Policy Title:	**Audit Process**
Department:	**Markets Growth & Retention**
Business Unit:	**Regulatory Oversight & Improvement**
Approved By:	**Senior Manager, Regulatory Oversight & Improvement**
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PRODUCTS AFFECTED

- Minnesota Senior Health Options (MSHO) – Medica DUAL Solution®
- Minnesota Senior Care Plus (MSC+) – Medica Choice Care℠ MSC+
- Special Needs BasicCare (SNBC) – Medica AccessAbility Solution®
- Special Needs BasicCare (SNBC) Special Needs Plan – Medica AccessAbility Solution Enhanced®

DEFINITIONS

Care Plan: The document developed in consultation with the member, the member's treating physician, health care or support professional, or other appropriate individuals, and where appropriate, the member's family, caregiver, or representative. The Care Plan, taking into account the extent of and need for any family or other supports for the member, identifies the necessary health, housing support, rehabilitation, Home and Community-Based services, and other services to be furnished to the member. The Care Plan for MSHO and MSC+ Elderly Waiver members must meet the federal and state requirements related to person-centered planning. Medica does not require the use of a specific Care Plan.. If a delegate plans to use a care plan other than those provided by Medica prior approval is required by Medica. Upon launch of the revised MnCHOICES application, the Community Support Plan will be referred to as the Assessment Summary and the Comprehensive Care Plan will be referred to as the Support Plan.

CMS: Centers for Medicare & Medicaid Services under the U.S. Department of Health and Human Services.

Delegate: A Care System, Agency or County contracted with Medica to provide care coordination to Medica members enrolled in the MSHO, MSC+, SNBC or SNBC Enhanced products. For purposes of this Policy, the term Delegate also includes Medica Health Services staff that provide care coordination services to members in the above products.

DHS: Minnesota Department of Human Services

Department of Human Services (DHS) Audit Protocol: The blueprint for conducting annual audits, created by DHS in collaboration with Minnesota (MN) Health Plans. The protocol aligns Elderly Waiver (EW), Non-EW, and SNBC annual audit requirements with the current year's contract requirements.

Elderly Waiver (EW): A Medical Assistance (MA) program that funds home and community-based services for people age 65 and older who require the level of care provided in a nursing facility, are eligible for long term care under Medical Assistance, and who choose to reside in the community**.**

Health Risk Assessment (HRA) and Assessment Tools for MSHO/MSC+

NOTE: Medica owned tools can be found on the Medica Care Coordination website under Tools and Forms. All DHS tools can be found on the DHS eDocs site.

- DHS 3428 Minnesota Long Term Care Consultation Services Assessment Form (LTCC) used for all MSHO/MSC+ EW members, and MSHO/MSC+ members with PCA services.
- DHS 3428D Supplemental Waiver PCA Assessment – used for assessing for PCA services. This is used in addition to completing the LTCC (DHS 3428).
- DHS 3428G Minnesota Service Change Form for EW and AC Participants- used for items/needs that have changed since the last assessment or reassessment was completed resulting in need for changes in services or service plan. This does NOT represent a full reassessment.
- DHS 3428H Health Risk Assessment– used for MSHO/MSC+ Non-EW members without PCA services and for MSHO/MSC+ members on other waivers (used for members on Community Access for Disability (CADI), Brain Injury (BI), or Developmental Disability (DD) waivers).
- Institutional Member Assessment- used for MSHO/MSC+ members identified as institutional, these members may reside in a nursing facility or ICF/DD home.
- Transfer Member Health Risk Assessment- for MSHO/MSC+ community members that have transferred into Medica or transferred between MSHO and MSC+ and have had an LTCC/HRA/MnCHOICES assessment within the past 365 days. Can only be used if CC is able to obtain a copy of the full assessment previously completed with the member. This does NOT represent a full assessment. NOTE: The Transfer Member Health Risk Assessment is NOT used for members residing in an institutional living setting. The Transfer Member Health Risk Assessment can NOT to be used when a member transfers to MSHO/MSC+ from SNBC, unless the assessment is reflective of determination for opening Elderly Waiver (65th birthday assessment and must be a full LTCC or Full MnCHOICES assessment).

Health Risk Assessment (HRA) and Assessment Tool for SNBC/SNBC Enhanced

NOTE: All DHS tools can be found the DHS eDocs site

- DHS form 3428H Health Risk Assessment- used for all SNBC members regardless of product, waiver status, or living setting.
- Transfer Member Health Risk Assessment- for SNBC/SNBC Enhanced members that have transferred into Medica or transferred between SNBC and SNBC Enhanced and have had a 3428H assessment within the past 365 days. Can only be used if CC is able to obtain a copy of the full assessment previously completed with the member. This does NOT represent a full assessment. NOTE: NOT to be used when a member is new to the SNBC product.

Home and Community Based Services (HCBS): Services provided under a federal waiver under §1915(c) of the SSA, 42 USC §1396n, and Minnesota Statutes, §§256B.092, subd. 4, and 256S. These services are for

members who meet specific eligibility criteria including being at risk of institutional care if not for the provision of HCBS services. The services are intended to prevent or delay Nursing Facility placements.

PURPOSE

To describe the Medica audit process, which assures that all Delegates that provide Care Coordination for Medica members have care coordination procedures in place that help ensure compliance with DHS, CMS, when applicable, and Medica requirements for the provision of care coordination services to Medica members enrolled in the MSHO, MSC+, SNBC and SNBC Enhanced products.

POLICY

Delgates that provide Care Coordination for Medica members are required to have procedures in place to comply with DHS, CMS, when applicable, and Medica requirements for the provision of care coordination services.

Medica Regulatory Oversight & Improvement staff will audit member records for the presence of identified contractual requirements, DHS Protocol elements, and Medica Protocol elements annually. Medica will utilize the following Audit Protocols and policies:

- DHS Managed Care (MSHO and MSC+) Elderly Waiver Care Planning Audit Protocol
- DHS Managed Care (MSHO and MSC+) Non-Elderly Waiver Care Planning Audit Protocol
- DHS Managed Care (SNBC) Care Planning Audit Protocol
- Medica Institutional Audit Protocol
- Transition of Care Policy
- Unable to Reach Refuser Member Policy

Medica reserves the right to add additional elements to the Audit Protocol based on Medica priorities or identified areas of concern.

PROCEDURE

1. FILE IDENTIFICATION AND SAMPLING METHODOLOGY
    a. Medica Regulatory Oversight & Improvement staff requests a list of all MSHO, MSC+, SNBC, and SNBC Enhanced members from Healthcare Economics Team. The list includes all members who were active in the preceding year.
    b. Medica sorts data by Delegate and creates an audit sample.
    c. Medica staff contacts each of the Delegates, via secure email, with a list of members identified for a random audit sample.
        i. Medica may request the Delegate to stratify the list by Care Coordinator (CC) or activity level (i.e., member with completed HRA or refusal/unable to reach member).
            1. Stratification allows for the work of multiple CCs to be reviewed.
            2. Stratification allows for the determination of active vs. inactive cases.
        ii. Upon completion of stratification, if requested, adjustments may be made to the initial audit sample
        iii. The random audit sample may consist of:
            1. Thirty (30) eligible EW MSHO/MSC+ Health Risk Assessments and Care Plans.
            2. Thirty (30) eligible SNBC/SNBC Enhanced Health Risk Assessments and Care Plans

3. Ten (10) eligible Non-EW MSHO/MSC+ Health Risk Assessments and Care Plans.
4. Five (5) eligible MSHO/MSC+, Institutional Member Health Risk Assessments, when applicable.
5. Five (5) eligible MSHO, MSC+, SNBC & SNBC Enhanced Transition documents, when applicable.
6. Five (5) eligible MSHO, SNBC Enhanced Unable to Reach/Refuser documents, when applicable.

d. Medica notifies each Delegate of the finalized audit sample via secure email.
   i. All Delegates will receive their finalized audit list at least one (1) month prior to their scheduled Audit.
   ii. During the MSHO/MSC+ EW and SNBC/SNBC Enhanced Audit, the Medica staff will randomly select eight (8) of the thirty (30) member's records on the finalized audit list for review.
      1. If any of the eight (8) records produce a "not met" score, then the remaining twenty-two (22) records will be audited for the elements resulting in "not met" findings.
      2. For Delegates with fewer than thirty (30) eligible records, eight (8) records will be pulled from all eligible records.
      3. If a Delegate has fewer than eight (8) eligible records, then all eligible records will be reviewed.
   iii. During the MSHO/MSC+ Non-EW Audit, Medica staff will randomly select five (5) of the ten (10) member records on the finalized audit list for review.
      1. If any of the five (5) records produce a "not met" score then the remaining five (5) charts will be audited for the elements resulting in "not met" findings.
      2. For Delegates with fewer than ten (10) eligible records, five (5) records will be pulled from all eligible records.
      3. If a Delegate has fewer than five (5) eligible records, then all eligible records will be reviewed.
   iv. During the Institutional Audit, Medica staff will review all five (5) of the records on the finalized audit list for review. If concerns are identified, the Clinical Improvement Lead may request up to five (5) additional records for review.
   v. During the Transition of Care Audit, Medica staff will review five (5) records from each product type, when available. If concerns are identified, the Clinical Improvement Lead may request additional records for review.
   vi. During the Unable to Reach/Refuser Audit, Medica staff will review five (5) records from MSHO and five (5) records from SNBC Enhanced products, when available.

2. SCHEDULING OF AUDITS
   a. Audit schedules are determined by Medica with input from the Delegates. Medica will make every effort to accommodate the Delegate when scheduling audits.
   b. Medica will send a confirmation email to each Delegate once the date and time is mutually agreed upon.
   c. Medica will send audit tools including, but not limited to the Audit Report Forms, DHS Audit Protocols, and Medica Audit Protocols, when applicable.

3. SOURCES OF EVIDENCE
    a. The following sources of evidence may be utilized during the Audit:
        i. Comprehensive Care Plan/Care Plan/Community Support Plan (CSP)/Coordinated Services and Supports Plan (CSSP)
        ii. Health Risk Assessment/LTCC/MnCHOICES Assessment/Transfer HRA/Institutional Assessment/MMIS data
        iii. PCA Assessments
        iv. HCBS Service Plan
        v. Residential Services (RS) Tools and Plan
        vi. Member Signature Page
        vii. Case Notes
        viii. Member and/or Primary Care Physician (PCP) Letters
        ix. Additional Letters (Welcome Letter, DHS 5181, DHS 5841, Provider Summary Letter)
        x. Other documentation, upon request, that is relevant to the audit

4. SCORING THE AUDIT
    a. Each element needs to be scored as "Met", "Not Met", or "Not Applicable".
    b. During the MSHO/MSC+ EW and SNBC/SNBC Enhanced Audit
        a. If the first eight (8) records of the audit score 100% "Met" on all elements; the Audit is complete.
        b. If any element is "Not Met" in any of the first eight (8) charts; the Auditors will proceed to review the next twenty-two (22) charts for the element(s) that were "Not Met".
        c. For MSHO/MSC+ EW Audits, the following three (3) elements, per DHS/CMS requirements, must score 100%. For all other elements, a score of 95% or above is considered a passing score.
            i. Annual Reassessment of Elderly Waiver
            ii. Care Plan completed within thirty (30) days of assessment
            iii. Enrollee Choice
    c. During the MSHO/MSC+ Non-EW Audit
        a. If the first five (5) records of the audit score 100% "Met" on all elements, the Audit is complete.
        b. If any element is "Not Met" in any of the first five (5) charts, the Auditors will proceed to review the next five (5) charts for the element(s) that were "Not Met"
    d. During the MSHO/MSC+ Institutional Audit
        a. Five (5) records are pulled
        b. If any element is "Not Met" The Clinical Improvement Lead determines if additional charts need to be pulled, if CAP is issued, or if education is provided.
    e. During the Transition of Care Audit
        a. If any element is "Not Met" The Clinical Improvement Lead determines if additional charts need to be pulled, if CAP is issued, or if education is provided.
    f. During the Unable to Reach/Refuser Audit
        a. If any element is "Not Met" The Clinical Improvement Lead determines if additional charts need to be pulled, if CAP is issued, or if education is provided.

5. EXIT INTERVIEW AND WRITTEN FEEDBACK

a. After the Audit is complete, Medica will offer the Delegate the opportunity for an exit interview.
    i. During the exit interview, chart audit results are shared with Care Coordinators and/or Supervisors.
    ii. Delegates also have an opportunity to make suggestions on the audit process.
b. Medica provides each Delegate with written feedback on the audit findings.
    i. The report summarizes the following:
        1. Audit Results
        2. Strengths
        3. Opportunities for Improvement (OFI)
        4. Corrective Action Plan (CAP)

6. CORRECTIVE ACTION PLAN (CAP)
    a. In the MSHO/MSC+ EW Audit, a CAP is implemented for any elements that score 95% or less after all thirty (30) charts are reviewed or for the three (3) elements identified above in 4c, for a score of less than 100%.
    b. In the SNBC/SNBC Enhanced Audit, a CAP is implemented for any elements that score 95% or less after all thirty (30) charts are reviewed.
    c. In the MSHO/MSC+ Non-EW Audit, a CAP is implemented for any unmet elements that are identified in more than one (1) chart.
    d. In the Institutional Audit, a CAP may be implemented at the discretion of the Medica Regulatory Oversight & Improvement team based on audit findings.
    e. In the Transition of Care Audit, a CAP may be implemented at the discretion of the Medica Regulatory Oversight & Improvement team based on audit findings.
    f. In the Unable to Reach/Refuser Audit, a CAP may be implemented at the discretion of the Medica Regulatory Oversight & Improvement team based on audit findings.
    g. If a CAP is indicated, the designated Delegate Lead will be notified of the results of the Audit and be asked to complete a written response to the CAP.
    h. Medica recommends the use of a format that includes: identifying the deficiency, root cause, outcome measures, interventions, timeline and who the responsible person is for completion of the CAP.
    i. The Delegate is required to respond to the CAP within thirty (30) days after receiving notification.
    j. Once Medica receives the written response to the CAP, it is reviewed to determine approval.
    k. The Delegate is notified via email of approval of the CAP.
    l. The Regulatory Oversight & Improvement Department may determine that a follow-up CAP Audit is necessary, based on the nature or amount of deficiencies noted.
        i. The follow-up CAP Audit may be either a desk or onsite audit.
        ii. The auditor may request additional records for review from the Delegate.
        iii. The follow-up CAP Audit will include only elements identified as deficient in the initial audit.
        iv. If a follow-up CAP Audit is completed and is satisfactory, no further follow-up will be required from the Delegate.
        v. If a follow-up CAP Audit is completed and elements continue to produce a deficiency, Medica may require an addendum to the initial CAP worksheet discussing additional action items that will be put in place to rectify issue(s).

vi. Ongoing identified concerns will be shared with Medica's Medicaid and SNP Leadership team.

7. TRAINING AUDIT
    a. Training to Delegates is ongoing.
    b. Regulatory Oversight & Improvement staff is available for questions on a year round basis.
    c. Regulatory Oversight & Improvement staff are available to participate in CC web-ex training that may include the following topics:
        i. Contract Requirements
        ii. DHS Protocol Elements
        iii. CMS Requirements
        iv. Opportunities for Improvement
    d. When a Delegate is new to Medica Care Coordinated Products, their initial audit is considered a "training audit."
        i. The DHS audit scoring will apply during "training audits"; however the results will not be reported to the state.
        ii. The "training audit" will not be subjected to a Corrective Action Plan unless potential or actual harm to members is identified.
        iii. During the "training audit", identified opportunities for improvement are addressed by education and training.

8. HIGH PERFORMING DELEGATES
    a. High Performing Delegates may be considered for audits to be completed by Medica every other year rather than annually. Audit results will be considered by Medica, and Medica Regulatory Oversight & Improvement team determines if a Delegate meets the high performer definition.
    b. High performer determination will be made based on the following criteria:
        i. No CAPs issued during the previous two (2) years audit results for all products within Medica. As a high performer, delegates will be audited every other year as long as they maintain no CAP status for all products.
        ii. High performers will still be required to participate in DHS and/or Medica meetings to stay informed on protocol and process changes during their gap year.
        iii. High performers may still be required to participate in additional required audits.
        iv. High performers will need to attest that there is a current internal audit plan in place.
        v. Internal audit results will need to be maintained by each delegate
        vi. Medica retains the right to request submission of internal audit results.

9. EVALUATION BY STATE & CMS DESIGNATED AUDITORS
    a. Annually prior to September 15th, Medica will submit a written audit report to DHS using the Managed Care Organization (MCO) Delegate Review Reporting Template or other template as specified by DHS.
    b. Medica will produce the following items for review and evaluation by the state designated auditors upon request:
        a. Care Plan
        b. Health Risk Assessment Tools
        c. Case Management and Care System Audit Reports via SNAP survey

d. Case Management and Care System Audit Protocols & Tools
e. Model of Care

c. Medica will produce files as required for the DHS/Minnesota Department of Health Triennial Compliance Audit (TCA).
d. Medica will produce files as required for the CMS Model of Care (MOC) Audit.

Cross References

DHS Managed Care (MSHO and MSC+) Elderly Waiver Care Planning Audit Protocol
DHS Managed Care (MSHO and MSC+) Non-Elderly Waiver Care Planning Audit Protocol
DHS Managed Care SNBC Care Planning Audit Protocol
Medica Institutional Audit Protocol
Medica TOC Audit Tool
Medica UTR/Ref Audit Tool
MSHO/MSC+ DHS Contract
SNBC DHS Contract

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