

Minnesota Department of Health  
Compliance Monitoring Division  
Managed Care Systems Section



# **Metropolitan Health Plan**

## **Quality Assurance Examination**

For the period:

May 1, 2005 – April 30, 2008

### **Final Report**

**December 18, 2008**

Examiners:

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**Minnesota Department of Health**  
**Executive Summary:**

The Minnesota Department of Health (MDH) conducted a Quality Assurance Examination of Metropolitan Health Plan (MHP) to determine whether it is operating in accordance with Minnesota and applicable Federal law. MDH has found that MHP is compliant with Minnesota and applicable Federal law, except in the areas outlined in the “Deficiencies” and “Mandatory Improvements” sections of this report. “Mandatory Improvements” are required corrections that must be made to policy/procedures, documents or processes to be compliant with the law but have not yet adversely affected enrollees or enrollee rights. The “Recommendations” listed are areas where, although compliant with law, MDH identified improvement opportunities.

**To address recommendations, MHP should:**

Expand upon its explanation of its organizational quality committee structure, quality communication system, and the scope of the quality assurance program in the quality assurance plan.

Clearly indicate in the credentialing and recredentialing policy/procedure what committee dates MHP uses and inputs into their credentialing system for the delegated entities.

Review its process of developing two annual evaluations to look for and reduce redundancies and to provide one comprehensive annual evaluation that both summarizes and analyzes the individual quality and utilization monitoring data and improvement activities as well as critically analyzing the overall quality program for effectiveness.

Improve documentation to clearly and consistently indicate what providers are notified orally and in writing, indicate on the DTR all the parties receiving the DTR, and have the attending health care professional’s name on the DTR.

Continue to work with DHS to improve and simplify the DTR process for previously authorized services.

Develop and implement written guidelines that employ quality improvement methodology to assess geographic and timely access for its enrollees.

Consistently and clearly describe under what circumstances a referral is necessary, the procedures for requesting a referral and the procedures for appealing the plan’s determination.

Combine the numerous UM policies into one encompassing policy to better coordinate and improve UM processes.

Describe under what circumstances and through what method a physician consultant of same or similar specialty will be chosen.

**To address mandatory improvements MHP must:**

Revise its organizational provider policy to be consistent with the standard and its internal contracting process.

Revise its Appeal and Grievance, and Medical Administration (as applicable) policies and procedures to include all the required elements.

Revise its policy to accurately reflect ten business days or 14 calendar days and to be consistent in their terminology in all the policies (business days versus calendar days).

Combine its processes for lack of information and authorization extension into one policy and state in the policy/procedure MHP's actual process.

Revise its reconstructive surgery policy to be consistent with the law.

**To address deficiencies, MHP and its delegates must:**

Ensure the length of the recredentialing cycle is within a 36-month time frame.

Have mechanisms in place to evaluate practitioner-specific complaints and adverse events and the practitioner's history of issues at least every six months to incorporate into the recredentialing process.

Include in the Quality Evaluation an analysis of the data collected to identify problems or potential problems.

Give a detailed description of the proposed quality activities that includes measurable objectives and time frames in the annual work plan.

Clearly indicate on the DTR the determination (whether it is a denial, termination, or reduction) and the reason for the determination.

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

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Darcy Miner, Director  
Compliance Monitoring Division

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## I. Introduction

A. History: Metropolitan Health Plan (MHP) was established as a not-for-profit, state-certified health maintenance organization (HMO) in 1983. The health plan was an enterprise initiative of Hennepin County. MHP's initial purpose was to provide the traditional patients of Hennepin County Medical Center (HCMC) and community clinics with access to managed care, as well as fee-for-service health programs.

Voluntary Medical Assistance enrollment began in 1984 with 800 enrollees. In 1990, Minnesota General Assistance recipients were mandated into prepaid managed care programs. In 1994, MHP expanded to include public program enrollment in Anoka, Carver and Scott counties. In 1996, MHP began offering MinnesotaCare, a program of the state of Minnesota. In 1997, MHP became a provider of the Minnesota Senior Health Options (MSHO) program.

MHP expanded its core network in 2004 to include Polk and Mower counties located at opposite ends of the state. Residents in both counties may now receive Prepaid Medical Assistance, General Assistance Medical Care and MinnesotaCare services through MHP. An MHP MSHO plan also became available in Polk County.

In 2006, MHP added two Medicare Advantage programs, MHP North Star Advantage and North Star Advantage Plus. These programs are for people entitled to Medicare benefits under Part A or enrolled in Part B, and who live in Anoka, Carver, Chisago, Dakota, Hennepin, Ramsey, Scott, Sherburne, Washington or Wright counties.

B. Membership: MHP's self-reported enrollment as of April 2008 consisted of the following:

<b>Product</b>	<b>Enrollment</b>
Prepaid Medical Assistance Program	11,677
MinnesotaCare	1,928
General Assistance Medical Care	1,540
MSHO	786
MSC	633
MSC+	52
SNBC	2
<b>Total</b>	<b>16,618</b>

C. Onsite Examination Dates: August 18, 2008 – August 22, 2008

D. Examination Period: May 1, 2005 – April 30, 2008  
File Sample Period: May 1, 2007 – April 30, 2008

- E. Sampling Methodology: Due to the small sample sizes and the methodology used for sample selection for the quality assurance examination, the results cannot be extrapolated as an overall deficiency rate for the health plan.
- F. Performance Standard: For each instance of non-compliance with applicable law or rule identified during the course of the quality assurance examination, which covers a three-year audit period, the health plan is cited with a deficiency.

## II. Quality Program Administration

### Minnesota Rules, Part 4685.1110. Program

Subp. 1.	Written Quality Assurance Plan	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subp. 2.	Documentation of Responsibility	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subp. 3.	Appointed Entity	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subp. 4.	Physician Participation	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subp. 5.	Staff Resources	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subp. 6.	Delegated Activities	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subp. 7.	Information System	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subp. 8.	Program Evaluation	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subp. 9.	Complaints	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subp. 10.	Utilization Review	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subp. 11.	Provider Selection and Credentialing	<input type="checkbox"/> Met	<input checked="" type="checkbox"/> Not Met
Subp. 12.	Qualifications	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subp. 13.	Medical Records	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met

Subp. 1. Minnesota Rules, part 4685.1110, subpart 1, states that the quality assurance plan must contain specific elements. Although all the required elements were present, MHP's quality assurance plan could be improved by the following:

- Including in the MHP quality structure, the newly developed delegation oversight committee and the UM committee as it gets more formalized in the organization.
- Communication of the separate elements are included, however articulating the overall system for communicating quality activities internally, to network providers and to enrollees would provide clarity of the communication process.
- More clearly stating or summarizing the clinical, organizational and consumer components as listed in Minnesota Rules, part 4685.1115, subpart 2. They are present but scattered throughout the document.

#### **(Recommendation #1)**

Subp. 11. Minnesota Rules, part 4685.1110, subpart 11, states that the health plan must have procedures for credentialing and recredentialing providers that are, at a minimum, consistent with accepted community standards. MDH understands the community standard to be NCQA credentialing and recredentialing standards. MDH reviewed a total of 47 credentialing and recredentialing files from MHP and its delegates as follows:

<b>Organization</b>	<b># Files</b>
<b>Credentialing</b>	
MHP	10
NorthPoint	3
HCMC	7
Innovis	10
<b>Recredentialing</b>	
MHP	10
NorthPoint	0
HCMC	1
Innovis	6
<b>Total</b>	<b>47</b>

The standard for the length of the recredentialing cycle is within a 36-month time frame. MHP’s policy did not specify the 36 month recredentialing time frame and file review revealed two recredentialing files outside of the 36 month time frame. **(Deficiency #1)**. Also included in the recredentialing standards is that the health plan must have mechanisms in place to evaluate practitioner-specific complaints and adverse events and the practitioner’s history of issues at least every six months. The six Innovis recredentialing files did not contain documentation that the complaints and adverse events were collected and reviewed during the recredentialing process. Additional information submitted by MHP and its delegate Innovis contained a form in the recredentialing files to collect information related to quality and complaints, however the form was blank in all the files. While the blank form provided information as to the process Innovis used to gather practitioner complaint and quality information, it did not provide outcome evidence that they were following their process. **(Deficiency #2)** In addition, the committee dates in the MHP credentialing system were different than the dates supplied in all of the Innovis credentialing and recredentialing files. MHP was not able to explain the conflicting dates. The credentialing and recredentialing policy/procedure should clearly dictate what committee dates MHP uses and inputs into their credentialing system. **(Recommendation #2)**

Organizational credentialing standards require the inclusion of free-standing surgical centers and behavioral health provider organizations with which it contracts. The MHP policy states that surgery centers are not required to be credentialed and does not address behavioral health care facilities. Additional information submitted indicated MHP is appropriately assessing behavioral health organizations and does not assess free-standing surgery centers since they do not contract with them. MHP must change its Organizational Provider policy to be consistent with the standard and its internal contracting process. **(Mandatory Improvement #1)**

Other observations during file review included one file for a physician assistant who had prescription privileges but no current DEA and one file MDH was unable to read the date on the attestation. There was ample evidence that these files were not representative of normal credentialing processes.

**Minnesota Rules, Part 4685.1115. Activities**

- Subp. 1. Ongoing Quality Evaluation Met Not Met
- Subp. 2. Scope Met Not Met

**Minnesota Rules, Part 4685.1120. Quality Evaluation Steps**

Subp. 1.	Problem Identification	<input type="checkbox"/> Met	<input checked="" type="checkbox"/> Not Met
Subp. 2.	Problem Selection	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subp. 3.	Corrective Action	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subp. 4.	Evaluation of Corrective Action	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met

Subp. 1. Minnesota Rules, part 4685.1120, subpart 1, states that the quality evaluation is to include the ongoing monitoring of process, structure, and outcomes and the evaluation of the data collected to identify problems or potential problems. MHP completes two evaluations with some of the same data presented in both. In addition, data is also presented in the annual work plan. However, not all the data introduced in the evaluations is analyzed, compared to benchmarks or compared to previous years (examples include the utilization data on page 28 and the HEDIS data). The purpose of the annual evaluation is to review all the pertinent monitoring and data from all parts of the organization and to analyze/evaluate that data to determine improvement opportunities. Any identified opportunities, issues, or potential problems are then brought forward into the work plan for the next year. Data that is not analyzed/evaluated should not be included in the annual evaluation since it does not follow the quality evaluation steps as outlined in the Rule. **(Deficiency #3)**. MHP may want to review the annual evaluations and other key quality documents. The goal would be to look for and reduce redundancies and to provide one comprehensive annual evaluation that both summarizes and analyzes the individual quality and utilization monitoring data and improvement activities, as well as critically analyzing the overall quality program for effectiveness. **(Recommendation #3)**

**Minnesota Rules, Part 4685.1125. Focused Study Steps**

Subp. 1.	Focused Studies	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subp. 2.	Topic Identification and Selection	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subp. 3.	Study	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subp. 4.	Corrective Action	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subp. 5.	Other Studies	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met

**Minnesota Rules, Part 4685.1130. Filed Written Plan and Work Plan**

Subp. 1.	Written Plan	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subp. 2.	Work Plan	<input type="checkbox"/> Met	<input checked="" type="checkbox"/> Not Met

Subp. 2. Minnesota Rules, part 4685.1130, subpart 2, states that the annual work plan is to give a detailed description of the proposed quality activities that includes measurable objectives and time frames. While the planned focus studies included these elements, the performance

improvement projects (PIPs) included in the work plan did not include the required elements. While the PIPs need to meet the BBA requirements, they are also an integral part of your quality improvement activity and need to be included in your organizational quality work plan to meet the requirements of the Rule. **(Deficiency #4)**

### III. Grievance Systems

MDH examined MHP’s public program grievance system for compliance with the federal BBA law (42 CFR 438, subpart F) and the DHS 2008 Model Contract, Article 8.

MDH reviewed a total of 43 grievance system files:

File Type	# Files
Grievance Files	8
Appeal Files (Clinical)	13
Appeal Files (Non-clinical)	8
State Fair Hearing	7
Quality of Care Grievances	7
<b>Total</b>	<b>43</b>

#### Section 8.1. §438.402 General Requirements

- |  |   |                                  |
|--|---|----------------------------------|
| Sec. 8.1.1. Components of Grievance System | <input checked="" type="checkbox"/> Met | <input type="checkbox"/> Not Met |
| Sec. 8.1.2. Timeframes for Disposition     | <input checked="" type="checkbox"/> Met | <input type="checkbox"/> Not Met |
| Sec. 8.1.3. Legal Requirements             | <input checked="" type="checkbox"/> Met | <input type="checkbox"/> Not Met |

§438.400(a)(3) (contract section 8.1.1) requires that managed health care plans establish internal grievance procedures. During file review, MDH found that MHP grievance and appeal files were thoroughly investigated, well-documented, and resolved in a timely manner with all the appropriate notifications. However, MHP’s Grievance System policies and procedures are not consistent with federal and state law, and must be revised. The following are the specific items that must be revised:

- §438.408 (d)(2) and (e) (contract section 8.4.7), states “The written notice of resolution of Appeal must include the results of the resolution process. . .” MHP’s policy and procedure AGC003, Medicaid Appeals and Grievances, states “Oral appeals may be resolved through oral communication.” MHP’s policy is not consistent with law.
- Minnesota Statutes, section 62M.06, subdivision 2 (a), states the HMO must ensure reasonable access to its consulting physician or health care provider. Policy and procedure, APG0003, states “the individual making the decision must be a Health Care Professional with appropriate clinical expertise . . .” MHP policy does not mention access to the consulting physician.
- Minnesota Statutes, section 62M.06, subdivision 2 (b), states the plan must notify the enrollee and attending health care professional by telephone of its determination on the

expedited appeal. Policy APG0003 states “Final decision of an expedited appeal must be made known to the Member” and “MHP must send out written notification and must make reasonable efforts to notify the Member by telephone prior to sending out written notification.” The procedure doesn’t state that MHP must notify both enrollee and provider by telephone.

- Minnesota Statutes, section 62M.06, subdivision 3 (a), states a plan shall notify in writing the enrollee, attending health care professional, and claims administrator of its determination on the appeal. APG0003 states the “A/G coordinator notifies the Member/complainant in writing of MHP’s decision . . .” It does not mention the attending health care professional.
- Minnesota Statutes, section 62M.06, subdivision 3 (d), states the process established by a plan may include defining a period within which an appeal must be filed to be considered. APG0003 page 3 states 90 days from DTR. However page 16, Pre-service Appeals, states “Allow at least 180 calendar days after notification of the denial for the member to file an appeal.” The two time lines stated are not consistent.
- Minnesota Statutes, section 62M.06, subdivision 3 (f), states, if the plan would uphold its denial upon appeal, the plan must ensure that a physician in the same or a similar specialty as typically manages the medical condition, procedure, or treatment under discussion is reasonably available to review the case. The Medical Administration policy, “Appeal Process,” states “MHP will have either the Medical Director or the Assistant Medical Director review the appeal, whoever did not make the initial decision to deny. In chiropractic, mental health and dental cases, an appeal will go to same specialty to make the determination.” The MHP procedure is not consistent with Minnesota law.
- Minnesota Statutes, section 62M.09, subdivision 6, states a plan must use physician consultants in the appeal process that are board certified by the American Board of Medical Specialists or the American Board of Osteopathy. The MHP Medical Administration policy, “MHP Physician Consultants,” states “MHP will use physician consultants in the appeal process. The Physician consultants will include as needed and available, specialists who are board certified, or board eligible and working towards certification in a specialty board approved by the American board of Medical Specialists or the American Board of Osteopathy.” Physician consultants must be board certified.

**(Mandatory Improvement #2)**

Section 8.2. §438.404	DTR Notice of Action to Enrollees		
Sec. 8.2.1.	General requirements	<input type="checkbox"/> Met	<input checked="" type="checkbox"/> Not Met
Sec. 8.2.2.	§438.404 (c) Timing of DTR Notice		
A.	§438.404 (c)(1) Previously Authorized Services	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
B.	§438.404 (c)(2) Denials of Payment	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
C.	§438.404 (c)(3) Standard Authorizations	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
D.	§438.404 (c)(4) Extensions of Time	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
E.	§438.404 (c)(5) Delay in Authorizations	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
F.	§438.404 (c)(6) Expedited Authorizations	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Sec. 8.2.3.	§438.420 (b) Continuation of Benefits Pending Decision		
		<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met

§438.404(b) (contract section 8.2.1.B) states that the content of the DTR must include a clear, detailed description in plain language of the reason for the denial, termination, or reduction (DTR) and the action the MCO has taken or plans to take. MHP changed the DTR process in 2007 so that DTRs come through the CCMS system. The DTRs in 2008 do not specify the action the MCO has taken since they do not indicate if the service was denied, terminated or reduced. The DTR states it is a notice of action regarding “*Denial/Reduction/Termination of Service*”. In addition, in the box labeled Reason for Action, abbreviations are used so that the enrollee may not understand the reason for the action. For example, a file from April 2008 had the reason “*NMN:0308 DNY RECORDS DONT SUP CARE IS NEEDED*”. A corrective action plan was put in place by MHP in August 1, 2008 which is outside of the audit time period. MHP must clearly indicate on the DTR the determination (whether it is a denial, termination or reduction) and the reason for the determination. **(Deficiency #5)** [Also see Minnesota Statutes 62M.05, subdivision 3a(c)]

Other observations during file review revealed one file with the incorrect reason for the DTR. There was ample evidence that this file was not representative of the normal DTR processes.

§438.404 (contract section 8.2.2.C) states when an initial determination is made to deny or limit services, notification must be provided by telephone within one working day after making the determination to the attending health care professional and a written notification must be sent to the attending health care professional and enrollee. In the documentation provided in the files, it was not consistently clear as to which “provider” was verbally notified of the denial, the attending health care professional or vendor. Evidence was presented validating that the provider, member and vendor all got the DTR appropriately. However, the DTR does not indicate all those providers receiving the DTR thus the enrollee is not informed. In addition, in cases involving a third party vendor (such as PCA), the vendor of services is listed in the “Provider Name” field instead of the attending health care professional while the attending health care professional is not listed on the DTR at all. MHP should improve documentation to clearly and consistently indicate what providers are notified orally and in writing, indicate on the DTR all the parties receiving the DTR, and have the attending health care professional’s name on the DTR. **(Recommendation #4)**

[Also see Minnesota Statutes, section 62M.05, subdivision 3(a) and 62M.06, subdivision 3(a)]

§438.404 (c)(1) (contract section 8.2.2.A) states that for previously authorized services the MCO must mail the notice to the enrollee at least ten days before the date of the proposed Action. MHP was able to show evidence that enrollees are informed ten days in advance of the action. The process MHP follows for service reductions, such as PCA services, is that enrollees get five contacts regarding the action. The contacts include two written authorizations, one DTR, a letter explaining the ten days and a telephone call. This is a very confusing and cumbersome process for both MHP and the enrollee. MHP states they are participating in a workgroup with DHS to improve the DTR process. MHP should continue to work with DHS to improve and simplify the DTR process for previously authorized services to be less confusing to the enrollee. **(Recommendation #5)**

§438.404(c) (3) (contract section 8.2.2.C) states that decisions for utilization review must be communicated to the attending health care professional and enrollee within ten business days of

the request. The MHP policy entitled *Service Authorization* (revised 2/08) states that they are to process requests for service authorization within 14 business days of receipt and if further medical information be requested to base a decision, MHP will wait 14 days from the request of information then act on the information given. The policy should state within 10 business days or 14 calendar days. File review indicated MHP was within the regulatory timelines for standard authorizations with the exception of one file. Another policy from Medical Administration policy/procedure *Service Authorization* states MHP must complete requests for service authorization within 14 days of receipt, not specifying business or calendar. MHP must revise its policy to accurately reflect ten business days or 14 calendar days and MHP should be consistent in their terminology in all the policies (business days versus calendar days). **(Mandatory Improvement #3)** [Also see Minnesota Statutes, section 62M.05, subdivision 3a(a)]

§438.404 (c)(4) (contract section 8.2.2D) states that the MCO may extend the timeframe by an additional 14 days for resolution of a standard authorization if the enrollee or the provider requests the extension, or if the MCO justifies a need for additional information. The MHP policy entitled *Service Authorization* states that if an enrollee or provider will not release the necessary information for MHP to make a medical necessity determination within 14 calendar days, MHP may deny the request due to insufficient information. The *Extension Policy* states that an extension may be granted for an additional 14 calendar days. The two policies are inconsistent. For Medicaid plans, the extension policy (for BBA) and the lack of information policy (for 62M) should be consistent. Their actual process is to deny unless the enrollee or provider requests the extension. No files reviewed contained an extension. MHP must combine its processes for lack of information and authorization extension and state in the policy/procedure MHP's actual process. **(Mandatory Improvement #4)** [Also see Minnesota Statutes, section 62M.05, subdivision 3a(c)]

<b>Section 8.3. §438.408</b>	<b>Internal Grievance Process Requirements</b>	
Sec. 8.3.1. §438.402 (b)	Filing Requirements	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met
Sec. 8.3.2. §438.408 (b)(1)	Timeframe for Resolution of Grievances	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met
Sec. 8.3.3. §438.408 (c)	Timeframe for Extension of Resolution of Grievances	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met
Sec. 8.3.4. §438.406	Handling of Grievances	
A. §438.406 (a)(2)	Written Acknowledgement	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met
B. §438.416	Log of Grievances	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met
C. §438.402 (b)(3)	Oral or Written Grievances	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met
D. §438.406 (a)(1)	Reasonable Assistance	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met
E. §438.406 (a)(3)(i)	Individual Making Decision	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met
F. §438.406 (a)(3)(ii)	Appropriate Clinical Expertise	

§438.408 (b)(1) (contract section 8.3.2.). MDH found one oral grievance that was not resolved within ten days.

**Section 8.4. §438.408**

**Internal Appeals Process Requirements**

- Sec. 8.4.1. §438.402 (b) Filing Requirements Met Not Met
- Sec. 8.4.2. §438.408 (b)(2) Timeframe for Resolution of Standard Appeals Met Not Met
- Sec. 8.4.3 §438.408 (b) Timeframe for Resolution of Expedited Appeals
- A. §438.408 (b)(3) Expeditious Resolution and oral notice Met Not Met
- B. §438.410 (b) Punitive Action Prohibited Met Not Met
- C. §438.410 (c) Denial of Request for Expedited Appeal Met Not Met
- Sec. 8.4.4. §438.408 (c) Timeframe for Extension of Resolution of Appeals Met Not Met
- Sec. 8.4.5. §438.406 Handling of Appeals
- A. §438.406 (b)(1) Oral Inquiries Met Not Met
- B. §438.406 (a)(2) Written Acknowledgement Met Not Met
- C. §438.406 (a)(1) Reasonable Assistance Met Not Met
- D. §438.406 (a)(3)(i) Individual Making Decision Met Not Met
- E. §438.406 (a)(3)(ii) Appropriate Clinical Expertise  
        [See Minnesota Statutes, section 62M.06, subd. 3(f)]
- F. §438.406 (b)(2) Opportunity to Present Evidence Met Not Met
- G. §438.406 (b)(3) Opportunity to Examine the Case File Met Not Met
- H. §438.406 (b)(4) Parties to the Appeal Met Not Met
- Sec. 8.4.6. Subsequent Appeals Met Not Met
- Sec. 8.4.7. §438.408 (e) Notice of Resolution of Appeals Met Not Met
- Sec. 8.4.8. §438.424 (a) Reversed Appeal Resolutions Met Not Met
- Sec. 8.4.9. §438.420 (d) Upheld Appeal Resolutions Met Not Met

§438.406 (a)(2) (contract section 8.4.5). MDH found one appeal in which the written acknowledgement was sent after the ten day timeline.

**Section 8.5. §438.416 (c) Maintenance of Grievance and Appeal Records**

Met Not Met

**Section 8.7. §438.408 (f) State Fair Hearings**

- Section 8.7.2. §438.408 (f) Standard Hearing Decisions Met Not Met
- Section 8.7.5. §438.420 Continuation of Benefits Pending Resolution of State Fair Hearing Met Not Met
- Section 8.7.6. §438.424 Compliance with State Fair Hearing Resolution Met Not Met

**Minnesota Rules, Part 4685.1900. Records of Complaints**

Subp. 1.	Record Requirements	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subp. 2.	Log of Complaints §438.416 (a)	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met

**IV. Access and Availability**

**Minnesota Statutes, Section 62D.124. Geographic Accessibility**

Subd. 1.	Primary Care; Mental Health Services; General Hospital Services	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subd. 2.	Other Health Services	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subd. 3.	Exception	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met

**Minnesota Rules, Part 4685.1010. Availability and Accessibility**

Subp. 2.	Basic Services	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subp. 5.	Coordination of Care	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subp. 6.	Timely Access to Health Care Services	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met

Subp. 2. Minnesota Rules, part 4685.1010, subpart 2, states the plan “. . . shall develop and implement written standards or guidelines that assess the capacity of each provider network to provide timely access to health care services . . .” MHP prepares geographic access maps quarterly and prepares memos regarding the results for the metro area, Mower and Polk Counties. MHP provided the memo for all 2007 and the second quarter of 2008. MDH found the following:

- In the 2007 Mower/Polk counties memo, MHP incorrectly applied a standard of 60 miles, rather than 30 miles (as required by Minnesota Statutes, section 62D.124), for geographic accessibility of primary care, mental health and general hospitals. The 2008 Polk County mental health map states that the radius measure is 60 miles, however the radius as mapped is not consistent with 30 or 60 miles. MHP should consistently apply the correct standard for geographic access.
- Specialty providers in the 2007 memo include home health, rehabilitation, DME and vision. The 2008 memo identifies specialty providers as those multi-specialty clinics in Polk County and lists the available specialties. MHP should consistently define “specialty” and should consider the specialty needs of enrollees in Polk County and if the contracted network meets those needs.
- The memos do not evaluate or draw conclusions regarding geographic access. Furthermore, the content of the memos is not reported across departments. Geographic access is not included in the Annual Quality Evaluation. MHP should evaluate and report meaningful findings regarding the geographic accessibility of its network.

While the MDH review focused on Polk County, MHP should consider the shortcomings in its assessment process throughout its service area.

MHP also performs quarterly timeliness surveys for providers from each county in the service area. The Annual Evaluation included a table of wait times for scheduling appointments. The results were averaged across the year, across all counties, without reference to the type of appointment—routine or acute. MHP should evaluate and report meaningful findings across departments to ascertain how timely access affects, or is affected by other aspects of MHP operations.

Assessment of geographic and timely access could provide more useful information with more rigorous methodology. Quality improvement methodology assumes the health plan will assess the situation, identify issues, collect and analyze pertinent data, identify opportunities for improvement, take action and evaluate the effectiveness of the action.

**(Recommendation #6)**

Subp. 2, J. Minnesota Rules, part 4685.1010, subpart 2, J, states referral procedures must be described in an enrollee's evidence of coverage and must clearly describe under what circumstances a referral is necessary, the procedures for requesting a referral and the procedures for appealing the plan's determination. According to staff interviews, MHP no longer requires referrals to specialists, regardless if the provider is part of the network or not, as long as the provider will accept Minnesota Medicaid reimbursement rates and will accept MHP enrollees. If the specialist is out of state the enrollee does not need a referral, however the enrollee will need a service authorization to ensure the claim is paid. This information is not clearly stated in the enrollee documents and does not consistently describe the requirements.

- MHP's January 2008 Certificate of Coverage for PMAP, page 6, states, "You do not need a referral to see a Plan network specialist."
- MHP's January 2008 Member Handbook and Provider Directory, page 3, states, "There may be some medical services you need that you can't get from your medical home. MHP does not require a referral for you to see specialists in the MHP network. MHP also does not require a referral for you to see specialists in Minnesota who are not in the MHP network. The non-network specialist must be enrolled as a Minnesota Health Care Program (MHCP) provider, accept MHCP rates from MHP and be willing to see MHP members."

**(Recommendation #7)**

**Minnesota Statutes, Section 62Q.55. Emergency Services**

Met Not Met

**Minnesota Statutes, Section 62Q.121. Licensure of Medical Directors**

Met Not Met

**Minnesota Statutes, Section 62Q.527. Coverage of Nonformulary Drugs for Mental Illness and Emotional Disturbance**

- Subd. 2. Required Coverage for Anti-psychotic Drugs Met Not Met
- Subd. 3. Continuing Care Met Not Met
- Subd. 4. Exception to formulary Met Not Met

**Minnesota Statutes, Section 62Q.535. Coverage for Court-Ordered Mental Health Services**

- Subd. 1. Mental health services Met Not Met
- Subd. 2. Coverage required Met Not Met

**Minnesota Statutes, Section 62Q.56. Continuity of Care**

- Subd. 1. Change in health care provider; general notification Met Not Met
- Subd. 1a. Change in health care provider; termination not for cause Met Not Met
- Subd. 1b. Change in health care provider; termination for cause Met Not Met
- Subd. 2. Change in health plans Met Not Met
- Subd. 2a. Limitations Met Not Met
- Subd. 2b. Request for authorization Met Not Met
- Subd. 3. Disclosures Met Not Met

**Minnesota Rules, 4685.0700. Comprehensive Health Maintenance Services**

- Subp. 3. Permissible limitations Met Not Met
- Subp. 4. Permissible exclusions Met Not Met

**V. Utilization Review**

MDH reviewed a total of 49 utilization review denial files as follows:

<b>Utilization Review File Stratification</b>	<b># Files</b>
DME	2
PCA	22
Inpatient	3
Skilled Nursing	1
Professional Medical	3
Chiropractic	6
Formulary	4
Mental Health	8
<b>Total</b>	<b>49</b>

**Minnesota Statutes, Section 62M.04. Standards for Utilization Review Performance**

- Subd. 1. Responsibility on Obtaining Certification Met Not Met
- Subd. 2. Information upon which Utilization Review is Conducted Met Not Met
- Subd. 3. Data Elements Met Not Met
- Subd. 4. Additional Information Met Not Met
- Subd. 5. Sharing of Information Met Not Met

**Minnesota Statutes, Section 62M.05. Procedures for Review Determination**

- Subd. 1. Written Procedures Met Not Met
- Subd. 2. Concurrent Review Met Not Met
- Subd. 3. Notification of Determinations Met Not Met
- Subd. 3a. Standard Review Determination
  - (a) Initial determination to certify (10 business days) Met Not Met
  - (b) Initial determination to certify (telephone notification) Met Not Met
  - (c) Initial determination not to certify Met Not Met
  - (d) Initial determination not to certify (notice of rights to external appeal) Met Not Met
- Subd. 3b. Expedited Review Determination Met Not Met
- Subd. 4. Failure to Provide Necessary Information Met Not Met
- Subd. 5. Notifications to Claims Administrator Met Not Met

Subd.1. Minnesota Statutes, section 62M.05, subdivision 1, states that an HMO must have written procedures to ensure that utilization reviews are conducted in accordance with 62M requirements. While MHP has numerous policies/procedures that cover all the utilization review requirements, MHP may want to combine the numerous policies into one encompassing UM policy to better coordinate and improve UM processes. **(Recommendation #8)**

Subd. 3a(a). Minnesota Statutes, section 62M.05, subdivision 3a (a), states that decisions for utilization review must be communicated to the attending health care professional and enrollee within ten business days of the request. The MHP policy entitled *Service Authorization* (revised 2/08) states that they are to process requests for service authorization within 14 business days of receipt and if further medical information be requested to base a decision, MHP will wait 14 days from the request of information then act on the information given. The policy should state within ten business days or 14 calendar days. File review indicated MHP was within the regulatory timelines for standard authorizations with the exception of one file. Another policy from Medical Administration states MHP must complete requests for service authorization within 14 days of receipt, not specifying business or calendar. MHP must revise its policy to accurately reflect ten business days or 14 calendar days and MHP should be consistent in their terminology in all the policies (business days versus calendar days).

**(Mandatory Improvement #3)**

[Also see §438.404(c)(3) (contract section 8.2.2.C)]

Subd. 3a(c). Minnesota Statutes, section 62M.05, subdivision 3a(c), states when an initial determination is made to deny or limit services, notification must be provided by telephone within one working day after making the determination to the attending health care professional and a written notification must be sent to the attending health care professional and enrollee. In the documentation provided in the files, it was not consistently clear as to which “provider” was verbally notified of the denial, the attending health care professional or vendor. Evidence was presented validating that the provider, enrollee and vendor all got the DTR appropriately. However, the DTR does not indicate all those providers receiving the DTR, thus the enrollee is not informed. In addition, in cases involving a third party vendor (such as PCA), the vendor of services is listed in the “Provider Name” field instead of the attending health care professional while the attending health care professional is not listed on the DTR at all. MHP should improve documentation to clearly and consistently indicate what providers are notified orally and in writing, indicate on the DTR all the parties receiving the DTR, and have the attending health care professional’s name on the DTR. **(Recommendation #4)** [Also see §438.404 (contract section 8.2.2.C)]

Minnesota Statutes, section 62M.05, subdivision 3a(c), also states the written notification of denial must include the principal reason for the determination. MHP changed the DTR process in 2007 so that DTRs come through the CCMS system. The DTRs in 2008 do not specify the action the MCO has taken since they do not indicate if the service was denied, terminated or reduced. The DTR states it is a notice of action regarding “*Denial/Reduction/Termination of Service*”. In addition, in the box labeled Reason for Action, abbreviations are used so that the enrollee may not understand the reason for the action. For example, a file from April 2008 had the reason “*NMN:0308 DNY RECORDS DONT SUP CARE IS NEEDED*”. A corrective action plan was put in place by MHP in August 1, 2008 which is outside of the audit time period. MHP must clearly indicate on the DTR the determination (whether it is a denial, termination, or reduction) and the reason for the determination. **(Deficiency #5)** [Also see §438.404 (contract section 8.2.1. B)]

Subd. 4. Minnesota Statutes, section 62M.05, subdivision 3a(c), states that an HMO must have written procedures to address the failure of a provider or enrollee to provide the necessary information for review. The MHP policy entitled *Service Authorization* states that if an enrollee or provider will not release the necessary information for MHP to make a medical necessity determination within 14 calendar days, MHP may deny the request for insufficient information. The *Extension Policy* states that an extension may be granted for an additional 14 calendar days. The two policies are inconsistent. For Medicaid plans, the extension policy (for BBA) and the lack of information policy (for 62M) should be consistent. MHP stated their actual process is to deny unless the enrollee or provider requests the extension. No files reviewed contained an extension. MHP must combine its processes for lack of information and extension and state in the policy/procedure MHP’s actual process. **(Mandatory Improvement #4)**  
[Also see §438.404(c)(4)) (contract section 8.2.2.D)]

**Minnesota Statutes, Section 62M.06. Appeals of Determinations not to Certify**

Subd. 1.	Procedures for Appeal	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subd. 2.	Expedited Appeal	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subd. 3.	Standard Appeal		
	(a) Appeal resolution notice timeline	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
	(b) Documentation requirements	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
	(c) Review by a different physician	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
	(d) Time limit in which to appeal	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
	(e) Unsuccessful appeal to reverse determination	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
	(f) Same or similar specialty review	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
	(g) Notice of rights to External Review	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subd. 4.	Notifications to Claims Administrator	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subd. 6.	Physician consultants.	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met

Subd. 3(a). Minnesota Statutes, section 62M.06, subdivision 3(a), states the health plan must notify the enrollee and the attending health care professional of the appeal determination. MDH reviewed 14 clinical appeals. Twelve clinical appeal DTRs did not document that a copy was sent to the attending health care professional. MHP stated (and file review confirmed) that DTRs are generated from its CCMS system, the same system that generates DTRs for the initial service authorization denials. However, the current DTR does not inform the enrollee that the attending health care professional also receives the DTR. **(Recommendation #4)**  
[Also see §438.404 (contract section 8.2.2.C.)]

Subd. 3 (f). Minnesota Statutes, section 62M.06, subdivision 3 (f), states that if a determination is appealed for clinical reasons, the plan must ensure that a physician in the same or similar specialty as typically manages the condition, procedure or treatment is reasonably available to review the case. File review confirmed that MHP appropriately seeks consultation through appropriate specialty providers. However, UM policies and procedures did not describe under what circumstances and through what methodology a physician consultant will be chosen. **(Recommendation #9)**

**Minnesota Statutes, Section 62M.08. Confidentiality**

Met Not Met

**Minnesota Statutes, Section 62M.09. Staff and Program Qualifications**

Subd. 1.	Staff Criteria	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subd. 2.	Licensure Requirement	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subd. 3.	Physician Reviewer Involvement	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subd. 3a.	Mental Health and Substance Abuse Review	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subd. 4.	Dentist Plan Reviews	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subd. 4a.	Chiropractic Reviews	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subd. 5.	Written Clinical Criteria	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subd. 6.	Physician Consultants	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met

- Subd. 7. Training for Program Staff Met Not Met
- Subd. 8. Quality Assessment Program Met Not Met

**Minnesota Statutes, Section 62M.10. Accessibility and on-site Review Procedures**

- Subd. 1. Toll-free Number Met Not Met
- Subd. 2. Reviews during Normal Business Hours Met Not Met
- Subd. 7. Availability of Criteria Met Not Met

**Minnesota Statutes, Section 62M.11. Complaints to Commerce or Health**

- Met Not Met

**Minnesota Statutes, Section 62M.12. Prohibition on Inappropriate Incentives**

- Met Not Met

**Minnesota Statutes, Section 62D.12. Prohibited Practices**

- Subd. 19. Coverage of service Met Not Met

**Minnesota Statutes, Section 62A.25. Reconstructive Surgery**

- Subd. 2. Required coverage Met Not Met

Subd. 2. Minnesota Statutes, section 62A.25, subdivision 2, states that the health plan must provide benefits for reconstructive surgery when such service is incidental to or follows surgery resulting from injury, sickness or other diseases of the involved part or when such service is performed on a covered dependent child because of congenital disease or anomaly which has resulted in a functional defect. The MHP Policy entitled “*Reconstructive/Cosmetic Procedures*” is not consistent with the law since it states that “reconstructive surgery is covered when incidental to or follows surgery resulting from injury, sickness or other diseases of the involved part because of congenital disease or anomaly which resulted in a functional defect as determined by the attending physician.” MHP sent back a revised policy with the correct language with a memo saying that in the last revision with cutting and pasting, some words were left out. MDH asked MHP to have a list of all reconstructive surgery denials for the past three years. Only one denial was identified by MHP in the three years of the exam period. A sample of six reconstructive surgery files was reviewed (one denial and five approvals) to determine compliance with the law. All files reviewed showed that MHP is following the law in its utilization review of reconstructive surgery. MHP must revise its reconstructive surgery policy to be consistent with the law. **(Mandatory Improvement #5)**

## **VI. Participating Entity Interviews**

MDH visited Hennepin County Medical Center, a Joint Commission accredited credentialing delegate and North Point, a new credentialing delegate as of January 2008. Files were reviewed and their credentialing processes were discussed at both organizations.

## **VII. Recommendations**

1. To better comply with Minnesota Rules, part 4685.1110, subpart 1, MHP should expand upon its explanation of MHP's organizational quality committee structure, quality communication system, and the scope of the quality assurance program in the quality assurance plan.
2. To better comply with Minnesota Rules, part 4685.1110, subpart 11, MHP should clearly indicate in the credentialing and recredentialing policy/procedure what committee dates MHP uses and inputs into their credentialing system for the delegated entities.
3. To better comply with Minnesota Rules, part 4685.1120, MHP should review its process of developing two annual evaluations to look for and reduce redundancies and to provide one comprehensive annual evaluation that both summarizes and analyzes the individual quality and utilization monitoring data and improvement activities as well critically analyzing the overall quality program for effectiveness.
4. To better comply with 42 CFR 438.404 (contract section 8.2.2.C.), Minnesota Statutes, section 62M.05, subdivision 3 (a), and Minnesota Statutes, section 62M.06, subdivision 3(a), MHP should improve documentation to clearly and consistently indicate what providers are notified orally and in writing, indicate on the DTR all the parties receiving the DTR, and have the attending health care professional's name on the DTR.
5. To better comply with 42 CFR 438.404 (c)(1) (contract section 8.2.2.A), MHP should continue to work with DHS to improve and simplify the DTR process for previously authorized services.
6. To better comply with Minnesota Rules, part 4685.1010, subpart 2, MHP should develop and implement written guidelines that employ quality improvement methodology to assess geographic and timely access for its enrollees.
7. To better comply with Minnesota Rules, part 4685.1010, subpart 2, J, MHP should consistently and clearly describe under what circumstances a referral is necessary, the procedures for requesting a referral and the procedures for appealing the plan's determination.

8. To better comply with Minnesota Statutes, section 62M.05, subdivision 1, MHP should combine the numerous policies into one encompassing UM policy to better coordinate and improve UM processes.
9. To better comply with Minnesota Statutes, section 62M.06, subdivision 3 (f), MHP should revise its procedures to describe under what circumstances and through what method a physician consultant of the same or similar specialty will be chosen.

### **VIII. Mandatory Improvements**

1. To comply with Minnesota Rules, part 4685.1110, subpart 11, MHP must revise its organizational provider policy to be consistent with the community standard and its internal contracting process.
2. To comply with 42 CFR 438.400(a)(3) (contract section 8.1.3), MHP must revise its Appeal and Grievance, and Medical Administration (as applicable) policies and procedures to include all requirements of law and contract.
3. To comply with 42 CFR 438.404(c)(3) (contract section 8.2.2.C), and Minnesota Statutes, section 62M.05, subdivision 3a(a), MHP must revise its policy to accurately reflect ten business days or 14 calendar days and MHP should be consistent in their terminology in all the policies (business days versus calendar days).
4. To comply with 42 CFR 438.404 (c)(4) (contract section 8.2.2D), and Minnesota Statutes, section 62M.05, subdivision 3a(c), MHP must combine its processes for lack of information and authorization extension and state in the policy/procedure MHP's actual process.
5. To comply with Minnesota Statutes, section 62A.25, subdivision 2, MHP must revise its reconstructive surgery policy to be consistent with the law.

### **IX. Deficiencies**

1. To comply with Minnesota Rules, part 4685.1110, subpart 11, MHP must ensure the length of the recredentialing cycle is within the 36-month time frame.
2. To comply with Minnesota Rules, part 4685.1110, subpart 11, in the recredentialing process, MHP must have mechanisms in place to evaluate practitioner-specific complaints and adverse events and the practitioner's history of issues at least every six months.

3. To comply with Minnesota Rules, part 4685.1120, subpart 1, MHP must include in the Quality Evaluation an analysis of the data collected to identify problems or potential problems.
4. To comply with Minnesota Rules, part 4685.1130, subpart 2, MHP must give a detailed description of the proposed quality activities that includes measurable objectives and time frames in the annual work plan.
5. To comply with 42 CFR 438.404(b) (contract section 8.2.1B), and Minnesota Statutes, section 62M.05, subdivision 3a(c), MHP must clearly indicate on the DTR the determination (whether it is a denial, termination or reduction) and the reason for the determination.