DEPARTMENT OF HEALTH

Blue Plus

QUALITY ASSURANCE EXAMINATION - 2021

Date: August 2, 2023

Blue Plus Preliminary Report

For the Period: August 1, 2018 to June 30, 2021
Examiners: Elaine Johnson, RN, BS, CPHQ; Tom Major, MA, MDiv.;
Issue Date: August 2, 2023

Minnesota Department of Health
Managed Care Systems Section
PO Box 64882
St. Paul, MN 55164-0882
651-201-5100
health.mcs@state.mn.us
www.health.state.mn.us

As requested by Minnesota Statutes, Section 3.197: This report cost approximately $125.00 to prepare, including staff time, printing and mailing expenses.

Upon request, this material will be made available in an alternative format such as large print, Braille or audio recording. Printed on recycled paper.

MINNESOTA DEPARTMENT OF HEALTH
EXECUTIVE SUMMARY

The Minnesota Department of Health (MDH) conducted a Quality Assurance Examination of HMO Minnesota (dba "Blue Plus") to determine whether it is operating in accordance with Minnesota Law. Our mission is to protect, maintain and improve the health of all Minnesotans. 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 should:

- Blue Plus should take steps to ensure that enrollees are able to access the correct and current written complaint form on-line.

To address mandatory improvements, Blue Plus and its delegates must:

- Review its quality-of-care definition in all policies and processes, to be sure that the definition as it applies to Minnesota enrollees includes all required elements.
- Revise its complaint form to remove references to a specific, single Independent Review Organization in its references to the state external review process.
- Review its process for determining the type of specialty physicians that review specific types of medications to make the adverse determinations.
- Make sure that the Commissioner of Health is referenced in its utilization review enrollee correspondence.

To address deficiencies, Blue Plus and its delegates must:

- Review its Quality-of-Care complaint processes to ensure that notification timelines are met in all quality of care investigations.
- Ensure that complaint decision notifications include a statement of the right of the enrollee to file a complaint with the Minnesota Department of Health at any time, including the toll-free number for the department.

- Make reasonable efforts to provide prompt oral notice of an extension made to resolve a grievance pursuant to 42 CFR §438.408 (c) and DHS Contract section 8.2.3.1.

- Make reasonable efforts to provide prompt oral notice of an extension for the resolution of an appeal pursuant to 42 CFR §438.408 (c) and DHS Contract section 8.4.4.

- Send a written acknowledgment within ten (10) days of receiving the request for an appeal of a DTR action or any other MCO action pursuant to 42 CFR §438.406 (b)(1) and DHS Contract section 8.4.5.2.

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.

Signed on file

9/14/2023

Diane Rydrych, Director
Health Policy Division

Date

Contents

I. Introduction ... 6
II. Quality Program Administration ... 8
Program ... 8
Activities ... 9
Quality Evaluation Steps ... 10
Focused Study Steps ... 10
Filed Written Plan and Work Plan ... 10
III. Quality of Care ... 11
Quality of Care Complaints ... 11
IV. Complaint and Grievance Systems ... 12
Complaint Systems ... 12
Complaint Resolution ... 12
Appeal of the Complaint Decision ... 13
Notice to Enrollees ... 13
External Review of Adverse Determinations ... 13
Grievance System ... 14
General Requirements ... 14
Internal Grievance Process Requirements ... 15
Finding: Extension of Resolution of Grievances ... 15
DTR Notice of Action to Enrollees ... 16
Internal Appeals Process Requirements ... 17
State Fair Hearings ... 20
V. Access and Availability ... 20
Geographic Accessibility ... 20
Essential Community Providers ... 20
Availability and Accessibility ... 20
Emergency Services ... 21
Licensure of Medical Directors ... 21
Coverage of Nonformulary Drugs for Mental Illness and Emotional Disturbance ... 21
Coverage for Court-Ordered Mental Health Services ... 21
Continuity of Care ... 21

VI. Utilization Review 22
Standards for Utilization Review Performance 22
Procedures for Review Determination 22
Appeals of Determinations Not to Certify 23
Confidentiality 25
Staff and Program Qualifications 25
Complaints to Commerce or Health 26
Prohibition of Inappropriate Incentives 26
VII. Summary of Findings 27
Recommendations 27
Mandatory Improvements 27
Deficiencies 27

I. Introduction

1. History: Founded in 1974, Blue Plus, a subsidiary of Blue Cross and Blue Shield of Minnesota (Blue Cross), is a Minnesota nonprofit licensed health maintenance organization (HMO) that offers health plans and networks throughout Minnesota to individuals and groups through contracted networks of health care providers. Aware Integrated, Inc., a Minnesota nonprofit corporation, is the parent holding company of Blue Cross. The Blue Plus Board of Directors, consisting of forty percent enrollee elected directors, oversees Blue Plus. In addition to offering a range of commercial products, Blue Plus currently contracts with both the Centers for Medicare & Medicaid Services (CMS) and the Minnesota Department of Human Services (DHS) to provide the benefits of both Medicare and the Minnesota Medical Assistance (Medicaid) program to enrollees. This program is also known as the Minnesota Senior Health Options (MSHO) program. Blue Plus also contracts with DHS to deliver and administer Minnesota Senior Care Plus and also contracts with DHS to deliver and administer MinnesotaCare and the Prepaid Medical Assistance Program (PMAP).

2. Membership: Blue Plus self-reported Minnesota enrollment as of June 30, 2021 consisted of the following:

Self-Reported Enrollment

Product	Enrollment
Fully Insured Commercial	
Large Group	4
Small Employer Group	5982
Individual	33139
Minnesota Health Care Programs – Managed Care (MHCP-MC)	
Families & Children	374829
MinnesotaCare	33391
Minnesota Senior Care (MSC+)	4444
Minnesota Senior Health Options (MSHO)	8306
Special Needs Basic Care	0
Total	460,095

3. Virtual Onsite Examination Dates: September 20, 2021 to September 24, 2021,

4. Examination Period: August 1, 2018 to June 30, 2021
   File Review Period: August 1, 2020 to June 30, 2021
   Commercial UM Denial Files: January 1, 2021, to June 30, 2021

   Opening Date: June 23, 2021

5. National Committee for Quality Assurance (NCQA)**:** Blue Plus is accredited by NCQA for its Exchange PPO and Medicaid HMO products based on 2020 NCQA standards. The Minnesota Department of Health (MDH) evaluated and used results of the NCQA review in one of three ways:

    a. If NCQA standards do not exist or are not as stringent as Minnesota law, the accreditation results were not used in the MDH examination process [No NCQA checkbox].

    b. 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 ☐].

    c. If the NCQA standard was the same or more stringent than Minnesota law, but the plan was accredited with less than 100% of the possible points or MDH identified an opportunity for improvement, MDH conducted its own examination.

6. 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.

7. 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 has sufficient evidence that a plan’s overall operation is compliant with an applicable law. Sufficient evidence may be obtained through:

    1) file review;
    2) policies and procedures; and
    3) interviews.

II. Quality Program Administration

Program

Minnesota Rules, Part 4685.1110

Subparts	Subject	Met	Not Met	NCQA
Subp. 1.	Written Quality Assurance Plan	☒Met	☐ Not Met	
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	

Finding: Delegated Activities

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 and processes 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	QOC	Complaints/ Grievances	Appeals	Cred	Claims	Disease Mgmt	Network	Care Coord
Prime Therapeutics, LLC (Prime)	x	x	x	x	x	x		x	

Entity	UM	QOC	Complaints/ Grievances	Appeals	Cred	Claims	Disease Mgmt	Network	Care Coord
Amerigroup Partnership Plan (AGP) - MHCP only	x		x	x		x			x
Delta Dental of MN (DDMN) MHCP Only	x	x	x	x	x			x	
Secure Care (Chiro and PT) Comm and MHCP		x			x			x	
Winona health Services					x				
Cass County									x
Le Sueur County									x
Lake Region Health Care Clinic									x

MDH Post Exam note: Blue Plus implemented a corrective action plan with Delta Dental - Minnesota (DDMN) in October 2021 and updated it in February 2022. The CAP addressed the DDMN deficiencies identified in the exam. The cap included increased monitoring by both Blue Plus and DDMN as well as increased reporting and regularly scheduled meetings.

Finding: Provider Selection and Credentialing

Subp. 11**.** Minnesota Rules, part 4685.1110, subpart 11, states the plan must have policies and procedures for provider selection, credentialing and recredentialing that, at a minimum, are consistent with community standards. MDH recognizes the community standard to be NCQA. Blue Plus scored 100% on all 2020 NCQA Credentialing/recredentialing standards.

Activities

Minnesota Rules, Part 4685.1115

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

Quality Evaluation Steps

Minnesota Rules, Part 4685.1120

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

Focused Study Steps

Minnesota Rules, Part 4685.1125

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

Filed Written Plan and Work Plan

Minnesota Rules, Part 4685.1130

Subparts	Subject	Met	Not Met
Subp. 1.	Written Plan	☒Met	☐ Not Met
Subp. 2.	Work Plan	☒Met	☐ Not Met
Subp. 3.	Amendments to Plan	☒Met	☐ Not Met

Finding: Amendments to Written Plan (Program Description)

Subp. 1and 3. Minnesota Rules, part 4685.1130, subparts 1 and 3, require HMOs have a written quality plan (quality program description) that is consistent with the requirements set forth in Minnesota Rules, 4685.1110, subparts 1 through 13. The written quality plan must be submitted to MDH for approval with any changes/revisions.

MDH reviewed Blue Plus's Quality Improvement Program Description 2021 during the exam, and it was found to have met all the criteria of Minnesota Rules, 4685.1110, subparts 1 through 13 and was subsequently approved.

III. Quality of Care

MDH reviewed a total of 39 quality of care grievance and complaint system files.

Quality of Care File Review

File Source	# Reviewed
Quality of Care	
MHCP Grievances	24
Commercial Complaints	15
Total	**39**

Quality of Care Complaints

Minnesota Statutes, Section 62D.115

Subparts	Subject	Met	Not Met
Subd. 1.	Definition	☐Met	☒ Not Met
Subd. 2.	Quality of Care Investigations	☐Met	☒ Not Met

Finding: Quality of Care Complaints

Subd. 1 Minnesota Statutes, Section 62D.115, Subdivision 1, defines a "quality of care complaint" as an "an expressed dissatisfaction regarding health care services resulting in potential or actual harm to an enrollee."

The Blue Plus quality of care policy definition does not provide specificity to define a quality-of-care complaint under Minnesota law. Blue Plus must review its quality-of-care definition in all policies and processes, to be sure that the definition as it applies to Minnesota enrollees includes all elements of MN Statutes, § 62D.115, Subd. 1. (**Mandatory Improvement #1).**

In our review of Blue Plus Quality of Care complaint files, MDH found two (2) files in which the acknowledgement notification to the enrollee exceeded ten (10) calendar days. Blue Plus must review its Quality-of-Care complaint processes to ensure that notification timelines are met in all quality of care investigations, pursuant to MN Statutes, § 62D.115, Subd. 2 and § 62Q.69, Subd. 2. (**Deficiency #1).**

IV. Complaint and Grievance Systems

Complaint Systems

MDH examined Blue Plus' fully-insured commercial complaint system for compliance with complaint resolution requirements of Minnesota Statutes, Chapter 62Q.69 through 62Q.73. Our review of Blue Plus policies and procedures as they apply to complaints, non-clinical appeals, and external appeal processes to be compliant.

Complaint System File Review

File Source	# Reviewed
Complaint Files	
Blue Plus Written and Oral	30
Non-Clinical Appeals	9
Total	*39*

Complaint Resolution

Minnesota Statutes, Section 62Q.69.

Section	Subject	Met	Not Met
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

Finding: Complaint Form

<u>MN Stats. 62Q.69 Subd. 2</u>

External appeal rights are documented in the Blue Plus written complaint form, but these appeal rights incorrectly state that external appeal will be handled by one specific contracted Independent Review Organization (IRO). This incorrectly states how the external review process is managed by MDH, pursuant to §62Q.73. Blue Plus must revise its complaint form to remove references to a specific, single IRO in its references to the state external review process pursuant to §62Q.73. **(Mandatory Improvement #2)**

MDH found in some Blue Plus written complaint forms submitted by enrollees, the form includes a statement of the right to file a complaint with the Minnesota Department of Commerce, rather than the Minnesota Department of Health. However, the Blue Plus current

written complaint form includes a statement of the right to file a complaint with the Minnesota Department of Health, and the toll-free number for contacting MDH. Discussion during the examination process indicated that some enrollees had accessed an older incorrect complaint form on-line for submission of their written complaint. Blue Plus should take steps to ensure that enrollees are able to access the correct and current written complaint form on-line. **(Recommendation #1)**

Finding: Notification of Complaint Decision

Subd. 3.

During file review, MDH found two (2) files where the notification of the complaint decision did not include a statement of the right of the enrollee to file a complaint with the Minnesota Department of Health. Pursuant to Minnesota Statutes, §62Q.69, Subd. 3 (d), Blue Plus must ensure that complaint decision notifications include a statement of the right of the enrollee to file a complaint with the Minnesota Department of Health at any time, including the toll-free number for the department. **(Deficiency #2.)**

Appeal of the Complaint Decision

Minnesota Statutes, Section 62Q.70

Section	Subject	Met	Not Met
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

Notice to Enrollees

Minnesota Statutes, Section 62Q.71

Section	Subject	Met	Not Met
62Q.71.	Notice to Enrollees	☒ Met	☐ Not Met

External Review of Adverse Determinations

Minnesota Statutes, Section 62Q.73

Section	Subject	Met	Not Met
Subd. 3.	Right to External Review	☒ Met	☐ Not Met

Grievance System

MDH examined Blue Plus' Minnesota Health Care Programs Managed Care Programs – Managed Care (MHCP-MC) grievance system for compliance with the federal law (42 CFR 438, subpart F) and the DHS 2020 Contract, Article 8.

MDH reviewed a total of 90 grievance system files, 50 UM Denials (MHCP Denial, Terminations, Reductions), 42 Clinical Appeals, 60 non-clinical appeals, and 11 State Fair Hearing files.

Grievance System File Review

File Source	# Reviewed
Grievances	
AGP	30
Delta	30
Prime Therapeutics	30
DTRs	
AGP	8
Delta	30
Prime Therapeutics	12
Clinical Appeals	
AGP	
Delta	30
Prime Therapeutics	12
Non-Clinical Appeals	
AGP	30
Delta Dental	30
State Fair Hearing	
Delta	11
Total	253

General Requirements

DHS Contract, Section 8.1

Section	42 CFR	Subject	Met	Not Met
Section 8.1.	§438.402	General Requirements		

Section	42 CFR	Subject	Met	Not Met
Sec. 8.1.1.		Components of Grievance System	☒Met	☐ Not Met

Internal Grievance Process Requirements

DHS Contract, Section 8.2

Section	42 CFR	Subject	Met	Not Met
Section 8.2.	§438.408	Internal Grievance Process Requirements		
Section 8.2.1.	§438.402 (c)	Filing Requirements	☒Met	☐ Not Met
Section 8.2.2.	§438.408 (b)(1), (d)(1)	Timeframe for Resolution of Grievances	☒Met	☐ Not Met
Section 8.2.3.	§438.408 (c)	Timeframe for Extension of Resolution of Grievances	☐Met	☒ Not Met
Section 8.2.4.	§438.406	Handling of Grievances		
8.2.4.1	§438.406 (b)(1)	Written Acknowledgement	☒Met	☐ Not Met
8.2.4.2	§438.416	Log of Grievances	☒Met	☐ Not Met
8.2.4.3	§438.402 (c)(3)	Oral or Written Grievances	☒Met	☐ Not Met
8.2.4.4	§438.406 (a)	Reasonable Assistance	☒Met	☐ Not Met
8.2.4.5	§438.406 (b)(2)(i)	Individual Making Decision	☒Met	☐ Not Met
8.2.4.6	§438.406 (b)(2)(ii)	Appropriate Clinical Expertise	☒Met	☐ Not Met
Section 8.2.5.	§438.408 (d)(1)	Notice of Disposition of a Grievance		
8.2.5.1	§438.404 (b) §438.406 (a)	Oral Grievances	☒Met	☐ Not Met
8.2.5.2	§438.404 (a), (b)	Written Grievances	☒Met	☐ Not Met

Finding: Filing Requirements

Section 8.2.1 42 CFR §438.402 (c) (DHS Contract section 8.2.1), states the Enrollee, or the Provider acting on behalf of the Enrollee with the Enrollee's written consent, may file a Grievance on a matter regarding an Enrollee's dissatisfaction about any matter other than an MCO Action.

One AmeriGroup (AGP) file, labeled as a grievance was in response to a prior authorization. This case should have been handled as a non-clinical appeal.

Finding: Extension of Resolution of Grievances

Section 8.2.3. 42 CFR §438.408 (c)(2) (DHS Contract section 8.2.3), states the MCO must make reasonable efforts to provide prompt oral notice and provide written notice within two (2) calendar days to the enrollee of the reason for the decision to extend the timeframe if the MCO determines that an extension is necessary.

In one Delta Dental grievance file and one Prime Therapeutics grievance file, there was no evidence of reasonable efforts to provide prompt oral notice of the extension. Prime Therapeutics had not provided this prompt oral notice of extension since it began reviewing grievances in January 2019. Prime Therapeutics began to implement the requirements for prompt oral notification of an extension in September 2021 in response to this finding.

Therefore, MDH finds that Blue Plus and its delegates must make reasonable efforts to provide prompt oral notice of an extension made to resolve a grievance pursuant to 42 CFR §438.408 (c)(2) and DHS contract, section 8.2.3.1. **(Deficiency #3)**

MDH Post Exam note: Blue Plus implemented a corrective action plan in October 2021 and updated it in February 2022. The CAP addressed deficiencies identified in the exam. The cap included increased monitoring by both Blue Plus and its delegates as well as increased reporting and regularly scheduled meetings.

DTR Notice of Action to Enrollees

DHS Contract, Section 8.3

Section	42 CFR	Subject	Met	Not Met
Section 8.3.	§438.10 §438.404	DTR Notice of Action to Enrollees		
Section 8.3.1.	§438.10(c), (d) §438.402(c) §438.404(b)	General Requirements	☒Met	☐ Not Met
Section 8.3.2	§438.402 (c), §438.404 (b)	Content of DTR Notice of Action	☒Met	☐ Not Met
8.3.2.1	§438.404	Notice to Provider	☒Met	☐ Not Met
Section 8.3.3.	§438.404 (c)	Timing of DTR Notice		
8.3.3.1	§431.211	Previously Authorized Services	☒Met	☐ Not Met
8.3.3.2	§438.404 (c)(2)	Denials of Payment	☒Met	☐ Not Met
8.3.3.3	§438.210 (c)(d)	Standard Authorizations		
(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
8.3.3.4	§438.210 (d)(2)(i)	Expedited Authorizations	☒Met	☐ Not Met
8.3.3.5	§438.210 (d)(1)	Extensions of Time	☒Met	☐ Not Met
8.3.3.6	§438.210(d)(3) and 42 USC 1396r-8(d)(5)	Covered Outpatient Drug Decisions	☒Met	☐ Not Met

Section	42 CFR	Subject	Met	Not Met
8.3.3.7	§438.210 (d)(1)	Delay in Authorizations	☒Met	☐ Not Met

Finding: Telephone or Fax Notice Within One Working Day after Making the Determination

8.3.3.3(2) 42 CFR §438.210 (c),(d) (DHS Contract section 8.3.3.3(2), states MCO must provide notice to the attending Provider and hospital by telephone or fax within one business day after making the determination.

Initial review of DeltaDental notice of DTR action processed prior to June 14, 2021 indicated five (5) files with no telephone/fax notice within one business day after making determination. DDMN had instituted an improvement initiative on June 14, 2021. After June 14, 2021, all UM decisions, both benefit and service received an oral notice within one working day. Additional files were reviewed from DDMN, and all prior authorization decisions had an oral notice to the provider.

Finding: Notification Letters

Sec. 8.3.3.3(3) 42 CFR §438.210 (c),(d) DHS Contract section 8.3.3.3(3), states MCO must provide the notice to the attending provider, enrollee and hospital, in writing, and the notice must include the process to initiate an appeal, within ten (10) business days following receipt of the request for the service

Review of Delta Dental – Minnesota (DDMN), Denial, Termination or Reduction (DTR) files indicated 3 files where the written notice stated "We are unable to process this claim because the submitted billing NPI does not match the billing .... A licensed dentist has reviewed this request." DDMN and Blue Plus identified that the letters were issued as part of a manual fix for notification letters. Due to the requirement of issuing notification to the provider, Delta Dental expanded their process to issue administrative denial letters. As part of this manual process, the letter included the correct administrative denial information which was on a templated letter. This template included denial rationale based on the initial request information, including that a dentist had reviewed the case, which is not accurate. These letters were only in production from June 14-30, 2021. Beginning July 1, 2021 the denial notification was automated to only include the specific information related to the denial. The letters after July 1 would include appropriate denial rationale for either an administrative denial or a clinical denial.

Internal Appeals Process Requirements

DHS Contract, Section 8.4

Section	42 CFR	Subject	Met	Not Met
Section 8.4.	§438.404	Internal Appeals Process Requirements		

Section	42 CFR	Subject	Met	Not Met
Sec. 8.4.1.	§438.402 (b)	One Level Appeal	☒Met	☐ Not Met
Sec. 8.4.2.	§438.408 (b)	Filing Requirements	☒Met	☐ Not Met
Sec. 8.4.3.	§438.408	Timeframe for Resolution of Appeals		
8.4.3.1	§438.408 (b)(2)	Standard Appeals	☒Met	☐ Not Met
8.4.3.2	§438.408 (b)(3)	Expedited Appeals	☒Met	☐ Not Met
8.4.3.3	§438.408 (c)(3)	Deemed Exhaustion	☒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		
8.4.5.1	§438.406 (b)(3)	Oral Inquiries	☒Met	☐ Not Met
8.4.5.2	§438.406 (b)(1)	Written Acknowledgment	☐Met	☒ Not Met
8.4.5.3	§438.406 (a)	Reasonable Assistance	☒Met	☐ Not Met
8.4.5.4	§438.406 (b)(2)	Individual Making Decision	☒Met	☐ Not Met
8.4.5.5	§438.406 (b)(2)	Appropriate Clinical Expertise (See Minnesota Statutes, sections 62M.06, and subd. 3(f) and 62M.09	☒Met	☐ Not Met
8.4.5.6	§438.406 (b)(4)	Opportunity to Present Evidence	☒Met	☐ Not Met
8.4.5.7	§438.406 (b)(5)	Opportunity to Examine the Care File	☒Met	☐ Not Met
8.4.5.8	§438.406 (b)(6)	Parties to the Appeal	☒Met	☐ Not Met
8.4.5.9	§438.410 (b)	Prohibition of Punitive Action Subsequent Appeals	☒Met	☐ Not Met
Sec. 8.4.6.		Subsequent Appeals		
Sec. 8.4.7.	§438.408 (d)(2)	Notice of Resolution of Appeals		
8.4.7.1	§438.408 (d)(2)	Written Notice Content	☒Met	☐ Not Met
8.4.7.2	§438.210 (c)	Appeals of UM Decisions	☒Met	☐ Not Met
8.4.7.3	§438.410 (c) and .408 (d)(2)(ii)	Telephone Notification of Expedited Appeals (Also see Minnesota Statutes section 62M.06, subd.2)	☒Met	☐ Not Met
Sec. 8.4.8.	§438.424	Reversed Appeal Resolutions	☒Met	☐ Not Met
Sec. 8.5.	§438.420 (b)	Continuation of Benefits Pending Appeal or State Fair Hearing	☒Met	☐ Not Met

Finding: Timeframe for Resolution of Appeals

Sec. 8.4.3. 42 CFR §438.408 (DHS Contract section 8.4.3), states that the MCO must resolve each appeal as expeditiously as enrollee's health requires, not to exceed thirty (30) days after receipt of the Appeal.

AGP non-clinical file review indicated one file that exceed the 30 day requirement (43 days).

Finding: Timeframe for Extension of Resolution of Appeals

Sec. 8.4.4. 42 CFR §438.408 (c)(2) (DHS Contract section 8.4.4.). DHS Contract section 8.4.4. states that the MCO must make reasonable efforts to provide prompt oral notice and provide

written notice within two (2) calendar days to the Enrollee of the reason for the decision to extend the timeframe if the MCO determines that an extension is necessary.

During its review of clinical and non-clinical appeals files, MDH found five (5) instances where there was no evidence of reasonable efforts to provide prompt oral notice of the MCO's extension of an appeal determination decision.

Therefore, MDH finds that Blue Plus and its delegates must make reasonable efforts to provide prompt oral notice of the extension for the resolution of an appeal pursuant to 42 CFR §438.408 (c) and the DHS contract, section 8.4.4. **(Deficiency #4)**

Finding: Written Acknowledgment

8.4.5.2 42 CFR §438.406 (b)(1) (DHS Contract section 8.4.5.2) states the MCO must send a written acknowledgment within ten (10) days of receiving the request for an appeal of a DTR action.

MDH review of DeltaDental appeal files indicated 4 files with acknowledgement letters that exceed the 10-day requirement.

Therefore, MDH finds that Blue Plus delegate, DeltaDental of Minnesota, must send a written acknowledgment within ten (10) days of receiving the request for an Appeal of a DTR action or any other MCO action pursuant to 42 CFR §438.406 (b)(1) and the DHS Contract, section 8.4.5.2. **(Deficiency #5)**

State Fair Hearings

DHS Contract, Section 8.8

Section	42 CFR	Subject	Met	Not Met
Section 8.8.	§438.416 (c)	State Fair Hearings		
Sec. 8.8.2.	§438.408 (f)	Standard Hearing Decisions	☒Met	☐ Not Met
Sec. 8.8.5.	§438.424	Compliance with State Fair Hearing Resolution	☒Met	☐ Not Met

V. Access and Availability

Geographic Accessibility

Minnesota Statutes, Section 62D.124

Subdivision	Subject	Met	Not Met
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

Essential Community Providers

Minnesota Statutes, Section 62Q.19

Subdivision	Subject	Met	Not Met
Subd. 3.	Contract with Essential Community Providers	☒Met	☐ Not Met

Availability and Accessibility

Minnesota Rules, Part 4685.1010

Subparts	Subject	Met	Not Met
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

Emergency Services

Minnesota Statutes, Section 62Q.55

Subdivision	Subject	Met	Not Met
Subd. 1.	Access to Emergency Services	☒Met	☐ Not Met
Subd. 2.	Emergency Medical Condition	☒Met	☐ Not Met

Licensure of Medical Directors

Minnesota Statutes, Section 62Q.121

Section	Subject	Met	Not Met
62Q.121.	Licensure of Medical Directors	☒Met	☐ Not Met

Coverage of Nonformulary Drugs for Mental Illness and Emotional Disturbance

Minnesota Statutes, Section 62Q.527.

Subdivision	Subject	Met	Not Met
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

Coverage for Court-Ordered Mental Health Services

Minnesota Statutes, Section 62Q.535

Subdivision	Subject	Met	Not Met
Subd. 2.	Coverage required	☒Met	☐ Not Met

Continuity of Care

Minnesota Statutes, Section 62Q.56

Subdivision	Subject	Met	Not Met	N/A
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	☐

Subdivision	Subject	Met	Not Met	N/A
Subd. 1b.	Change in health care provider, termination for cause	☒Met	☐ Not Met	☐
Subd. 2.	Change in health plans (applies to group, continuation and conversion coverage)	☒Met	☐ Not Met	☐ N/A

VI. Utilization Review

MDH examined Blue Plus's utilization review (UR) system under Minnesota Statutes, chapter 62M. A total of 42 utilization review files were reviewed.

UR System File Review

File Source	# Reviewed
Commercial UM Denial Files	
Blue Plus	12
Prime	30
Commercial Clinical Appeal Files	
Blue Plus	30
Total	42

Standards for Utilization Review Performance

Minnesota Statutes, Section 62M.04

Subdivision	Subject	Met	Not Met
Subd. 1.	Responsibility on Obtaining Certification	☒Met	☐ Not Met
Subd. 2.	Information upon which Utilization Review is Conducted	☒Met	☐ Not Met

Procedures for Review Determination

Minnesota Statutes, Section 62M.05

Subdivision	Subject	Met	Not Met	NCQA
Subd. 1.	Written Procedures	☒Met	☐ Not Met	

Subdivision	Subject	Met	Not Met	NCQA
Subd. 2.	Concurrent Review	☐Met	☐ Not Met	☒ NCQA
Subd. 3.	Notification of Determination	☒Met	☐ Not Met	
Subd. 3a.	Standard Review Determination	☒Met	☐ Not Met	
(a)	Initial determination to certify or not (10 business days)	☒Met	☐ Not Met	☐ NCQA
(b)	Initial determination to certify (telephone notification)	☒Met	☐ Not Met	
(c)	Initial determination not to certify (notice within 1 working day)	☒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	

Appeals of Determinations Not to Certify

Minnesota Statutes, Section 62M.06

Subdivision	Subject	Met	Not Met
Subd. 1.	Procedures for Appeal	☐Met	☒ Not Met
Subd. 2.	Expedited Appeal	☒Met	☐ Not Met
Subd. 3.	Standard Appeal		
(a)	Procedures for appeals written and telephone	☒Met	☐ Not Met
(b)	Appeal resolution notice timeline	☒Met	☐ Not Met
(c)	Documentation requirements	☒Met	☐ Not Met
(d)	Review by a different physician	☒Met	☐ Not Met
(e)	Defined time period in which to file appeal	☒Met	☐ Not Met
(f)	Unsuccessful appeal to reverse determination	☒Met	☐ Not Met
(g)	Same or similar specialty review	☒Met	☐ Not Met
(h)	Notice of rights to external review	☒Met	☐ Not Met
Subd. 4.	Notifications to Claims Administrator	☒Met	☐ Not Met

Finding: Appeal resolution notice timeline

Subd. 3. Minnesota Statutes, section 62M.06, subdivision 3(b) states a utilization review organization shall notify in writing the enrollee, attending health care professional, and claims administrator of its determination on the appeal within 15 days after receipt of the notice of appeal.

One clinical appeal exceeded the 15-day requirement for the determination. Blue Plus stated the case originally closed in 3 days but was later audited by the clinical team where it was identified that the original reviewer was the same person who reviewed the initial appeal. The case was reopened and overturned to allow per state requirement

Finding: Rights to External Review

Subd. 3(h). Minnesota Statutes 62M.06, subdivision 3(h) states if the adverse 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.

One Blue Plus clinical appeal file went to external review and the independent reviewer (MCMC) states "has determined that this appeal request does not involve medical judgement and is an ineligible appeal. Therefore, we are unable to perform the requested appeal review." The Blue Plus letter in the file states: designated Independent Review Organization (IRO) completed their review and decided to uphold our decision. Notice of this decision was sent directly to you by the IRO. Blue Plus determined the Case not handled correctly by IRO and Liaison.

Confidentiality

Minnesota Statutes, Section 62M.08

Subdivision	Subject	Met	Not Met
Subd. 1.	Written Procedures to Ensure Confidentiality	☒Met	☐ Not Met

Staff and Program Qualifications

Minnesota Statutes, Section 62M.09

Subdivision	Subject	Met	Not Met	NCQA
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

Finding: Physician Reviewer Involvement

Subd. 3. Minnesota Statutes, section 62M.09, subdivision 3, states the physician conducting the review and making the adverse determination must have the same or similar medical specialty as a provider that typically treats or manages the condition for which the health care service has been requested. Notwithstanding paragraph (a), a review of an adverse determination involving a prescription drug must be conducted by a licensed pharmacist or physician who is competent to evaluate the specific clinical issues presented in the review.

Blue Plus process is to require its pharmacy benefits manager, Prime Therapeutics, LLC ("Prime") to utilize licensed pharmacists to review all initial adverse pharmacy determinations. Blue Plus also requires Prime to provide that a secondary review of all adverse pharmacy determinations be performed by a physician. This is consistent with NCQA requirements. These requirements apply to both commercial and Minnesota Health Care Program (MHCP) lines of business. These reviews are conducted by the Medical Review Institute of America (MRIoA), a national clinical utilization review organization consisting of board-certified physicians. MRIoA randomly assigns physicians for the review. Specific to MHCP, Prime has advised that MRIoA

has created a comprehensive proprietary drug list that details which drugs require a specialty review. A proprietary drug list for the Commercial pharmacy specialty review is not in place.

MDH, after internal discussions and a meeting with Blue Plus, determined that since Blue Plus utilizes a physician reviewer for a secondary review on pharmacy adverse determinations, that physician reviewer must be “competent to evaluate the specific clinical issues presented in the review”. MDH is not prescriptive as to what specialist is appropriate for review of specific types of medication adverse determinations, however that physician must meet the requirement of “competent to evaluate the specific clinical issues presented in the review”.

Therefore, MDH finds that Blue Plus must review its process for determining the type of specialty physicians that review specific types of medications to make the adverse determinations. **(Mandatory Improvement #3)** Blue Plus may want to investigate, in coordination with Prime, generating a comprehensive medication list that details which medications require a specialty match, similar to what has been developed for the MHCP.

Complaints to Commerce or Health

Minnesota Statutes, Section 62M.11

Section	Subject	Met	Not Met
62M.11.	Complaints to Commerce or Health	☐Met	☒ Not Met

Finding: Complaints to Department of Health

Minnesota Statutes 62M.11, states an enrollee may file a complaint regarding an adverse determination directly to the commissioner responsible for regulating the utilization review organization. Most notifications of adverse determinations properly reference the right to submit a complaint to the Commissioner of Health. In some cases, process errors resulted in notifications referring to the Commissioner of Commerce. Therefore, MDH finds that Blue Plus must ensure that the Commissioner of Health is referenced in its utilization review notifications of adverse determination. **(Mandatory Improvement #4)**

Prohibition of Inappropriate Incentives

Minnesota Statutes, Section 62M.12

Section	Subject	Met	Not Met	NCQA
62M.12.	Prohibition of Inappropriate Incentives	☐Met	☐ Not Met	☒NCQA

VII. Summary of Findings

Recommendations

1. Blue Plus should take steps to ensure that enrollees are able to access the correct and current written complaint form on-line, pursuant to MN Statutes, § 62Q.69, Subd. 2.

Mandatory Improvements

1. To comply with MN Statutes, § 62D.115, Subd. 1, Blue Plus must review its quality of care definition in all policies and processes, to be sure that the definition as it applies to Minnesota enrollees includes all required elements.

2. To comply with MN Statutes, § 62Q.69, Subd. 2, Blue Plus must revise its complaint form to remove references to a specific, single IRO in its references to the state external review process pursuant to §62Q.73.

3. To comply with MN Statutes, § 62M.09, Subd. 3, Blue Plus must review its process for determining the type of specialty physicians that review specific types of medications to make the adverse determinations.

4. To comply with MN Statutes, §62M.11, Blue Plus must ensure that the Commissioner of Health is referenced in its utilization review notifications of adverse determination.

Deficiencies

1. To comply with MN Statutes, § 62D.115, Subd. 2 and § 62Q.69, Subd. 2, Blue Plus must review its Quality-of-Care complaint processes to ensure that notification timelines are met in all quality of care investigations.

2. To comply with MN Statutes, §62Q.69, Subd. 3 (d), Blue Plus must ensure that complaint decision notifications include a statement of the right of the enrollee to file a complaint with the Minnesota Department of Health at any time, including the toll-free number for the department.

3. To comply with 42 CFR §438.408 (c) and DHS Contract section 8.2.3.1, Blue Plus and its delegates must make reasonable efforts to provide prompt oral notice of an extension made to resolve a grievance.

4. To comply with 42 CFR §438.408 (c) and DHS Contract section 8.4.4., Blue Plus and its delegates must make reasonable efforts to provide prompt oral notice of an extension for the resolution of an appeal.

5. To comply with 42 CFR §438.406 (b)(1) and DHS Contract section 8.4.5.2, Blue Plus and its delegate, Delta Dental of Minnesota, must send a written acknowledgment within ten (10) days of receiving the request for an Appeal of a DTR action or any other MCO action.