Minnesota Department of Health
Health Regulation Division
Managed Care Systems Section

Final Report

Medica Health Plans

Quality Assurance Examination
For the Period:

March 1, 2012 through December 31, 2014

Final Issue Date:

July 22nd, 2015

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Minnesota Department of Health
Executive Summary

The Minnesota Department of Health (MDH) conducted a Quality Assurance Examination of Medica Health Plans (Medica) in March of 2015 to determine whether it is operating in accordance with Minnesota law. MDH has found that Medica 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, Medica should:

Better describe the type of oversight Medica will perform; and

Provide additional detail found in the certificate of coverage description of the complaint process in its complaint form; and

Revise its Certificates of Coverage to state refunds are provided by the external review entity and should revise policies/procedures to state that the external review entity notifies Medica of the request for external review.

To address mandatory improvements, Medica must:

Revise its policy/procedure on items included in the complaints resolution letters to include the "reasons for the determination"; and

Revise its grievance/appeal policy/procedure to state it will not take punitive action against a provider who requests an expedited resolution or supports an enrollee's appeal; and

Revise Certificates of Coverage and policies/procedures to state that, if the enrollee is eligible, a non-formulary drug for mental illness or emotional disturbance drug may continue to be covered for up to a year; and

Revise its pharmacy utilization management policy/procedure to reflect its actual practice and to be consistent with Minnesota law.

To address deficiencies, Medica and its delegates must:

Inform the oral complainant that the complaint can be submitted in writing following the 10th day; and

Consistently offer assistance in completing the complaint/grievance form including an offer to complete the form and send it to the enrollee for signature.

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
Health Regulation Division

7/14/15
Date

Contents

I. Introduction

A. History:
In 1975 physician members of the Hennepin County Medical Society founded Physicians Health Plan, an open access nonprofit HMO. In 1991 Physicians Health Plan merged with another nonprofit Twin Cities HMO, Share Health Plan, to form Medica. In 1994 Medica merged with HealthSpan to form Allina Health System, which provided both health insurance and health care. Medica became an independent company in 2001. Medica serves individuals, employers, third-party administrators and government programs in Minnesota and select counties in Wisconsin, North Dakota and South Dakota. Medica's broadest regional network includes 27,000 providers at more than 4,000 facilities. More than 96 percent of Minnesota providers participate in this network.

B. Membership: Medica self-reported enrollment as of January 2, 2014, consisted of the following:

Product	**Enrollment**
Fully Insured Commercial	
Large Group	441
Small Employer Group	0
Individual	389
Minnesota Health Care Programs-Managed Care (MHCP-MC)	
Families & Children	131,782
MinnesotaCare	21,966
Minnesota Senior Care (MSC+)	3,123
Minnesota Senior Health Options (MSHO)	10,025
Special Needs Basic Care (SNBC)	20,247
Total	**187,973**

C. Onsite Examinations Dates: March 16 through 19, 2015

D. Examination Period: March 1, 2012 through December 31, 2014
File Review Period: January 1 through December 31, 2014
Opening Date: January 7, 2015

E. National Committee for Quality Assurance (NCQA): Medica is accredited by NCQA based on 2013 standards. The Minnesota Department of Health (MDH) evaluated and used results of the NCQA review in one of three ways:

1. If NCQA standards do not exist or are not as stringent as Minnesota law, the accreditation results will not be used in the MDH examination process [No NCQA checkbox].
2. If the NCQA standard was the same or more stringent than Minnesota law and the health plan was accredited with 100% of the possible points, the NCQA results were accepted as meeting Minnesota requirements [NCQA ☒] unless evidence existed indicating further investigation was warranted [NCQA ☐].

3. If the NCQA standard was the same or more stringent than Minnesota law, but the review resulted in less than 100% of the possible points on NCQA's score sheet or as an identified opportunity for improvement, MDH conducted its own examination.

F. 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.

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

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**	**Complaint/ Grievances**	**Cred**	**Claims**	**Network**	**Care Coord**
MedImpact	Apprvls					X	X	
Medica Behavioral Health	X	Level 1	X	X	X	X	X	Case Mgmt
Optum Physical Health	X	Level 1		X And QOC	X			
Bluestone Physicians								X
Carver Co.								X
Norman Co.								X

Medica has a robust oversight process for its delegates, including annual oversight audits of each delegated function and corrective action plans, as needed. Audit reports are presented to the oversight committee and are annually monitored for contract renewal. In the case of care coordination delegates (e.g., Bluestone Physicians, Carver and Norman Counties), oversight includes partnership meetings and outreach education opportunities. Medica provided a list of reports it prepares based on its annual oversight audits for care coordination. MDH suggests that this list be included in the care coordination delegation agreements to expand on the type of oversight it will perform for care coordination functions. **(Recommendation #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. A total of 12 quality of care complaint and grievance files were reviewed as follows:

Quality of Care File Review	
QOC File Source	**# Reviewed**
Complaints—Commercial Products	
Medica (all)	3
Grievances—MHCP-MC Products	
Medica	6
MBH	2
Optum (all)	1
Total	**12**

Minnesota Rules, Part 4685.1115. Activities

Subp. 1	Ongoing Quality Evaluation	☐ Met	☐ Not Met	☒ NCQA
Subp. 2	Scope	☐ Met	☐ Not Met	☒ NCQA

Minnesota Rules, Part 4685.1120. Quality Evaluation Steps

Subp. 1	Problem Identification	☐ Met	☐ Not Met	☒ NCQA
Subp. 2	Problem Selection	☐ Met	☐ Not Met	☒ NCQA
Subp. 3	Corrective Action	☐ Met	☐ Not Met	☒ NCQA
Subp. 4	Evaluation of Corrective Action	☐ Met	☐ Not Met	☒ NCQA

Minnesota Rules, Part 4685.1125. Focus Study Steps

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

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

Subp. 1	Written Plan	☒ Met	☐ Not Met	
Subp. 2	Work Plan	☐ Met	☐ Not Met	☒ NCQA

III. Complaints and Grievance Systems

Complaint System

MDH examined Medica fully-insured commercial complaint system under Minnesota Statutes, chapter 62Q.
MDH reviewed a total of 27 Complaint System files.

Complaint System File Review	
Complaint Files (Oral and Written)	25
Non-Clinical Appeal (All)	2
Total # Reviewed	**27**

Minnesota Statutes, Section 62Q.69. Complaint Resolution

Subp. 1	Establishment	☒ Met	☐ Not Met
Subp. 2	Procedures for Filing a Complaint	☐ Met	☒ Not Met
Subd. 3.	Notification of Complaint Decisions	☐ Met	☒ Not Met

Subd. 2. Minnesota Statutes, section 62Q.69, subdivision 2, states that a complainant may submit a complaint to a health plan company either by telephone or in writing. If a complaint is submitted orally and the resolution of the complaint, as determined by the complainant, is partially or wholly adverse to the complainant, or the oral complaint is not resolved to the satisfaction of the complainant by the health plan company within ten days of receiving the complaint, the health plan company must inform the complainant that the complaint may be submitted in writing.

In two of the 25 complaint files reviewed, oral complaints were registered with Medica's customer service staff and documentation reflected neither complaint was resolved within 10 days. There is no evidence of the complainant being informed the complaint could be submitted in writing following the 10th day. **(Deficiency #1)**

In addition, subdivision 2 states that if the resolution of an oral complaint is partially or wholly adverse to the Enrollee, or the oral complaint is not resolved to the satisfaction of the Enrollee, the MCO must inform the Enrollee that the complaint may be submitted in writing. The MCO must also offer to provide the Enrollee with any assistance needed to submit a written complaint, including an offer to complete the complaint form, and promptly mail the completed form to the Enrollee for his/her signature. MDH reviewed the customer service representatives' online guide, and interviewed Medica's commercial complaint team. The online guide included the offer of assistance in completing the complaint form and sending it to the enrollee for signature. However, in three oral complaint files, MDH did not see evidence that they offered assistance in completing the form. **(Deficiency #2)** [See 42 CFR 438.408 (d)(1) (DHS Contract section 8.2.5(a)) for the same deficiency.]

Subd.3. Minnesota Statutes, section 62Q.69, subdivision 3, states that the health plan company must notify the complainant in writing of its decision and the reasons for it. Medica's policy/procedures, *Complaint: Minnesota Fully Insured (COM001P)* lists what items must be included in the resolution letter. "Reasons for the determination" did not appear on the list and must be part of the resolution letter. **(Mandatory Improvement #1)**

Medica's commercial complaint form describing the complaint process and enrollee rights is technically correct. To enhance the enrollee's immediate understanding of the complaint procedures and their rights, MDH advises Medica to provide some of the detail found in the EOC and COC in its complaint form. **(Recommendation # 2)**

Minnesota Statutes, Section 62Q.70. Appeal of the Complaint Decision

Subp. 1	Establishment	☒ Met	☐ Not Met
Subp. 2	Procedures for Filing an Appeal	☒ Met	☐ Not Met
Subd. 3.	Notification of Appeal Decisions	☒ Met	☐ Not Met

Minnesota Statutes, Section 62Q.71. Notice to Enrollees

☒ Met ☐ Not Met

Minnesota Statutes, Section 62Q.73. External Review of Adverse Determinations

Subd. 3.	Right to External Review	☒ Met	☐ Not Met
Subd. 6.	Process	☒ Met	☐ Not Met

Subd. 3 Minnesota Statutes, section 62Q.73, subdivision 3, states in pertinent part, that the written request must be accompanied by a filing fee of $25. The fee may be waived by the commissioner of health or commerce in cases of financial hardship and must be refunded if the adverse determination is completely reversed. The Medica Elect and Medica Essential Certificate of Coverage External Appeal (page 119) states, "The Department of Health or Department of Commerce, as applicable, will refund the filing fee if the review organization completely reverses Medica's decision." The statement is correct for the Department of Commerce. However, for products regulated by MDH, refunds are provided by the external review entity. Medica should revise its Certificates of Coverage to accurately state the refund process. **(Recommendation #3)**

Subd. 6 Minnesota Statutes, section 62Q.73, subdivision 6, states in pertinent part, that the assigned external review entity must provide immediate notice of the review to the enrollee and to the health plan company. In the 2014 Utilization Management Program Description (page 22), Medica states "The entity then forwards the request to Medica." The context suggests the "entity" is the regulatory agency. Medica's Utilization Management Program Description and policies/procedures should correctly state that the external review entity notifies Medica of the request for external review. **(Recommendation #3)**

Grievance System

MDH examined Medica's Minnesota Health Care Programs Managed Care Programs-Managed Care (MHCP-MC) grievance system for compliance with the federal law (42 CFR 438, subpart E) and the DHS 2013 Model Contract, Article 8.

MDH reviewed a total of 50 grievance system files:

Grievance System File Review	
File Source	**# Reviewed**
Grievances	29
Medica	25
Optum (all)	1
MBH (all)	3
Non-Clinical Appeals	11
Medica	10
MBH (all)	1
State Fair Hearing	10
Total	**50**

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	☒ Met	☐ Not Met
Sec. 8.2.2.	§438.408 (b)(1)	Timeframe for Resolution of Grievances	☒ Met	☐ Not Met
Sec. 8.2.3.	§438.408 (c)	Timeframe for Extension of Resolution of Grievances	☒ Met	☐ Not Met
Sec. 8.2.4.	§438.406	Handling of Grievances		
(A)	§438.406 (a)(2)	Written Acknowledgement	☒ Met	☐ Not Met
(B)	§438.416	Log of Grievances	☒ Met	☐ Not Met
(C)	§438.402 (b)(3)	Oral or Written Grievances	☒ Met	☐ Not Met
(D)	§438.406 (a)(1)	Reasonable Assistance	☒ Met	☐ Not Met
(E)	§438.406 (a)(3)(i)	Individual Making Decision	☒ Met	☐ Not Met
(F)	§438.406 (a)(3)(ii)	Appropriate Clinical Expertise	☒ Met	☐ Not Met
Sec. 8.2.5	§438.408 (d)(1)	Notice of Disposition of a Grievance		
(A)	§438.408 (d)(1)	Oral Grievances	☐ Met	☒ Not Met
(B)	§438.408 (d)(1)	Written Grievances	☒ Met	☐ Not Met

§438.408 (d)(1). (DHS contract section 8.2.5 (A)), states if the resolution of an oral grievance is partially or wholly adverse to the Enrollee, or the oral Grievance is not resolved to the satisfaction of the Enrollee, the MCO must inform the Enrollee that the Grievance may be submitted in writing. The MCO must also offer to provide the Enrollee with any assistance needed to submit a written Grievance, including an offer to complete the Grievance form, and promptly mail the completed form to the Enrollee for his/her signature pursuant to Minnesota Statutes, section 62Q.69, subdivision 2. The on-line guide states customer service representatives will offer assistance in completing the grievance form and sending it to the enrollee for signature. However in file review, six of 24 oral grievances did not document an offer of assistance in completing the written form. MDH did not see evidence that Medica consistently offered assistance in submitting the grievance form including an offer to complete the form and promptly sending to the enrollee for signature. **(Deficiency #2)**
[See Minnesota Statutes, section 62Q.69, subdivision 2.]

Section 8.3.	**§438.404**	**DTR Notice of Action to Enrollees**		
Sec. 8.3.1.		General Requirements	☒ Met	☐ Not Met
Sec. 8.3.2.	§438.404 (c)	Timing of DTR Notice		
(A)	§438.210 (c)	Previously Authorized Services	☒ Met	☐ Not Met
(B)	§438.404 (c)(2)	Denials of Payment	☒ Met	☐ Not Met
(C)	§438.210 (c)	Standard Authorizations	☒ Met	☐ Not Met
(1)	To the attending health care professional and hospital by telephone or fax within one working day after making the determination		☒ 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
(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

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

Section 8.4	§438.408	Internal Appeals Process Requirements		
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 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	☒ Met	☐ Not Met
(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 [See Minnesota Statutes, sections 62M.06, and 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 Case File	☒ 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
(A)	§438.408 (d)(2) and (e)	Written Notice Content	☒ 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 [Also see Minnesota Statutes section 62M.06, subd. 2]	☒ Met	☐ Not Met
(D)		Unsuccessful appeal of UM determination	☒ Met	☐ Not Met
Sec, 8.4.8.	§438.424	Reversed Appeal Resolutions	☒ Met	☐ Not Met

§438.402(b). DHS contract section 8.4.1, states an appeal may be filed orally or in writing. In file review, Medica's acknowledgement letters state the enrollee "must" complete the written appeal form. It goes on to state that Medica will investigate the enrollee's appeal. MDH found that Medica investigated the appeal, whether or not the form was completed. Medica should discuss the text of its acknowledgement letter to ensure that it is consistent with federal law and DHS contract requirements.

§438.410 (b). DHS contract section 8.4.5 (I), states, the plan must not take punitive action against a provider who requests an expedited resolution or supports an enrollee's appeal. As a policy required by contract and law, the statement should be reflected in its policy/procedures. **(Mandatory Improvement #2)**

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

Minnesota Rules, Part 4685.1010. Availability and Accessibility

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

Minnesota Statutes, Section 62Q.55. Emergency Services

☒ Met ☐ Not Met

Minnesota Statutes, Section 62Q.527. Coverage of Non-formulary Drugs for Mental Illness and Emotional Disturbance

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

Subd. 3. Minnesota Statutes, section 62Q.527, subdivision 3, states that enrollees receiving a prescribed drug to treat a diagnosed mental illness or emotional disturbance may continue to receive the prescribed drug for up to one year....when a health plan's drug formulary changes or an enrollee changes health plans and the medication has been shown to effectively treat the patient's condition. Medica's MHCP-MC and MinnesotaCare Evidence of Coverage documents state that the drug will be covered for up to one year, however, the Medica Elect and Medica Essential Certificate of Coverage document lacks this required clarity. Further, Medica's policies/procedures did not state that the drug may be covered for up to a year. Medica must revise the Certificate of Coverage and policies/procedures to state that if the enrollee is eligible, the drug may be covered for up to a year. **(Mandatory Improvement #3).**

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

Subd. 2.	Coverage required	☒ Met	☐ Not Met

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

Subd. 1.	Change in health care provider, general notification	☒ Met	☐ Not Met
Subd. 1a.	Change in health care provider, termination not for cause	☒ Met	☐ Not Met
Subd. 1b.	Change in health care provider, termination for cause	☒ Met	☐ Not Met
Subd. 2.	Change in health plans	☒ Met	☐ Not Met

V. Utilization Review

UM System File Review	
File Source	**#Reviewed**
UM Denial Files	
Commercial	
Medica	4
MedImpact	3
Optum	1
MHCP-MC	
Medica	8
MedImpact	5
Optum (all)	2
MBH (all)	2
Subtotal	*25*
Clinical Appeal Files	
Commercial	
Medica (all)	2
MHCP-MC	
Medica	5
Optum (all)	1
MBH (all)	4
Subtotal	*12*
Total	**37**

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	☒ NCQA
Subd. 3.	Notification of Determination	☒ Met	☐ Not Met	
Subd. 3a.	Standard Review Determination	☒ Met	☐ Not Met	
(a)	Initial determination to certify (10 business days)	☐ Met	☐ Not Met	☒ NCQA
(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	☐ NCQA

Subd. 3b.	Expedited Review Determination	☐ Met	☐ Not Met	☒ NCQA
Subd. 4.	Failure to Provide Necessary Information	☒ Met	☐ Not Met	
Subd. 5.	Notifications to Claims Administrator	☒ Met	☐ Not Met	

Subd. 3a (c). Minnesota Statutes, section 62M.05, subdivision 3a (c), states in pertinent part that, upon request, the plan must provide the criteria used to determine the necessity, appropriateness, and efficacy of the health care service. Minnesota Rules, part 4685.0100, subpart 9b, provides the definition for medical necessity. The definition of medical necessity within Medica's *Pharmacy Utilization Management Request* Policy and *Turnaround Times for Medical Necessity Reviews* (UM 0055P), does not mirror the definition in Minnesota Rules however, within the policy it notes the wording of the medical necessity definition in the member's benefit document may vary from the policy definition. The medical necessity definition within the member's benefit document had all the required elements and according to staff interviews, is used when the Medical Director makes a pharmacy determination for commercial and MHCP-MC enrollee reviews. Medica must revise its policies/procedures to reflect its actual practice and to be consistent with Minnesota law. **(Mandatory Improvement #4)**

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

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

Minnesota Statutes, Section 62M.08. Confidentiality

☐ Met ☐ Not Met ☒ NCQA

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

Subd. 1.	Staff Criteria	☐ Met	☐ Not Met	☒ NCQA
Subd. 2.	Licensure Requirements	☐ Met	☐ Not Met	☒ NCQA
Subd. 3.	Physician Reviewer Involvement	☐ Met	☐ Not Met	☒ NCQA
Subd. 3a	Mental Health and Substance Abuse Review	☒ Met	☐ Not Met	
Subd. 4.	Dentist Plan Reviews	☐ Met	☐ Not Met	☒ NCQA

Subd. 4a.	Chiropractic Reviews	☐ Met	☐ Not Met	☒ NCQA
Subd. 5.	Written Clinical Criteria	☐ Met	☐ Not Met	☒ NCQA
Subd. 6.	Physician Consultants	☐ Met	☐ Not Met	☒ NCQA
Subd. 7.	Training for Program Staff	☐ Met	☐ Not Met	☒ NCQA
Subd. 8.	Quality Assessment Program	☐ Met	☐ Not Met	☒ NCQA

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

☒ Met ☐ Not Met

VI. Recommendations

1. To better comply with Minnesota Rules, part 4685.1110, subpart 6, MDH recommends that the reports Medica prepares as a result of its annual oversight be included in the care coordination delegation agreements to better describe the type of oversight Medica will perform.

2. To better comply with Minnesota Statutes, section 62Q.69, subdivision 3, MDH recommends Medica provide additional detail found in the certificate of coverage description of the complaint process in its complaint form.

3. To better comply with Minnesota Statutes, section 62Q.73, subdivisions 3 and 6, MDH recommends that, for products regulated by MDH, Medica should revise its Certificates of Coverage to state refunds are provided by the external review entity. In addition, Medica's Utilization Management Program Description and policies/procedures should correctly state that the external review entity notifies Medica of the request for external review

VII. Mandatory Improvements

1. To comply with Minnesota Statutes, section 62Q.69, subdivision 3, Medica must revise its policy/procedure on items included in the complaints resolution letters to include the "reasons for the determination".

2. To comply with 42 CFR 438.410 (b), (DHS contract section 8.4.5 (I)), Medica must revise its grievance/appeal policy/procedure to state it will not take punitive action against a provider who requests an expedited resolution or supports an enrollee's appeal.

3. To comply with Minnesota Statutes, section 62Q.527, subdivision 3, Medica must revise Certificates of Coverage and policies/procedures to state that, if the enrollee is eligible, a non-formulary drug for mental illness or emotional disturbance drug may continue to be covered for up to a year.

4. To comply with Minnesota Statutes, section 62M.05, subdivision 3a (c), Medica must revise its pharmacy utilization management policy/procedure to reflect its actual practice and to be consistent with Minnesota law.

VIII. Deficiencies

1. To comply with Minnesota Statutes, section 62Q.69, subdivision 2, Medica must inform the oral complainant that the complaint can be submitted in writing following the 10th day.

2. To comply with Minnesota Statutes, section 62Q.69, subdivision 2, and 42 CFR 438.408 (d)(1) (DHS Contract section 8.2.5(a)), Medica must consistently offer assistance in completing the complaint/grievance form including an offer to complete the form and send it to the enrollee for signature.