DEPARTMENT OF HEALTH

Itasca Medical Care

QUALITY ASSURANCE EXAMAINATION

Final Report

For the Period: November 1, 2015 – August 1, 2018
Examiners: Elaine Johnson, RN, BS, CPHQ and Kate Eckroth, MPH
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MINNESOTA DEPARTMENT OF HEALTH
EXECUTIVE SUMMARY

The Minnesota Department of Health (MDH) conducted a Quality Assurance Examination of IMCare 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 IMCare 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.

To address mandatory improvements, IMCare and its delegates must:

Ascertain the level of satisfaction of the complainant and include more specific documentation in the file that a written form and assistance was offered in completing the form when the resolution is not clearly resolved to the satisfaction of the enrollee;

Delete from its policy *MHCP-MC Grievances (2.05.14)* the requirement to report complaint data to the Minnesota Department of Health. This requirement is only for commercial HMOs. The reporting requirement for MCO Grievances is through DHS;

Include in its policy/procedure the requirement to offer a provider contract to any designated essential community provider located in the service area.

To address deficiencies, IMCare and its delegates must:

Have a written process that clearly describes how and what is reviewed for each of the delegated activities and show evidence that delegation oversight is performed on each delegated activity;

Correctly categorize calls as grievances when the enrollee, or provider acting on behalf of the enrollee, indicates dissatisfaction about any matter other than an MCO action.

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.

Diane Rydrych, Director — Date
Health Policy Division

Contents

I. Introduction

History: The Itasca Medical Care (IMCare) program was established in 1982 as a collaborative effort involving the Minnesota Department of Human Services (DHS), Itasca County and the local community providers. IMCare was approved by the Minnesota Department of Health (MDH) in 2002 to meet all regulatory compliance requirements as a County-Based Purchasing entity. In 1985, IMCare expanded to include the Medical Assistance program and in 1996 further extended their coverage to include MinnesotaCare. In 2005, IMCare brought on the Minnesota Senior Care Plus (MSC+) population. Finally, the Medicare population, Minnesota Senior Health Options (MSHO), was included in 2006. IMCare currently serves approximately 8,645 enrollees in Itasca County.

1. Membership: IMCare self-reported enrollment as of June 18, 2018 consisted of the following:

Self-Reported Enrollment

Product	Enrollment
Minnesota Health Care Programs – Managed Care (MHCP-MC)	
Families & Children	7,330
MinnesotaCare	634
Minnesota Senior Care (MSC+)	220
Minnesota Senior Health Options (MSHO)	461
Total	**8,645**

1. Onsite Examination Dates: August 13 to 17, 2018

2. Examination Period: November 1, 2015 to August 1, 2018
   File Review Period: June 1, 2017 to May 31, 2018
   Opening Date: May 24, 2018

3. 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.

4. Performance Standard: For each instance of non-compliance with applicable law or rule identified during the quality assurance examination, which examination 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

Quality Program

Minnesota Rules, Part 4685.1110

		☒	☐
Subp. 2.	Documentation of Responsibility	☒	☐
		☒	☐
Subp. 4.	Physician Participation	☒	☐
		☒	☐
Subp. 6.	Delegated Activities		
		☒	☐
Subp. 8.	Program Evaluation	☒	☐
		☒	☐
Subp. 10.	Utilization Review	☒Met	☐ Not Met
		☒	☐
Subp. 12.	Qualifications	☒	☐
		☒	☐

Finding: Delegated Activities

Subp. 6. Minnesota Rules, part 4685.1110, subpart 6, states the HMO must develop and implement review and reporting requirements to assure that the delegated entity performs all delegated activities. The standards and processes established by the National Committee for Quality Assurance (NCQA) for delegation are considered the community standard and, as such, were used for the purposes of this examination. The following delegated entities and functions were reviewed.

Delegated Entities and Functions

Itasca Public Health								X	

IMCare delegates network of providers, which includes pharmacy credentialing, retail network auditing, pharmacy help desk, claims processing, formulary management, fraud/abuse programs, patient safety quality management, medication management, and disease management to CVS/Caremark. IMCare conducts ongoing and annual reviews of CVS/Caremark,

but does not have a documented process for how and what is reviewed for each specific CVS/Caremark activity. IMCare does provide an annual Delegation Oversight Report to CVS/Caremark indicating a summary of the findings, however it does not describe oversight for all activities delegated and what was reviewed to ensure compliance. During onsite discussions, IMCare was able to verbally state their process for reviewing the delegate, but there was no documentation of what was specifically reviewed and a summary for each delegated activity. IMCare must have a written process that clearly describes how and what is reviewed for each of the delegated activities, and show evidence that delegation oversight is performed on each delegated activity. **(Deficiency #1)**

Finding: Provider Selection and Credentialing

Subp. 11. Minnesota Rules, part 4685.1110, subpart 11, states the plan must have policies and procedures for provider selection, credentialing and recredentialing that, at a minimum, are consistent with community standards. MDH recognizes the community standard to be NCQA.

MDH reviewed a total of 33 credentialing and recredentialing files as indicated in the table below. All files met the credentialing standards.

Credentialing File Review

Physicians	8
Re-Credential	
Allied	8
Total	33

Activities

Minnesota Rules, part 4685.1115

Subp. 2.	Scope	☒ Met	☐ Not Met

Quality Evaluation Steps

Minnesota Rules, part 4685.1120

Subp. 2.	Problem Selection	☒Met	☐ Not Met
Subp. 4.	Evaluation of Corrective Action	☒Met	☐ Not Met

Focus Study Steps

Minnesota Rules, part 4685.1125

		☒	☐
Subp. 2.	Topic Identification and Selections	☒Met	☐ Not Met
		☒	☐
Subp. 4.	Corrective Action	☒Met	☐ Not Met
		☒Met	☐ Not Met

Filed Written Plan and Work Plan

Minnesota Rules, part 4685.1130

		☒	☐
Subp. 2.	Work Plan	☒Met	☐ Not Met
		☒Met	☐ Not Met

Finding: Work Plan

Subp. 2. Minnesota Rules part 4685.1130, subpart 2, states the plan will annually prepare a written work plan of the proposed quality activities that will be conducted and outlines some content requirements. IMCare's *2018 Annual Quality and Utilization Management Work Plan* is

a very thorough document, meeting the mandatory State content requirements as well as DHS mandated activities.

Finding: Amendments to Plan

Subp. 3. Minnesota Rules, part 4685.1130, subpart 3, requires any modifications to the written quality assurance plan must be approved by the commissioner of health. The *2018 Itasca Medical Care Quality Improvement Program Description* was reviewed, approved and discussed during the course of the MDH examination.

Quality of Care

A total of 2 quality of care grievance files were reviewed.

Quality of Care File Review

Quality of Care Complaints

Minnesota Statutes, Section 62D.115

		☒	☐
Subd. 2.	Quality of Care Investigations	☒Met	☐ Not Met

Finding: Quality of Care

Subd. 2. Minnesota Statutes, 62D.115, subdivision 2, states the plan must have a process for the receipt, investigation and follow up of quality of care complaints. Even though not mandated by law, IMCare policies and processes are compliant with the Statute. IMCare quality of care investigations are thorough and completed by the Medical Director, all allegations are addressed, conclusions of the investigation are supported by evidence, and appropriate follow up is done.

III. Grievance and Appeal Systems

MDH examined IMCare's Minnesota Health Care Programs Managed Care Programs – Managed Care (MCHP-MC) grievance system for compliance with the federal law (42 CFR 438, subpart F) and the DHS 2017 Contract, Article 8.

MDH reviewed a total of 6 grievance system files which was the total universe of files.

Grievance System File Review

Written	none
Non-Clinical Appeals	3
Total	**6**

General Requirements

DHS Contract, Section 8.1

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

Internal Grievance Process Requirements

DHS Contract, Section 8.2

	§438.408	Internal Grievance Process Requirements		
Sec. 8.2.1.	§438.402 (c)	Filing Requirements	☐Met	☒ Not Met
Sec. 8.2.2.	§438.408 (b)(1), (d)(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 (b)(1)	Written Acknowledgement	☒Met	☐ Not Met

			☒	☐
(C)	§438.402 (c)(3)	Oral or Written Grievances	☒Met	☐ Not Met
			☒	☐
(E)	§438.406 (b)(2)(i)	Individual Making Decision	☒Met	☐ Not Met
			☒Met	☐ Not Met
Sec. 8.2.5.	**§438.408 (d)(1)**	**Notice of Disposition of a Grievance**		
			☐Met	☒ Not Met
(B)	§438.404 (a), (b)	Written Grievances	☒Met	☐ Not Met

Finding: Filing Requirements

Sec. 8.2.1. 42 CFR 438.402(c) (DHS Contract section 8.2.1) states the enrollee, or provider acting on behalf of the enrollee, may file a grievance on a matter regarding an enrollee's dissatisfaction about any matter other than an MCO action. IMCare has only two grievances in the entire one year file review period, which is abnormally low in comparison to other plans. Discussion was held regarding the definition of grievance versus inquiry classifications. Specific calls were discussed that MDH would have classified as grievances but were not classified as such by IMCare. **(Deficiency #2)** MDH requires IMCare to form an internal work group to do a comprehensive ongoing review of all calls and how they are classified and assess needed modifications to the grievance process. IMCare will consult with the Managed Care Ombudsman office after forming its work group. The number and/or percentage of calls to be reviewed will be dependent on the total number of calls. Progress will be monitored via video conferences with the ombudsman office on an ongoing basis until grievance reporting has improved. MDH will follow up on grievance process improvements at mid-cycle.

Finding: Oral Grievances

Sec. 8.2.5(A). 42 CFR 438.406(a) (DHS Contract 8.2.5(A)), states for oral grievances, if the resolution is not resolved to the satisfaction of the enrollee, the MCO must inform the enrollee that the grievance may be submitted in writing and must offer assistance to complete. There was no clear indication if the complainant was satisfied with the resolution in the two oral grievance files reviewed and no clear offer of assistance. IMCare must ascertain the level of satisfaction of the complainant and include more specific documentation in the file that a written form and assistance was offered in completing the form when the resolution is not clearly resolved to the satisfaction of the enrollee. **(Mandatory Improvement #1)**

DTR Notice of Action to Enrollees

DHS Contract, Section 8.3

	§438.10 §438.404	DTR Notice of Action to Enrollees		
Sec. 8.3.1.	**§438.10(c), (d) §438.402(c) §438.404(b)**	**General Requirements**	☒Met	☐ Not Met
Section 8.3.2.	**§438.404 (c)**	**Timing of DTR Notice**		
(A)	§431.211	Previously Authorized Services	☒Met	☐ Not Met
(B)	§438.404 (c)(2)	Denials of Payment	☒Met	☐ Not Met
(C)	§438.210 (c)(d)	Standard Authorizations		
(1)		As expeditiously as the enrollee's health condition requires	☒Met	☐ Not Met
(2)		To the attending health care professional and hospital by telephone or fax within one working day after making the determination	☒Met	☐ Not Met
(3)		To the provider, enrollee and hospital, in writing, and must include the process to initiate an appeal, within ten (10) business days following receipt of the request for the service, unless the MCO receives an extension of the resolution period	☒Met	☐ Not Met
(D)	§438.210 (d)(2)(i)	Expedited Authorizations	☒Met	☐ Not Met
(E)	§438.210 (d)(1)	Extensions of Time	☒Met	☐ Not Met
(F)	§438.210(d)(3) and 42 USC 1396r-8(d)(5)	Covered Outpatient Drug Decisions	☒Met	☐ Not Met
(G)	§438.210 (d)(1)	Delay in Authorizations	☒Met	☐ Not Met

Internal Appeals Process Requirements

DHS Contract, Section 8.4

	§438.404	Internal Appeals Process Requirements		
Sec. 8.4.1.	**§438.402 (b)**	**One Level Appeal**	☒Met	☐ Not Met
	§438.408 (b)	Filing Requirements		
Sec. 8.4.3.	**§438.408**	**Timeframe for Resolution of Appeals**		
			☒	☐
(B)	§438.408 (b)(3)	Expedited Appeals	☒Met	☐ Not Met
			☒	☐
Sec. 8.4.4.	**§438.408 (c)**	**Timeframe for Extension of Resolution of Appeals**	☒Met	☐ Not Met
	§438.406	Handling of Appeals		
(A)	§438.406 (b)(3)	Oral Inquiries	☒Met	☐ Not Met
			☒	☐
(C)	§438.406 (a)	Reasonable Assistance	☒Met	☐ Not Met
			☒	☐
(E)	§438.406 (b)(2)	Appropriate Clinical Expertise (See Minnesota Statutes, sections 62M.06, and subd. 3(f) and 62M.09	☒Met	☐ Not Met
(G)	§438.406 (b)(5)	Opportunity to Examine the Care File	☒Met	☐ Not Met
			☒	☐
(I)	§438.410 (b)	Prohibition of Punitive Action Subsequent Appeals	☒Met	☐ Not Met
Sec. 8.4.6.		**Subsequent Appeals**		
Sec. 8.4.7.	**§438.408 (d)(2)**	**Notice of Resolution of Appeals**		
(A)	§438.408 (d)(2)	Written Notice Content	☒Met	☐ Not Met
(B)	§438.210 (c)	Appeals of UM Decisions	☒Met	☐ Not Met
(C)	§438.410 (c) and .408 (d)(2)(ii)	Telephone Notification of Expedited Appeals (Also see Minnesota Statutes section 62M.06, subd.2)	Met	Not Met
Sec. 8.4.8.	**§438.424**	**Reversed Appeal Resolutions**	Met	Not Met
Sec. 8.5.	**§438.420 (b)**	**Continuation of Benefits Pending Appeal or State Fair Hearing**	☒Met	☐ Not Met

Maintenance of Grievance and Appeal Records

DHS Contract, Section 8.6 – 8.7

	§438.416	Maintenance of Grievance and Appeal Records	☒Met	☐ Not Met
Section 8.7	**§438.416**	**Reporting of Grievances to the State**	☐Met	☒ Not Met

Finding: Reporting of Grievances

Sec. 8.7. 42 CFR 438.416 (DHS Contract section 8.7), states the MCO submits to DHS a quarterly report of all grievances. In the policy *MHCP-MC Grievances (2.05.14)* it states that *"effective January 1, 2018, IMCare must report complaint/grievance data to the Minnesota Department of Health (MDH) annually, in a format developed, implemented and distributed by MDH."* This requirement is only for commercial HMOs. The reporting requirement for MCO Grievances is through DHS. This statement must be deleted from the policy. **(Mandatory Improvement #2)**

State Fair Hearings

DHS Contract, Section 8.10

Section	42 CFR	Subject	Met	Not Met
Section 8.10	**§438.416 (c)**	**State Fair Hearings**		
Sec. 8.10.2	§438.408 (f)	Standard Hearing Decisions	☒Met	☐ Not Met
Sec. 8.10.5	§438.424	Compliance with State Fair Hearing Resolution	☒Met	☐ Not Met

IV. Access and Availability

Geographic Accessibility

Minnesota Statutes, Section 62D.124

Subdivision	Subject	Met	Not Met
Subd. 1.	Primary Care, Mental Health Services, General Hospital Services	☒Met	☐ Not Met
Subd. 2.	Other Health Services	☒Met	☐ Not Met
Subd. 3.	Exception	☒Met	☐ Not Met

Essential Community Providers

Minnesota Statutes, Section 62Q.19

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

Finding: Contract to Essential Community Provider

Subd. 3. Minnesota Statutes, 62Q.19, subdivision 3 (and DHS Contract 9.3.9), states a health plan must offer a provider contract to any designated essential community provider located within the area served by the health plan company. Geo-access review showed IMCare performs this in practice, however it was not in policy/procedure. IMCare must include in its policy/procedure the requirement to offer a provider contract to any designated essential community provider located in the service area. **(Mandatory Improvement #3)**

Availability and Accessibility

Minnesota Rules 4685.1010

Subparts	Subject	Met	Not Met
Subp. 2.	Basic Services	☒Met	☐ Not Met
Subp. 5.	Coordination of Care	☒Met	☐ Not Met
Subp. 6.	Timely Access to Health Care Services	☒Met	☐ Not Met

Emergency Services

Minnesota Statutes, Section 62Q.55

Subd. 2	Emergency Medical Condition	☒Met	☐ Not Met

Licensure of Medical Directors

Minnesota Statutes, Section 62Q.121

		☒Met	☐ Not Met

Coverage of Nonformulary Drugs for Mental Illness and Emotional Disturbance

Minnesota Statutes, Section 62Q.527

		☒	☐
Subd. 3.	Continuing Care	☒Met	☐ Not Met
		☒Met	☐ Not Met

Coverage for Court-Ordered Mental Health Services

Minnesota Statutes, Section 62Q.535

Subd. 2.	Coverage required	☒Met	☐ Not Met

Continuity of Care

Minnesota Statutes, Section 62Q.56

		☒	☐	
Subd. 1a.	Change in health care provider, termination not for cause	☒	☐	
		☒	☐	
Subd. 2.	Change in health plans (applies to group, continuation and conversion coverage)	☒	☐	☐ N/A
Subd. 2a.	Limitations	☒Met	☐ Not Met	
Subd. 2b.	Request for authorization	☒Met	☐ Not Met	
Subd. 3.	Disclosures	☒Met	☐ Not Met	

V. Utilization Review

MDH examined IMCare's utilization review (UR) system under Minnesota Statutes, chapter 62M. A total of 13 utilization review files were reviewed.

UR System File Review

File Source	# Reviewed
UM Denial Files	10
Clinical Appeals Files	3 (all)
Total	13

Standards for Utilization Review Performance

Minnesota Statutes, Section 62M.04

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

Procedures for Review Determination

Minnesota Statutes, Section 62M.05

		☒	☐
Subd. 2.	Concurrent Review	☒Met	☐ Not Met
		☒	☐
Subd. 3a.	Standard Review Determination	☒Met	☐ Not Met
		☒	☐
(b)	Initial determination to certify (telephone notification)	☒Met	☐ Not Met
		☒	☐
(d)	Initial determination not to certify (notice of right to appeal)	☒Met	☐ Not Met
		☒	☐
Subd. 4.	Failure to Provide Necessary Information	☒Met	☐ Not Met
		☒Met	☐ Not Met

Appeals of Determinations Not to Certify

Minnesota Statutes, Section 62M.06

		☒	☐
Subd. 2.	Expedited Appeal	☒Met	☐ Not Met
		☒	☐
(a)	Appeal resolution notice timeline	☒Met	☐ Not Met
		☒	☐
(c)	Review by a different physician	☒Met	☐ Not Met
		☒	☐
(e)	Unsuccessful appeal to reverse determination	☒Met	☐ Not Met
		☒	☐
(g)	Notice of rights to external review	☒Met	☐ Not Met
		☐Met	☐ Not Met (N/A)

Confidentiality

Minnesota Statutes, Section 62M.08

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

Staff and Program Qualifications

Minnesota Statutes, Section 62M.09

Subdivision	Subject	Met	Not Met
Subd. 1.	Staff Criteria	Met	Not Met
Subd. 2.	Licensure Requirements	☒Met	☐ Not Met
Subd. 3.	Physician Reviewer Involvement	Met	Not Met
Subd. 3a.	Mental Health and Substance Abuse Review	☒Met	☐ Not Met
Subd. 4.	Dentist Plan Reviews	Met	Not Met
Subd. 4a.	Chiropractic Reviews	☒Met	☐ Not Met
Subd. 5.	Written Clinical Criteria	Met	Not Met
Subd. 6.	Physician Consultants	☒Met	☐ Not Met

		☒	☐
Subd. 8.	Quality Assessment Program	☒Met	☐ Not Met

Complaints to Commerce or Health

Minnesota Statutes, Section 62M.11

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

VI. Summary of Findings

Mandatory Improvements

1. To comply with 42 CFR 438.406(a) (DHS Contract 8.2.5(A), IMCare must ascertain the level of satisfaction of the complainant and include more specific documentation in the file that a written form and assistance was offered in completing the form when the resolution is not clearly resolved to the satisfaction of the enrollee.

2. To comply with 42 CFR 438.416 (DHS Contract section 8.7), IMCare must delete from its policy *MHCP-MC Grievances (2.05.14)* the requirement to report complaint data to the Minnesota Department of Health. This requirement is only for commercial HMOs. The reporting requirement for MCO Grievances is through DHS.

3. To comply with Minnesota Statutes, 62Q.19, subdivision 3 (and DHS Contract 9.3.9), IMCare include in its policy/procedure the requirement to offer a provider contract to any designated essential community provider located in the service area.

Deficiencies

1. To comply with Minnesota Rules, part 4685.1110, subpart 6, IMCare must have a written process that clearly describes how and what is reviewed for each of the delegated activities, and show evidence that delegation oversight is performed on each delegated activity.

2. To comply with 42 CFR 438.402(c) (DHS Contract section 8.2.1), IMCare must correctly categorize calls as grievances when the enrollee, or provider acting on behalf of the enrollee, indicates dissatisfaction about any matter other than an MCO action.