minnesota Statutes, chapter 62D.

Darcy Miner, Director
Division of Compliance Monitoring
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I. Introduction

A. History: The Itasca Medical Care (IMCare) program is administered by Itasca County Health and Human Services (ICCHS). IMCare enrollees are those who are eligible for benefits under Minnesota Health Care Programs (Medical Assistance (MA), General Assistance Medical Care (GAMC) and MinnesotaCare). IMCare began in 1982 with GAMC. Prepaid Medicaid was implemented on July 1, 1985, as a demonstration project and expanded to include MinnesotaCare in 1996. IMCare has since become a county based purchasing organization. Minnesota Senior Care (MSC) was added in June of 2005 and a Medicare Advantage product, Minnesota Senior Health Option (MSHO), was added in January 2006. In addition to residents of Itasca County, people in southern Koochiching, eastern Cass, and northern Aitkin counties may choose to enroll in IMCare.

B. Membership: IMCare’s current membership is as follows:

<table>
<thead>
<tr>
<th>Enrollment</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Prepaid Medical Assistance Program</td>
<td>9,352</td>
</tr>
<tr>
<td>MinnesotaCare</td>
<td>5,076</td>
</tr>
<tr>
<td>General Assistance Medical Care</td>
<td>1,467</td>
</tr>
<tr>
<td>Minnesota Senior Health Options</td>
<td>489</td>
</tr>
<tr>
<td>Total</td>
<td>16,384</td>
</tr>
</tbody>
</table>

C. Onsite Examination Dates: August 7 through August 10, 2006

D. Examination Period: October 1, 2003 through April 30, 2006

E. 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.

F. 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.

G. Indication of Compliance: In the body of the report, if the “yes” box is marked, it means the health plan was in compliance with the corresponding standard and if the “no” box is marked, it means the plan was not in compliance with the corresponding standard.

II. Quality Program Administration

Minnesota Rules, Part 4685.1110. Program
Subp. 1. Written Quality Assurance Plan □yes ☑no
Subp. 2. Documentation of Responsibility

Subp. 3. Appointed Entity

Subp. 4. Physician Participation

Subp. 5. Staff Resources

Subp. 6. Delegated Activities

Subp. 7. Information System

Subp. 8. Program Evaluation

Subp. 9. Complaints

Subp. 10. Utilization Review

Subp. 11. Provider Selection and Credentialing

Subp. 12. Qualifications

Subp. 13. Medical Records

Subp. 2. Minnesota Rules, Part 4685.1110, subpart 2 states, in pertinent part, that the HMO’s governing body must review and approve the quality assurance program activities. No documentation could be supplied showing that the written plan, *Itasca Medical Care Quality Assurance Plan 2005*, was reviewed and approved by the Itasca County Health and Human Services Board of Commissioners. (Deficiency # 1) Review of the 2006 plan indicated all elements were present in the plan and that it was reviewed and approved by the Board on June 27, 2006. This plan needs to be submitted to MDH for approval.

Subp. 6. Minnesota Rules, part 4685.1110, subpart 6, mandates that the HMO retain responsibility for performance of all delegated activities and requires the HMO to develop review and reporting procedures to ensure that the delegate performs the delegated functions as required. The standards set forth by the National Committee for Quality Assurance (NCQA) are considered the community standard for delegation, and such, were used for the purposes of this examination.

IMCare delegates include Caremark, which provides pharmacy network services, and DST, which provides claim processing. Review of the *Oversight of Delegated Functions* policy, vendor contracts and interviews indicated, for both delegates, that the contracts do not describe the process by which the organization evaluates the delegated entities’ performance and IMCare did not annually evaluate the delegates’ performance. (Deficiency # 2). IMCare regularly receives and analyzes reports from its delegates, however these reports could be more clearly specified in the vendor contracts. (Recommendation # 1)

Subp. 9. Minnesota Rules, part 4685.1110, subpart 9C, states, in pertinent part, that the data on complaints related to quality of care must be reported to and evaluated by the appointed quality assurance entity at least quarterly. Complaints are reported annually in the annual program evaluation, however no documentation was submitted that demonstrated quarterly reporting to the quality program. (Deficiency # 3). Two quality of care files were reviewed, which showed adequate investigation, documentation and follow up on the identified issues.

Subp. 10. Minnesota Rules, part 4685.1110, subpart 10 mandates that data from the HMO’s utilization review activities must be reported to the quality assurance program at least quarterly.
for analysis. Review of minutes from the QI/UR Committee and the Task Force Committee did not have documentation of quarterly reporting to the quality program. (Deficiency # 4)

Subp. 11. Minnesota Rules, part 4685.1110, subpart 11 states that the HMO must have policies and procedures for provider selection, credentialing, and recredentialing that, at a minimum, are consistent with accepted community standards. The standards set forth by the National Committee for Quality Assurance (NCQA) are considered the community standard, and such, were used for the purposes of this examination.

<table>
<thead>
<tr>
<th>Credentialing and Recredentialing</th>
<th>Credentialing</th>
<th>Recredentialing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allied Health Professionals</td>
<td>8</td>
<td>20</td>
</tr>
<tr>
<td>Physicians/Dentists</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>2006 Physicians/Dentists</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>Totals</td>
<td>16</td>
<td>32</td>
</tr>
</tbody>
</table>

Substantial improvement in the credentialing files and processes were noted and as a result, eight allied health and eight physician/dentist files were reviewed. Of those 16 credentialing files, no files contained documentation of site visits or evaluations of medical record–keeping practices at each site. Interviews and review of the documents submitted revealed site visits had not been done since 2003. (Deficiency # 5) Site Visits policy was initiated in June 2006 and a site visit tracking log submitted for review identified 12 clinics as high-volume, four of which have been visited since June 2006.

Twenty allied health and seven physician/dentist files were reviewed for compliance with recredentialing standards. 19 out of the 27 files reviewed were outside of the 36-month recredentialing timeline. In addition, 23 out of the 27 files had no documentation that specific complaints or the practitioner’s history of issues had been investigated as part of the recredentialing process. (Deficiency # 6) Interviews with staff indicated they had identified areas in the recredentialing process needing improvement and had instituted changes. Five additional recredentialing files were reviewed (from May and June of 2006), all of which showed compliance with all of the recredentialing standards.

The process for clean files is to have the Medical Director sign as approved and the list of clean files approved by the Medical Director then goes to the Provider Advisory Committee for review and approval. In the case of the Medical Director’s recredentialing file, IMCare’s Associate Director signed the approval, rather than the approval coming from the Provider Advisory Committee. In addition, in the case of clean files, the credentialing/recredentialing approval document does not indicate the date in which the Provider Advisory Committee reviewed that provider. (Recommendation # 2)

Facility Provider Certification policy initiated in June 2006 was reviewed along with a Facility Provider Tracking Log and Facility Provider Certification Form, which identified the contracted medical and behavioral health organizations to be assessed as well as identifying the assessment criteria. However, there was no documentation that initial and ongoing assessment of
organizational providers with which it intends to or has contracted had taken place during the review period. (Deficiency # 7)

**Minnesota Rules, Part 4685.1115. Activities**

<table>
<thead>
<tr>
<th>Subp.</th>
<th>Ongoing Quality Evaluation</th>
<th>yes</th>
<th>no</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subp.</td>
<td>Scope</td>
<td>yes</td>
<td>no</td>
</tr>
</tbody>
</table>

Subp. 2. Minnesota Rules, part 4685.1115, subpart 2, states the HMO must conduct quality evaluation activities and those activities must address the specified components described in subpart 2. Numerous activities outlined in the 2005 work plan were not evaluated in the 2005 annual evaluation, some of which include the lead and dental focus studies, monitoring activities of pharmacy services, home care, DME, referral management, and member education. (Deficiency # 8)

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

<table>
<thead>
<tr>
<th>Subp.</th>
<th>Problem Identification</th>
<th>yes</th>
<th>no</th>
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</thead>
<tbody>
<tr>
<td>Subp.</td>
<td>Problem Selection</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Subp.</td>
<td>Corrective Action</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Subp.</td>
<td>Evaluation of Corrective Action</td>
<td>yes</td>
<td>no</td>
</tr>
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**Minnesota Rules, Part 4685.1125. Focused Study Steps**

<table>
<thead>
<tr>
<th>Subp.</th>
<th>Focused Studies</th>
<th>yes</th>
<th>no</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subp.</td>
<td>Topic Identification and Selection</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Subp.</td>
<td>Study</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Subp.</td>
<td>Corrective Action</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Subp.</td>
<td>Other Studies</td>
<td>yes</td>
<td>no</td>
</tr>
</tbody>
</table>

The focus studies and performance improvement projects (PIPs) reviewed and discussed with staff included:

- Hypertension (2005 project)
- Cardiovascular Risk for Persons with Diabetes (2006 proposed collaborative project for County Based Purchasing)
- Prenatal (Focus Study)
- Improving Dental Visits (Focus Study)
- Improving Lead Testing (Focus Study)

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

<table>
<thead>
<tr>
<th>Subp.</th>
<th>Written Plan</th>
<th>yes</th>
<th>no</th>
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</thead>
<tbody>
<tr>
<td>Subp.</td>
<td>Work Plan</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Subp.</td>
<td>Amendments to Plans</td>
<td>yes</td>
<td>no</td>
</tr>
</tbody>
</table>

Subp. 2. Minnesota Rules, part 4685.1130, subpart 2 mandates the HMO annually prepare a written work plan, approved by the governing body, that gives a detailed description of the
proposed quality activities with a timetable for completion and to describe the proposed focus studies using prescribed elements. Review of the The Itasca Medical Care 2006 Annual Work Plan revealed only a very brief description of the improvement initiatives; lack of clarity as to the specific activities that were going to be performed for each clinical activity for that year (e.g. interventions, measurement year, etc); and lack of specificity as to study methodology and outcome measures in numerous areas (e.g. utilization, access/availability, authorization timeliness) (Deficiency # 9)

III. Grievances and Appeals
MDH examined IMCare’s public programs grievance system for compliance with the Balanced Budget Act, 42 CFR 438, subpart F (BBA) as outlined in the DHS Model Contract, Article 8.

MDH reviewed a total of 62 grievance system files:

<p>| | |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Grievance Files</td>
<td>30</td>
</tr>
<tr>
<td>Appeal Files</td>
<td>26</td>
</tr>
<tr>
<td>State Fair Hearing Files</td>
<td>6</td>
</tr>
<tr>
<td>Total</td>
<td>62</td>
</tr>
</tbody>
</table>

**Section 8.1. §438.402 General Requirements**

- Section 8.1.1. §438.402(a) Components of Grievance System [X]yes [ ]no
- Section 8.1.2. §438.408(a) Timeframes for Disposition [X]yes [ ]no

**Section 8.2. §438.404 DTR Notice of Action to Enrollees**

- Section 8.2.1. General requirements [X]yes [ ]no
- Section 8.2.2. §438.404 (c) Timing of DTR Notice
  - A. §438.404 (c)(1) Previously Authorized Services [X]yes [ ]no
  - B. §438.404 (c)(2) Denials of Payment [X]yes [ ]no
  - C. §438.404 (c)(3) Standard Authorizations [X]yes [ ]no
  - D. §438.404 (c)(4) Extensions of Time [X]yes [ ]no
  - E. §438.404 (c)(5) Delay in Authorizations [X]yes [ ]no
  - F. §438.404 (c)(6) Expedited Authorizations [X]yes [ ]no
- Section 8.2.3. §438.420 Continuation of Benefits Pending Decision [X]yes [ ]no

§438.404 (c)(4). DHS Contract section 8.2.2.D allows a 14-day extension of the standard authorization timeline. The extension is noted in the IMCare Pre-service Review policy and procedure (#024-013 effective April 2006). However, at the time of the onsite exam, IMCare staff was unaware that the extension applied to utilization review (service authorization) determinations and no extensions were requested. IMCare had a number of utilization denials due to a lack of information. (See MS §62M.05, subd. 3a (a)) IMCare may improve its utilization review process by implementing the 14-day extensions when a service authorization lacks sufficient information to make a determination. (Recommendation # 3)
Section 8.3. §438.408 Internal Grievance Process Requirements

Section 8.3.1. §438.402(b) Filing Requirements
Section 8.3.2. §438.408 (b) Timeframe for Resolution of Grievances
Section 8.3.3. §438.408 (c) Timeframe for Extension of Resolution of Grievances

Section 8.3.4. §438.406 Handling of Grievances
   A. §438.406 (a)(2) Written Acknowledgement
   B. §438.416 Log of Grievances
   C. §438.402(b)(3) Oral or Written Grievances
   D. §438.406 (a)(1) Reasonable Assistance
   F. §438.406 (a)(3)(ii) Appropriate Clinical Expertise

[See Minnesota Statutes, section 62M.06, subd. 3(f)]

Section 8.4. §438.408 Internal Appeals Process Requirements

Section 8.4.1. §438.408 (b)(1) Filing Requirements
Section 8.4.2. §438.408 (b)(2) Timeframe for Resolution of Standard Appeals
Section 8.4.3. §438.408 (b)(3) Timeframe for Resolution of Expedited Appeals
   A. §438.408 (d)(2)(ii) Expeditious Resolution and oral notice
   B. §438.410 (b) Punitive Action Prohibited
   C. §438.410 (c) Denial of Request for Expedited Appeal

Section 8.4.4. §438.408(c) Timeframe for Extension of Resolution of Appeals

Section 8.4.5. §438.406 Handling of Appeals
   A. §438.406 (b)(1) Oral Inquiries
   B. §438.406 (a)(2) Written Acknowledgement
   C. §438.406 (a)(1) Reasonable Assistance
   E. §438.406 (a)(3)(ii) Appropriate Clinical Expertise
   F. §438.406(b)(2) Opportunity to Present Evidence
   G. §438.406(b)(3) Opportunity to Examine the Case File
   H. §438.406(b)(4) Parties to the Appeal

Section 8.4.7. §438.408 (d)(2) Notice of Resolution of Appeals
Section 8.4.8. §438.424 Reversed Appeal Resolutions
Section 8.4.9. §438.420(d) Upheld Appeal Resolutions

Section 8.5. §438.416 Maintenance of Grievance and Appeal Records
Section 8.7. $\S$438.408 (f) State Fair Hearings

Section 8.7.2. §438.408 (f) Standard Hearing Decisions  ☒yes ☐no

Section 8.7.5. §438.420 Continuation of Benefits Pending Resolution of State Fair Hearing  ☒yes ☐no

Sec. 8.7.6. §438.424 Compliance with State Fair Hearing Resolution  ☒yes ☐no

Section 8.7.7. §438.408 (f)(2) Representation of MCO Determinations  ☒yes ☐no

Within the meaning of the BBA, an appeal is defined, in pertinent part, as a request for the health plan to review an “Action,” whereas a grievance is defined, in pertinent part, as “an expression of dissatisfaction about any matter other than an Action.” (See BBA §438.400(b))

While on site at the health plan, MDH reviewed 30 files which the plan had categorized as grievances. Only six of these files were actually grievances within the meaning of the BBA. In these six files, the plan met the requirements of Section 8.3 in resolving these cases. Five of these six grievances were filed and resolved during the first three months of 2006, and the sixth grievance dated back to November 2005. Based upon review of these six grievance files, combined with information obtained during staff interviews and review of the plan’s current policies and procedures, the plan has made recent significant improvements in its grievance and appeal system.

However, nineteen of the 30 files that were categorized as grievances were actually verbal appeals within the meaning of BBA Section 438.400(b). Most of these cases were resolved to the member’s satisfaction. However, in none of these cases did the plan provide the member with a written response. The plan is required to provide a written response to all appeals, whether the appeal is submitted to the plan verbally or in writing. See BBA §§438.408(d)(2), 438.408(e). (Deficiency # 10)

Two of the 30 files categorized as grievances were actually inquiries. The information contained in both of both of these files shows the plan adequately responded to the members’ inquiries.

Finally, in three of the 30 files categorized as grievances, it was not possible to identify whether the cases were actually grievances or appeals because the files contained so little documentation.

While on site at the health plan, MDH also reviewed 26 files which the plan had categorized as appeals. Only four of these files were handled according to the requirements of the BBA. Three of these four appeals were filed and resolved during the first three months of 2006, and the fourth appeal occurred in August 2005. Based upon review of these four appeal files, combined with information obtained during staff interviews and review of the plan’s current policies and procedures, the plan has made recent significant improvements in its grievance and appeal system.

There were eleven additional files that were correctly categorized as verbal appeals. However, none of these files contained written acknowledgment letters, written resolutions, or appeals
notice. Even when a verbal appeal is resolved to the member’s satisfaction, the plan is required to provide a written response to all appeals, whether the appeal is submitted to the plan verbally or in writing. See §§438.408(d)(2), 438.408(e). (See Deficiency # 10)

IV. Access and Availability

Minnesota Statutes, Section 62D.124. Geographic Accessibility
Subd. 1. Primary Care; Mental Health Services; General Hospital Services
   ☑yes ☐no
Subd. 2. Other Health Services
   ☑yes ☐no

Subd. 1. Minnesota Statutes, section 62D.124, states that the maximum travel distance must be the lesser of 30 miles or 30 minutes to the nearest provider of primary care, general hospital and mental health services. IMCare’s 2006 Quality Program evaluation verifies that IMCare’s behavioral health network meets the statutory requirement. However, the Availability of Network policy and procedure states that behavioral health providers are specialty practitioners for which the geographic distribution standard is 60 miles or 60 minutes. (Recommendation # 4)

Minnesota Statutes, Section 62D.09. Information to Enrollees.
Subd. 5. Participating providers
   ☑yes ☐no

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
Subp. 7. Access to Emergency Care
   ☑yes ☐no

Subp. 2. Minnesota Rules, part 4685.1010, subpart 2, A (1), requires the plan make primary care physician services available and accessible 24 hours per day, seven days per week within its service area, including regularly scheduled appointments during normal business hours and 24-hour answering services.

IMCare surveys primary care clinics to verify 24-hour, seven day per week availability. MDH found no evidence that services were not available 24-hours a day. However, IMCare has no means to enforce timely availability. Provider contract forms did not contain a requirement for 24-hour, seven day per week access, including 24-hour answering service. The revised Provider Manual did not contain this provision. (Recommendation # 5)

Subp. 5. Minnesota Rules, part 4685.1010, subpart 5, B, states that, if the plan requires referrals, it must inform its primary care and other authorized providers of their responsibility to provide written referrals and any procedures that must be followed.
IMCare's referral policy focuses on standing referrals. IMCare certificates of coverage state that specialists require a referral and out of area or out of plan services require a written referral from the primary care provider and may require prior authorization from IMCare. In practice, providers request IMCare approval of referrals/prior authorizations for specialty providers. The Provider Manual states that the provider must complete the Referral/Prior Authorization form. IMCare recently reduced the paperwork burden for referrals to certain specialty clinics. A provider bulletin was sent to each primary care provider. However, the policy change was not included in the referral policy and procedure or in the revised Provider Manual.

(Recommendation # 6)

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

☑️yes  ☐no

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

☑️yes  ☐no

**Minnesota Statutes, Section 62A.15. 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

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

☑️yes  ☐no

**Minnesota Statutes, 62Q.527. Coverage of Nonformulary 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

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

- Subd. 1. Mental health services  
  ☑️yes  ☐no
- Subd. 2. Coverage required  
  ☑️yes  ☐no
Minnesota Statutes, Section 62Q.56. Continuity of Care
Subd. 1. Change in health care provider; general notification

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

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

Subd. 2. Change in health plans

Subd. 2a. Limitations

Subd. 2b. Request for authorization

Subd. 3. Disclosures

Subds. 1 and 1a. Minnesota Statutes, section 62Q.56, states that health plans that require selection of a primary care provider must prepare a written plan for continuity of care in the event of a primary care, specialty or hospital provider termination or a change in health plans. The plan must include how the plan will notify enrollees of the termination and the available providers, the procedures for transfer to other providers, and the process for identifying how affected enrollees with special needs or who are at-risk will be identified and provided continuity of care. The written plan must explain the criteria that will be used to determine whether a need for continuity of care exists and how continuity of care will be provided.

The IMCare policy on continuity of care describes the process IMCare will use to notify enrollees of the termination and the process for enrollee selection of primary care providers. The continuity of care policy and procedure does not describe how IMCare will identify affected enrollees with special needs or the criteria that will be used to determine if the need for continuity exists or how the criteria will be applied. IMCare also has policies and procedures for care coordination and a policy on enrollees with special needs that address these issues. However, the relevant processes are not combined in one document.

Staff interviews indicated that when a provider terminates, all enrollees are provided continuity of care. IMCare identified two providers (individuals in private practice) that terminated within the examination period. IMCare identified the affected enrollees and determined that only one enrollee needed continuity of care and the retiring provider had arranged for ongoing care with an associate. (Recommendation # 7)

Minnesota Statutes, Section 62Q.58. Access to Specialty Care
Subd. 1. Standing Referral

Subd. 1a. Mandatory Standing Referral

Subd. 2. Coordination of Services

Subd. 3. Disclosure

Subd. 4 Referral
V. Utilization Review
MDH reviewed 30 utilization review files in which the initial determination was a denial of services. Utilization review appeals were examined under Section III. Grievances and Appeals above.

Minnesota Statutes, Section 62M.04. Standards for Utilization Review Performance
Subd. 1. Responsibility on Obtaining Certification [ ] yes [ ] no
Subd. 2. Information upon which Utilization Review is Conducted [ ] yes [ ] no
Subd. 3. Data Elements [ ] yes [ ] no
Subd. 4. Additional Information [ ] yes [ ] no
Subd. 5. Sharing of Information [ ] yes [ ] no

Minnesota Statutes, Section 62M.05. Procedures for Review Determination
Subd. 1. Written Procedures [ ] yes [ ] no
Subd. 2. Concurrent Review [ ] yes [ ] no
Subd. 3a. Standard Review Determination [ ] yes [ ] no
Subd. 3b. Expedited Review Determination [ ] yes [ ] no
Subd. 4. Failure to Provide Necessary Information [ ] yes [ ] no
Subd. 5. Notifications to Claims Administrator [ ] yes [ ] no

Subd. 3a (a). Minnesota Statutes, section 62M.05, subdivision 3a, (a), states that an initial determination on all requests for utilization review must be communicated to the provider and enrollee in accordance with this subdivision within ten business days of the request. MDH reviewed 30 utilization review denials. Of these, three files exceeded the ten-day timeframe. Timeliness of utilization determinations was also noted in the 2003 MDH Quality Assurance Examination. Consequently, timeliness of utilization review determinations is a repeat deficiency. (Deficiency # 11)

Subd. 3a (c). Minnesota Statutes, section 62M.05, subdivision 3a, (c), states that when the initial determination is not to certify, the plan must, upon request, provide the enrollee or provider with the criteria used to make the determination and the source of the criteria. The IMCare Denial, Termination or Reduction (DTR) notice did not indicate the enrollee or provider right to request the criteria. (Recommendation # 8)

Subd. 4. Minnesota Statutes, section 62M.05, subdivision 4, states that a plan must have written procedures to address the failure of a provider or enrollee to provide the necessary information for review. If the information is not received, the plan may deny certification in accordance with its own policy. In utilization review files where IMCare requested additional information, no IMCare record and no notice to the enrollee or provider documented the due date for information necessary to make pre-service determinations. (Recommendation # 9)

Minnesota Statutes, Section 62M.06. Appeals of Determinations not to Certify
Utilization Review appeals were reviewed under Section III, Grievances and Appeals, above.

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

- yes
- no

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

<table>
<thead>
<tr>
<th>Subd.</th>
<th>Criteria</th>
<th>yes</th>
<th>no</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Staff Criteria</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>2.</td>
<td>Licensure Requirement</td>
<td>yes</td>
<td>no</td>
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<tr>
<td>3.</td>
<td>Physician Reviewer Involvement</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>3a.</td>
<td>Mental Health and Substance Abuse Review</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>4.</td>
<td>Dentist Plan Reviews</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>4a.</td>
<td>Chiropractic Reviews</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>5.</td>
<td>Written Clinical Criteria</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>6.</td>
<td>Physician Consultants</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>7.</td>
<td>Training for Program Staff</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>8.</td>
<td>Quality Assessment Program</td>
<td>yes</td>
<td>no</td>
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</tbody>
</table>

**Subd. 5.** Minnesota Statutes, section 62M.09, subdivision 5, requires that the plan's clinical decisions be supported by written clinical criteria and review procedures. The plan must use written clinical criteria, as required, for determining the appropriateness of the certification request. The IMCare Pre-service Review (effective April 2006) Utilization Management Criteria and Assessment (#024-009 effective August 2001 and revised April 2006) policies and procedures state that the QI/UR Nurse and the Physician Reviewer will review the clinical information against the UM Department medical necessity criteria, clinical practice guidelines and/or medical policy. In current practice, IMCare uses InterQual, CDMI public programs criteria and the community standard. However, the utilization review denial files did not include documentation of the use of clinical criteria. (Recommendation #10)

**Subd. 8.** Minnesota Statutes, section 62M.09, subdivision 8, states that the plan must have written documentation of an active quality assessment program. IMCare's 2006 quality work plan included timeliness of service authorizations and interrater reliability. Monitoring of interrater reliability was to begin the second quarter of 2006. IMCare provided results of the DHS EQRO audit of interrater reliability. IMCare will use the same tool as the EQRO auditors. However, it is not clear that IMCare has yet performed its own interrater reliability monitoring, according to its work plan. (Recommendation #11)

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

<table>
<thead>
<tr>
<th>Subd.</th>
<th>Procedure</th>
<th>yes</th>
<th>no</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Toll-free Number</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>2.</td>
<td>Reviews during Normal Business Hours</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>3.</td>
<td>Identification of On-site Review Staff</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>4.</td>
<td>On-site Reviews</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>5.</td>
<td>Oral Requests for Information</td>
<td>yes</td>
<td>no</td>
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<tr>
<td>6.</td>
<td>Mutual Agreement</td>
<td>yes</td>
<td>no</td>
</tr>
</tbody>
</table>
Subd. 7. Availability of Criteria

☑ yes ☐ no

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

☑ yes ☐ no

VII. Recommendations

1. To better comply with Minnesota Rules, Part 4685.1110, subpart 6, IMCare should clearly specify in its vendor delegation contracts the reports and frequency of reports it expects from its delegates.

2. To better comply with Minnesota Rules, Part 4685.1110, subpart 11, IMCare should have the credentialing committee approve the Medical Director’s recredentialing and should indicate on the credentialing/recredentialing approval documents the date in which the credentialing committee reviewed that provider.

3. To better comply with BBA Sections 438.404 (c)(4), IMCare should implement 14-day extensions when a service authorization lacks sufficient information to make a determination.

4. To better comply with Minnesota Statutes, section 62D.124, IMCare should revise its Availability of Network policy and procedure to indicate that the enrollee’s travel time to the nearest behavioral health provider is 30 miles or 30 minutes. Annual evaluation of geographic distribution of mental health providers should also be based on the 30 mile or 30 minute standard.

5. To better comply with Minnesota Rules, part 4685.1010, subpart 2, A (1), IMCare should revise its provider manual to include the requirement that primary care clinics maintain 24-hour, seven day per week availability, including a 24-hour answering service.

6. To better comply with Minnesota Rules, part 4685.1010, subpart 5, B, IMCare should clarify its policy and procedure regarding referrals/prior authorizations (as well as standing referrals). In addition, IMCare should revise its Provider Manual to include the recent policy change that prior authorization to certain specialty providers is no longer required.

7. To better comply with Minnesota Statutes, section 62Q.56, IMCare should revise its continuity of care policy and procedure to encompass relevant policy and procedures such as who will identify affected enrollees with special needs, the criteria to be used to determine the need for continuity of care and how the criteria will be applied, as described in other policies and procedures.
8. To better comply with Minnesota Statutes, section 62M.05, subdivision 3a, (c), IMCare's DTR should include the enrollee and provider right to request the criteria and the source of the criteria used to make the determination not to certify.

9. To better comply with Minnesota Statutes, section 62M.05, subdivision 4, IMCare should document the due date for information necessary to make pre-service determinations in its records and in its notice to the enrollee and provider.

10. To better comply with Minnesota Statutes, section 62M.09, subdivision 5, IMCare should document the written clinical criteria used when making utilization review determinations in its records and in the notice to the enrollee and the provider.

11. To better comply with Minnesota Statutes, section 62M.09, subdivision 8, IMCare should implement its interrater reliability consistent with its 2006 Quality Work Plan.

VIII. Deficiencies

1. To comply with Minnesota Rules, Part 4685.1110, subpart 2, IMCare’s governing body must review and approve the written quality plan.

2. To comply with Minnesota Rules, Part 4685.1110, subpart 6, IMCare must include in vendor delegation contracts the process by which the plan will evaluate the delegated entities’ performance and must, at least annually, evaluate the delegated entities’ performance.

3. To comply with Minnesota Rules, Part 4685.1110, subpart 9, data on complaints related to quality of care must be reported to and evaluated by IMCare’s quality assurance program at least quarterly.

4. To comply with Minnesota Rules, Part 4685.1110, subpart 10, data from IMCare’s utilization review activities must be reported to the quality assurance program for analysis at least quarterly.

5. To comply with Minnesota Rules, Part 4685.1110, subpart 11, (credentialing) IMCare must assess and implement ongoing monitoring of the quality, safety, accessibility and medical record keeping practices of office sites where care is delivered.

6. To comply with Minnesota Rules, Part 4685.1110, subpart 11, (recredentialing) IMCare must ensure the length of the recredentialing cycle is within the 36-month time frame and must have mechanisms to incorporate ongoing monitoring of practitioner complaints and adverse events into the recredentialing process.

7. To comply with Minnesota Rules, Part 4685.1110, subpart 11, (organizational providers) IMCare must evaluate the quality of medical and behavioral health organizational providers with which it contracts.
8. To comply with Minnesota Rules, Part 4685.1115, subpart 2, IMCare must include in its annual quality program evaluation all activities outlined in its annual work plan and address the specified components.

9. To comply with Minnesota Rules, Part 4685.1130, subpart 2, IMCare must include in its annual work plan a detailed description of the proposed quality and monitoring activities and must include the prescribed elements.

10. To comply with BBA Sections 438.408(d)(2) and 438.408(e), IMCare must identify and categorize all grievances and appeals and provide a written response to all appeals, whether the appeal is submitted to the plan verbally or in writing.

11. To comply with Minnesota Statutes, section 62M.05, subdivision 3a,(a), IMCare must communicate determinations to the provider and enrollee within ten business days.