DEPARTMENT OF HEALTH

Hennepin Health

QUALITY ASSURANCE EXAMAINATION

April 9, 2020

Final Report

For the Period: January 1, 2017 – June 30, 2019
Examiners: Elaine Johnson, RN, BS, CPHQ and Kate Eckroth, MPH
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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. MDH findings are as follows:

To address recommendations, Hennepin Health should:

None

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

Revise the *2019 Credentialing Program* to use the consistent definition of quality of care as defined in the quality program and be more specific in its description of its process for ongoing monitoring of complaints in the recredentialing process;

Review and revise the two UM documents (*UM Program Description 2019* and Policy UMP0001 *Utilization Management Program*) and the two DTR policy documents (OPS0004 *Denial, Termination, or Reductions* and UMP0007 *Denial, Termination, or Reduction)* to decrease redundancy and improve readers' ability to determine which document has the required information;

Revise its utilization management program description to be specific as to Hennepin Health's actual practice for dental and chiropractic utilization and appeal reviews.

To address deficiencies, Hennepin Health and its delegates must:

Do a comprehensive review of all calls to determine how they are classified and thereafter to assess needed modifications to the grievance process and submit to MDH a separate and specific corrective action plan addressing this process by March 30, 2020;

Provide a more thorough review of its provider networks and ensure services are timely and adequately provided based on member population needs;

Provide evidence of ongoing monitoring of appointment availability for its contracted providers and this process must be included in the applicable policy and procedure.

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.

4/9/2020

Diane Rydrych, Director
Health Policy Division

Date

Contents

I. Introduction

History: Hennepin Health, formerly known as Metropolitan Health Plan (MHP), has functioned as a Hennepin County-owned and operated health maintenance organization (HMO) since 1983. Hennepin Health is the only county-run HMO in Minnesota and currently operates and bears financial risk for three products—Prepaid Medical Assistance Program (PMAP), Special Needs BasicCare (SNBC) and MinnesotaCare—in its Hennepin County service area. As of August 2019, Hennepin Health serves approximately 24,000 Hennepin County residents as members.

Hennepin Health's PMAP and MinnesotaCare products are centered around an accountable care model focused on integrating county and community services into health care settings to address the social determinants of health, and to streamline access to health care and social services for Hennepin County residents. The core of the Hennepin Health provider network includes Hennepin Healthcare (HCMC), NorthPoint Health & Wellness, Children's Hospitals and Clinics of Minnesota, North Memorial Medical Center, and Fairview Health Services.

1. Membership: Hennepin Health self-reported enrollment as of June 1, 2019 consisted of the following:

Self-Reported Enrollment

Product	Enrollment
Minnesota Health Care Programs – Managed Care (MHCP-MC)	
Families & Children	20,745
MinnesotaCare	1,485
Minnesota Senior Care (MSC+)	N/A
Minnesota Senior Health Options (MSHO)	N/A
Special Needs Basic Care (SNBC)	1,976
Total	24,206

1. Onsite Examination Dates: September 9 through 13, 2019

2. Examination Period: January 1, 2017 to June 30, 2019
   File Review Period: July 1, 2018 to June 30, 2019
   Opening Date: June 26, 2019

3. 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.

4. 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, outlines the requirements of the written quality assurance plan. MDH approved Hennepin Health's written plan during the course of the exam.

MDH finds that Hennepin Health's future written quality assurance plan should include the Enrollee Advisory Group, initiated in 2019. **(Refer to finding under Minnesota Statutes, section 62D.06, Enrollee Advisory Body)**

Finding: Delegated Activities

Subp. 6. Minnesota Rules, part 4685.1110, subpart 6, states that if an HMO delegates performance of quality assurance activities to other entities, 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
TMG Health						X			
Navitus Health Solutions					X	X	X		
Delta Dental	X		X	X	X	X	X		X
Children's Health Care					X				
Fairview Health Services					X				
Meridian Services								X	
Touchstone Mental Health								X	
Hennepin Healthcare					X				

Hennepin Health is part of the Minnesota Credentialing Collaborative, which performed the credentialing annual oversight review of Delta Dental, Fairview, and Hennepin Healthcare.

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 accepted community standards. MDH recognizes the community standard to be NCQA. The credentialing standards from the *2019 NCQA Standards and Guidelines for the Accreditation of Health Plans* was used for the purposes of this examination.

MDH reviewed a total of 81 credentialing and recredentialing files as indicated in the table below.

Credentialing File Review

File Source	# Reviewed
Hennepin Health – Initial	
Physicians	8
Allied	8
Hennepin Health - Re-Credential	
Physicians	17
Allied	16
Hennepin Health - Organizational	16

File Source	# Reviewed
Minneapolis Children's – Initial	
Physicians and Allied	8
Minneapolis Children's - Re-credential	
Physicians and Allied	8
Total	**81**

Recredentialing standards require the plan to collect and review complaints and investigate practitioner-specific complaints upon their receipt, and also to evaluate the practitioner's history of complaints for use in the recredentialing process. One Hennepin Health recredentialing file did not contain evidence that complaints were reviewed in the recredentialing process of the practitioner.

MDH noted Hennepin Health's credentialing policies and procedures have significantly improved. Hennepin Health created a comprehensive document*, 2019 Credentialing Program*, which encompasses its credentialing and recredentialing processes. Page six of this document indicates that Hennepin Health has a different quality of care definition in the credentialing program document than in its Quality Program. Hennepin Health must revise the definition of quality of care to be consistent with its use in the quality program. The document does contain its credentialing-compliant processes; however the description of quality of care and complaints must be clearer and more specific as to its actual process for complaint monitoring in the recredentialing process and its coordination with the quality of care and complaint processes.

Accordingly, MDH finds that Hennepin Health must revise the *2019 Credentialing Program* to use the consistent definition of quality of care as defined in the quality program and be more specific in its description of its process for ongoing monitoring of complaints in the recredentialing process. **(Mandatory Improvement #1)**

Activities

Minnesota Rules, part 4685.1115

Subparts	Subject	Met	Not Met
Subp. 1.	Ongoing Quality Evaluation	☒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.	Annual Work Plan	☒Met	☐ Not Met
Subp. 3.	Amendments to Plan	☒Met	☐ Not Met

Enrollee Advisory Body

Minnesota Statutes, Section 62D.06

Section	Subject	Met	Not Met
Subd. 1 - 2.	Enrollee Advisory Body	☒Met	☐ Not Met

Subd. 2 Minnesota Statutes, section 62D.06, subdivision 2, states that the plan must establish an enrollee advisory body to afford the enrollees an opportunity to express their opinions in the matters of policy and operation by the use of advisory referenda on major policy decisions or through the use of other mechanisms as may be prescribed or permitted by the commissioner of health.

Hennepin Health initiated the establishment of an advisory board in March 2019, subsequent to a finding from the last financial examination performed by Minnesota Department of Commerce. Hennepin Health is on track with its corrective action plan with the development of a charter, internal planning meetings and enrollee elections. The first enrollee advisory group meeting is planned for October 2019.

III. Quality of Care

MDH reviewed nine quality of care grievance files. In addition, MDH reviewed all quality of care policies and procedures and were found to meet all the requirements of Minnesota Statutes section 62D.115. Hennepin Health's policies and procedures were thorough and the quality of care investigations process addressed all allegations in each quality of care grievance. In each investigation, Hennepin Health's conclusions were supported by evidence and appropriate follow up was completed.

Quality of Care File Review

File Source	# Reviewed
Quality of Care Grievances – MHCP – MC Products	9

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 Complaint Investigations	☒Met	☐ Not Met

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 F) and the DHS 2019 Contract, Article 8.

MDH reviewed a total of 21 grievance system files, which was the total universe of files.

Grievance System File Review

File Source	# Reviewed
Grievances	
Written	1
Oral	7
Non-Clinical Appeals	8
State Fair Hearing	5 (all)
Total	**21**

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		
Section 8.2.1.	§438.402 (c)	Filing Requirements	☐Met	☒ Not Met
Section 8.2.2.	§438.408 (b)(1), (d)(1)	Timeframe for Resolution of Grievances	☒Met	☐ Not Met
Section 8.2.3.	§438.408 (c)	Timeframe for Extension of Resolution of Grievances	☒Met	☐ Not Met
Section 8.2.4.	§438.406	Handling of Grievances		
8.2.4.1	§438.406 (b)(1)	Written Acknowledgement	☒Met	☐ Not Met

Section	42 CFR	Subject	Met	Not Met
8.2.4.2	§438.416	Log of Grievances	☒Met	☐ Not Met
8.2.4.3	§438.402 (c)(3)	Oral or Written Grievances	☒Met	☐ Not Met
8.2.4.4	§438.406 (a)	Reasonable Assistance	☒Met	☐ Not Met
8.2.4.5	§438.406 (b)(2)(i)	Individual Making Decision	☒Met	☐ Not Met
8.2.4.6	§438.406 (b)(2)(ii)	Appropriate Clinical Expertise	☒Met	☐ Not Met
Section 8.2.5.	**§438.408 (d)(1)**	**Notice of Disposition of a Grievance**		
8.2.5.1	§438.404 (b) §438.406 (a)	Oral Grievances	☒Met	☐ Not Met
8.2.5.2	§438.404 (a), (b)	Written Grievances	☒Met	☐ Not Met

Finding: Filing Requirements

Sec. 8.2.1. 42 CFR 438.402(c) (*see also* DHS Contract section 8.2.1) states the enrollee, or provider acting on behalf of the enrollee, may file a grievance on a matter regarding an enrollee's dissatisfaction about any matter other than an MCO action. Hennepin Health has just 52 grievances in the entire one year file review period, which is abnormally low in comparison to other plans. According to DHS data for the reporting period of 2016 through the 2nd quarter of 2019, Hennepin Health's average grievance rate was 2.03 (per 10,000 enrollee member months) versus 7.00 (per 10,000 enrollee member months) for all other health plans. This is indicative that not all inquiries and/or incoming calls are being accurately classified as grievances. **(Deficiency #1)**

During an initial investigation, Hennepin Health indicated that it is updating its training materials to record issues resolved over the phone in a single phone call to be considered a grievance even if the member does not request that it be considered as such.

Therefore, MDH requires Hennepin Health to do a comprehensive review of all calls to determine how they are classified and thereafter to assess needed modifications to the grievance process. Hennepin Health must submit to MDH a separate and specific corrective action plan addressing this process by March 30, 2020.

Hennepin Health must present details of its new training to the manager of the Managed Care Ombudsman Office. As part of its corrective action, Hennepin Health must also meet with the Ombudsman Office to talk through calls to ensure proper categorization. The meetings will take place on a quarterly basis until no longer needed. The purpose of the discussions will be to support Hennepin Health in improving the capturing of grievances.

Denial, Termination, or Reduction (DTR) Notice of Action to Enrollees

DHS Contract, Section 8.3

Section	42 CFR	Subject	Met	Not Met
Section 8.3.	§438.10 §438.404	DTR Notice of Action to Enrollees	☒Met	☐ Not Met
Section 8.3.1.	§438.10(c), (d) §438.402(c) §438.404(b)	General Requirements	☒Met	☐ Not Met
Section 8.3.2	§438.402 (c), §438.404 (b)	Content of DTR Notice of Action	☒Met	☐ Not Met
8.3.2.1	§438.404	Notice to Provider	☒Met	☐ Not Met
Section 8.3.3.	§438.404 (c)	Timing of DTR Notice		
8.3.3.1	§431.211	Previously Authorized Services	☒Met	☐ Not Met
8.3.3.2	§438.404 (c)(2)	Denials of Payment	☒Met	☐ Not Met
8.3.3.3	§438.210 (c)(d)	Standard Authorizations		
(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 ten (10) business days following receipt of the request for the service, unless the MCO receives an extension of the resolution period	☒Met	☐ Not Met
8.3.3.4	§438.210 (d)(2)(i)	Expedited Authorizations	☒Met	☐ Not Met
8.3.3.5	§438.210 (d)(1)	Extensions of Time	☒Met	☐ Not Met
8.3.3.6	§438.210(d)(3) and 42 USC 1396r-8(d)(5)	Covered Outpatient Drug Decisions	☒Met	☐ Not Met
8.3.3.7	§438.210 (d)(1)	Delay in Authorizations	☒Met	☐ Not Met

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)	One Level Appeal	☒Met	☐ Not Met
Sec. 8.4.2.	§438.408 (b)	Filing Requirements	☒Met	☐ Not Met
Sec. 8.4.3.	§438.408	Timeframe for Resolution of Appeals		
8.4.3.1	§438.408 (b)(2)	Standard Appeals	☒Met	☐ Not Met
8.4.3.2	§438.408 (b)(3)	Expedited Appeals	☒Met	☐ Not Met
8.4.3.3	§438.408 (c)(3)	Deemed Exhaustion	☒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		
8.4.5.1	§438.406 (b)(3)	Oral Inquiries	☒Met	☐ Not Met
8.4.5.2	§438.406 (b)(1)	Written Acknowledgment	☒Met	☐ Not Met
8.4.5.3	§438.406 (a)	Reasonable Assistance	☒Met	☐ Not Met
8.4.5.4	§438.406 (b)(2)	Individual Making Decision	☒Met	☐ Not Met
8.4.5.5	§438.406 (b)(2)	Appropriate Clinical Expertise (See Minnesota Statutes, sections 62M.06, and subd. 3(f) and 62M.09	☒Met	☐ Not Met
8.4.5.6	§438.406 (b)(4)	Opportunity to Present Evidence	☒Met	☐ Not Met
8.4.5.7	§438.406 (b)(5)	Opportunity to Examine the Care File	☒Met	☐ Not Met
8.4.5.8	§438.406 (b)(6)	Parties to the Appeal	☒Met	☐ Not Met
8.4.5.9	§438.410 (b)	Prohibition of Punitive Action Subsequent Appeals	☒Met	☐ Not Met
Sec. 8.4.6.		Subsequent Appeals		
Sec. 8.4.7.	§438.408 (d)(2)	Notice of Resolution of Appeals		
8.4.7.1	§438.408 (d)(2)	Written Notice Content	☒Met	☐ Not Met
8.4.7.2	§438.210 (c)	Appeals of UM Decisions	☒Met	☐ Not Met
8.4.7.3	§438.410 (c) and .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
Sec. 8.5.	§438.420 (b)	Continuation of Benefits Pending Appeal or State Fair Hearing	☒Met	☐ Not Met

State Fair Hearings

DHS Contract, Section 8.10

Section	42 CFR	Subject	Met	Not Met
Section 8.10	§438.416 (c)	State Fair Hearings		
Sec. 8.10.2	§438.408 (f)	Standard Hearing Decisions	☒Met	☐ Not Met
Sec. 8.10.5	§438.424	Compliance with State Fair Hearing Resolution	☒Met	☐ Not Met

V. Access, Availability, and Continuity of Care

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.	Waiver	☒Met	☐ Not Met

Finding: Timely Access to Health Care Services

Subds. 1 and 2 Minnesota Statutes, section 62D.124, subdivisions 1 and 2, require a health maintenance organization to have primary care and mental health services, and hospitals within 30 miles or 30 minutes of its service area. HMOs must also have specialty physicians within 60 miles or 60 minutes. A geographic accessibility review of geo-access maps and data analysis is used to verify if those networks are adequate.

The geo-access maps Hennepin Health submitted indicate that it provides coverage for its members within the 30 miles/30 minutes or 60 miles/60 minutes standards. However, assessing only geo-access maps is not sufficient to ensure networks are adequately meeting member needs on a timely basis. For example, Hennepin Health provided evidence that it reviews grievances and appeals related to access on a quarterly basis, yet it did not include this data or analysis in its provider network adequacy report, which can be found in the *2018 Quality Program Evaluation*. It also did not assess out of network utilization trends to evaluate any unmet service needs or review Consumer Assessment of Healthcare Providers and Systems (CAHPS) satisfaction surveys. Lastly, the report did not provide sufficient review or discussion of quality improvement plans or interventions related to access that affect members.

MDH finds that Hennepin Health must provide a more thorough review of its provider networks and ensure services are timely and adequately provided based on member population needs. **(Deficiency #2)**

Essential Community Providers

Minnesota Statutes, Section 62Q.19

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

Availability and Accessibility

Minnesota Rules, part 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

Finding: Timely Access to Health Care Services

Subp. 2 and 6 Minnesota Rules, part 4685.1010, subparts 2 and 6, require that the health maintenance organization, in coordination with participating providers, develop and implement written standards that assess the capacity of each provider network to provide timely access to health care services in accordance with subpart 6. Under subpart 6, the health maintenance organization is required to have providers be accessible to enrollees on a timely basis and have written appointment scheduling guidelines. The HMO should verify provider compliance with these requirements through ongoing monitoring of appointment availability to ensure providers are delivering timely services consistent with Hennepin Health's written standards.

Hennepin Health includes standards for timely access to services by provider type in its *PVR0004 Provider Availability and Accessibility* policy/procedure. In the *2018 Quality Program Evaluation*, Hennepin Health reviewed one appointment availability survey conducted by one of its contracted provider's health care system, which provides services to approximately 50% of Hennepin Health's members. The survey did not assess appointment availability against Hennepin Health's written standards.

Following an onsite discussion with MDH, Hennepin Health submitted a mid-year survey conducted in 2019 that assessed the impact of adding a provider group to its network. This survey helped capture a larger proportion of its members. However, the survey provided no analysis or indication of which of the surveyed clinics were in compliance with Hennepin Health's standards.

MDH finds that Hennepin Health must provide evidence of ongoing monitoring of appointment availability for its contracted providers. Monitoring must adequately represent clinics in its membership, and must also verify compliance with Hennepin Health's written standards. This process must be included in the applicable policy and procedure. **(Deficiency #3)**

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

VI. Utilization Review

Consistent with Minnesota Statutes chapter 62M, MDH examined Hennepin Health's utilization review (UR) system, including the review of 42 utilization review files.

UR System File Review

File Source	# Reviewed
UM Denial Files	32
Clinical Appeals Files	10
Total	**42**

Standards for Utilization Review Performance

Minnesota Statutes, Section 62M.04

Subdivision	Subject	Met	Not Met
Subd. 1.	Responsibility for 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 Procedures

Subd. 1. Minnesota Statutes, section 62.M.05, subdivision 1, states the plan must have written procedures to assure utilization review activities are conducted in accordance with the law. DHS contract (Families and Children contract) section 6.15.3 also states the plan must have in place and follow written policies and procedures for utilization review that meet the requirements specified in Minnesota Statutes sections 62M.05 and 62M.09.

Hennepin Health has two documents—the *UM Program Description 2019* and Policy UMP0001 *Utilization Management Program*—with some similar information. Hennepin Health explains this discrepancy by noting that one document is high-level and the other is for day-to-day use by staff. Similarly, there are two policy documents, entitled OPS0004 *Denial, Termination, or Reductions* and UMP0007 *Denial, Termination, or Reduction.*

It is too difficult to review compliance when the relevant information is distributed between more than one document, and when said documents contain some similar information and some different information. Hennepin Health would benefit from reviewing the two sets of documents to decrease redundancy, allow for better flow and enhance access to the required information.

MDH finds that Hennepin Health must review the two UM documents and the two DTR policy documents to decrease redundancy and improve readers' ability to determine which document has the required information. **(Mandatory Improvement #2)**

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		
(a)	Procedures for appeals written and telephone	☒Met	☐ Not Met
(b)	Appeal resolution notice timeline	☒Met	☐ Not Met
(c)	Documentation requirements	☒Met	☐ Not Met
(d)	Review by a different physician	☒Met	☐ Not Met
(e)	Defined time period in which to file appeal	☒Met	☐ Not Met
(f)	Unsuccessful appeal to reverse determination	☒Met	☐ Not Met
(g)	Same or similar specialty review	☒Met	☐ Not Met
(h)	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

Finding: Dentist and Chiropractic Reviews

Subd. 4 and 4a. Minnesota Statutes, section 62M.09, subdivision 4 and 4a, states a dentist/ chiropractor must review all cases in which a determination not to certify a dental/chiropractic service or procedure for clinical reasons is appropriate and an appeal has been made.

On page 11 of Hennepin Health's *2019 UM Program Description*, the plan recites the statute verbatim for dentists, but does not address chiropractors. The plan should be more specific as to what Hennepin Health's actual practice really is. For example, Hennepin Health's practice is for a dentist to do all dental reviews, both UM and appeals. The actual practice for chiropractic review is not addressed, thus unknown.

Therefore, MDH finds that Hennepin Health must revise its UM plan to be specific as to Hennepin Health's actual practice for dental and chiropractic UM and appeal reviews. **(Mandatory Improvement #3)**

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

No Recommendations

Mandatory Improvements

1. To comply with Minnesota Rules, part 4685.1110, subpart 11, Hennepin Health must revise the *2019 Credentialing Program* to use the consistent definition of quality of care as defined in the quality program and be more specific in its description of its process for ongoing monitoring of complaints in the recredentialing process.

2. To comply with Minnesota Statutes, section 62.M.05, subdivision 1, Hennepin Health must review and revise the two UM documents (*UM Program Description 2019* and Policy UMP0001 *Utilization Management Program*) and the two DTR policy documents (OPS0004 *Denial, Termination, or Reductions* and UMP0007 *Denial, Termination, or Reduction)* to decrease redundancy and improve readers' ability to determine which document has the required information

3. To comply with Minnesota Statutes, section 62M.09, subdivision 4 and 4a, Hennepin Health must revise its utilization management program description to be specific as to Hennepin Health's actual practice for dental and chiropractic UM and appeal reviews.

Deficiencies

1. To comply with 42 CFR 438.402(c) (*see also* DHS Contract section 8.2.1), Hennepin Health must do a comprehensive review of all calls to determine how they are classified and thereafter to assess needed modifications to the grievance process. Hennepin Health must submit to MDH a separate and specific corrective action plan addressing this process by March 30, 2020.

2. To comply with Minnesota Statutes, section 62D.124, subdivisions 1 and 2, Health must provide a more thorough review of its provider networks and ensure services are timely and adequately provided based on member population needs.

3. To comply with Minnesota Rules, part 4685.1010, subparts 2 and 6, Hennepin Health must provide evidence of ongoing monitoring of appointment availability for its contracted providers. Monitoring must adequately represent clinics in its membership, and must also verify compliance with Hennepin Health's written standards. This process must be included in the applicable policy and procedure.