Minnesota Department of Health
Compliance Monitoring Division
Managed Care Systems Section

Final Report

Blue Plus

Quality Assurance Examination
For the Period:

May 1, 2010 to March 31, 2013

Final Issue Date:
January 16, 2014

Examiners
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Minnesota Department of Health
Executive Summary

The Minnesota Department of Health (MDH) conducted a Quality Assurance Examination of Blue Plus to determine whether it is operating in accordance with Minnesota law. MDH has found that Blue Plus is compliant with Minnesota and federal law, except in the areas outlined in the "Deficiencies" and 'Mandatory Improvements" sections of this report. "Deficiencies" are violations of law. "Mandatory Improvements" are required 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, Blue Plus and its delegates should:

Explain enrollee rights and the limited timeframe to submit evidence for an expedited appeal at the time of the initial denial.

Improve the explanation of appeal rights on its notification letters to be more understandable to the enrollee.

Consider verbally informing the enrollee of the denial and of the right to submit an expedited appeal when processing expedited utilization determinations.

To address mandatory improvement, Blue Plus must:

Revise the Delta Dental delegation agreement to include specific utilization review activities and oversight of the delegated utilization activities.

Revise the delegation documents as follows:

- Consistently describe care coordination activities and responsibilities across contracts and guidelines.
- Describe the process by which the organization evaluates the delegate's performance.
- State what reports, if any are regularly required and/or to state what reporting is ad hoc.

Revise its policy, CSC/GP-M-2011-012, *Blue Plus Public Programs Grievance Policy*, as follows:

- Accurately state the timeframe for filing a grievance
- Accurately state that all extensions of grievance timeframes must generate a written notice of extension, and

- Accurately state that customer service will provide assistance in completing the grievance form and mail the form to the enrollee for signature.

To address deficiencies, Blue Plus and its delegates must:

Perform a credentialing file review of Delta networks to ensure that Delta correctly implements its credentialing standards.

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

Date

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I. Introduction

A. History:

Founded in 1974, Blue Plus, also a fully owned subsidiary of Aware Integrated, Inc., is a licensed health maintenance organization (HMO). An independent board, consisting of 40 percent member-elected directors, oversees Blue Plus. In addition to offering a range of fully-insured commercial products, Blue Plus currently holds a contract with CMS and the Minnesota Department of Human Services (DHS) to deliver and administer Prepaid Medical Assistance Program (PMAP), MinnesotaCare (MNCare), Minnesota Senior Care Plus (MSC+), and Minnesota Senior Health Options (MSHO). Blue Plus has provided Minnesota Health Care Programs – Managed Care coverage since 1993.

B. Membership: Blue Plus self-reported enrollment as of March 31, 2013 consisted of the following:

Product	**Enrollment**
Fully Insured Commercial	
Large Group	1491
Small Employer Group	163
Individual	249
Minnesota Health Care Programs-Managed Care (MHSP-MC)	
Families & Children	78220
MinnesotaCare	41500
Minnesota Senior Care (MSC+)	3310
Minnesota Senior Health Options (MSHO)	9068
Special Needs Basic Care (SNBC)	NA
Medicare	
Medicare Advantage	NA
Medicare Cost	NA
Total	134001

C. Onsite Examinations Dates: June 17, 2013 to June 21, 2013

D. Examination Period: May 1, 2010 to March 31, 2013
File Review Period: April 1, 2012 to March 31, 2013
Opening Date: April 16, 2013

E. National Committee for Quality Assurance (NCQA): Blue Plus is accredited by NCQA based on 2011 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, 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, 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, that covers a three year audit period, the health plan is cited with a deficiency. A deficiency will not be based solely on one outlier file if MDH had sufficient evidence obtained through: 1) file review; 2) policies and procedures; and 3) interviews, that a plan's overall operation is compliant with an applicable law.

II. Quality Program Administration

Minnesota Rules, Part 4685.1110. Program

Subp. 1.	Written Quality Assurance Plan	Met ☒	Not Met ☐	NCQA ☐
Subp. 2.	Documentation of Responsibility	Met ☐	Not Met ☐	NCQA ☒
Subp. 3.	Appointed Entity	Met ☐	Not Met ☐	NCQA ☒
Subp. 4.	Physician Participation	Met ☐	Not Met ☐	NCQA ☒
Subp. 5.	Staff Resources	Met ☐	Not Met ☐	NCQA ☒
Subp. 6.	Delegated Activities	Met ☐	Not Met ☒	NCQA ☐
Subp. 7.	Information System	Met ☐	Not Met ☐	NCQA ☒
Subp. 8.	Program Evaluation	Met ☒	Not Met ☐	NCQA ☐
Subp. 9.	Complaints	Met ☒	Not Met ☐	
Subp. 10.	Utilization Review	Met ☒	Not Met ☐	
Subp. 11.	Provider Selection and Credentialing	Met ☒	Not Met ☐	NCQA ☐
Subp. 12.	Qualifications	Met ☒	Not Met ☐	NCQA ☐
Subp. 13.	Medical Records	Met ☒	Not Met ☐	

Subp. 1. Minnesota Rules, part 4685.1110, subpart 1, states the health plan will have a written quality assurance plan and lists the elements it should include. MDH commends Blue Plus for its new and very unique format use in its program description. It has ten focus areas with corresponding high level goals and outcome measures.

Subp. 6. Minnesota Rules, part 4685.1110, subpart 6, states the HMO must develop and implement review and reporting requirements to assure that the delegated entity performs all

delegated activities. The standards established by the National Committee for Quality Assurance (NCQA) for delegation are considered the community standard and, as such, were used for the purposes of this examination. The following delegated entities and functions were reviewed:

Delegated Entities and Functions								
Entity	**UM**	**UM Appeals**	**QM**	**Complaints/ Grievances**	**Cred**	**Claims**	**Network**	**Care Coord**
Prime Therapeutics (PTI)	X							
Delta Dental	X	X		X			X	
Olmsted Medical Center					X (oversight)			
Avera Health					X (oversight)			
Lake Region Health Care Clinic								X
Fillmore County								X
St. Louis County								X

Blue Plus did not score 100% in its NCQA review of delegated credentialing. The standard for credentialing delegation states the plan should semiannually evaluate the regular reports submitted by the delegated entity. Blue Plus did a corrective action plan for NCQA dated March 2012. A spreadsheet entitled *Evaluation of Delegate Semiannual Reporting* was created which is evidence the reporting is evaluated. The spreadsheet was initiated in March 2012. MDH also reviewed the credentialing delegation oversight done by Blue Plus for Olmstead Medical Center and Avera Health. Blue Plus has corrected the issue.

Subp. 6. If the plan delegates performance of activities, the plan's delegation agreement must describe the delegated activities.

Delta

The Blue Plus delegation agreement (page 10) notes that Blue Plus and Delta will enter into a separate delegation agreement for utilization review activities. The network and Administrative Services Agreement was signed in October 2012. Blue Plus stated that the delegation agreement has never included specific utilization review activities, although Delta has performed these functions and Blue Plus has performed oversight, the utilization review addendum has not yet been executed. MDH notes that the Blue Plus 2011 and 2012 oversight summaries documented that Blue Plus reviewed prior authorization denial and appeal files. Blue Plus and Delta Dental must revise the delegation agreement to include specific utilization review activities and oversight of the delegated utilization activities. **(Mandatory Improvement #1)**

Blue Plus states that it contracts with Delta Dental to provide a "credentialed network." The agreement states Delta must ensure that its dentists meet all applicable laws, regulation, rules and

orders and all applicable credentialing standards of Delta. Blue Plus annually reviews Delta's credentialing standards. However, Blue Plus does not perform file review. Blue Plus must perform a credentialing file review of Delta providers to ensure that Delta correctly implements its credentialing standards. **(Deficiency #1)**

Care Coordination

Blue Plus contracts with multiple counties (the specific county agency may vary) to provided care coordination for enrollees covered under the Elderly Waiver (EW) or MSHO and MSC+ enrollees. MDH reviewed the agreements with St. Louis and Fillmore Counties, and Lake Region Healthcare Clinic.

- A delegation agreement must describe the activities and responsibilities of the parties Blue Plus provided contracts and four sets of guidelines for MSHO and MSC+ enrollees who dwell in the community or in a nursing facility. The documents include inconsistencies; for example, a consistent definition of a care coordinator. Blue Plus must revise its delegation documents to be consistent across contracts and guidelines.

- A delegation agreement must describe the process by which the organization evaluates the delegate's performance. The guidelines (page 33) state that the Blue Plus contract with DHS and CMS requires the auditing of care coordination activities on an annual basis. This is not a complete or sufficient description of Blue Plus oversight activities, including a file review.

- A delegation agreement must require at least semiannual reporting by the delegate. Neither the restated agreement nor the guidelines include a list of required reports, their frequency or due dates; although staff states the care coordination entities provide multiple reports, primarily ad hoc. (Article XI of the restated agreement requires quarterly reports of complaints; however, Blue Plus no longer delegates grievance resolution to delegated counties.) The delegation agreement should state what reports, if any are regularly required and/or state what reporting is ad hoc.

(Mandatory Improvement #2)

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

Quality of Care File Review	
QOC File Source	**# Reviewed**
Complaints—Commercial Products	0
(No commercial QOC complaints)	
Grievances—MHCP-MC Products	
Blue Plus	8
Delta Dental	8
Total	**16**

Minnesota Rules, Part 4685.1115. Activities

Subp. 1.	Ongoing Quality Evaluation	☐Met	☐Not Met	☒NCQA
Subp. 2.	Scope	☐Met	☐Not Met	☒NCQA

Minnesota Rules, Part 4685.1120. Quality Evaluation Steps

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

Minnesota Rules, Part 4685.1125. Focus Study Steps

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

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

Subd. 1.	Written Plan	☒Met	☐Not Met	
Subp. 2.	Work Plan	☒Met	☐Not Met	☐NCQA

III. Complaints and Grievance Systems

Complaint System

MDH examined the Blue Plus fully-insured commercial complaint system under Minnesota Statues, chapter 62Q.
MDH reviewed a total of 35 Complaint System files.

Complaint System File Review	
Complaint Files (Oral and Written)	30
Non-Clinical Appeal	5
Total # Reviewed	**35**

Minnesota Statutes, Section 62Q.69. Complaint Resolution

Subd. 1.	Establishment	☒Met	☐Not Met

Subd. 2.	Procedures for Filing a Complaint	☒Met ☐Not Met
Subd. 3.	Notification of Complaint Decisions	☒Met ☐Not Met

Subd. 2 and 3(a). Minnesota Statutes, section 62Q.69, subdivision 2(b), states that upon receipt of a written complaint, the health plan company must notify the complainant within 10 business days that the complaint was received; and Minnesota Statutes, section 62Q.69, subdivision 3(a), states the HMO must notify the complainant in writing of the decision no later than 30 days after receipt. One file exceeded the 10 business day acknowledgement letter timeline (41 days) and exceeded the 30 day notification timeline (61 days).

Subd. 3(c). Minnesota Statutes, section 62Q.69, subdivision 3(c,) states the notification must inform the complainant of the right to submit the complaint at any time to the commissioner of health for investigation. In one file the notification letter directed the enrollee to the Department of Commerce rather than the Department of Health.

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

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

Grievance System

MDH examined Blue Plus's Minnesota Health Care Programs - Managed Care (MCHP-MC) grievance system for compliance with the federal law (42 CFR 438, subpart F) and the DHS 2013 Model Contract, Article 8.

MDH reviewed a total of 66 grievance system files:

Grievance System File Review	
File Source	**# Reviewed**
Grievances	
Blue Plus	30
Delta Dental	10
Non-Clinical Appeals	
Blue Plus	15
Delta Dental	5
State Fair Hearings	
Blue Plus	5
Delta Dental	1
Total	**66**

Section 8.1. §438.402 General Requirements
Sec. 8.1.1 Components of Grievance System ☐Met ☒Not Met

Sec. 8.1.1. 42 CFR section 438.402 (contract section 8.1.1), states that the plan must have a Grievance System in place that includes a grievance process, an appeal process and access to the State Fair Hearing system. MDH found that grievance policies/procedures included the following errors or omissions:

§438.402(b) (contract section 8.2.1), states the enrollee or provider may file a grievance within 90 days of enrollee's dissatisfaction about any matter other than an action. Blue Plus policy CSC/GP-M-2011-012, *Blue Plus Public Programs Grievance Policy*, correctly defines a grievance as "An expression of dissatisfaction about any matter other than an action." However, the policy later states, Grievances must be filed within 90 calendar days from the date of the "DTR notice or action." Since a grievance is, by definition, something other than an action, and a DTR is issued as the result of an action, this statement is incorrect and must be revised.

§438.408(c) (contract section 8.2.3), states the MCO may extend the timeframe for resolution of a grievance by 14 days. The MCO must provide "written notice to the enrollee of the reason for the decision to extend the timeframe." The policy, CSC/GP-M-2011-012, *Blue Plus Public Programs Grievance Policy (*page 6, #5, a), states the enrollee may be notified of the oral grievance response by telephone before the extension expires. "If the enrollee is unreachable by telephone, a written extension letter is sent within 10 calendar days." Blue Plus must revise its policy to state all extensions of grievance timeframes must generate a written notice of extension.

[The two issues above were corrected during the on-site portion of the exam.]

§438.404 (a) (contract section 8.2.5 (A)), states if the enrollee is not satisfied with the resolution to an oral grievance the MCO must inform the enrollee that the grievance may be submitted in writing. "The MCO must also offer to provide the enrollee with any assistance

needed to submit a written grievance, including an offer to complete the grievance form, and promptly mail the completed form to the enrollee for his/her signature." Policy CSC/GP-M-2011-012, *Blue Plus Public Programs Grievance Policy* (page 5), states **"**if the oral grievance is not to the satisfaction of the enrollee, the enrollee may file a written grievance to Blue Plus." The policy goes on to state "Customer service will provide the enrollee assistance in submitting a written grievance to Blue Plus." It is not sufficient to state that customer service will provide assistance. Blue Plus must revise its policy to state the assistance it will offer, including to complete the form and mail it for signature.
(Mandatory Improvement #3)

In one file the enrollee made an oral grievance regarding the behavior of her provider and about missing glasses. The missing glasses were not investigated and the grievance was not referred to quality of care. The enrollee was not offered a written grievance form or assistance in completing the form.

Section 8.2.	§438.408	Internal Grievance Process Requirements	
Sec. 8.2.1.	§438.402 (b)	Filing Requirements	☒Met ☐Not Met
Sec. 8.2.2.	§438.408 (b)(1)	Timeframe for Resolution of Grievances	☒Met ☐Not Met
Sec. 8.2.3.	§438.408 (c)	Timeframe for Extension of Resolution of Grievances	☒Met ☐Not Met
Sec. 8.2.4.	§438.406	Handling of Grievances	
(A)	§438.406 (a)(2)	Written Acknowledgement	☒Met ☐Not Met
(B)	§438.416	Log of Grievances	☒Met ☐Not Met
(C)	§438.402 (b)(3)	Oral or Written Grievances	☒Met ☐Not Met
(D)	§438.406 (a)(1)	Reasonable Assistance	☒Met ☐Not Met
(E)	§438.406 (a)(3)(i)	Individual Making Decision	☒Met ☐Not Met
(F)	§438.406 (a)(3)(ii)	Appropriate Clinical Expertise	☒Met ☐Not Met
Sec. 8.2.5.	§438.408 (d)(1)	Notice of Disposition of a Grievance	
(A)	§438.408 (d)(1)	Oral Grievances	☒Met ☐Not Met
(B)	§438.408 (d)(1)	Written Grievances	☒Met ☐Not Met

Section 8.3.	**§438.404**	**DTR Notice of Action to Enrollees**	
Sec. 8.3.1.		General Requirements	☒Met ☐Not Met
Sec. 8.3.2.	§438.404 (c)	Timing of DTR Notice	
(A)	§438.210 (c)	Previously Authorized Services	☒Met ☐Not Met
(B)	§438.404 (c)(2)	Denials of Payment	☒Met ☐Not Met
(C)	§438.210 (c)	Standard Authorizations	☒Met ☐Not Met
(1)		As expeditiously as the enrollee's health condition requires	☒Met ☐Not Met

(2) To the attending health care professional and hospital by telephone or fax within one working day after making the determination ☒Met ☐Not Met

(3) To the provider, enrollee and hospital, in writing, and must include the process to initiate an appeal, within ten (10) business days following receipt of the request for the service, unless the MCO receives an extension of the resolution period ☒Met ☐Not Met

(D) §438.210 (d)(2)(*i*) Expedited Authorizations ☒Met ☐Not Met

(E) §438.210 (d)(1) Extensions of Time ☒Met ☐Not Met

(F) §438.210 (d) Delay in Authorizations ☒Met ☐Not Met

Sec. 8.3.3. §438.420 (b) Continuation of Benefits Pending Decision ☒Met ☐Not Met

Sec. 8.3.1. 42 CFR section 438.404 (contract section 8.3.1), states the content of the denial, termination or reduction notice (DTR), Notice of Action must include a clear and detailed description in plain language of the reasons for the Action. In the DTRs from Delta Dental, Blue Plus's delegate, the system generated DTR notices insert the American Dental Association language in the space provided for the reason for the denial, which is not consistently understandable to the member. The system does not have the ability to add free text. Delta Dental, in addition to the DTR notice, also provides a letter to the enrollee that gives a clear, detailed and understandable reason for the denial. Delta Dental also includes the Explanation of Benefits with the letter. MDH commends Delta Dental for this thorough process to communicate the denial.

Section 8.4. §438.408 Internal Appeals Process Requirements

Sec. 8.4.1. §438.402 (b) Filing Requirements ☒Met ☐Not Met

Sec. 8.4.2. §438.408 (b)(2) Timeframe for Resolution of Expedited Appeals ☒Met ☐Not Met

Sec. 8.4.3. §438.408 (b) Timeframe for Resolution of Expedited Appeals

(A) §438.408 (b)(3) Expedited Resolution of Oral and Written Appeals ☒Met ☐Not Met

(B) §438.410 (c) Expedited Resolution Denied ☒Met ☐Not Met

(C) §438.410 (a) Expedited Appeal by Telephone ☒Met ☐Not Met

Sec. 8.4.4. §438.408 (c) Timeframe for Extension of Resolution of Appeals ☒Met ☐Not Met

Sec. 8.4.5. §438.406 Handling of Appeals

(A) §438.406 (b)(1) Oral Inquiries ☒Met ☐Not Met

(B) §438.406(a)(2) Written Acknowledgement ☒Met ☐Not Met

(C) §438.406(a)(1) Reasonable Assistance ☒Met ☐Not Met

(D) §438.406(a)(3) Individual Making Decision ☒Met ☐Not Met

(E) §438.406(a)(3) Appropriate Clinical Expertise ☒Met ☐Not Met

[See Minnesota Statutes, sections 62M.06, and subd. 3(f) and 62M.09]

(F) §438.406(b)(2) Opportunity to Present Evidence ☒Met ☐Not Met

(G) §438.406 (b)(3) Opportunity to examine the Case File
☒Met ☐Not Met

(H) §438.406 (b)(4) Parties to the Appeal ☒Met ☐Not Met

(I) §438.410 (b) Prohibition of Punitive Action ☒Met ☐Not Met

Sec. 8.4.6. Subsequent Appeals ☒Met ☐Not Met

Sec. 8.4.7. §438.408 (d)(2) and (e) Notice of Resolution of Appeals
☒Met ☐Not Met

(A) §438.408 (d)(2) and (e) Written Notice Content
☒Met ☐Not Met

(B) §438.210 (c) Appeals of UM Decisions ☒Met ☐Not Met

(C) §438.210 (c) and .408 (d)(2)(*ii*) Telephone Notification of Expedited Appeals
☒Met ☐Not Met

[Also see Minnesota Statutes section 62M.06, subd. 2]

(D) Unsuccessful appeal of UM determination ☒Met ☐Not Met

Sec. 8.4.8. §438.424 Reversed Appeal Resolutions
☒Met ☐Not Met

Sec. 8.4.5(F) 42 CFR section 438.406 (b)(2) (contract section 8.4.5 (F)), states the MCO must provide the enrollee a reasonable opportunity to present evidence and allegations of fact or law. In addition, for expedited appeal resolutions, the MCO must inform the Enrollee of the limited time available to present evidence in support of their appeal. The *Consumer Services Center—Blue Plus Public Programs Appeals Procedure* (page 3, #2a) states that when a request to expedite an appeal is granted, the CSC Liaison calls the enrollee to explain the right to submit evidence and inform the enrollee of the limited time available to present evidence in support of the appeal. Some amount of the 72 hours has already been used to determine if the appeal meets criteria for expediting. Blue Plus could better serve its enrollees by explaining enrollee rights and the limited timeframe to submit evidence at the time of the initial denial, particularly if the initial request for authorization was expedited. **(Recommendation #1)**

Section 8.5. §438.416 (c) Maintenance of Grievance and Appeal Records
☒Met ☐Not Met

Section 8.9. §438.416 (c) State Fair Hearings

Sec. 8.9.2. §438.408 (f) Standard Hearing Decisions ☒Met ☐Not Met

Sec. 8.9.5. §438.420 Continuation of Benefits Pending Resolution of State Fair Hearing
☒Met ☐Not Met

Sec. 8.9.6. §438.424 Compliance with State Fair Hearing Resolution
☒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

Subp. 2. Blue Plus conducts excellent evaluation of its enrollees' timely access to services through a number of factors, including timely availability of next appointments, call abandonment and time to phone answering, telephone care, returned calls, enrollee satisfaction, etc. Blue Plus identifies gaps and interventions, and evaluates timely access every six months.

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

UM System File Review	
File Source	**#Reviewed**
UM Denial Files	
Commercial	
Blue Plus	12
PrimeTherapeutics	30
MHCP-MC	
Blue Plus	8
Delta	8
PrimeTherapeutics	8
Subtotal	*66*
Clinical Appeal Files	
Commercial	8
MHCP-MC	
Blue Plus	8
Delta	10
Subtotal	*26*
Total	**92**

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 appeal) ☒Met ☐Not Met ☐NCQA

Subd. 3b. Expedited Review Determination ☐Met ☒Not Met ☐NCQA

Subd. 4. Failure to Provide Necessary Information ☒Met ☐Not Met

Subd. 5. Notifications to Claims Administrator ☒Met ☐Not Met

Subd. 3a. (d) Minnesota Statutes, section 62M.05, subdivision 3a(d), states when an initial determination is made not to certify, the written notification must inform the enrollee and the attending health care professional of the right to submit an appeal to the internal appeal process. In Prime Therapeutics (Blue Plus's pharmacy delegate) notification letters the appeal rights language has the necessary information, but the wording may be confusing to the enrollee. Blue Plus and Prime Therapeutics may want to restate the appeal rights language in its notification letters to be more understandable to the enrollee**. (Recommendation #2)**

Subd. 3b. Minnesota Statutes, section 62M.05, subdivision 3b(a), states an expedited initial determination must be utilized if the attending health care professional believes that an expedited determination is warranted. In one Prime Therapeutic UM denial file the physician had requested the determination to be expedited but the request was not processed as expedited.

Subd. 3b. Minnesota Statutes, section 62M.05, subdivision 3b(b), states in pertinent part, that when an expedited initial determination is made not to certify, the utilization review organization must notify the enrollee and the attending health care professional as expeditiously as the enrollee's medical condition requires, but no later than 72 hours. The HMO must also notify the enrollee of the right to submit an appeal to the expedited internal appeal as described in section 62M.06 and the procedure for initiating an internal expedited appeal. In the three expedited Prime Therapeutic (PTI) UM files reviewed, the provider was notified verbally of the denial and informed of the expedited appeal, however the enrollee was notified with a written notification sent by US mail. In order to better and more expeditiously serve the enrollee, PTI, when processing expedited utilization determinations should consider verbally informing the enrollee of the denial and the right to submit an expedited appeal. **(Recommendation #3)**

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

Subd. 1. Procedures for Appeal ☒Met ☐Not Met

Subd. 2. Expedited Appeal ☒Met ☐Not Met

Subd. 3. Standard Appeal

(a) Appeal resolution notice timeline ☒Met ☐Not Met

(b) Documentation requirements ☒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	

Subd. 3(g). Minnesota Statutes, section 62M.06, subdivision 3(g), states if the initial determination is not reversed on appeal, the utilization review organization must include in its notification the right to submit the appeal to the external review process described in section 62Q.73 and the procedure for initiating the external process. In two files where the denial was upheld upon appeal, the member was directed to the Department of Commerce rather than the Department of Health. Blue Plus, during internal audits, noted that the wrong letterhead or template was being used for the outcome notification letters. A corrective action plan was initiated and completed prior to opening the MDH Quality Assurance Examination. Subsequent audits showed compliance. MDH commends Blue Plus for identifying and correcting this issue.

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

(Commercial only) ☒Met ☐Not Met

VI. Recommendations

1. To better comply with 42 CFR section 438.406 (b)(2) (contract section 8.4.5 (F)), Blue Plus could explain enrollee rights and the limited timeframe to submit evidence for an expedited appeal at the time of the initial denial.

2. To better comply with Minnesota Statutes, section 62M.05, subdivision 3a(d), Blue Plus and Prime Therapeutics could improve the explanation of appeal rights on its notification letters to be more understandable to the enrollee.

3. To better comply with Minnesota Statutes, section 62M.05, subdivision 3b(b), Prime Therapeutics, Blue Plus's pharmacy delegate, when processing expedited utilization determinations, should consider verbally informing the enrollee of the denial and of the right to submit an expedited appeal.

VII. Mandatory Improvements

1. To comply with Minnesota Rules, part 4685.1110, subpart 6, Blue Plus and its delegate, Delta Dental, must revise the delegation agreement to include specific utilization review activities and oversight of the delegated utilization activities.

2. To comply with Minnesota Rules, part 4685.1110, subpart 6, Blue Plus and its care coordination delegates must revise the delegation documents as follows:

    - Consistently describe care coordination activities and responsibilities across contracts and guidelines.
    - Describe the process by which the organization evaluates the delegate's performance.
    - State what reports, if any are regularly required and/or to state what reporting is ad hoc.

3. To comply with 42 CFR section 438.402 (contract section 8), Blue Plus must revise its policy, CSC/GP-M-2011-012, *Blue Plus Public Programs Grievance Policy*, as follows:
    - Accurately state the timeframe for filing a grievance
    - Accurately state that <u>all</u> extensions of grievance timeframes must generate a written notice of extension, and
    - Accurately state that customer service will provide assistance in completing the grievance form and mail the form to the enrollee for signature.

VIII. Deficiencies

1. To comply with Minnesota Rules, part 4685.1110, subpart 6, Blue Plus must perform a credentialing file review of Delta providers to ensure that Delta correctly implements its credentialing standards.