Hennepin Health

QUALITY ASSURANCE EXAMINATION

DEPARTMENT OF HEALTH

Final Report

For the Period: June 1, 2014 – December 31, 2016
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MINNESOTA DEPARTMENT OF HEALTH
EXECUTIVE SUMMARY

The Minnesota Department of Health (MDH) conducted a Quality Assurance Examination of Hennepin Health 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 Hennepin Health 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 complaint with law, MDH identified improvement opportunities.

To address recommendations, Hennepin Health should:

Evaluate its quality structure description in the written plan so that it accurately represents what is in practice, what is best for the organization and what was represented to MDH verbally.

Improve its pre-delegation process by generating and maintaining inclusive documentation summarizing the results of a pre-delegation assessment, recommendations/actions for next steps and any follow-up.

Revisit its written policy and process for medical record evaluation to be consistent with what is done in practice and to incorporate use of electronic medical record by practitioners.

Revisit its written quality plan (Quality Program Description) on an annual basis to keep pace with its practice and to incorporate identified changes resulting from the evaluation of the overall effectiveness of the quality program.

Consider adopting a more consistent format for documenting and investigating quality of care complaints to ensure all allegations are being address, and to update its process to ensure quality of care complaints are consistently tracked and trended by provider.

Review all of its policies and procedures related to utilization management and authorization of services to consolidate the policies, eliminate redundancies and enhance usability.

To address mandatory improvements, Hennepin Health and its delegates must:

Revise its policy/procedure to address who is responsible for delegation oversight, where delegation oversight activities are reported, and who has final authority.

Include in its annual evaluation a review of the overall effectiveness of its quality program.

Improve on its documentation of what contingencies are in place when the provider has no hospital admitting privileges.

Update its policy/procedure to include contracting with essential community providers.

To address deficiencies, Hennepin Health and its delegates must:

Have a process in place to adequately document the results of its pre-delegation assessments to ensure that all delegated functions are evaluated and meet the organization's needs.

Complete a pre-delegation assessment within 12 months prior to implementing a delegate agreement.

Review all its credentialing policies/procedures and revise as necessary so that credentialing policies/procedures are specific to Hennepin Health, are accurate in their application, accurately reflect its current practices, are free of redundancies, and convey consistent information. The revision of policies/procedures must include the identified areas laid out in this report;

Have a designated, active Credentialing Committee that uses a peer-review process to make recommendations regarding credentialing decisions;

Ensure the time period from attestation signature to credentialing date does not exceed 180 days;

Submit its written quality plan to MDH for approval when making any revisions.

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.

9/19/2017

Gilbert Acevedo, Assistant Commissioner — Date
Health Systems Bureau

Contents

I. Introduction

1. History: Hennepin Health was founded in 1983 as Metropolitan Health Plan (MHP). It is a non-profit state-certified Health Maintenance Organization with Hennepin County and is overseen by seven Hennepin County commissioners. It maintains a contract with the Department of Human Services (DHS) to provide health care coverage to Medical Assistance Families and Children enrollees as well as coverage for MinnesotaCare and Special Needs Basic Care (SNBC) enrollees. Hennepin Health has adopted a holistic model utilizing various social services that help address barriers in access to health care.

2. Membership: Hennepin Health self-reported enrollment as of December 1, 2016 consisted of the following.

Self-Reported Enrollment

Product	Enrollment
Fully Insured Commercial	
Large Group	N/A
Small Employer Group	N/A
Individual	N/A
Minnesota Health Care Programs – Managed Care (MHCP-MC)	
Families & Children	9,624
MinnesotaCare	337
Minnesota Senior Care (MSC+)	N/A
Minnesota Senior Health Options (MSHO)	2,368
Total	**12,329**

3. Onsite Examination Dates: February 27, 2017 – March 2, 2017.

4. Examination Period: June 1, 2014 – December 31, 2016
   File Review Period: January 1, 2016 – November 30, 2016
   Opening Date: November 23, 2016

5. 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.

6. Performance Standard: For each instance of non-compliance with applicable law or rule identified during the quality assurance examination, which examination 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

Quality Program

Minnesota Rules, Part 4685.1110

Subparts	Subject	Met	Not Met
Subp. 1.	Written Quality Assurance Plan	☒Met	☐ Not Met
Subp. 2.	Documentation of Responsibility	☒Met	☐ Not Met
Subp. 3.	Appointed Entity	☒Met	☐ Not Met
Subp. 4.	Physician Participation	☒Met	☐ Not Met
Subp. 5.	Staff Resources	☒Met	☐ Not Met
Subp. 6.	Delegated Activities	☐Met	☒ Not Met
Subp. 7.	Information System	☒Met	☐ Not Met
Subp. 8.	Program Evaluation	☐Met	☒ Not Met
Subp. 9.	Complaints	☒Met	☐ Not Met
Subp. 10.	Utilization Review	☒Met	☐ Not Met
Subp. 11.	Provider Selection and Credentialing	☐Met	☒ Not Met
Subp. 12.	Qualifications	☒Met	☐ Not Met
Subp. 13.	Medical Records	☒Met	☐ Not Met

Finding: Written Quality Assurance Plan

Subp. 1. Minnesota Rules, part 4685.1110, subpart 1, states the HMO shall have a written quality assurance plan that includes all areas addressed in subpart 1, which includes organizational structure and scope of the program. Hennepin Health has a Utilization Management Committee and a credentialing program, that are present in the scope of the Quality Plan; these areas are not represented as part of the quality organizational committee structure. It is unclear where delegation oversight and compliance fit in the structure, if at all. Hennepin Health should evaluate its quality structure description in the written plan so that it accurately represents what is in practice, what is best for the organization and what was represented to MDH verbally. **(Recommendation 1)**

Finding: Delegated Activities

Supb. 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 and processes 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	Grievances	Cred	Claims	Network	Care Coord	Customer Service
Delta Dental				X QOC					
Navitus Health Solutions (PBM)					X	X	X		X
Mental Health Resources								X	
TMG Health, Inc. (Claims)						X			
Hennepin County Medical Center (HCMC)					X				

Navitus was a new delegate to Hennepin Health beginning in January 1, 2016. Delegation standards include the requirement for a pre-delegation assessment to be done to evaluate the delegate's capacity to meet the requirements set forth in the contract. The pre-delegation documents submitted for review do not include:

- Documentation that credentialing files were reviewed against standards, or
- Results of any policy/procedure review.

Hennepin Health provided a checklist that indicated policy/procedure documents were requested; however, there is no documentation of the findings of any policy/procedure review or that credentialing files were reviewed against standards. Hennepin Health must have a process in place to adequately document the results of its pre-delegation assessments to ensure that all delegated functions are evaluated and meet the organization's needs. **(Deficiency #1)**

Hennepin Health submitted documents such as checklists, Excel spreadsheets and meeting minutes to MDH as evidence; however, there was not inclusive documentation summarizing the results of those documents for the pre-delegation assessment with recommendation/actions for next steps. Hennepin Health should improve its pre-delegation process by generating and maintaining inclusive documentation summarizing the results of a pre-delegation assessment, recommendations/actions for next steps and any follow-up. **(Recommendation #2)**

TMG Health, Inc. was a new delegate to Hennepin Health in April of 2015. The pre-delegation assessment was completed during 2013. The standards state that the health plan must do a pre-delegation assessment of the new delegate within 12 months prior to implementing delegation. If the time between the pre-delegation assessment and implementation exceeds 12 months, the health plan must conduct another pre-delegation assessment. The time between when Hennepin Health's pre-delegation assessment and when TMG Health began as a delegate exceeded 12 months; however, Hennepin Health did not conduct another pre-delegation assessment prior to the delegation agreement starting. **(Deficiency #2)** Hennepin Health's pre-delegation assessment evaluated TMG Health's ability to meet certain standards as outlined in a checklist. There was no documentation in this assessment indicating a summary of the findings of the assessment. **(See same Recommendation #2 above)**

In addition, the policy *Subcontractual Relationship and Delegated Entities (CON0004)* did not address who is responsible for delegation oversight, where delegation oversight activities are reported, and who has final authority. **(Mandatory Improvement #1)**

Finding: Program Evaluation

Subp. 8. Minnesota Rules, part 4685.1110, subpart 8, states an evaluation of the overall quality assurance program shall be conducted at least annually. MDH reviewed the 2014 and 2015 quality evaluation reports. The 2014 evaluation states, *"The goal of this Evaluation is to provide a broad overview of MHP's and Hennepin Health's various activities and to conduct an objective review of each project."* The purpose of the evaluation should be more encompassing, that is to:

- Describe and evaluate completed and ongoing QI activities;
- Trend QI measures over time and compare to performance objectives; and
- Review the overall effectiveness of the quality program.

The quality evaluations reviewed included a review of individual activities and a trending of measures; however, the overall quality program was not evaluated to determine its progress in meeting its goals. This overall program evaluation may include an effectiveness summary of areas such as its program resources, QI committee structure, practitioner and/or leadership involvement, or any identified structure or program changes for the subsequent year. For example, the 2014 evaluation states *"Effective January 1st, 2015, MHP discontinued its CMS Medicare Managed Care contracts for both the Senior product (MSHO) and the Dual SNBC product. MHP's contracts for MSHO/MSC+ and Dual SNBC with DHS ended as of December 31, 2014."* This statement of organizational change suggests that the organization, in evaluating the overall quality program, might evaluate the impact of this change on areas such as committee membership or structure, reporting relationships, quality improvement programs and enrollee involvement, and resources. Hennepin Health should address how this change reflects on the goals and objectives laid out in the program description and how this change reflects on the organization's Triple Aim goals. Furthermore, if the overall quality program were evaluated as part of the annual evaluation, MDH would expect a revision of the Quality Program Description (written quality plan) in response to this organizational change. However, none was submitted **(see Deficiency #6).** Hennepin Health must include in its annual evaluation a review of the overall effectiveness of its quality program, which will be reviewed with the 2016 annual evaluation (completed in 2017). **(Mandatory Improvement #2).**

Finding: Provider Selection and Credentialing

Subp. 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 recognizes the community standard to be NCQA.

MDH reviewed a total of 63 credentialing and recredentialing files as indicated in the table below.

Credentialing File Review

File Source	# Reviewed
Initial	
Physicians	8
Allied	17
Re-Credential	
Physicians	15
Allied	8
Organizational	15
Total	63

Credentialing standards dictate the health plan must have well-defined credentialing and recredentialing processes for evaluating and selecting licensed practitioners and organizations to provide care to its members and must follow those processes.

MDH found in its review that Hennepin Health's credentialing/recredentialing policies/procedures which were submitted for review are generic and not specific to Hennepin Health. MDH expects that policies/procedures will be specific to Hennepin Health, appropriate in their application, accurately reflect its current practices, be free of redundancies, and convey consistent information. For example, the following is a partial list of areas not included in Hennepin Health's policies/procedures:

- Process for ensuring listings in practitioner directories are consistent with credentialing data;
- Range of actions that Hennepin Health may take to improve practitioner performance;
- What specific incidents are reportable to authorities, how/when incidents are reported, and who is responsible;
- Policy Credentialing Policy (CDPOOOI) states Hennepin Health will ensure that practitioners are notified of credentialing and recredentialing decisions within 60 calendar days. In practice, practitioners are notified of initial credentialing decisions, but not of recredentialing decisions.

Hennepin Health must review all its credentialing policies/procedures and revise them so that they are specific to Hennepin Health, accurate in their application, accurately reflect

its current practices, are free of redundancies, and convey consistent information. **(Deficiency #3)**

Credentialing standards dictate the organization must have a designated Credentialing Committee that uses a peer-review process to make recommendations regarding credentialing decisions. A Credentialing Committee is discussed in two separate policies; however, in practice there is no credentialing committee, resulting in the Medical Director making all credentialing decisions, regardless of status of the file. In order to obtain meaningful advice and expertise from participating practitioners, Hennepin Health must have a designated, active Credentialing Committee. **(Deficiency #4)**

File review indicated two files exceeded the 180-day timeline from date of attestation signature to credentialed date. The time period from attestation signature to credentialing date must not exceed 180 days. **(Deficiency #5)**

Eleven files specified the provider had no hospital admitting privileges. It was not readily apparent in the files what contingencies were in place for hospital admissions in these instances. Hennepin Health must improve on its documentation of what contingencies are in place when the provider has no hospital admitting privileges. **(Mandatory Improvement #3)**

Organizational recredentialing was not performed in 2015. In January 2016, a corrective action plan was developed identifying 165 organizations requiring credentialing. The process was completed in December 2016.

In addition to the above, Hennepin Health (formerly Metropolitan Health Plan) has had numerous credentialing/recredentialing issues dating back to 2008. Hennepin Health is in the process of implementing a credentialing management system. This is an opportunity to do a root cause analysis of all previous credentialing issues to develop and incorporate necessary process changes to foster and maintain a stable credentialing system. Hennepin Health will develop a corrective action plan addressing the root cause analysis performed on all the credentialing issues. MDH will review, approve and monitor the plan.

Finding: Medical Records

Subp. 13. Minnesota Rules, part 4685.1110, subpart 13, states the organization is responsible to conduct ongoing evaluation of medical records. With the advent of the electronic medical record (EMR), the organization should revisit its written policy and process for medical record evaluation and be consistent with what is done in practice. **(Recommendation 3)**

Activities

Minnesota Rules, part 4685.1115

Subparts	Subject	Met	Not Met
Subp. 1.	Ongoing Quality Evaluation	☒Met	☐ Not Met

Subparts	Subject	Met	Not Met
Subp. 2.	Scope	☒Met	☐ Not Met

Quality Evaluation Steps

Minnesota Rules, part 4685.1120

Subparts	Subject	Met	Not Met
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

Focus Study Steps

Minnesota Rules, part 4685.1125

Subparts	Subject	Met	Not Met
Subp. 1.	Focused Studies	☒Met	☐ Not Met
Subp. 2.	Topic Identification and Selections	☒Met	☐ Not Met
Subp. 3.	Study	☒Met	☐ Not Met
Subp. 4.	Corrective Action	☒Met	☐ Not Met
Subp. 5.	Other Studies	☒Met	☐ Not Met

Filed Written Plan and Work Plan

Minnesota Rules, part 4685.1130

Subparts	Subject	Met	Not Met
Subp. 1.	Written Plan	☒Met	☐ Not Met
Subp. 2.	Work Plan	☒Met	☐ Not Met
Subp. 3.	Amendments to Plan	☐Met	☒ Not Met

Finding: Amendments to Plan

Subp. 3. Minnesota Rules, part 4685.1130, subpart 3, states the health plan may change its written quality assurance plan by filing notice with the Commissioner of Health for approval.

Hennepin Health has not submitted its written quality improvement plan (Quality Program Description) to MDH for approval since 2013. Hennepin Health staff stated its internal policy requires the written plan be revised every two years. The written plan was revised in 2016 and approved by the Board in September 2016, but was not submitted to MDH for approval; nor did Hennepin Health follow its own policy. Hennepin Health is required to submit the written quality plan to MDH for approval when making any revisions. **(Deficiency #6)** Given the variability of the health care environment, Hennepin Health should revisit its written quality plan on an annual basis to keep pace with its practice and incorporate identified changes resulting from the evaluation of the overall effectiveness of the quality program, which needs to be done annually. **(Recommendation #4)**

III. Quality of Care

A total of 12 quality of care grievance files were reviewed.

Quality of Care File Review

File Source	# Reviewed
Quality of Care Grievances – MHCP – MC Products	
Hennepin Health	8
Delta Dental	4
Total	12

Quality of Care Complaints

Minnesota Statutes, Section 62D.115

Subparts	Subject	Met	Not Met
Subd. 1.	Definition	☒Met	☐ Not Met
Subd. 2.	Quality of Care Investigations	☒Met	☐ Not Met

Finding: Quality of Care Investigation

Subd. 2. Minnesota Statutes, section 62.115, subdivision 2 (d and e), states that any complaint with an allegation regarding quality of care or service must be investigated by the health maintenance organization. "Conclusions of each investigation must be supported with evidence..." In three of the eight quality of care files conducted by Hennepin Health, the investigation's documentation was unclear regarding what the initial complaints were and if they were adequately reviewed. Hennepin Health should consider adopting a more consistent format when documenting how complaints are identified and investigated to ensure that each allegation in the enrollee's complaint is reviewed.

In addition, Minnesota Statutes, section 62D.115, subdivisions 2 (g), states that each "quality of care complaint...must be tracked and trended for review by the health maintenance organization by provider type..." In two of the transportation quality of care files investigated, it was unclear during file review if the complaints were tracked by provider type once the investigation was complete. During the quality of care discussions with staff, Hennepin Health stated that they do not have a specific tool to track all quality of care transportation complaints, but that if they stated that they do not have a specific tool to track all quality of care transportation complaints, but that if they started to notice a pattern it would be addressed by staff with a possibility to discuss the need for education and training for that particular provider. Hennepin Health should develop a process for all quality of care complaints to be tracked and trended by provider type to become in compliance with the new law. **(Recommendation #5)**

IV. Grievance and Appeal Systems

MDH examined Hennepin Health'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 2016 Contract, Article 8.

MDH reviewed a total of 19 grievance system files.

Grievance System File Review

File Source	# Reviewed
Grievances	
Written	0
Oral	8
Non-Clinical Appeals	7
State Fair Hearing	4
Total	19

General Requirements

DHS Contract, Section 8.1

Section	42 CFR	Subject	Met	Not Met
Section 8.1	§438.402	General Requirements		
Sec. 8.1.1		Components of Grievance System	☒Met	☐ Not Met

Internal Grievance Process Requirements

DHS Contract, Section 8.2

Section	42 CFR	Subject	Met	Not Met
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

DTR Notice of Action to Enrollees

DHS Contract, Section 8.3

Section	42 CFR	Subject	Met	Not Met
Section 8.3	§438.408	DTR Notice of Action to Enrollees		
Sec. 8.3.1		General Requirements	☒Met	☐ Not Met
Section 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 (b)(c)(d)	Standard Authorizations	☒Met	☐ Not Met
(1)		As expeditiously as the enrollee's health condition requires	☒Met	☐ Not Met
(2)		To the attending health care professional and hospital by telephone or fax within one working day after making the determination	☒Met	☐ Not Met
(3)		To the provider, enrollee and hospital, in writing, and must include the process to initiate an appeal, within two (10) business days following receipt of the request for the service, unless the MCO receives an extension of the resolution period	☒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. 8.3.3.	§438.420 (b)	Continuation of Benefits Pending Decision	☒Met	☐ Not Met

Finding: Standard Authorizations

§438.210(b) 42 C.F.R. §438.210 (b)(c)(d), states that the MCO have in place, and follow written policies and procedures for processing requests for authorization of services. Hennepin Health has two DTR policies, originating from two different departments, two appeals policies and three policies addressing timelines, two of which give citations, but not the actual timeframes, then direct the reader to a third policy. There are 30 individual utilization management policies. Hennepin Health should review all its policies related to utilization management and authorization of services to consolidate policies, eliminate redundancies and enhance usability. **(Recommendation #6) (Also see Minnesota Statutes, Section 62M.05, subdivision 1)**

Internal Appeals Process Requirements

DHS Contract, Section 8.4

Section	42 CFR	Subject	Met	Not Met
Section 8.4	§438.404	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	☒Met	☐ Not Met
(A)	§438.408 (b)(3)	Expedited Resolution of Oral and Written Appeals	☒Met	☐ Not Met
(B)	§438.410 (c)	Expedited Appeal by 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	☒Met	☐ Not Met
(A)	§438.406 (b)(1)	Oral Inquiries	☒Met	☐ Not Met
(B)	§438.406 (a)(2)	Written Acknowledgment	☒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 (See Minnesota Statutes, sections 62M.06, subd. 3(f), and 62M.09	☒Met	☐ Not Met
(F)	§438.406 (b)(2)	Opportunity to Present Evidence	☒Met	☐ Not Met
(G)	§438.406 (b)(3)	Opportunity to Examine the Care File	☒Met	☐ Not Met
(H)	§438.406 (b)(4)	Parties to the Appeal	☒Met	☐ Not Met
(I)	§438.410 (b)	Prohibition of Punitive Action Subsequent Appeals	☒Met	☐ Not Met
Sec. 8.4.6.		Subsequent Appeals	☒Met	☐ Not Met
Sec. 8.4.7.	§438.408 (d)(2),(e)	Notice of Resolution of Appeals	☒Met	☐ Not Met
(A)	§438.408 (d)(2),(e)	Written Notice Content	☒Met	☐ Not Met
(B)	§438.210 (c)	Appeals of UM Decisions	☒Met	☐ Not Met
(C)	§438.210 (c) and 438.408 (d)(2)(ii)	Telephone Notification of Expedited Appeals (Also see Minnesota Statutes section 62M.06, subd.2)	☒Met	☐ Not Met
Sec. 8.4.8	§438.424	Reversed Appeal Resolutions	☒Met	☐ Not Met

Maintenance of Grievance and Appeal Records

DHS Contract, Section 8.5

Section	42 CFR	Subject	Met	Not Met
Section 8.5	§438.416 (c)	Maintenance of Grievance and Appeal Records	☒Met	☐ Not Met

State Fair Hearings

DHS Contract, Section 8.9

Section	42 CFR	Subject	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

V. Access and Availability

Geographic Accessibility

Minnesota Statutes, Section 62D.124

Subdivision	Subject	Met	Not Met
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

Essential Community Providers

Minnesota Statutes, Section 62Q.19

Subdivision	Subject	Met	Not Met
Subd. 3.	Contract to Essential Community Providers	☐Met	☒ Not Met

Finding: Contract to Essential Community Provider

Subd. 3. Minnesota Statutes, section 62Q.19, subdivision 3, states that a health plan company must offer a provider contract to any designated essential community provider (ECP) located within the area served by the health plan, and cannot restrict access to members seeking ECP services. There is nothing stated in the PVR0004 Provider Availability and Accessibility policy and procedure to address Hennepin Health's contracts with ECPs. Hennepin Health stated that they do not restrict access to their enrollees for out of network providers, and it is evident that they do contract with ECPs. Hennepin Health must update its policy to include that it will contract with any ECP in the service area so that internal Hennepin Health staff are consistently aware that the plan must contract with ECPs. **(Mandatory Improvement #4)**

Availability and Accessibility

Minnesota Rules 4685.1010

Subparts	Subject	Met	Not Met
Subp. 2.	Basic Services	☒Met	☐ Not Met
Subp. 5.	Coordination of Care	☒Met	☐ Not Met
Subp. 6.	Timely Access to Health Care Services	☒Met	☐ Not Met

Emergency Services

Minnesota Statutes, Section 62Q.55

Subdivision	Subject	Met	Not Met
Subd. 1	Access to Emergency Services	☒Met	☐ Not Met
Subd. 2	Emergency Medical Condition	☒Met	☐ Not Met

Licensure of Medical Directors

Minnesota Statutes, Section 62Q.121

Section	Subject	Met	Not Met
62Q.121	Licensure of Medical Directors	☒Met	☐ Not Met

Coverage of Nonformulary Drugs for Mental Illness and Emotional Disturbance

Minnesota Statutes, Section 62Q.527

Subdivision	Subject	Met	Not Met
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

Coverage for Court-Ordered Mental Health Services

Minnesota Statutes, Section 62Q.535

Subdivision	Subject	Met	Not Met
Subd. 1.	Mental Health Services	☒Met	☐ Not Met
Subd. 2.	Coverage required	☒Met	☐ Not Met

Continuity of Care

Minnesota Statutes, Section 62Q.56

Subdivision	Subject	Met	Not Met	N/A
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 (applies to group, continuation and conversion coverage)	☐Met	☐ Not Met	☒ N/A
Subd. 2a,	Limitations	☒Met	☐ Not Met	
Subd. 2b.	Request for authorization	☒Met	☐ Not Met	
Subd. 3.	Disclosures	☒Met	☐ Not Met	

VI. Utilization Review

A total of 27 utilization review files were reviewed.

UR System File Review

File Source	# Reviewed
UM Denial Files	15
Clinical Appeals Files	12
Total	27

Standards for Utilization Review Performance

Minnesota Statutes, Section 62M.04

Subdivision	Subject	Met	Not Met
Subd. 1.	Responsibility on Obtaining Certification	☒Met	☐ Not Met
Subd. 2.	Information upon which Utilization Review is Conducted	☒Met	☐ Not Met

Procedures for Review Determination

Minnesota Statutes, Section 62M.05

Subdivision	Subject	Met	Not Met
Subd. 1.	Written Procedures	☒Met	☐ Not Met
Subd. 2.	Concurrent Review	☒Met	☐ Not Met
Subd. 3.	Notification of Determination	☒Met	☐ Not Met
Subd. 3a.	Standard Review Determination	☒Met	☐ Not Met
(a)	Initial determination to certify or not (10 business days)	☒Met	☐ Not Met
(b)	Initial determination to certify (telephone notification)	☒Met	☐ Not Met
(c)	Initial determination not to certify (notice within 1 working day)	☒Met	☐ Not Met
(d)	Initial determination not to certify (notice of right to 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

Finding: Written Procedure

Subd. 1. Minnesota Statutes, section 62M.05, subdivision 1, states that the organization must have written procedures to ensure that review determinations are conducted in accordance with requirements. Hennepin Health has two DTR policies, originating from two different departments, two appeals policies and three policies addressing timelines, two of which give citations but not the actual timeframes, then direct the reader to a third policy. There are 30 individual utilization management policies. Hennepin Health should review all its policies related to utilization management and authorization of services to consolidate policies, eliminate redundancies and enhance usability. **(Recommendation #6) [Also see 42 C.F.R. §438.210(b) (c) (d)]**

Appeals of Determinations Not to Certify

Minnesota Statutes, Section 62M.06

Subdivision	Subject	Met	Not Met
Subd. 1.	Procedures for Appeal	☒Met	☐ Not Met
Subd. 2.	Expedited Appeal	☒Met	☐ Not Met
Subd. 3.	Standard Appeal	☒Met	☐ Not Met
(a)	Appeal resolution notice timeline	☒Met	☐ Not Met
(b)	Documentation requirements	☒Met	☐ Not Met
(c)	Review by a different physician	☒Met	☐ Not Met
(d)	Time limit in which to appeal	☒Met	☐ Not Met
(e)	Unsuccessful appeal to reverse determination	☒Met	☐ Not Met
(f)	Same or similar specialty review	☒Met	☐ Not Met
(g)	Notice of rights to external review	☒Met	☐ Not Met
Subd. 4.	Notifications to Claims Administrator	☒Met	☐ Not Met

Confidentiality

Minnesota Statutes, Section 62M.08

Subdivision	Subject	Met	Not Met
Subd. 1.	Written Procedures to Ensure Confidentiality	☒Met	☐ Not Met

Staff and Program Qualifications

Minnesota Statutes, Section 62M.09

Subdivision	Subject	Met	Not Met
Subd. 1.	Staff Criteria	☒Met	☐ Not Met
Subd. 2.	Licensure Requirements	☒Met	☐ Not Met
Subd. 3.	Physician Reviewer Involvement	☒Met	☐ Not Met
Subd. 3a.	Mental Health and Substance Abuse Review	☒Met	☐ Not Met
Subd. 4.	Dentist Plan Reviews	☒Met	☐ Not Met
Subd. 4a.	Chiropractic Reviews	☒Met	☐ Not Met
Subd. 5.	Written Clinical Criteria	☒Met	☐ Not Met
Subd. 6.	Physician Consultants	☒Met	☐ Not Met
Subd. 7.	Training for Program Staff	☒Met	☐ Not Met
Subd. 8.	Quality Assessment Program	☒Met	☐ Not Met

Complaints to Commerce or Health

Minnesota Statutes, Section 62M.11

Section	Subject	Met	Not Met	N/A
62M.11	Complaints to Commerce or Health	☐Met	☐ Not Met	☒N/A

VII. Summary of Findings

Recommendations

1. To better comply with Minnesota Rules, part 4685.1110, subpart 1, Hennepin Health should evaluate its quality structure description in the written plan so that it accurately represents what is in practice, what is best for the organization and what was represented to MDH verbally.

2. To better comply with Minnesota Rules, part 4685.1110, subpart 6, Hennepin Health should have inclusive documentation summarizing the results of a pre-delegation assessment and any recommendations/actions for next steps.

3. To better comply with Minnesota Rules, part 4685.1110, subpart 13, Hennepin Health should revisit it written policy and process for medical record evaluation to be consistent with what is done in practice and to incorporate use of electronic medical record.

4. To better comply with Minnesota Rules, part 4685.1130, subpart 3, Hennepin Health should revisit its written quality plan on an annual basis to keep pace with its practice and incorporate identified changes resulting from the evaluation of the overall effectiveness of the quality program.

5. To better comply with Minnesota Statutes, section 62D.115, subdivision 2, Hennepin Health should consider adopting a more consistent format when investigating and documenting quality of care complaints to ensure that each allegation in the enrollee's complaint is being address. Hennepin Health should also change its process for tracking and trending all quality of care complaints by provider type to ensure they are in compliance with the new law.

6. To better comply with 42 CFR §438.210(b)(c)(d) and Minnesota Statutes, section 62M.05, subdivision 1, Hennepin Health should review all of its policies and procedures related to utilization management and authorization of services to consolidate the policies, eliminate redundancies and enhance usability.

Mandatory Improvements

1. To comply with Minnesota Rules, part 4685.110, subpart 6, Hennepin Health must revise its policy/procedure *Subcontractual Relationship and Delegated Entities* to address who is responsible for delegation oversight, where delegation oversight activities are reported and who has final authority.

2. To comply with Minnesota Rules, part 4685.1110, subpart 8, Hennepin Health must include in its annual evaluation a review of the overall effectiveness of its quality program.

3. To comply with Minnesota Rules, part 4685.1110, subpart 11, Hennepin Health must improve on its documentation of what contingencies are in place when the provider has no hospital admitting privileges.

4. To comply with Minnesota Statutes, section 62Q.19, subdivision 3, Hennepin Health must update its policy/procedure *Provider Availability and Accessibility* to address the requirement that Hennepin Health will contract with any essential community provider and will not restrict access to the enrollee.

Deficiencies

1. To comply with Minnesota Rules, part 4685.1110, subpart 6, Hennepin Health must have a process in place to adequately document the results of its pre-delegation assessments to ensure that all delegated functions are evaluated and meet the organization's needs.

2. To comply with Minnesota Rules, part 4685.1110, subpart 6, Hennepin Health must complete a pre-delegation assessment within 12 months prior to implementing a delegate agreement.

3. To comply with Minnesota Rules, part 4685.1110, subpart 11 and the community standard, Hennepin Health must review all its credentialing policies/procedures and revise as necessary so that credentialing policies/procedures are specific to Hennepin Health, are accurate in their application, accurately reflect its current practices, are free of redundancies, and convey consistent information. The revision of policies/procedures must include the identified areas laid out in this report.
4. To comply with Minnesota Rules, part 4685.1110, subpart 11 and the community standard, Hennepin Health must have a designated, active Credentialing Committee that uses a peer review process to make recommendations regarding credentialing decisions.

5. To comply with Minnesota Rules, part 4685.1110, subpart 11 and the community standard, Hennepin Health must ensure the time period from attestation signature to credentialing date does not exceed 180 days

6. To comply with Minnesota Rules, part 4685.1130, subpart 3, Hennepin Health must submit its written quality plan to MDH for approval when making any revisions.