Subject Delegation Oversight for Care Coordination (MSHO/MSC+ and SNBC)	**Attachments** ☒ Yes ☐ No
Key words Delegation, Oversight, Care Coordination, Delegate, MSHO/MSC+, SNBC	AD 004
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Manual HealthPartners Administrative Manual	**Last Review Date** **4/1/2018**
Issued By Professional Services Network Management and Hospital and Regional Network Management	**Next Review Date** **4/1/2019**
Applicable All Primary Care Providers All Specialty Care Providers All Facilities and Providers Care systems, agencies, and counties that subcontract with HealthPartners to provide care coordination for MSHO, MSC+ and/or SNBC members	**Origination Date** **9/1/2017** **Retired Date**
Review Responsibility Sue Oestreich, Ashley Horak, Laurel Rose, Bev Vacinek, Cheryl Wilson, and Quanah Walker	**Contact** Carolyn Koch

Products:

☐ Fully Insured ☐ Self-Insured ☐ Medicare ☐ Medicare Advantage ☐ Medicaid ☒ MSHO

☒ MSC+ ☒ SNBC WI Marketplace

I. PURPOSE

Define delegation oversight activities conducted by those delegates contracted by HealthPartners to provide care coordination services for MSHO/MSC+/SNBC members and to define HealthPartners expectations of those delegates.

II. POLICY

HealthPartners oversees contracted delegates in order to ensure delegated partners provide care coordination to members according to our Care Coordination administrative policy.

PROCEDURE(S)

HealthPartners conducts delegation oversight activities throughout the year and expects delegated partners to adhere to regulatory requirements issued by the Center for Medicare and Medicaid

Services (CMS), Minnesota Department of Human Services (DHS) and HealthPartners. Contracted delegates are also expected to participate in quality improvement activities initiated by HealthPartners, to utilize reports provided by HealthPartners to effectively manage care coordination of assigned members, and to provide HealthPartners with key care coordination metrics on a routine basis.

A. HealthPartners conducts delegation oversight activities throughout the year and includes, but is not limited to, the following activities:

1) Annual Delegate Review/Attestation (Annual)

HealthPartners reviews each delegate's performance annually regarding compliance with CMS, DHS and HealthPartners requirements as part of its Annual Delegation Review/Attestation. Delegates are expected to complete an attestation regarding the review and understanding of care coordination policies, procedures and workflows. Review will include but is not limited to:

a. Use of sub-delegates
b. Use of licensed and non-licensed (SNBC only) professionals as care coordinators
c. Monthly membership reconciliation
d. Caseload ratios for care coordinators
e. Continuing education and training of care coordinators
f. Review and attestation of required HealthPartners policy and procedures

2) Health Risk Assessment and Care Plan Audit (includes EW Audit for MSHO/MSC+ members) (Annual)

HealthPartners conducts an annual audit of Health Risk Assessments (HRAs) and Individualized Care Plans (ICPs) for a sampling of members assigned to each delegate. HealthPartners uses the MN DHS MSHO/MSC+ Elderly Waiver Care Plan and Non-Elderly Waiver Audit Protocols for MSHO/MSC+ membership and the MN DHS SNBC Audit Protocol for SNBC membership. The auditor conducts the chart review, calculates a compliance score and shares findings with each delegate. A corrective action plan (CAP) is required for any element not meeting audit requirements. The MSHO/MSC+ audit is conducted by the HealthPartners Disease and Case Management (DCM) department and the SNBC audit is completed by DCM and Behavioral Health departments.

3) Healthcare Effectiveness Data and Information Set (HEDIS) and STARS Data Collection (Annual)

HealthPartners expects the delegate to provide the necessary information for select MSHO members regarding HEDIS and/or STARS measures to ensure HealthPartners meets reporting requirements. Delegates receive a list of members and are expected to return the requested documentation within the prescribed time frame.

4) Health Outcome Survey (HOS) (Annual) and Consumer Assessment of Health Care Providers and Systems (CAHPS) (Annual)

HealthPartners administers two Medicare surveys to its MSHO members which are HOS, a patient-reported outcomes measure, and CAHPS, a patient experience measure. Although delegate specific results are not available, the performance of the delegates' care coordinators

may influence the outcomes of the surveys and HealthPartners expects delegates to provide appropriate clinical and customer services.

5) Liaison – HealthPartners Primary Contact (Daily Availability)

   HealthPartners assigns a liaison to each delegate as their primary contact. The role of the liaison is to provide guidance to the delegate regarding care coordination. The liaison can be reached by phone, email or fax. HealthPartners also provides a webpage for delegates which contains forms, care guides, templates and other clinical resources.

6) Monthly Expectations(Monthly)

   HealthPartners requires each delegate to complete monthly tasks including those stated below:

   1 Review their monthly enrollment list for accuracy
   2 Ensure each member has an assigned care coordinator
   3 Complete and return the HRA Log with the requested information including assessment status, method of assessment, and completion dates. The HRA Log for MSHO/MSC+ also includes care plan completion dates and unable-to-reach information.
   4 Complete and return the HP Care Transition Post Discharge Assessment form for each member when a care transition occurs, (MSHO/MSC+ only, SNBC care transition support is documented in case notes). The form collects information about the member's post discharge assessment and transition from an acute care setting including medication review, red flags, changes and interventions.

   The information provided allows HealthPartners to monitor delegate performance and meet regulatory requirements. HealthPartners DCM department monitors the delegate's completion of these tasks.

7) Patient Satisfaction Survey (Annual)

   HealthPartners completes annual surveys of its MSHO/MSC+ and SNBC members to allow members to share feedback about their experience. The surveys evaluate the care provided by its care coordinators and the member's satisfaction with the provided services. The performance of the delegates' care coordinators influence the outcomes of the surveys and HealthPartners expects delegates to provide appropriate clinical and customer services. The annual surveys are conducted in the fall of each year and the results are shared with DCM leadership.

8) Site Visit and/or Meetings (minimum one per year)

   HealthPartners Care Coordination and Behavioral Health leaders will meet with delegates during the year, whether in-person, at the delegate's site or by conference call, to discuss the contractual relationship, clinical services, administrative policies and opportunities for improvement to better meet the needs of the members. Site visits for delegate audits and conference calls for discussing audit results may serve as the annual meeting. Delegates can also request a meeting when desired.

9) Training of Delegate Providers and Staff (ongoing)

HealthPartners provides multiple training opportunities throughout the year for the delegates' care coordinators, providers and staff. Training will occur when necessary to communicate regulatory or other changes in a timely manner. MSHO Model of Care (MOC) training is required to be completed for care coordinators and providers serving HealthPartners members. Delegates are required to maintain attendance records including sign in sheets of those who attended, train those who did not attend, train new employees, and record training of those who did and did not attend.

B. HealthPartners expects its delegates to participate, as requested, in regulatory reviews, audits and ad-hoc reporting by CMS and DHS including but not limited to:

1) CMS Audit of Health Plan including Model of Care for MSHO only (per CMS schedule)

   For those delegates who serve MSHO members, HealthPartners expects delegates to provide the necessary information needed for a CMS Audit of Health Plan, also called CMS Program Audit of the MSHO product. The CMS Program Audit includes an audit of the MSHO Model of Care. The audits are unscheduled and can occur at any time. The CMS Program Audit includes a chart review and delegates will be required to provide member chart information under a very short turnaround time, less than two business days, and also need to have a designated care coordination representative available for additional requests during the audit. DCM team members will notify and communicate with the delegates prior to and during the audit. HealthPartners expects delegates to maintain a constant state of audit readiness.

2) CMS Part C Element #13 Special Need Plan Care Coordination for MSHO only (Annual)

   For those delegates who serve MSHO members, HealthPartners expects delegates to provide the necessary information needed for the Medicare Part C Plan Reporting Requirements, specifically Element 13 Special Needs Plans Care Management. Delegates are expected to complete the monthly HRA Log, as described as part of Monthly Expectations. At calendar year end, delegates are expected to submit the December HRA Log and any outstanding HP Unable to Reach forms promptly, in early January, to ensure HealthPartners meets the CMS deadline in February.

3) DHS EW/Non EW and SNBC Care Plan Audit Summaries (Annual)

   Each year, HealthPartners submits a summary report of the MSHO/MSC+ EW and non-EW Care plan audit and SNBC audit results to DHS. HealthPartners completes the summary reports in the fall of each year in accordance with DHS audit protocols and may require additional input from the delegate when completing the summary.

4) DHS Audit of Health Plan – Quality Assurance Examination and Triennial Compliance Assessment (every three years)

   The DHS Audit of Health Plan typically conducted by the MN Department of Health (MDH), includes the Quality Assurance Examination and the Triennial Compliance Assessment. The audits occur every three years to ensure compliance with MN law and DHS contract requirements. The audit includes a HRA Care Plan audit using the MN DHS Elderly Waiver audit protocols for MSHO/MSC+ members and MN DHS SNBC audit protocols. The audits include a chart review and delegates are required to provide member chart information under a very short turnaround time and also need to be available for additional requests during the audit period. DCM team members will communicate with the delegates prior to and during the audit. HealthPartners expects delegates to maintain a constant state of audit readiness.

C. HealthPartners expects its delegates to support HealthPartners Quality Improvement Program and to participate, as requested, in quality improvement initiatives including:

1) Quality Improvement Activities (including Quality Improvement Projects, Performance Improvement Projects and Chronic Care Improvement Projects.) (annual and multi-year) HealthPartners establishes multi-year initiatives in collaboration with CMS and DHS based on the HealthPartners Triple Aim: improving health, providing a better experience and making health care more affordable. HealthPartners expects its delegates to participate in these activities such as reporting clinical data or implementing new procedures when requested.

2) Quality Measures (ad hoc)
HealthPartners has established quality measures with benchmarks and goals for our Triple Aim and Model of Care initiatives. HealthPartners expects its delegates to participate in the activities such as reporting clinical data or implementing new procedures when requested.

D. HealthPartners expects its delegates to review and utilize reports provided to the delegate by HealthPartners regarding the delegate's assigned members and the member's utilization of services including but not limited to:

1) Enrollment reports (monthly)
HealthPartners delivers, through its secure provider portal, monthly reports about the members assigned to the delegate. Enrollment information includes new members as well as current or future membership changes. HealthPartners expects delegates to use the reports to manage their members and reconcile the lists to insure accuracy and care coordination assignments.

2) Utilization reports (daily)
HealthPartners delivers, through its secure provider portal, daily hospital admission reports for members assigned to the delegate. HealthPartners expects delegates to use the reports to support members throughout each transition of care. Delegate are expected to emphasize post-discharge support to decrease the member's likelihood of experiencing an avoidable readmission.

3) Utilization reports (monthly)
HealthPartners delivers, through its secure provider portal, ongoing reports about the members assigned to the delegate. Information includes inpatient admissions, emergency room visit claims, members with chronic conditions and other key metric reports. HealthPartners expects delegates to use the reports to manage their members and ensure safe, timely, effective, efficient, equitable and patient centered healthcare to those members.

E. Delegates are expected to remain compliant and complete the delegation oversight activities, expectations and requirements in a responsive, professional and timely manner throughout the year.

Delegates are expected to maintain appropriate communication with HealthPartners including a centralized intake phone and fax number and centralized email address with secure encryption capabilities with HealthPartners.

Delegates are expected at a minimum to complete each activity or request within the requested time frame. HealthPartners leadership will notify the delegate when they are delinquent in their responsibilities. When a delegate is considered delinquent in their responsibilities, the delegate will be subject to an escalating corrective action process. The escalating corrective action process includes, but not limited to, the following:

1) Additional requests by HealthPartners for missing or improved participation and/or documentation
2) Meeting between leadership to discuss issues/deficiencies and written corrective action plan completed by the delegate
3) Follow-up review and interaction with delegate, as needed, by appropriate staff
4) Decision by HealthPartners' leadership to require delegate to complete additional corrective action. Corrective action may include additional audits, suspension of new enrollment and recommendation to termination the delegate's contract for providing care coordination services.

IV. DEFINITIONS

Care Coordination: The assignment of an individual who coordinates the provision of all Medicare and Medicaid health and long-term care services for MSHO/MSC+ and/or SNBC members. The care coordinator is responsible for completing the health risk assessment and person-centered care plan with the member and for providing support and coordination of care between member, health professional and care settings.

Care Transitions
Care Transitions, or Transitions of Care, refers to the movement of patients between health care settings and home as the patient's condition and care needs change. The goals are to improve safe transitions, improve quality of care, and reduce avoidable readmissions.

Disease and Case Management (DCM)
A department within HealthPartners with the mission to improve the health and care of HealthPartners high risk members while serving as good stewards of health care resources. Care Coordination services for MSHO/MSC+ and SNBC products are housed in DCM.

Delegate
A care coordination entity providing services to members of a HealthPartners' MSHO/MSC+ and/or SNBC product. Care Coordination entities are typically Counties, Agencies and/or Care Systems, but could be other types of organizations as well.

Delegation Oversight
The process by which the health plan contracts with another entity (agency, county and/or care system) to perform care coordination services to the health plans member on behalf of the health plan, while the health plan retains final authority. The health plan establishes and implements an effective system for routine monitoring and identification of compliance risk with its delegates.

Health Risk Assessment (HRA)
The Health Risk Assessment tool meets DHS and HealthPartners requirements. For MSHO/MSC+ members, the tool used is the state's Long Term Care Consultation tool. The health risk assessment shall include questions designed to identify health risks and chronic conditions, including but not limited to: 1) activities of daily living, 2) risk of hospitalizations, 3) need for primary and preventive care, 4) mental health needs, 5) rehabilitative services, and 6) protocols for follow up to assure that physician visits, additional assessments or Case Management interventions are provided when indicated.

Minnesota Senior Care Plus (MSC+)
The Minnesota mandatory Prepaid Medical Assistance Plan (PMAP) for enrollees' age sixty five (65) and over. MSC+ used § 1915 (b) waiver authority for State Plan services, and § 1915 (c) waiver authority for Home and Community-based Services. MSC+ includes Elderly Waiver services for Enrollees who qualify, and one hundred and eighty (180) days of Nursing Facility care.

Minnesota Senior Health Options (MSHO)
The Minnesota prepaid managed care program, pursuant to Minnesota Statutes, § 256B.69, subd. 23, that provides integrated Medicare and Medicaid services for Medicaid eligible seniors, age sixty-five (65) and over. MSHO includes Elderly Waiver services for Enrollees who qualify and one hundred and eighty (180) days of Nursing Facility care.

Model of Care (MOC)
In accordance with CMS regulations, the Model of Care (MOC) provides the basic framework under which a special needs plan (including MSHO) will meet the needs of its enrollees. The MOC is a vital quality improvement tool and integral component for ensuring that the unique needs of each enrollee are identified and addressed through the plan's care management practices. It provides the foundation for promoting quality, care management and care coordination processes.

Prepaid Medical Assistance Plan (PMAP)
A Minnesota program authorized under Minnesota Statutes, § 256B.69 and Minnesota Rules, Parts 9500.1450 through 9500.1464.

Post Discharge
See Care Transitions

Special Needs Basic Care
The Minnesota prepaid managed care program, pursuant to Minnesota Statutes, § 256B.69, subd.28, that provides Medicaid services and/or integrated Medicare and Medicaid services to Medicaid eligible people with disabilities who are ages eighteen (18) through sixty-four (64).

V. COMPLIANCE

Failure to comply with this policy or the procedures may result in disciplinary action, up to and including termination.

VI. ATTACHMENTS

None

VII. OTHER RESOURCES

HealthPartners Code of Conduct
HealthPartners First Tier Downstream Related Entity (FDR) Policy
HealthPartners Fraud Waste and Abuse (FWS) Policy
HealthPartners Care Coordination (CC) for MSHO Policy
HealthPartners Care Coordination (CC) for SNBC Policy
HealthPartners and DHS Contract for MSHO/MSC+
HealthPartners and DHS Contract for SNBC

VIII. APPROVAL(S)

Laurel Rose
Director, Disease and Case Management

IX. ENDORSEMENT