Sanford Health Plan

QUALITY ASSURANCE EXAMINATION

DEPARTMENT OF HEALTH

Preliminary Report

For the Period: August 1, 2014 – May 31, 2017
Examiners: Elaine Johnson, RN BS, CPHQ and Kate Eckroth, MPH
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Minnesota Department of Health
Managed Care Systems Section
PO Box 64882
St. Paul, MN 55164-0882
651-201-5100
health.mcs@state.mn.us
www.health.state.mn.us

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MINNESOTA DEPARTMENT OF HEALTH
EXECUTIVE SUMMARY

The Minnesota Department of Health (MDH) conducted a Quality Assurance Examination of Sanford Health Plan (Sanford) to determine whether it is operating in accordance with Minnesota Law. Our mission is to protect, maintain and improve the health of all Minnesotans. MDH has found that Sanford is compliant with Minnesota and Federal law, except in the areas outlined in the "Deficiencies" and Mandatory Improvements" sections of this report. Deficiencies are violations of law. "Mandatory Improvements" are required corrections that must be made to non-compliant policies, documents or procedures where evidence of actual compliance is found or where the file sample did not include any instances of the specific issue of concern. The "Recommendations" listed are areas where, although complaint with law, MDH identified improvement opportunities.

To address recommendations, Sanford should:

Update its quality of care policy to include the definition of what quality of care complaints warrant peer protection confidentiality in order to be consistent with Minnesota Statute, chapter 62D.115, subdivision 2(c) (effective January 1, 2018).

Clarify its process for credentialing oversight of pharmacy providers to include the specific elements reviewed (for example Medicare/Medicaid sanction review), number of files and assure review of both initial credentialed and recredentialed files.

To address mandatory improvements, Sanford and its delegates must:

Revise their definition of quality of complaints to be comprehensive and more consistent with the law;

Update their policy/procedure to indicate investigational procedures by severity level;

Revise the timeline for oral complaints to indicate 10 days, and *not* business days;

Update their policy/procedure to indicate that they must offer a provider contract to an essential community provider located within the service area;

Update their policy/procedure to describe how members are identified for culturally appropriate care and/or language barriers and what criteria is used to determine eligibility;

Clearly designate in the UM policy that:

- The right to appeal is available to both the enrollee and the attending health care professional for all appeals;
- A written designation of representation is not required for a physician filing an appeal or expedited appeal.

To address deficiencies, Sanford and its delegates must:

Revise its practice to:

- Submit to MDH its written quality plan for approval with any revisions;
- Include information on peer review, utilization management and credentialing processes;
- Obtain approval of the written quality plan from its Board of Directors.

Ensure its annual quality program evaluation reviewed by its Board of Directors;

Ensure its annual quality work plan was approved by its Board of Directors;

Revise its practice and policy to require a physician to make the denial determination on pharmaceutical denials.

This report including these deficiencies, mandatory improvements and recommendations is approved and adopted by the Minnesota Commissioner of Health pursuant to authority in Minnesota Statutes, chapter 62D.

7/10/18

Martha Burton Santibáñez, Assistant Director — Date
Health Regulation Division

Contents

I. Introduction

1. History:

Sanford Health Plan is a not-for-profit, community-based HMO that began operations on January 1, 1998. Managed care services are provided to large and small groups in North Dakota, South Dakota, Iowa, and, in Minnesota, by Sanford Health Plan of Minnesota. Originally called Sioux Valley Health Plan, it changed its name in March 2007 to acknowledge the gift of Denny T. Sanford to the Sioux Valley Hospital & Health System.

Sanford's Minnesota HMO is a risk-bearing product that provides benefits for in-network services with higher cost sharing for out-of-network services. Extensive care management services are available.

On November 2, 2009, Sanford Health Plan's parent organization, Sanford Health merged with North Dakota's largest health system, MeritCare. MeritCare has many regional sites in North Dakota and Northwest Minnesota.

Sanford Health is comprised of Sanford USD Medical Center and a network of community hospitals and clinics in South Dakota, Southwest Minnesota, Northwest Iowa, and Northeast Nebraska. It is known for its comprehensive health services, and growing research and education programs. In 2006, a $400 million gift from Denny Sanford has enabled Sanford Health to initiate significant new programs in Children's Health and Research, an initiative to find a cure for Type 1 Diabetes, and the establishment of Children's World Clinics and Health Campus development which includes the new Sanford Children's Hospital. The new combined organization has been collectively renamed, Sanford Health.

Sanford Health Plan and Sanford Health Plan of Minnesota (DBA Sanford Health Plan), both non-profit entities currently cover nearly 180,000 lives and serve North Dakota, South Dakota, northwest Iowa and western Minnesota. The Sanford Health-MeritCare merger along with Sanford Health Plan's expansion into North Dakota has created the opportunity to expand Sanford Health Plan in the greater western Minnesota market bringing more choice and competition to Minnesota residents.

In April 2011, the Sanford Health Plan submitted, and the Minnesota Department of Health subsequently approved, a service area expansion request for twenty three additional Minnesota Counties.

In June 2016, Sanford Health Plan submitted, and the Minnesota Department of Health subsequently approved, a service area expansion request for ten additional Minnesota Counties.

Sanford Health Plan is licensed to sell large group and small group plans and TPA services in 45 western Minnesota counties. Small group plans are sold off-exchange only (not on MNSure). Sanford Health Plan is licensed to sell Medicare Supplement and Medicare Select Plans in 13 southwest Minnesota counties.

2. Membership: Sanford self-reported Minnesota enrollment as of May 1, 2017 consisted of the following:

Self-Reported Enrollment

Product	Enrollment
Fully Insured Commercial	
Large Group (Signature Series or High Deductible Health Plan)	171
Small Group (Signature Series Grandfathered or Simplicity)	30
Total	201

3. Onsite Examination Dates: August 14, 2017 – August 15, 2017.

4. Examination Period: August 1, 2014 – May 31, 2017
   File Review Period: May 1, 2016 – May 31, 2017
   Opening Date: May 15, 2017

5. National Committee for Quality Assurance (NCQA): Sanford is accredited for its commercial HMO product by NCQA based on 2016 standards. The Minnesota Department of Health (MDH) evaluated and used results of the NCQA review in one of three ways:
   a. If NCQA standards do not exist or are not as stringent as Minnesota law, the accreditation results were not used in the MDH examination process [No NCQA checkbox].
   b. If the NCQA standard was the same or more stringent than Minnesota law and the health plan was accredited with 100% of the possible points, the NCQA results were accepted as meeting Minnesota requirements [NCQA ☒], unless evidence existed indicating further investigation was warranted [NCQA ☐].

6. Sampling Methodology: Due to the small sample sizes and the methodology used for sample selection for the quality assurance examination, the results cannot be extrapolated as an overall deficiency rate for the health plan.

7. Performance Standard: For each instance of non-compliance with applicable law or rule identified during the quality assurance examination, that covers a three-year audit period, the health plan is cited with a deficiency. A deficiency will not be based solely on one outlier file if MDH had sufficient evidence obtained through: 1) file review; 2) policies and procedures; and 3) interviews, that a plan's overall operation is compliant with an applicable law.

II. Quality Program Administration

Program

Minnesota Rules, Part 4685.1110

Subparts	Subject	Met	Not Met	NCQA
Subp. 1.	Written Quality Assurance Plan	☐Met	☒ Not Met	
Subp. 2.	Documentation of Responsibility	☒Met	☐ Not Met	☐ NCQA
Subp. 3.	Appointed Entity	☒Met	☐ Not Met	☐ NCQA
Subp. 4.	Physician Participation	☒Met	☐ Not Met	☐ NCQA
Subp. 5.	Staff Resources	☐Met	☐ Not Met	☒ NCQA
Subp. 6.	Delegated Activities	☒Met	☐ Not Met	☐ NCQA
Subp. 7.	Information System	☐Met	☐ Not Met	☒ NCQA
Subp. 8.	Program Evaluation	☐Met	☒ Not Met	☐ NCQA
Subp. 9.	Complaints	☒Met	☐ Not Met	
Subp. 10.	Utilization Review	☒Met	☐ Not Met	
Subp. 11.	Provider Selection and Credentialing	☐Met	☐ Not Met	☒ NCQA
Subp. 12.	Qualifications	☐Met	☐ Not Met	☒ NCQA
Subp. 13.	Medical Records	☒Met	☐ Not Met	

Finding: Written Quality Assurance Plan

Subp. 1. Minnesota Rules, part 4685.1110, outlines the elements that must be included in the written quality assurance plan and requires the written plan to be approved by the governing body. Furthermore, Minnesota Rules, part 4685.1130, subpart 3, states the written plan must be submitted to the Commissioner of Health for approval with any revisions.

Sanford's written quality plan, *Quality Improvement Program Policy (MM-56)*, dated 11/09/2016 was submitted for review for purposes of the MDH exam. However, this was not submitted for approval to MDH. In addition, the plan is missing information on peer review and credentialing with minimal information regarding its utilization management (UM) processes. Since Sanford has a separate Credentialing and UM Plan, it may want to refer to them in the written quality plan and submit both along with the written quality plan. Sanford was not able to provide evidence that its Board of Directors approved the 2016 written quality plan. Sanford must revise its practice to:

- Submit to MDH its written quality plan for approval with any revisions;
- Include information on peer review, utilization management and credentialing processes;
- Obtain approval of the written quality plan from its Board of Directors.

(Deficiency #1) See also Minnesota Rules, part 4685.1130, subpart 3.

Finding: Delegated Activities

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

Delegated Entities and Functions

Entity	UM	Claims	Network Mgmt	Cred	Complaints	Appeals	Disease Mgmt	QOC
Express Scripts Inc.		X	X	X				
Eviti	X (Oncology Approvals)							

Sanford delegates credentialing as a part of the Network function to Express Scripts. Credentialing files are reviewed by a third party evaluation process. Sanford could clarify the process for credentialing oversight to include the specific elements reviewed (for example sanction review), number of files and assure review of both initial credentialed and recredentiled files. **(Recommendation #2)**

Finding: Program Evaluation

Subp. 8. Minnesota Rules, part 4685.1110, subpart 8, states the results of Sanford's annual quality evaluation must be communicated to the governing body. Sanford was not able to show evidence that its Board of Directors reviewed its annual quality program in 2016. Sanford must ensure its annual quality program evaluation reviewed by its Board of Directors. **(Deficiency #2)**

Activities

Minnesota Rules, Part 4685.1115

Subparts	Subject	Met	Not Met	NCQA
Subp. 1.	Ongoing Quality Evaluation	☒Met	☐ Not Met	☐ NCQA
Subp. 2.	Scope	☒Met	☐ Not Met	☐ NCQA

Quality Evaluation Steps

Minnesota Rules, Part 4685.1120

Subparts	Subject	Met	Not Met	NCQA
Subp. 1.	Problem Identification	☒Met	☐ Not Met	☐ NCQA
Subp. 2.	Problem Selection	☒Met	☐ Not Met	☐ NCQA
Subp. 3.	Corrective Action	☒Met	☐ Not Met	☐ NCQA
Subp. 4.	Evaluation of Corrective Action	☒Met	☐ Not Met	☐ NCQA

Focus Study Steps

Minnesota Rules, Part 4685.1125

Subparts	Subject	Met	Not Met
Subp. 1.	Focused Studies	☒Met	☐ Not Met
Subp. 2.	Topic Identification and Selections	☒Met	☐ Not Met
Subp. 3.	Study	☒Met	☐ Not Met
Subp. 4.	Corrective Action	☒Met	☐ Not Met
Subp. 5.	Other Studies	☒Met	☐ Not Met

Filed Written Plan and Work Plan

Minnesota Rules, Part 4685.1130

Subparts	Subject	Met	Not Met
Subp. 1.	Written Plan	☒Met	☐ Not Met
Subp. 2.	Work Plan	☐Met	☒ Not Met
Subp. 3.	Amendments to Plan	☐Met	☒ Not Met

Finding: Annual Work Plan and Amendments to Written Plan

Subp. 2. Minnesota Rules, part 4685.1130, subpart 2, states that the annual quality work plan must be approved by the governing body. Sanford was not able to show evidence that its annual quality work plan was approved by its Board of Directors. **(Deficiency #3)**

Subp. 3. Minnesota Rules, part 4685.1130, subpart 3, requires the written quality plan (Sanford's *Quality Improvement Program Policy* (MM-56) to be submitted for approval to MDH with any revisions. **(Deficiency #1 Refer to Minnesota Rules, part 4685.1110)**

Finding: Provider Selection and Credentialing

Subp. 11. Minnesota Rules, part 4685.1110, subpart 11, states the plan must have policies and procedures for provider selection, credentialing and recredentialing that, at a minimum, are consistent with community standards. MDH recognizes the community standard to be NCQA. Sanford scored 100% on the credentialing module in its last NCQA accreditation, thus MDH accepts this as evidence of compliance.

III. Quality of Care

Subp. 9. Minnesota Rules, part 4685.1110, subpart 9, states the quality program must conduct ongoing evaluation of enrollee complaints related to quality of care. There were no quality of care complaint files to review. MDH did a thorough review of Sanford's policy/procedures related to quality of care and had onsite discussions to ensure compliance with the law.

Quality of Care Complaints

Minnesota Statutes, Section 62D.115

Subparts	Subject	Met	Not Met
Subd. 1.	Definition	☐Met	☒ Not Met
Subd. 2.	Quality of Care Investigations	☐Met	☒ Not Met

Finding: Quality of Care Complaints

Subd. 1 Minnesota Statutes, section 62D.115, subdivision 1, defines quality of care complaints as "an expressed dissatisfaction regarding health care services...to the extent that they affect the clinical quality of health care services rendered: access; provider and staff competence; clinical appropriateness of care; communications; behavior; facility and environmental considerations...". In Sanford's policy/procedure, *Medical Management Program (MM-49),* the definition of quality of care is stated as, "*The degree to which health services increase the likelihood of desired health outcomes and are consistent with current professional knowledge*". The definition does not indicate the type of complaints that may warrant a quality of care review such as complaints related to behavior or facility. Sanford must revise their definition of quality of care complaints to be comprehensive and more consistent with the law. **(Mandatory Improvement #1)**

Subd. 2 Minnesota Statutes, section 62D.115, subdivision 2(c), states that the quality of care investigation must, "...include a description of each quality of care complaint level of severity including: classification of complaints that warrant peer protection confidentiality....and investigation procedures for each level of severity." Sanford does not have a definition for what quality of care complaints warrant peer protection confidentiality. Beginning in January of 2018, the law defined what complaints warrant peer protection confidentiality effective as of January 1, 2018. Sanford must update their policy/procedure to specify which quality of care complaints warrant peer protection confidentiality as defined by Minnesota Statutes 62D.115 effective January 1, 2018. **(Recommendation #1)** Sanford does not have a policy/procedure to indicate investigational procedures by severity level for quality of care complaints. Sanford must update their policy/procedure to indicate investigational procedures by severity level. **(Mandatory Improvement #2)**

IV. Complaint Systems

MDH examined Sanford fully-insured commercial complaint system under Minnesota Statutes, chapter 62Q. MDH reviewed a total of 2 Complaint System files (all files within the file review period).

Complaint System File Review

File Source	# Reviewed
Complaint Files	
Written	2
Oral	0
Non-Clinical Appeals	0
Total	***2***

Minnesota Statutes, Section 62Q.69. Complaint Resolution

Section	Subject	Met	Not Met
Subd. 1	Establishment	☒ Met	☐ Not Met
Subd. 2	Procedures for Filing a Complaint	☐ Met	☒ Not Met
Subd. 3.	Notification of Complaint Decisions	☒ Met	☐ Not Met

Finding: Complaint Resolution

Subd. 2 Minnesota Statutes, section 62Q.69, subdivision 2, states, "...if a complaint is submitted orally and...not resolved to the satisfaction of the complainant, by the health plan company

within ten days of receiving the complaint, the health plan company must inform the complainant that the complaint may be submitted in writing." In Sanford's *Medical Management Program Appendix A* (MM-49) policy/procedure, the time frame for resolving an oral complaint incorrectly states that they must be resolved in 10 business days. In Sanford's *Member Complaints MN Commercial Members* (MS-49) policy/procedure the timelines are correctly stated. During onsite discussions with MDH, Sanford indicated that while both policy/procedures are referred to by staff, the *Medical Management Program* (MM-49) policy/procedure is their master document. Sanford must revise the timeline for oral complaints to indicate 10 days, *not* business days. **(Mandatory Improvement #3)**

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

Section	Subject	Met	Not Met
Subd. 1	Establishment	☒ Met	☐ Not Met
Subd. 2	Procedures for Filing an Appeal	☒ Met	☐ Not Met
Subd. 3.	Notification of Appeal Decisions	☒ Met	☐ Not Met

Minnesota Statutes, Section 62Q.71.

Section	Subject	Met	Not Met
62Q.71	Notice to Enrollees	☒ Met	☐ Not Met

Minnesota Statutes, Section 62Q.73. External Review of Adverse Determination

Section	Subject	Met	Not Met
Subd. 3	Right to External Review	☒ Met	☐ Not Met
Subd. 6	Process	☒ Met	☐ Not Met

V. Access and Availability

Geographic Accessibility

Minnesota Statutes, Section 62D.124

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

Essential Community Providers

Minnesota Statutes, Section 62Q.19

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

Finding: Essential Community Providers

Subd. 3 Minnesota Statutes, section 62Q.19, subdivision 3, states that a health plan company must offer a provider contract to any designated essential community provider (ECP) located within the area served by the health plan, and cannot restrict access to members seeking ECP services. There is nothing stated in Sanford's policy and procedure, *Provider Access Availability Standards* (MM-50) that addresses contracting with ECPs. Sanford does have contracts with ECPs. Sanford must update its policy indicating that they must offer a provider contract to an ECP located within the service area. **(Mandatory Improvement #4)**

Availability and Accessibility

Minnesota Rules, Part 4685.1010

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

Emergency Services

Minnesota Statutes, Section 62Q.55

Subdivision	Subject	Met	Not Met
Subd. 1	Access to Emergency Services	☒Met	☐ Not Met
Subd. 2	Emergency Medical Condition	☒Met	☐ Not Met

Licensure of Medical Directors

Minnesota Statutes, Section 62Q.121

Section	Subject	Met	Not Met
62Q.121	Licensure of Medical Directors	☒Met	☐ Not Met

Coverage of Nonformulary Drugs for Mental Illness and Emotional Disturbance

Minnesota Statutes, Section 62Q.527

Subdivision	Subject	Met	Not Met
Subd. 2.	Required Coverage for Anti-psychotic Drugs	☒Met	☐ Not Met
Subd. 3.	Continuing Care	☒Met	☐ Not Met
Subd. 4.	Exception to Formulary	☒Met	☐ Not Met

Coverage for Court-Ordered Mental Health Services

Minnesota Statutes, Section 62Q.535

Subdivision	Subject	Met	Not Met
Subd. 2.	Coverage required	☒Met	☐ Not Met

Continuity of Care

Minnesota Statutes, Section 62Q.56

Subdivision	Subject	Met	Not Met	N/A
Subd. 1.	Change in health care provider, general notification	☐Met	☒ Not Met	
Subd. 1a.	Change in health care provider, termination not for cause	☒Met	☐ Not Met	
Subd. 1b.	Change in health care provider, termination for cause	☒Met	☐ Not Met	
Subd. 2.	Change in health plans (applies to group, continuation and conversion coverage)	☒Met	☐ Not Met	☐

Finding: Change in Health Care Provider

Subd. 1 Minnesota Statutes, section 62Q.56, subdivision1, describes what is required of the health plan when continuity of care services apply for enrollees. The written plan must include, "...who will identify enrollees with special medical needs or at special risk and what criteria will be used for this determination..." This statute indicates enrollees with cultural or language barriers are included with those having special medical needs. Sanford's policy/procedure, *Transition of Care* (MM-44), indicates that enrollees receiving culturally appropriate services or members who do not speak English are eligible for continuity of cares services when an in-network provider does not offer these services. However, there is no clear process for how this is determined. During discussions while onsite for the MDH exam, Sanford stated that they identify members in need of culturally appropriate care or those with language barriers by assessing annual demographics data and patient complaints related to patient preferences to determine which members may be eligible for these services. Sanford also stated that members new to Sanford or current members whose providers were terminated receive a *Transition of Care Form* which explains when continuity of care services may apply and allows members to make a written request. However, this form does not specifically mention that enrollees with cultural or language barriers may be eligible nor does it include questions that address any cultural or language barriers that the requesting member may have. Sanford must revise their policy/procedure to explain how members are identified and what criteria is used to determine who is eligible. **(Mandatory Improvement #5)**

VI. Utilization Review

MDH examined Sanford's utilization review (UR) system under Minnesota Statutes, chapter 62M. MDH reviewed a total of 9 UR System files (all files within the file review period).

UR System File Review

File Source	# Reviewed
UM Denial Files	9
Clinical Appeals Files	0
Total	9

Standards for Utilization Review Performance

Minnesota Statutes, Section 62M.04

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

Procedures for Review Determination

Minnesota Statutes, Section 62M.05

Subdivision	Subject	Met	Not Met	NCQA
Subd. 1.	Written Procedures	☒Met	☐ Not Met	
Subd. 2.	Concurrent Review	☐Met	☐ Not Met	☒ NCQA
Subd. 3.	Notification of Determination	☒Met	☐ Not Met	
Subd. 3a.	Standard Review Determination	☒Met	☐ Not Met	
(a)	Initial determination to certify or not (10 business days)	☒Met	☐ Not Met	☐ NCQA
(b)	Initial determination to certify (telephone notification)	☒Met	☐ Not Met	
(c)	Initial determination not to certify (notice within 1 working day)	☒Met	☐ Not Met	
(d)	Initial determination not to certify (notice of right to appeal)	☒Met	☐ Not Met	
Subd. 3b.	Expedited Review Determination	☒Met	☐ Not Met	☐ NCQA
Subd. 4.	Failure to Provide Necessary Information	☒Met	☐ Not Met	
Subd. 5.	Notifications to Claims Administrator	☒Met	☐ Not Met	

Findings: Initial Determination Not to Certify

Subd. 3a(c) Minnesota Statutes 62M.05, subdivision 3a(c), states notification must be provided by telephone, by facsimile to a verified number, or by electronic mail to a secure electronic mailbox within one working day after making the determination to the attending health care professional. One UM denial file did not show evidence of a notification to the attending health care professional within one working day of the determination decision.

Appeals of Determinations Not to Certify

Minnesota Statutes, Section 62M.06

Subdivision	Subject	Met	Not Met	NCQA
Subd. 1.	Procedures for Appeal	☐Met	☒ Not Met	
Subd. 2.	Expedited Appeal	☐Met	☒ Not Met	
Subd. 3.	Standard Appeal	☒Met	☐ Not Met	
(a)	Appeal resolution notice timeline	☒Met	☐ Not Met	
(b)	Documentation requirements	☒Met	☐ Not Met	
(c)	Review by a different physician	☒Met	☐ Not Met	☐ NCQA
(d)	Time limit in which to appeal	☒Met	☐ Not Met	
(e)	Unsuccessful appeal to reverse determination	☒Met	☐ Not Met	☐ NCQA
(f)	Same or similar specialty review	☒Met	☐ Not Met	
(g)	Notice of rights to external review	☒Met	☐ Not Met	☐ NCQA
Subd. 4.	Notifications to Claims Administrator	☒Met	☐ Not Met	

Finding: Procedures for Appeal

Subd. 1 and 2. Minnesota Statutes, section 62M.06, subdivision 1 and 2. Subdivision 1 states the right to appeal must be available to the enrollee and to the attending health care professional.

Subdivision 2 states that when a denial is made for an initial determination of a health care service requiring review and the attending health care professional believes that the determination warrants an expedited appeal, the plan must ensure that the enrollee and the attending health care professional have an opportunity to appeal the determination on an expedited basis. Sanford's policy *Utilization Management* (MM-49) states *"Members have the right to file a complaint (grievance) or an appeal of any adverse determination by the Plan. The Authorized Representative's written designation of representation from the Member should accompany the request. For Expedited Appeals, a health care practitioner with knowledge of the Member's condition (e.g., treating practitioner) may act as the Member's authorized representative.* Sanford's policy must clearly designate that:

- The right to appeal is available to both the enrollee and the attending health care professional for all appeals;

- A written designation of representation is not required for a physician filing an appeal or expedited appeal.

(Mandatory Improvement #6)

Confidentiality

Minnesota Statutes, Section 62M.08

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

Staff and Program Qualifications

Minnesota Statutes, Section 62M.09

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

Finding: Physician Reviewer Involvement

Subd. 3. Minnesota Statutes, section 62M.09, subdivision 3, states a physician must review all cases in which the utilization review organization has concluded that a determination not to certify for clinical reasons is appropriate. In two pharmaceutical UM denial files, a pharmacist rendered the denial decision rather than a physician. Furthermore, Sanford's policy *Utilization Management* (MM-49) states the *"Senior Director of Pharmacy may make authorization and denial decisions on pharmacy requests for South Dakota, Minnesota, and North Dakota Plan members."* Sanford must revise its practice and policy to require a physician to make the denial determination on pharmaceutical denials. **(Deficiency #4)**

Complaints to Commerce or Health

Minnesota Statutes, Section 62M.11

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

Summary of Findings

Recommendations

1. To better comply with Minnesota Statutes, section 62D.115, subdivision 2(c), Sanford should update its quality of care policy to include a definition of what quality of care complaints warrant peer protection confidentiality.

2. To better comply with Minnesota Rules, part 4685.1110, subpart 6, Sanford should clarify its process for credentialing oversight of pharmacy providers to include the specific elements reviewed (for example Medicare/Medicaid sanction review), number of files and assure review of both initial credentialed and recredentialed files.

Mandatory Improvements

1. To comply with Minnesota Statutes, section 62D.115, subdivision 1, Sanford must revise their definition of quality of care complaints to be comprehensive and more consistent with the law.

2. To comply with Minnesota Statutes, section 62D.115, subdivision 2(c), Sanford must update their policy/procedure to indicate investigational procedures by severity level.

3. To comply with Minnesota Statutes, section 62Q.69, subdivision 2, Sanford must revise the timeline for oral complaints to indicate 10 days, and *not* business days.

4. To comply with Minnesota Statutes, section 62Q.19, subdivision 3, Sanford must update their policy/ procedure to indicate that they must offer a provider contract to an essential community provider located within the service area.

5. To comply with Minnesota Statutes, section 62Q.56, subdivision 1, Sanford must update their policy/procedure to indicate how members are identified for culturally appropriate care and/or language barriers and what criteria is used to determine eligibility.

6. To comply with Minnesota Statutes, section 62M.06, subdivisions 1and 2, Sanford must revise its policy to clearly designate that:
   - The right to appeal is available to both the enrollee and the attending health care professional for all appeals;
   - A written designation of representation is not required for a physician filing an appeal or expedited appeal.

Deficiencies

1. To comply with Minnesota Rules, parts 4685.1110 and 4685.1130, Sanford must
   - Submit to MDH its written quality plan for approval with any revisions;

- Include information on its peer review, utilization management and credentialing processes;
- Obtain approval of the written quality plan from its Board of Directors.

2. To comply with Minnesota Rules, part 4685.1110, subpart 8, Sanford must have its annual quality program evaluation reviewed by its Board of Directors.

3. To comply with Minnesota Rules, part 4685.1130, subpart 2, Sanford must be able to show evidence that its annual quality work plan was approved by its Board of Directors.

4. To comply with Minnesota Statutes, section 62M.09, subdivision 3, Sanford must revise its practice and policy to require a physician to make the denial determination on pharmaceutical denials.