

Minnesota Department of Health
Compliance Monitoring Division
Managed Care Systems Section



Final Report

Medica Health Plans

Quality Assurance Examination
For the Period:
June 1, 2009 to December 31, 2011

Final Issue Date:
Tuesday, July 31, 2012

Examiners
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Minnesota Department of Health Executive Summary

The Minnesota Department of Health (MDH) conducted a Quality Assurance Examination of Medica Health Plans 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 Medica 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, Medica and its delegates should:

Consider including the oversight summaries of all the delegates’ functions in the delegates’ assessment reports.

Consider adding to the documentation of the telephonic peer to peer review done by Medica Behavioral Health, that expedited appeal rights were offered.

To address mandatory improvements, Medica must:

Describe in the Elderly Waiver care coordination delegation agreements the process by which the organization evaluates the delegated entity's performance.

Revise complaint system policies/procedures to ensure complaint system definitions, actual processes and file universes are consistent with definitions in Minnesota Statutes, section 62Q.68 through .70.

Revise its policies, *Fully Insured Complaints* and *Written Complaints*, to ensure that acknowledgement letter timelines are consistent with Minnesota law and across policies/procedures.

Revise its policy *Clinical Appeals: State Public Programs (CA021P)* to include the following regarding State Fair Hearings:

- The MCO shall respond with the following information about an Appeal within one working day of receiving the request from the State Fair Hearing Office:
 - a) Whether an appeal was filed with an MCO;
 - b) The date the appeal was filed;
 - c) The resolution of the appeal;
 - d) The date it was resolved; and

- The MCO shall notify the state and the State Fair Hearing Office of changes to the name or phone number of the contact within one working day of any change

Revise its policies/procedures CM104P, *Turnaround Times for Medical Necessity Reviews*, as follows:

- Replace the extension of initial UM determination timelines for delays beyond Medica's control with an extension only in the event Medica does not have enough information to make a determination, consistent with Minnesota Statutes, section 62M.05, subdivision 3a(a).
- Ensure a servicing or referring provider is defined consistent with "attending health care professional," consistent with Minnesota Statutes, section 62M.05, subdivision 3a(c).

To address deficiencies, Medica and its delegates must:

Perform an annual substantive evaluation of all delegated activities for MedImpact.

Offer the enrollee a written complaint form, including all the rights afforded the enrollee under Minnesota law, and assistance in completing the complaint form if an oral complaint is not resolved to the satisfaction of the enrollee.

Resolve oral complaints within ten calendar days.

Revise its practices to ensure that the enrollee is accurately advised of the enrollee's right to file a complaint with Commissioner of Health at any time. Medica also must ensure those enrollees potentially eligible for external review are accurately notified of their right and the procedures for initiating the process through the Minnesota Department of Health. Because this is the same issue identified in the last two MDH Quality Exams (final reports dated January 10, 2007, and September 30, 2009), this is, again, a repeat deficiency.

For standard authorization decisions that deny or limit services, provide the notice to the provider and enrollee within ten business days.

Revise policies/procedures to ensure all urgent care is available within 24 hours. In addition, Medica and its delegates must survey provider timely availability against the correct standard.

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:

Medica Health Plans (Medica) is a not-for-profit, open access health maintenance organization (HMO) that provides health coverage in the state of Minnesota by serving approximately 295,000 HMO members through individual policies, employer based plans, and government programs. Medica was founded by physicians and began operations in January 1975 as Physicians Health Plan (PHP). It was Minnesota's first open-access health plan. In 1991, PHP merged with Share to become Medica. In 1994, Medica and HealthSpan merged to form Allina Health System. Medica separated from Allina and became an independent company in 2001.

Medica has the highest accreditation status, Excellent, from the National Committee for Quality Assurance (NCQA®). NCQA's 2011 – 2012 Health Insurance Plan Rankings for Medicaid plans have ranked Medica as the #11 Medicaid HMO plan in the United States. In addition, Medica was the highest ranked HMO Medicaid plan in Minnesota.

B. Membership:

Medica's self-reported enrollment as of December 31, 2011 consisted of the following:

Product	Enrollment
<i>Fully Insured Commercial</i>	
Large Group	12949
Small Employer Group	167
Individual	669
<i>Minnesota Health Care Programs- Managed Care (MHSP-MC)</i>	
Families & Children	114781
MinnesotaCare	33307
Minnesota Senior Care (MSC+)	2851
Minnesota Senior Health Options (MSHO)	9910
Special Needs Basic Care (SNBC)	2220
<i>Medicare</i>	
Medicare Advantage	368
Medicare Cost	117981
<i>Total</i>	295,203

C. Onsite Examinations Dates: March 12, 2012 to March 19, 2012

D. Examination Period: June 1, 2009 to December 31, 2011
File Review Period: January 1, 2011 to December 31, 2011
Opening Date: December 21, 2011

- E. National Committee for Quality Assurance (NCQA): Medica is accredited by NCQA based on 2010 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 - 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 <input checked="" type="checkbox"/>	Not Met <input type="checkbox"/>	NCQA <input type="checkbox"/>
Subp. 2.	Documentation of Responsibility	Met <input type="checkbox"/>	Not Met <input type="checkbox"/>	NCQA <input checked="" type="checkbox"/>
Subp. 3.	Appointed Entity	Met <input type="checkbox"/>	Not Met <input type="checkbox"/>	NCQA <input checked="" type="checkbox"/>
Subp. 4.	Physician Participation	Met <input type="checkbox"/>	Not Met <input type="checkbox"/>	NCQA <input checked="" type="checkbox"/>
Subp. 5.	Staff Resources	Met <input type="checkbox"/>	Not Met <input type="checkbox"/>	NCQA <input checked="" type="checkbox"/>
Subp. 6.	Delegated Activities	Met <input type="checkbox"/>	Not Met <input checked="" type="checkbox"/>	NCQA <input type="checkbox"/>
Subp. 7.	Information System	Met <input type="checkbox"/>	Not Met <input type="checkbox"/>	NCQA <input checked="" type="checkbox"/>
Subp. 8.	Program Evaluation	Met <input checked="" type="checkbox"/>	Not Met <input type="checkbox"/>	NCQA <input type="checkbox"/>
Subp. 9.	Complaints	Met <input checked="" type="checkbox"/>	Not Met <input type="checkbox"/>	
Subp. 10.	Utilization Review	Met <input checked="" type="checkbox"/>	Not Met <input type="checkbox"/>	

- 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. 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
MedImpact Healthcare Services	Approve only					X	X	
Medica Behavioral Health (MBH)	X	X	X	X	X		X	
OptumHealth Physical Health (OHPH)	X	X	X	X	X		X	
Pinnacle Services								X
Community Involvement Programs (CIP)								X
Wright County								X

Medica has delegated to MedImpact Health Services the functions of UM approvals, claims and network. Medica receives regular reports from MedImpact summarizing claims denials, approvals, duplicates and reversals. Medica meets with MedImpact quarterly and discusses these reports. However, Medica has not done annual oversight of the claims function. **(Deficiency #1)** Medica recognized the need to oversee this function and has begun to initiate this process; however it was not completed prior to initiating this examination.

A delegation agreement should describe the process by which the organization evaluates the delegated entity's performance. Under the agreement's addendum, *Provider Requirements for Medicare, Medicaid and State Government Programs*, Item 21, the agreement states that Medica or its designee will monitor Provider's performance of any delegated activities on an ongoing basis. In practice, Medica performs audits of EW care plans annually, provides educational support and conducts regular meetings with the counties and vendors. The delegation agreements for Community Involvement Program (CIP), Pinnacle and Wright County do not describe the evaluation process. **(Mandatory Improvement #1)**

Medica may want to consider including the oversight summaries of all the delegates' functions in the delegates' assessment reports. **(Recommendation #1)** Medica reports the delegation activities and oversight to the appropriate quality committees.

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 total of 20 quality of care complaint and grievance files were reviewed as follows:

Quality of Care File Review	
QOC File Source	# Reviewed
<i>Complaints—Commercial Products</i>	
Medica	8
MBH	3
<i>Grievances—MHCP-MC Products</i>	
Medica	5
MBH	4
Total	20

Medica is very thorough in its review of quality of care files. Potential quality of care cases not only come from enrollee complaints/grievances but also from internal departments, including credentialing. The quality of care processes are closely linked to recredentialing and frequently utilized by them to do provider investigations. During a discussion of a non-clinical appeal file with MDH, Medica identified a potential quality of care concern and the file was sent for quality of care review. MDH commends Medica for its commitment to quality of care.

Minnesota Rules, Part 4685.1115. Activities

- Subp. 1. Ongoing Quality Evaluation Met Not Met NCQA
- Subp. 2. Scope Met Not Met NCQA

Medica’s annual evaluation document for 2011 did an excellent job of summarizing and analyzing the quality activities in 2011 as well as evaluating the overall quality program.

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
 Subd. 2. Work Plan Met Not Met NCQA

Medica’s annual work plan is a comprehensive document that is robustly updated quarterly and reported to the quality committee.

III. Complaints and Grievance Systems

Complaint System

MDH examined Medica fully-insured commercial complaint system under Minnesota Statutes, chapter 62Q.

MDH reviewed a total of 23 Complaint System files as follows:

Complaint System File Review	
Complaint Files--Oral and Written	
Medica	14
MBH (all)	6
Non-Clinical Appeal	
Medica	3
MBH (all)	0
Total # Reviewed	23

Note: OPHH had no complaints or appeals (non-clinical).

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. 1. Minnesota Statutes, section 62Q.69, subdivision 1, states each health plan must establish and maintain an internal complaint resolution process that meets the requirements of the section to provide for the resolution of a complaint initiated by a complainant.

Medica’s policies/procedures included all elements required by law. However, Medica’s terminology led to mutual confusion. Minnesota Statutes identify complaints (oral and written) and appeals (clinical and non-clinical). Medica’s “complaints,” included oral and written complaints. “First level appeals included written complaints and clinical appeals. “Second level appeals included non-clinical appeals. Terminology was an issue when MDH requested non-

clinical appeal files. Medica provided first and second level appeals, rather than second level appeals only. Medica must refine complaint system policies/procedures to assure complaint system definitions, actual processes and file universes are consistent with definitions in Minnesota Statutes, section 62Q.68 through .70. **(Mandatory Improvement #2)**

Subd. 2. Minnesota Statutes, section 62Q.69, subdivision 2(a), states if an oral complaint is not resolved to the satisfaction of the enrollee, the plan must inform the complainant that the complaint may be submitted in writing. The plan must offer assistance in completing the form, including an offer to mail the completed form for signature. The complaint form must include, in pertinent part, a description of the internal complaint procedure with time limits and notice that the complainant has the right to file a complaint with the appropriate commissioner (Health) at any time.

In practice, when Medica resolves an oral complaint and if the enrollee is not satisfied, the enrollee is transferred to the “appeals” coordinator who takes the enrollee’s complaint over the phone, investigates and sends a written reply. In nine Medica and three Medica Behavioral Health (MBH) oral complaint files, the enrollee was not offered a written complaint form or assistance in completing the complaint form at end of their initial oral complaint. Without receiving a written complaint form, the member doesn’t receive notice of internal appeal rights nor the right to appeal at any time to the Department of Health in a timely manner consistent with Minnesota law. **(Deficiency #2)**

Subd. 2. Minnesota Statutes, section 62Q.69, subdivision 2(b), states upon receipt of a written complaint, the plan must notify the complainant within ten days that the complaint was received. Medica’s policy, *Fully Insured Complaints*, states staff will send an acknowledgement letter within five working days. Medica’s procedure, *Written Complaints*, states Medica will send an acknowledgement letter to the member within ten business days. Timelines must be consistent with Minnesota law and across policies/procedures. **(Mandatory Improvement #3)**

Subd. 2. Minnesota Statutes, section 62Q.69, subdivision 2(a), states oral complaints must be resolved within ten days of receipt. Medica policies/procedures: *Fully Insured Complaints*, *Oral Complaints*, and *First Level Appeals – Contractual* (non-clinical), all state that oral complaints must be resolved within ten calendar days. Behavioral health complaints are delegated to MBH. All three MBH complaint files were oral, however the review took greater than ten calendar days (26, 28 and 22 days). **(Deficiency #3)**

Subd. 3(c). Minnesota Statutes, section 62Q.69, subdivision 3(c), states the resolution notice must inform the complainant of the right to submit the complaint at any time to either the commissioner of health or commerce for investigation and the toll-free telephone number of the appropriate commissioner. Similarly, Minnesota Statutes, section 62M.11, states an enrollee may file a complaint regarding a determination not to certify directly to the commissioner responsible for regulating the organization. Minnesota Statutes, section 62Q.70, subdivision 2(b), states if the appeal decision is partially or wholly adverse to the complainant, the notice must advise the complainant of the right to submit the appeal decision to the external review process and the procedure for initiating the external process. Minnesota Statutes, section 62M.06, subdivision 3(g), states if the initial

determination is not reversed on appeal, the plan must include in its notification the right to submit the appeal to the external review process and the procedure for initiating the external process. Minnesota Statutes, section 62Q.73, subdivision 3(a), states any enrollee who has received an adverse determination may submit a written request for an external review of the adverse determination to the commissioner of health if the request involves a plan regulated by that commissioner. Notification of the enrollee's right to external review must accompany the denial.

In 2006, the MDH exam cited Medica with a deficiency under Minnesota Statutes, section 62Q.69, subdivision 3(c), for UBH acknowledgement letters that referenced both the Departments of Health and Commerce. The same files also referenced North Dakota and Wisconsin regulatory agencies. The report also noted that in 2004 delegation oversight, Medica suggested that UBH revise its response letters, which UBH reported it had done, but one of the incorrect files was dated after UBH's corrective action plan.

In 2009, the MDH exam again cited Medica with a (repeat) deficiency under Minnesota Statutes, section 62Q.69, subdivision 3(c), when three commercial complaint files were directed to the Department of Commerce. We noted the 2006 deficiency involved different processes and different staff and Medica fully corrected the deficient process found in 2006. MDH also found a deficiency under Minnesota Statutes, section 62Q.70, subdivision 3(b), where the notification in nine non-clinical appeals directed the enrollee to the Department of Commerce for external appeal. The deficiency cross-referenced Minnesota Statutes, section 62Q.73. Finally, MDH found a Mandatory Improvement under Minnesota Statutes, section 62M.06, subdivision 3(g), because four appeal notices referred the enrollee to both the Minnesota Departments of Commerce and Health.

During the current MDH Quality Exam, four commercial UM denial files (two Medica and two pharmacy files) and one commercial clinical appeal (Medica) incorrectly referred the enrollee to the Department of Commerce or gave appeal rights for self-insured groups (protected by federal law only). **(Deficiency #4)** Because this is the same issue identified in the last two MDH Quality Exams (final reports dated January 10, 2007, and September 30, 2009), this is, again, a repeat deficiency. [Also see **Minnesota Statutes, sections 62M.11; 62Q.70, subdivision 2(b); 62M.06, subdivision 3(g); and 62Q.73, subdivision 3(a)**]

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

- | | | | |
|----------|----------------------------------|---|---|
| Subd. 1. | Establishment | <input checked="" type="checkbox"/> Met | <input type="checkbox"/> Not Met |
| Subd. 2. | Procedures for Filing an Appeal | <input checked="" type="checkbox"/> Met | <input type="checkbox"/> Not Met |
| Subd. 3. | Notification of Appeal Decisions | <input type="checkbox"/> Met | <input checked="" type="checkbox"/> Not Met |

[See Minnesota Statutes, section 62Q.69, subdivision 3(c)]

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

[See Minnesota Statutes, section 62Q.69, subdivision 3(c)]

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

[See Minnesota Statutes, section 62Q.69, subdivision 3(c)]

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

[See Minnesota Statutes, section 62Q.69, subdivision 3(c)]

Grievance System

MDH examined Medica'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 2011 Model Contract, Article 8.

MDH reviewed a total of 49 grievance system files as follows:

Grievance System File Review	
File Source	# Reviewed
<i>Grievances</i>	
Medica	10
MBH	7
<i>Non-Clinical Appeals</i>	
Medica	22
MBH	5
<i>State Fair Hearing</i>	
Total	49

Section 8.1. §438.402 General Requirements

Sec. 8.1.1 Components of Grievance System Met Not Met

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

- | | | | |
|-------------|--------------------|--|--|
| | | <input checked="" type="checkbox"/> Met | <input type="checkbox"/> Not Met |
| (B) | §438.404 (c)(2) | Denials of Payment | <input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met |
| (C) | §438.210 (c) | Standard Authorizations | |
| | (1) | As expeditiously as the enrollee's health condition requires | <input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met |
| | (2) | To the attending health care professional and hospital by telephone or fax within one working day after making the determination | <input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met |
| | (3) | To the provider, enrollee and hospital, in writing, and must include the process to initiate an appeal, within ten business days following receipt of the request for the service, unless the MCO receives an extension of the resolution period | <input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met |
| (D) | §438.210 (d)(2)(i) | Expedited Authorizations | <input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met |
| (E) | §438.210 (d)(1) | Extensions of Time | <input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met |
| (F) | §438.210 (d) | Delay in Authorizations | <input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met |
| Sec. 8.3.3. | §438.420 (b) | Continuation of Benefits Pending Decision | <input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met |

§438.210 (c). 42 CFR 438.210(c) (contract section 8.3.2.(A)), states for previously authorized services, the MCO must mail the notice to the enrollee and the attending health care provider at least ten days before the date of the proposed action. Medica Behavioral Health (MBH), Medica's delegate, had four files in which the previously authorized services were stopped prior to ten days (ranged from eight to nine days). It was starting the ten days at the time of the verbal notice of denial, not when the DTR was mailed. MBH discovered this issue and initiated a corrective action plan (CAP) on September 5, 2011, prior to MDH opening the exam. MDH reviewed an additional eight files after CAP completion and all files were correct as to the ten days advance notice. MDH commends MBH for discovering and correcting this issue.

§438.210 (c). 42 CFR 439.210 (c) (contract section 8.3.2.(C)(3)), states for standard authorization decisions that deny or limit services, the MCO must provide the notice to the provider and enrollee within ten business days. Three of Medica's UM/DTR files exceeded the ten business day timeline (ranging from 13 to 16 business days). **(Deficiency #5)**
[Also see 62M.05, subdivision 3a]

- | | | |
|------------------------------|--|--|
| Section 8.4. §438.408 | Internal Appeals Process Requirements | |
| Sec. 8.4.1. §438.402 (b) | Filing Requirements | <input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met |
| Sec. 8.4.2. §438.408 (b)(2) | Timeframe for Resolution of Expedited Appeals | <input checked="" type="checkbox"/> Met <input type="checkbox"/> 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 | <input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met |
| (B) §438.410 (c) | Expedited Resolution Denied | <input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met |
| (C) §438.410 (a) | Expedited Appeal by Telephone | <input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met |
| Sec. 8.4.4. §438.408 (c) | Timeframe for Extension of Resolution of Appeals | <input checked="" type="checkbox"/> Met <input type="checkbox"/> 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) §438.408(e)(1) Unsuccessful appeal of UM determination Met Not Met

Sec, 8.4.8. §438.424 Reversed Appeal Resolutions Met Not Met

§438.410 (a). 42 CFR 438.410(a) (contract section 8.4.3 (C)), states when a determination not to certify a health care service is made prior to or during an ongoing service, and the attending health care professional believes that an expedited appeal is warranted, the MCO must ensure that the enrollee and the attending health care professional have an opportunity to appeal the determination over the telephone. One Medica file did not have verbal notification of the right to expedited appeal. Medica instituted a corrective action plan in May/June 2011. Rightfax was initiated in which a fax of the DTR is sent to the provider on the same day as the decision. The fax notification contains the right to expedited appeal. All expedited denials after the CAP completion date were compliant. MDH commends Medica for improving this process.

[Also see Minnesota Statutes, section 62M.06, subdivision 2(a)]

MBH had two files which were benefit denials, where there were no further benefits available. MBH does a peer to peer review with the requesting physician upon a denial and offers appeal rights to the physician with that phone call; thus the physician is told immediately upon denial he/she can appeal. MBH should consider adding to the documentation of the telephonic peer to peer review that expedited appeal rights were offered. **(Recommendation #2) [Also see Minnesota Statutes, section 62M.06, subdivision 2(a)]**

§438.408(e)(1) 42 CFR 438.408(e)(1) (contract section 8.4.7 (D)), states if an enrollee or attending healthcare professional is unsuccessful in an appeal of a UM determination, the MCO must provide, in pertinent part, the qualifications of the reviewer. One file did not contain the qualifications of the reviewer, where an RN, Medical Director and same/similar specialist had reviewed the case upon appeal. The notification did contain the qualifications of Medical Director and RN, but not the specialist. All other files contained the qualifications. **[Also see Minnesota Statutes, section 62M.05, subdivision 3(e).]**

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

§438.416 (c). 42 CFR 438.416(c) (contract section 8.9.2) states:

- The MCO shall respond with the following information about an appeal within one working day of receiving the request from the State Fair Hearing Office:
 - a) whether an appeal was filed with an MCO;
 - b) the date the appeal was filed;
 - c) the resolution of the appeal;
 - d) the date it was resolved; and
- The MCO shall notify the state and the State Fair Hearing Office of changes to the name or phone number of the contact within one working day of any change.

These statements were not included in the policy *Clinical Appeals: State Public Programs* (CA021P). Medica must revise its policy to include the above information. **(Mandatory Improvement #4)**

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. Minnesota Rules, part 4685.1010, subpart 2, states the plan must develop and implement written standards or guidelines that assess the capacity of each provider network to provide timely access to health care services. Minnesota Rules, part 4685.0100, subpart 16, defines urgently needed care as needed as soon as possible, usually within 24 hours. Medica’s Quality Management policy/procedure, *Practitioner and Provider Accessibility*, states the behavioral health standard for urgent care is 48 hours. Minnesota Rules does not provide for a separate standard for behavioral health urgent care. In addition, the Medica Behavioral Health (MBH) policy/procedure *Care Advocacy Definitions List* (page 3) defines “Urgent (Access Level)” and states, “All members needing urgent care are to be offered an appointment within 48 hours.” Under agreement with Medica, MBH manages the behavioral health network and evaluates the geographic and timely availability of the network. The 2010 annual report of MBH (page 21) states the rates at which enrollees “waited two days or less to see a clinician” The annual evaluation of MBH confirms that MBH evaluated behavioral health urgent access at the incorrect, 48 hours, standard. Committee minutes confirm that Medica accepted this evaluation. **(Deficiency #6)**

Minnesota Statutes, Section 62Q.55. Emergency Services

- Met Not Met
- 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
<i>UM Denial Files</i>	
Commercial	
Medica	16
Pharmacy	17
MBH	7
OPHP	5
MHCP-MC	
Medica	31
Pharmacy	8
MBH	16
OPHP	8
<i>Subtotal</i>	108
<i>Clinical Appeal Files</i>	
Commercial	
Medica	14
MBH	2
OPHP	3
MHCP-MC	
Medica	31
MBH	8
OPHP	11
<i>Subtotal</i>	69
Total	177

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 external 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. 1. Minnesota Statutes, section 62M.05, subdivision 1, states the plan must have written procedures to ensure that review are conducted in accordance with utilization review law. The following policies/procedures need to be revised to be consistent with Minnesota law:

- Minnesota Statutes, section 62M.05, subdivision 3a(a), states an initial determination for utilization review must be communicated to the provider and enrollee within ten business days of the request, provided that all information reasonably necessary is made available. Policy/procedure CM104P, *Turnaround Times for Medical Necessity Reviews*, page 2, states if an initial non-urgent review is delayed because of circumstances beyond Medica’s control, the turnaround time may be extended up to 15 additional days. Minnesota law does not allow for an extension, except for a lack of information. This language is found in US Department of Labor law, but not in Minnesota law.
- Minnesota Statutes, section 62M.05, subdivision 3a(c), states, when an initial determination is made not to certify, telephone or fax notice must be given to the “attending health care professional.” CM104P, *Turnaround Times for Medical Necessity Reviews*, page 3, states, telephonic/fax notice will be made to the “servicing provider” and if appropriate, the “referring provider.” Neither of these terms is defined. Minnesota law specifies “attending health care professional;” In practice, Medica sends the denial notice to both the attending health care professional and the primary care provider. Medica must revise its policy/procedure to ensure a servicing or referring provider is defined consistent with “attending health care professional.”

(Mandatory Improvement #5)

Subd. 3a(a). Minnesota Statutes 62M.05, subdivision 3a(a), states for standard authorization decisions that deny or limit services, the plan must provide the notice to the provider and enrollee within ten business days. Three of Medica's UM/DTR files exceeded the ten business day timeline (ranging from 13 to 16 business days). **(Deficiency #5)**
[Also see 42 CFR 439.210 (c) (contract section 8.3.2.(C)(3))]

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

Subd. 1.	Procedures for Appeal	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met	
Subd. 2.	Expedited Appeal	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met	
Subd. 3.	Standard Appeal			
	(a) Appeal resolution notice timeline	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met	
	(b) Documentation requirements	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met	
	(c) Review by a different physician	<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	<input checked="" type="checkbox"/> NCQA
	(d) Time limit in which to appeal	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met	
	(e) Unsuccessful appeal to reverse determination	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met	<input type="checkbox"/> NCQA
	(f) Same or similar specialty review	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met	
	(g) Notice of rights to external review	<input type="checkbox"/> Met	<input checked="" type="checkbox"/> Not Met	<input type="checkbox"/> NCQA
Subd. 4.	Notification to Claims Administrator	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met	

Subd. 2. Minnesota Statutes, section 62M.06, subdivision 2(a), states when a determination not to certify a health care service is made prior to or during an ongoing service, and the attending health care professional believes that an expedited appeal is warranted, the MCO must ensure that the enrollee and the attending health care professional have an opportunity to appeal the determination over the telephone. One Medica file did not have verbal notification of the right to expedited appeal. Medica instituted a corrective action plan in May/June 2011. Rightfax was initiated in which a fax of the DTR is sent to the provider on the same day as the decision. The fax notification contains the right to expedited appeal. All expedited denials after the CAP completion date were compliant. MDH commends Medica for improving this process. **[Also see 42 CFR 438.410(a) (contract section 8.4.3 (C))]**

Medica Behavioral Health (MBH) had two files which were benefit denials, where there were no further benefits available. MBH does a peer to peer review with the requesting physician upon a denial and offers appeal rights to the physician with that phone call, thus the physician is told immediately upon denial he/she can appeal. MBH should consider adding to the documentation of the telephonic peer to peer review that expedited appeal rights were offered.

(Recommendation #2)

[Also see 42 CFR 438.410(a) (contract section 8.4.3 (C))]

Subd. 3(e). Minnesota Statutes, section 62M.06, subdivision 3(e), states if an enrollee or attending healthcare professional is unsuccessful in an appeal of a UM determination, the MCO must provide, in pertinent part, the qualifications of the reviewer. One file did not contain the qualifications of the reviewer, where an RN, Medical Director and same/similar specialist had reviewed the case upon appeal. The notification did contain the qualifications of Medical Director and RN, but not the specialist. All other files contained the qualifications. **[Also see 42 CFR 438.408(e)(1) (contract section 8.4.7 (D))]**

Subd. 3(g). [See Minnesota Statutes, section 62Q.69, subdivision 3(c)]

Minnesota Statutes, Section 62M.08. Confidentiality

Met Not Met NCQA

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

Subd. 1.	Staff Criteria	<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	<input checked="" type="checkbox"/> NCQA
Subd. 2.	Licensure Requirements	<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	<input checked="" type="checkbox"/> NCQA
Subd. 3.	Physician Reviewer Involvement	<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	<input checked="" type="checkbox"/> NCQA
Subd. 3a.	Mental Health and Substance Abuse Review	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met	
Subd. 4.	Dentist Plan Reviews	<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	<input checked="" type="checkbox"/> NCQA
Subd. 4a.	Chiropractic Reviews	<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	<input checked="" type="checkbox"/> NCQA
Subd. 5.	Written Clinical Criteria	<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	<input checked="" type="checkbox"/> NCQA
Subd. 6.	Physician Consultants	<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	<input checked="" type="checkbox"/> NCQA
Subd. 7.	Training for Program Staff	<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	<input checked="" type="checkbox"/> NCQA
Subd. 8.	Quality Assessment Program	<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	<input checked="" type="checkbox"/> NCQA

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

Met Not Met

[See Minnesota Statutes, section 62Q.69, subdivision 3(c)]

Recommendations

1. To better comply with Minnesota Rules, part 4685.1110, subpart 6, Medica may want to consider including the oversight summaries of all the delegates' functions in the delegates' assessment reports.
2. To better comply with 42 CFR 438.410(a) (contract section 8.4.3 (C)) and Minnesota Statutes, section 62M.06, subdivision 2(a), MBH may want to consider adding to the documentation of the telephonic peer to peer review that expedited appeal rights were offered.

Mandatory Improvements

1. To comply with Minnesota Rules, part 4685.1110, subpart 6, Medica must describe in the Elderly Waiver care coordination delegation agreements the process by which the organization evaluates the delegated entity's performance.
2. To comply with Minnesota Statutes, section 62Q.69, subdivision 1, Medica must revise complaint system policies/procedures to assure complaint system definitions, actual processes and file universes are consistent with definitions in Minnesota Statutes, section 62Q.68 through .70.
3. To comply with Minnesota Statutes, section 62Q.69, subdivision 2(b), Medica must revise its policies, *Fully Insured Complaints* and *Written Complaints*, to ensure that acknowledgement letter timelines are consistent with Minnesota law and across policies/procedures.
4. In order to comply with 42 CFR 438.416(c) (contract section 8.9.2), Medica must revise its policy *Clinical Appeals: State Public Programs* (CA021P) to include the following regarding State Fair Hearings:
 - The MCO shall respond with the following information about an appeal within one working day of receiving the request from the State Fair Hearing Office:
 - a) whether an appeal was filed with an MCO;
 - b) the date the appeal was filed;
 - c) the resolution of the appeal;
 - d) the date it was resolved; and
 - The MCO shall notify the state and the State Fair Hearing Office of changes to the name or phone number of the contact within one working day of any change.
5. To comply with Minnesota Statutes, 62M.05, subdivision 1, Medica must revise its policies/procedures as follows:
 - CM104P, *Turnaround Times for Medical Necessity Reviews*, to replace the extensions of initial UM determinations timelines for delays beyond Medica's control with an extension only in the event Medica does not have enough information, consistent with Minnesota Statutes, 62M.05, subdivision 3a(a).
 - CM104P, *Turnaround Times for Medical Necessity Reviews*, to ensure a servicing or referring provider is defined consistent with "attending health care professional," consistent with Minnesota Statutes, section 62M.05, subdivision 3a(c).

Deficiencies

1. To comply with Minnesota Rules, part 4685.1110, subpart 6, Medica must perform an annual substantive evaluation of all delegated activities for MedImpact.

2. To comply with Minnesota Statutes, section 62Q.69, subdivision 2(a), Medica and its delegates must offer the enrollee a written complaint form, including all the appeal rights afforded the enrollee under Minnesota law, and assistance in completing the complaint form if an oral complaint is not resolved to the satisfaction of the enrollee.
3. To comply with Minnesota Statutes, section 62Q.69, subdivision 2(a), Medica and its delegates must resolve oral complaints within ten calendar days.
4. To comply with Minnesota Statutes, sections 62Q.69, subdivision 3(c); 62M.11; 62Q.70, subdivision 2(b); 62M.06, subdivision 3(g); and 62Q.73, subdivision 3(a); Medica must revise its processes to ensure that the enrollee is accurately advised of the right to file a complaint with Commissioner of Health at any time. In addition, Medica must ensure those enrollees potentially eligible for external review are accurately notified of their right and the procedures for initiating the process through the Minnesota Department of Health. Because this is the same issue identified in the last two MDH Quality Exams (final reports dated January 10, 2007, and September 30, 2009), this is, again, a repeat deficiency.
5. To comply with 62M.05, subdivision 3a, and 42 CFR 439.210 (c) (contract section 8.3.2 (C)(3)), Medica must, for standard authorization decisions that deny or limit services, provide the notice to the provider and enrollee within ten business days.
6. To comply with Minnesota Rules, part 4685.1010, subpart 2, Medica and its delegates must revise policies/procedures to ensure all urgent care is available within 24 hours. In addition, Medica and its delegates must survey provider timely availability against the correct standard.