PRODUCTS AFFECTED

- Medica DUAL Solution® – for Minnesota Senior Health Options (MSHO) enrollees
- Medica Choice Care℠ – for Minnesota Senior Care Plus (MSC+) enrollees
- Medica AccessAbility Solution® – for Special Needs Basic Care (SNBC) enrollees

DEFINITIONS

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

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

**Special Needs Basic Care (SNBC):** 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).

**Care Plan:** Medica does not require the use of a specific Care Plan. Any Care Plan that meets the Department of Human Services (DHS) audit protocol requirements and all of the elements of the Community Support Plan (CSP) DHS e-doc form #2925 may be used. If a delegate plans to use a care plan other than those provided by Medica (Collaborative Care Plan or AccessAbility Solution Care Plan), prior approval is required by the Medica Regulatory Oversight & Improvement Department.
Department of Human Services (DHS) Audit Protocol: The blueprint for conducting annual audits, created by DHS and the Collaboration of 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 Program (EW): A Medical Assistance program that funds home and community-based services for people 65 and older who required the level of care provided in a nursing facility, and who choose to reside in the community.

Health Risk Assessment (HRA) for MSHO/MSC+: Medica requires the use of the DHS form 3428 Minnesota Long Term Care Consultation Services Assessment Form (LTCC) or DHS form 3427 LTC Screening Document (MSC+ non-Elderly Waiver (EW) without Personal Care Assistance (PCA) only) as the tools for HRA, unless otherwise specified in individual circumstances. Medica will require use of the MnChoices Assessment tool using the DHS required roll out schedule. The assessment of members, pursuant to Minnesota Statutes, § 256B.0911, is for the purpose of preventing or delaying Nursing Facility placements to offer cost-effective alternatives that are appropriate for the member’s needs, and to assure appropriate admissions to a Nursing Facility. LTCC assessments shall be completed by a qualified professional, defined for the purposes of the LTCC as a social worker, public health nurse, registered nurse, physician assistant, nurse practitioner, or physician. The qualified professional shall use the form designated by the STATE to determine eligibility for Nursing Facility placement or Home & Community Based Services (HCBS).

The HRA will assess a history of the person’s life, important places for the person at home, at school and/or work and in the community, opportunities for social relationships, opportunities for developing and exercising self-advocacy, persons strengths, preferred method of communication, meaningful choices in daily life that are important to the person and what he or she likes and dislikes, current physical and/or mental and/or chemical health status and/or issues, including clinical and support needs, mobility issues, communication issues, transportation issues, rituals and routines important to the person. The HRA will include the person’s goals/aspirations/visions for the future, person’s preferred type of living situation, with whom the person wants to live, with whom the person wants to socialize, work/education/productive activities, social, leisure, religious activities and/or other interests the person wants to participate in, skills or leisure activities the person wants to learn, skill or plans the person wants to develop related to controlling his or her own personal resources, possible barriers to achieving the life the person want to live. This includes, but is not limited to, identifying appropriate services and evaluating effectiveness of services.

Health Risk Assessment (HRA) for SNBC: The Health Risk Assessment tool meets DHS and Medica requirements. 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.

Home and Community Based Services (HCBS): These are services provided under a federal waiver under § 1915(c) of the Social Security Act, 42 U.S.C § 1396n, and pursuant to Minnesota Statutes, § 256B.092 subd. 4, and § 256B.0915. 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 Intermediate Care Facility/Developmentally Disabled (ICF/DD) placements, Nursing Facility (NF) placements, or neurobehavioral rehabilitative hospitalizations.

PURPOSE
To describe the Medica audit process, which assures that all Counties, Agencies, and Care Systems that provide Care Coordination for Medica members have care coordination procedures in place that determines Medica is meeting DHS and Centers for Medicare and Medicaid Services (CMS), when applicable, contractual requirements for all Medica State Public Programs members.

POLICY
Counties, Agencies, and Care Systems that provide Care Coordination for Medica members are required to have procedures in place to authenticate compliance with DHS and CMS, and when applicable, assure that contractual requirements are being met.

Medica Regulatory Oversight & Improvement staff will audit Care Plans and Health Risk Assessments for the presence of identified contractual requirements, DHS Protocol elements, and Medica Protocol elements annually. Medica Audit staff will utilize the following Audit Protocols:

- 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 (once finalized)
- DHS Managed Care (SNBC) Care Planning Audit Protocol
- Medica Institutional Audit Protocol

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+, and SNBC members (EW, Non-EW, Community, and Institutional) from Government Programs Operations Staff. The list includes all members who were active in the preceding year.
   b. The Clinical Improvement Lead sorts data by County, Agency, and Care System.
c. The Clinical Improvement Lead contacts each of the Delegates, via secure email, with a list of members identified for verification and stratification.
   i. The Clinical Improvement Lead may request the Delegate to stratify the list by Care Coordinator (CC).
      1. Stratification will ensure that the works of multiple CC’s are assessed.
      2. Stratification is not necessary for Delegates with fewer than three CC’s.
   ii. Upon completion of stratification, the Clinical Improvement Lead selects a random audit sample for each Delegate.
   iii. The random audit sample may consist of:
       1. Thirty (30) eligible EW MSHO and MSC+ Health Risk Assessments and Care Plans.
       2. Thirty (30) SNBC Health Risk Assessments and Care Plans.
       3. Ten (10) eligible Non-EW MSHO and MSC+ Health Risk Assessments and Care Plans.
       4. Five (5) eligible MSHO, MSC+, or SNBC Institutional Member Health Risk Assessments and Care Plans, when applicable.

d. The Clinical Improvement Lead 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 and MSC+ EW and SNBC Audit, the Clinical Improvement Lead will randomly select eight (8) of the thirty (30) members 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 and MSC+ Non-EW Auditor, the Clinical Improvement Lead 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, the Clinical Improvement Lead will review all 5 of the records on the finalized audit list for review. If concerns are identified, the Clinical Improvement Lead may request up to 5 additional records for review.
2. SCHEDULING OF AUDITS
   a. The Clinical Improvement Lead will make every effort to accommodate the County, Agency, and Care System when scheduling audits.
   b. Audit schedules are determined by the Clinical Improvement Lead with input from the Delegates.
   c. The Clinical Improvement Lead will send a confirmation email to each Delegate once the date and time is mutually agreed upon.
   d. The Clinical Improvement Lead will send audit tools including, but not limited to the Audit Report Form, DHS Audit Protocol, and Medica Audit Protocol.
   e. If Delegates are contracted for more than one product, the Clinical Improvement Lead may choose to schedule a separate audit date for each product. Additional Auditors may also be on site if needed.

3. SOURCES OF EVIDENCE
   a. The following sources of evidence may be utilized during the Audit:
      i. Comprehensive Care Plan
      ii. MCO Health Risk Assessment (initial assessment conducted at time of enrollment) and/or LTCC/MnCHOICES Assessment
      iii. HCBS Service Plan
      iv. Residential Services (RS) Tools and Plan
      v. Member Signature Page
   b. Supplemental sources of evidence may be utilized during the Audit:
      i. Case notes to supplement Comprehensive Care Plan
      ii. Member and/or Primary Care Physician (PCP) Letters

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 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.

5. EXIT INTERVIEW EXIT INTERVIEW AND WRITTEN FEEDBACK
   a. After the Audit is complete, the Clinical Improvement Lead will offer the County, Agency, or Care System the opportunity for an exit interview.
      i. During the exit interview, chart audit results are shared Care Coordinators and/or Supervisors.
      ii. Counties, Agencies, and Care Systems will also have an opportunity to evaluate the audit and or make suggestions on the audit process.
   b. Medica provides each County, Agency, and Care System with written feedback on the audit findings.
      i. The report summarizes the following:
         1. Audit Results
         2. Strengths
         3. Opportunities for Improvement (OFI)

6. CORRECTIVE ACTION PLAN (CAP)
   a. In the MSHO/MSC+ EW Audit, Corrective Action Plans are 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 Audit, Corrective Action Plans are implemented for any elements that score 95% or less after all thirty (30) charts are reviewed.
   c. In the MSHO/MSC+ Non-EW Audit, Corrective Action Plans are implemented for any elements that score 95% or less after all ten (10) charts are reviewed.
   d. In the Institutional Audit, Corrective Action Plans are implemented at the discretion of the Clinical Improvement Lead based on audit findings.
   e. If a CAP is indicated, the designated CCP Delegate Lead will be notified of the results of the Audit and asked to complete a written response to the CAP.
   f. Medica recommends the use of the Minnesota Department of Health (MDH) format. This format includes: identifying the deficiency, root cause, outcome measures, interventions, timeline and who the responsible person is for completion of the CAP.
   g. The Delegate is required to respond to the CAP within thirty (30) days after receiving notification.
   h. Once Medica receives the written response to the CAP, it is reviewed by Regulatory Oversight & Improvement Department to determine approval.
   i. The Delegate is notified via email of approval of the CAP.
   j. 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 up to ten (10) 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).

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 participate in biannual training including, but not limited to:
      i. Contract Requirements
      ii. DHS Protocol Elements
      iii. Opportunities for Improvement
   d. When a County, Agency, or Care System 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. EVALUATION BY STATE & CMS DESIGNATED AUDITORS
   a. Annually prior to September 15th, Medica will submit Managed Care Organization (MCO) Delegate Review Reporting Template to 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
      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
Medica Institutional Audit Protocol