

Managed Care Public Programs 2012 Quality Strategy

Revised October 2011



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Performance Measurement and Quality Improvement Division

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Table of Content

Quality Strategy

- I. Introduction
- II. Quality Strategy Outcomes
- III. DHS Compliance with Federal BBA Managed Care Regulations
- IV. Quality Strategy Standards
- V. Quality Strategy Oversight

Appendences:

Appendix A: Data Collection Burden Reduction

Appendix B: Core Quality Strategy Components

Appendix C: DHS Supplemental Triennial Compliance Assessment



Minnesota Department of Human Services

2012 Quality Strategy

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I. Introduction.

The DHS Quality Strategy (Quality Strategy) is a requirement of the 1997 Balance Budget Act (BBA) Medicaid managed care provisions [42 CFR 438.202(a)]. The State Medicaid Agency must have a written strategy for assessing and improving the quality of health care services offered by Managed Care Organizations (MCOs). The federally mandated regular reporting on the Quality Strategy's implementation, effectiveness and compliance with federal and state standards is addressed in the Annual Technical Report (ATR) produced by the External Quality Review Organization (EQRO) [42 CFR 438.202(e), 438.364].

The Quality Strategy has been developed to monitor and oversee the publicly funded managed care Minnesota Health Care Program's (MHCP) three DHS/MCO Contracts:

- Families and Children Contract: Families & Children Medical Assistance (F&C MA), and MinnesotaCare. Managed care General Assistance Medical Care (MC GAMC) program was terminated as of June 1, 2010. The Affordable Care Act offered states the option to expand Medical Assistance (MA) by including adults without children. In early 2011, Minnesota expanded MA to include these adults in the F&C Contract.
- MSHO/MS C+ Contract: Minnesota Senior Health Options (MSHO) and Minnesota Senior Care Plus (MS C+)
- Special Needs Basic Care (SNBC) Contract
- Minnesota Disability Health Options (MnDHO) Contract. The MDHO program ended January 1, 2011.

The Quality Strategy assess the quality and appropriateness of care and service provided by MCOs for all managed care contracts, program and enrollees, but in some areas there are additional or alternative Medicare Advantage benefits.

The Quality Strategy incorporates elements of current DHS/MCO Contract requirements, Minnesota HMO licensing requirements (Minnesota Statutes, Sections 62D, 62M, 62Q), and federal Medicaid Managed Care Regulations (42 CFR 438). The combination of these requirements (contract and licensing) and standards (quality assurance and performance improvement) is the core of DHS' responsibility to ensure the delivery of quality care and services in publicly funded managed health care programs. Annually, DHS assesses the quality and appropriateness of health care services, monitors and evaluates the MCO's compliance with state and federal Medicaid and Medicare managed care requirements and, when necessary, impose corrective actions and appropriate sanctions if MCOs are not in compliance with these requirements and standards. The outcome of DHS' quality improvement activities is included in the ATR.



II. Quality Strategy Outcomes.

The Quality Strategy puts into operation theories and precepts that influence the purchasing of managed health care services for managed care publicly funded programs. Purchasing quality health care services is the primary outcome of the Quality Strategy. To achieve this outcome there must be measurement of improvement in enrollee health status and satisfaction as a function of cost.¹ It is anticipated the Quality Strategy will result in seven essential outcomes which includes:

- Purchasing quality health care services,
- Protect the health care interest of managed care enrollees through monitoring,
- Assist in the development of affordable health care,
- Review and realign DHS policy and procedures that act as unintended barriers to the effective and efficient delivery of health care services,
- Focused health care prevention and chronic disease improvements consistent with enrollee demographics and cultural needs,
- Improve the health care delivery system's capacity to deliver desired medical care outcomes through process standardization, improvement and innovations, and
- Strengthen the relationship between the patients and health care providers.

The realization of these seven outcomes is dependent upon the integration of the following Continuous Quality Improvement fundamentals:

- **Continuity and Consistency of Purpose.** DHS must establish clear parameters and values to guide clinical and service improvements that are systematic and focused. Improvements take time to evolve and mature. A measured, thoughtful, strategic and a systematic purchasing approach must be employed to achieve sustained improvement.
- **Accountability and Transparency.** As stewards of public trust and funds, DHS must hold the MCOs accountable for the quality of the health care services provided. The Quality Strategy holds MCOs accountable through the use of consistent quality and performance measures reported to enrollees and public stakeholders. The scope of these measures spans many aspects of care and service with a particular focus on the ability to obtain the greatest health improvement at the lowest cost, balanced by conformity with social preferences.
- **Value.** The worth of the quality and services provided will be determined in relation to the long-term health care outcomes and satisfaction of the ultimate consumers, the managed care enrollee population. The Quality Strategy will repeatedly ask and evaluate findings to the question; *“Did the delivery system provide care and services in the appropriate quantity, quality and timing to realize the maximum attainable health care improvement at the most advantageous balance between cost and benefit?”*
- **Consumer Informed Choice and Responsibility.** The most effective and efficient health care delivery system includes the enrollee/patient in the health decision process. In order for the patient to participate, they must be provided with the prerequisite health care knowledge. Even if the patient is an informed consumer, they must also assume responsibility to reduce high-risk behaviors as part of an effort to realize optimum outcomes. Enrollee willingness

¹ Often in special needs populations improvement measurement focuses on maintenance or efforts to slow the decline in status which is a commonly expected outcome of a chronic condition.



to reduce high-risk behaviors is dependent upon the delivery system providing care and services that conform to patient preference of access, patient-doctor relationships, and the effects of care.

The best assessment of the DHS Quality Strategy is not just in the measurement of compliance with state and federal requirements, but also in enrollee satisfaction and demonstrated improvements in the care and services provided to our enrollees. Improvements in care and services can be assessed in the outcomes of the contracted MCO's annual Performance Improvement Projects as required by 42 CFR 438.240(1). The EQRO annual evaluation addresses all elements of the Quality Strategy and strives to provide effective recommendations for improvement.

III. DHS Compliance with Federal BBA Managed Care Regulations.

The Quality Strategy applies to all managed care products purchased by DHS from MCOs. Unless otherwise noted, standards, monitoring strategies and evaluation techniques apply to all managed care products. Elements of the Quality Strategy are reflected in the Contract between the State and the MCOs and are supported by Minnesota Law and Rules or federal regulations.

DHS' Quality Strategy has been developed to incorporate federal Medicaid Managed Care Regulation 42 CFR 438.202, and it:

- Acts as a written strategy for assessing and improving the quality of managed care services offered by all MCOs,
- Solicits input of recipients and other stakeholders on the strategy,
- Ensures MCO compliance with state and 42 CFR 438 (Subparts D and F) requirements,
- Requires periodic reviews to evaluate strategy effectiveness, make revisions, and
- Submit regular reports on the implementation and effectiveness of the strategy through the ATR and Quality Strategy updates.

DHS developed and published its initial written Quality Strategy in the State Register for public comment in June of 2003. The Quality Strategy was also presented in June 2003 to the Medicaid Citizen's Advisory Committee for input and comments. The Quality Strategy was reviewed in June 2004, and no revisions were made. Annually the Quality Strategy is reviewed and minor updates were incorporated.

To avoid duplication, the Quality Strategy assessment of mandatory activities includes information obtained from private accreditation reviews in addition to MDH's triennial Quality Assurance Examination. Using information obtained from these sources helps reduce the work the MCO would otherwise have to do to collect information for the EQRO review (42 CFR 438.360). DHS, MDH, MCOs and NCQA have spent considerable time meeting to determine how information gathered by NCQA can be used to minimize the data collection burden and still provide the EQRO information to complete its assessment consistent with 42 CFR 438.364. Discussions to identify additional opportunities to reduce the data collection burden through equivalency are ongoing. Currently three MCOs are accredited by NCQA; if an NCQA accreditation review indicates the MCO did not obtain 100 percent compliance with a standard (or element) MDH completes the entire review of that standard during their triennial on-site review. If the MCO is in 100 percent



compliance with NCQA Standards considered by DHS as equal or greater than state and federal requirements, MDH will not audit the applicable section. Attachment A provides a current listing of the NCQA standards that are comparable, and reduces the data collection burden.

DHS intends to review the effectiveness of the Quality Strategy at least annually. Significant future modifications will be published in the State Register to obtain public comment, presented to the Medicaid Citizen’s Advisory Committee and reported to CMS. The Quality Strategy is available on the DHS public website for all interested parties to review.

IV. Quality Strategy Standards.

The Quality Strategy is organized to reflect the standards outlined in Subpart D of the Medicaid Managed Care Regulations. Subpart D is divided into three sections; Access, Structure/Operations, and Measurement/Improvement Standards. Each standard has multiple components as indicated in the following table.

Access Standards
438.206 Availability of services
438.207 Assurances of adequate capacity and services
438.208 Coordination and continuity of care
438.210 Coverage and authorization of services
Structure and Operational Standards
438.214 Provider selection
438.218 Enrollee information
438.224 Confidentiality
438.226 Enrollment and disenrollment
438.228 Grievance systems
438.230 Subcontractual relationships and delegation
Measurement and Improvement Standards
438.236 Practice guidelines
438.240 Quality assessment and performance improvement program
438.242 Health information systems

Each of the standards is described in Appendix B, including the methods used to assess compliance with the standards. Appendix B also describes state and federal requirements in addition to 42 CFR 438. Annually in the ATR the EQRO:

- Assess each contracted MCO’s strengths and weaknesses with respect to quality, timeliness and access to health care services,
- Provide recommendations for improving quality of services furnished by each MCO,
- Provide appropriate comparative information about all MCOs,
- Assess the degree to which each MCO has addressed problems and effected changes as previously identified by the State or MDH or as recommended by the EQRO,
- Evaluate the implementation and effectiveness of the Quality Strategy, and
- Advise DHS on opportunities for improvement.



V. Quality Strategy Oversight.

The Minnesota Department of Health regulates Health Maintenance Organizations (HMOs/MCOs) and County-Based Purchasing (CBPs) entities doing business in Minnesota. MDH conducts a triennial Quality Assurance Examination of all MCOs to monitor and assess compliance with state licensing regulations. While the primary purpose of the MDH Quality Assurance Examination is to monitor compliance with Minnesota's HMO licensing regulations, some of the information collected and assessed can be used by the EQRO to assess DHS and CMS requirements, reducing the MCO data collection burden (42 CFR 438.360).² DHS and MDH have worked collaboratively to assure that when possible, information collected for the Quality Assurance Examination is consistent with federal EQR protocols to avoid the duplication of mandatory data collection. If MDH discovers a compliance deficiency a corrective action and mid-cycle follow-up review is required to ensure all deficiencies are resolved. The EQRO uses information from the Quality Assurance Examination and follow-up deficiency audits to determine MCO compliance with DHS and CMS requirements. Other reports will be gathered directly from the MCO such as the annual MCO Quality Work Plan and Evaluation. All information will be provided to the EQRO for their validation and evaluation, resulting in the detailed Annual Technical Report.

The scope of the EQRO activities is described in Subpart E of 42 CFR 438. Annually the State or the contracted EQRO, is required to conduct three mandatory activities and, at the State's discretion, conduct five optional activities. The State must annually perform the following three mandatory activities:

- Validation of performance improvement projects,
- Validation of performance measures, and
- MCO compliance with Medicaid structure and operational standards.

In future years, depending on funding, clinical or non-clinical focus studies may be undertaken. As these focus studies are developed the MCOs will be consulted and may be requested to assist with operational efforts. When these optional activities are completed they will be included in the annual EQRO report.

The attached appendixes provide additional details on DHS quality improvement activities:

- Appendix A, "Data Collection Burden Reduction" provides a summary of NCQA standards that are comparable and will be utilized by the EQRO to reduce the duplication of the data collection as required by 42 CFR 438.360 (b)(4).
- Appendix B, "Core Quality Strategy Components" provides a brief explanation of each core standard, MCO duties, oversight activities, and reporting requirements for the EQRO to use in its review and evaluation of MCO compliance with the standards.

² Beginning in calendar year 2007, MDH during the Quality Assurance Examination collects additional compliance information for DHS public programs. Attachment C provides a detailed description of the additional compliance information MDH collects for DHS. Compliance information collected by MDH will be reviewed by DHS and corrective action will be taken as necessary.



Minnesota Department of **Human Services**

- Appendix C, DHS Triennial Compliance Assessment (TCA) provides a detailed listing of additional compliance information collected for DHS and provided to the EQRO to evaluate in the ATR.



Appendix A

Data Collection Burden Reduction

The following table provides private accreditation (NCQA) standards that are comparable to BBA Managed Care regulations (42 CFR 438.360). Comparable information is used to reduce the triennial audit data collection burden. NCQA standards are reviewed and assessed on an ongoing basis to determine if any changes to the list are necessary.

BBA Regulation	NCQA Standard“100% Compliance” ³
Utilization Review and Over/Under Utilization of Services 42 CFR 438.240 (b)(3)	UM 1-4, UM 10-15
Health Information Systems 42 CFR 438.242	Annual NCQA Certified HEDIS Compliance Audit ¹
Quality Assessment and Performance Improvement Program 42 CFR 438.240 (e)(1-2)	QI 1, Element B
Clinical Practice Guidelines 42 CFR 438.236 (b-d)	QI 9, Elements A
Case Management and Care Coordination 42 CFR 438.208 (b)(1-3)	QI 4, Element B; QI 5
Access and Availability of Care and Services 42 CFR 438.206	QI 3, Element A, QI 4 Elements A-D, QI 5 Elements A-C, RR 4, MED 1
Emergency Room and Post Stabilization Care 42 CFR 438.114	UM 12
Confidentiality 42 CFR 438.208 (b)(4), 438.224, and 45 CFR Parts 160 and 164, Part 431, Subpart F	RR 6, Elements A-G
Subcontractual Relationships and Delegation 42 CFR 438.230	QI 13, UM 15, CR 12, RR 8, MEM 9
Credentialing and Recredentialing 42 CFR 438.214 (b)	CR 1-11, QI 4, QI 5

1. An MCO will be considered to have met the requirements in BBA 42 CFR 438: if the previous three annual NCQA Certified HEDIS Compliance Audits indicate; a). all performance measures are reportable, and b). the MCO provides the audit reports from the previous three years for review.
2. DHS/MCO Contract Section 7.3(A) Disease Management Program Standards. If the MCO has diabetes, asthma, and cardiac disease management programs that achieves 100 percent compliance with the NCQA QI 8, the MCO will not need to further demonstrate compliance.

³ 2011 NCQA Standards and Guidelines for Accreditation of Health Plans, effective July 1, 2011.



APPENDIX B

Core Quality Strategy Components

ACCESS STANDARDS

42 CFR 438.206 Availability of services.

MCO Duties

In a managed care delivery system, the MCO agrees to provide all services to enrollees through its Contract with the State. Any services or benefits provided under the State Plan that are not covered though the Contract is identified in the MCO's Certificate of Coverage (COC). The MCO must provide information to enrollees on how to access State Plan services not covered though the Contract. Under Contract with the State, the MCO provides the same or equivalent services as provided in fee-for-service, or at its own expense, exceed the State limits provided through the fee-for-service (FFS) delivery system. The MCO may also provide additional or substitute services.

Enrollees receive information in the COC regarding what services are covered and how to access those services through the MCO. Enrollees also receive information regarding their rights and responsibilities under managed care via a brochure issued by DHS. MCOs are required to make enrollment materials available in prevalent non-English languages and to translate any MCO specific information vital to an enrollees understanding of how to access necessary services. This ensures that information regarding MCO services and enrollee rights are available to enrollees with limited English proficiency (LEP). These documents are updated on a regular basis. The Rights and Responsibilities brochures are also available on the DHS public website.

Through the Contract, the MCO agrees to provide services that are sufficient to meet the health care needs of enrollees such as physician services, inpatient and outpatient hospital services, dental services, behavioral health services, therapies, pharmacy, and home care services

The MCO must meet the requirements of 42 CFR 438.214 (b) for credentialing of its providers. For community-based special needs plan enrollees (MSHO, and SNBC), MCOs are also liable for a specified limited nursing facility benefit. All State Plan services not covered by the DHS/MCO Contract can be accessed through Medicaid FFS. The MCO must ensure that female enrollees have direct access to women's health specialists within the network, both for covered routine and preventive health care services. An OB/GYN may serve as a primary care provider. The MCO must provide for a second opinion from a qualified health care professional within its network or arrange to obtain one outside the network at no cost to the enrollee. If an MCO's provider network is unable to provide services required by an enrollee, the MCO must adequately and timely cover services outside the network for as long as the current MCO provider network is unable to provide the needed services.

The State offers a number of special needs programs that either integrate Medicaid and Medicare benefits and requirements or, combine Medicaid benefits with a Medicare Advantage Special Needs



Plan (SNP) to serve persons with disabilities or persons age 65 years and older who often have comorbid chronic care needs. Though these special needs plans, enrollees have access to coordinated benefits and care, including Medicare pharmacy benefits, to meet their specific health care needs. The State's special needs programs are described below:

- **Minnesota Senior Health Options (MSHO):** A voluntary managed care program that integrates Medicare and Medicaid through State contracts with SNPs. MSHO operates under a 1915(a) waiver and provides eligible persons, age 65 and older all Medicare benefits including Part D pharmacy benefits, Medicaid State Plan services, Elderly Waiver (EW) services (as permitted under a 1915(c) waiver), and the first 180 days of care in a nursing facility after which time coverage reverts to Fee-For-Service (FFS). The MCO agrees to provide home and community elderly waiver (EW) services and must have a network of providers for home and community based services (HCBS). A significant feature of the MSHO program is the provision of care coordination. Each MSHO enrollee is assigned a care coordinator upon initial enrollment. Care coordinators assist enrollees in navigating the health care system and work with enrollees to ensure that care is provided in appropriate settings. Enrollment in MSHO is an alternative to mandatory enrollment in the MSC+ program.
- **Special Needs Basic Care (SNBC):** A voluntary managed care program that integrates Medicare and Medicaid through State contracts with MCO SNPs. SNBC operates under a 1915(a) waiver that provides eligible persons, age 18-64 with all types of disabilities, Medicaid State Plan services, except PCA and PDN services, all Medicare services under parts A, B and D and the first 100 days of care in a nursing facility after which time coverage reverts to FFS.⁴ SNBC enrollees have access to care/disease management and case management. Waiver services are provided to SNBC enrollees on a FFS basis and are not the responsibility of the MCO.

Oversight Activities

An annual assessment of available services is based on a review of provider networks, including review of Provider Directories and Primary Care Network Lists (PCNLs), and an ongoing assessment of changes to MCO networks, the results of the MDH triennial Quality Assurance Examination, the DHS Triennial Compliance Assessment, and review of complaint data regarding access to services. DHS will also develop service utilization measures based on encounter data to aid in this assessment.

DHS uses a protocol to review COCs, PCNLs and Provider Directories. This includes review of information on what services may be accessed directly and services which need a referral as well as availability of services such as primary care, specialty care, women's health services, second opinions, access to services out-of network services, transitional services, limitation on cost sharing not to exceed the in-network cost, and access to covered Medicaid services not covered by the MCO Contract.

⁴ Eligible persons selecting SNBC must enroll before age 65, but they may remain in the program past the age of 65 unless they enroll in the Elderly Waiver program.



DHS addresses provider payment issues on a case-by-case basis. Enrollee complaints regarding requests to pay for medically necessary services either in or out-of-network are brought to the attention of DHS contract managers or the DHS Managed Care Ombudsman's Office. DHS brings these matters to the MCO for investigation and appropriate action. This includes situations requiring out-of-network care. MCOs must provide all required services.

DHS monitors patterns of written and oral grievance and appeals to determine whether there are specific concerns regarding availability of services, access to women's health services, second opinions or complaints about cost for services in or out-of-network. Issues and trends are addressed at periodic meetings with each MCO. Identified issues are referred to the MCO for correction.

MDH monitors this standard every three years through its Quality Assurance Examination. This will include a review of the MCO's policy and procedure for second opinions. DHS has added an exam component for review of out-of-network care. The results of the MDH review are turned over to the EQRO for review. MDH will conduct follow-up as part of its mid-cycle review if deficiencies are identified.

Reports and Evaluation

Annually, the EQRO will summarize and evaluate all information submitted to DHS and assess each MCO's compliance with this standard. The EQRO will also make recommendations for improving the quality of health care services furnished by each MCO.

MCOs are also expected to meet the service needs of specific publicly funded populations. At the time of initial enrollment, the State provides the MCO with information about enrollee language and ethnicity and whether an enrollee is pregnant. The MCO can use this information to help match an enrollee with appropriate medical and language services.

At the time an individual applies for Medical Assistance or for other public health care programs, the county worker or MinnesotaCare worker collects information on each applicant's race, ethnicity and primary language spoken. There are fields in the State's information system to collect this data. DHS race categories mirror the United States Census categories. Ethnicity is collected based on the applicant's report. Primary language is also collected at the time of application and applicants are asked if they require an interpreter to access the health care system. DHS transfers race or ethnicity and language information to MCOs for new enrollees. Upon receipt of this enrollment information indicating the need for interpreter services the MCO contacts the enrollee by phone or mail in the appropriate language to inform the enrollee how to obtain primary health care services.

42 CFR 438.207 Assurance of adequate capacity and services.

MCO Duties

In a managed care delivery system, the MCO, through its Contract with DHS, assures the State that it has the capacity to provide all health care services identified in the Contract to publicly funded enrollees. The signed Contract represents that assurance. The MCO also assures DHS that those services are sufficient to meet the health care needs of enrollees and a sufficient capacity to meet community standards.



The DHS/MCO Contract requires the MCO maintain an adequate number of hospitals, nursing facilities, health care professionals, and allied and paramedical personnel distributed across sufficient service sites for the provision of all covered services. The MCO's provider network must meet MDH requirements for distance or travel time, adequate resources, timely access, and reasonable appointment times.

The MCO is required by contract to provide a complete list of participating providers. On an annual basis, the MCO must provide a complete Provider Directory including primary care, specialty care, dental, behavioral health, and hospital providers. In addition, the MCOs must provide Primary Care Network Lists (PCNLs) that include the names and locations of primary care providers, hospital affiliations, providers taking new patients, languages spoken in the clinics, how to access behavioral health services, and other important information. The PCNLs are updated quarterly.

DHS requires MCOs to pay out-of-network providers for required services that the MCO is not able to provide within its own provider network. The MCO is required to provide enrollees with common carrier transportation to the out-of-network provider if necessary. If a particular specialty service is not available within the MCO's immediate service area, the MCO must provide transportation. Treatment and transportation are provided at no cost to the enrollee except for permitted cost sharing arrangements.

MCOs must submit provider network information at the time of their initial entry into a contract or new service area with DHS. MCOs must have service area approval from MDH before DHS will sign a contract. MCOs must also update provider network information quarterly.

MCOs must update provider network information quarterly. The Contract between the State and the MCO requires that all contracted provider terminations are reported to the State, including the number of individuals who are affected by such terminations the impact on the MCO's provider network and the resolution for enrollees affected by the termination. There are provisions in state law that covers continuity of care in the event of a provider termination. In the case of a "significant change" (material modification) the MCO must notify the State as soon as the change is known. In the event of such a material modification, the enrollee has the right to change providers within the MCO or to change to another MCO. The MCO must notify affected enrollees in writing and give them the opportunity to change primary care providers from among the remaining choices or to change to another MCO.

Waiver Services Provider Networks for MSHO/SNBC. These special needs programs have relatively open networks for home and community-based services so that enrollees have sufficient access to providers for these services. Since these are voluntary products, enrollees can always disenroll to MSC+ from MSHO or to managed care/FFS from SNBC if necessary to access a certain HCBS provider.

Oversight Activities

MDH reviews and approves provider networks during the initial MCO licensure process and any



service area expansion of an MCO. MDH also reviews MCO provider networks during the Quality Assurance Examination conducted every three years. MDH will conduct a follow-up evaluation if deficiencies are identified. MDH reviews the impact of provider terminations on an MCO's provider network. MCO policies and procedures are reviewed for access requirements under Minnesota Statutes 62D (for HMOs). Minnesota access standards require that primary care providers are available within 30 minutes or 30 miles and specialty care within 60 minutes or 60 miles, unless there are no providers within those limits. In such cases, state law permits application of a community standard. During clinic site visits, MDH assesses appointment availability and waiting times. Utilization management activities are also reviewed. Grievances are audited to determine if any patterns resulting from access issues can be identified. The results of the MDH assessments are made available to DHS. DHS reviews the results to determine whether there are any issues that affect contract compliance and if so, requires corrective action by the MCO. Results of the MDH QA Examination are also made available to the EQRO for review.

At the time of initial entry of an MCO into a region for a DHS Contract, DHS reviews the MCO's proposed provider network for completeness. MCOs must have service area approval from MDH before DHS will sign a contract. DHS works with local county agency staff to develop requests for proposals for each geographic region, including the identification of major providers as well as identification of gaps in the service area for potential responders to the Request for Proposal. County staff that have knowledge of recipient utilization and access patterns, also review initial provider network proposals and advise DHS of the relative strengths and weaknesses of the proposals. Minnesota Statutes 256B.69 specifically provides that local county boards may review proposed provider networks and make recommendations to DHS regarding the number of MCOs and which MCOs should receive contracts with DHS. In addition, the law also specifically provides that county boards may work with DHS to improve MCO networks until implementation.

DHS reviews Provider Directories annually and PCNLs quarterly to assure that all geographic areas have adequate networks. This review uses a protocol to ensure completeness of information required by 42 CRF 438.207 (names, addresses, languages, providers that are closed and open to new enrollees). Materials provided to enrollees and potential enrollees by MCOs must be approved prior to distribution. MCOs are required to publish a phone number so an enrollee or potential enrollee can get information on changes that occur after materials are printed. MCOs may also include this information on their websites after DHS reviews and approves the website information.

DHS periodically maps MCO provider networks to evaluate network accessibility. DHS reviews grievance and appeals, both written and oral, to determine whether access to services is adequate, and to identify problems and trends. DHS reviews and evaluates provider network changes in the event of a change in provider access including the closing or loss of a clinic, or a substantive change in the MCO provider network. If a provider network change results in a lack of adequate coverage, the MCO may be removed as an option for assignment, or the MCO Contract in a particular county may be terminated. A referral may be made to MDH to evaluate whether the MCO meets state standards.

Reports and Evaluation

Annually, the EQRO will summarize and evaluate all information gathered and assess each MCO's



compliance with this standard. The EQRO will also make recommendations for improving the quality of health care services furnished by each MCO.

42 CFR 438.208 Coordination and continuity of care.

MCO Duties

Under this section, MCOs are required to ensure coordination of all care provided to enrollees and to ensure continuity of care. This includes coordination of care and benefits when multiple providers, or provider systems or multiple payers are involved. DHS contracts with MCOs for a comprehensive range of Medicaid and MinnesotaCare benefits. DHS does not contract for partial benefit sets such as a behavioral health carve-out. In Minnesota, persons who have insurance coverage from a Health Maintenance Organization (HMO) are excluded from enrollment unless they are covered by a HMO that contracts to provide services as an MCO under Minnesota Health Care Programs (MHCP). In such a case, the enrollee may voluntarily enroll in MHCP that is in the same MCO. The contracted MCO is required to coordinate care and benefits if there are differences in benefits or networks. MCOs must ensure that each enrollee has access to a primary care provider to coordinate the enrollee's care.

The MCO is required to have written procedures that ensure that each enrollee has an ongoing source of primary care appropriate to his or her needs and a provider formally designated as primarily responsible for coordinating the health care services furnished to the enrollee.

The MCO is responsible for the care management of all enrollees. The MCO's care management system must be designed to coordinate primary care and all other covered services to its enrollees and promote and assure service accessibility, attention to individual needs, continuity of care, comprehensive and coordinated service delivery, culturally appropriate care, and fiscal and professional accountability. The MCO must also have procedures for an individual needs assessment, diagnostic assessment, the development of an individual treatment plan based on the needs assessment, the establishment of treatment goals and objectives, the monitoring of outcomes, and a process to ensure that treatment plans are revised as necessary. There is also a strategy to ensure that all enrollees and/or authorized family members or guardians are involved in treatment planning and consent to the medical treatment.

If an enrollee needs a treatment plan for any condition, it is the responsibility of the enrollee's primary care provider to develop the plan. The enrollee must be allowed to participate in the development of his or her plan to the extent possible according to the enrollee's health status.

MSHO and SNBC programs have "care coordinators", "health coordinators" "case manager or navigation assistant" whose role is to coordinate care for enrollees. Care coordination is required under the DHS/MCO Contract Article 6. The MSHO and SNBC Contract specify detailed care coordination requirements that hold the care coordinator/health coordinator/navigation assistant responsible for coordinating care that includes assurances that enrollees have an ongoing source of primary care. Under these programs a care plan is developed that combines the primary care, chronic disease management and long-term needs including HCBS. Care plan development involves the enrollee's participation to the extent possible according to the enrollee's health status.



In MSHO and SNBC, dual-eligible enrollees get their Medicaid and Medicare services from the same MCO. On the other hand, MSC+ enrollees may receive their Medicare services from a Medicare FFS plan or by enrolling in a Medicare Advantage managed care plan that is different from their MSC+ MCO. The MSC+ MCO must coordinate services with the Medicare plan. However, most seniors required to enroll in MSC+ have chosen to enroll in MSHO instead where all their Medicare and Medicaid services are covered by one health plan. MCOs are expected to comply with requirements for care coordination and continuity of care, as stated in the MSHO/ MSC+ and SNBC Contracts.

Oversight

DHS reviews the COCs to assess each MCO's procedures for ensuring coordination and continuity of care and the procedures for ensuring that each enrollee has access to a primary care provider. In addition, MSHO/ MSC+ MCOs are required to audit a sample of care plans of waiver enrollees to assess the implementation of care plan requirements for each care system and county care coordination system. The care plan audit examines evidence of comprehensive care planning as stipulated in the Comprehensive Care Plan Audit Protocol. DHS also reviews grievance and appeal data to identify whether access to primary care providers, care coordination or continuity of care are issues requiring systematic follow-up. In addition, DHS follows up on a case-by-case basis on specific grievance and appeals regarding coordination and continuity of care.

The EQRO in the past and now MDH conduct triennial "look behind" audit of a sample of MSHO/ MSC+ MCO care plan audits to assess each MCO's compliance with the standard outlined in the Comprehensive Care Plan Audit Protocol to identify areas for a closer examination.

Special Health Care Needs

MCO Duties

The MCO must identify enrollees who may need additional health care services through method(s) approved by DHS. These methods must include analysis of claims data for diagnoses and utilization patterns (both under and over) to identify enrollees who may have special health care needs.

MCOs must analyze claims data to identify enrollees 18 years and older as required in the DHS/MCO Contract. In addition to claims data, the MCO may use other data to identify enrollees with special health care needs such as health risk assessment surveys, performance measures, medical record reviews, enrollees receiving personal care assistant (PCA) services, requests for pre-authorization of services and/or other methods developed by the MCO or its contracted providers.

The mechanisms implemented by the MCO must assess enrollees identified and monitor the treatment plan set forth by the treatment team. The assessment must utilize appropriate health care professionals to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring.



If the assessment determines the need for a course of treatment or regular care monitoring, the MCO must have a mechanism in place to allow enrollees to directly access a specialist such as a standing referral or a pre-approved number of visits as appropriate for the enrollee's condition and identified needs.

MSHO/SNBC: The State has determined that all enrollees in MSHO and SNBC are considered to meet the requirements for enrollees with special health care needs. In MSHO and SNBC, all enrollees are screened and assessed to determine whether they have special needs. In MSHO, the MCO is required to have providers with geriatric expertise and to provide Elderly Waiver home and community based services to eligible individuals. In SNBC, the MCO provides primary care providers with knowledge and interest in serving people with disabilities. The MCO must provide Community Alternatives for Disabled Individuals (CADI) and Traumatic Brain Injury (TBI) waiver services to eligible individuals. Contracts with MCOs also require them to have mechanisms to pay for additional or substitute services.

Oversight

The MCO will submit to DHS a claims analysis to identify enrollees with special health care needs and the analysis must include the following information:

- The annual number of enrollees identified for each ambulatory care sensitive condition (ACSC),
- Annual number of assessments completed by the MCO or referrals for assessments completed, and

MSHO: DHS staff review enrollee screening and assessment documents that are submitted by care coordinators for enrollees in need of home and community based services. EW services that will be reviewed and evaluated by the State: the Care Plan, Case Management and Care System audit reports and audit protocols as required in sections 7.9.3 and 9.3.5, and the Annual EW Quality Assurance Plan, required in 7.2.4.

Reports and Evaluation

Annually, the EQRO will summarize and evaluate all information gathered and assess each MCO's compliance with this standard. The EQRO will also make recommendations for improving the quality of health care services furnished by each MCO.

42 CFR 438.210 Coverage and authorization of services.

MCO Duties

Article 6 of the F&C MA Contract specifies which services must be provided and which services are not covered. Medical necessity is defined. The Contract requires that all medically necessary services be covered unless specifically excluded from the Contract. The MCO must have in place policies for authorization of services and must inform enrollees how services may be accessed (whether direct access is permitted, when a referral is necessary, and from whom). In the Contract, federal, and state law specify time frames for decisions, whether standard or expedited. (See Grievances and Appeals in Article 8 of the Contract) The COC must inform enrollees how to



access State Plan services not covered by the MCO's contract.

When a service is denied, terminated, or reduced, the MCO must give the enrollee a notice of action including a description of the enrollees' rights with respect to MCO appeals and State Fair Hearing process.

Oversight Activities

On a quarterly basis, MCOs submit specific information about each notice of action to the State Ombudsman Office. This office reviews this information and tracks trends in denial, termination and reduction of services.

Review of encounter data also provides information regarding coverage and authorization of services. DHS monitors enrollee complaints related to service access.

Every three years, MDH conducts an on-site Quality Assurance Examination. This audit includes a review of service authorization and utilization management activities of the MCO or its subcontractor(s). DHS works closely with MDH in preparing for these audits and has the opportunity to identify special areas of concern for review. MDH conducts a follow-up exam if deficiencies are identified. The results of this examination are made available to DHS. DHS reviews the results to determine whether there are any issues that affect contract compliance and if so, requires corrective action by the MCO. The results of the MDH audit are also made available to the EQRO for review.

MSHO/SNBC: DHS has an interagency agreement with MDH for review of specified Medicaid requirements, including specific MSHO items. The MSHO Contract requires that MCOs conduct on-site audits of provider care systems and provide information about care system performance at the State's annual site visit. DHS also reviews MSHO encounter data with comparisons to Families and Children MA and MA FFS. DHS developed a database combining Medicaid and Medicare data about dual eligibles to enable data analysis of the dual-eligible population. The State works with a collaborative created by MCOs participating in MSHO to track a core set of "Value Added" utilization measures. Analysis of utilization patterns will also be conducted for SNBC.

Reports and Evaluation

Annually, the EQRO will summarize and evaluate all information gathered and assess each MCO's compliance with this standard. The EQRO will also make recommendations for improving the quality of health care services furnished by each MCO.

STRUCTURE AND OPERATIONAL STANDARDS

42 CFR 438.214 Provider selection.

MCO Duties

In a managed care delivery system, the MCO selects, reviews, and retains a network of providers that may not include all available providers. Since the MCO has a limited network of providers



from which the enrollee may select, the MCO has a responsibility to monitor these providers for compliance with state licensing requirements and MCO operational policies and procedures.

The MCO is required to have an established Credentialing and Recredentialing program that monitors and reviews the panel of providers for the quantity of provider types and ensures providers are qualified and competent. The MCO's Credentialing and Recredentialing program must follow National Committee for Quality Assurance (NCQA) standards.

The MCO is prohibited from discriminating against providers that serve high-risk populations or specialize in conditions that require costly treatment. The MCO is prohibited from contracting with or employing providers that are excluded from participation in Federal Health Care programs.

Oversight Activities

At least once every three years, MDH conducts an audit of MCO compliance with state and federal requirements. The results of the MDH examination are reviewed by the EQRO. MDH will conduct a follow-up Mid-cycle Examination if deficiencies are identified.

Reporting and Evaluation

Annually, the EQRO summarizes and evaluates all information submitted to DHS and assess each MCO's compliance with this standard. The EQRO makes recommendations for improving the quality of health care services as necessary.

42 CFR 438.218 Enrollee information.

Enrollee information must meet the requirements of 438.10 (Information Requirements).

There are specific requirements for current enrollees and for potential enrollees. In Minnesota, the State or the local agency provides most information to potential enrollees. Most, but not all enrollee information is provided by the MCOs.

MSHO/SNBC: MCOs with Medicare Advantage SNPs are also subject to Medicare regulations, which permit and require MCOs to market to potential and current enrollees. Thus, MCOs in the MSHO/SNBC programs market and provide most of the information to potential enrollees.

State Duties

DHS must ensure that enrollment notices, informational, instructional and marketing materials are provided at a 7th grade reading level. The State or local agency provides information to most potential enrollees through written enrollment materials. Potential enrollees may also choose to attend a presentation. This information is designed to help enrollees and potential enrollees understand the managed care program. The State must identify the prevalent non-English languages spoken throughout the state and make written information available in those languages. The State must make oral interpretation services available in any language and must provide information about how to access interpretation services. Information must be available in alternative formats to address special needs, such as hearing or visual impairment, and must inform enrollees and potential enrollees about how to access those formats.



MCO Duties

Enrollment notices, informational, instructional and marking materials, and notice of action, must be provided at a 7th grade reading level. The MCO must identify the prevalent non-English languages spoken within its service area throughout the state and take reasonable steps to ensure meaningful access to the MCO's programs and services by persons with Limited English Proficiency (LEP). The MCO must make oral interpretation services available in any language and must provide information about how to access interpretation services. Information must be available in alternative formats that take into account the enrollee's special needs, including those who are visually impaired or have limited reading proficiency. The MCO must inform enrollees about how to access those formats.

Oversight Activities

The State provides enrollment materials, which meet the requirements above, to the local agency for distribution to all enrollees or potential enrollees. By Contract, the State must review and approve all MCO notices and educational/enrollment materials prior to distribution to enrollees or potential enrollees. MCO enrollees receive a membership card and other materials, including a Provider Directory and a Certificate of Coverage upon enrollment. Providers use the enrollee's MCO member card to verify enrollment status through the Eligibility Verification System (EVS). If the provider finds a discrepancy between data provided by the MCO and the data available on EVS, the provider contacts the State provider help desk. The help desk verifies the system data and refers the problem to the enrollment coordinator group to resolve with the MCO.

Reporting and Evaluation

Annually, the EQRO summarizes and evaluates all information submitted to DHS and assess each MCO's compliance with this standard. The EQRO makes recommendations for improving the health care services furnished by each MCO.

The State will conduct site visits at the local agencies to monitor managed care presentations and review enrollment activities.

A. Information for Potential Enrollees

State Duties

The State or local agency must provide specific information to each potential enrollee who becomes eligible to enroll in a mandatory or voluntary Medicaid managed care program. The following information is provided within a timeframe that allows the potential enrollee to choose among available MCOs and includes:

- The basic features of managed care,
- Which populations are enrolled on a mandatory basis, populations excluded from enrollment or those free to enroll voluntarily,
- MCO responsibility for coordination of care,
- Summary information specific to each MCO operating in the potential enrollee's service area which includes benefits covered, cost sharing, service area, names, locations, and phone numbers of providers, primary care physicians, specialists, hospital affiliation, special



services, evening or weekend hours, any non-English language spoken by providers, and providers not accepting new patients,

- A description of benefits available under the State Plan that are not covered by the MCO Contract, and how and where enrollees may obtain those benefits,
- Cost sharing, and
- How transportation is provided.

MCO Duties

The MCO must provide PCNLs, which include summary information specific to each MCO operating in the potential enrollee's service area. The information must include names, locations, phone numbers, primary care physicians, specialists, hospital affiliation, special services, evening or weekend hours, non-English language spoken by providers, and providers not accepting new patients. MCOs are required to provide a telephone number for enrollees and potential enrollees to call to get information about changes that have occurred since the documents were printed. MCOs may also make this information available on their websites.

B. Information for Enrollees

State Duties

The State will notify all enrollees of their disenrollment rights also referred as open enrollment in September of each year to be effective January 1st of the following year. Each year during open enrollment, the State must provide the enrollees the opportunity to request specified information. This information includes:

- The basic features of managed care,
- Which populations are excluded from enrollment or are free to enroll voluntarily,
- MCO responsibility for coordination of care,
- Summary information specific to each MCO operating in the potential enrollee's service area, which includes benefits covered, cost sharing, service area, names, locations, phone numbers of providers, any non-English language spoken by providers, providers not accepting new patients, and
- Benefits available under the State Plan, which are not covered under the Contract. The information includes how and where enrollees may obtain those benefits,
- Cost sharing, and
- How transportation is provided.

At least annually, the State must notify enrollees about their rights and responsibilities, and information on grievance, appeal, and State Fair Hearing procedures. Annually, and upon request, each enrollee will receive information within a specific timeframe in a comparative chart-like format, the MCOs service areas, benefits covered under the Contract, cost sharing and quality and performance indicators including enrollee satisfaction. Each enrollee must also receive a written notice of any change that the State defines as significant.

MCO Duties

MCOs furnish enrollment materials to each enrollee within a reasonable time (15 days) after the



MCO receives notice of the recipient's enrollment from the State. Each enrollee must receive a written notice of any information change that the State defines as significant and any restrictions on the enrollee's freedom of choice among network providers. The MCO must provide each enrollee with specific information. This includes information about how to access services, services that may be accessed directly or require a referral, and how an enrollee may choose a primary care provider. This information is included in the Certificate of Coverage (COC), Primary Care Network List (PCNLs) and Provider Directory.

Oversight Activities

The State provides the MCO with a model COC. The MCO must submit its COC for approval to both DHS and MDH prior to distribution. The State provides requirements and guidelines for information to be included in PCNLs and Provider Directories. This information includes use of the language block and submission of the results of a test for readability of the document. The MCO's PCNL and Provider Directory must be approved by DHS prior to use. Protocols are used for review of all of these documents.

MSHO/SNBC: These programs utilize integrated Medicare and Medicaid materials. The State develops model materials for this purpose whenever possible, incorporating both Medicare and Medicaid requirements. Informational material, enrollment material, websites and other recipient information that contains statements about the benefit package is subject to review and approval by the State and the CMS Medicare Regional Office. Consumer Advisory Committees for these programs also provide input and review of enrollment processes and materials. DHS plays a significant role in working with the MCO and county staff in assisting potential and current enrollees with eligibility issues. DHS also follows up on complaints about the enrollment process.

Reporting and Evaluation

Annually, the EQRO summarizes and evaluates all information submitted to DHS and assess each MCO's compliance with this standard. The EQRO may make recommendations for improving the health care services furnished by each MCO.

42 CFR 438.224 Confidentiality.

MCO Duties

All managed care Contracts require MCOs to comply with 45 CFR parts 160 and 164, subparts A and E to the extent that these requirements are applicable, and requires that MCOs comply with subpart F of Section 42 CFR 431.

Oversight Activities

The State has incorporated the requirements of 45 CFR parts 160 and 164, subparts A and E into its contracts with MCOs.

The State monitors MCO compliance with all applicable confidentiality requirements.

Reporting and Evaluation

Annually, the EQRO summarizes and evaluates all information submitted to DHS and assess each



MCO's compliance with this standard. The EQRO may make recommendations for improving the MCO's assurance of confidentiality.

42 CFR 438.226 Enrollment and disenrollment.

Provisions for enrollment and disenrollment must meet the requirements of 42 CFR 438.56. Disenrollment provisions apply to all enrollees whether the enrollment is mandatory or voluntary. Enrollees may request disenrollment either orally or in writing to the State or local agency. Enrollees may request disenrollment when they:

- Move out of the MCO's service area,
- Need related services to a procedure performed at the same time and all services are not available with the MCO's network and the PCP or another provider determines that receiving the service separately would cause undue risk,
- Have other reasons including but not limited to poor quality of care, lack of access to services or lack of access to providers experienced in dealing with the enrollee's health care needs,
- For cause at any time,
- Once during the first year of enrollment, and without cause at least once every twelve months,
- During the 90 days following the date of the recipient's initial enrollment with the MCO, or the date the State sends the recipient notice of the enrollment, whichever is later.
- Upon automatic reenrollment if the loss of eligibility has caused the recipient to miss the annual open enrollment opportunity, or
- When the State imposes intermediate sanctions.

MSHO/SNBC: Enrollment and disenrollment functions for Medicaid are performed by the State rather than through the local agency or the MCO. For Medicare enrollment and disenrollment, most MCOs have contracted with the State to serve as a Third-Party-Administrator. Enrollees in these voluntary programs are permitted to disenroll at any time, with or without cause, with the disenrollment usually effective in the next month according to Medicare timelines.

State Duties

A determination for disenrollment must be made no later than the first day of the second month following the month in which the enrollee requests disenrollment or the request is considered approved. Automatic reenrollment in the same MCO is provided if the disenrollment period is for a period of 2 months or less, if the enrollee establishes eligibility within 2 months or less.

MCO Duties

MCOs are precluded by the DHS/MCO Contract from requesting that an enrollee be disenrolled from MC MHCP for any reason. MCOs must refer any requests for disenrollment to the State or local agency. MCOs are permitted to request that an enrollee be disenrolled only if the enrollee becomes ineligible for Medicaid, moves out of the service area, or engages in disruptive behavior as specified in 42 CFR 422.74.



Oversight Activities

The State monitors all requests for disenrollment.

Enrollees have access to information about their right to disenroll from county staff, MCO staff, and care coordinators. The information is provided in managed care program brochures, the Certificate of Coverage, and Notice of Rights and Responsibilities brochure mailed to enrollees by the State.

State staff also monitors disenrollment through grievance and appeals, disenrollment surveys (enrollees who change MCOs or disenroll from MSHO), disenrollment statistics, and frequent communications with MCO staff and care coordinators.

Annually, the EQRO summarizes and evaluates all information submitted to DHS and assess each MCO's compliance with this standard. The EQRO will make recommendations for improving the health care services furnished by each MCO.

42 CFR 438.228 Grievance system.

MCO Duties

A grievance system provides an opportunity for managed care enrollees to express dissatisfaction with medical services provided. The MCO and DHS grievance and appeal process ensures that enrollees and providers have input into the health care decision-making process.

MCOs are required to have a Grievance System which includes an oral and written grievance process, an oral and written appeal process, and access to the State Fair Hearing system. The process must allow a provider to act on behalf of the enrollee with the enrollee's written permission.

The MCO must assist enrollees, as needed, in completing forms and navigating the grievance and appeal process. The appeal process must provide that oral inquiries seeking to appeal an action be treated as an appeal with the opportunity to present evidence in person as well as in writing.

The MCO must dispose of each grievance and resolve each appeal, whether orally or in writing, and provide notice, as expeditiously as the enrollee's health condition requires, but no later than the timeframes established by state and federal laws, and that are specified in the Contract.

A State Fair Hearing must be permitted as specified by the State. The MCO must be a party to the State Fair Hearing and must comply with hearing decisions promptly and expeditiously.

The MCO must send a notice of action to each enrollee when it denies, terminates, or reduces a service or when it denies payment for a service. The notice must state the action taken; the type of service or claim that is being denied, terminated, or reduced; the reason for the action; and the rules or policies which support the action. The notice must include a rights notice, explaining the enrollee's right to appeal the action. The MCO must continue to provide previously authorized benefits when an enrollee appeals the denial, termination, or reduction of those benefits and the timelines and other conditions for continuation of benefits are met, as specified in the Contract.



The MCO must maintain grievance and appeal records, and provide notification to the State, as specified in the Contract.

MSHO/SNBC: Enrollees of these programs also have access to Medicare grievance and appeals processes. In order to simplify access to both the Medicare and Medicaid grievance systems, the State has developed an integrated process in conjunction with CMS that allows the MCO to make integrated coverage decisions for both Medicare and Medicaid. Enrollees continue to have access to grievance and appeal procedures under both programs.

Oversight Activities

On a quarterly basis, the MCO must report specified information about each notice of action to the state Managed Care Ombudsman Office. This office reviews this information and tracks trends in the MCO's Grievance System.

DHS integrates data provided by MDH through the Quality Assurance Examination with the data collected directly from MCOs by DHS in order to analyze appeal and grievance procedures, timelines, and outcomes of grievances, appeals, and State Fair Hearings.

At least once every three years, MDH audits MCO compliance with state and federal grievance and appeal requirements. The results of the MDH audit are made available to DHS. DHS reviews the results to determine whether there are any issues that affect contract compliance and if so, requires corrective action by the MCO. The results of the MDH audit are also reviewed by the EQRO. MDH will conduct a follow-up examination if deficiencies are identified.

Reporting and Evaluation

Data collected from DHS and MDH grievance and appeal investigations are integrated to provide feedback on the grievance system and serve as a basis for recommending policy changes.

Annually, the EQRO summarizes and evaluates all information submitted to DHS and assess each MCO's compliance with this standard. The EQRO will also make recommendations for improving the quality of health care services furnished by each MCO.

42 CFR 438.230 Subcontractual relationships and delegation.

MCO Duties

The MCO may choose to delegate certain health care services or functions (e.g., dental, chiropractic, mental health services) to another organization with greater expertise for efficiency or convenience, but the MCO retains the responsibility and accountability for the function(s). The MCO is required to evaluate the subcontractor's ability to perform the delegated function(s). This is accomplished through a written agreement that specifies activities and reporting responsibilities of the subcontractor and provides for revoking the delegation or imposing sanctions if the subcontractor's performance is not adequate. When the MCO delegates a function to another organization, the MCO must do the following:



- Evaluate the prospective subcontractor's ability to perform the activities, before delegating the function,
- Have a written agreement with the delegate that specifies activities and reporting responsibilities and how sanctions / revocation will be managed if the delegate's performance is not adequate,
- Annually monitor the delegates' performance, and
- If the MCO identifies deficiencies or areas for improvement, the MCO/delegate must take corrective action.
- Provide to the State an annual schedule identifying subcontractors, delegated functions and responsibilities, and when the subcontractor's performance will be reviewed.

MSHO/SNBC: MCOs are also required to audit their care systems annually.

Oversight Activities

At least once every three years, MDH audits MCO compliance with state and federal requirements in a review of delegated activities. MDH will conduct a follow-up review if deficiencies are identified. The results of the MDH audit are made available to DHS. DHS reviews the results to determine whether there are any issues that affect contract compliance and if so, requires corrective action by the MCO. The results of the MDH audit are also reviewed by the EQRO.

MCOs annually monitor the subcontractor's ability to perform the delegated functions. The results of the review are provided to the EQRO for evaluation. If an MCO identifies deficiencies or areas for improvement, the MCO will inform DHS of the corrective action. Corrective action information will be provided to the EQRO to be included in its evaluation.

MSHO/SNBC: MDH QA Examination reviews MCO subcontracts for compliance with Contract requirements.

Reporting and Evaluation

Annually, the EQRO summarizes and evaluates all information submitted to DHS and assess each MCO's compliance with this standard. The EQRO may make recommendations for improving the quality of health care services furnished by each MCO.

MEASUREMENT AND IMPROVEMENT STANDARDS

42 CFR 438.236 Practice guidelines.

MCO Duties

Adoption and application of practice guidelines are essential to encourage appropriate provision of health care services and promote prevention and early detection of illness/disease. Providers that agree and follow guidelines based upon current clinical evidence have the potential to identify and change undesirable health care processes and reduce practice variation.

MCOs are required to adopt, disseminate and apply practice guidelines. The guidelines must be evidence based, consider the needs of enrollees and be adopted in consultation with providers. The



guidelines must be reviewed and updated periodically to remain in concurrence with new medical research findings and recommended practices. The MCO must apply the guidelines in utilization decisions, enrollee education and coverage of services.

Oversight Activities

At least once every three years, MDH audits MCO compliance with state and federal requirements. The results of the MDH audit are reviewed by the EQRO. A follow-up examination is conducted if deficiencies are identified.

The MCO must annually audit provider compliance with the practice guidelines and report to the State the findings of their audits. Each year, DHS provides the MCO's practice guideline audits to the EQRO for review.

Reporting and Evaluation

Annually, the EQRO summarizes and evaluates all information gathered and assess each MCO's compliance with this standard. The EQRO also makes recommendations for improving the quality of health care services furnished by each MCO.

42 CFR 438.240 Quality assessment and performance improvement program.

MCO Duties

Conducting quality improvement projects provides a mechanism for the MCO to target high risk, high volume or problem prone care or service areas that can be improved with a focused strategic intervention(s). These projects are designed to identify and subsequently introduce evidence-based interventions to improve the quality of care and services for the at-risk enrollees. Quality improvement projects reflect continuous quality improvement concepts including identifying areas of care and service that need improvement, conducting follow-up, reviewing effectiveness of interventions, making additional changes, and repeating the improvement cycle as needed.

Each year the MCO must select a topic for a performance improvement project on which to conduct a quality improvement project. These projects may take several years to complete but must demonstrate sustained improvement as required by CMS protocol. Projects must be designed to achieve, through ongoing measurements and interventions, significant improvements in clinical and non-clinical areas sustained over time.

Proposed projects are submitted to DHS for review and validation assuring the project meets the following criteria:

- Have a favorable effect on health outcomes,
- Use measurements of performance that are objective quality indicators,
- Implement system interventions to achieve improvement in quality,
- Evaluate the effectiveness of the interventions, and
- Plan and initiate activities that will increase or sustain the improvements obtained.

When a project is completed the MCO writes a final report and submit to DHS for review. The final report describes the impact and effectiveness of the project.



Oversight Activities

Each year the MCO selects a project topic and submit to DHS a project proposal describing the project to be undertaken beginning in the next calendar year. The project usually span a three to four year period with an annual interim report, due upon request, leading to a final project report. DHS reviews and recommends changes as appropriate and submit the final reports to the EQRO for evaluation to determine if significant improvement has been achieved and if it will be sustained over time.

The MCO is expected to include all quality program requirements in the project, where appropriate; such as mechanisms to detect both under and over utilization of services, and assess the quality and appropriateness of care provided to enrollees with special health care needs if they are included in the project population.

Reporting and Evaluation

Annually, the EQRO summarizes and evaluates all information gathered and assess each MCO's compliance with this standard. The EQRO also makes recommendations for improving the quality of health care services furnished by each MCO.

42 CFR 438.242 Health information systems.

MCO Duties

A health information system must have the capabilities to produce valid encounter data, performance measures and other data necessary to support quality assessment and improvement, as well as managing the care delivered to enrollees.

The MCO must maintain a health information system that collects, analyzes, integrates and reports data that achieves the MCO quality improvement efforts. The system must also provide information that supports the MCO's compliance with state and federal standards.

The model Contract sets standards for encounter data reporting and submission that meet the requirements of Section 1903(m)(2)(A)(xi) of the Social Security Act, 42 U.S.C. Section 1396b(m)(2)(A)(xi). This includes formats for reporting, requirements for patient and encounter specific information, information regarding treating provider and timeframes for data submission.

The Health Information System is required to possess a reasonable level of accuracy and administrative feasibility, be adaptable to changes as methods improve, incorporate safeguards against fraud and manipulation, and shall neither reward inefficiency nor penalize for verifiable improvements in health status.

Oversight Activities

Annually, DHS contracts with an NCQA Certified HEDIS Auditor to assess its information system's capabilities. The auditor's report is reviewed by the EQRO and a determination made on DHS and MCO's compliance.



When MCOs submit encounter data to DHS, automated systems data audits are conducted to ensure data integrity for accuracy and administrative feasibility. In 2008, DHS established a unit dedicated to the improvement of encounter data quality. The Encounter Data Quality Unit (EDQU) monitors encounter data submission and works with MCOs on corrections.

Reporting and Evaluation

MMIS contains more than 100 automated edits that are applied to MCO submissions. MCO submissions are manually reviewed in two separate processes for format, accuracy, and possible duplication. MCOs receive reports on data quality and completeness. DHS monitors service

utilization using encounter data that has been uploaded to the data warehouse. Potential problems and issues are identified and the MCOs are notified. DHS uses encounter data to develop Risk Adjustment Calculation and reporting.

Annually, the EQRO summarizes and evaluates all information gathered and assess each MCO's compliance with this standard. The EQRO also makes recommendations for improving the quality of health care services furnished by each MCO.

SANCTIONS

42 CFR 438.700 Basis for imposition of sanctions.

The Contract between the State and the MCO contain provisions for intermediate sanctions. These sanctions are referred to as “remedies” for partial breach of the Contract. A sanction may be applied for any breach of the Contract, including quality of care. The State may impose a sanction if it determines that the MCO has failed substantially to provide medically necessary services, has inappropriately required or allowed its providers to require enrollees to pay cost-sharing, has discriminated among enrollees based on health status or need for care, has falsified or misrepresented information provided to the State or CMS, or has failed to comply with the physician incentive plan requirements.

If a quality of care issue were subject to sanction, the MCO would be notified of the breach and would be given an opportunity to cure the breach. The amount of time allowed for the MCO to cure the breach depends on the seriousness of the issue, and whether there is risk to enrollees in allowing time for the MCO to cure. Failure to cure within the designated time frame would result in the imposition of a remedy or sanction.

In determining a remedy or sanction, the State is obligated to consider the number of enrollees or recipients, if any, affected by the breach, the effect of the breach on enrollees' health and enrollees' and recipients' access to health services or, in the case that only one enrollee or recipient is affected, the effect of the breach on that enrollee's or recipient's health, whether the breach is an isolated incident or part of a pattern of breaches, and the economic benefits, if any, derived by the MCO as a result of the breach.



Minnesota Department of **Human Services**

The type of sanctions included in the Contract satisfies most of the requirements of 42 CFR Section 438.702 and Section 438.704. The State may impose temporary management of the MCO. The Contract has provisions for due process for the MCOs, including the opportunity to cure a breach and access to a mediation panel. The State's rights to terminate a contract are defined in the Contract.



Appendix C

DHS Supplemental Triennial Compliance Assessment Information (Information gathered during the MDH QA Examination) October 2011

During the QA Examination, MDH will collect and validate MCO compliance information for DHS publicly funded managed care programs.⁵ The compliance information will be gathered and reported for each publicly funded program (Family & Children MA, MinnesotaCare, MSHO, MSC+, and SNBC) as appropriate. MDH will produce a written summary of the information gathered during the MCO's QA Examination. Listed below are the areas that MDH will gather compliance information for DHS Supplemental Triennial Compliance Assessment (TCA).

1. Coverage of Services. 2010 Contract Sections 6.8.1 Medical Necessity and 6.24.3 Service Authorization and Utilization Review^{6,7}

- A. Unless otherwise provided in this agreement, or otherwise mandated by state or federal law, the MCO shall be responsible for the provision and cost of health care services as described in Article 6 only when such services are deemed to be Medically Necessary by the MCO.
- B. The MCO, and if applicable its subcontractor, must have in place and follow written policies and procedures for utilization review that reflect current standards of medical practice in processing requests for initial or continued Service Authorization of services as specified in Minnesota Statutes, sections 62M.05 and 62M.09. The MCO's policies and procedures shall ensure the following:
 - (1) Consistent application of review criteria for authorization decisions;
 - (2) Consultation with the requesting provider when appropriate;
 - (3) Decisions to deny an authorization request or authorize it in an amount, duration, or scope that is less than requested be made by a health care professional who has appropriate clinical expertise in treating the enrollee's health condition; and
 - (4) Notification to the requesting Provider and written notice to the enrollee of the MCO's decision to deny or limit the request for services.

2. Accessibility of Providers. 2010 Contract Section 6.21^{8,9,10}

- A. In accordance with Minnesota Statutes, Section 62D.124, the MCO must demonstrate that its Provider network is geographically accessible to enrollees in its Service Area. In determining the MCO's compliance with the access standards, DHS may consider an exception granted to the MCO by MDH for areas where the MCO cannot meet these standards.
- B. In accordance with the DHS/MCO managed care contracts for MSHO, and MSC+, the MCO must demonstrate that it offers a range of choice among Waiver providers such that there is evidence of procedures for ensuring access to an adequate range of waiver and nursing facility services so that

⁵ DHS/MCO Contracts and current NCQA Standards and Guidelines for the Accreditation of Health Plans.

⁶ MSHO/MS C+ Contract Sections 6.5.1 and 6.17.3, SNBC Contract Sections 6.44.1 and 6.56.3

⁷ 42 CFR 438.210 (a) (b)

⁸ MSHO/MS C+ Contract Section 6.16; SNBC Contract Section 6.57.

⁹ 42 CFR 438.206(b)(1)

¹⁰ MSHO/MS C+ Contract Sections 6.1.3 (C) (2) and 6.1.4 (E).



appropriate choices among nursing facilities and/or waiver services may be offered to meet the individual need as of Enrollees who are found to require a Nursing Facility Level of Care.¹¹

3. QI Program Structure. 2010 Contract Section 7.1.1.

- A. The MCO must incorporate into its quality assessment and improvement program the standards as described in 42 CFR 438, Subpart D (access, structure and operations, and measurement and improvement).

4. Utilization Management. 2010 Contract Section 7.1.3

- A. The MCO shall adopt a utilization management structure consistent with state regulations and current NCQA “Standards and Guidelines for the Accreditation of Health Plans.” The MCO shall facilitate the delivery of appropriate care and monitor the impact of its utilization management program to detect and correct potential under and over utilization. The MCO shall:

- (1) Choose the appropriate number of relevant types of utilization data, including one type related to behavioral health to monitor.
- (2) Set thresholds for the selected types of utilization data and annually quantitatively analyze the data against the established thresholds to detect under and overutilization.
- (3) Conduct qualitative analysis to determine the cause and effect of all data not within thresholds.
- (4) Analyze data not within threshold by medical group or practice.
- (5) Take action to address identified problems of under or overutilization and measure the effectiveness of its interventions.¹²

- B. The following are the 2010 NCQA Standards and Guidelines for the Accreditation of Health Plans UM 1-4 and 10-14.

- (1) ***NCQA Standard UM 1: Utilization Management Structure***
The organization clearly defines the structures and processes within its utilization management (UM) program and assigns responsibility to appropriate individuals.
 - (a) Element A: Written Program Description
 - (b) Element B: Physician Involvement
 - (c) Element C: Behavioral Health Involvement
 - (d) Element D: Annual Evaluation
- (2) ***NCQA Standard UM 2: Clinical Criteria for UM Decision***
To make utilization decisions, the organization uses written criteria based on sound clinical evidence and specifies procedures for appropriately applying the criteria.
 - (a) Element A: UM Criteria
 - (b) Element B: Availability of Criteria
 - (c) Element C: Consistency in Applying Criteria
- (3) ***NCQA Standard UM 3: Communication Services***
The organization provides access to staff for members and practitioners seeking information about the UM process and the authorization of care.
 - (a) Element A: Access to Staff

¹¹ Evidence that choice is offered to Enrollees qualifying for a Nursing Home Level of Care is reviewed #15.

¹² 42 CFR 438. 240(b)(3)



- (4) ***NCQA Standard UM 4: Appropriate Professionals***
Qualified licensed health professionals assess the clinical information used to support UM decisions.
 - (a) Element D: Practitioner Review of BH Denials
 - (b) Element F: Affirmative Statement About Incentives

- (5) ***NCQA Standard UM 10: Evaluation of New Technology***
The organization evaluates the inclusion of new technologies and the new application of existing technologies in the benefits plan. This includes medical and behavioral health procedures, pharmaceuticals, and devices.
 - (a) Element A: Written Process
 - (b) Element B: Description of the Evaluation Process
 - (c) Element C: Implementation of New Technology

- (6) ***NCQA Standard UM 11: Satisfaction with the UM Process***
The organization evaluates member and practitioner satisfaction with the UM process.
 - (a) Element A: Assessing Satisfaction with UM Process.

- (7) ***NCQA Standard UM 12: Emergency Services***
The organization provides, arranges for or otherwise facilitates all needed emergency services, including appropriate coverage of costs.
 - (a) Element A: Policies and Procedures

- (8) ***NCQA Standard UM 13: Procedures for Pharmaceutical Management***
The organization ensures that its procedures for pharmaceutical management, if any, promote the clinically appropriate use of pharmaceuticals
 - (a) Element A: Policies and Procedures
 - (b) Element B: Pharmaceutical Restrictions/Preferences
 - (c) Element C: Pharmaceutical Patient Safety Issues
 - (d) Element D: Reviewing and Updating Procedures
 - (e) Element F: Availability of Procedures
 - (f) Element G: Considering Exceptions

- (9) ***NCQA Standard UM 14: Triage and Referral for Behavior Health Care***
The organization has written standards to ensure that any centralized triage and referral functions for behavioral health services are appropriately implemented, monitored and professionally managed. *This standard applies only to organizations with a centralized triage and referral process for behavioral health, both delegated and non-delegated.*
 - (a) Element A: Triage and Referral Protocols

5. Special Health Care Needs. 2010 Contract Section 7.1.4 A-C.^{13, 14}

- A. The MCO must have effective mechanisms to assess the quality and appropriateness of care furnished to Enrollees with special health care needs.
 - (1) Mechanisms to identify persons with special health care needs,
 - (2) Assessment of enrollees identified (Senior and SNBC Contract - care plan), and
 - (3) Access to specialists.

¹³ 42 CFR 438.208 (c)(1-4)

¹⁴ MSHO/MSC+ Contract Section 7.1.4 A-C.



6. Practice Guidelines. 2010 Contract Section 7.1.5¹⁵

- A. The MCO shall adopt preventive and chronic disease practice guidelines appropriate for children, adolescents, prenatal care, young adults, adults, seniors age 65 and older, and as appropriate for people with disabilities populations.
 - (1) Adoption of practice guidelines. The MCO shall: adopt guidelines based on valid and reliable clinical evidence or a consensus of Health Care Professionals in the particular field; consider the needs of the MCO enrollees; adopt in consultation with contracting Health Care Professionals; review and update them periodically as appropriate.
 - (2) Dissemination of guidelines. The MCO shall ensure that guidelines are disseminated to all affected Providers and, upon request, to enrollees and potential enrollees.
 - (3) Application of guidelines. The MCO shall ensure that these guidelines are applied to decisions for utilization management, enrollee education, coverage of services, and other areas to which there is application and consistency with the guidelines.

7. Credentialing/Recredentialing: 2010 Contract Sections 7.1.6 C, F, G.

- A. Discrimination Against Providers Serving High Risk Populations. The MCO is prohibited from discriminating against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.
- B. Provider Discrimination. The MCO shall not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. This section shall not be construed to prohibit the MCO from including providers only to the extent necessary to meet the needs of the MCO's enrollees or from establishing any measure designated to maintain quality and control costs consistent with the responsibilities of the MCO. If the MCO declines to include individuals or groups of providers in its network, it must give the affected providers written notice of the reason for its decision.
- C. Affiliated Provider Access Standards. The MCO shall require all affiliated providers to meet the access standards required by this Contract, and applicable state and federal laws.¹⁶ The MCO shall monitor, on a periodic or continuous basis, but no less than every 12 months, the providers' adherence to these standards.

8. Annual Evaluation. 2010 Contract Section 7.1.8^{17, 18,}

- A. The MCO must conduct an annual quality assessment and performance improvement program evaluation consistent with state and federal regulations and current NCQA "Standards for Accreditation of Managed Care Organization". This evaluation must review the impact and effectiveness of the MCO's quality assessment and performance improvement program including performance on standardized measures (example: HEDIS®) and MCO's performance improvement projects.
- B. NCQA QI 1, element B: There is an annual written evaluation of the QI program that includes:

¹⁵ 42 CFR 438.236

¹⁶ F&C Contract Section 6.16, MSHO/MSC+ Contract Section 6.10, SNBC 6.49.

¹⁷ 42 CFR 438.240(e)

¹⁸ MSHO/MSC+ Contract Section 7.1.8 also includes the requirement that the MCO must include the "Quality Framework for the Elderly" in its Annual Evaluation.



- (1) a description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service
- (2) a trending of measures to assess performance in the quality and safety of clinical care and quality of service
- (3) analysis of the results of QI initiatives, including barrier analysis
- (4) evaluation of the overall effectiveness of the QI program, including progress toward influencing network-wide safe clinical practices.

9. Interim and Completed Performance Improvement Projects: 2010 Contract Section 7.2.^{19 20}

- A. Interim Project Reports. By December 1st of each calendar year, the MCO must produce an interim performance improvement project report for each current project. The interim project report must include any changes to the project(s) protocol steps one through seven and steps eight and ten as appropriate.
- B. Completed PIP Project Improvements Sustained Over Time. Real changes in fundamental system processes result in sustained improvements:
 - (1) Were PIP intervention strategies sustained following project completion?
 - (2) Has the MCO monitored post PIP improvements?

10. Disease Management: 2010 Contract Section 7.3²¹

- A. The MCO shall make available a Disease Management Program for its Enrollees with diabetes, asthma and heart disease.
- B. The MCO's Disease Management Program shall be consistent with current NCQA "Standards and Guidelines for the Accreditation of Health Plans" -- QI Standard Disease Management.
- C. If the MCO's diabetes, asthma and heart disease management programs have achieved 100 percent compliance during the most recent NCQA Accreditation Audit of QI Standard- Disease Management, the MCO will not need to further demonstrate compliance.

11. MCO Grievance Process Requirements: 2010 Contract Section 8.2.

8.2.2. Timeframe for Resolution of a Grievances.

- A) Oral Grievances must be resolved within ten (10) days of receipt.
- (B) Written Grievances must be resolved within thirty (30) days of receipt.
- (C) Oral Grievances may be resolved through oral communication, but the MCO must send the Enrollee a written decision for written Grievances.

8.2.3. Timeframe for Extension of Grievance Resolution. The MCO may extend the timeframe for resolution of a Grievance by an additional fourteen (14) days if the Enrollee or the Provider requests the extension, or if the MCO justifies that due to a need for additional information, the extension is in

¹⁹ 42 CFR 438.240 (d)(2)

²⁰ CMS Protocols, Conducting Performance Improvement Projects, Activity 10.

²¹ MSHO/MS+ Contract Section 7.3, require only diabetes and heart DM programs. SNBC Contract Section 7.4.



the Enrollee's interest. The MCO must provide written notice to the Enrollee of the reason for the decision to extend the timeframe if the MCO determines that an extension is necessary. The MCO must issue a notice of resolution no later than the date the extension expires.

8.2.4. Handling of Grievances.

- (A) The MCO must mail a written acknowledgment to the Enrollee or Provider acting on behalf of the Enrollee, within ten (10) days of receiving a written Grievance, and may combine it with the MCO's notice of resolution if a decision is made within the ten (10) days.
- (B) The MCO must maintain a log of all Grievances, oral and written.
- (C) The MCO must not require submission of a written Grievance as a condition of the MCO taking action on the Grievance.
- (D) The MCO must give Enrollees any reasonable assistance in completing forms and taking other procedural steps, including but not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.
- (E) The individual making a decision on a Grievance shall not have been involved in any previous level of review or decision-making.
- (F) If the MCO is deciding a Grievance regarding the denial of an expedited resolution of an Appeal or one that involves clinical issues, the individual making the decision must be a Health Care Professional with appropriate clinical expertise in treating the Enrollee's condition or disease. The MCO shall make a determination in accordance with the timeframe for an expedited Appeal.

8.2.5. Notice of Disposition of a Grievance.

- (A) Oral Grievances may be resolved through oral communication. If the resolution, as determined by the Enrollee, is partially or wholly adverse to the Enrollee, or the oral Grievance is not resolved to the satisfaction of the Enrollee, the MCO must inform the Enrollee that the Grievance may be submitted in writing. The MCO must also offer to provide the Enrollee with any assistance needed to submit a written Grievance, including an offer to complete the Grievance form and promptly mail the completed form to the Enrollee for his/her signature pursuant to Minnesota Statutes § 62Q.69, subdivision 2. Oral resolution must include the results of the MCO investigation and actions related to the Grievance and the MCO must inform the Enrollee of options for further assistance through the Managed Care Ombudsman and/or review by MDH.
- (B) When a Grievance is filed in writing, the MCO must notify the Enrollee in writing of its disposition. The written notice must include the results of the MCO investigation, the MCO actions relative to the Grievance, and options for further review through the Managed Care Ombudsman, and MDH.

- 12. Denial, Termination, or Reduction (DTR) Notice of Action to Enrollees. 2010 Contract Section 8.3.** If the MCO denies, reduces or terminates services or claims that are: 1) requested by an Enrollee; 2) ordered by a Participating Provider; 3) ordered by an approved, non-Participating Provider; 4) ordered by a care manager; or 5) ordered by a court, the MCO must send a DTR notice to the Enrollee that meets the requirements of this section.

8.3.1. General DTR Requirements.



- (A) **Written Notice.** The DTR must meet the language requirements of 42 CFR § 438.10(c). The DTR must also:
- (1) Be available in alternative formats as required by section 3.2.2 (B);
 - (2) Be approved in writing by the DHS, pursuant to section 3.2.4 (B);
 - (3) Maintain confidentiality for Family Planning Services (i.e. ensure that all information related to Family Planning is provided only to the Enrollee, in a confidential manner); and
 - (4) Be sent to the Enrollee.
 - (5) The MCO may have its subcontractor send the DTR to the Enrollee only if MCO has received prior written approval by the DHS. The MCO must submit in advance for DHS approval any DTR notification and member rights form that will be used by subcontractor.
- (B) **Content of DTR.** The DTR must include:
- (1) The Action that the MCO has taken or intends to take;
 - (2) The type of service or claim that is being denied, terminated, or reduced;
 - (3) A clear detailed description in plain language of the reasons for the Action;
 - (4) The specific federal or state regulations that support or require the Action, whichever applies. Nothing in this paragraph prevents the MCO from providing more specific information;
 - (5) The date the DTR was issued;
 - (6) The effective date of the Action if it results in a reduction or termination of on-going or previously authorized services;
 - (7) The date the MCO received the request for Service Authorization if the Action is for a denial, limited authorization, termination or reduction of a requested service;
 - (8) The first date of service, if the Action is for denial, in whole or in part, of payment for a service;
 - (9) The DHS' language block with an MCO phone number that Enrollees may call to receive help in translation of the notice;
 - (10) A phone number that Enrollees may call at the MCO to obtain information about the DTR.
 - (11) The Notice of Member Rights that must include but is not limited to:
 - (a) The Enrollee's right (or Provider on behalf of Enrollee with the Enrollee's written consent) to file an Appeal with the MCO;
 - (b) The requirements and timelines for filing an MCO Appeal pursuant to 42 CFR § 438.402;



- (c) The Enrollee's right to file a request for a State Fair Hearing without first exhausting MCO's Appeal procedures, or up to thirty (30) days after the MCO's final determination.;
 - (d) The process the Enrollee must follow in order to exercise these rights;
 - (e) The circumstances under which expedited resolution is available and how to request it for an Appeal or State Fair Hearing;
 - (f) The Enrollee's right to continuation of benefits, how to request that benefits be continued, and under what circumstances the Enrollee may have to pay for these services if the Enrollee files an Appeal at the MCO or requests a State Fair Hearing; and
 - (g) The right to seek an expert medical opinion from an external organization in cases of Medical Necessity, at the DHS' expense, for consideration at State Fair Hearings.
- (C) Notice to Provider. The MCO must notify the Provider of the Action. For denial of payment, notice may be in the form of an Explanation of Benefits (EOB), Explanation of Payments, or Remittance Advice. The MCO must also notify the Provider of the right to Appeal a DTR pursuant to section 8.4.1, and provide an explanation of the Appeal process. This notification may be through Provider contracts, Provider manuals, or through other forms of direct communication such as Provider newsletters.

8.3.2. Timing of the DTR Notice.

- (A) Previously Authorized Services. For previously authorized services, the MCO must mail the Notice to the Enrollee and the attending health care Provider at least ten (10) days before the date of the proposed Action in accordance with 42 CFR § 438.404(c)(1). The following criteria must also be met:
- (1) The ongoing medical service must have been ordered by a Participating or authorized non-Participating Provider who is a treating physician, osteopath, dentist, mental health professional, or chiropractor.
 - (2) The service must be eligible for payment according to Minnesota Statutes, § 256B.0625 and Minnesota Rules, Part 9505.0170 to 9505.0475.
 - (3) All procedural requirements regarding Service Authorization must have been met.
- (B) Denials of Payment. For denial of payment, the MCO must mail the DTR notice to the Enrollee at the time of any Action affecting the claim.
- (C) Standard Authorizations. For standard authorization decisions that deny or limit services, the MCO must provide the notice:
- (1) As expeditiously as the Enrollee's health condition requires;
 - (2) To the attending Health Care Professional and hospital by telephone or fax within one working day after making the determination;
 - (3) To the Provider, Enrollee and hospital, in writing within ten (10) business days following receipt of the request for the service, unless the MCO receives an extension of the resolution period pursuant to section 8.2.3;



- (D) Expedited Authorizations. For expedited Service Authorizations, the MCO must provide the determination as expeditiously as the Enrollee's health condition requires, not to exceed seventy-two (72) hours of receipt of the request for the service. Expedited Service Authorizations are for cases where the Provider indicates, or the MCO determines, that following the standard timeframe could seriously jeopardize the Enrollee's life or health, or ability to attain, maintain or regain maximum function.
- (E) Extensions of Time. The MCO may extend the timeframe by an additional fourteen (14) days for resolution of a standard authorization if the Enrollee or the Provider requests the extension, or if the MCO justifies a need for additional information and how the extension is in the Enrollee's interest. The MCO must provide written notice to the Enrollee of the reason for the decision to extend the timeframe, and the Enrollee's right to file a Grievance if he or she disagrees with the MCO's decision to extend. The MCO must issue a determination no later than the date the extension expires.
- (F) Delay in Authorizations. For Service Authorizations not reached within the timeframe specified in 42 CFR § 438.210(d) (1), the MCO must provide a notice of denial on the date the timeframe expires.

8.3.3. Continuation of Benefits Pending Decision.

- (A) If an Enrollee files an Appeal with the MCO before the date of the Action proposed on a DTR, the MCO, in accordance with 42 CFR § 438.420(b), may not reduce or terminate the service until ten (10) days after a written decision is issued in response to that Appeal, unless: (A) the Enrollee withdraws the Appeal; or, (B) if the Enrollee has requested a State Fair Hearing with a continuation of benefits, until the State Fair Hearing decision is reached.
- (B) The continuation of benefits is not required if the Provider who orders the service is not an MCO Participating Provider or authorized non-Participating Provider.

13. MCO Appeals Process Requirements: 2010 Contract Section 8.4.

8.4.1. Filing Requirements. The Enrollee or the Provider acting on behalf of the Enrollee with the Enrollee's written consent, may file an Appeal within ninety (90) days of the DTR Notice of Action or for any other Action taken by the MCO as it is defined in 42 CFR § 438.400(b). In addition, attending Health Care Professionals may Appeal utilization review decisions at the MCO level without the written signed consent of the Enrollee in accordance with Minnesota Statutes, § 62M.06. An Appeal may be filed orally or in writing. The initial filing determines the timeframe for resolution. If the Appeal is filed orally, the MCO must assist the Enrollee, or Provider filing on behalf of the Enrollee, in completing a written signed Appeal. Once the oral Appeal is reduced to writing by the MCO, and pending the Enrollee's signature, the MCO must:

- (A) Resolve the Appeal in favor of the Enrollee, regardless of receipt of a signature, or
- (B) If no signed Appeal is received within thirty (30) days, the MCO may resolve the Appeal as if a signed appeal was received.

8.4.2. Timeframe for Resolution of Standard Appeals.²² The MCO must resolve each Appeal as expeditiously as Enrollee's health requires, not to exceed thirty (30) days after receipt of the Appeal.

8.4.3 Timeframe for Resolution of Expedited Appeals²³

²² MSHO/MSC+ and SNBC Contract Section 8.4.3

²³ MSHO/MSC+ and SNBC Contract Section 8.4.4



- (A) The MCO must resolve and provide written notice of resolution for both oral and written Appeals as expeditiously as the Enrollee's health condition requires, not to exceed seventy-two (72) hours after receipt of the Appeal.
- (B) If the MCO denies a request for expedited Appeal, the MCO shall transfer the denied request to the standard Appeal process, preserving the first filing date of the expedited Appeal. The MCO must notify the Enrollee of that decision orally within twenty-four (24) hours of the request and follow up with a written notice within two days.
- (C) 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. In such an Appeal, the MCO must ensure reasonable access to the MCO's consulting physician as authorized by Minnesota Statutes § 62M.06, subd.2 (a).

8.4.4. Timeframe for Extension of Resolution of Appeals.²⁴ An extension of the timeframes of resolution of Appeals of fourteen (14) days is available for standard and expedited Appeals if the Enrollee requests the extension or the MCO justifies both the need for more information and that an extension is in the Enrollee's interest. The MCO must provide written notice to the Enrollee of the reason for the decision to extend the timeframe if the MCO determines that an extension is necessary. The MCO must issue a determination no later than the date the extension expires.

8.4.5. Handling of Appeals²⁵

- (A) All oral inquiries challenging or disputing a DTR Notice of Action or any Action as defined in 42 CFR § 438.400(b) shall be treated as an oral Appeal and shall follow the requirements of section 8.4.1.
- (B) The MCO must send a written acknowledgment within ten (10) days of receiving the request for an Appeal and may combine it with the MCO's notice of resolution if a decision is made within the ten (10) days.
- (C) The MCO must give Enrollees any reasonable assistance required in completing forms and taking other procedural steps, including but not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TDD and interpreter capability.
- (D) The MCO must ensure that the individual making the decision was not involved in any previous level of review or decision-making.
- (E) If the MCO is deciding an Appeal regarding denial of a service based on lack of Medical Necessity, the MCO must ensure that the individual making the decision is a Health Care Professional with appropriate clinical expertise in treating the Enrollee's condition or disease, as provided for in Minnesota Statutes, § § 62M.06, 62M.09 and 42 CFR § 438.406(a)(3)(ii).
- (F) The MCO must provide the Enrollee with a reasonable opportunity to present evidence and allegations of fact or law, in person, by telephone, as well as in writing. For expedited Appeal resolutions, the MCO must inform the Enrollee of the limited time available to present evidence in support of their Appeal.

²⁴ MSHO/MSC+ and SNBC Contract Section 8.4.5

²⁵ MSHO/MSC+ and SNBC Contract Section 8.4.6



- (G) The MCO must provide the Enrollee, and his or her representative, an opportunity, before and during the Appeals process, to examine the Enrollee's case file, including medical records, and any other documents and records considered during the Appeal process.
- (H) The MCO must include as parties to the Appeal, the Enrollee, his or her representative, or the legal representative of a deceased Enrollee's estate.
- (I) The MCO must not take punitive action against a Provider who requests an expedited resolution or supports an Enrollee's Appeal.

8.4.6 Subsequent Appeals.²⁶ If an Enrollee Appeals a decision from a previous Appeal on the same issue, and the MCO decides to hear it, for purposes of the timeframes for resolution, this will be considered a new Appeal.

8.4.7. Notice of Resolution of Appeal.²⁷

- (A) The MCO must provide a written notice of resolution for all Appeals, and must include in the text of the notice: (1) the results of the resolution process and date it was completed; and (2) the Enrollee's right to request a State Fair Hearing if the resolution was adverse to the Enrollee. The MCO must include with the notice a copy of the DHS' Notice of Rights.
- (B) For Appeals of Utilization Management (UM) decisions, the written notice of resolution shall be sent to the Enrollee and the attending health care professional,
- (C) The MCO must notify the Enrollee and attending health care professional by telephone of its determination on an expedited appeal as expeditiously as the Enrollee's medical condition requires, but no later than seventy-two (72) hours after receiving the expedited Appeal.

8.4.8. Reversed Appeal Resolutions. If a decision by an MCO is reversed by the Appeal process, the MCO:

- (A) Must comply with the Appeal decision promptly and as expeditiously as Enrollee's health condition requires: and
- (B) Must pay for any services the Enrollee already received that are the subject of the Appeal.

8.5. Maintenance of Grievance and Appeal Records. The MCO must maintain records of all Grievances, DTRs, Appeals and State Fair Hearings.

14. Advance Directives Compliance: 2010 Contract Section 17 Advance Directives Compliance^{28 29}

- A. The MCO agrees to provide all Enrollees at the time of enrollment a written description of applicable State law on advance directives and the following:
 - (1) Information regarding the enrollee's right to accept or refuse medical or surgical treatment; and to execute a living will, durable power of attorney for health care decisions, or other advance directive.
 - (2) Written policies of the MCO respecting the implementation of the right; and

²⁶ MSHO/MS+ and SNBC Contract Section 8.4.7

²⁷ MSHO/MS+ and SNBC Contract Section 8.4.8

²⁸ MSHO/MS+ and SNBC Contract Article 17,

²⁹ Pursuant to 42 U.S.C. 1396a(a)(57) and (58), 42 C.F.R. 489.100-104 and 42 C.F.R. 422.128



- (3) Updated or revised changes in State law as soon as possible, but no later than 90 days after the effective date of the change.
 - (4) Information that complaints concerning noncompliance with the Advance Directive requirement may be filed with the State survey and certification agency (i.e. Minnesota Department of Health), pursuant to 42 CFR 422.128 as required in 42 CFR 438.6(i).
- B. To require MCO's providers to ensure that it has been documented in the enrollee's medical records whether or not an individual has executed an advance directive.
 - C. To not condition treatment or otherwise discriminate on the basis of whether an individual has executed an advance directive.
 - D. To comply with State law, whether statutory or recognized by the courts of the State on Advance Directives, including Laws of Minnesota 1998, Chapter 399, §38.
 - E. To provide, individually or with others, education for MCO staff, providers and the community on advance directives.
- 15. Validation of MCO Care Plan Audits for MSHO and MSC+³⁰.** MDH will collect information for DHS to monitor MCO Care Plan Audit activities as outlined in the DHS/MCO MSHO/MS C+ Contract.
- A. DHS will provide MDH with a Data Collection Guide for the random sample of 30 MCO enrollees (plus an over sample of 10 MCO enrollees for missing or unavailable enrollee records) for MSHO and MSC+ program. Of the 40 records sampled, 20 records will be for members new to the MCO within the past 12 months and other 20 records will be for members who have been with the MCO for more than 12 months. Instructions on selecting the sample are included in the Data Collection Guide.
 - B. MDH will request the MCO make available during the MDH QA Examination on-site audit the identified enrollee records. A copy of the Data Collection Guide and data collection tool will be included with MDH'S record request.
 - C. An eight-thirty audit methodology will be used to complete a data collection tool for each file in each sample consistent with the Data Collection Guide.
 - D. Within 60 days of completing the on-site MDH QA Examination, MDH will provide DHS with a brief report summarizing the data collection results, any other appropriate information and the completed data collection tools.
- 16. Information System.^{31 32}** The MCO must operate an information system that supports initial and ongoing operations and quality assessment and performance improvement program. The MCO must maintain a health information system that collects, analyzes, integrates, and reports data. During each of the past three years, all MCO MDH annual HEDIS performance measures have been certified reportable by an NCQA HEDIS audit.
- 17. Other areas by mutual agreement.**

³⁰ MSHO/MS C+ Contract sections 6.1.3(A)(2), 6.1.3(A)(3), 6.1.3(A)(4), 6.1.4(B)(4), 6.1.4(B)(5),

³¹ Families and Children, Seniors and SNBC Contract Section 7.1.2

³² 42 CFR 438.242