Minnesota Department of Human Services

Managed Care (MSHO and MSC+) Elderly Waiver Care Planning Audit
(as required under 7.1.4.D., 7.8.3, and 9.3.7 of the 2016 MSHO/MSC+ contract)

2018 Audit Protocol

Final 4-30-18

(Referred to as the "Care Plan Data Collection Guide" in the DHS Triennial Compliance Assessment (TCA) conducted by the Minnesota Department of Health)

Goal: To facilitate an interdisciplinary, holistic, and preventive approach to determine and meet the health care and supportive services needs of enrollees.

Description:

- The Audit Protocol/Data Collection Guide is presented by element, first presenting outcomes related to assessment and enrollment/disenrollment and then followed by outcomes related to comprehensive care planning and waiver services. It also incorporates person-centered planning requirements. The method and acceptable evidence for determining outcome achievement is described for each desired outcome and the criteria for achieving a "met" or "not met" score is outlined in the middle column of the matrix under the heading "Method for measuring outcome achievement." This 2018 Audit Protocol was developed for use in auditing care plans created in 2018 in CY2019.

- Currently, MSHO/MSC+ health plans use the LTCC for assessment. MnCHOICES is referenced only to reflect that at some point MSHO/MSC+ health plans will begin using MnCHOICES for assessment. DHS will inform health plans when MnCHOICES can be used for MSHO/MSC+.

MCO sampling instructions:

- The sampling method is to be applied to each delegate under contract with the MCO for care coordination (MSHO) and case management (MSC+). The sample can proportionately combine MSHO and MSC+ enrollees assuming enrollees of both programs receive the same level of care coordination.

MCO sampling instructions: (continued)

- Each MCO will randomly sample by delegate 30 eligible EW MSHO/MSC+ care plans for each delegate of which 8 will be randomly selected for review[1]. If any of the 8 records produce a "not met" score for any of the outcomes outlined in the Audit Protocol/Data Collection Guide, then the remaining 22 records will be examined for the outcome(s) resulting in "not met" findings. For delegates with fewer than 30 eligible care plans, then 8 care plans will be pulled from all eligible care plans. If a delegate has fewer than 8 eligible care plans, then all eligible care plans will be reviewed for that delegate.

- Because some elements pertaining to assessment apply to new enrollees (new enrollees within the last 12 months) and others to existing cases (enrollees for more than 12 months), MCOs should ensure that they have an adequate number of cases to evaluate compliance per these elements.

Sources of Evidence:

- Sources of evidence may include the following: Comprehensive Care Plan case notes to supplement Comprehensive Care Plan, MCO Health Risk Assessment (initial assessment conducted at time of enrollment), LTCC/MnCHOICES Assessment, HCBS service plan and the Residential Services Tool and Plan if applicable.

Reporting:

MCO reporting to DHS:

- MCOs will complete a report via Snap survey for MSHO and MSC+ for each delegate under contract with the MCO for care coordination (MSHO) and case management (MSC+) indicating the results of the audit.
- MCOs will prepare a summary of key findings and recommendations. Findings are reported at the delegate level. Reports include corrective actions indicated and opportunities for improvement identified as well as performance on specific requirements related to care plans. Additional follow-up information will be reported to DHS in such a manner that DHS can determine that corrective actions were implemented, including a plan for monitoring completion of required actions.
- Refer to the "MCO 20187 Care Plan Audit Report Instructions" for information about reporting findings in the "MCO Care Plan Audit Report Format" tool.

[1] Additional cases are selected in the initial sampling for replacement purposes.

MDH sampling instructions for the Triennial Compliance Assessment (TCA):

- When conducting care plan reviews for the DHS TCA, DHS will randomly sample 20 "new" care plans and 20 "existing" care plans from the MCO's program population, resulting in a total of 40 sampled care plans. For elements pertaining only to "new" care plans and elements pertaining only to "existing" care plans.

- For elements pertaining only to "new" care plans and elements pertaining only to "existing" care plans, MDH will randomly sample 8 from each sub-sample for those elements. After the completion of the elements unique to "new" and "existing", MDH will then sample four care plans from each subsample of "new" and "existing" care plans for a total of 8 care plans. MDH will then review these 8 care plans. If any of the 8 care plans produce a "not met" score for any of the outcomes outlined in the Audit Protocol/Data Collection Guide, then 22 of the remaining care plans (combining "new" and "existing" subsamples) will be examined for the outcome(s) resulting in "not met" findings.

MDH reporting to DHS:

- MDH will prepare a summary report of the care plan review findings for DHS. DHS will respond to deficient findings as it determines appropriate.

1. ENROLLEE ASSESSMENT

Desired outcome: All enrollees will receive a complete assessment as applicable within required timelines.

Method for measuring outcome achievement (met as determined by all of the following):

1.1 Timeliness:

a. Initial HRA completed within 30 calendar days of enrollment **or**

An explanation is documented if HRA attempted but not completed within 30 calendar days of enrollment date when:

- enrollee refused completion of the initial HRA, or
- enrollee was admitted to a hospital before the 30th calendar day, or
- enrollee was admitted to a nursing facility for a short-term stay of 30 or fewer days before the 30th calendar day after enrollment date **or**

b. Reassessment completed within 365 days of previous assessment; **or**
An explanation is documented if completed but not within 365 days of previous assessment **or**

c. LTCC/HRA completed within 20 calendar days of member request; **or**
An explanation is documented if completed but not within 20 calendar days of the request

1.2 Complete:

All (100%) of the fields relevant to the enrollee's assessment are completed with pertinent information or noted as Not Applicable or Not Needed as appropriate

a. All (100%) items within each domain listed below in the assessment are completed, or noted as Not Applicable or Not Needed as appropriate.

(1) Section A - Assessment Information (Section A)
(2) Section B - Information About Me (Section B)
(3) Section C - Assessment Information (Section C)
(4) Section F - My Health (Section L)
(5) Section G - Taking Care of Myself (Section M)
(6) Section H - My Emotional and Mental Health (Section E)
(7) Section I- My Safety (Section F)
(8) Section J - Assessment Results (Section G)
(9) Section K - Service Plan Summary (Section H)

(10) Section O - Caregiver Assessment (Section P)

1.3 Complete for Person-Centered Domains

a. All (100%) of the fields within each domain listed below are completed with pertinent information or noted as Not Applicable or Not Needed as appropriate.

(1) Section D - My Everyday Life (Section N)
(2) Section E - Relationships and Community Connections (Section D)

Not met as determined by the following:
The above stated requirements are not met per each sub-element.

Source of Evidence:LTCC or MnCHOICES assessment. Sections noted are those found in DHS Form 3428. Sections in ( ) are comparable sections from DHS Form 3428A.

Contract Citation(s):
6.1.4(A)(1)

6.1.5(B)(1)
6.1.24 (A)
6.1.14 (C)

CMS Assurance Performance Measure #3, #4 and #5; data source is MMIS

Federal PCP requirement: 1.3

2. COMPREHENSIVE CARE PLAN - Timeliness

Desired Outcome: Enrollees receive a completed Comprehensive Care Plan within 30 calendar days of a completed LTCC/MnCHOICES Assessment.

Method for measuring outcome achievement (met as determined by at least one of the following):

a. Comprehensive Care Plan is completed and sent to member within 30 calendar days of the date of a completed LTCC/MnCHOICES assessment; **or**

If not sent, a member related explanation of status is documented;

Not met as determined by the following:
None of the above stated methods to meet this requirement are documented.

Source of Evidence:
Comprehensive care plan, care coordinator notes.

Contract Citation(s):
6.1.4(A)(2)
6.1.5(B)(4)
6.1.14(B)

CMS Assurance Performance Measure #19

3. COMPREHENSIVE CARE PLAN – Assessed Needs Addressed

Desired Outcome: The Comprehensive Care Plan (CCP) addresses all enrollee assessed needs and preferences, and reflects an interdisciplinary, holistic and preventive focus.

Method for measuring outcome achievement (met as determined by all of the following):

3.1 The CCP addresses assessed needs in areas of life identified as important for the person.

a. All enrollee's assessed needs and concerns related to primary care, acute care, long-term services and supports , mental health, behavioral, and service needs and concerns are addressed in the care plan;

and

b. The need for services essential to the health and safety of the enrollee is documented;

and

c. If essential services are included in the plan, a back-up plan for provision of essential services is also documented;

and

d. There is a plan described for community-wide disasters, such as weather related conditions included.

Not met as determined by the following:
The above stated requirements are not met per each sub-element.

Source of Evidence:
Care plan.

Contract Citation(s):
6.1.4(A)(2) and (3)
6.1.5(B)(4)
6.1.14(B)

CMS Assurance Performance Measures #12 and #13

3.2 The CCP addresses requests for assistance in areas of life identified as important to the person.

a. If the enrollee indicated they want assistance related to social, recreational, leisure or religious activities, this assistance is addressed in the care plan;

and

b. If the enrollee indicated they want assistance related to social or family relationships, this assistance is addressed in the care plan;

and

c. If the enrollee indicated they want assistance related to employment or volunteering, this assistance is addressed in the care plan.

Source of evidence:
Care Plan

Federal PCP requirement

4. COMPREHENSIVE CARE PLAN – Goals

Desired Outcome: The enrollee's goals or skills to be achieved are included in plan, are related to the enrollee's preferences and how the enrollee wants to live their life, and there is a plan to achieve their goals.

Method for measuring outcome achievement (met as determined by all of the following):

a. Goals and/or skills selected by the enrollee to be achieved are clearly described;

and

b. Action steps, including services or supports needed, are identified and describe what needs to be done to assist the enrollee to achieve the goals or skills;

and

c. Monitoring progress towards goals is included;

and

d. Target dates for goal completion are included (at least month and year);

and

e. Outcome/achievement dates are included;(at least month and year);

and

f. People/providers responsible for assisting the enrollee in completing each step are identified.

Not met as determined by the following:
The above stated requirements are not met per each sub-element.

Source of Evidence:
Care plan and item F.9a related to training on assistive devices.
Provider care plan/summary.

Citation(s):
42 CFR, Section 441.725, contract cite for compliance with federal requirements

Contract Citation(s):
6.1.4(A)(2) and (3)
6.1.5(B)(4)
6.1.14(B)

CMS Assurance Performance Measure #14
Federal PCP requirement

5. COMPREHENSIVE CARE PLAN - Choice

Desired Outcome: The enrollee is provided information related to, and makes informed choices about, long-term care services and providers.
Method for measuring outcome achievement (met as determined by all of the following):

a. The enrollee was offered choices among HCBS services;

and

b. The enrollee was given information to enable the enrollee to choose among providers of HCBS services chosen.

Source of Evidence:

Care plan budget worksheet or equivalent
Services Summary Section K or H of LTCC (e-docs #3428 or #3428A respectively) or MnCHOICES Assessment Form or equivalent document.

Not met as determined by the following:
No evidence of choice in each desired outcome is found.

Contract Citation(s):
6.1.14(B)
6.1.14(L)(1)
6.1.24(A)(10)(a)

CMS Assurance Performance Measure #27

6. COMPREHENSIVE CARE PLAN - Safety Plan/Personal Risk Management Plan

Desired Outcome: The enrollee has a plan to address identified safety issues and risks.

Method for measuring outcome achievement (met as determined by all of the following):

a. Discussion between care coordinator and enrollee regarding safety concerns/risks is documented;

and

b. The plan for managing risks discussed is included in the care plan **or**

It is documented that no plan for managing risks is needed.

and

c. If there are areas in which opportunities for choice are limited due to safety concerns/risk, these are listed in the care plan. (Person-Centered Planning Comments, Sections E and I; in DHS Form 3428A, Sections D and F).

Not met as determined by the following:
The above stated requirements are not met per each sub-element.

Source of Evidence:
Care plan section.

Contract Citation(s):
6.1.14(B)(1)
6.1.4(A)(2)(b)

CMS Assurance Performance Measure #29

7. COMPREHENSIVE CARE PLAN – Informal and Formal Services

Desired Outcome: The enrollee receives a description of their formal and informal services that contains all required elements.

Method for measuring outcome achievement (met as determined by all of the following):

The enrollee's comprehensive care plan includes:

a. type of services to be furnished;

and

b. the amount, frequency, duration and cost of each service;

and

c. the type of provider, and name of provider if known, furnishing each service including non-paid care givers and other informal community supports or resources; **or**

If not all elements completed, an explanation of status must be present and documented.

Not met as determined by the following:
The above stated requirements are not met per each sub-element.

Source of Evidence:
Care plan.

Contract Citation(s):
6.1.14(B)(1)

CMS Assurance Performance Measure #23

8. COMPREHENSIVE CARE PLAN – Caregiver Support

Desired Outcome: Informal caregivers are identified and supported in the plan.

Method for measuring outcome achievement (met as determined by the following):

If a non-paid caregiver is identified in the LTCC/MnCHOICES Assessment, then met is determined by the following:

a. If a caregiver assessment was completed and supports were requested, the supports are incorporated into the care plan.

Not met as determined by the following:
The above stated requirements are not met per each sub-element.

Source of Evidence:
LTCC/MnCHOICES Caregiver Interview.
Care Plan - Service Plan.

Contract Citation(s):
6.1.14(A)
6.1.14(B)

CMS Assurance Performance Measure #23

9. COMPREHENSIVE CARE PLAN – Housing and Transition

Desired Outcome: The enrollee has a transition plan to support housing choice.

Method for measuring outcome achievement (met as determined by all of the following):

a. If the enrollee indicated they want assistance in exploring housing options, the transition plan (My Move Plan) reflects a goal, steps to be taken, potential barriers;

and

b. The transition plan (My Move Plan) is attached to the Care Plan.

Not met as determined by the following:
The above stated requirements are not met per each sub-element.

Source of Evidence:
DHS Form 3428: Section E., items E.12, E.13, and E.13a; or DHS Form 3428A, Section D, items D.12, D.13 and D.13a.
Preparation of transition plan that meets transition plan requirements (action steps).
My Move Plan.

Citation:
42 CFR, Section 441.725

Contract Citation:
6.1.24

CMS Assurance Performance Measure#13, #14
Federal PCP requirement

10. COMMUNICATION OF CARE PLAN/ SUMMARY - Physician

Desired Outcome: The enrollee's primary care physician receives a Care Plan Summary.

Method for measuring outcome achievement (met as determined by all of the following):

a. Evidence of care coordinator communication of care plan elements with Primary Care Physician (PCP).

Not met as determined by the following:
Evidence not present of communication of care plan summary to PCP.

Source of Evidence:
Care plan.
Case notes.

Contract Citation(s):
6.1.4 (A)(2)(a)
6.1.14(B)(5)

11. COMMUNICATION OF CARE PLAN/SUMMARY -Enrollee and Providers

Desired Outcome: The support plan is signed and dated by and disseminated to all relevant parties.

Method for measuring outcome achievement (met as determined by all of the following):

a. The care plan is signed and dated by the enrollee or authorized representative;

and

b. The care plan reflects the enrollee's choice of providers who are to receive the care plan/summary;

and

c. Documentation indicates the care plan/summary was sent to the provider(s) within 30 days of the completion of the care plan, including date and method;

and

d. Documentation indicates that the care plan/summary was sent again, including date and method, to providers who have not returned the communication tool within 60 days of the completion of the care plan.

Not met as determined by the following:
The above stated requirements are not met per each sub-element.

Source of Evidence:
Care plan.

Citation:
42 CFR, Section 441.725

CMS Assurance Performance Measure #23, #24
Federal PCP requirement

12. COMPREHENSIVE CARE PLAN – Enrollee Requests for Updates

Desired Outcome: The plan includes a method for the individual to request updates to the plan, as needed.

Method for measuring outcome achievement (met as determined by all of the following):

a. The Care Plan includes how the individual can request changes to the plan.

Not met as determined by the following:
The care plan does not include how the individual can request changes to the plan.

Source of Evidence:
Care plan.

Citation(s):
42 CFR, Section 441.725, contract cite for compliance with federal requirements

Contract Citation(s):
6.1.4(B)(5)
6.1.5(B)(16)(d)

Federal PCP requirement

13. CARE COORDINATOR FOLLOW-UP PLAN

Desired Outcome: Enrollees have a care coordinator follow-up or contact plan related to identified concerns or needs[2], and the plan is implemented.

Method for measuring outcome achievement (met as determined by all of the following):

a. Care Coordinator documents their plan for enrollee contact;

and

b. Care Coordinator documents contact with enrollee according to plan; **or**

Documents the reason the plan was not followed.

Not met as determined by the following:
The above stated requirements are not met per each sub-element.

Source of Evidence:
Care plan.

Contract Citation(s):
6.1.4(B)(6)
6.1.5(B)(16)(e)

Federal PCP requirement

[2] Follow-up plan must address based on individual needs:

Identified preventive care concerns including but not limited to annual physical, immunizations, screening exams such as dementia screening, vision and hearing exams, health care (advance) directive, dental care, tobacco use, and alcohol use.

Identified long-term care and community support concerns including but not limited to caregiver support, environmental and personal safety (e.g. falls prevention), home management, personal assistance, and supervision, long-term health-related needs (e.g., clinical monitoring, special treatments, medication monitoring, and palliative/hospice care).

Identified medical care concerns including but not limited to the management of chronic disease such as hypertension, CHF/heart disease, respiratory /lung disease, diabetes, and joint/muscle disease.

Identified mental health care concerns including but not limited to depression, dementia, and other mental illness.

14. ANNUAL PREVENTIVE HEALTH EXAM

Desired Outcome: Enrollee engages in conversation about the need for an annual, age–appropriate comprehensive preventive health exam with care coordinator.

Method for measuring outcome achievement (met as determined by all of the following):

a. Documentation is present in enrollee's Comprehensive Care Plan that substantiates a conversation was initiated with enrollee about the need for an annual, age-appropriate comprehensive preventive health exam.

Not met as determined by the following:
No evidence of conversation about the importance of annual preventive health care present in enrollee's Comprehensive Care Plan.

Source of Evidence:
Care plan.

Contract Citation(s):
6.1.4(B)(2)
6.1.5(A)(2)
6.1.6(B)

15. ADVANCE DIRECTIVE

Desired Outcome: Enrollee has opportunity for annual discussion about and/or completion of an Advance Directive.

Method for measuring outcome achievement (met as determined by any of the following):

a. Advance Directive exists; **or**

Care coordinator documents annual initiation of conversation about Advance Directive; **or**

Care coordinator documents enrollee's refusal to complete an Advance Directive; **or**

Care coordinator documents reason why Advance Directive conversation was not initiated.

Not met as determined by the following:
None of the above stated methods to meet this requirements are documented.

Source of Evidence:
Care Plan.

Contract Citation(s):
6.1.4(A)(2)(c)
6.1.5(B)(4)

16. APPEAL RIGHTS

Desired Outcome: Enrollee receives information about their appeal rights.

Method for measuring outcome achievement (met as determined by all of the following):

a. Completed and signed care plan indicates receipt of appeal rights; **or**

Other MCO signed documentation in enrollee file indicates receipt of appeal rights.

Not met as determined by the following:
No documentation that the enrollee received information about their appeal rights.

Source of Evidence:
Care plan, other signed documentation.

Contract Citation(s):
3.4.G
6.1.14 (B)

Federal PCP requirement

17. DATA PRIVACY

Desired Outcome: Enrollee receives information about data privacy.

Method for measuring outcome achievement (met as determined by all of the following):

a. Completed and signed care plan indicates receipt of data privacy information; **or**

Other MCO signed documentation in enrollee file indicates receipt of data privacy information.

Not met as determined by the following:
No documentation that the enrollee received information about data privacy.

Source of Evidence:
Care plan, other signed documentation.

Contract Citation(s):
6.1.4(B)(13)
6.1.5(B)(16)(l)
6.1.4(A)(2)
6.1.5(B)(4)