

Minnesota Department of Health  
Compliance Monitoring Division  
Managed Care Systems Section



## **Final Report**

# **Metropolitan Health Plan**

Quality Assurance Examination  
For the period:  
May 1, 2008 to April 30, 2011

*Final Issue Date:*  
December 22, 2011

Examiners:  
Elaine Johnson, RN, BS, CPHQ  
Susan Margot, MA

**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 law. MDH has found that MHP is compliant with Minnesota and 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 noncompliant policies, documents or procedures where evidence of actual compliance is found in relevant files or where the file sample did not include any instances of the specific issue of concern. The “Recommendations” listed are areas where, although compliant with law, MDH identified improvement opportunities.

**To address recommendations, MHP should:**

Include an analysis of all delegated functions in its audit summary of the delegate.

Track complaints regarding MHP staff for improvement purposes and categorize them as “quality of service” complaints.

Utilize the same spreadsheet format for all types of organizational providers and the spreadsheet should contain all the information the plan is required to collect.

Include the specific disease management outcome measures in the work plan as well as specific interventions put in place.

Document its initiative(s) to improve network access in network reporting and the annual evaluation.

**To address mandatory improvements, MHP must:**

Improve documentation in its Quality Management Committee minutes to clearly reflect approval of the quality documents.

Revise its policy/procedure, PVR0005 *Provider Availability and Accessibility*, to state the following:

- The 30 mile or 30 minute geographic accessibility standard for mental health services.
- The method, miles or minutes, used to determine geographic access and the description of the current zip code process.
- The standards and how it defines, specifies or assesses network access as its policy purports.
- A clear description of women’s health care providers and Direct Access.

Revise its policy/procedure PVR0004, *Provider Availability and Accessibility*, to state that it will ensure 24 hours per day and seven days per week access through a 24 hour nurse line and remove any outdated statements.

Revise its policy procedure UMR0032, *Pharmacy Nonformulary Requests*, to state that it is required to cover non-formulary drugs for emotional disturbance or mental health; will not charge a special deductible, co-payment or coinsurance; and that the authorization may be extended annually.

Revise its policy/procedure PVR0001, *Provider Termination: Continuity of Care*, to state the following:

- Who will identify enrollees with special needs, risks or circumstances.
- What criteria will be used to determine special need.
- How enrollees may access specialty services.
- How it defines “in good standing.”

MHP must also revise policy/procedure UMR0031, *Continuity-Transitional Services*, to state it must grant a request for authorization unless the enrollee does not meet the criteria.

Revise its *Appeal Policy* (UMR0027) to include the more stringent same/similar language from the statute rather than just citing the statute.

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

Revise delegation documents to state: the list of allowed uses; a description of the safeguards against inappropriate use; stipulations that subdelegates will have similar safeguards; that the delegate provides individuals with access to their PHI; informs MHP if inappropriate uses of the information occur; and ensures that PHI is returned, destroyed or protected if the delegation agreement ends.

Perform the following organizational credentialing and recredentialing functions:

- Confirm that the provider is in good standing with state and federal regulatory bodies;
- Verify licensure, accreditation, and current liability insurance and include copies of the verification in the file;
- Include documentation that provider complaints are taken into consideration;
- Provide documentation of the previous credentialing committee date to determine recredentialing time line.

Include the correct telephone number for MDH.

Provide a complete summary of the review findings, qualifications of the reviewers, including any license, certification, or specialty designation and the relationship between the enrollee's diagnosis and the review criteria used as the basis for the decision, including the specific rationale for the reviewer's decision in its appeal notifications in which the denial is upheld upon appeal and include this language in its appeals policy.

Perform a comprehensive evaluation of its provider network (including delegated networks) of both the geographic accessibility and timely availability of providers. The evaluation must, consistent with Minnesota Rules, part 4685.1120, document a methodology for gathering data, analysis of the data, identification of any issues, interventions or the rationale if no intervention and the reporting mechanism for sharing the results of network monitoring with the entire organization.

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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Date

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## I. Introduction

### A. History:

Metropolitan Health Plan (MHP), a not-for-profit, state-certified HMO, was licensed by the state in October 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.

Voluntary Medical Assistance enrollment began in 1984 with 800 enrollees. MHP was administered by a staff of two, borrowed from HCMC. In 1985, MHP's staff expanded to 25 employees in anticipation of significant growth. The growth was projected due to the Minnesota Department of Human Services demonstration project. The project mandated Medical Assistance recipients' enrollment into prepaid managed care programs.

In 1986, MHP developed Healthline (later renamed *HealthConnection*), an after-hours phone triage center for all members, staffed by registered nurses. 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 an original participant of the Minnesota Senior Health Options (MSHO) program.

Today, MHP provides coverage for MinnesotaCare, Medical Assistance, Minnesota Senior Care Plus, and Minnesota Senior Health Options enrollees residing in Anoka, Carver, Hennepin, and Scott counties. MHP also covers Special Needs BasicCare enrollees residing in Hennepin County through its Cornerstone Solutions plan.

The seven elected Hennepin County Commissioners are responsible for the oversight of MHP and delegate operational responsibility to Hennepin County Administration.

MHP uses a large network of medical centers and clinics and more than 2,500 primary and specialty physicians. Contracted providers offer a full range of services. MHP has contracts with its providers and has no ownership interest in administrative offices, clinics, physician groups, hospitals or other service providers or facilities.

B. Membership: MHP self-reported enrollment as of December 31, 2010 consisted of the following:

<b>Product</b>	<b>Enrollment</b>
<b><i>Minnesota Health Care Programs-Managed Care (MHCP-MC)</i></b>	
Families & Children (PMAP)	13,604
MinnesotaCare	2,729
Minnesota Senior Care (MSC+)	657

Minnesota Senior Health Options (MSHO)	692
Special Needs Basic Care (SNBC)	458
<b>Medicare</b>	
Medicare Advantage	46
<b>Total</b>	<b>18,186</b>

- C. Onsite Examination Dates: May 23, 2011 to May 26, 2011
- D. Examination Period: May 1, 2008 to April 30, 2011  
File Review Period: March 1, 2010 to February 28, 2011  
MHP MDH Examination Opened: March 9, 2011
- 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. A deficiency will not be based solely on one outlier file if MDH had sufficient evidence obtained through: 1) file review; 2) policies and procedures; and 3) interviews that a plan's overall operation is compliant with an applicable law.

## II. Quality Program Administration

### 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 type="checkbox"/> Met            | <input checked="" 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 type="checkbox"/> Met            | <input checked="" 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. 3. Minnesota Rules, part 4685.1110, subpart 3, states the governing body shall designate a quality assurance entity to be responsible for operation of quality assurance program activities. This entity shall maintain records of its quality assurance activities and report quality activities to

the governing body at least quarterly. MHP’s Quality Management Committee is the designated quality assurance entity. One function of that committee is to approve the quality documents, specifically the written quality program description, annual work plan and the annual evaluation. MHP’s Quality Management Committee minutes do not consistently and clearly indicate the committee reviewed and approved these documents. MHP must improve documentation in its Quality Management Committee minutes to better reflect review and approval of the quality documents. **(Mandatory Improvement #1)**

MDH commends MHP for its high caliber reporting to its governing body of the quality activities.

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

<b>Delegated Entities and Functions</b>								
	<b>UM</b>	<b>UM Appeals</b>	<b>QM</b>	<b>Grievances</b>	<b>Cred</b>	<b>Claims</b>	<b>Network</b>	<b>Care Coord</b>
Delta Dental	x	x		x	x	x	x	
Mayo Health Systems					x			
CareMark						x	x	
Meridian								x
TouchStone								x

One of the functions delegated to Delta Dental is that of network management. Geographic access analysis was completed but was not included in Delta Dental’s 2009 or 2010 audit summary. MHP’s oversight of CareMark’s delegated network management function was not included in the audit summary. MHP may want to include the analysis of all delegated functions in its audit summaries. **(Recommendation #1)** There was no oversight of CareMark’s claims function for 2010. Staff stated claims oversight for 2010 was in process. MDH will follow up with this at mid-cycle.

If the delegation arrangement includes the use of protected health information (PHI) by the delegate, the delegation document must state (consistent with HIPAA regulation) the list of allowed uses; a description of the safeguards against inappropriate use; stipulations that subdelegates will have similar safeguards; that the delegate provides individuals with access to their PHI; informs the organization if inappropriate uses of the information occur; and ensures that PHI is returned, destroyed or protected if the delegation agreement ends. None of these requirements were listed in the Touchstone or Meridian delegation agreements. **(Deficiency #1)**

In addition, within 12 months of implementation, the delegation agreement must include, at least, semiannual reporting from the delegate to the organization. The plan must document substantive evaluation of regular reports, including thorough review and analysis. The delegation agreements



were signed in 2011 and did not include any reporting requirements. MDH will follow up on reporting provisions of the delegation agreements and MHP evaluation at mid-cycle.

Subp. 9. Minnesota Rules, part 4685.1110, subpart 9, states the quality program must conduct ongoing evaluation of enrollee complaints related to quality of care. A total of five quality of care complaint/grievance files were reviewed. All quality of care files were reviewed according to the quality of care policy/procedure.

Three grievance files involved allegations regarding MHP employees. The cases were appropriately investigated and documented. However, the cases were not considered quality complaints. MHP could track these complaints for improvement purposes and categorize them as “quality of service” complaints. **(Recommendation #2)**

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 50 credentialing and recredentialing files (including physician and allied providers) from MHP as follows:

<b>Credentialing and Recredentialing File Review</b>				
<b>File Source</b>	<b># Reviewed Physician</b>	<b># Reviewed Allied</b>	<b># Reviewed Organizational</b>	<b>Total # Reviewed</b>
Initial Credentialing	8	8	0	16
Recredentialing	8	8	18	34
<b>Total</b>	<b>16</b>	<b>16</b>	<b>18</b>	<b>50</b>

Recredentialing:

The standards require provider credentialing and recredentialing, including ongoing monitoring of complaints and quality issues between recredentialing cycles. One quality of care file was closed with no quality of care finding, but with a remark to flag the provider’s credentialing file to follow for similar issues. MHP provided the email requesting the flag; however neither the email nor flag were noted in the recredentialing file.

Organizational Credentialing:

Organizational credentialing standards require that the plan confirms that the provider is in good standing with state and federal regulatory bodies. It also requires verification of licensure and accreditation. Further, organizational providers need to be re-credentialed every 36 months with documentation that internal provider complaints are taken into consideration in the recredentialing process. In MHP’s 18 organizational provider files:

- No documentation in 18 files that state and federal regulatory bodies were checked
- No documentation in 18 files that provider complaints were taken into consideration
- No copy confirmation of licensure in three files

- Unable to determine in the 18 files the recredentialing timeline of 36 months since the previous credentialing committee date was not available
- No copy documentation in six files of current liability insurance

**(Deficiency #2)**

Organizational provider file lists were submitted to MDH using three different formats. MHP should utilize the same format for all types of providers and the spreadsheet should contain all the information the plan is required to collect. **(Recommendation #3)**

MHP submitted two corrective action plans dated March 22, 2010 and February 23, 2011, enumerating eight areas of correction, of which some of the above bulleted areas were included. However, given the recredentialing cycle, there were no files showing that the plan was successful in correcting the issues.

**Minnesota Rules, Part 4685.1115. Activities**

- |          |                            |   |                                  |
|----------|----------------------------|---|----------------------------------|
| Subp. 1. | Ongoing Quality Evaluation | <input checked="" type="checkbox"/> Met | <input type="checkbox"/> Not Met |
| Subp. 2. | Scope                      | <input checked="" type="checkbox"/> Met | <input type="checkbox"/> Not Met |

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

- |          |                                 |   |                                  |
|----------|---------------------------------|---|----------------------------------|
| Subp. 1. | Problem Identification          | <input checked="" type="checkbox"/> Met | <input 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 |

MDH commends MHP on the improvements made to its annual evaluation. The 2010 evaluation was a very thorough document with qualitative and quantitative analysis and identified barriers and next steps.

**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 checked="" type="checkbox"/> Met | <input type="checkbox"/> Not Met |

MDH commends MHP for the improvements made to its annual quality work plan. MHP may want to include the specific disease management outcome measures in the work plan as well as specific interventions put in place. **(Recommendation #4)**

### III. Grievance Systems

MDH examined MHP’s Minnesota Health Care Programs-Managed Care (MHCP-MC) grievance system for compliance with the federal law (42 CFR 438, subpart F) and the DHS 2009 Model Contract, Article 8.

MDH reviewed a total of 46 grievance system files:

<b>Grievance System File Review</b>	
<b>File Source</b>	<b># Reviewed</b>
<b>Grievance</b>	<b>30</b>
<b>Non Clinical Appeals</b>	<b>8</b>
<b>State Fair Hearings</b>	<b>8</b>
<b>Total</b>	<b>46</b>

[Clinical appeals are evaluated under utilization review statutes. See section V.]

#### Section 8.1. §438.402 General Requirements

Sec. 8.1.1. Components of Grievance System Met Not Met

MDH commends MHP on thoroughly investigated grievances. MHP follows up to ensure complete resolution.

#### Section 8.2. §438.408 Internal Grievance Process Requirements

Sec. 8.2.1. §438.402 (b) Filing Requirements Met Not Met

Sec. 8.2.2. §438.408 (b)(1) Timeframe for Resolution of Grievances  
Met Not Met

Sec. 8.2.3. §438.408 (c) Timeframe for Extension of Resolution of Grievances  
Met Not Met

Sec. 8.2.4. §438.406 Handling of Grievances

- (A) §438.406 (a)(2) Written Acknowledgement Met Not Met
- (B) §438.416 Log of Grievances Met Not Met
- (C) §438.402 (b)(3) Oral or Written Grievances Met Not Met
- (D) §438.406 (a)(1) Reasonable Assistance Met Not Met
- (E) §438.406 (a)(3)(i) Individual Making Decision Met Not Met
- (F) §438.406 (a)(3)(ii) Appropriate Clinical Expertise Met Not Met

Sec. 8.2.5. §438.408 (d)(1) Notice of Disposition of a Grievance.  
(A) §438.408 (d)(1) Oral Grievances Met Not Met

(B) §438.408 (d)(1) Written Grievances Met Not Met

§438.404(a). 42 CFR 438.404 (a) (contract sec. 8.2.5 (B)), states the MCO must inform the Enrollee of options for further assistance through the Managed Care Ombudsman and/or review by the Minnesota Department of Health. In eight grievances, written responses provided an incorrect phone number for MDH. The correct numbers are 651-201-5176 or 800-657-3916. MHP must provide enrollees with the correct telephone number for MDH. **(Deficiency #3)**

**Section 8.3. §438.404 DTR Notice of Action to Enrollees**

Sec. 8.3.1. General requirements Met Not Met

Sec. 8.3.2. §438.404 (c) Timing of DTR Notice

(A) §438.210 (c) Previously Authorized Services Met Not Met

(B) §438.404 (c)(2) Denials of Payment Met Not Met

(C) §438.210 (c) Standard Authorizations Met Not Met

(D) §438.210 (d)(2)(i) Expedited Authorizations Met Not Met

(E) §438.210 (d)(1) Extensions of Time Met Not Met

(F) §438.210 (d) Delay in Authorizations Met Not Met

Sec. 8.2.3. §438.420 (b) Continuation of Benefits Pending Decision Met Not Met

§438.210 (c). 42 CFR §438.210 (c) (contract section 8.3.2 (C)), states for standard authorization decisions the MCO must notify the attending health care professional of the denial by telephone or fax within one working day and provide the written notice of denial (DTR) within ten business days. In one UM denial file there was no evidence of a telephone or fax notification within one business day to the attending health care professional. In that same file, the written notification time line criteria of ten days was exceeded (35 days).

**[Also see 62M.05, subdivision 3a(a) and (c)]**

It was noted by MDH that in the DTRs regarding partial denial of psychology hours, MHP gave an excellent explanation on the DTR that would be very understandable to enrollees.

**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) Expedited Resolution of Oral and Written Appeals

Met Not Met

(B) §438.410 (c) Expedited Resolution Denied Met Not Met

(C) §438.410 (a) Expedited Appeal by Telephone Met Not Met

Sec. 8.4.4. §438.408 (c)	Timeframe for Extension of Resolution of Appeals	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Sec. 8.4.5. §438.406	Handling of Appeals		
(A) §438.406 (b)(1)	Oral Inquiries	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
(B) §438.406 (a)(2)	Written Acknowledgement	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
(C) §438.406 (a)(1)	Reasonable Assistance	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met .
(D) §438.406 (a)(3)	Individual Making Decision	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
(E) §438.406 (a)(3)	Appropriate Clinical Expertise		
	[See Minnesota Statutes, sections 62M.06, subd. 3(f) and 62M.09]		
(F) §438.406 (b)(2)	Opportunity to Present Evidence	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
(G) §438.406 (b)(3)	Opportunity to Examine the Case File	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
(H) §438.406 (b)(4)	Parties to the Appeal	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
(I) §438.410(b)	Prohibition of Punitive Action	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Sec. 8.4.6.	Subsequent Appeals	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Sec. 8.4.7. §438.408 (d)(2) and (e)	Notice of Resolution of Appeals		
(A) §438.408 (d)(2) and (e)	Written Notice Content	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
(B) §438.210 (c)	Appeals of UM Decisions	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
(C) §§438.210 (c) and .408(d)(2)(ii)	Telephone Notification of Expedited Appeals	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
	[Also see Minnesota Statutes, section 62M.06, subd. 2]		
(D) §438.408 (d)(2) and (e)	Notification contents in unsuccessful UM appeal	<input type="checkbox"/> Met	<input checked="" type="checkbox"/> Not Met
	[Also see Minnesota Statutes 62M.06, subd. 3(e)]		
Sec. 8.4.8. §438.424	Reversed Appeal Resolutions	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met

**[See Minnesota Statutes, section 62M.06, subdivision 3(f)]**

§438.408 (d)(2) and (e). 42 CFR, §438.408 (d)(2) and (e) (contract section 8.4.7(D)). DHS legal requirements for the Grievance section (contract section 8.1.3) require that MCO's must meet the requirements of Minnesota Statutes, section 62M.06. Minnesota Statutes, section 62M.06, subdivision 3(e), states, in pertinent part, that an attending healthcare professional or enrollee who has been unsuccessful in an attempt to reverse a determination not to certify shall be provided a complete summary of the review findings, qualifications of the reviewers, including any license, certification, or specialty designation and the relationship between the enrollee's diagnosis and the review criteria used as the basis for the decision, including the specific rationale for the reviewer's decision. In 26 out of 30 files (all the files where the denial was upheld upon appeal) the qualifications of the reviewer were not included in the notification nor was this included in the appeals policy. **(Deficiency #4) [Also see Minnesota Statutes, section 62M.06, subdivision 3(e)]**

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

Met Not Met

**Section 8.9. §438.408 (f) State Fair Hearings**

Section 8.9.2. §438.408 (f) Standard Hearing Decisions Met Not Met

Section 8.9.5. §438.420 Continuation of Benefits Pending Resolution of State Fair Hearing

Met Not Met

Section 8.9.6. §438.424 Compliance with State Fair Hearing Resolution

Met Not Met

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

Subp. 1. Record Requirements Met Not Met

Subp. 2. Log of Complaints (§438.416 (a)) Met Not Met

**IV. Access and Availability**

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

Subd. 1. Primary Care; Mental Health Services; General Hospital Services

Met Not Met

Subd. 2. Other Health Services Met Not Met

Subd. 3. Exception Met Not Met

Subd. 1. Minnesota Statutes, section 62D.124, subdivision 1, states that the plan must ensure the maximum travel distance (or time) must be the lesser of 30 miles or 30 minutes to the nearest provider of primary care, mental health and general hospital services. The plan must designate which method is used. MHP’s policy/procedure PVR0005 states that Primary Care and hospitals will be within 30 miles or 30 minutes. In addition, the policy/procedure is not consistent with Minnesota law because:

- It does not discuss mental health services, nor does it define primary care to include mental health services.
- It does not designate which method, miles or minutes, is used to determine geographic access. The policy/procedure does not describe the zip code process currently used by MHP.

The policy/procedure also states that MHP “Establishes and maintains provider network access standards” that define the type of provider that may be used, identify the types of mental health providers in the network, specify the types of providers who may serve as a member’s primary care “physician,” and assess other means of transportation members rely on.

- It does not state what these standards are or how MHP defines, specifies or assesses network access.

The policy/procedure states that MHP provides or arranges for necessary specialist care and in particular gives women the option of direct access to a women’s health specialist within the network. Minnesota Rules, part 4685.0100, subpart 12a, states that an OB/GYN may serve as a primary care provider. Minnesota Statutes, section 62Q.52, states that female enrollees may have direct access to an OB/GYN without a referral for annual preventive OB/GYN care, maternity care, or care of acute gynecological conditions.

- The policy/procedure suggests that a women’s health care provider is specialty care and it does not clearly explain Direct Access.

**(Mandatory Improvement #2)**

Subds. 1 and 2. Minnesota Statutes, section 62D.124, subdivisions 1 and 2, requires that the nearest provider of primary care, mental health and general hospital services must be the lesser of 30 miles or 30 minutes. All other services must be within 60 miles or 60 minutes. MHP has developed an alternative measure of geographic access using zip codes--still based upon statutory standards--recognizing that nearly its entire service area falls within a 30 mile radius.

MHP provided its data table and meeting minutes showing discussion of its methodology. In interviews, MDH staff verbally identified a gap in one zip code. However no report showed analysis of the data, identification of any issues, interventions or outcomes of geographic access monitoring. MHP must annually assess the geographic accessibility of its provider network. Minnesota Rules, part 4685.1120, provides the framework for the assessment: ongoing monitoring, evaluation of data, identification of issues, analysis, corrective action and communication of the results. **(Deficiency #5) [Also see Minnesota Rules, part 4685.1010, subpart 2, below]**

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

Subp. 2.	Basic Services	<input type="checkbox"/> Met	<input checked="" 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 type="checkbox"/> Met	<input checked="" type="checkbox"/> Not Met

Subp. 2. Minnesota Rules, part 4685.1010, subpart 2, states the plan must develop and implement written standards or guidelines that assess the capacity of each provider network to provide timely access to health care services.

MHP’s policy/procedure PVR 0004, *Provider Availability and Accessibility*, includes a detailed description of appointment availability guidelines and a survey process with reporting to contracting, medical administration, and quality management areas. MHP did not provide its work papers, but provided access and availability survey reports to the Utilization Committee dated November 2009, May 2010 and January 2011. The 2009 Annual Evaluation stated, “85-100% of providers surveyed were able to provide services within the established guidelines.” The report and committee minutes did not include any analysis, identify gaps in timely access or identify interventions. The results of the provider survey were not sufficiently detailed to permit conclusions about the network capacity or to facilitate an improvement initiative.

In addition, MHP delegates network management to Caremark. Caremark prepared a list of its network pharmacies, thoroughly analyzed the data and presented their findings to MHP's pharmacy manager. The pharmacy manager signed a summary concluding there were no gaps in the pharmacy network. There is no indication how this information is reported to the organization as a whole, for example through the quality or delegation oversight committees or in the annual evaluation.

MHP must perform a comprehensive evaluation of its provider network (including delegated networks) of both the geographic accessibility and timely availability of providers. The evaluation must document a methodology for gathering data, analyzing the data, identification of any issues, interventions or the rationale if no intervention and the communication mechanism for sharing the results of network monitoring with the entire organization. **(Deficiency #5)**  
**[Also see §62D.124, subdivisions 1 and 2]**

MHP described its process to increase mental health utilization for enrollees in their Cornerstone product. MHP focused on increased access, identified community mental health providers, enhanced mental health provider payments and contracted with 90 percent of identified providers. MDH commends MHP for improved mental health access. The process should be documented in network reporting and the Annual Evaluation. **(Recommendation #5)**

Subp. 2. Minnesota Rules, part 4685.1010, subpart 2, states that primary and specialty care must be available and accessible 24 hours per day, seven days per week within the service area. The plan must have written standards for regularly scheduled after hours clinics, a 24-hour answering service with standards for call-back times based on what is medically appropriate to each situation, back-up coverage referrals to urgent care centers, and specialty physician services to which enrollees do not have continued access. Policy/procedure PVR0004, *Provider Availability and Accessibility*, states the principal of access 24 hours per day and seven days per week, but does not indicate how MHP will ensure 24 hour, seven days per week. MHP offers *HealthConnect*, a 24 hour nurse line, to all its members. MHP should revise its policy/procedure to state that it ensures 24 hours per day, seven days per week access through a 24 hour nurse line.

In addition, policy/procedure PVR0004 states after-hour's access is determined by quality management site visits. This information is outdated. MHP must remove any outdated statements. **(Mandatory Improvement #3)**

**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

Subds. 2 - 4. Minnesota Statutes, section 62Q.527, subdivisions 2 through 4, require coverage for antipsychotic drugs to treat emotional disturbance or mental illness, regardless of whether the drug is in the health plan’s drug formulary, if the prescribing provider certifies that the drug must be dispensed as written to provide maximum medical benefit to treat the patient. MHP’s policy UMR0032, *Pharmacy Nonformulary Requests*, references this statute, however, the policy/procedure does not state the requirement to cover non-formulary drugs for emotional disturbance or mental health; does not state the plan is prohibited from charging a special deductible, co-payment or coinsurance; or that the authorization may be extended annually. **(Mandatory Improvement #4)**

**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

Subds. 1, 1a, 2. Minnesota Statutes, section 62Q.56, subdivision 1, states the plan must explain how it will provide for continuity of care including: how it will inform affected enrollees about the termination; about other participating providers and the transfer of care; about the transfer of care for enrollees with special needs, risks or circumstances; about who will identify enrollees with special needs or risk and what criteria will be used; and about how continuity of care will be provided. Policy/procedure PVR0001, *Provider Termination: Continuity of Care*, states MHP will pull a report of affected members and the member notice will include instruction on the transfer procedures. The policy/procedure also states members will have the option to continue services with the provider/practitioner based upon MHP’s open access for specialty care (refer to

Provider Geographic Access policy). The policy/procedure further states, “Service authorizations are not needed for accessing specialty physician care from any Minnesota licensed provider or MHP contracted provider in good standing.” The policies/procedures are not consistent with Minnesota law for the following reasons:

- It does not state who will identify enrollees with special needs, risks or circumstances.
- It does not state what criteria will be used to determine special need.
- It contradicts the cited reference, PVR0005, *Provider Geographic Accessibility*, that states, “MHP arranges for specialty care outside of the provider network when network providers are unavailable or inadequate to meet a member’s medical needs.” It is also contradicts policy/procedure UMR0031, *Referral/Consultation by Specialist*, that states, “Enrollees can self-refer to any specialist within the network.” Enrollees must have authorization for out of network specialty services.
- It states the terminating provider must remain “in good standing.” Subdivision 1a provides that the termination is “not for cause.”
- MHP also provided UMR0031, *Continuity-Transitional Services*. It states “MHP may require the member to receive the services by an MHP Provider if such a transfer of care would not create undue hardship for the member and is clinically appropriate.” It does not state, as provided by subdivision 2, “the health plan company must grant the request for authorization unless the enrollee does not meet the criteria provided in this paragraph.”

**(Mandatory Improvement #5)**

**V. Utilization Review**

UM System File Review	
File Source	# Reviewed
<i>UM Denial Files</i>	30
<i>Clinical Appeal Files</i>	30
<b>Total</b>	<b>60</b>

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

- |          |  |   |                                  |
|----------|--|---|----------------------------------|
| Subd. 1. | Responsibility on Obtaining Certification              | <input checked="" type="checkbox"/> Met | <input type="checkbox"/> Not Met |
| Subd. 2. | Information upon which Utilization Review is Conducted | <input checked="" type="checkbox"/> Met | <input type="checkbox"/> Not Met |
| Subd. 3. | Data Elements  | <input checked="" type="checkbox"/> Met | <input type="checkbox"/> Not Met |
| Subd. 4. | Additional Information                                 | <input checked="" type="checkbox"/> Met | <input type="checkbox"/> Not Met |
| Subd. 5. | Sharing of Information                                 | <input checked="" type="checkbox"/> Met | <input type="checkbox"/> Not Met |

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

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

Subd. 3a(a). Minnesota Statutes, section 62M.05, subdivision 3a(a), states an initial determination on requests for utilization review must be communicated within 10 business days. In one file the communication of the determination exceeded 10 business days (35 days).

Subd. 3a(c). Minnesota Statutes, section 62M.05, subdivision 3a(c), states when an initial determination is made not to certify, notification must be provided by telephone, by facsimile to a verified number, or by electronic mail to a secure electronic mailbox within one working day after making the determination to the attending health care professional. In one file the attending health care professional was not notified within one working day.

[Also see 42 CFR §438.210 (c) (contract section 8.3.2 (C))]

**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 type="checkbox"/> Met	<input checked="" type="checkbox"/> Not Met
	(f) Same or similar specialty review	<input type="checkbox"/> Met	<input checked="" 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. 3(e). Minnesota Statutes, section 62M.06, subdivision 3(e), states, in pertinent part, that an attending healthcare professional or enrollee who has been unsuccessful in an attempt to reverse a determination not to certify shall be provided a complete summary of the review findings, qualifications of the reviewers, including any license, certification, or specialty designation and the relationship between the enrollee's diagnosis and the review criteria used as the basis for the decision, including the specific rationale for the reviewer's decision. In 26 out of 30 files (all the

files where the denial was upheld upon appeal) the qualifications of the reviewer were not included in the notification nor were the contents of this statute included in the appeals policy. **(Deficiency #4)**

Subd. 3(f). Minnesota Statutes, section 62M.06, subdivision 3(f), states, “In cases of appeal to reverse a determination not to certify for clinical reasons, the HMO must ensure that a physician of the HMO’s choice 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.” MHP’s *Appeal Policy* (UMR0027) states that MHP will ensure that the individual making the decision is a professional with appropriate clinical expertise in treating the member’s condition or disease as provided for in Minnesota Statutes, sections 62M.06, 62M.09 and in 42 CFR 438.406(a)(3)(ii). Rather than just citing the statute, MHP must use the more stringent language from the statute in the policy **(Mandatory Improvement #6)**.

**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               | <input checked="" type="checkbox"/> Met | <input type="checkbox"/> Not Met |
| Subd. 8.  | Quality Assessment Program               | <input checked="" type="checkbox"/> Met | <input type="checkbox"/> Not Met |

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

- |          |                                      |   |                                  |
|----------|--------------------------------------|---|----------------------------------|
| Subd. 1. | Toll-free Number                     | <input checked="" type="checkbox"/> Met | <input type="checkbox"/> Not Met |
| Subd. 2. | Reviews during Normal Business Hours | <input checked="" type="checkbox"/> Met | <input type="checkbox"/> Not Met |
| Subd. 7. | Availability of Criteria             | <input checked="" type="checkbox"/> Met | <input type="checkbox"/> 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

**VI. Recommendations**

1. To better comply with Minnesota Rules, part 4685.1110, subpart 6, MHP should include an analysis of all delegated functions in its audit summary of the delegate.
2. To better comply with Minnesota Rules, part 4685.1110, subpart 9, MHP should track complaints regarding MHP staff for improvement purposes and categorize them as “quality of service” complaints.
3. To better comply with Minnesota Rules, part 4685.1110, subpart 11, MHP should utilize the same spreadsheet format for all types of organizational providers and the spreadsheet should contain all the information the plan is required to collect.
4. To better comply with Minnesota Rules, part 4685.1130, MHP should include the specific disease management outcome measures in the work plan as well as specific interventions put in place.
5. To better comply with Minnesota Rules, part 4685.1010, subpart 2, MHP should document its initiative(s) to improve network access in network reporting and the annual evaluation.

**VII. Mandatory Improvements**

1. To comply with Minnesota Rules, part 1110, subpart 3, MHP must improve documentation in its Quality Management Committee minutes to clearly reflect approval of the quality documents.
2. To comply with Minnesota Statutes, section 62D.124, subdivision 1, MHP must revise its policy/procedure, PVR0005 *Provider Geographic Accessibility*, to state the following:
  - The 30 mile or 30 minute geographic accessibility standard for mental health services.

- The method, miles or minutes, used to determine geographic access and a description of its current zip code process.
- The standards and how it defines, specifies or assesses network access as its policy purports.
- A clear description of women’s health care providers and Direct Access.

3. To comply with Minnesota Rules, part 4685.1010, subpart 2, MHP must revise its policy/procedure PVR0004 to state that it will ensure 24 hours per day and seven days per week access through a 24 hour nurse line and remove any outdated statements.

4. To comply with Minnesota Statutes, section 62Q.527, subdivisions 2 through 4, MHP should revise its policy procedure UMR0032, *Pharmacy Nonformulary Requests*, to state that it is required to cover non-formulary drugs for emotional disturbance or mental health; will not charge a special deductible, co-payment or coinsurance; and that the authorization may be extended annually.

5. To comply with Minnesota Statutes, section 62Q.56, subdivision 1, MHP must revise its policy/procedure PVR0001, *Provider Termination: Continuity of Care*, to include the following:

- Who will identify enrollees with special needs, risks or circumstances.
- What criteria will be used to determine special need.
- How enrollees may access specialty services.
- How it defines “in good standing.”

MHP must also revise policy/procedure UMR0031, *Continuity-Transitional Services*, to state it must grant a request for authorization unless the enrollee does not meet the criteria.

6. To comply with Minnesota Statutes, section 62M.06, subdivision 3(f), MHP must revise its *Appeal Policy* (UMR0027) to include the more stringent same/similar language from the statute rather than just citing the statute.

### **VIII. Deficiencies**

1. To comply with Minnesota Rules, part 4685.1110, subpart 6, MHP’s delegation document must state: the list of allowed uses; a description of the safeguards against inappropriate use and stipulations that subdelegates will have similar safeguards; that the delegate provides individuals with access to their PHI; informs MHP if inappropriate uses of the information occur; and ensures that PHI is returned, destroyed or protected if the delegation agreement ends.

2. To comply with Minnesota Rules, part 4685.1110, subpart 11, MHP must, for organizational credentialing and recredentialing:

- Confirm that the provider is in good standing with state and federal regulatory bodies;
- Verify licensure, accreditation, and current liability insurance and include copies of the verification in the file;
- Include documentation that provider complaints are taken into consideration;

- Provide documentation of the previous credentialing committee date to determine recredentialing time line.
3. To comply with 42 CFR 438.404 (a), MHP written responses to enrollees must include the correct telephone number for MDH.
  4. To comply with 42 CFR, §438.408 (d)(2) and (e) and Minnesota Statutes, section 62M.06, subdivision 3(e), MHP must provide a complete summary of the review findings, qualifications of the reviewers, including any license, certification, or specialty designation and the relationship between the enrollee's diagnosis and the review criteria used as the basis for the decision, including the specific rationale for the reviewer's decision in its appeal notifications in which the denial is upheld upon appeal and include this language in its appeals policy.
  5. To comply with Minnesota Statutes, section 62D.124, subdivisions 1 and 2, and Minnesota Rules, part 4685.1010, subpart 2, MHP must perform a comprehensive evaluation of its provider network (including delegated networks) of both the geographic accessibility and timely availability of providers. The evaluation must, consistent with Minnesota Rules, part 4685.1120, document a methodology for gathering data, analysis of the data, identification of any issues, interventions or the rationale if no intervention and the mechanism for communicating the results of network monitoring with the entire organization.