

Minnesota Department of Health
Compliance Monitoring Division
Managed Care Systems Section



Final Report
PreferredOne Community Health Plan

Quality Assurance Examination
For the period:
January 1, 2009 to July 31, 2011

Final Issue Date:
April 10, 2012

Examiners:
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Minnesota Department of Health
Executive Summary:

The Minnesota Department of Health (MDH) conducted a Quality Assurance Examination of PreferredOne Community Health Plan (PCHP) to determine whether it is operating in accordance with Minnesota law. MDH has found that PCHP is compliant with Minnesota and Federal law, except in the areas outlined in the “Deficiencies” and “Mandatory Improvements” sections of this report. “Mandatory Improvements” are required corrections that must be made to noncompliant policies, documents or procedures where evidence of actual compliance is found in relevant files 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, PCHP should:

Evaluate the pharmacy network as part of its annual network assessment to provide a more comprehensive report of its network and ensure that network findings are communicated to the organization at large.

Add to its Quality of Care complaints policy/procedure to identify levels of severity and identify PCHP responsibility to report various legal authorities: NPDB, Board of Medical Practice, etc.

To address mandatory improvements, PCHP must:

Revise policy/procedure MP/C001, *Court-Ordered Mental Health Services* to clearly distinguish its liability for court-ordered mental health evaluations and court-order care.

Revise its policy/procedure *Timelines of Behavioral Health, Non-Behavioral Health, Chiropractic and Pharmacy Decisions (MM/P005)*, to delete the Department of Labor language stating that if more than 15 days are needed to process a claim due to circumstances beyond the plan’s control, the initial 15 day period may be extended by an additional 15 days.

Revise its policy/procedure *Pre-service Appeals (MM/P008A)* to include the language that it will ensure reasonable access to its consulting physician or health care provider.

After exhausting the second appeal, include in the notification letters the remaining right of external appeal available to the enrollee rather than stating the full appeal rights so as not to mislead the enrollee.

To address deficiencies, PCHP and its delegates must:

Submit to MDH for approval any revisions to its written quality assurance plan.

Document that a complaint form and assistance with the form was offered if the oral complaint is not resolved to the satisfaction of the complainant.

Revise policy/procedure NM019, *Availability of Practitioners and Guidelines for Practitioner Expansion*, to designate which measure (miles or minutes) is used and must include hospitals. In addition, the PCHP network evaluation must include hospitals.

Revise its policy/procedure NM032 *Standards of Appointment Accessibility* to state urgent care for medical and behavioral health must be available within 24 hours. In addition, PCHP must survey its behavioral health providers against the 24 hour urgent care standard. Because the same policy was a mandatory improvement in the 2009 Quality Assurance Exam is incorrect at this Exam, this is a repeat deficiency.

Provide accurate dates in its appeal notification letters to ensure an accurate summary of the review findings.

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:

PreferredOne Community Health Plan (“PCHP”) is a Minnesota nonprofit corporation organized on December 2, 1994 under Chapter 317A of the Minnesota Statutes. PCHP became operational in 1996. Contributing members of PCHP are Fairview Health Services and North Memorial Health Care. The sole non-contributing member is PreferredOne Physician Associates (PPA). Minnesota Statutes provide that 40 percent of an HMO’s Board be enrollees of the health plan. The current Board of Directors consists of ten members: two representatives each from Fairview, North Memorial, and PPA; and four consumer board members elected by the PCHP membership.

PCHP offers a variety of fully-insured HMO products for both large and small employers and features an open-access provider network. Plans feature a variety of benefit options including 100 percent preventive coverage and options for out-of-network coverage.

B. Membership:

PCHP’s self-reported enrollment as of December 31, 2010 consisted of the following:

Product	Product Name or Description	Enrollment
<i>Fully insured Commercial</i>		
Large Group	Non-deductible	2127
	Low deductible	3009
	High Deductible	6824
	HSA	4794
	HRA	2652
	PCA	314
Small Employer Group	Non-deductible	889
	Low Deductible	1630
	High Deductible	3639
	HSA	12761
	HRA	703
	PCA	0
<i>Total</i>		39,342

C. Onsite Examination Dates: October 24, 2011 to October 27, 2011

D. Date Examination Opened: August 24, 2011

Examination Period: January 1, 2009 to July 31, 2011

File Review Period: August 1, 2010 to July 31, 2011

- E. National Committee for Quality Assurance (NCQA): PCHP is accredited by NCQA based on 2009 standards. The Minnesota Department of Health (MDH) evaluated and used results of the NCQA review in one of three ways.
- If NCQA standards do not exist or are not as stringent as Minnesota law, the review results will not be used for evaluation [no NCQA box].
 - If the NCQA review was the same or more stringent than Minnesota law and the health plan was accredited with 100% of the possible points, the NCQA review result was accepted as meeting Minnesota requirements [NCQA] unless evidence existed indicating further investigation was warranted [NCQA].
 - 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 course of the quality assurance examination, which 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	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met	<input type="checkbox"/> NCQA
Subp. 2.	Documentation of Responsibility	<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	<input checked="" type="checkbox"/> NCQA
Subp. 3.	Appointed Entity	<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	<input checked="" type="checkbox"/> NCQA
Subp. 4.	Physician Participation	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met	<input type="checkbox"/> NCQA
Subp. 5.	Staff Resources	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met	<input type="checkbox"/> NCQA
Subp. 6.	Delegated Activities	<input type="checkbox"/> Met	<input checked="" type="checkbox"/> Not Met	<input type="checkbox"/> NCQA ¹
Subp. 7.	Information System	<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	<input checked="" type="checkbox"/> NCQA
Subp. 8.	Program Evaluation	<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	<input checked="" type="checkbox"/> NCQA
Subp. 9.	Complaints	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met	
Subp. 10.	Utilization Review	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met	
Subp. 11.	Provider Selection and Credentialing	<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	<input checked="" type="checkbox"/> NCQA
Subp. 12.	Qualifications	<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	<input checked="" type="checkbox"/> NCQA
Subp. 13.	Medical Records	<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	<input checked="" type="checkbox"/> NCQA

¹ NCQA delegation standards are equivalent to Minnesota law for credentialing and quality improvement functions only.

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								
	UM	UM Appeals	QM	QOC	Complaints	Cred	Claims	Network
ExpressScripts (ESI)							X	X
Health Services Management (HSM)	X	X	X	X		X		X

PCHP delegates network management and claims processing to its pharmacy benefit manager, ExpressScripts (ESI). PCHP annually audits ESI, including evaluation of its website and timely updates to the formulary. PCHP also receives annual network evaluations and monthly reports of claims adjudication. The reports are reviewed by the director of pharmacy; however the analysis is not reported to any committee, included in annual oversight results or any network assessment. PCHP must review and report on all delegated functions. PCHP should consider evaluating the pharmacy network as part of its annual network assessment to provide a more comprehensive report of its network and ensure that network findings are reported to the organization at large. **(Recommendation #1)**

Subd. 9. Minnesota Rules, part 4685.1110, subpart 9, states the quality program must conduct ongoing evaluation of enrollee complaints related to quality of care. The one quality of care complaint filed in 2010 was reviewed. The complaint was thoroughly investigated, reviewed and documented according to the PCHP policy/procedure. PCHP should consider an addition to its Quality of Care complaints policy/procedure that identifies levels of severity and identifies PCHP responsibility to report various legal authorities: NPDB, Board of Medical Practice, etc. **(Recommendation #2)**

Minnesota Rules, Part 4685.1115. Activities

- Subp. 1. Ongoing Quality Evaluation
- Subp. 2. Scope

- Met Not Met NCQA
- 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. Focused 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

- Subp. 1. Written Plan Met Not Met
- Subp. 2. Work Plan Met Not Met NCQA
- Subp. 3. Amendments to Plan Met Not Met

Subp. 3. Minnesota Rules, Part 4685.1130, states the HMO may change its written quality assurance plan by filing notice with the Commissioner of Health. PCHP revised its written quality plan in 2010 but did not submit it to MDH for approval. **(Deficiency #1)**

III. Complaint Systems

Complaint System

MDH examined 29 fully-insured commercial complaint system files under Minnesota Statutes, chapter 62Q.

Complaint System File Review	
Complaint and Appeal File Source	# Reviewed
<i>Complaint Files (Oral and Written)</i>	15
<i>Non-Clinical Appeal (all)</i>	4
Total	29

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. Minnesota Statutes, section 62Q.69, subdivision 2, states if the oral complaint is not resolved to the satisfaction of the complainant, the plan must inform the complainant that the complaint may be submitted in writing. The plan must also offer to provide the complainant with any assistance needed to submit a written complaint, including an offer to complete the complaint form for a complaint that was previously submitted orally and promptly mail the completed form to the complainant for the complainant's signature. In four of six oral complaints, PCHP records did not document that a complaint form and assistance with the form were offered. **(Deficiency #2)**

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

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

Subd. 1. Minnesota Statutes, section 62D.124, subdivision 1, states that the maximum travel distance or time shall be the lesser of 30 miles or 30 minutes for primary care, mental health services and general hospital services. The plan must designate which method is used. Policy/procedure NM019 *Availability of Practitioners and Guidelines for Practitioner Expansion*, states the 30 mile or 30 minute standard for primary care and behavioral health but does not include hospitals. In addition, the network evaluation did not include hospitals. The

policy/procedure must designate which measure is used and must include hospitals. In addition, the PCHP network evaluation must include hospitals. **(Deficiency #3)**

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 services. Minnesota Rules, part 4685.0100, subpart 2, defines urgently needed care as needed within 24 hours. Policy/procedure NM032 states that urgent care for behavioral health must be available within 48 hours. Minnesota Rules do not permit a distinction between medical and behavioral health timely availability and urgent care must be available within 24 hours, not 48 hours. In addition, PCHP must survey its behavioral health providers against the 24 hour urgent care standard. **(Deficiency #4)** The MDH quality assurance examination report issued July 10, 2009, included a Mandatory Improvement requiring that timelines and definitions for urgent and emergency care must be consistent between policies and be compliant with the definitions as stated in Minnesota Rules. Because “urgent care” as identified in the policy NM032 is inconsistent with Minnesota Rules and because the same policy was a mandatory improvement in the 2009 Quality Assurance Exam that is not corrected, this is a repeat deficiency.

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

Subd. 2. Minnesota Statutes, section 62Q.535, subdivision 2 (a), states the plan will be financially liable for the evaluation if performed by a participating provider and the plan will be responsible for the care in the individual treatment plan if the care is covered by the plan if provided by a participating provider or another provider as required by law. Policy/procedure MP/C001, *Court-Ordered Mental Health Services*, states in pertinent part, “To be eligible for coverage all of the following must be met . . . 2. The court ordered behavioral care evaluation must be performed by a participating licensed psychiatrist or doctoral level licensed psychologist. . . .” The plan is liable for the evaluation only if it is performed by a participating provider. The plan is liable for the court ordered care if it is covered by the enrollee’s contract and if the care is ordered to be performed by a participating provider or by another provider required by rule or law. For example, the court-ordered evaluation is performed by a non-participating provider. The court-ordered care is only available at a non-participating provider or the participating provider does not have an opening for the enrollee at the time it is needed. In this example, the plan is not liable for the evaluation, but it is liable for the court-ordered care. The policy/procedure must clearly distinguish the plan’s liability for the evaluation and court-ordered mental health care. **(Mandatory Improvement #1)**

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>	
PCHP	30

UM System File Review	
File Source	# Reviewed
HSM	10
<i>Subtotal</i>	49
<i>Clinical Appeal Files</i>	
PCHP	30
HSM	9
<i>Subtotal</i>	39
Total	88

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 rights 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. 3a. Minnesota Statutes, section 62M.05, subdivision 3a(a), states an initial determination on all requests for utilization review must be communicated to the provider and enrollee within ten business days (15 calendar days) of the request. In one file the timeline was exceeded (17 days).

Subd. 4. Minnesota Statutes, section 62M.05, subdivision 4, states the HMO must have written procedures to address the failure of a provider or enrollee to provide the necessary information for review. In PCHP’s policy/procedure *Timelines of Behavioral Health, Non-Behavioral Health, Chiropractic and Pharmacy Decisions (MM/P005)*, it states that “if more than 15 days are needed to process a claim due to circumstances beyond the plan’s control, the initial 15 day period may be extended by an additional 15 days”. This language is found in the Department of

Labor law, but not in Minnesota HMO Statutes. This goes beyond the Minnesota HMO laws. The policy/procedure must be revised to delete this statement. **(Mandatory Improvement #2)**

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 type="checkbox"/> Met | <input checked="" 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 checked="" type="checkbox"/> Met | <input type="checkbox"/> Not Met | <input 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 type="checkbox"/> Met | <input checked="" 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. | Notifications to Claims Administrator | <input checked="" type="checkbox"/> Met | <input type="checkbox"/> Not Met | |

Subd. 2. Minnesota Statutes, section 62M.06, subdivision 2, states that in expedited appeals, the HMO must ensure reasonable access to its consulting physician or health care provider. In the policy/procedure *Pre-service Appeals* (MM/P008A) this language is not present. PCHP must revise its policy to include that it will ensure reasonable access to its consulting physician or health care provider. **(Mandatory Improvement #3)**

Subd. 3(e). Minnesota Statutes, section 62M.06, subdivision 3(e), states that an attending health care professional or enrollee who has been unsuccessful in an attempt to reverse a determination not to certify shall be provided a complete summary of the review findings. In two HSM files there were discrepancies in the dates on the notification letters resulting in an inaccurate summary of the review findings. **(Deficiency #5)**

Subd. 3(g). Minnesota Statutes, section 62M.06, subdivision 3(g), states if the initial determination is not reversed on appeal, the HMO must include in its notification the right to submit the appeal to the external review process procedure for initiating. In two HSM appeal files, the notification letters after the second appeal gave the enrollees the full appeal rights rather than only the remaining right of external review, which is misleading to the enrollee. **(Mandatory Improvement #4)**

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 Requirement	<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	<input checked="" type="checkbox"/> NCQA
Subd. 3.	Physician Reviewer Involvement	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met	<input type="checkbox"/> NCQA
Subd. 3a.	Mental Health and Substance Abuse Review	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met	
Subd. 4a.	Chiropractic Reviews	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met	<input 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 checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met	<input 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

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

Met Not Met NCQA

VI. Recommendations

1. To better comply with Minnesota Rules, part 4685.1110, subpart 6, PCHP should evaluate the pharmacy network as part of its annual network assessment to provide a more comprehensive report of its network and ensure that network findings are communicated to the organization at large.
2. To better comply with Minnesota Rules, part 4685.1110, subpart 9, PCHP should add to its Quality of Care complaints policy/procedure to identify levels of severity and identify PCHP responsibility to report various legal authorities: NPDB, Board of Medical Practice, etc.

VII. Mandatory Improvements

1. To comply with Minnesota Statutes, section 62Q.535, subdivision 2(a), PCHP must revise policy/procedure MP/C001, *Court-Ordered Mental Health Services*, to clearly distinguish its liability for court-ordered mental health evaluations and court-order care.
2. To comply with Minnesota Statutes, section 62M.05, subdivision 4, PCHP must revise its policy/procedure *Timelines of Behavioral Health, Non-Behavioral Health, Chiropractic and Pharmacy Decisions (MM/P005)*, to delete the language stating that if more than 15 days are needed to process a claim due to circumstances beyond the plan’s control, the

initial 15 day period may be extended by an additional 15 days. This language is found in the Department of Labor laws, but not in Minnesota HMO Statutes.

3. To comply with Minnesota Statutes, section 62M.06, subdivision 2, PCHP must revise its policy/procedure *Pre-service Appeals* (MM/P008A) to include the language that it will ensure reasonable access to its consulting physician or health care provider.
4. To comply with Minnesota Statutes, section 62M.06, subdivision 3(g), PCHP's delegate, after exhausting the second appeal, must include in the notification letters the remaining right of external appeals available to the enrollee rather than stating the full appeal rights so as not to mislead the enrollee.

VII. Deficiencies

1. To comply with Minnesota Rules, part 4685.1130, PCHP must submit to MDH for approval any revisions to its written quality assurance plan.
2. To comply with Minnesota Statutes, section 62Q.69, subdivision 2, PCHP complaint records must document that a complaint form and assistance with the form was offered if the oral complaint is not resolved to the satisfaction of the complainant.
3. To comply with Minnesota Statutes, section 62D.124, subdivision 1, PCHP policy/procedure NM019, *Availability of Practitioners and Guidelines for Practitioner Expansion*, must designate which measure (miles or minutes) is used and must include hospitals. In addition, the PCHP network evaluation must include hospitals.
4. To comply with Minnesota Rules, part 4685.1010, subpart 2, PCHP must revise its policy/procedure NM032 *Standards of Appointment Accessibility* to state urgent care for medical and behavioral health must be available within 24 hours. In addition, PCHP must survey its behavioral health providers against the 24 hour urgent care standard. Because the same policy was a mandatory improvement in the 2009 Quality Assurance Exam is incorrect at this Exam, this is a repeat deficiency.
5. To comply with Minnesota Statutes, section 62M.06, subdivision 3(e), PCHP's delegate must provide accurate dates in its appeal notification letters to ensure an accurate summary of the review findings.