



**OFFICE OF THE LEGISLATIVE AUDITOR**  
**STATE OF MINNESOTA**

**EVALUATION REPORT**

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**Minnesota Department of  
Health Oversight of HMO  
Complaint Resolution**

**FEBRUARY 2016**

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February 2016

Members of the Legislative Audit Commission:

At your request, the Office of the Legislative Auditor evaluated the Minnesota Department of Health's (MDH's) oversight of complaint resolution for people enrolled in health maintenance organizations (HMOs). This report presents the results of our evaluation.

We found that state law allows people enrolled in HMOs to file a wide range of complaints with their HMOs and MDH. However, state law limits the department's authority to adequately investigate all types of complaints. We make a number of recommendations for the Legislature that would better define and strengthen MDH's regulatory authority over HMOs' complaint processes, especially as they relate to quality of care issues.

Our evaluation was conducted by Jo Vos (evaluation manager), Jodi Munson Rodriguez, and Ellen Dehmer. The Minnesota Department of Health and the state's HMOs cooperated fully with our evaluation.

Sincerely,

A handwritten signature in black ink, appearing to read "Jim Nobles".

James Nobles  
Legislative Auditor

A handwritten signature in black ink, appearing to read "Judy Randall".

Judy Randall  
Deputy Legislative Auditor



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# Summary

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## **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. (pp. 3-7)
- 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. (pp. 3-5, 8)
- 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. (pp. 33-34)
- 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. (pp. 23-24)
- State law sets forth—and HMOs use—comprehensive and transparent processes to resolve some types of complaints, but not others. (pp. 13-16)
- Complaint resolution requirements for "quality of care" complaints—those concerning the timeliness, quality, or appropriateness of healthcare services—lack comprehensiveness and transparency. (pp. 13-16)
- State law does not clearly define the types of complaints eligible for review by independent organizations outside of HMOs and MDH. (p. 41)
- 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. (pp. 19-23)

### **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. (p. 36)
- Develop standard definitions and categories for complaints and require HMOs to report data accordingly. (pp. 21-22)

The Legislature should:

- Define the types of issues that should be investigated as confidential quality of care complaints. (p. 30)
- Give MDH full access to HMOs' confidential quality of care complaint investigations. (p. 31)
- More clearly define MDH's authority to investigate and resolve complaints that HMO enrollees file with the department. (p. 34)
- More clearly define the types of complaints eligible for independent external review. (pp. 41-42)
- Require HMOs to report complaint data annually to MDH, using definitions and categories established by the department. (pp. 21-22)

## 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.

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# Introduction

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Minnesotans obtain health insurance in a variety of ways, including through health plans offered by health maintenance organizations (HMOs) regulated by the Minnesota Department of Health (MDH). Because healthcare is so important to consumers, state and federal laws require that health insurers have complaint resolution procedures in place for enrollees dissatisfied with their plan's decisions or actions.

In April 2015, the Legislative Audit Commission directed the Office of the Legislative Auditor (OLA) to evaluate MDH's oversight of complaint resolution for HMO enrollees. Our evaluation addressed the following research questions:

- **How adequately does MDH oversee HMOs' internal complaint resolution processes?**
- **Does MDH have sufficient authority to ensure that HMOs comply with state and federal requirements?**
- **How thoroughly does MDH investigate complaints filed with the department?**
- **To what extent does the department oversee the independent external review process specifically available to HMO enrollees?**

We used a variety of methods to answer these questions. First, we reviewed state and federal laws and regulations related to complaint resolution as well as HMO and MDH policies, procedures, reports, and other documents. Second, we analyzed statewide data on complaints filed with MDH and HMOs. Third, we examined individual complaints filed with MDH by HMO enrollees and reports from independent external review organizations.<sup>1</sup> Fourth, we assessed MDH's quality assurance program as it relates to the complaint process. Finally, we interviewed various state agency staff and HMO representatives.

Our evaluation is narrowly focused on MDH's complaint resolution responsibilities, which are centralized in its Managed Care Section. We did not examine other department activities more broadly related to HMOs, including issuing certificates of authority, examining financial solvency, or ensuring provider network adequacy. Also, we did not directly examine how well HMOs resolve individual complaints, but instead focused on how well MDH oversees those processes through its quality assurance program. Finally, HMO enrollees can also file complaints with state agencies responsible for licensing health-related professionals, facilities, and programs. We did not examine HMO enrollees' experiences using these options.

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<sup>1</sup> Some HMO enrollees can have their complaints reviewed by special review organizations outside of HMOs and MDH. We discuss this option in Chapter 3.



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# Chapter 1: Background

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The vast majority of Minnesotans—approximately 95 percent of the state’s population in 2014—have health insurance to help pay for their medical expenses. By enrolling in a health plan, consumers agree to pay a preset rate (often referred to as a premium). In return, health insurers agree to provide medical services or pay for a certain amount of enrollees’ medical bills. Given the important role health insurance can play in an individual’s overall health and financial stability, state and federal laws have been passed to protect enrollees’ rights. One such protection is requiring a comprehensive process for resolving enrollee complaints. Laws require that health insurers have procedures in place for enrollees to file complaints when they are dissatisfied with their health insurer’s decisions or actions. In addition, health insurers must provide enrollees with information about external complaint resolution options.

Although health insurers are required to provide enrollees with information about complaint resolution options, these processes are complex and can be confusing. Health insurers are regulated by a variety of state and federal agencies and, depending on the type of health plan enrollees have and the nature of their complaint, their options for resolving a complaint can vary. This can and does present challenges. For example, enrollees may not know which governmental agency regulates their health plan and, therefore, which agency can help them resolve their complaint.

This evaluation focuses on the Minnesota Department of Health’s (MDH’s) role in overseeing complaint resolution processes for one type of health insurer—health maintenance organizations (HMOs). In this chapter, we describe MDH’s role in regulating health plans, including the types of plans it does and does not regulate.

## HEALTH INSURERS

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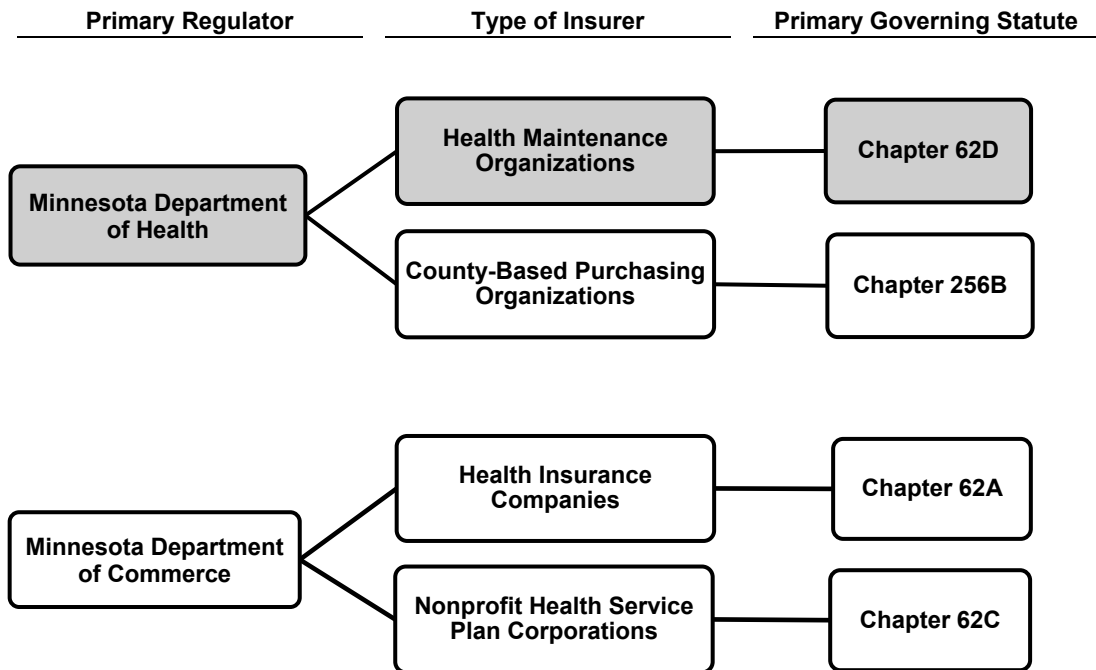
Minnesota’s framework for regulating health insurance, designed more than 50 years ago, is fragmented. An assortment of public, private, and nonprofit organizations provide health insurance to Minnesotans, with each type of insurer operating under its own set of laws and regulations. As shown in Exhibit 1.1, two state agencies, the departments of Commerce and Health, have primary responsibility for regulating health insurers in Minnesota. This complex framework adds to the general confusion enrollees may face when they are dissatisfied with some aspect of their healthcare.

*Health maintenance organizations* represent one type of health insurer. Their roots in Minnesota can be traced back to the mid-1940s, when railroad workers in northern Minnesota established a prepaid health plan for their members.<sup>1</sup> However, MDH was not

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<sup>1</sup> Under prepaid health plans, health insurers agree to provide or pay for enrollees’ healthcare in exchange for a set premium.

### Exhibit 1.1: Minnesota Regulation of Health Insurers



NOTE: This evaluation focuses on the shaded boxes.

SOURCE: Office of the Legislative Auditor, 2015.

responsible for regulating HMOs until the Legislature passed the *Health Maintenance Act of 1973*.<sup>2</sup>

**In Minnesota, health maintenance organizations are nonprofit corporations or local units of government that provide or arrange for comprehensive health services for their enrollees based on fixed, prepaid sums, regardless of the frequency or extent of services provided.**

Unlike their counterparts in many other states, HMOs in Minnesota cannot operate as for-profit businesses. They are, however, similar to HMOs nationwide in that they operate under a “managed care” model. This means, among other things, that healthcare is delivered through an approved network of hospitals, doctors, and other professionals. Enrollees generally must obtain a referral from their HMO before seeing specialists outside

<sup>2</sup> *Laws of Minnesota* 1973, ch. 670. At the time this law was passed, legislators debated whether they should place HMOs under the Department of Commerce or MDH. They eventually decided on MDH for two primary reasons. First, they viewed HMOs as something new and experimental, and they wanted to create less stringent regulations for them that would allow for more growth. Second, they thought HMO regulation should include monitoring of medical care, something better suited to MDH than commerce. Office of the Legislative Auditor, Program Evaluation Division, *Health Plan Regulation* (St. Paul, 1988), 10, 21. In 1973, Congress also enacted federal HMO legislation. *The Health Maintenance Organization Act of 1973*, Public Law 93-222, December 29, 1973.



their HMO's network of treatment providers. Historically, HMOs have been required to provide comprehensive services, which now include emergency care, emergency ground ambulance transportation services, inpatient hospital and physician care, and outpatient and preventive health services. For the most part, HMOs must offer annual open enrollment periods, and they cannot refuse to enroll or reenroll individuals for health-related reasons. Further, they have generally been required to base their premiums on a community-wide basis rather than an individual enrollee's health, medical history, or gender.

To operate in Minnesota, HMOs must obtain a certificate of authority (often referred to as a license) from MDH.<sup>3</sup> At the close of 2015, nine HMOs were licensed to operate in Minnesota. Eight were nonprofit corporations: Blue Plus, Group Health, Gundersen Health Plan Minnesota, HealthPartners, Medica Health Plans, PreferredOne Community Health Plan, Sanford Health Plan of Minnesota, and UCare Minnesota.<sup>4</sup> One HMO was part of local government: Metropolitan Health Plan. Our evaluation focuses on how MDH oversees the complaint resolution processes in these HMOs.

Although our evaluation did not include other types of insurers, we briefly describe them to illustrate the complexity of Minnesota's regulatory framework. As shown previously in Exhibit 1.1, MDH also regulates *county-based purchasing organizations* (CBPs). These are individual counties or groups of counties that offer health plans for certain residents enrolled in public assistance programs.<sup>5</sup> At the end of 2015, three CBPs encompassing 26 counties were operating in the state.

The Minnesota Department of Commerce licenses and regulates *commercial health insurance companies* and *nonprofit health service plan corporations*. A major distinction between these two types of entities is that service plan corporations are nonprofits as opposed to insurance companies that generally operate for profit. Both have traditionally offered fee-for-service health plans. In such plans, for a preset premium, enrollees can see the primary care provider of their choice. Insurance companies and health service plans pay healthcare providers based on the actual services provided to their enrollees. In 2014, 30 health insurance companies and 3 nonprofit health service plans were licensed by the Department of Commerce.<sup>6</sup>

Since the creation of HMOs, the types of health plans available to Minnesotans have become increasingly similar. According to a report by the Henry J. Kaiser Family Foundation, health plans offered by virtually all types of health insurers currently involve some aspects of managed care.<sup>7</sup> For example, many commercial insurance companies now offer health plans that allow enrollees to lower their monthly premiums or other medical

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<sup>3</sup> *Minnesota Statutes* 2015, 62D.04.

<sup>4</sup> In 1992, Group Health merged with MedCenters Health Plan to form HealthPartners. Group Health and HealthPartners operate as one, fully integrated entity and share the same complaint systems, member services, data systems, and all other staff and programs. However, they hold separate HMO licenses. For the purposes of our evaluation, we analyzed them as one entity.

<sup>5</sup> *Minnesota Statutes* 2015, 256B.692. The counties enter into contracts with the Minnesota Department of Human Services that require ongoing regulatory oversight by MDH. County-based purchasing organizations must meet many of the same requirements as HMOs, but are not licensed.

<sup>6</sup> Blue Cross Blue Shield of Minnesota, a major provider of comprehensive healthcare coverage, is licensed as a nonprofit health service plan corporation. Some other states license Blue Cross Blue Shield as an insurance company. Another nonprofit health service plan licensed by the department only provides dental coverage.

<sup>7</sup> The Henry J. Kaiser Family Foundation, *How Private Health Coverage Works: A Primer 2008 Update* (Menlo Park, CA: The Henry J. Kaiser Family Foundation, April 2008), 4.

costs if they agree to seek treatment from a network of approved providers—a concept borrowed from HMOs.

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**Passage of the *Affordable Care Act* in 2010 further diminished distinctions between health maintenance organization plans and other types of health plans available to Minnesotans.**

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Under the *Affordable Care Act* (ACA), commercial insurance companies and nonprofit health service corporations must adopt policies, procedures, and benefit structures similar to those of HMOs.<sup>8</sup> For example, they must provide a balance of services across ten basic categories, including hospitalization, emergency care, and preventive services, and they cannot deny coverage to or impose exclusions or waiting periods on individuals with preexisting medical conditions. Further, insurance premiums can only be based on age, tobacco use, and geography.

## HEALTH MAINTENANCE ORGANIZATION HEALTH PLANS

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Although HMOs all offer the same general type of health insurance—managed care—the plans themselves are often tailored for different types of clientele. This affects how HMOs process complaints. It may also present additional challenges to enrollees as they attempt to maneuver the complaint resolution process.

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**The Minnesota Department of Health’s authority over health maintenance organizations’ complaint processes varies, depending on the type of health plan offered.**

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As shown in Exhibit 1.2, MDH has full regulatory authority over HMOs’ *fully insured commercial health plans*. These plans serve groups of people (generally employer groups) as well as individuals and families seeking coverage on their own. Fully insured plans guarantee benefits to enrollees under contracts that transfer the financial risk of paying for healthcare services from employers or individuals to HMOs. Employers or individuals pay a set premium, regardless of the amount of covered services used. Health maintenance organizations that offer these plans must pay all appropriate costs for enrollees, as outlined in plan contracts.

The Minnesota Department of Health has partial authority over HMOs’ *state-regulated public health plans*. These plans serve public assistance recipients enrolled in managed care programs operated by the Minnesota Department of Human Services (DHS).<sup>9</sup> For the most part, these health plans operate under federal regulations promulgated by the Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services.<sup>10</sup>

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<sup>8</sup> *Patient Protection and Affordable Care Act of 2010*, Public Law 111-148, sec. 2719(4), March 23, 2010.

<sup>9</sup> These programs include Minnesota Senior Health Options, Special Needs Basic Care, Prepaid Medical Assistance, and MinnesotaCare.

<sup>10</sup> Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, 42 *CFR* Part 438 (2015); and 45 *CFR* Part 147 (2015).

**Exhibit 1.2: Minnesota Department of Health Regulatory Authority Over Health Maintenance Organization Plans**

HMO Plans at Least Partially Under MDH's Authority	HMO Plans Not Under MDH's Authority
<b>Fully insured commercial:</b> Plans serve large and small groups (generally employer groups) and individuals/families seeking coverage on their own	<b>Self-insured:</b> Plans serve employees whose employers assume the financial risk for providing healthcare services
<b>State-regulated public:</b> Plans serve public assistance recipients enrolled in managed care programs operated by the Minnesota Department of Human Services	<b>Medicare:</b> Plans serve individuals 65 years of age or older and younger individuals who have a disability

NOTES: HMO refers to health maintenance organization and MDH refers to the Minnesota Department of Health.

SOURCE: Office of the Legislative Auditor, 2015.

Federal regulations set up a somewhat different regulatory structure for these health plans and give DHS, rather than MDH, primary authority over the plans.<sup>11</sup> However, DHS has an interagency agreement with MDH that requires health department staff to periodically review certain aspects of public assistance plans, including their complaint processes.<sup>12</sup>

The Minnesota Department of Health has very limited authority over complaint resolution in *Medicare plans* that HMOs offer to state residents, although HMOs that offer such plans must be licensed by MDH. These plans serve eligible individuals 65 years of age or older as well as individuals younger than 65 who have a disability. The Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, not MDH, regulates Medicare plans, including complaint resolution.<sup>13</sup>

Finally, MDH has no authority over *self-insured health plans*. The U.S. Department of Labor, not MDH, regulates these plans.<sup>14</sup> In contrast to fully insured plans, employers, rather than health plans, assume the financial risk for providing healthcare services to enrollees in self-insured plans. Employers offering these plans generally do not process claims themselves. Instead, they contract with other entities—sometimes HMOs—to act as administrative agents for them. For example, the State of Minnesota self-insures the health plans it offers to state employees, and Minnesota Management and Budget contracts with three HMOs to administer the plans.

**ENROLLMENT**

As noted previously, the great majority of Minnesotans have some type of health insurance. According to a recent report, 95 percent of all Minnesotans had health insurance in 2014,

<sup>11</sup> At the same time, MDH licenses the HMOs that provide these plans.

<sup>12</sup> We discuss these activities, commonly referred to as quality assurance examinations, in Chapter 2.

<sup>13</sup> 42 CFR, Part 422 (2015).

<sup>14</sup> *Employment Retirement Income Security Act* (ERISA), Public Law 93-406, September 2, 1974.

most often (33 percent) through their employers' self-insured health plans. In addition, 23 percent were enrolled in fully insured group commercial plans, 17 percent in Medicare plans, 16 percent in public assistance plans, and 6 percent in individual commercial plans.<sup>15</sup>

Because we wanted the most recent enrollment data available, we asked each HMO for their total enrollment in commercial and public plans regulated by MDH. As Exhibit 1.3 shows, several HMOs enrolled both commercial and public assistance clients, although enrollment varied considerably among HMOs.

### Exhibit 1.3: Health Maintenance Organization Enrollment, June 30, 2015

Health Maintenance Organization	Commercial Enrollment	Public Enrollment	Total Enrollment	Percentage of Total
UCare	10,125	396,885	407,010	41%
HealthPartners <sup>a</sup>	143,126	105,158	248,284	25
Medica	20	197,291	197,311	20
Blue Plus	11,016	106,051	117,067	12
Metropolitan Health	0	14,196	14,196	1
PreferredOne	5,575	0	5,575	1
Sanford	461	0	461	<1
Gundersen	265	0	265	<1
Total	170,588	819,581	990,169	100%

NOTES: Percentages do not total 100 due to rounding. Enrollment data only include health maintenance organization plans at least partially regulated by the Minnesota Department of Health.

<sup>a</sup> Although HealthPartners and Group Health hold separate HMO licenses, they operate as one, fully-integrated system. Consequently, we treat them as one entity and refer to them as HealthPartners.

SOURCE: Office of the Legislative Auditor, analysis of health maintenance organization data, 2015.

### Only 18 percent of all Minnesotans were enrolled in health maintenance organization plans at least partially regulated by the Minnesota Department of Health at the end of fiscal year 2015.

The Minnesota Department of Health oversees complaint resolution processes for only a fraction of all Minnesotans—18 percent. According to our estimates, about 15 percent and 3 percent of Minnesotans were enrolled in HMOs' public and commercial plans, respectively, at the close of fiscal year 2015.

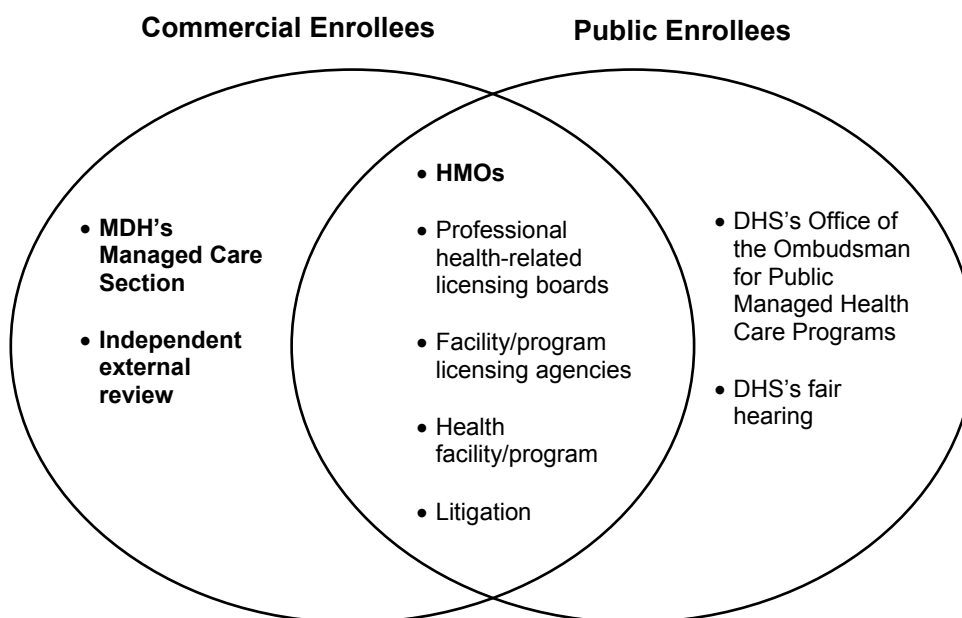
## COMPLAINT RESOLUTION OPTIONS

State law defines "complaint" to encompass a wide range of benefit-related problems, including issues related to: coverage exclusions or restrictions; eligibility for services; payment denials or limitations; plan administration; and the medical necessity of covered

<sup>15</sup> Minnesota Department of Commerce, *2016 Rate Summary* (St. Paul, 2015), 3.

services.<sup>16</sup> The definition also includes quality-related problems about the quality, timeliness, and appropriateness of healthcare services. As we noted previously, state and federal laws provide HMO enrollees with various options when they want to file a complaint about their healthcare or services. Exhibit 1.4 shows the variety of complaint options available to HMO enrollees, although our evaluation focuses only on the bold options.

### Exhibit 1.4: Complaint Resolution Options for Health Maintenance Organization Enrollees



NOTES: DHS refers to the Minnesota Department of Human Services, HMOs refers to health maintenance organizations, and MDH refers to the Minnesota Department of Health. Bold options refer to the complaint options examined in this report.

SOURCE: Office of the Legislative Auditor, 2015.

### Complaint resolution options available to health maintenance organization enrollees depend on the type of health plan and complaint.

Both *commercial* and *public* plan enrollees may file a complaint with: (1) their HMO; (2) a professional health-related licensing board, such as the Minnesota Board of Medical Practice; (3) an individual facility or program, such as a hospital or chemical dependency treatment center; and (4) a state agency that investigates or licenses health-related facilities or programs, such as MDH's Office of Health Facility Complaints or DHS's Licensing

<sup>16</sup> *Minnesota Statutes* 2015, 62Q.68, subd. 2. Plan administration refers to a variety of "office" problems, such as enrollees not receiving the proper membership materials or being issued incorrect identification cards.

Division.<sup>17</sup> Enrollees may also seek legal recourse. They can choose one or more of these options, but HMOs and MDH cannot investigate complaints while they are under litigation.

Additionally, *commercial* plan enrollees may file a complaint with MDH's Managed Care Section.<sup>18</sup> Under certain circumstances, they may also ask that an independent external organization review decisions made by their HMOs.<sup>19</sup> As we explain more fully in Chapter 3, these organizations use appropriately qualified professionals to review enrollees' complaints and determine whether actions taken by HMOs complied with state laws and enrollees' plans. Enrollees can choose one or both of these options. Complaints under litigation are not eligible for external review.<sup>20</sup>

*Public* plan enrollees have many of the same complaint options available to them as commercial plan enrollees, with two main differences. We noted previously that DHS manages health plans that serve public assistance recipients. Consequently, public HMO enrollees may ask DHS's Office of the Ombudsman for Public Managed Health Care Programs (rather than MDH) for assistance when dissatisfied with their HMOs' decisions.<sup>21</sup> In addition, public enrollees may request a "fair hearing" before an administrative law judge in lieu of an independent external review.<sup>22</sup> As part of the fair hearing process, they may also ask that one of the state's external review organizations provide an expert medical opinion on their complaint.<sup>23</sup>

As noted earlier, we focused our evaluation on three complaint options that MDH oversees: (1) complaint resolution within HMOs; (2) complaint resolution within the department itself; and (3) independent external review. These three options are available to commercial HMO enrollees, and Exhibit 1.5 shows how they relate to one another. Exhibit 1.5 also provides similar detail for public plan enrollees.<sup>24</sup>

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<sup>17</sup> Other professional health-related licensing boards include the Minnesota boards of Behavioral Health and Therapy, Chiropractic Examiners, Dentistry, Dietetics and Nutrition, Marriage and Family Therapy, Nursing, Nursing Home Administrators, Optometry, Pharmacy, Physical Therapy, Podiatric Medicine, Psychology, Social Work, and Veterinary Medicine, and the Office of Unlicensed Complementary and Alternative Health Care Practice in MDH. *Minnesota Statutes* 2015, 214.01, subd. 2.

<sup>18</sup> The following two chapters focus on the three complaint resolution processes under the purview of MDH's Managed Care Section, which we hereafter simply refer to as MDH.

<sup>19</sup> The state uses three independent review organizations to review certain types of decisions made by HMOs. The review organizations can either uphold (affirm) or overturn (reverse) HMO decisions. We examine HMO enrollees' use of this option in Chapter 3.

<sup>20</sup> *Minnesota Statutes* 2015, 62Q.68, subd. 2, generally limits access to MDH, HMO, and external review processes to complaints not under litigation.

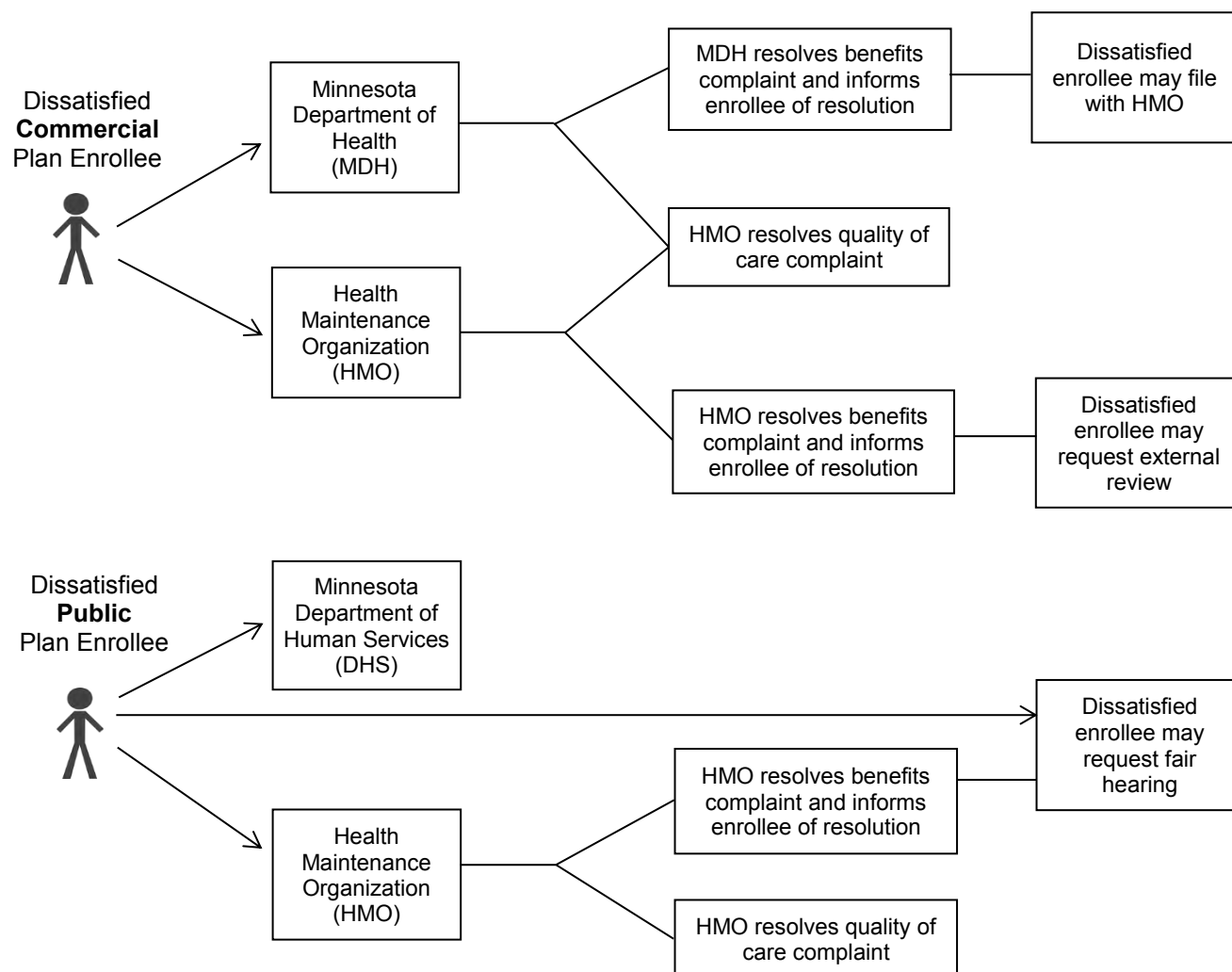
<sup>21</sup> The Office of the Ombudsman for Public Managed Health Care Programs acts as a facilitator on behalf of dissatisfied public plan enrollees to help them resolve problems. Unlike MDH, the office has no direct statutory authority to overturn HMOs' decisions.

<sup>22</sup> Fair hearings are formal proceedings similar to trials, but without juries. After hearing testimony and reviewing evidence presented by complainants and health plans, administrative law judges make decisions and file written reports. See *Minnesota Statutes* 2015, 62Q.73, subd. 2; and 256.045, subd. 3a.

<sup>23</sup> *Minnesota Statutes* 2015, 62Q.73, subd. 2(b).

<sup>24</sup> Our evaluation did not examine the complaint resolution process within DHS or the fair hearing process. We did, however, look at how HMOs process complaints from public plan enrollees.

## Exhibit 1.5: Overview of Complaint Resolution Processes for Health Maintenance Organization Enrollees



NOTES: Dissatisfied commercial plan enrollees may file a complaint with MDH at any time, regardless of whether they have filed a complaint with their HMO. Only certain types of benefits complaints, as we describe in Chapter 2, may go to external review or a fair hearing. Although DHS does not accept complaints from public plan enrollees, enrollees may ask the department for assistance when dissatisfied with their HMOs' decisions. In addition, MDH may help dissatisfied public plan enrollees with certain types of complaints.

SOURCE: Office of the Legislative Auditor, 2015.

As is shown, HMOs and MDH process complaints about benefits differently than they process complaints about quality. When enrollees complain about their benefits, they have an additional level of review available to them with entities separate from their HMOs. These external entities generally have the authority to overturn HMOs' decisions. In contrast, enrollees' complaints related to quality are investigated and resolved solely by HMOs. Furthermore, there is no external review option available for enrollees with these types of issues built into the complaint resolution process.

In the following two chapters, we describe each of the complaint resolution processes under MDH's purview more fully and present data on the volume and characteristics of the complaints filed. As we will show, enrollees are much more likely to file complaints with their HMOs than with MDH. Furthermore, despite the numerous ways HMOs and MDH inform enrollees about their ability to request an external or outside review of their complaints, very few HMO enrollees have done so.



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# Chapter 2: Complaint Resolution at Health Maintenance Organizations

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As discussed in Chapter 1, health maintenance organizations (HMOs) must provide their enrollees with a comprehensive complaint resolution process.<sup>1</sup> The Minnesota Department of Health (MDH) is responsible for ensuring that these processes comply with state and federal regulations. This chapter discusses how HMOs resolve complaints, describes the volume and types of complaints they receive, and examines how well MDH oversees complaint resolution at HMOs.

Overall, we found that HMOs have established the required complaint processes, and MDH periodically ensures that HMOs follow these processes. However, the department does not routinely monitor complaints on an ongoing basis, and its ability to review how HMOs resolve certain types of complaints is limited.

## COMPLAINT RESOLUTION PROCESSES

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Although generally regulated separately, HMOs' complaint resolution processes for commercial and public health plan enrollees must meet many of the same requirements. For example, both must explain the complaint options available to enrollees in their membership materials.<sup>2</sup> This includes telling enrollees how to file a complaint with their HMO, informing them of their right to file a complaint with state regulatory agencies, and describing how to request an independent external review or fair hearing.<sup>3</sup>

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**State law sets forth comprehensive and transparent processes for resolving enrollees' benefit-related complaints, but does not set forth transparent and comprehensive processes for quality-related complaints.**

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Exhibit 2.1 shows the complaint resolution process in HMOs for *commercial* plan enrollees who are dissatisfied with some aspect of their healthcare, as set forth in state law. As the

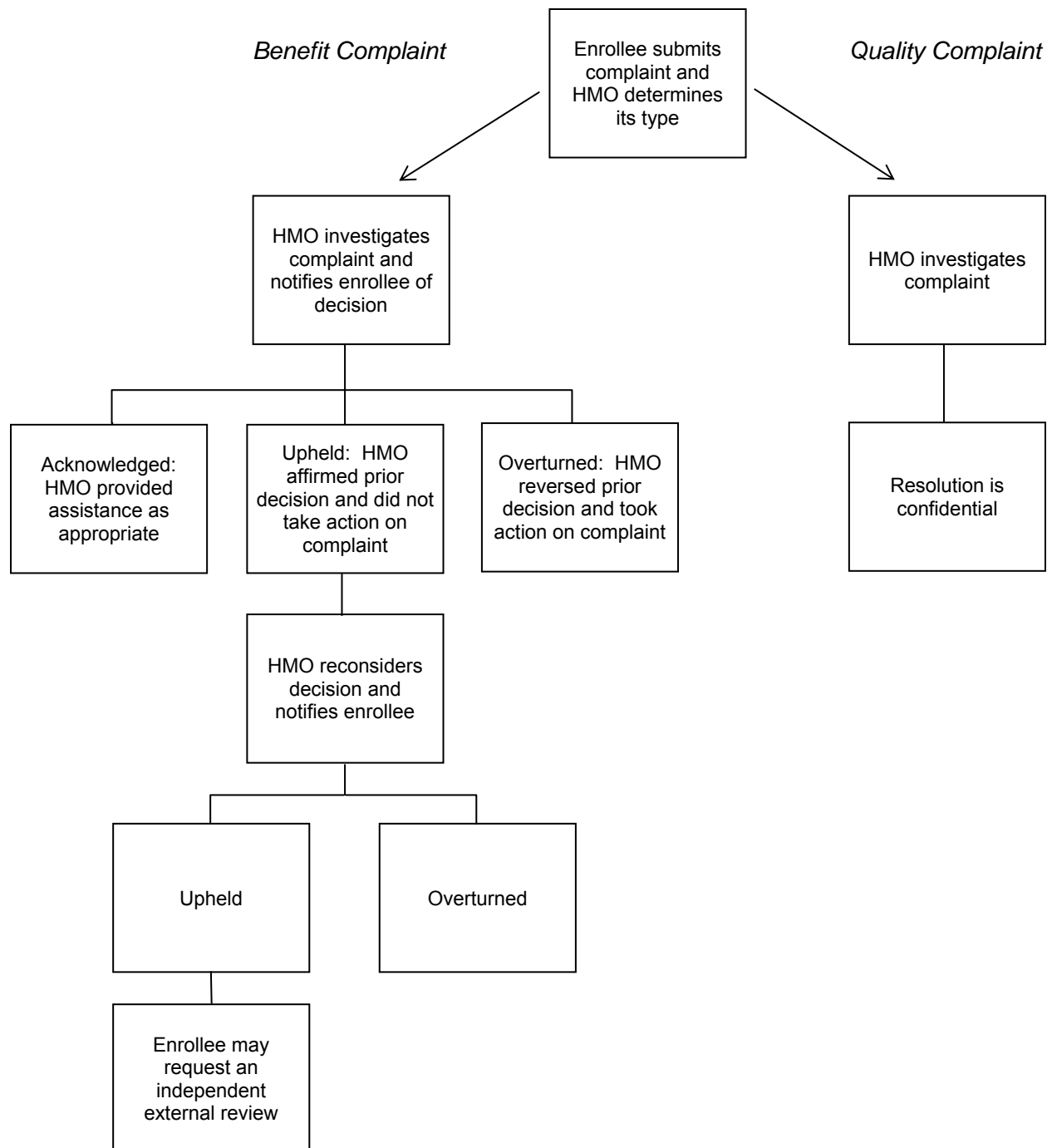
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<sup>1</sup> *Minnesota Statutes* 2015, 62Q.69-62Q.70; and 42 *CFR*, sec. 438 (2015). Throughout this report, we use the term "complaint resolution" to refer to those mechanisms available to health plan enrollees dissatisfied with their plan or one of its providers. Depending on the type of health plan, the governmental agency responsible for regulating the plan, and the nature of the complaint, enrollees file complaints, grievances, or appeals to express their dissatisfaction. Except where noted, we use the term "complaint resolution" to include the processes used to resolve all of these and the term "complaint" to refer to the first time a dissatisfied enrollee contacts his or her HMO.

<sup>2</sup> *Minnesota Statutes* 2015, 62D.07, subd. 3(5); and 62D.09, subd. 8.

<sup>3</sup> The state uses three independent review organizations to review certain types of commercial plan decisions made by HMOs. The review organizations can either uphold (affirm) or overturn (reverse) HMO decisions. We examine this option in Chapter 3. Fair hearings, available to public plan enrollees, are formal proceedings similar to trials, but without juries. After hearing testimony and reviewing evidence presented by complainants and health plans, administrative law judges make decisions and file written reports. The fair hearings process was outside the scope of our evaluation.

## Exhibit 2.1: Health Maintenance Organization Complaint Resolution Process for Commercial Plan Enrollees



NOTES: HMO refers to health maintenance organization. At times, HMOs may partially overturn previous decisions. Under certain circumstances, commercial enrollees may request an independent external review after filing a complaint with their HMO only once.

SOURCE: Office of the Legislative Auditor, 2015.

exhibit shows, enrollees can go through a multilevel process within their HMO when they have problems related to benefits. Benefit-related complaints may involve a variety of problems, including issues related to: coverage exclusions or restrictions; eligibility for services; payment denials or limitations; plan administration; and the medical necessity of covered services. 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 may be able to ask that an independent entity outside their HMO review their complaint.

In contrast, the process for resolving quality of care complaints—those related to the quality, timeliness, or appropriateness of healthcare services—is less transparent and comprehensive. Although enrollees may submit complaints about quality issues, such as unprofessional behavior or poorly performed medical procedures, HMOs cannot, under certain circumstances, tell enrollees how these types of complaints were resolved. Thus, enrollees never have an opportunity to ask their HMO to reconsider its decision. Furthermore, enrollees do not have the state’s independent external review option available to them.

Exhibit 2.2 shows the complaint process in HMOs for *public* plan enrollees, as outlined in state and federal laws. As with commercial enrollees, the complaint process is neither comprehensive nor transparent when public enrollees have problems related to quality of care. Public enrollees have similar complaint options available to them when they have benefit problems, although HMOs are only required to reconsider some types of decisions they have made about public enrollees’ benefits once.

To learn more about how HMOs implement the procedures outlined in Exhibits 2.1 and 2.2, we reviewed HMO policies and procedures and talked with HMO staff. Because statutes more clearly set forth the requirements for resolving *benefit-related complaints*, we found that practices across HMOs for resolving this type of complaint are similar. For the most part, customer service representatives take enrollees’ complaints over the telephone, but enrollees may also submit them in writing. Customer service staff research complaints with assistance from medical directors or other HMO personnel when necessary, and they inform enrollees about their complaint’s resolution. At times, this process might simply involve listening to enrollees and acknowledging their dissatisfaction with some aspect of their healthcare. Conversely, it could require a variety of actions by the HMO.<sup>4</sup> For example, the HMO could decide to overturn its original decision—in effect agreeing with the enrollee. The HMO could also decide that its original decision was correct in the first place. Regardless, if enrollees are not satisfied with how their HMO resolved their complaint, HMO representatives inform them of other options they may pursue to resolve their issue, including asking the HMO to reconsider its decision.

As we noted previously, *quality of care complaints* can refer to a variety of issues, including healthcare providers’ attitude or skill, customer service, or the cleanliness of healthcare centers. State and federal laws and regulations do not clearly outline requirements for quality of care investigations, which gives HMOs considerable flexibility. This type of complaint is often handled by dedicated quality management staff, but initial reviews are conducted by a variety of professionals across HMOs. In some HMOs, quality managers or liaisons conduct preliminary investigations, referring them to nurses or doctors as needed. In other HMOs, nurses or doctors review every quality of care complaint. Also, some

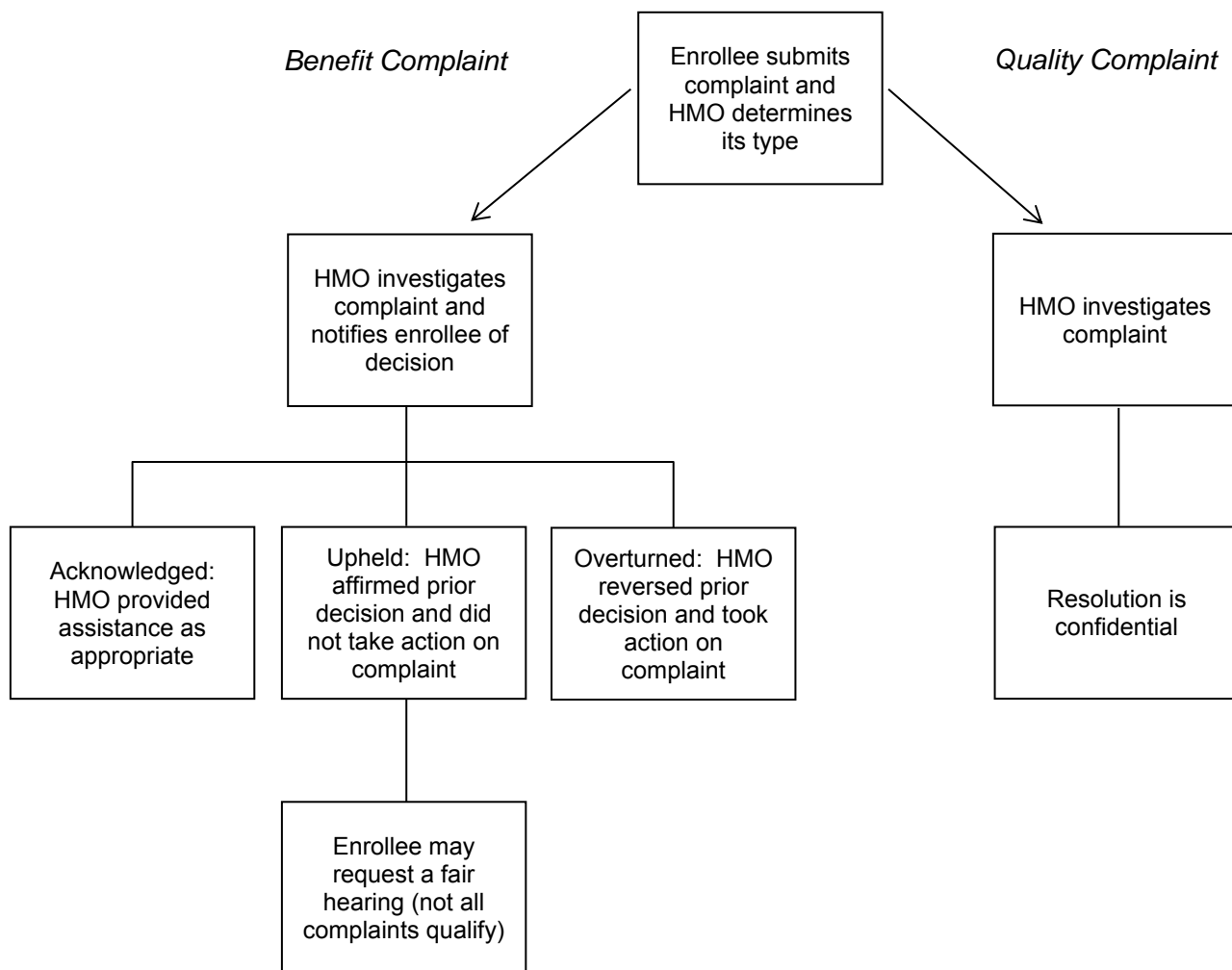
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<sup>4</sup> We discuss the range of actions HMOs take to resolve complaints later in this chapter.

HMOs categorize these complaints according to their level of severity, and they handle complaints with different levels of severity in different ways. As we explain later in this chapter, HMOs cannot provide complainants with information about how their quality of care complaints were investigated or resolved.

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### Exhibit 2.2: Health Maintenance Organization Complaint Resolution Process for Public Plan Enrollees



NOTES: HMO refers to health maintenance organization. At times, HMOs may partially overturn previous decisions. In addition to the actions illustrated in this exhibit, HMOs must provide a second medical opinion upon enrollee request.

SOURCE: Office of the Legislative Auditor, 2015.

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## DATA COLLECTION AND REPORTING

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Although many aspects of the complaint resolution processes available to commercial and public enrollees are similar, the ways in which the departments of Human Services and Health monitor complaint resolution for public and commercial health plans differ significantly. As we discuss below, the Department of Human Services (DHS) requires public health plans to periodically submit complaint data to the department, using categories and definitions developed by DHS. This allows the department to monitor complaints from public enrollees across HMOs on an ongoing basis. In contrast, MDH staff told us there are no equivalent reporting requirements for commercial plans. Thus, MDH has no ability to perform ongoing monitoring outside of its triennial quality assurance examinations, which we discuss later in this chapter. In the following section, we first explain the more robust ongoing oversight DHS provides and then compare it to MDH's oversight.

### Public Health Plans

The Department of Human Services requires that all HMOs sign a contract indicating they agree to comply with agency requirements for public plans, including the process HMOs must use to report and resolve complaints.

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**The Department of Human Services requires health maintenance organizations to report specific information about complaints filed by public plan enrollees on a quarterly basis.**

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Health maintenance organizations must document a variety of information about public enrollees' complaints, such as the dates they were received and resolved. In addition, HMO staff must categorize complaints from public enrollees by type, using categories and subcategories developed by DHS, as shown in Exhibit 2.3. For example, all complaints related to insurance identification cards would be recorded as "HMO administration" issues. Likewise, HMOs must document how they resolved the complaints using DHS-defined resolution codes. To standardize this process, DHS has developed a manual that specifies how HMOs should collect and report data. The department also hosts quarterly teleconferences with HMO staff to ensure consistent data collection practices across HMOs.

To learn about the number and types of complaints filed by public plan enrollees, we collected data from HMOs for fiscal years 2014 and 2015.

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**Relatively few public plan enrollees filed complaints with their health maintenance organizations in fiscal years 2014 and 2015.**

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Public plan enrollees filed about 15,900 complaints with their HMOs during the last two fiscal years—an average of 11 complaints per 1,000 enrollees.<sup>5</sup> The average number of complaints per enrollee varied little across HMOs, ranging from 5 to 15 complaints per 1,000 enrollees.

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<sup>5</sup> Federal regulations separate complaints into two distinct groups based on subject matter and use terminology different from what we use in this report. As noted earlier, we grouped different types of issues together and refer to them simply as "complaints" for clarity and readability purposes.

### Exhibit 2.3: Types of Complaints from Public Plan Enrollees, Fiscal Years 2014 and 2015

Complaint Type	Examples	Percentage of Complaints
Coverage	Denying requested services Denying referrals for a medical professional other than their primary doctor or outside their approved network	48%
Access	Delays in scheduling an appointment Long wait times Transportation delays	24
Communication and Behavior	Disrespectful or rude staff Insufficient time spent with enrollee Delays in communicating test results	13
HMO Administration	Issues with identification cards Difficulties with the enrollment process	6
Billing and Financial	Denying payment for a service Issues with the amount billed to enrollee	4
Technical Competence	Inappropriate medical treatment Incorrect or delayed diagnosis	3
Coordination of Care	Failure to follow up Failure to provide information at time of care	1
Facilities and Environment	Uncomfortable or unsafe environment	1
Total		100%

NOTE: Percentages do not total 100 due to rounding.

SOURCES: Office of the Legislative Auditor, analysis of Department of Human Services *Managed Care Organization Online Grievance/DTR/Appeal Reporting Web Application Manual*, 2013; and health maintenance organization data, 2015.

Although public plan enrollees filed complaints about a variety of problems, nearly half (48 percent) were about coverage issues. As noted in Exhibit 2.3, these types of complaints generally involved HMOs' decisions to deny or limit a healthcare service. For example, an HMO could determine that an enrollee's condition does not qualify him or her for a certain type of surgery. In addition, almost a quarter of complaints (24 percent) were about access to care. These were primarily issues with transportation, which health plans must provide to ensure public enrollees can get to and from their medical appointments. For instance, enrollees may complain that a transport vehicle arrived much later than requested, which made them late for a doctor's appointment. Thirteen percent of complaints were related to communication and behavior, such as rude receptionists or delays in communicating test results. The remaining 15 percent of complaints were related to a variety of other issues, including HMO administration and billing.

### Health maintenance organizations resolved about one-third of the complaints filed by public enrollees in fiscal years 2014 and 2015 by overturning their original decisions.

Exhibit 2.4 shows the various ways HMOs resolved complaints from public enrollees in the last two fiscal years. Health maintenance organizations resolved 33 percent of complaints by overturning their previous decisions, meaning they decided in favor of enrollees. For instance, an enrollee could complain that his or her doctor recommended ten physical therapy sessions, but the HMO paid for only eight. If the HMO determined that the enrollee

### Exhibit 2.4: Resolution of Complaints Filed by Public Plan Enrollees, Fiscal Years 2014 and 2015

Complaint Resolution	Description	Percentage of Complaints
Acknowledged	HMO listened to complainants and provided assistance as appropriate	34%
Overtaken	HMO reversed a prior decision and took action to address a complaint	33
Upheld	HMO affirmed a prior decision and did not take further action	24
Referred for Quality Review	HMO sent the complaint to staff that specialize in quality of care complaints for review	5
Partially Upheld	HMO affirmed part of a prior decision, but reversed part of it as well; an enrollee's request was only approved in part	1
Other	The complaint was resolved through other actions, such as the enrollee withdrawing the complaint	2
Total		100%

NOTES: HMO refers to health maintenance organization. Percentages do not total 100 due to rounding.

SOURCES: Office of the Legislative Auditor, analysis of Department of Human Services *Managed Care Organization Online Grievance/DTR/Appeal Reporting Web Application Manual*, 2013; and health maintenance organization data, 2015.

was entitled to all ten sessions, the complaint would be “overturned.” Conversely, HMOs “upheld” 24 percent of public complaints—meaning HMOs did not reverse their original decisions.

As shown in Exhibit 2.4, HMOs “acknowledged” about one-third of the complaints received, which means they could neither prove nor disprove that the reported incidents occurred or no action was necessary, and thus simply documented the complaint. In these cases, some HMO staff told us they focused on helping enrollees rather than proving who was right or wrong. For example, if the enrollee thought his or her treatment provider was rude, HMO staff may help the enrollee find a new provider. In other instances, enrollees may simply want to “vent” to someone, but do not want to contact their clinic to complain.

The contracts HMOs sign with DHS require them to resolve complaints from public plan enrollees within certain timeframes, depending on the type of complaint and how enrollees filed them (orally or in writing). For example, oral complaints about access to care must be resolved within 10 days, while written complaints must be resolved within 30 days. Overall, we found that, on average, HMOs resolved complaints filed by public plan enrollees well within statutory requirements.

## Commercial Health Plans

As we discuss later in this chapter, MDH examines HMOs’ complaint resolution policies and procedures and reviews complaint files once every three years for both public and commercial plans. In the interim, unlike DHS, MDH does not place any data collection and reporting requirements on commercial HMO health plans.

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**A lack of reliable data impairs the Minnesota Department of Health's ability to adequately monitor health maintenance organizations' complaint resolution processes on an ongoing basis.**

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Until 2012, state law and MDH rules required that HMOs report very general information about enrollee complaints.<sup>6</sup> In 2011, the Legislature created a work group to develop recommendations to “eliminate redundant, unnecessary, and obsolete state mandated reporting or data submittals” by healthcare providers.<sup>7</sup> The work group found that the categories HMOs used to submit the required data were too broad to be informative and, consequently, the reports were not used.<sup>8</sup> As a result, the 2012 Legislature eliminated the requirement that HMOs submit annual complaint reports to MDH.<sup>9</sup>

According to MDH, the department did not ask HMOs to report data in the previously required reports in a consistent manner. Our review of the reports filed by HMOs prior to 2012 found that HMOs varied so significantly in how they reported data that the reports were useless to MDH and enrollees alike.

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**Health maintenance organization practices for identifying and recording information about commercial complaints vary so greatly that data are largely meaningless.**

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As discussed in Chapter 1, statutes set forth a broad definition of a complaint.<sup>10</sup> It can include a variety of problems related to enrollee benefits, such as coverage or payment issues. It can also involve problems about the quality, timeliness, and appropriateness of healthcare services. The Minnesota Department of Health has not required that HMOs use this definition to uniformly identify complaints. Likewise, it has not developed any categories for reporting types of complaints, nor has it required HMOs to use the categories set forth by DHS for public plans.

In interviewing HMO staff and reviewing their policies and procedures, we learned that HMOs identify commercial complaints differently from one another. For example, some HMOs open a complaint file any time an enrollee calls to express dissatisfaction with their healthcare or services. Other HMOs open a complaint file only if they cannot resolve the problem during their initial contact with the enrollee. For example, two frustrated enrollees each call their separate HMOs because they cannot schedule an appointment with their doctors until next month. At each HMO, staff would help the enrollees find an appointment sooner with another doctor. At one HMO, this interaction would be recorded as a

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<sup>6</sup> *Minnesota Statutes* 2011, 62M.09, subd. 9; and *Minnesota Rules*, 4685.2000, posted prior to 1984.

<sup>7</sup> *Laws of Minnesota* 2011, First Special Session, ch. 9, art. 6, sec. 90.

<sup>8</sup> Minnesota Management and Budget, *Report to the 2012 Legislature: Regulatory Simplification and Reduction of Provider Reporting and Data Submission Requirements* (St. Paul, 2012), 11.

<sup>9</sup> *Laws of Minnesota* 2012, ch. 247, art. 1, sec. 32. The work group also examined the reporting requirements DHS places on HMOs' public plans. The group recommended keeping these reports because DHS used the data to monitor HMO compliance with complaint processing requirements. The group further noted that DHS has simplified and streamlined data collection by creating an online web-based application that allows HMOs to directly upload data, which has improved the quality of the data collected. Minnesota Management and Budget, *Regulatory Simplification and Reduction*, 8-9.

<sup>10</sup> *Minnesota Statutes* 2015, 62Q.68, subd. 2.



complaint, because the enrollee was initially dissatisfied. At the other, it would not be recorded as a complaint because, although the enrollee was initially dissatisfied, the problem was immediately resolved.

Although complaint data are not recorded in a consistent manner across HMOs, we wanted to present some basic information about commercial complaints filed with HMOs. Because MDH does not routinely collect complaint data from HMOs, we requested these data from HMOs for fiscal years 2014 and 2015.

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**Health maintenance organizations recorded, on average, 86 complaints for every 1,000 commercial plan enrollees in fiscal years 2014 and 2015.**

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Overall, commercial HMO enrollees filed about 29,700 complaints in fiscal years 2014 and 2015—an average of 86 complaints per 1,000 enrollees. However, this figure varied from 1 to 97 complaints per 1,000 enrollees across the seven HMOs offering commercial plans.

Due to differences in how HMOs identify complaints, it is difficult to draw conclusions about the volume of commercial complaints filed with HMOs. On the one hand, a high number of complaints per enrollee could indicate a high level of enrollee dissatisfaction with their HMOs. Conversely, it might simply mean that an HMO uses a broad definition for identifying complaints in the first place.

Likewise, HMOs categorize complaints in a variety of ways. Each individual HMO develops its own categories to describe the types of commercial complaints it receives. For example, one HMO may use the term “networks” while another uses “access issues” to describe the same type of problem. Consequently, it is not possible to present accurate summary data on the types of problems commercial plan enrollees have with their health plans.<sup>11</sup>

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**RECOMMENDATIONS****The Legislature should:**

- **Require that health maintenance organizations report commercial plan complaint data annually to the Minnesota Department of Health, using standard definitions and categories developed by the department.**

**The Minnesota Department of Health should:**

- **Develop standard definitions and categories for commercial health plan complaints and require health maintenance organizations to report data accordingly.**
- 

A lack of consistent reporting on commercial complaints impairs MDH’s ability to identify trends as they arise or detect variations across HMOs. We noted earlier in this chapter that DHS requires regular, consistent reporting about complaints filed by enrollees in public HMO plans. In DHS, the Office of the Ombudsman for Public Managed Healthcare

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<sup>11</sup> At most, we can say that very few complaints filed by commercial plan enrollees were related to quality of care—about 2 percent.

Programs collects the information and uses it to detect potential problems and track trends. For example, one DHS official told us that a health plan was reporting very few oral complaints, so the office noted this difference for follow-up. Without regular reporting from commercial plans, MDH must wait several years to identify potential problems and cannot compare current information across HMOs. The Legislature repealed previous requirements that HMOs report commercial complaint data annually, largely because the data were meaningless. We think the reporting requirement should be restored—but with data that is meaningful and useful to MDH and policymakers.

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**Health maintenance organizations overturned their original decision in 12 percent of the complaints filed by commercial plan enrollees in fiscal years 2014 and 2015.**

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In addition to recording complaint types in multiple ways, HMOs' practices for documenting complaint resolution varied. While the majority of HMOs recorded how they resolved commercial complaints, two of the seven HMOs with commercial enrollees did not. The remaining five HMOs overturned their original decisions in 12 percent of the roughly 29,700 complaints filed by enrollees. As shown in Exhibit 2.5, HMOs upheld their prior decisions—meaning they did not change them—for 32 percent of the complaints. For the largest proportion of complaints—54 percent—HMOs “acknowledged” enrollees' complaints. As explained previously, this means they could not prove whether an incident occurred or not and, therefore, did not take further action. Some HMO staff said enrollees may call simply to voice frustration but do not expect a resolution. For example, enrollees may be upset because they had to wait more than an hour to see their doctor at their last appointment. They may call their HMO to complain, but they do not want the HMO to contact the clinic and negatively affect their relationship with their provider.

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**Exhibit 2.5: Resolution of Complaints Filed by Commercial Plan Enrollees, Fiscal Years 2014 and 2015**

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Complaint Resolution	Description	Percentage of Complaints
Acknowledged	HMO listened to complainants and provided assistance as appropriate	54%
Upheld	HMO affirmed a prior decision and did not take further action	32
Overturned	HMO reversed a prior decision and took action to address a complaint	12
Referred for Quality Review	HMO sent the complaint to staff that specialize in quality of care complaints for review	1
Other	Complaint resolved through other actions, such as the enrollee withdrawing the complaint	<1
Total		100%

NOTES: HMO refers to health maintenance organization. Percentages do not total 100 due to rounding.

SOURCE: Office of the Legislative Auditor, analysis of health maintenance organization data, 2015.

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As shown earlier in Exhibit 2.1, some commercial enrollees have a second opportunity to ask their HMO to reconsider decisions that are unfavorable to complainants.<sup>12</sup> For example, some enrollees file complaints with their HMO because they think they were charged incorrectly for a doctor's visit. If their HMO tells them its decision was upheld and they were charged correctly, these enrollees could "appeal" that decision and ask their HMO to reconsider its decision a second time.

Commercial HMO enrollees filed few appeals (about 540) in fiscal years 2014 and 2015—on average, 2 appeals per 1,000 enrollees. The number of commercial appeals varied across HMOs, from fewer than 1 to 24 appeals per 1,000 enrollees. Health maintenance organizations upheld their previous decisions in 55 percent of the appeals, and they overturned their decisions in 36 percent. A higher percentage of HMO decisions may be overturned after reconsidering them a second time because enrollees and health plans have more time to gather and consider evidence in support of enrollees' requests. The remaining 9 percent were resolved in a variety of ways, such as enrollees withdrawing their appeal.

State law requires HMOs to resolve complaints from commercial plan enrollees within certain timeframes, depending on the type of complaint and how enrollees filed them (orally or in writing).<sup>13</sup> For example, if HMOs have not resolved an oral complaint within ten days, they must offer to help enrollees file a written complaint. They must generally resolve written complaints and appeals from commercial enrollees within 30 days. Overall, we found that, on average, HMOs resolved complaints and appeals filed by enrollees well within statutory requirements.

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## MINNESOTA DEPARTMENT OF HEALTH OVERSIGHT

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As noted earlier in this chapter, one of MDH's roles is to oversee complaint resolution processes at HMOs. The main way the department does this is through its triennial examination of HMOs' quality assurance programs, one aspect of which is complaint resolution.

### Oversight of Quality Assurance Programs

State law requires that health maintenance organizations establish quality assurance programs, a requirement unique to health maintenance organizations.<sup>14</sup> These programs are designed to ensure that HMOs: (1) assess or evaluate the quality of care they provide; (2) identify problems or shortcomings in their delivery of care; (3) design activities to address these problems; and (4) monitor the effectiveness of corrective steps.

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<sup>12</sup> Health maintenance organizations do not have to offer a second level of internal appeal to people enrolled in individual plans or to enrollees who request and are denied authorization to pay for a medical procedure before the procedure is performed.

<sup>13</sup> *Minnesota Statutes* 2015, 62Q.69, subds. 2(a) and 3(a); and 62M.06, subd. 3(a).

<sup>14</sup> *Minnesota Statutes* 2015, 62D.14.

The Minnesota Department of Health examines each HMO's quality assurance program at least once every three years to determine whether programs meet federal and state requirements, including evaluating enrollee complaints.<sup>15</sup>

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**Overall, the Minnesota Department of Health's quality assurance examinations ensure that health maintenance organizations have complaint resolution processes in place, but they do not address whether the health insurers' final decisions have been appropriate.**

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Although state law gives MDH the authority to evaluate the quality, appropriateness, and timeliness of services performed by HMOs' providers, MDH does not assess the appropriateness of HMOs' determinations during quality examinations.<sup>16</sup> Instead, the department reviews the processes HMOs use to make their determinations. Our analysis of MDH's most recent quality assurance examinations confirmed that MDH did not cite any HMO for making inappropriate decisions in resolving enrollee complaints.

Department staff have developed extensive policies and procedures to guide their reviews. The triennial examinations consist of four modules, one of which is complaint systems.<sup>17</sup> Department staff told us the examination process is largely consistent across HMOs, regardless of their size or individual features. If an HMO has had a recurring issue, however, MDH may put more emphasis on that subject matter than it would at other HMOs.

When evaluating complaint resolution processes, MDH determines whether HMOs monitor complaints on an ongoing basis. This includes ensuring that HMOs track complaints, assess trends, and implement effective corrective action plans when necessary. Health maintenance organizations must identify quality of care complaints and monitor them separately.<sup>18</sup>

To ensure that HMOs' complaint resolution processes comply with applicable regulations, MDH reviews their policies and procedures and a sample of complaint files. The department uses the same process to review commercial and public plan files, which is shown in Exhibit 2.6.<sup>19</sup>

To prepare for the examination, MDH asks HMOs to submit a list of all complaint-related files six to eight weeks prior to the department's on-site visit. Based on the size of the health plan, MDH staff said they may question the HMO if the number of complaint files reported is more or less than expected. While MDH does not cite HMOs for not having the expected number of complaints, staff told us they can use this as an indicator that HMOs may be using inappropriate definitions or processes.

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<sup>15</sup> *Minnesota Statutes* 2015, 62D.14; and *Minnesota Rules*, 4685.1115, subp. 2, posted October 11, 2007.

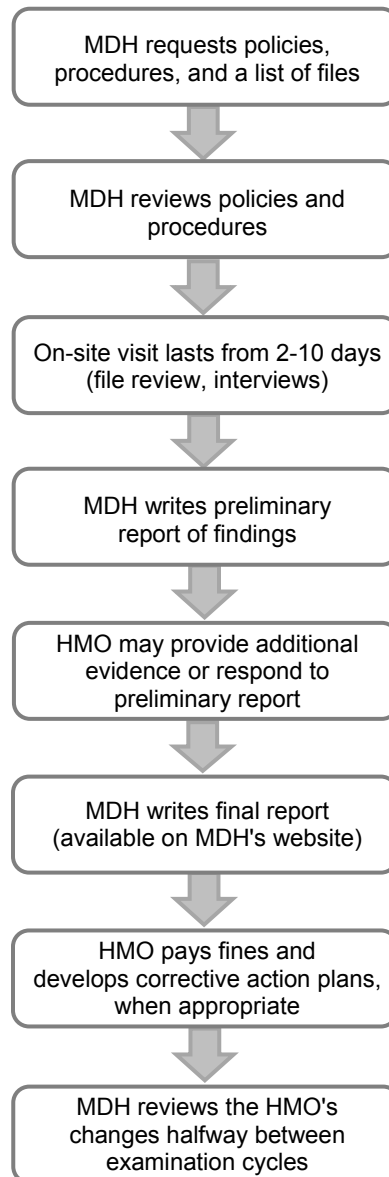
<sup>16</sup> *Minnesota Statutes* 2015, 62D.14.

<sup>17</sup> The other three modules are: quality improvement, network adequacy, and preservice approvals and denials.

<sup>18</sup> *Minnesota Rules*, 4685.1110, subp. 9, posted October 11, 2007.

<sup>19</sup> As noted in Chapter 1, MDH completes quality assurance examinations for both commercial and public HMO plans, thereby minimizing oversight redundancies.

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**Exhibit 2.6: Minnesota Department of Health Quality Assurance Examination Process**

NOTES: MDH refers to the Minnesota Department of Health and HMO refers to health maintenance organization.

SOURCES: Office of the Legislative Auditor and Minnesota Department of Health, 2015.

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**Prior to its on-site quality assurance visit, the Minnesota Department of Health provides health maintenance organizations the order in which the department will review complaint files as well as a guide for reviewing those files for completeness.**

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Using the HMO's list of complaints, MDH identifies a sample for each type of complaint file to be reviewed and tells the HMO which files it has selected. The department bases its sampling methodology on standards used by the National Committee for Quality Assurance (NCQA), a health plan accrediting organization.<sup>20</sup> If available, HMOs provide MDH with a sample of 30 files for each type of complaint to be reviewed. For each sample, MDH establishes the order that it will review the files. If the first eight files in the sample show evidence of compliance with requirements, MDH stops reviewing that type of file.<sup>21</sup>

To assist HMOs with their preparation, MDH gives them a guide to the examination process. This guide encourages HMOs to complete an internal audit of their files prior to the department's on-site visit to ensure they have evidence of compliance with requirements.<sup>22</sup> The department expects HMOs to have the files ready for its review before the first day of its on-site visit.

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## RECOMMENDATION

**The Minnesota Department of Health should not advise health maintenance organizations of the order in which the department will review complaint files during their quality assurance examinations.**

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Good auditing practices require that agencies examine a representative sample of files to determine organizations' adherence to regulations.<sup>23</sup> If the sample is not representative, it does not reflect the HMO's overall process, therefore compromising the integrity of the examination. By giving HMOs a substantial period of time to prepare files prior to the examination, the files ultimately reviewed by the department may not reflect how well HMOs routinely document their complaint processing practices. However, HMOs must pull together a considerable amount of information for the department's review, and MDH has a limited amount of time to complete its examination. Therefore, the long file preparation period may be reasonable. To increase the representativeness of the sample it examines though, MDH should, at a minimum, revise its practices by not revealing the exact order in which files will be reviewed. Although MDH randomly selects the files it reviews, a practice that increases the sample's representativeness, advising HMOs of the

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<sup>20</sup> Ernest Valente, "An Explanation of the '8 and 30' File Sampling Procedure Used by NCQA During Accreditation Survey Visits" (electronic document, May 1, 2001).

<sup>21</sup> At the same time, MDH reserves the right to review all 30 files, especially if there is a problem in one file. If there is a consistent issue and the HMO concedes the problem will continue to surface, MDH staff told us they may issue a violation without reviewing all of the files. The department may also request additional files to review.

<sup>22</sup> Minnesota Department of Health, *Monitoring Guide 2015: Template: Initial Document Request* (electronic document, Minnesota Department of Health, St. Paul), 4d. In an interview with staff from one HMO, we learned that they use MDH's guidelines to perform a mock examination of the files the department selected for review prior to the on-site visit. They use this process to ensure its policies and procedures align with state law.

<sup>23</sup> United States Government Accountability Office and President's Council on Integrity and Efficiency, *Financial Audit Manual 1* (Washington, D. C., 2008), 450-2.

order in which they will be reviewed decreases the representativeness. This is especially true given that HMOs know MDH will stop reviewing files if the first eight are compliant.

## Quality Assurance Outcomes

As part of the quality assurance examination, MDH cites HMOs for violations when policies, procedures, or files lack or provide inaccurate information.<sup>24</sup> To better understand the types of problems MDH's quality assurance examinations identified in terms of complaint resolution, we examined each HMO's most recent examination completed between 2012 and 2014.

Overall, most quality assurance violations that MDH cited were related to complaint processing rather than other topics covered by the examination. For example, in some cases HMOs provided enrollees with incorrect information in response to their complaints. Recently, MDH cited seven HMOs for 31 complaint-related violations, or an average of 4 violations per HMO.<sup>25</sup> Violations per HMO ranged from two to nine.

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### **The Minnesota Department of Health most frequently cited health maintenance organizations for unclear or noncompliant policies or documents during the latest quality assurance examinations.**

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As shown in Exhibit 2.7, 12 of the 31 violations HMOs were cited for involved noncompliant or unclear policies, procedures, or documents. The department also frequently cited HMOs for inadequate oversight of delegates (8 of 31 violations).<sup>26</sup> Less than half of the violations (12 of 31) directly affected individuals—for example, the timeliness in which HMOs acted or the accuracy of their correspondence to complainants.

State law allows MDH to levy an administrative penalty against an HMO for violating statutes or rules.<sup>27</sup> The department must base penalties on: (1) the number of enrollees affected by the violation; (2) the effect of the violation on enrollees' health and access to services, including the effect on a single enrollee's health; (3) whether the violation is an isolated incident or a pattern of behavior; and (4) the economic benefits derived by the HMO from the violation. Although not stated in statute, MDH considers additional factors when levying penalties, such as whether the HMO had previously been cited for the same violation. Penalties for each violation cannot exceed \$25,000.

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<sup>24</sup> We use the aggregate term "violation" to include deficiencies and mandatory improvements. The department issues a deficiency when it discovers issues with an HMO's files or in documents that are not file-related, but can affect enrollees, such as an HMO's *Certificate of Coverage* or quality reports. It issues a mandatory improvement when an HMO has violated the law in its policies or procedures, but files are compliant or do not show evidence of noncompliance. If a mandatory improvement is not resolved by the next examination, MDH will issue a deficiency.

<sup>25</sup> At the time of our analysis, Gundersen Health Plan Minnesota had been licensed less than three years, and MDH had not yet examined the HMO. As a result, our analysis covers seven rather than eight HMOs. As noted in Chapter 1, for the purposes of our evaluation, we analyzed HealthPartners and Group Health as one entity.

<sup>26</sup> A delegate is a separate organization that an HMO contracts with to provide specific types of services to its enrollees. For example, HMOs frequently provide dental services through delegates.

<sup>27</sup> *Minnesota Statutes* 2015, 62D.17, subd. 1.

## Exhibit 2.7: Quality Assurance Examination Violations

Type of Violation	Example	Total Violations
Delegate Oversight	One HMO's delegate sent some enrollees notification letters with incorrect information about appeal rights.	8
Policy Compliance	One HMO's policy stated that oral complaints must be resolved within ten business days instead of ten calendar days.	7
Policy Clarity	One HMO's policy stated that, if an enrollee's oral complaint is not resolved to his or her satisfaction, the HMO will help the enrollee complete a written complaint form. The HMO needed to specify how it would assist enrollees, including filling out the form and mailing it to the enrollee to sign.	5
Recordkeeping	An HMO did not document that it offered a written complaint form and assistance in completing the form to all enrollees whose oral complaints were not resolved to their satisfaction.	4
Timeliness	HMOs must send a notice to enrollees and providers ten business days prior to denying or limiting services. One HMO exceeded the time limit with some notices being sent within 13 to 16 business days.	3
Notification of Appeal Rights	When some enrollees' oral complaints were not resolved within ten days, one HMO did not offer them written complaint forms. Without the form, enrollees may not be aware of other complaint options, including their right to contact the Minnesota Department of Health.	2
Referral	One HMO provided complaint options for the wrong type of plan and referred some enrollees to the Minnesota Department of Commerce rather than the Minnesota Department of Health.	2
Total Violations		31

NOTES: HMO refers to health maintenance organization. A delegate is a separate organization that an HMO contracts with to provide specific types of services to its enrollees, such as dental services.

SOURCE: Office of the Legislative Auditor, analysis of health maintenance organizations' 2012-2014 quality assurance examinations.

### As a result of health maintenance organizations' most recent quality assurance examinations, the Minnesota Department of Health issued administrative penalties totaling \$49,500 for complaint-related violations.

Total penalties for complaint-related violations paid by the seven HMOs in their most recent examination cycle were less, overall, than in the previous two examination cycles—\$49,500 compared with \$106,500 and \$89,500, respectively. Most recently, penalties per HMO ranged from \$3,000 to \$28,500, with a median penalty of \$6,000.<sup>28</sup>

Health maintenance organizations can dispute a penalty by requesting an administrative hearing and judicial review.<sup>29</sup> However, MDH told us that it is very rare for an HMO to request an administrative hearing. Instead, MDH said most HMOs express their disagreement with a penalty by discussing it with department staff.

<sup>28</sup> Only five of the seven HMOs that MDH examined received penalties related to complaint resolution during the most recent examination cycle.

<sup>29</sup> *Minnesota Statutes* 2015, 62D.17, subd. 1.



## Limitations in the Quality Assurance Process

We mentioned earlier that HMOs classify some complaints as “quality of care.” In the quality assurance examination, MDH provides HMOs with examples of what could be included in a quality of care definition. Examples include the environment at a facility as well as the actual healthcare received. But because state law does not explicitly define quality of care, MDH does not require HMOs to use a specific definition for quality of care. This gives HMOs flexibility in how they classify these types of complaints. However, classifying complaints as quality of care has important ramifications for both enrollees and MDH’s regulatory authority.

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### **State and federal laws require health maintenance organizations to classify as confidential certain types of investigations into complaints about quality of care.**

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When enrollees file complaints about the quality of care they received, HMOs may use a “peer-review protected” process to investigate those complaints. In these situations, healthcare professionals—ideally professional peers—evaluate the work or behavior of their counterparts to determine whether those under review have met accepted standards of care in rendering their services.

State and federal laws require HMOs to treat the peer-review process as confidential, as long as it meets statutory requirements.<sup>30</sup> This means that, for the most part, proceedings and resulting actions and documents are not made public, and they are not accessible to complainants. When HMOs use a peer review process to investigate quality of care complaints, they can only inform enrollees that their complaints will be investigated. They cannot provide complainants with any additional information about how their complaints were resolved, or if the HMO took any correctional steps as a result. This effectively negates complainants’ rights to appeal their HMOs’ decisions. Because enrollees do not know how their complaints were resolved, they cannot appeal an unfavorable outcome.

In general, statutes providing for the confidentiality of the peer review process are intended to improve healthcare quality and encourage self-monitoring in the medical profession.<sup>31</sup> It is believed that providing the public with access to peer review materials could make healthcare professionals reluctant to participate openly in peer review or make candid reports about their peers.

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### **Neither state law nor the Minnesota Department of Health has developed an official definition for quality of care complaints, which has resulted in some health maintenance organizations adopting a broad definition.**

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Some HMOs routinely classify complaints related to communication, facilities, access to care, and other nonmedical issues as quality of care complaints. Because some HMOs told us they consider all quality of care complaint investigations confidential, this broad classification may unnecessarily limit complainants’ access to information about investigations not directly related to providing professional healthcare. For example, if an

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<sup>30</sup> *Minnesota Statutes* 2015, 145.61-145.66; and 42 U.S. Code, sec. 11137 (2015).

<sup>31</sup> *Amaral v. St. Cloud Hosp.*, 586 N.W.2d 141, 143-144 (Minn. App. 1998).

enrollee filed a complaint about poor lighting in a facility's parking lot, an HMO could classify that complaint as a quality of care issue. Consequently, even if the HMO, upon investigation, confirmed that lighting was indeed insufficient and upgraded it, the HMO would not inform the enrollee of its actions.

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## RECOMMENDATION

**The Legislature, in consultation with the Minnesota Department of Health, should define the types of problems or issues that should be investigated as confidential quality of care complaints.**

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Earlier in this chapter, we recommended that the Legislature require HMOs to annually report commercial complaint data to MDH, using standard definitions and categories developed by the department. Because of the confidentiality provisions surrounding the peer review process, we think the Legislature should better define what types of complaints should be identified as quality of care complaints, thereby qualifying their investigation as "peer-review protected." This designation denies complainants the satisfaction of knowing how or if their complaint was investigated and resolved. This could, in turn, negatively affect their opinion of their HMO or their ability to advocate for themselves or their dependents. For these reasons, the Legislature should ensure that complainants' access to information about their complaint's investigation is limited only when truly necessary.

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**State law does not specifically give the Minnesota Department of Health authority to review all materials related to complaint investigations classified as confidential.**

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Another problem with the quality of care complaint resolution process involves MDH's ability to adequately review these types of complaint files. State law gives MDH access to "original information, documents, or records acquired" in the peer review process.<sup>32</sup> The law does not, however, specifically give the department access to the discussion or materials produced during the peer review process. Staff told us their statutory authority to examine quality of care issues is limited, and HMOs do not provide consistent access to all documents relevant to quality of care complaint investigations. For example, according to MDH staff, one HMO does not allow the department access to any peer-protected information.<sup>33</sup> Furthermore, in the absence of statutory guidance, MDH officials do not believe they have the regulatory authority to require HMOs to change their peer review process, even if the department finds problems. The lack of clear statutory authority limits MDH's ability to effectively review and regulate this aspect of the complaint resolution process.

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<sup>32</sup> *Minnesota Statutes* 2015, 145.64, subd. 5.

<sup>33</sup> A 2015 Minnesota House of Representatives bill addressed some of MDH's concerns regarding quality of care complaints. However, the bill did not have any legislative hearings, and there was no Senate companion. H.F. 1943, 2015 Leg., 89<sup>th</sup> Sess. (MN).

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## RECOMMENDATION

**The Legislature should give the Minnesota Department of Health full regulatory authority over, and access to, health maintenance organizations' confidential investigations into quality of care complaints.**

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We agree that public health can be improved through thorough, confidential reviews. However, MDH is responsible for ensuring that HMOs comply with state and federal laws regarding complaint resolution, including quality of care complaints. Although compliance with state law is a condition of licensure, the department does not have sufficient authority to enforce all statutory provisions.

Just as MDH regularly reviews other types of investigations, we think the department should regularly examine quality of care complaint investigations to ensure they meet legal requirements. Currently, MDH cannot fully perform this function because the department is not legally guaranteed full access to all peer-review materials. This prevents staff from assessing whether peer reviewers are appropriately certified considering the specialty under review, or if HMOs appropriately classified quality of care complaints in the first place.

Giving MDH complete access to such information could improve public trust in the complaint resolution process. It could also help allay concerns some complainants might have about the lack of feedback from their HMOs when they have quality of care complaints. Although MDH would not be able to disclose what it learns to complainants, the process would, at a minimum, provide more assurance that complaints are being investigated.

This chapter has examined complaint resolution *inside* HMOs. In the following chapter, we examine two additional options HMO enrollees have to ask *outside* entities to examine the appropriateness of some of their HMOs' decisions.



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# Chapter 3: Other Complaint Resolution Options

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As noted in Chapter 1, Minnesotans enrolled in commercial health maintenance organization (HMO) plans may file complaints with the Minnesota Department of Health (MDH) in lieu of or addition to filing them with their HMOs. Enrollees dissatisfied with their HMOs' decisions may also, under certain circumstances, ask MDH to arrange for an independent external review of their complaints. This chapter examines these two options.

Overall, we found that very few HMO enrollees filed complaints with MDH or requested an independent external review. When they did, these entities generally resolved their complaints in a timely and appropriate manner.

## MINNESOTA DEPARTMENT OF HEALTH

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State law requires that HMOs provide commercial enrollees with a Bill of Rights.<sup>1</sup> Among other things, this document informs enrollees of their right to file complaints with the Commissioner of Health if they have problems with their HMO or one of its providers. However, the department's authority to investigate and resolve the complaints it receives is limited and somewhat unclear.

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**While enrollees may file all types of complaints with the Minnesota Department of Health, state law only gives the department explicit authority to resolve certain types of complaints.**

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The Minnesota Department of Health has clear statutory authority to resolve complaints regarding "coverage."<sup>2</sup> In these instances, MDH may overturn HMOs' decisions and order that services required by law or health plan be provided to complainants. But neither statutes nor department policies and procedures clearly define what coverage means.

As we discuss later in this chapter, many of the complaints MDH received in fiscal years 2014 and 2015 involved coverage issues that were *technical* in nature—for example, whether complainants were entitled to certain services according to their contracts or whether their bills were computed properly.<sup>3</sup> But other complaints involved coverage issues more *medical* in nature—for example, whether certain procedures were medically necessary. Both of these types of issues could pertain to coverage, giving MDH the

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<sup>1</sup> *Minnesota Statutes* 2015, 62D.07, subds. 3b(5) and 3c.

<sup>2</sup> *Minnesota Statutes* 2015, 62D.11, subd. 1a.

<sup>3</sup> Contracts, also called certificates of coverage, evidence of coverage, or summary plan descriptions, are documents that describe, in detail, the services covered; services not covered (exclusions); actions enrollees must take to receive benefits (including copays, deductibles, referrals, and preapprovals); and the process for filing complaints and appeals.

authority to resolve them. However, they require different levels and types of expertise to resolve.

In addition, state law does not specify how MDH should handle complaints clearly not related to coverage—for example, quality of care complaints. Quality of care complaints may relate to a variety of issues, including incorrect diagnoses or disrespectful behavior. The Legislature has not given the department explicit authority to resolve quality-related complaints, so it is unclear how MDH should handle these and other noncoverage-related complaints.

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## RECOMMENDATION

**The Legislature should clarify the Minnesota Department of Health’s authority to investigate and resolve complaints that health maintenance organization enrollees file with the department.**

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Health maintenance organization enrollees should be able to file all types of complaints with MDH, but state law should more clearly define the department’s role in investigating and resolving them. The department told us it does not have medical staff processing complaints and is not equipped to make medical determinations. For that reason, in practice, MDH staff suggest complainants take benefit issues more medical in nature to an independent external review organization, which we discuss later in this chapter.

Likewise, MDH complaint resolution staff do not have the medical expertise to resolve complaints related to quality of care. As shown earlier in Exhibit 1.5, MDH staff send these complaints to HMOs for investigation. However, as we noted in Chapter 2, according to the department, its access to HMOs’ quality of care investigation files is inconsistent. We previously recommended in Chapter 2 that the Legislature give MDH staff the explicit authority to examine all documents and records HMOs use to investigate quality of care complaints using the peer-protected review process. Because these investigations are confidential, MDH cannot share outcomes with complainants. However, increased regulatory authority over quality of care investigations would help MDH ensure that HMOs conduct them according to internal policies and state law.

## Complaint Resolution Procedures

Although state law requires MDH to accept complaints, it does not set forth minimum requirements or expectations for its complaint resolution process.<sup>4</sup>

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**In the absence of state regulation, the Minnesota Department of Health has developed an informal process for investigating some complaints, but it handles other complaints inconsistently.**

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Although MDH officials told us they do not have official policies regarding complaint investigations, staff have developed some informal procedures. The department encourages enrollees to submit complaints in writing, but will investigate complaints filed by telephone as well. According to MDH staff, as a first step, they determine whether a complaint

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<sup>4</sup> *Minnesota Statutes* 2015, 62D.11, subd. 1a; and 62Q.106.

concerns a commercial HMO plan. If it does and the complaint is related to billing or another coverage issue, MDH investigates and communicates its decision to the complainant via telephone or letter.

If a health plan is under MDH authority, but the complaint relates to quality of care, MDH sends the complaint to the HMO for investigation. Although “quality of care” is not defined in statute or rule, MDH considers these complaints to include issues with provider or staff competence, communications, behavior, or environment. After the HMO’s investigation is concluded, MDH reviews the HMO’s investigation to determine whether it followed proper procedures. This includes ensuring that all of the complainant’s issues were addressed and corrective action by the HMO, when necessary, resolved the issue. The department does not examine the appropriateness of the actual resolution. As with HMOs, MDH does not tell complainants how their quality of care complaints were resolved.

Although MDH has informal procedures for resolving complaints under its jurisdiction, it does not follow similar procedures for handling complaints outside its regulatory authority—for example, complaints from Medicare or self-insured plan enrollees. Department staff help resolve some complaints, forward some to other agencies, and provide some complainants with contact information for appropriate entities to handle their complaints. It is unclear how staff determine which nonjurisdictional complaints they will help resolve. For example, as we discuss in the next section, MDH at least partially investigated seven complaints submitted by Medicare enrollees. However, staff advised three other Medicare enrollees to contact the Centers for Medicare and Medicaid Services for assistance because MDH does not regulate Medicare plans.

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## RECOMMENDATION

### **The Minnesota Department of Health should develop internal policies and procedures for processing all complaints it receives from health plan enrollees.**

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We think MDH should develop more formal policies and procedures that address how jurisdictional complaints should be handled, especially those requiring medical expertise. Because the department is not equipped to make medical determinations, staff told us they suggest that enrollees submit complaints more medical in nature to an independent external review organization. This practice should be formalized so that it is consistently observed in the future for all complaints under the department’s authority.

In addition, MDH should develop formal policies and procedures that address how nonjurisdictional complaints should be handled. While MDH’s willingness to help with complaints outside the department’s authority is commendable, it could also be confusing for complainants. For example, they may not understand why MDH was able to facilitate a resolution for one Medicare recipient, but not another. By consistently handling all complaints, the department can decrease confusion and avoid unreasonable expectations that MDH can or should resolve all complaints.

Regardless of whether MDH investigates a nonjurisdictional complaint, it generally provides complainants with information about other complaint resolution options. As discussed previously in Chapter 1, other options might include one of Minnesota’s

professional health-related licensing boards or state agencies responsible for licensing facilities or programs.<sup>5</sup>

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## RECOMMENDATION

**The Minnesota Department of Health should forward all quality of care complaints it receives to the appropriate professional health-related licensing board or state agency for investigation.**

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In addition to sending quality of care complaints to HMOs, we think that MDH should routinely refer all quality of care complaints it receives to the appropriate professional health-related licensing board. While MDH currently advises individuals of this option on its website, the department does not regularly forward all such complaints directly to the licensing boards for investigation. In addition, MDH should routinely forward the quality of care complaints it receives that are more directly related to state licensed facilities or programs (rather than professionals) to the appropriate licensing agency for investigation.

Filing quality-related complaints with health licensing boards rather than MDH offers complainants three main advantages. First, the licensing boards generally have the necessary medical expertise to make independent judgments on quality of care issues, and they routinely deal with quality-related issues. Second, boards responsible for licensing health-related professionals routinely notify complainants about complaint outcomes. Third, as we discussed in Chapter 2, state law requires that the health-related licensing boards post information on their public websites whenever they take certain types of action against licensees.<sup>6</sup> In doing so, the boards increase transparency for the general public, not just HMO complainants.

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**The Minnesota Department of Health inconsistently collects and reports data on the complaints it receives.**

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Finally, MDH uses a database to record basic information about the timeframe and resolution of complaints received by the department. However, we found inconsistencies in how dates were recorded, and MDH staff did not routinely document actions they took to address complaints. For example, staff did not always indicate when they communicated with the complainant or contacted the HMO. Furthermore, when we examined the department's individual complaint files, we found some files missing and others that only contained handwritten notes.

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<sup>5</sup> For example, Minnesota's professional health-related licensing boards investigate complaints regarding the behavior or actions of their licensees. In addition to investigating complaints from coworkers and other professionals, the boards investigate complaints from members of the public. They include the Minnesota boards of Behavioral Health and Therapy, Chiropractic Examiners, Dentistry, Dietetics and Nutrition, Marriage and Family Therapy, Medical Practice, Nursing, Nursing Home Administrators, Optometry, Pharmacy, Physical Therapy, Podiatric Medicine, Psychology, Social Work, and Veterinary Medicine, and the Office of Unlicensed Complementary and Alternative Health Care Practice in MDH. *Minnesota Statutes* 2015, 214.01, subd. 2.

<sup>6</sup> *Minnesota Statutes* 2015, 214.072. Health maintenance organizations must report all disciplinary actions that they take against certain healthcare professionals to the appropriate professional health-related licensing board. However, HMOs are not required to make their actions public, and the health-related licensing boards are not required to post actions taken by other groups, such as HMOs, on their public websites.



We also found discrepancies in how MDH recorded complaints not under its authority. For example, the department did not document resolutions for some nonjurisdictional complaints even though staff at least partially investigated them, but for others it did.

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## RECOMMENDATION

**The Minnesota Department of Health should improve the accuracy and consistency of information in its complaint management database.**

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We think MDH needs to improve its documentation practices, including recording (1) actions taken to handle nonjurisdictional complaints, (2) actions taken to resolve jurisdictional complaints, and (3) information about how complaints were resolved. Maintaining an accurate and consistent complaint database would increase transparency and facilitate continuity in complaint handling. It would also allow the department to identify complaint trends and more precisely respond to questions the Legislature or others might have.

## Complaint Characteristics

As we discussed in Chapter 1, Minnesota's framework for regulating health insurance is complex. As a result, health plan enrollees may not know which governmental agency regulates their health plan and, therefore, which agency can help them resolve their complaint.<sup>7</sup>

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**Health plan enrollees filed very few complaints with the Minnesota Department of Health in fiscal years 2014 and 2015, with most of them outside the department's regulatory authority.**

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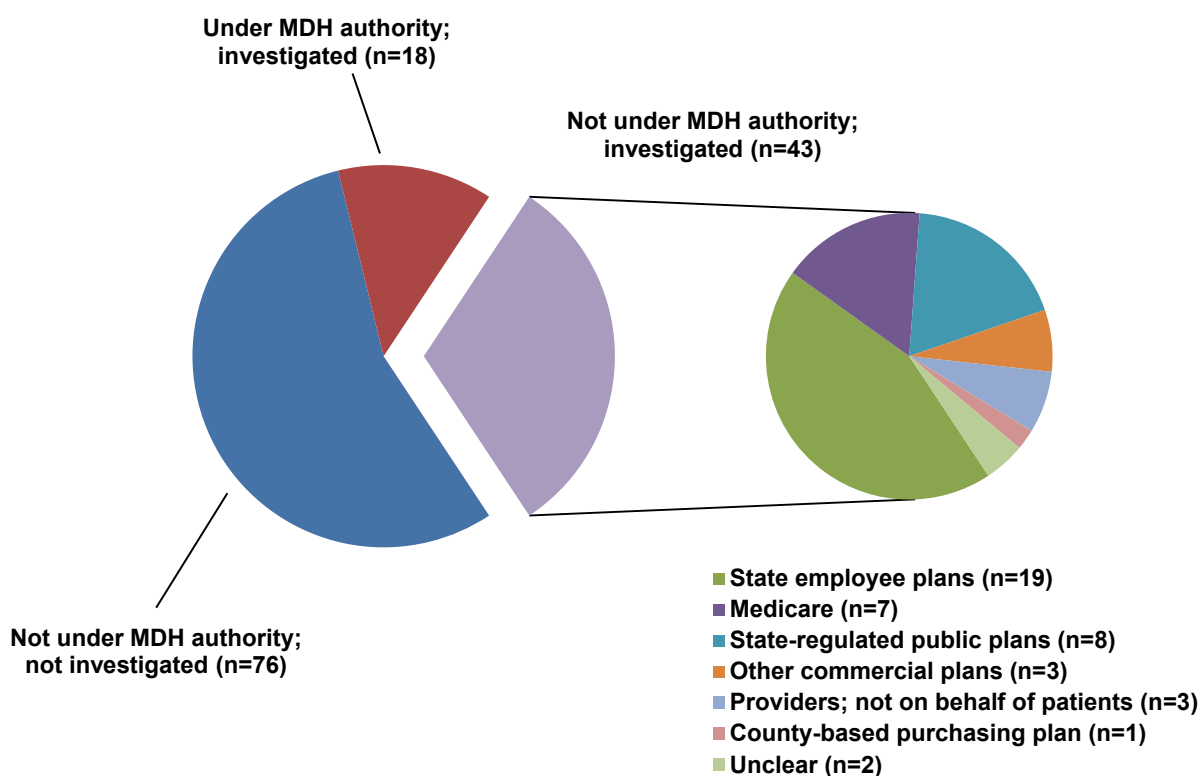
As shown in Exhibit 3.1, MDH received 137 complaints in fiscal years 2014 and 2015, but only 18 were from commercial HMO enrollees and, therefore, under MDH's authority. This represents only 13 percent of all complaints the department received.

Although the majority of complaints (119) concerned health plans not regulated by MDH, the department at least partially investigated more than one-third (43) of the nonjurisdictional complaints it received in fiscal years 2014 and 2015. For example, the department assisted Minnesota Management and Budget (MMB) with 19 complaints from state employees enrolled in the state's self-insured health plan. Although MDH told us it does not have medical professionals processing complaints, MMB staff said they typically work with MDH because they believe it has the expertise and experience to help resolve complex complaints. According to MMB, this arrangement is informal, and MDH does not receive payment for its assistance.

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<sup>7</sup> Information provided by health plans may further confuse enrollees. For example, as explained in Chapter 1, state employees are covered by a self-insured health plan overseen by Minnesota Management and Budget (MMB). The Minnesota Department of Health has no regulatory authority over self-insured plans. However, one of the three HMOs acting as claims administrators for MMB provides contact information for the "Minnesota Commissioner of Health Appeals" rather than MMB on its membership cards.

### Exhibit 3.1: Complaints Received by the Minnesota Department of Health, Fiscal Years 2014 and 2015



NOTES: MDH refers to the Minnesota Department of Health. Numbers in parentheses show the number of complaints MDH received. Complaints regarding health plans not under the department's regulatory authority that it investigated are listed under the smaller breakout.

SOURCE: Office of the Legislative Auditor, analysis of Minnesota Department of Health data, 2015.

In addition to helping MMB, MDH helped eight public assistance plan enrollees and seven Medicare enrollees during this time period. Department staff also assisted nine complainants with various other types of plans outside the department's regulatory authority.

#### Coverage issues comprised the largest group of complaints the Minnesota Department of Health investigated in fiscal years 2014 and 2015.

As shown in Exhibit 3.2, 8 of the 18 complaints under MDH's authority were related to coverage. Enrollees with these types of complaints believed that HMOs were denying payment for services that should be paid for by their health plan. For example, two HMOs billed enrollees for eye exams, stating that preventive vision services were not covered by the enrollees' health plans. The enrollees both argued that they were treating medical issues, not receiving preventive care, and the exams should be covered.

### Exhibit 3.2: Types of Complaints Resolved by the Minnesota Department of Health, Fiscal Years 2014 and 2015

Type of Complaint	Description	Number of Complaints Received
Coverage	Denying requested services or medications because they are not covered by enrollees' plans	8
Billing	Incorrectly applied payments Incorrect charges	4
Quality of Care	Issues regarding the quality, timeliness, or appropriateness of care	3
Access	Denying access to providers outside the approved network Providers in network are not conveniently located for enrollees	2
Premiums	Issues with premium rates	1
Total		18

SOURCE: Office of Legislative Auditor, analysis of Minnesota Department of Health data, 2015.

The department also received complaints related to billing and quality of care. Of the 18 complaints under MDH's jurisdiction, 4 were related to billing issues, including plans not processing claims and premium payments correctly. Three other complaints were related to quality of care, such as providers allegedly failing to treat patients' conditions according to accepted standards. The three remaining complaints were related to access issues, such as the distance enrollees had to travel to reach an in-network provider or high premiums (the amount enrollees pay HMOs each month for health insurance).

#### The Minnesota Department of Health overturned about one-third of the complaints filed by commercial enrollees in fiscal years 2014 and 2015.

The department upheld HMOs' decisions in 8 of the 18 complaints filed by enrollees of health plans under MDH's authority, and it overturned HMOs' decisions in 6.<sup>8</sup> In instances where MDH ruled in favor of complainants, department staff required action by the HMOs, such as covering services or developing corrective action plans. Three complaints were related to quality of care, and MDH directed the HMOs to investigate them. In these instances, the department neither upheld nor overturned the HMOs' actions. In one case, MDH did not record a resolution because the complainant had not yet requested the service in question, so there was no decision for MDH to review.

#### When the Minnesota Department of Health had clear regulatory authority over the health plan and type of complaint filed, the quality of the department's investigation was generally adequate.

Although timelines for MDH investigations are not specified in law or internal policy, the department investigated complaints in a timely manner. It responded to complainants promptly—on average, within three days. Overall, MDH resolved complaints under its

<sup>8</sup> As explained in Chapter 2, when a complaint is "upheld," the HMO's decision was affirmed, and no action is taken. If it is "overturned," the decision was determined to be incorrect, and the HMO must take corrective action.

authority within 23 days, on average. This is within the timeframes established in statute for commercial complaint resolution at HMOs.<sup>9</sup>

Department files for most of the complaints under MDH's authority contained documentation indicating how staff investigated and resolved the complaints. Documentation included items such as MDH's communication with complainants and HMO representatives, complainants' medical records, contracts, and federal and state laws. In 13 of the 18 complaints under MDH's authority, MDH's files contained enough information for us to determine that the department's investigation was thorough, and we generally concurred with MDH's conclusions. We thought MDH did not adequately address all concerns raised by the complainant in only one case.

In four cases, however, complaint files did not contain enough information for us to determine the adequacy of MDH's investigation. Three of these complaints were related to quality of care. These files contained little information about the HMO's investigation or MDH's review, and it is not clear what information the department reviewed. Often, MDH quality of care files contained nothing more than the original complaint forms and a very brief checklist MDH used when reviewing HMOs' investigations. As noted previously, statutes do not clearly give MDH authority to investigate and resolve complaints related to quality of care, and the department's informal procedures for investigating or documenting quality of care complaints are not clearly specified.<sup>10</sup> In the fourth case, the file contained only a few handwritten notes, and we could not clearly determine how MDH resolved the complaint.

## INDEPENDENT EXTERNAL REVIEW

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State and federal laws require that HMOs provide enrollees with the opportunity to ask independent organizations to review certain HMO decisions that are not favorable to the enrollee.<sup>11</sup> During this process, professionals outside the HMO review contracts, medical records, and other documentation to determine whether the HMO's decision was consistent with the enrollee's contract and sound medical practice. If the independent review organization determines the HMO's decision was not correct, it may overturn the decision. By law, HMOs must comply with the independent review organization's determination.<sup>12</sup> Complainants who are not satisfied with independent review organizations' decisions may still pursue legal action through the courts.

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<sup>9</sup> *Minnesota Statutes* 2015, 62Q.69, subd. 3. Health maintenance organizations generally must resolve complaints within 30 days.

<sup>10</sup> Earlier in this chapter as well as in Chapter 2, we made recommendations to address these problems.

<sup>11</sup> *Minnesota Statutes* 2015, 62Q.73; and *Patient Protection and Affordable Care Act of 2010*, Public Law 111-148, sec. 2719(4), March 23, 2010.

<sup>12</sup> *Minnesota Statutes* 2015, 62Q.73, subd. 8; and *Affordable Care Act*, sec. 2719(b)(14). State law allows HMOs to seek judicial review of an external review organization's decision on the grounds that it was arbitrary and capricious or involved an abuse of discretion.

Minnesota has required HMOs to offer commercial health plan enrollees with an independent external review option since 1999.<sup>13</sup> This system, overseen by MDH, changed somewhat with passage of the federal *Affordable Care Act* (ACA) in 2010.<sup>14</sup>

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**Although state law provides commercial plan enrollees with the opportunity to have “adverse determinations” reviewed by independent organizations, the law does not clearly define what constitutes an adverse determination.**

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Adverse determinations are defined as decisions relating to a healthcare service or claim that have been appropriately reviewed by the HMO, and the decisions are not in favor of complainants.<sup>15</sup> But, as we explained in Chapter 2, the statutory definition for complaints includes quality of care issues.<sup>16</sup> Therefore, the statutory definition for adverse determination does not clearly exclude quality issues from the independent external review process. But because quality of care investigations are generally peer protected, their resolutions are confidential. Complainants cannot request an independent external review because they do not know how the HMO resolved their complaint. Thus, in practice, complaints related to quality of care are not reviewed through this process.

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## RECOMMENDATION

**The Legislature should more clearly define the types of complaints eligible for the independent external review process, paying special attention to quality of care complaints.**

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Excluding quality of care complaints from the external review process may be appropriate, especially if the Legislature and MDH adopt our earlier recommendations to clarify statutes and refer quality-related complaints to the appropriate professional health-related licensing boards. 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 (NAIC), which has developed a model act for independent external review, and federal regulations for the *Affordable Care Act* set forth better definitions. For example, NAIC’s definition provides much more detail about the type of complaints eligible for external review than does Minnesota law. It defines an adverse determination as an HMO decision that:

An admission, availability of care, continued stay or other health care service that is a covered benefit has been reviewed and, based upon information provided, does not meet the health carrier’s requirements for medical necessity, appropriateness, health care setting, level of care or

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<sup>13</sup> *Laws of Minnesota* 1999, ch. 239, sec. 36.

<sup>14</sup> For example, ACA regulations require that states contract with more than one outside review organization, use review organizations accredited by a nationally recognized private accrediting organization, assign cases to review organizations on a random basis, and ensure that filing fees are returned to enrollees when review organizations completely reverse their HMOs’ decisions. 45 *CFR*, sec. 147.136 (2015).

<sup>15</sup> *Minnesota Statutes* 2015, 62Q.73, subd. 1.

<sup>16</sup> *Minnesota Statutes* 2015, 62Q.68, subd. 2.

effectiveness, and the requested service or payment for the service is therefore denied, reduced or terminated.<sup>17</sup>

Federal regulations for the ACA provide similar detail about the types of decisions eligible for the federal external review process. They describe an adverse benefit determination as one that:

Involves medical judgment (including but not limited to, those based on the plan's or insurer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is experimental or investigational); . . . and a rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).<sup>18</sup>

Although the above definitions do not explicitly exclude quality of care complaints from the independent review process, they are more precise in describing the types of complaints or HMO decisions that are eligible for external review. While the above definitions are not perfect, they can provide a good starting point for the Legislature's consideration.

## Independent External Review Procedures

State law requires the Commissioner of Administration, in consultation with the commissioners of Health and Commerce, to contract with at least three independent review organizations. The organizations' role is to review HMO decisions that are "adverse" to enrollees.<sup>19</sup> As we previously noted, the statutory definition of an adverse determination is unclear.<sup>20</sup>

The Minnesota Department of Health's role in independent external review is limited. Enrollees file a request for an external review with MDH, and department staff review requests to determine whether (1) the enrollee is covered by a commercial HMO plan under its authority, (2) the complaint involves a denial of benefits, (3) the complaint cannot be resolved in favor of the complainant by MDH, and (4) the complainant has appropriately exhausted the HMO's complaint resolution processes. If the request for review meets these criteria, MDH randomly assigns an independent external review organization to review the complaint.<sup>21</sup>

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<sup>17</sup> National Association of Insurance Commissioners, *Uniform Health Carrier External Review Model Act* (Kansas City, MO: National Association of Insurance Commissioners, April 2010), Section 3A.

<sup>18</sup> 45 *CFR*, 147.136(d)(1)(ii) (2015).

<sup>19</sup> *Minnesota Statutes* 2015, 62Q.73, subd. 3.

<sup>20</sup> The Minnesota Department of Health, which facilitates the review process for commercial HMO enrollees, has interpreted the definition to include only HMO denials of benefits. As we explained in Chapter 1, benefits-related complaints may involve a variety of problems dealing with: coverage exclusions or restrictions; eligibility; payment denials or limitations; or the medical necessity of covered services. According to MDH's interpretation, complaints about quality of care are not eligible for external review.

<sup>21</sup> Health maintenance organization enrollees in public assistance plans are offered a fair hearing in lieu of an independent external review. According to state law, fair hearings are available to any person whose application for assistance has been denied or not acted upon with reasonable promptness; services have been suspended, reduced, terminated; or claimed to have been paid incorrectly. *Minnesota Statutes* 2015, 62Q.73, subd. 2; and 256.045, subd. 3a.

External review organizations must ensure that each request receives an independent, thorough review. The organizations must ensure that the administrative staff and medical experts they assign to review a complaint do not have any conflicts of interest. For example, individual reviewers cannot have previously reviewed the case in question for that particular HMO. Organizations must assign expert reviewers who are knowledgeable about the condition and treatment in question. For medical issues, experts who are practicing physicians must review information provided by the enrollee and HMO about the condition being treated and the proposed treatment plan. The expert reviewer may request additional information, if necessary, and is required to utilize and cite current research on the condition in question.

Unless a review is expedited for medical reasons, external reviewers must issue a report within 40 days of receiving the review request.<sup>22</sup> Expedited reviews must be completed within 72 hours of request.<sup>23</sup> The review organization's final report must contain the reviewer's determination and rationale. While the determination is binding on the HMO, it is not binding on the enrollee, who may choose to pursue litigation.

Health maintenance organizations bear the majority of the cost for external reviews. Enrollees must submit a \$25 fee when requesting an external review (which is forwarded to the review organization involved), but MDH can waive the fee for financial hardship. Contracts in effect from July 2014 through July 2016 allow external review organizations to charge HMOs \$425 to \$650 for a standard review and \$515 to \$795 for an expedited one.

## Independent External Review Characteristics

To gain a better understanding of the process, we reviewed MDH's independent external review files for fiscal years 2014 and 2015. State law requires that HMOs advise enrollees of the independent external review option whenever certain HMO decisions are not favorable to the enrollee.<sup>24</sup> In addition, HMOs are required to describe this option in their membership materials. The Minnesota Department of Health also provides information about this option on its webpage and, at times, in correspondence with complainants.

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### **Very few commercial plan enrollees have requested that independent organizations review their health maintenance organization's decisions.**

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Despite adequate notice about this option, MDH received only 47 requests for an independent external review in fiscal years 2014 and 2015. Of these, only 27 involved

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<sup>22</sup> The Department of Administration's contracts with independent external review organizations require that reviewers submit their final reports within 40 days of request rather than the 45 days required in state law. *Minnesota Statutes* 2015, 62Q.73, subd. 6(c).

<sup>23</sup> *Minnesota Statutes* 2015, 62M.06, subd. 2(b); and 62Q.73, subd. 6(e)(2).

<sup>24</sup> *Minnesota Statutes* 2015, 62Q.70, subd. 3(b). As we discussed in Chapter 2, MDH's quality assurance process routinely examines the extent to which HMOs notified enrollees of their appeal rights when appropriate. Department examinations found few problems.

decisions made by HMOs under MDH's regulatory authority and met eligibility criteria.<sup>25</sup> More than three-fourths of the 27 reviews were completed by one company. Prior to state and federal regulations requiring that external reviews be randomly assigned, the State of Minnesota contracted solely with one company to perform this function. Maximus Federal Services, Inc., a review company based in Virginia, performed all 12 external reviews in fiscal year 2014. To comply with ACA requirements, contracts were signed with two additional review organizations in July 2014. In fiscal year 2015, nine reviews were completed by Maximus, five by Managed Medical Review Organization in Michigan, and one by Medical Review Institute of America, out of Utah.

Although complaints brought to external review often covered a range of issues, more than half of the reviews were primarily related to technical coverage issues, such as payments for chemical health treatment programs or preventive services. As shown in Exhibit 3.3, 14 of the 27 external reviews were related to technical coverage issues. Six reviews were primarily related to medical necessity, for example, the need for specific pain management treatments. Four were related to network issues; for example, one complainant wanted the HMO to cover treatment at a provider outside the HMO's network. Two more involved experimental procedures, such as new treatments for diseases, and one was regarding provider's fees.

### Exhibit 3.3: Types of Independent External Organization Reviews, Fiscal Years 2014 and 2015

Type of Complaint	Description	Number of Complaints Received
Coverage	Denying requested services or medications because they are not covered by enrollees' plans	14
Medical Necessity	Denying procedures or medications because enrollees' conditions do not meet medical necessity criteria	6
Access	Denying access to providers outside the approved network Providers in network are not conveniently located for enrollees	4
Investigative/ Experimental Procedure	Denying procedures or medications because they are not considered to be the safest or most effective methods for treating particular conditions	2
Provider's Fees	Amount charged by provider	1
Total		27

SOURCE: Office of Legislative Auditor, analysis of Minnesota Department of Health data, 2015.

### Standard independent external reviews were more likely to be completed within mandated timeframes than expedited reviews.

Standard reviews must be completed within 40 days, and the reviews we looked at were resolved, on average, within 38 days. Only 4 of the 27 reviews completed were expedited,

<sup>25</sup> The department also arranges external reviews for state employees, whose plans are managed by MMB. Eight of the external review requests MDH processed in the last two fiscal years came from MMB. In addition, the department referred 5 of the 47 requests it received to the Department of Commerce. Enrollees withdrew three requests after their HMOs decided to pay for the services in question. The department determined that four additional complaints were ineligible for review for a variety of reasons, including that the enrollee was covered by a Medicare or a self-insured plan.



and those reviews took, on average, 7 days to complete. Only one was completed within the 72 hours called for in statute.<sup>26</sup>

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**The state's independent external review organizations upheld more than three-fourths of the health maintenance organizations' decisions in fiscal years 2014 and 2015.**

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Of the 27 external reviews concerning HMOs under MDH's regulatory authority, reviewers upheld the HMO's decision in 22 cases and partially upheld them in 3 cases. Only two HMO decisions were overturned by the review organizations. One of the overturned cases was related to an experimental procedure and the other to coverage of a specific medication.

Medical specialists, including practitioners certified in anesthesiology and pain management, neurology, and other specialty areas, reviewed 14 of the 27 external review cases. Both attorneys and medical professionals reviewed 12 cases, and attorneys alone completed 8 of the reviews—cases in which contract benefits were disputed rather than medical issues. Three reviews were conducted by general practitioners, and in one case, it was unclear who conducted the review.

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## CONCLUSIONS

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Overall, we think the complaint resolution processes available to Minnesotans enrolled in HMO plans regulated by MDH are generally comprehensive and properly implemented when enrollees have complaints about their benefits. For the most part, this type of complaint includes problems involving coverage, eligibility, or billing. Data presented in Chapters 2 and 3 show that these types of problems comprise the majority of complaints from both commercial and public plan enrollees.

Commercial plan enrollees can go through a multilevel process to resolve benefit problems.<sup>27</sup> Although we think this process has several positive features, complainants' ability to have an independent external organization examine the appropriateness of their HMO's decision on their complaint is paramount. These reviews must be done by properly qualified individuals, depending on the nature of the complaint. This is important because enrollees' complaints often involve complex medical issues that go beyond MDH's capability to review or resolve. The review organizations' decisions are binding on HMOs, and HMOs must pay for the bulk of the costs.

The commercial complaint process for benefit issues has three other positive features. First, depending on the nature of their complaint, enrollees may have two opportunities for their HMO to reconsider its decision. Second, healthcare professionals who were not involved in making the original HMO decisions must review complaints. Third, HMOs notify enrollees how their complaints were resolved.

Although public plan enrollees have somewhat different complaint options when they have problems with their benefits, this process has some of the same safeguards we see in the

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<sup>26</sup> *Minnesota Statutes* 2015, 62Q.73, subd. 6(e)2.

<sup>27</sup> As discussed in Chapter 1, benefit-related complaints may involve a variety of problems dealing with: coverage exclusions or restrictions; eligibility; payment denials or limitations; administrative services; and the medical necessity of covered services.

commercial plan process. Health maintenance organizations must tell public enrollees how they have resolved their complaints, and enrollees have an external review option available to them—a fair hearing before an administrative law judge. To ensure a review by an appropriately certified medical professional, they can also ask to have one of the state’s independent review organizations consult on their complaint or request a second medical opinion from their HMO.

In contrast, requirements for resolving quality of care complaints for both commercial and public enrollees lack many safeguards to ensure that HMOs have made appropriate decisions.<sup>28</sup> Although enrollees may submit complaints about quality issues, such as unprofessional behavior or poorly performed medical procedures, neither HMOs nor MDH routinely tell enrollees how these types of complaints were investigated or resolved. Thus, enrollees never have an opportunity to ask their HMO to reconsider its decision or have an organization external to their HMO review their complaint. Furthermore, MDH’s access to information about HMOs’ resolution of quality-related complaints is limited.

Consequently, the majority of our recommendations for both the Legislature and MDH address this “black hole.” Our recommendations to (1) clarify MDH’s authority to review complaints, (2) better define complaint categories, and (3) require HMOs to annually report complaint data in a consistent and meaningful manner would help increase HMO accountability and transparency. Also, because we did not recommend significant changes to the confidential nature of the peer-protected review process, we think it is important for MDH to routinely involve the professional health-related licensing boards in quality of care complaints. Board members have, or have access to, considerably more expertise in medical issues than MDH. Thus, they are in a better position than MDH to determine whether such complaints merit some type of action by HMOs or state agencies. They may also share the results of their investigations with complainants. Board involvement in investigating quality of care complaints would not only add an extra level of transparency for complainants and the general public, but also increase HMO accountability.

Finally, an issue beyond the scope of our evaluation—but one that we encountered numerous times—concerns Minnesota’s confusing framework for regulating health insurance overall. We described the state’s fragmented regulatory system in Chapter 1, and in Chapter 2 we showed that the majority of complaints filed with MDH concern health plans not regulated by the department. It is clear that Minnesotans do not understand who regulates their type of plan.

In 2012, the Legislature required MDH, in consultation with the Minnesota Department of Commerce, to develop recommendations to “maximize efficiency” in regulating health insurers (including HMOs and insurance companies).<sup>29</sup> In its 2013 report, MDH recognized the confusing nature of Minnesota’s current regulatory system and questioned the need for maintaining separate regulatory systems for HMOs and other health insurers.<sup>30</sup> Not only do we generally agree with the questions MDH posed, we also agree that the Legislature should “take a fresh look at the way Minnesota regulates health coverage.”<sup>31</sup>

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<sup>28</sup> As discussed previously, quality of care complaints generally concern the timeliness, quality, and appropriateness of healthcare services.

<sup>29</sup> *Laws of Minnesota* 2012, ch. 247, art. 2, sec. 13.

<sup>30</sup> Minnesota Department of Health, *Administrative Efficiency in the Regulation of Minnesota Health Plan Companies* (St. Paul, February 2013), 18.

<sup>31</sup> *Ibid.*

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# List of Recommendations

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- The Legislature should require that health maintenance organizations report commercial plan complaint data annually to the Minnesota Department of Health, using standard definitions and categories developed by the department. (p. 21)
- The Minnesota Department of Health should develop standard definitions and categories for commercial health plan complaints and require health maintenance organizations to report data accordingly. (p. 21)
- The Minnesota Department of Health should not advise health maintenance organizations of the order in which the department will review complaint files during their quality assurance examinations. (p. 26)
- The Legislature, in consultation with the Minnesota Department of Health, should define the types of problems or issues that should be investigated as confidential quality of care complaints. (p. 30)
- The Legislature should give the Minnesota Department of Health full regulatory authority over, and access to, health maintenance organizations' confidential investigations into quality of care complaints. (p. 31)
- The Legislature should clarify the Minnesota Department of Health's authority to investigate and resolve complaints that health maintenance organization enrollees file with the department. (p. 34)
- The Minnesota Department of Health should develop internal policies and procedures for processing all complaints it receives from health plan enrollees. (p. 35)
- The Minnesota Department of Health should forward all quality of care complaints it receives to the appropriate professional health-related licensing board or state agency for investigation. (p. 36)
- The Minnesota Department of Health should improve the accuracy and consistency of information in its complaint management database. (p. 37)
- The Legislature should more clearly define the types of complaints eligible for the independent external review process, paying special attention to quality of care complaints. (p. 41)





PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

February 10, 2016

Mr. James Nobles  
Legislative Auditor  
Centennial Office Building, Room 140  
658 Cedar Street  
Saint Paul, MN 55101

Dear Mr. Nobles:

Thank you for the evaluation of the Minnesota Department of Health's process for oversight of Health Maintenance Organization (HMO) Complaint Resolution. We appreciate the effort of the Legislative Auditor to undertake a thorough evaluation of this complex process, and the professionalism the OLA staff in working with the Department's staff to develop a clear understanding of HMO complaint resolution processes.

Health care delivery and insurance has undergone significant change in recent years with the implementation of the Affordable Care Act (ACA). The ACA has resulted in significant increases in health care coverage which benefits patients and enrollees by ensuring access to health care when needed. With these changes, regulators, policymakers, health care providers, and insurers all have a responsibility to ensure that the health care provided to patients and enrollees is of the highest possible quality. Greater clarity and transparency in the HMO enrollee complaints resolution process is a key part of ensuring that health care quality continues to improve in Minnesota.

We agree with the Auditor's recommendations for improvement of the Department's process for receiving and reviewing complaints submitted by patients and enrollees. These improvements will include better documentation of our internal processes for reviewing complaints, and more effective communication to patients and enrollees via the Internet and other tools to describe the HMO complaint process and our role in oversight of HMO complaints.

We also agree that better definition and standard categories are needed to specify what constitutes a quality of care complaint reviewed by an HMO. Better definitions will help the HMOs use the quality of care complaints process to more effectively address enrollee concerns regarding health care that results, or may potentially result, in adverse health outcomes. Better definitions and use of standard categories by HMOs will also result in better data on complaints which the Department uses to assess how effectively HMOs resolve quality of care and other types of complaints submitted by HMO enrollees.

The Department will continue to improve on our work to facilitate enrollees' complaints pertaining to the health care they receive and its quality, insurance coverage, and other factors relative to the circumstances and setting in which the health care is provided. When addressing enrollees' health care complaints, the complexity

of current law makes it important to ensure that specific complaints go to the entity with the authority and expertise to review the consumer's concern. Minnesota health professional licensing boards should review complaints pertaining to licensed provider behavior, competency and quality. However, the Department of Health should retain authority to review complaints about HMO actions that affect patient care, insurance coverage, and other factors affecting health care and its delivery. The Department should continue to assist patients and enrollees in navigating current law complexities to ensure their health care complaints are addressed in a timely manner. This includes working with the Minnesota health professional licensing boards on health care complaints pertaining to licensed providers. It also requires providing HMO patients and enrollees with all necessary information regarding their rights for review of health care complaints and assistance in contacting the entity with appropriate review authority.

Finally, we agree that the Department's understanding of quality of care complaints would be enhanced by complete access to HMO quality of care complaint files. Improvements in this area include further defining in statute the types of issues and complaints that should be confidential under peer review organization law, and the kinds of issues that warrant enrollee access to this information. The purpose of the peer review process is to improve health care practice and quality, and prevent future health care actions that directly harm, or lead to the harm or death of patients. Any 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.

The Department will provide technical assistance to the Legislature on any effort to better define quality of care complaints, the types of complaints which constitute confidential quality of care complaints, categories for all types of health care complaints, and the authority of the Department to review HMO quality of care complaint investigations. Importantly, HMOs are just one component of our health care delivery system. Simplifying Minnesota's current health care complaint laws for patients and consumers may require comprehensive legislation that applies consistent standards to all health insurance carriers, addresses all kinds of complaints, and reconciles inconsistencies between Federal and state laws.

Again, we thank you and your staff for the thorough review of the Department's work regarding HMO complaint resolutions. We look forward to working with you and the Legislature to make improvements that enhance the clarity and transparency of the HMO Complaints review process for all Minnesotans.

Sincerely,

A handwritten signature in black ink, appearing to read "Edward P. Ehlinger", with a long horizontal flourish extending to the right.

Edward P. Ehlinger, M.D., M.S.P.H.  
Commissioner  
P.O. Box 64975  
St. Paul, MN 55164-0975

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*County Veterans Service Offices*, January 2008

### Health

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