



*Protecting, maintaining and improving the health of all Minnesotans*

July 30, 2014

Ms. Ruth Krystopolski  
Executive Director  
Sanford Health Plan of Minnesota  
300 Cherapa Place, Suite 201  
Sioux Falls, SD 57103

Re: Quality Assurance Examination  
Administrative Penalty

Dear Ms. Krystopolski:

The Department of Health recently conducted a Quality Examination of Sanford Health Plan of Minnesota (Sanford). The final report of the examination is enclosed. The examiners documented many areas in which Sanford is to be commended for being in full compliance with applicable statutes and rules. The examiners also identified two deficiencies in which Sanford's practices are not consistent with law or rule. We have determined that an administrative penalty is appropriate for these deficiencies. Please see the enclosed Stipulation and Order for specific information about the penalty.

Penalties are assessed by taking into consideration the number of enrollees affected, the actual or potential effect on health or access to health services, whether the violation is an isolated incident or part of a pattern of behavior, whether there is an economic benefit to the HMO and/or participating providers, what the HMO has done to remedy the violation, whether this is a repeat of a previous deficiency, and whether this is a willful violation of law.

Please be advised that Sanford has 15 days from today to file a written request for an administrative hearing and review of the Commissioner of Health's determination in this matter. Please send a written request to my attention at the address below. Such administrative hearing shall be subject to judicial review pursuant to Minnesota Statutes chapter 14. If no hearing is requested, please return the signed Stipulation and Order along with the check in the amount of \$6000 to me at the address below.

Please feel free to contact Gilbert Acevedo if you have any questions. You can reach Mr. Acevedo at 651-201-3727 or at [Gilbert.Acevedo@state.mn.us](mailto:Gilbert.Acevedo@state.mn.us).

Sincerely,

A handwritten signature in black ink that reads "Darcy Miner". The signature is written in a cursive style with a large, sweeping flourish at the end.

Darcy Miner, Director  
Compliance Monitoring Division  
Minnesota Department of Health  
P.O. Box 64882  
St. Paul, MN 55164-0882

Enc: 2

Minnesota Department of Health  
Compliance Monitoring Division  
Managed Care Systems Section



**Final Report**

**Sanford Health Plan of Minnesota**

Quality Assurance Examination  
For the Period: March 1, 2011 to January 31, 2014

*Final Issue Date:*  
July 30, 2014

Examiners  
Elaine Johnson, RN, BS, CPHQ  
Susan Margot, MA

## **Minnesota Department of Health Executive Summary**

The Minnesota Department of Health (MDH) conducted a Quality Assurance Examination of Sanford Health Plan to determine whether it is operating in accordance with Minnesota law. MDH has found that Sanford 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 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, Sanford should:**

None

### **To address mandatory improvement, Sanford must:**

Revise its Express Scripts Inc. (ESI) delegation agreement to include Sanford’s specific expectations for claims processing (reconciliation of invoices, timeliness and accuracy of claims payment, etc.), including the reports to be submitted, the frequency, what oversight is performed and the outcome of the oversight.

Revise its policy/procedures to provide a definition of quality of care complaints, clearly state who performs the investigation, any other entity’s role and Sanford’s role in the investigation, who makes the determination that the quality of care allegations are substantiated or unsubstantiated, who determines what intervention is appropriate and who oversees the implementation of the intervention regardless if the quality of care allegations are substantiated or not.

Revise its complaint system policy/procedure to state that it will inform the complainant of the right to submit the complaint in writing and offer assistance, including completing the complaint form and sending it for signature; and define external review for adverse determinations, clinical and non-clinical.

Revise its complaint and appeal policy/procedure to fully describe its internal appeal process for all types of clinical and non-clinical appeals, and to accurately state the enrollee’s rights to external review upon appeal.

Revise the appeal filing form to state that if the person filing the appeal is someone other than the patient or attending health care professional then patient signature authorization is required.

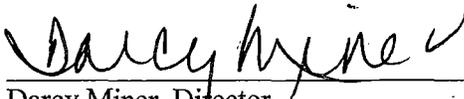
**To address deficiencies, Sanford and its delegates must:**

Revise its policy/procedure to state that oral complaints must be resolved within 10 calendar days of receipt and must implement the revised procedure to ensure oral complaints are resolved within the correct timeline.

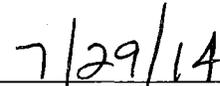
Revise the appeal rights notice to include:

- The right to appeal must be available to the enrollee and to the attending health care professional.
- For expedited appeals the organization must ensure that the enrollee and the attending health care professional have an opportunity to appeal the determination over the telephone.
- Establish procedures for appeals to be made either in writing or by telephone.

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:**

Sanford Health Plan is a not-for-profit, community-based HMO that began operations on January 1, 1998. Health services are provided to large and small groups in North Dakota, South Dakota, Iowa and in Minnesota, by Sanford Health Plan of Minnesota. Originally called Sioux Valley Health Plan, it changed its name in March 2007 to acknowledge the gift of Denny T. Sanford to the Sioux Valley Hospital & Health System. Sanford’s Minnesota HMO is a risk-bearing product that provides benefits for in-network services with higher cost sharing for out-of-network services. Extensive care management services are available.

In November 2009, Sanford Health Plan’s parent organization Sanford Health merged with Fargo, ND-based MeritCare launching a new organization: Sanford Health-MeritCare, now called Sanford Health.

Sanford Health Plan of Minnesota is currently licensed in 36 western Minnesota counties. For Minnesota, Sanford Health Plan has outlined a service area expansion for an additional 10 counties to align Sanford Health Plan’s service area with Sanford Health Plan’s provider region.

**B. Membership:**

Sanford Health Plan’s self-reported Minnesota enrollment as of December 31, 2013 consisted of the following:

<b>Product</b>	<b>Enrollment</b>
<b><i>Fully Insured Commercial</i></b>	
Large Group	422
Small Employer Group	15
Individual	NA
<b><i>Medicare</i></b>	
Medicare Advantage	NA
Medicare Cost	NA
<b><i>Total</i></b>	437

C. Onsite Examinations Dates: March 10, 2014 to March 14, 2014

D. Examination Period: March 1, 2011 to January 31, 2014  
File Review Period: February 1, 2012 to January 31, 2014  
Opening Date: December 31, 2013

E. National Committee for Quality Assurance (NCQA): Sanford Health Plan is accredited by NCQA based on 2013 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 then 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 then 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, covering 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 indicate 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 checked="" type="checkbox"/>	Not Met <input type="checkbox"/>	NCQA <input type="checkbox"/>
Subp. 3.	Appointed Entity	Met <input checked="" type="checkbox"/>	Not Met <input type="checkbox"/>	NCQA <input type="checkbox"/>
Subp. 4.	Physician Participation	Met <input checked="" type="checkbox"/>	Not Met <input type="checkbox"/>	NCQA <input 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 type="checkbox"/>	Not Met <input checked="" type="checkbox"/>	
Subp. 10.	Utilization Review	Met <input checked="" type="checkbox"/>	Not Met <input type="checkbox"/>	
Subp. 11.	Provider Selection and Credentialing	Met <input type="checkbox"/>	Not Met <input type="checkbox"/>	NCQA <input checked="" type="checkbox"/>
Subp. 12.	Qualifications	Met <input type="checkbox"/>	Not Met <input type="checkbox"/>	NCQA <input checked="" type="checkbox"/>
Subp. 13.	Medical Records	Met <input checked="" type="checkbox"/>	Not Met <input type="checkbox"/>	

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

<b>Delegated Entities and Functions</b>								
Entity	UM	UM Appeals	QM	Complaints/ Grievances	Cred	Claims	Network	Care Coord
Express Scripts	Approvals only					X	X	

Health plans must review delegate reports at least semiannually. Sanford Health Plan delegates claims processing and payment among other functions. While the delegation agreement with Express Scripts, Inc. (ESI) and the Annual Delegation Scorecard identify claims processing and adjudication as a delegated function, the documentation does not state what oversight of the claims functions was performed. Documentation verified that Sanford performs reconciliation of ESI claims twice monthly. Sanford must revise its delegation agreement to include Sanford’s specific expectations for claims processing (reconciliation of invoices, timeliness and accuracy of claims payment, etc.), including the reports to be submitted, the frequency, what oversight is performed and the outcome of the oversight. **(Mandatory Improvement #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. Sanford Health Plan received no quality of care complaints in the file period. MDH reviewed policy/procedures *Medical Management Program*, MM-49 and *Monitoring Policy*, PR-24. Read together, these policy/procedures address most of MDH expectations for quality of care complaints. Sanford Health Plan can better serve its enrollees by making the following revisions to its policy/procedures:

- Provide a definition of quality of care to guide identification of quality of care complaints. MDH considers quality to include technical competence and appropriateness of care, communication and behavior, facilities and environment, coordination of care and health plan administration.
- Clearly state who performs the investigation. If the investigation is performed by another entity, such as University of South Dakota, clearly state the entity’s role and Sanford Health Plan’s role in the investigation, who makes the determination that the quality of care allegations are substantiated or unsubstantiated, who determines what intervention is appropriate and who oversees the implementation of the intervention.

**(Mandatory Improvement #2)**

**Minnesota Rules, Part 4685.1115. Activities**

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

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

- Subp. 1. Problem Identification Met Not Met NCQA  
 Subp. 2. Problem Selection Met Not Met NCQA  
 Subp. 3. Corrective Action Met Not Met NCQA

Subp. 4. Evaluation of Corrective Action Met Not Met NCQA

Thank you for submitting to MDH Sanford Health Plan’s annual *Quality Improvement Program Evaluation*. It consisted of two evaluations, one for its clinical activities and the other for service and member satisfaction activities. The evaluations were concise, effectively displayed data over time and had excellent summaries of its improvement activities as well as a comprehensive summary of the overall effectiveness of its quality improvement program.

**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

Sanford Health Plan currently has six quality improvement activities. MDH commends Sanford for the significant improvements made in many of its improvement activities, particularly its adolescent health initiatives.

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

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

**III. Complaints Systems**

MDH examined Sanford Health Plan’s fully-insured commercial complaint system under Minnesota Statutes, chapter 62Q. MDH reviewed a total of five Complaint System files.

<b>Complaint System File Review</b>	
Complaint Files (Oral and Written)	5
Non-Clinical Appeal	0
<b>Total # Reviewed</b>	<b>5</b>

**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 a plan must establish and maintain an internal complaint resolution process that meets the requirements of this section to provide for the resolution of a complaint initiated by a complainant. The following revisions must be made to the complaint system policy/procedure:

- Minnesota Statutes, section 62Q.69, subdivision 2, further states the plan must inform the complainant that the complaint may be submitted in writing and must offer to provide the complainant with any assistance needed to submit a written complaint, including an offer to complete the complaint form and promptly mail the completed form to the complainant for signature. At the complainant’s request, the plan must provide the assistance requested. Sanford policy/procedure states it will “provide a complaint form to the complainant, which must be completed and returned to the Member Services Department for further consideration. Upon request, Member Services will provide assistance in submitting the complaint form.” Sanford’s policy/procedure does not offer assistance in submitting the form, including completing and sending it for signature. It requires the enrollee to request assistance. Sanford must revise its policy/procedure to state that it will inform the complainant of the right to submit the complaint in writing and offer assistance, including completing the complaint form and sending it for signature.
- Minnesota Statutes, section 62Q.73, subdivision 3, describes the external review process available for an adverse determination whether clinical or non-clinical. Sanford policy/procedure, MM-49 (page 36), states an external review is requested for a medical necessity final determination. The policy/procedure must be revised to define external review for adverse determinations, clinical or non-clinical.

**(Mandatory Improvement #3)**

Subd. 2 (a). Minnesota Statutes, section 62Q.69, subdivision 2 (a), states the oral complaint must be resolved “within 10 days of receiving the complaint.” Sanford’s policy/procedure, MM-49, page 36, B, 1, *Oral Complaints*, states, “within ten (10) business days of receipt.” In Minnesota Statutes, days are counted in calendar days, unless otherwise stated. In addition, one of the five complaints reviewed was an oral complaint. The complaint was resolved in more than 10 calendar days (12). The policy/procedure must be corrected to state the correct timeline and Sanford must implement the correct timeline. **(Deficiency #1)**

**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

Subd. 1. Minnesota Statutes, section 62Q.70, states the plan must establish an internal appeal process for reviewing its complaint decision.

- The policy/procedure, MM-49 (pages 38-40) describes a pre-service clinical appeal or a post-service claim appeal. If Sanford uses the pre- and post-service claim categories, it must address all elements of Minnesota Statutes, section 62Q.70 appeals and chapter 62M appeals. The policy/procedure must address pre- and post-service clinical appeals as well as pre- and post- service non-clinical appeals. Sanford must revise its policy/procedure to describe its internal appeal process for all types of clinical and non-clinical appeals.
- MM 49, pages 40-41 Item G, 1, states “If your complaint is denied based on our medical necessity criteria, you have the right to request an External Review upon receiving notice of our decision on your complaint.” A UM appeal is not a “complaint.” Minnesota law states for group health plans that an external review must be offered when a complaint decision relating to a health care service or claim has been appealed in accordance with section 62Q.70 and the appeal decision is partially or wholly adverse to the complainant or any initial determination not to certify that has been appealed in accordance with section 62M.06 and the appeal did not reverse the initial determination. [Emphasis added.] (Note: includes changes effective January 1, 2014.) Sanford must revise its policy/procedure MM-49 to state the enrollee’s rights to external review upon appeal.

**(Mandatory Improvement #4)**

**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

**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

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

Met Not Met

**Minnesota Statutes, Section 62Q.121. Licensure of Medical Directors**

Met Not Met

**Minnesota Statutes, Section 62Q.527. Coverage of Nonformulary Drugs for Mental Illness and Emotional Disturbance**

Subd. 2. Required Coverage for Anti-psychotic Drugs

Met Not Met

Subd. 3. Continuing Care

Met Not Met

Subd. 4. Exception to Formulary

Met Not Met

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

Subd. 1. Mental Health Services

Met Not Met

Subd. 2. Coverage Required

Met Not Met

**Minnesota Statutes, Section 62Q.56. Continuity of Care**

Subd. 1. Change in Health Care Provider, General Notification

Met Not Met

Subd. 1a. Change in Health Care Provider, Termination Not for Cause

Met Not Met

Subd. 1b. Change in Health Care Provider, Termination For Cause

Met Not Met

Subd. 2. Change in Health Plans

Met Not Met

Subd. 2a. Limitations

Met Not Met

Subd. 2b. Request for Authorization

Met Not Met

Subd. 3. Disclosures

Met Not Met

**V. Utilization Review**

<b>UM System File Review</b>	
<b>File Source</b>	<b>#Reviewed</b>
<i>UM Denial Files</i>	3
<i>Clinical Appeal Files</i>	2
<b>Total</b>	<b>5</b>

**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 submit internal 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

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

- Subd. 1. Procedures for Appeal Met Not Met  
 Subd. 2. Expedited Appeal Met Not Met  
 Subd. 3. Standard Appeal  
 Procedures for appeals to be made in writing or by telephone  
Met Not Met  
 (a) Appeal resolution notice timeline Met Not Met  
 (b) Documentation requirements Met Not Met  
 (c) Review by a different physician Met Not Met NCQA  
 (d) Time limit in which to appeal Met Not Met  
 (e) Unsuccessful appeal to reverse determination Met Not Met NCQA  
 (f) Same or similar specialty review Met Not Met

- (g) Notice of rights to external review Met Not Met NCQA  
 Subd. 4. Notification to Claims Administrator Met Not Met

In the three utilization denial files the appeal rights notice did not contain the following:

- Minnesota Statutes, section 62M.06, subdivision 1, states the right to appeal must be available to the enrollee and to the attending health care professional.
- Minnesota Statutes, section 62M.06, subdivision 2, states that for expedited appeals the organization must ensure that the enrollee and the attending health care professional have an opportunity to appeal the determination over the telephone.
- Minnesota Statutes, section 62M.06, subdivision 3, states the utilization review organization must establish procedures for appeals to be made either in writing or by telephone.

The appeal rights notice must be revised to include all of the above. **(Deficiency #2)**

In addition, the appeal filing form found in all three files indicate a patient signature is needed if any person other than the patient is filling out the form. As stated in Minnesota Statutes, section 62M.06, subdivision 1, the right to appeal must be available to the enrollee and to the attending health care professional. No patient authorization is required if the attending health care professional is appealing. In one of the appeals reviewed, the attending physician appealed, however the plan did not require patient authorization. The appeal filing form must be revised to state that if the person filing the appeal is someone other than the patient or attending health care professional then the patient signature authorization is required. **(Mandatory Improvement #5)**

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

Met Not Met NCQA

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

- Subd. 1. Staff Criteria Met Not Met NCQA  
 Subd. 2. Licensure Requirements Met Not Met NCQA  
 Subd. 3. Physician Reviewer Involvement Met Not Met NCQA  
 Subd. 3a. Mental Health and Substance Abuse Review Met Not Met  
 Subd. 4. Dentist Plan Reviews Met Not Met NCQA  
 Subd. 4a. Chiropractic Reviews Met Not Met NCQA  
 Subd. 5. Written Clinical Criteria Met Not Met NCQA  
 Subd. 6. Physician Consultants Met Not Met NCQA  
 Subd. 7. Training for Program Staff Met Not Met NCQA  
 Subd. 8. Quality Assessment Program Met Not Met NCQA

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

Met Not Met

## **VI. Recommendations**

None

## **VII. Mandatory Improvements**

1. To comply with Minnesota Rules, 4685.1110, subpart 6, Sanford must revise its ESI delegation agreement to include Sanford's specific expectations for claims processing (reconciliation of invoices, timeliness and accuracy of claims payment, etc.), including the reports to be submitted, the frequency, what oversight is performed and the outcome of the oversight.
2. To comply with Minnesota Rules, part 4685.1110, subpart 9, Sanford must revise its policies/procedures as follows:
  - Provide a definition of quality of care to guide identification of quality of care complaints. MDH considers quality to include technical competence and appropriateness of care, communication and behavior, facilities and environment, coordination of care and health plan administration.
  - Clearly state who performs the investigation. If the investigation is performed by another entity, such as University of South Dakota, clearly state the entity's role and Sanford's role in the investigation, who makes the determination that the quality of care allegations are substantiated or unsubstantiated, who determines what intervention is appropriate and who oversees the implementation of the intervention.
3. To comply with Minnesota Statutes, section 62Q.69, subdivision 1, Sanford must revise its complaint system policy/procedure as follows:
  - State that it will inform the complainant of the right to submit the complaint in writing and offer assistance, including completing the complaint form and sending it for signature.
  - Define external review for adverse determinations, clinical or non-clinical.
4. To comply with Minnesota Statutes, section 62Q.70, Sanford must revise its complaint and appeal policy/procedure to:
  - Fully describe its internal appeal process for all types of clinical and non-clinical appeals, and
  - Accurately state the enrollee's rights to external review upon appeal.
5. To comply with Minnesota Statutes, section 62M.06, subdivision 1, Sanford must revise its appeal filing form to state that if the person filing the appeal is someone other than the patient or attending health care professional, a patient signature authorization is required.

## VIII. Deficiencies

1. To comply with Minnesota Statutes, section 62Q.69, subdivision 2(a), Sanford must revise its policy/procedure to state that oral complaints must be resolved within 10 calendar days of receipt and must implement the revised procedure to ensure oral complaints are resolved within the correct timeline.
2. To comply with Minnesota Statutes, section 62M.06, subdivisions 1, 2 and 3, Sanford must revise its appeal rights notice to include:
  - The right to appeal must be available to the enrollee and to the attending health care professional.
  - For expedited appeal the enrollee and the attending health care professional must have an opportunity to appeal the determination over the telephone.
  - The organization must establish procedures for appeals to be made either in writing or by telephone.