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Minnesota Department of Health Oversight of HMO Complaint Resolution

The Legislature should better define MDH's regulatory authority over HMOs' complaint resolution processes, especially for "quality of care" complaints.

Key Facts and Findings:

- State and federal laws set up a complex system involving multiple agencies to regulate health insurers and the plans they offer.
- The Minnesota Department of Health (MDH) licenses and regulates health maintenance organizations (HMOs). At the close of fiscal year 2015, about 18 percent of Minnesotans were enrolled in HMO health plans at least partially under MDH's jurisdiction.
- State law allows HMO enrollees to file a wide variety of complaints with their HMOs and MDH, but laws limit the department's authority to adequately investigate all types of complaints.
- Although the quality assurance examinations that MDH conducts once every three years ensure that HMOs have complaint processes in place, they do not address whether HMOs' final decisions on complaints have been appropriate.
- State law sets forth—and HMOs use—comprehensive and transparent processes to resolve some types of complaints, but not others.
- Complaint resolution requirements for "quality of care" complaints—those concerning the timeliness, quality, or appropriateness of healthcare services—lack comprehensiveness and transparency.
- State law does not clearly define the types of complaints eligible for review by independent organizations outside of HMOs and MDH.
- MDH does not require that HMOs routinely collect and report data on enrollees' complaints in a consistent manner, which inhibits MDH's ability to provide ongoing monitoring of complaint resolution at HMOs.

Key Recommendations:

The Minnesota Department of Health should:

- For greater transparency and opportunity for outside review, forward quality of care complaints to the appropriate professional health-related licensing board for investigation.
- Develop standard definitions and categories for complaints and require HMOs to report data accordingly.

The Legislature should:

- Define the types of issues that should be investigated as confidential quality of care complaints.
- Give MDH full access to HMOs' confidential quality of care complaint investigations.
- More clearly define MDH's authority to investigate and resolve complaints that HMO enrollees file with the department.
- More clearly define the types of complaints eligible for independent external review.
- Require HMOs to report complaint data annually to MDH, using definitions and categories established by the department.

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Report Summary

The Minnesota Department of Health (MDH) licenses and regulates health maintenance organizations (HMOs). In Minnesota, HMOs must be either nonprofit corporations or local units of government. They operate under a managed care model, which means, among other things, that healthcare is delivered through a network of approved hospitals, doctors, and other professionals. HMOs provide or arrange for comprehensive health services for their enrollees based on fixed, prepaid sums, regardless of the frequency or extent of services provided. At the close of 2015, nine HMOs were licensed to operate in Minnesota. Eight were nonprofit corporations and one was part of local government.

MDH's authority over complaint resolution processes in HMOs varies and can be confusing.

Although HMOs all offer managed care health insurance, the plans themselves are often tailored for different types of clientele. This can affect both MDH's regulatory authority and how HMOs process complaints. For example, MDH has full regulatory authority over commercial HMO plans that serve groups of people (generally employer groups) and individuals and families seeking coverage on their own. But it has only partial authority over HMO plans that serve public assistance recipients enrolled in managed care programs operated by the Minnesota Department of Human Services (DHS). In these instances, MDH shares authority with DHS, and these enrollees have different complaint resolution processes available to them than commercial enrollees. At the end of fiscal year 2015, about 18 percent of Minnesotans were enrolled in HMO health plans at least partially under MDH's jurisdiction, which were the focus of our evaluation.

In contrast, MDH has little authority over complaint resolution in HMOs' Medicare plans or "self-insured" health plans where employers (rather than HMOs) pay enrollees' healthcare costs. HMOs often administer self-insured plans; for example, three HMOs administer health plans for State of Minnesota employees.

Requirements for resolving benefit-related complaints are more comprehensive and transparent than they are for complaints about quality.

HMO enrollees who have complaints related to their "benefits"—for example, disagreements about billing or whether certain treatment procedures are covered or medically necessary—may access a multilevel complaint resolution process within their HMO. Depending on the type of health plan they have or the exact nature of their problem, enrollees may have two opportunities to ask HMOs to reconsider their decisions. If enrollees are still dissatisfied, they can ask that an independent entity outside of their HMO review their complaint.

In contrast, requirements for resolving "quality of care" complaints—those related to the quality, timeliness, or appropriateness of healthcare services—offer considerably fewer opportunities for review. Also, although enrollees may submit complaints about quality issues, state and federal laws generally prevent HMOs and MDH from telling enrollees how such complaints were resolved.

MDH's authority to adequately investigate all types of complaints is limited.

Although enrollees may file all types of complaints with MDH, state law only gives MDH explicit authority to resolve complaints about "coverage," a term not defined in law or department policy. In these cases, statutes allow MDH to overturn HMOs' decisions and order that services be paid for or provided.

MDH has the necessary expertise to resolve *technical* coverage issues—for example, whether enrollees' plans entitle them to certain medical services or whether their bills are computed correctly. But MDH does not have the expertise to resolve coverage complaints *medical* in nature—for example, whether specific treatments are medically necessary.

Also, state law does not specify how MDH should handle complaints clearly not related to coverage—for example, quality of care complaints. Currently, MDH sends them to

HMOs for investigation. When enrollees file complaints about the quality of their care, HMOs may use a "peer-review protected" process to investigate those complaints. In these situations, appropriately qualified professionals evaluate whether the healthcare services provided met accepted standards of care. State and federal laws require HMOs to treat this process as confidential. Although MDH has access to original information and documents acquired during the peer review process, it does not have access to the discussion and documents produced during this process. This limits MDH's ability to adequately examine HMO processes for resolving quality of care complaints.

The Legislature should define the types of complaints that HMOs can classify as confidential.

Some HMOs routinely classify complaints related to communication, facilities, access to care, and other nonmedical issues as quality of care complaints. Because some HMOs consider all quality investigations confidential, complainants' access to information related to these complaints is unnecessarily limited. To increase transparency, the Legislature should ensure that enrollees' access to information about their complaint's investigation and resolution is limited only when truly necessary.

The Legislature should give MDH full access to HMOs' confidential quality of care investigations.

In general, statutes that allow for the confidentiality of the peer-review process are intended to improve healthcare quality and encourage self-monitoring in the medical profession. It is believed that giving the public access to peer-review materials could make healthcare professionals reluctant to participate openly in peer review or make candid reports about their peers.

We agree that public health can be improved through thorough, confidential reviews. But MDH should have full access to these reviews to ensure that HMOs comply with state laws—one of the department's major responsibilities.

Limited access to confidential complaint investigations also affects MDH's quality assurance examinations, which is the primary tool it uses to monitor HMOs' complaint processes. Conducted once every three years, the examinations ensure that HMOs have complaint processes in place, but they do not address whether HMOs' final decisions were appropriate. Providing greater access to HMOs' quality of care investigations would, at a minimum, help ensure that such complaints are processed appropriately.

MDH should send quality of care complaints to professional health-related licensing boards for investigation.

MDH advises complainants that they can also file a complaint with one of the professional health-related licensing boards, such as the Minnesota Board of Medical Practice. However, MDH does not regularly forward all such complaints it receives directly to the licensing boards for an "outside" investigation. These boards generally have the necessary professional expertise to make independent judgments on quality of care issues, and they have experience investigating quality-related complaints. Also, they routinely notify complainants about their complaint's resolution and post information on their public websites when they take certain types of actions. Involving the boards in quality of care investigations would give complainants the opportunity to have an outside entity assess their complaint. In addition, it would improve transparency for complainants and the general public, while increasing HMO accountability.

State law defining the types of complaints eligible for external review is unclear.

In some instances, HMO enrollees can ask that an organization outside of their HMO and MDH review their complaint—a process called independent external review. These reviews are done by qualified professionals, which is important because enrollees' complaints can involve complex medical issues. The review organizations' decisions are binding on HMOs, and HMOs must pay for the bulk of the cost of the reviews.

Statutory language regarding the types of complaints eligible for this level of review, however, is confusing. It defines eligible complaints simply as "adverse decisions"—

complaints about healthcare services or claims that an HMO has reviewed and decided against the complainant. Current language does not clearly exclude quality issues from the independent external review process. But because HMOs usually classify quality investigations as confidential, complainants cannot request an external review because they do not know how their HMO resolved their complaint. Thus, complaints related to quality of care are indirectly excluded from review by an independent external organization.

The Legislature should address whether quality of care complaints are eligible for external review.

Excluding quality of care complaints from the external review process may be appropriate, especially if the Legislature and MDH adopt our recommendations to clarify statutes and refer quality-related complaints to the appropriate professional health-related licensing board. However, to avoid confusion, we think the Legislature should better define the types of complaints eligible for external review, paying special attention to quality of care complaints.

Both the National Association of Insurance Commissioners, which has developed a model act for independent external review, and federal regulations for the *Affordable Care Act* set forth clearer definitions than Minnesota law. While their definitions are not perfect, they provide a good starting point for the Legislature.

HMOs should report meaningful complaint data to MDH.

Although statutes define what constitutes a "complaint," MDH does not require HMOs to use this definition to uniformly identify or categorize complaints. The same enrollee problem may be recorded as a complaint in one HMO, but not in another. As a result, the number of complaints per enrollee recorded by each HMO varies widely. Also, MDH does not require HMOs to routinely report complaint data to the department. This impairs MDH's ability to detect variations across HMOs or identify complaint-related trends as they arise. MDH needs to develop standard definitions and categories for reporting complaint data, and the Legislature needs to require their use.

Summary of Agency Response

In a letter dated February 10, 2016, Department of Health Commissioner Edward Ehlinger agreed with several of OLA's recommendations. He said the department will improve its process for receiving and reviewing complaints, including better documentation of internal processes. He also said that a better definition for quality of care complaints would help HMOs address certain enrollee health care concerns more effectively and provide MDH with better data to assess how well HMOs resolve complaints. The commissioner noted that MDH's "understanding of quality of care complaints would be enhanced by complete access to HMO quality of care complaint files" and that "legislative revisions to the scope or access to HMO quality of care complaint information should balance both enrollees' concerns and the need for continued health care quality improvement." While the commissioner agreed that Minnesota's health professional licensing boards "should review complaints pertaining to licensed provider behavior, competency and quality," he noted that MDH should retain authority to review other types of complaints. Finally, the commissioner said simplifying complaint laws may require comprehensive legislation to apply consistent standards to all health insurers.

The full evaluation report, *Minnesota Department of Health Oversight of HMO Complaint Resolution*, is available at 651-296-4708 or:
www.auditor.leg.state.mn.us/ped/2016/hmocomplaints.htm