

Minnesota Department of Health
Compliance Monitoring Division
Managed Care Systems Section



Final Report

Metropolitan Health Plan

Quality Assurance Examination
For the Period:
May 1, 2011 through February 28, 2014

Final Issue Date:
October 1, 2014

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 law. Our mission is to protect, maintain and improve the health of all Minnesotans. 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. Deficiencies are violations of law. “Mandatory Improvements” are required corrections that must be made to non-compliant policies, documents or procedures where evidence of actual compliance is found or where the file sample did not include any instances of the specific issue of concern. The “Recommendations” listed are areas where, although compliant with law, MDH identified improvement opportunities.

To address recommendations, MHP should:

Document all follow-up of a quality of care complaint CAP to evaluate its effectiveness and to confirm the provider has corrected the issue in a timely fashion

To address mandatory improvements, MHP and its delegates must:

To comply with Minnesota Rules, part 4685.1110, subpart 6, MHP must revise its care coordination delegation agreements to include at least semiannual reporting requirements of its Care Coordination delegates.

Revise its credentialing policies/procedures to reflect current standards and current MHP policy and practice. Policies/procedures must be prepared in a manner that provides functional direction for staff.

Include accurate documentation needs to be in its organizational credentialing files that clearly indicates the type of organization it is to determine the information needed from the organization for credentialing purposes.

Correct the grievance written notice to include additional review rights through the Managed Care Ombudsman and MDH.

Revise its policies *Denial, Termination and Reduction Notices* (UMP0007) and *Timeliness of Utilization Management (UM) Decisions* (UMP0005) to state for expedited service authorizations, the MCO must provide the determination as expeditiously as the Enrollee’s health condition requires, not to exceed seventy-two (72) hours of receipt of the request for the service.

Revise its policy *Timeliness of Utilization Management (UM) Decisions* (UMP0005) to include the provider may also request an extension for resolution of a standard authorization.

Update its policy/procedure to describe its current procedure for evaluating its network.

Accurately state referral procedures in its evidence of coverage and correct cross reference the instructions for seeing an out-of-network doctor.

Update emergency services policies/procedures as indicated in the body of the report.

Revise its policy/procedure UM0019, Court Ordered Mental Health Treatment, to is financially liable for the evaluation if performed by a participating provider, and to include that it must be given a copy of the court-order and the behavioral care evaluation.

Revise its continuity of care policies/procedures to reflect that it must grant the request for continuity if the enrollee meets criteria.

Revise its policy/procedure *Appropriate Professionals: Licensure of Utilization Management (UM) Staff (UMP0004)* to state that physician must review all cases in which the utilization review organization has concluded that a determination not to certify for clinical reasons is appropriate.

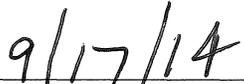
To address deficiencies, MHP and its delegates must:

Conduct all required verifications and assessments prior to contracting with the organization, which includes site visits on organizational providers that have not been accredited prior to contracting..

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.



Darcy Miner, Director
Compliance Monitoring Division



Date

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I. Introduction

A. History:

Founded in October 1983, Metropolitan Health Plan (MHP), a nonprofit, state-certified HMO, contracts with the Minnesota Department of Human Services (DHS) to provide health care coverage to Hennepin County residents who are enrolled in a Minnesota Health Care Program.

Voluntary Medical Assistance (MA) enrollment began in 1984 with 800 enrollees. A year later, MHP's staff expanded from two to 25 employees in anticipation of significant growth resulting from a DHS demonstration project that mandated MA recipients enroll in prepaid managed care programs. In 1990, Minnesota General Assistance recipients were also required to enroll in prepaid managed care programs. Four years later, MHP expanded its reach to include residents in Anoka, Carver and Scott counties, and then in 1997, the organization became an original participant of the Minnesota Senior Health Options (MSHO) program.

In 2011, MHP partnered with Hennepin County's Health and Human Services Department, NorthPoint Health and Wellness Clinic, and Hennepin County Medical Center to offer Hennepin Health, a plan that uses an integrated approach to health care by blending medical, behavioral health and social services. This combined initiative not only allows members to address their health issues, but also to receive assistance with any housing and/or social service needs they may have. MHP also offers coverage to Hennepin County residents eligible for the Minnesota Senior Care Plus and MSHO programs, and Cornerstone Solutions, a Special Needs Basic Care plan.

MHP is a department of Hennepin County that contracts with providers and does not have any ownership interest in administrative offices, clinics, physician groups, hospitals, or other service providers or facilities. The seven elected Hennepin County commissioners are responsible for the oversight of MHP and delegate operational responsibility to Hennepin County administration.

B. Membership: MHP self-reported enrollment as of February 1, 2014 consisted of the following:

Product	Enrollment
<i>Minnesota Health Care Programs- Managed Care (MHSP-MC)</i>	
Families & Children	7332
Minnesota Senior Care (MSC+)	532
Minnesota Senior Health Options (MSHO)	598
Special Needs Basic Care (SNBC)	2662
Total	11,126

- C. Onsite Examination Dates: May 12, 2014 through May 16, 2014
- D. Examination Period: May 1, 2011 through February 28, 2014
File Review Period: March 1, 2013 through February 28, 2014
Opening Date: February 18, 2014
- 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 quality assurance examination, that covers a three year audit period, the health plan is cited with a deficiency. A deficiency will not be based solely on one outlier file if MDH had sufficient evidence obtained through: 1) file review; 2) policies and procedures; and 3) interviews, that a plan's overall operation is compliant with an applicable law.

II. Quality Program Administration

Minnesota Rules, Part 4685.1110. Program

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

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:

Delegated Entities and Functions								
Entity	UM	UM Appeals	QM	Complaints/ Grievances	Cred	Claims	Network	Care Coord
Mental Health Resources								X
Reach for Resources								X
Axis								X
Meridian Services								X
HCMC					X			

Subd. 6. MHP delegates the function of Care Coordination (Care Guides) to Mental Health Resources, Reach for Resources, and Meridian Services. Delegation standards call for the contract or delegation agreement to contain at least semiannual reporting by the delegated entity to the organization. The delegation agreements for these entities do not contain reporting requirements. However, the annual oversight audits reflect there are the reporting requirements of transition of care logs, HRA tracking forms monthly, yearly signed confidentiality and conflict of interest statements and attendance at monthly meetings. MHP must revise the delegation agreements to include the reporting requirements of its Care Coordination delegates. **(Mandatory Improvement #1)**

Subd. 9. Minnesota Rules, part 4685.1110, subpart 9, states the quality program must conduct ongoing evaluation of enrollee complaints related to quality of care. The evaluation must be conducted according to the steps in Minnesota Rules, 4685.1120 (Quality Evaluation Steps). MDH reviewed a total of nine quality of care grievance files.

In one file, MHP asked for a corrective action plan (CAP) from the provider. The provider conducted ongoing internal audits, which were reported to MHP. The provider improved but was unable to consistently achieve 100% results. MHP did not document any additional follow-up of the provider's CAP. MHP should document all follow-up of a CAP to evaluate its effectiveness and to confirm the provider has corrected the issue in a timely fashion. **(Recommendation #1)**

Subd. 11. Minnesota Rules, part 4685.1110, subpart 11, states the plan must have policies and procedures for provider selection, credentialing and recredentialing that, at a minimum, are consistent with community standards. MDH understands the community standard to be NCQA.

Credentialing File Review	
File Source	# Reviewed
<i>MHP</i>	
<i>Physician Initial</i>	8
<i>Physician Recredential</i>	8
<i>Allied Initial</i>	8

<i>Allied Recredential</i>	8
<i>Organizational Initial</i>	10
<i>Organizational Recredential</i>	22
<i>HCMC</i>	
<i>Physician Initial</i>	8
<i>Physician Recredential</i>	8
<i>Allied Initial</i>	7
<i>Allied Recredential</i>	8
Total	95

Subp. 11. In addition to file review, MDH reviewed 20 policies/procedures, grids and flow charts, etc., as well as the Quality Program Written Description. Policies/procedures are extremely disorganized. For example, standards regarding a site visit due to a quality of care complaint are found in the *Medical Records Standards*. Standards for provisional credentialing are found in the *Credentialing Time Lines* policy/procedure. The Quality Program Written Description contained detail more appropriate to policies/procedures. Policies/procedures referenced NCQA elements that are outdated as of the 2014 NCQA Standards and Guidelines. MHP must revise its credentialing policies/procedures to reflect current standards and current MHP policy and practice. Policies/procedures must be prepared in a manner that provides functional direction for staff. **(Mandatory Improvement #2)**

In organizational credentialing there were inconsistencies between what was on the sample list as to the type of organization and what type of organization it actually was. Nothing in the file provided indicated the type of organization it was. For example, the sample list and application stated the organization was a home care agency with PCA, when according to the contract it actually was PCA only. Accurate documentation needs to be in the file that clearly indicates the type of organization it is to determine the information needed from the organization for credentialing purposes. **(Mandatory Improvement #3)**

Six organizations had site visits several months after the contract was signed and the organizations had been credentialed. MHP initiated a corrective action plan (CAP) on February 10, 2014, with the completion date of June 1, 2014. The CAP indicated that there had been no site visits done since January 2013 on the initial home care organizational providers. The CAP was initiated prior to the examination opening date of February 18, 2014; however the site visits were not completed prior to the opening date. MHP must conduct all required verifications and assessments prior to contracting with the organization, which includes site visits on organizational providers that have not been accredited prior to contracting. **(Deficiency #1)**

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 Met Not Met

- Subp. 2. Problem Selection Met Not Met
- Subp. 3. Corrective Action Met Not Met
- Subp. 4. Evaluation of Corrective Action Met Not Met

In 2012, MHP initiated an excellent new format in its annual *Evaluation of Quality Work Plan*. It contains three sets of quality goals from Institute for Healthcare Improvement, (Triple Aim), Institute of Medicine, and National Association for Healthcare Quality. These 11 goals are called Quality Connections. Each activity summarized in the evaluation relates back to one or more of the quality goals.

Minnesota Rules, Part 4685.1125. Focus Study Steps

- Subp. 1. Focused Studies Met Not Met
- Subp. 2. Topic Identification and Selection Met Not Met
- Subp. 3. Study Met Not Met
- Subp. 4. Corrective Action Met Not Met
- Subp. 5. Other Studies Met Not Met

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

- Subd. 1. Written Plan Met Not Met
- Subp. 2. Work Plan Met Not Met

III. Grievance Systems

MDH examined MHP’s Minnesota Health Care Programs Managed Care Programs-Managed Care (MCHP-MC) grievance system for compliance with the federal law (42 CFR 438, subpart E) and the DHS 2014 Model Contract, Article 8.

MDH reviewed a total of 52 grievance system files:

Grievance System File Review	
File Source	# Reviewed
Grievances	30
Non-Clinical Appeals	8
State Fair Hearing	14
Total	52

Section 8.1. §438.402 General Requirements

- Sec. 8.1.1 Components of Grievance System Met Not Met

Section 8.2. §438.408	Internal Grievance Process Requirements	
Sec. 8.2.1. §438.402 (b)	Filing Requirements	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met
Sec. 8.2.2. §438.408 (b)(1)	Timeframe for Resolution of Grievances	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met
Sec. 8.2.3. §438.408 (c)	Timeframe for Extension of Resolution of Grievances	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met
Sec. 8.2.4. §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	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met
Sec. 8.2.5. §438.408 (d)(1)	Notice of Disposition of a Grievance	
(A) §438.408 (d)(1)	Oral Grievances	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met
(B) §438.408 (d)(1)	Written Grievances	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met

§438.408 (d)(1) (sec. 8.2.5 (B)), states the written grievance notice must include options for further review through the Managed Care Ombudsman and MDH. The MHP written response refers offers additional review rights through the Managed Care Ombudsman and DHS, rather than MDH. Appeal rights notices included the correct information. MHP must correct the grievance written notice to include additional review rights through the Managed Care Ombudsman and MDH. **(Mandatory Improvement #4)**

Section 8.3. §438.404	DTR Notice of Action to Enrollees	
Sec. 8.3.1.	General Requirements	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met
Sec. 8.3.2. §438.404 (c)	Timing of DTR Notice	
(A) §438.210 (c)	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) §438.210 (c)	Standard Authorizations	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met
(1)	As expeditiously as the enrollee's health condition requires	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met
(2)	To the attending health care professional and hospital by telephone or fax within one working day after making the determination	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met
(3)	To the provider, enrollee and hospital, in writing, and must include the process to initiate an appeal, within ten(10) business days following receipt of the request for the service, unless the MCO receives an extension of the resolution period	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met
(D) §438.210 (d)(2)(i)	Expedited Authorizations	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met

- (E) §438.210 (d)(1) Extensions of Time Met Not Met
- (F) §438.210 (d) Delay in Authorizations Met Not Met
- Sec. 8.3.3. §438.420 (b) Continuation of Benefits Pending Decision
Met Not Met

42 CFR 438.210(d)(2) (contract section 8.3.2(D)) and Minnesota Statutes, section 62M.05, subdivision 3(b), states for expedited service authorizations, the MCO must provide the determination as expeditiously as the Enrollee's health condition requires, not to exceed seventy-two (72) hours of receipt of the request for the service. MHP's policy *Denial, Termination and Reduction Notices* (UMP0007) and policy *Timeliness of Utilization Management (UM) Decisions* (UMP0005) states that MHP may extend the timeframe for up to 48 hours due to lack of information. Neither the contract nor state law allow for an extension of an expedited request. **(Mandatory Improvement #5)** These policies were revised while MDH was onsite and are awaiting the approval process.

42 CFR 438.210(d)(1) (contract section 8.3.2(E)), states the MCO may extend the timeframe by an additional 14 days for the resolution of a standard authorization if the enrollee or provider requests the extension. MHP policy *Timeliness of Utilization Management (UM) Decisions* (UMP0005) members may voluntarily agree to extend the decision-making timeframe for urgent pre-service, non-urgent, pre-service, and post-service decisions for reasons other than a lack of necessary information or matters beyond MHP's control. Policy was revised while MDH was onsite to include the provider may also request an extension. The policy is awaiting the approval process. **(Mandatory Improvement #6)**

- 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 Expedited 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
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) Individual Making Decision Met Not Met
 - (E) §438.406(a)(3) Appropriate Clinical Expertise Met Not Met

[See Minnesota Statutes, sections 62M.06, and subd. 3(f) and 62M.09]

 - (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
- Met Not Met
- (H) §438.406 (b)(4) Parties to the Appeal Met Not Met
- (I) §438.410 (b) Prohibition of Punitive Action Met Not Met
- Sec. 8.4.6. Subsequent Appeals Met Not Met
- Sec. 8.4.7. §438.408 (d)(2) and (e) Notice of Resolution of Appeals Met Not Met
- Met Not Met
- (A) §438.408 (d)(2) and (e) Written Notice Content Met Not Met
- Met Not Met
- (B) §438.210 (c) Appeals of UM Decisions Met Not Met
- (C) §438.210 (c) and .408 (d)(2)(ii) Telephone Notification of Expedited Appeals Met Not Met
- Met Not Met
- [Also see Minnesota Statutes section 62M.06, subd. 2]
- Sec. 8.4.8. §438.424 Reversed Appeal Resolutions Met Not Met

Section 8.5. §438.416 (c) Maintenance of Grievance and Appeal Records
Met Not Met

Section 8.9. §438.416 (c) State Fair Hearings

- Sec. 8.9.2. §438.408 (f) Standard Hearing Decisions Met Not Met
- Sec. 8.9.5. §438.420 Continuation of Benefits Pending Resolution of State Fair Hearing Met Not Met
- Sec. 8.9.6. §438.424 Compliance with State Fair Hearing Resolution 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

Subds. 1 and 2. Minnesota Statutes, section 62D.124, states that within the plan's service area, the maximum travel distance must be the lesser of 30 miles or 30 minutes primary care, mental health services and general hospital services; and 60 miles or 60 minutes for other health

services. MHP performed geographic mapping on its networks, including specialists. The policy/procedure PVR0012, *Provider Geographic Accessibility DHS*, states the correct standards, however it references its former zip code based methodology. MHP must update the policy/procedure to describe its current procedure. **(Mandatory Improvement#7)**

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

Subp. 2. Minnesota Rules, part 4685.1010, subparts 2, I and J, states the plan is responsible for implementing a system that, to the greatest possible extent, assures that routine referrals, either by the plan or by a participating provider, are made to participating providers. Referral procedures must be described in the evidence of coverage. MDH reviewed policy/procedure UMP0023, *MHP Referrals and/or Service Authorizations for Specialty Care*. The policy/procedure states, MHP doesn't require referrals or service authorizations for specialty care in the MHP network, nor does MHP require a referral for members to see a specialist in Minnesota who are not in the MHP network. MHP ensures, to the greatest extent possible, that the enrollee is referred to an MHP participating provider. Referral procedures are described in the evidence of coverage.

- MDH reviewed the MSHO evidence of coverage. Page 33 states you must receive your care from a network provider. While this is standard language from the model evidence of coverage, it is not accurate in MHP's operations. MHP must accurately state referral procedures in its evidence of coverage.
- The policy/procedure further states, "For information about getting approval to see an out-of-network doctor, see Section 2.4 in this chapter." There is no section 2.4 in the chapter.

MHP must update its evidence of coverage to accurately state its referral procedures and must revise its policy/procedure to accurately cross reference instructions for seeing an out-of-network doctor.

(Mandatory Improvement #8)

Minnesota Statutes, Section 62Q.55. Emergency Services

Met Not Met

Minnesota Statutes, section 62Q.55 states requirements regarding emergency services and was updated effective May 24, 2013. In addition, the DHS contract has additional standards, as noted below.

- DHS contract section 6.1.20 A, states "Except for Critical Access Hospitals, visits to a hospital emergency department that are not an emergency, post-stabilization care or urgent care may not be reimbursed as Emergency or Urgent Care services." This information is not stated in the COC or the policy/procedure UMP0012.

- Policy/procedure UMP0012, page 2 states MHP may deny an emergency room claim based on a lack of information, but it must allow at least 45 days to provide the requested information before denying the claim based on lack of information. MN Statutes, section 62M.05, subdivision 3a(a), states the plan must communicate the initial determination to the provider and enrollee within 10 business days of the request, provided the plan has received all information. DHS contract section, 8.3.2 (E) states, the plan may extend the timeframe by an additional 14 days if justifies the need. Minnesota law does not provide for an extension. Nothing in law or contract states the plan must allow at least 45 days to provide the requested information. MHP must revise its policy/procedure to be consistent with Minnesota law and DHS contract 8.3.2.
- Page 2 states MHP does not deny coverage for any emergency service within the United States, its Territories and Canada.” CMS allows for care in Canada only under rare conditions. MHP must revise its policy/procedure to omit Canada or more specifically explain the circumstances under which it will cover emergency services in Canada.

(Mandatory Improvement #9) MHP made these changes to its policies/procedures during the on-site portion of the exam.

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 | <input checked="" type="checkbox"/> Met | <input type="checkbox"/> Not Met |
| Subd. 3. | Continuing Care | <input checked="" type="checkbox"/> Met | <input type="checkbox"/> Not Met |
| Subd. 4. | Exception to formulary | <input checked="" type="checkbox"/> Met | <input type="checkbox"/> Not Met |

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

- | | | | |
|----------|------------------------|---|---|
| Subd. 1. | Mental health services | <input checked="" type="checkbox"/> Met | <input type="checkbox"/> Not Met |
| Subd. 2. | Coverage required | <input type="checkbox"/> Met | <input checked="" type="checkbox"/> Not Met |

Subd. 2. Minnesota Statutes, section 62Q.535, states requirements for coverage of court ordered mental health. MDH reviewed MHP policy/procedure UM0019, *Court Ordered Mental Health Treatment*. MHP must make the following revisions to its policy/procedure.

- Subdivision 2 (a) states the plan is financially liable for the evaluation if performed by a participating provider. MHP must include this information in its policy/procedure.
- The statute also states that the plan must be given a copy of the court-order and the behavioral care evaluation. MHP must include these elements in its policy/procedure.

(Mandatory Improvement #10) MHP made these changes to its policies/procedures during the on-site portion of the exam.

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

Subd. 1.	Change in health care provider, general notification	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subd. 1a.	Change in health care provider, termination not for cause	<input type="checkbox"/> Met	<input checked="" type="checkbox"/> Not Met
Subd. 1b.	Change in health care provider, termination for cause	<input type="checkbox"/> Met	<input checked="" type="checkbox"/> Not Met
Subd. 2.	Change in health plans	<input type="checkbox"/> Met	<input checked="" type="checkbox"/> Not Met
Subd. 2a.	Limitations	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subd. 2b.	Request for authorization	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subd. 3.	Disclosures	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met

Subd. 1. Minnesota Statutes, section 62Q.56, states the plan must prepare a written plan that provides for continuity of care in case of a contract termination between the plan and any contracted primary care providers. MDH reviewed MHP policies/procedures PVR0001 *Provider/Practitioner Termination: Continuity of Care* and UMP0029, *Transition of Services and Continuity of Care*. MHP must make the following revisions:

- Subdivision 1a, (b), states that for all requests to receive services through current provider, the plan must grant the request unless the enrollee does not meet the criteria. PVR0001 (page 2, section A) states the enrollee will have the option to continue services with the provider/practitioner. MHP must revise its policy/procedure to reflect that it must grant the request if the enrollee meets criteria. [This finding was part of a mandatory improvement in the 2011 MDH exam. Policy/procedure UMP0031 was corrected and approved during the 2013 mid-cycle review. However, MHP revised and submitted UMP0029 for this examination and the corrected provision was omitted.] **(Mandatory Improvement #11)**

In further review of MHP policies/procedures PVR0001 and UMP0029, MDH noted the following:

- Subdivision 1b, states that when a provider is terminated for cause, the plan is not required to refer the enrollee back to the terminating provider. PVR0001 addresses the circumstance, however, for staff and enrollee reference the policy/procedure should specifically state the requirement.
- Subdivision 2, (a), states that, when an enrollee is subject to a change in health plans (transition of care), the plan must grant the request unless the enrollee doesn't meet the criteria. It also provides for continuity if the enrollee is receiving culturally appropriate services or if the enrollee doesn't speak English and the plan has no network provider who can communicate with the enrollee within time and distance requirements.

PVR0001 does not address transition services. UMP0029 addresses transition and continuity of care services. Page 2, item (b) addresses continuation of services when the enrollee transitions into MHP from another health plan. The internal process is different

for a new to MHP enrollee and for an enrollee whose provider leaves the network. The process doesn't include determinations based on provider terminations for cause or not for cause. However, the policy/procedure must describe the process for all the same criteria, including enrollees:

- Who are pregnant and beyond the first trimester
- Who have special needs (e.g., who will identify the enrollees and determine whether a plan for continuity exists.
- Who are receiving culturally appropriate services or do not speak English and the plan has no network provider who can communicate within the enrollee within time and distance requirements.

V. Utilization Review

UM System File Review	
File Source	#Reviewed
<i>UM Denial Files</i>	30
<i>Clinical Appeal Files</i>	8
Total	38

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

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 right 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. 3b. See 42 CFR 438.210(d)(2) (contract section 8.3.2(D) for **Mandatory Improvement #5.**

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. | Notification to Claims Administrator | <input checked="" type="checkbox"/> Met | <input type="checkbox"/> Not Met |

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 Requirements | <input checked="" type="checkbox"/> Met | <input type="checkbox"/> Not Met |
| Subd. 3. | Physician Reviewer Involvement | <input type="checkbox"/> Met | <input checked="" 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 |

Subd. 3. Minnesota Statutes, section 62M.09, subdivision 3 states a physician must review all cases in which the utilization review organization has concluded that a determination not to certify for clinical reasons is appropriate. MHP's policy *Appropriate Professionals: Licensure of Utilization Management (UM) Staff (UMP0004)* states, in pertinent part, that for physical therapy denials, a physician or a physical therapist must complete a review of the physical therapy service requested. File review revealed there were no utilization review denials done by physical therapists. The policy was revised while MDH was onsite and is awaiting the approval process (**Mandatory Improvement #12**)

In five pharmacy UM denial files the pharmacist did the denial. A CAP was done on 1/30/14 and a new process implemented on 2/3/14. There is a daily review of all files and in subsequent pharmacy UM denials the Medical Director does the denial after a review by the pharmacist.

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

(Commercial only)

Met Not Met NA

VI. Recommendations

1. To better comply with Minnesota Rules, part 4685.1110, subpart 9, MHP should document all follow-up of a quality of care complaint CAP to evaluate its effectiveness and to confirm the provider has corrected the issue in a timely fashion.

VII. Mandatory Improvements

1. To comply with Minnesota Rules, part 4685.1110, subpart 6, MHP must revise its care coordination delegation agreements to include at least semiannual reporting requirements of its Care Coordination delegates.
2. To comply with Minnesota Rules, part 4685.1110, subpart 11, MHP must revise its credentialing policies/procedures to reflect current standards and current MHP policy and practice. Policies/procedures must be prepared in a manner that provides functional direction for staff.
3. To comply with Minnesota Rules, part 4685.1110, subpart 11, MHP must include accurate documentation in its organizational credentialing files that clearly indicates the type of organization it is to determine the information needed from the organization for credentialing purposes.
4. To comply with §438.408 (d)(1) (sec. 8.2.5 (B)), MHP must correct the grievance written notice to include additional review rights through the Managed Care Ombudsman and MDH.
5. To comply with 42 CFR 438.210(d)(2) (contract section 8.3.2(D)) and Minnesota Statutes, section 62M.05, subdivision 3(b), MHP must revise its policies *Denial, Termination and Reduction Notices* (UMP0007) and *Timeliness of Utilization Management (UM) Decisions* (UMP0005) to state for expedited service authorizations, the MCO must provide the determination as expeditiously as the Enrollee's health condition requires, not to exceed seventy-two (72) hours of receipt of the request for the service.

6. To comply with 42 CFR 438.210(d)(1) (contract section 8.3.2(E)), MHP must revise its policy *Timeliness of Utilization Management (UM) Decisions* (UMP0005) to include the provider may also request an extension for resolution of a standard authorization.
7. To comply with Minnesota Statutes, section 62D.124, MHP must update its policy/procedure to describe its current procedure for evaluating its network.
8. To comply with Minnesota Rules, part 4685.1010, subparts 2, I and J, MHP must accurately state referral procedures in its evidence of coverage and correct cross reference the instructions for seeing an out-of-network doctor.
9. To comply with Minnesota Statutes, section 62Q.55, MHP must update emergency services policies/procedures as indicated in the body of the report.
10. To comply with Minnesota Statutes, section 62Q.535, MHP must revise its policy/procedure UM0019, *Court Ordered Mental Health Treatment*, to include it financially liable for the evaluation if performed by a participating provider, and to include that it must be given a copy of the court-order and the behavioral care evaluation.
11. To comply with Minnesota Statutes, section 62Q.56, subdivision 1, MHP must revise its continuity of care policies/procedures to reflect that it must grant the request for continuity if the enrollee meets criteria.
12. To comply with Minnesota Statutes, section 62M.09, subdivision 3, MHP must revise its policy/procedure *Appropriate Professionals: Licensure of Utilization Management (UM) Staff* (UMP0004) to state that physician must review all cases in which the utilization review organization has concluded that a determination not to certify for clinical reasons is appropriate.

VIII. Deficiencies

1. To comply with Minnesota Rules, part 4685.1110, subpart 11, MHP must conduct all required verifications and assessments prior to contracting with the organization, which includes site visits on organizational providers that have not been accredited prior to contracting.