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*)
2016 Audit Protocol
(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 in matrix format, first presenting outcomes related to assessment and enrollment/disenrollment and then followed by outcomes related to comprehensive care planning and waiver services. 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 2016 Audit Protocol was developed for use in auditing 2016 created care plans in CY2017.

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.
- 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 <u>all</u> 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.

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.

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

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.

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 summary report for MSHO and MSC+ for each delegate under contract with the MCO for care coordination (MSHO) and case management (MSC+), and will prepare a summary of key findings and recommendations. MCOs will complete a summary report of results from all delegates audited that compiles the results across your MCO. The MCO summary report must be forwarded to DHS.
- Refer to the "MCO 2016 Care Plan Audit Report Instructions" for information about reporting findings in the "MCO Care Plan Audit Report Format" tool. Findings are reported at the delegate level and are also aggregated at the MCO 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.

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.

	Desired outcome	Method for measuring outcome achievement	Contract Citation
1	INITIAL HEALTH RISK ASSESSMENT For all enrollees new to the MCO or product[2] within the last 12 months: Date of completed initial Health Risk Assessment or documented review of same is within 30 calendar days of enrollment and is verified for completeness	Met as determined by all of the following: — Date HRA completed is within 30 calendar days of enrollment date AND — HRA results are included in/attached to the enrollee's Comprehensive Care Plan AND — All (100%) of the fields relevant to the enrollee's program shall be completed with pertinent information or noted as Not Applicable or Not Needed as appropriate. OR — If attempted but not completed within 30 calendar days of enrollment date, an explanation must be present and documented: - person refused completion of the initial HRA, or - person was admitted to a hospital before the 30th calendar day, or - person was admitted to a nursing facility for a short-term stay of 30 or fewer days before the 30th calendar day after enrollment date Not Met as determined by the following: — The above stated requirements are not met Not applicable if enrollee has been a enrollee for more than 12 months	6.1.4(A)(1) 6.1.5(B)(1)

[2] For example, enrollee moves from MSHO to MSC+ or vice versa.

	Desired outcome	Method for measuring outcome achievement	Contract Citation
2	ANNUAL HEALTH RISK ASSESSMENT For enrollees who have been a enrollee of the MCO more than 12 months For EW enrollee - Measure only if MCO conducts an HRA separate from the LTCC/MnCHOICES Assessment. Otherwise, see measure Number 4 – Reassessment of EW	Met as determined by all of the following: — Date annual HRA is completed is within 365 days of previous HRA OR — Completed within 365 days (explanation for not completing within 365 days must be present) OR — If attempted but not completed, an explanation must be present and documented AND — All (100%) of the fields relevant to the enrollee's program shall be completed with pertinent information or noted as Not Applicable or Not Needed as appropriate. AND — Results are included in/attached to the enrollee's Comprehensive Care Plan Not Met as determined by the following: — HRA not completed or attempted within 365 days of previous HRA with no explanation of status	6.1.4(A)(1) 6.1.5(B)(1)

	Desired outcome	Method for measuring outcome achievement	Contract Citation
3	LONG TERM CARE CONSULTATION (LTCC/MnCHOICES Assessment–INITIAL) IF ENROLLEE IS OPENED or RE-OPENED TO EW by the MCO IN THE PAST 12 MONTHS: LTCC/MnCHOICES Assessment was completed and was timely	Met as determined by all of the following: — LTCC/MnCHOICES Assessment was completed within 20 calendar days of a request or referral AND — Results of the LTCC/MnCHOICES Assessment are included in/attached to the enrollee's Comprehensive Care Plan AND — All (100%) of the fields relevant to the enrollee's program shall be completed with pertinent information or noted as Not Applicable or Not Needed as appropriate. Not Met as determined by the following: — The above stated requirements are not met Not applicable if enrollee is not new to EW in the past 12 months	6.1.4(A)(2) 6.1.5(B) (4) 6.1.13(B)

	Desired outcome	Method for measuring outcome achievement	Contract Citation
4	ANNUAL REASSESSMENT OF EW For enrollees open to EW who have been an enrollee of the MCO for more than 12 months: Date of completed face-to-face re-assessment by use of the LTCC/MnCHOICES Assessment[3] is within 365 days of prior assessment or with change in condition, and is verified for completeness	Met as determined by all of the following: — Date re-assessment completed is within 365 days of previous assessment OR — Not completed within 365 days of previous assessment with explanation for not completing within 365 days OR — If attempted but not completed, an explanation must be present and documented AND — Assessment results are included in/attached to the enrollee's Comprehensive Care Plan AND — All (100%) of the fields relevant to the enrollee's program shall be completed with pertinent information or noted as Not Applicable or Not Needed as appropriate. Not Met as determined by the following: — Assessment not completed or attempted within 365 days of previous assessment with no explanation of status Not applicable if member is newly enrolled within the past 12 months	6.1.13(C)

[3] The LTCC/MnCHOICES Assessment will serve as the HRA.

	Desired outcome	Method for measuring outcome achievement	Contract Citation
5	COMPREHENSIVE CARE PLAN A Comprehensive Care Plan was completed within 30 calendar days of the completed LTCC/MnCHOICES Assessment based on issues and needs identified in the HRA and/or LTCC/MnCHOICES Assessment [4] and other sources such as medical records and enrollee and/or family input	Met as determined by the following: — Date Comprehensive Care Plan was completed is within 30 calendar days of completed LTCC/MnCHOICES Assessment ("Complete" defined as the date the plan was sent to enrollee) OR — If attempted but not completed, an explanation of status must be present and documented — enrollee was admitted to a hospital or nursing facility before the 30th calendar day — enrollee / legal representative / guardian / family chose a date more than 30 calendar days after completion of the LTCC/MnCHOICES Assessment Not Met as determined by the following: — Comprehensive Care Plan not completed or attempted within 30 calendar days of completed LTCC/MnCHOICES Assessment with no explanation of status	6.1.4(A)(2) 6.1.5(B)(4) 6.1.13(B)

[4] The LTCC/MnCHOICES Assessment may serve as the HRA.

6	COMPREHENSIVE CARE PLAN SPECIFIC ELEMENTS The Comprehensive Care Plan (CCP) should incorporate all elements of the Coordinated Services and Supports Plan (as reference, see DHS e-docs form #4166) The CCP must have an interdisciplinary, holistic, and preventive focus. To achieve this focus, the Comprehensive Care Plan must include the elements listed below: — Identification of enrollee needs and concerns, including identification of health and safety risks, and what to do in the event of an emergency — Goals and target dates identified — Interventions identified — Monitoring of outcomes and achievement dates are documented — Outcomes and achievement dates documented	Met as determined by the following: — Identification of enrollee primary care, acute care, long term care, mental health, behavioral, and social service needs and concerns AND — The plan addresses identified risks to health and safety and plans for addressing these risks AND — Documentation of services that are essential to the health and safety of the enrollee — If yes, a back-up plan for provision of documented essential services AND — A plan for community-wide disasters, such as weather related conditions AND — Goals and target dates (at least, month/year) identified AND — Interventions identified AND — Monitoring progress towards goals AND — Outcomes and achievement dates (at least, month/year) are documented AND — Care Plan signed by enrollee or authorized representative	6.1.4(A)(2) and (3) 6.1.5(B) (4) 6.1.13(B)

	Desired outcome	Method for measuring outcome achievement	Contract Citation
7	Follow-up plan for contact for preventive care[5], long-term care and community support[6], medical care[7], or mental health care[8], or any other identified concern	Follow up plan for contact for preventive care, long-term care and community support, medical care and other concerns included — Care Coordinator has documented their plan for enrollee contact AND — Care Coordinator documented contact with enrollee according to plan Not Met as determined by the following: — No enrollee contact plan or contact plan was not followed with no explanation of status given OR — One or more of the above items is not completed or attempted with no explanation of status given	

[5] Preventive care concerns may include but not be 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.

[6] Long-term care and community support concerns should include but not be 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).

[7] Medical care concerns should include but not be limited to the management of chronic disease such as hypertension, CHF/heart disease, respiratory /lung disease, diabetes, and joint/muscle disease.

[8] Mental health care concerns should include but not be limited to depression, dementia, and other mental illness.

	Desired outcome	Method for measuring outcome achievement	Contract Citation
8	Communication of Care Plan/Summary	Met as determined by the following: — Evidence of care coordinator communication of care plan elements with Primary Care Physician (PCP)	6.1.4 (A)(2)(a) 6.1.13 (B) (4)
9	SAFETY PLAN/ PERSONAL RISK MANAGEMENT PLAN Required to indicate that safety issues have been addressed in the service delivery plan	Met as determined by the following: — The person indicated that safety concerns were discussed with the care coordinator AND — The plan for managing risks that have been discussed is included. OR It is documented that no plan for managing risks is needed. Not Met as determined by the following: — The person does not indicate that safety concerns were discussed — OR There is no information provided about the safety plan, including no documentation that a plan for managing risks is not needed.	6.1.13(B)(1)

	Desired outcome	Method for measuring outcome achievement	Contract Citation
10	ANNUAL PREVENTIVE HEALTH EXAM	Met as determined by the following: — Documentation 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	6.1.4(B)(2) 6.1.5(A)(2) 6.1.6(B)

	Desired outcome	Method for measuring outcome achievement	Contract Citation
11	ADVANCE DIRECTIVE Advance Directive exists, or evidence that a discussion was initiated with the enrollee and/or planning is underway	Met as determined by the following: — Conversation about Advance Directive initiated OR — Enrollee refused to complete an Advance Directive OR — Care coordinator documented reason why Advance Directive conversation was not discussed OR — Advance Directive is completed Not met as determined by the following: — No evidence of conversation about Advance Directive present in enrollee's record	6.1.4(A)(2)(c) 6.1.5(B)(4)

	Desired outcome	Method for measuring outcome achievement	Contract Citation
12	ENROLLEE CHOICE Enrollee was given a choice between HCBS and Nursing Home Services (also indicates enrollee involvement in care planning)	Met as determined by the following: — Choice noted in Section J or G of LTCC/MnCHOICES Assessment Form (e-docs #3428 or #3428A respectively) or equivalent document (correlates to Section D of the LTCC Screening Document (e-docs #3427) AND — Completed and signed Care Plan AND — Documentation that a copy of the Comprehensive Care Plan summary[9] or Care Plan was provided to the enrollee Not Met as determined by the following: — No evidence of choice found as identified above	6.1.13(B)(10)(a) 6.1.13(B)

[9] Summary may include Comprehensive Care Plan goals and interventions, service recommendations, and at a minimum, all elements of the CSP, provided to enrollee. For reference, see section IX. Choosing Community Long Term Care in the Long Term Care Community Support Plan, e-docs form #2925.

	Desired outcome	Method for measuring outcome achievement	Contract Citation
13	CHOICE OF HCBS PROVIDERS Enrollee was given information to enable the enrollee to choose among providers of HCBS, and Enrollee made choices of provider(s)	Met as determined by the following: — Completed and signed Care Plan AND — Documentation that a copy of the Comprehensive Care Plan summary[10] or Care Plan was provided to the enrollee. Not Met as determined by the following: — No evidence of choice found as identified above	6.1.13(L)

[10] Summary may include Comprehensive Care Plan goals and interventions, service recommendations, and at a minimum, all elements of the CSP, provided to enrollee. For reference, see section IX. Choosing Community Long Term Care in the Long Term Care Community Support Plan, e-docs form #2925.

	Desired outcome	Method for measuring outcome achievement	Contract Citation
14	COORDINATED SERVICES AND SUPPORT PLAN – Community Services and Supports Section Coordinated Services and Support Plan developed and contains at a minimum the type of services to be furnished, the amount, frequency, duration and cost of each service and the type of provider furnishing each service including non-paid caregivers and other informal community supports or resources	Met as determined by the existence of a Community Support Plan that includes a section titled Community Services and Support (may be the service delivery plan or budget worksheet or something similar), that authorizes EW services and contains at a minimum, including clearly identified and documented links to assessed needs per the results of the LTCC/MnCHOICES Assessment: – type of services to be furnished AND – The amount, frequency, duration and cost of each service AND – 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 completed, an explanation of status must be present and documented Not Met will be determined as follows: – If one or more of the above items are not completed	6.1.13(B)(1)

	Desired outcome	Method for measuring outcome achievement	Contract Citation
15	CAREGIVER SUPPORT PLAN Caregiver support is planned if a caregiver is identified in the LTCC/MnCHOICES Assessment, a Caregiver Planning Interview would be conducted with that caregiver and caregiver would be referred for needed support	If a non-paid caregiver is identified in the LTCC/MnCHOICES Assessment, then Met as determined by all of the following: — Attached Caregiver Planning Interview/Caregiver Assessment in LTCC AND — Incorporation of caregiver services on the Budget Worksheet, if applicable. Not Met will be determined as follows: — If one or more of the above items are not completed	6.1.13(A) 6.1.13(B)
16	Appeal Rights Appeal rights information provided to enrollee	Met as determined by the following: — Completed and signed care plan OR — Other signed documentation in enrollee file	3.4.G

	Desired outcome	Method for measuring outcome achievement	Contract Citation
17	Data Privacy Data privacy information provided to enrollee	Met as determined by the following: — Completed and signed care plan OR — Other signed documentation in enrollee file	6.1.4(B)(13) 6.1.5(B)(16)(l)
18	Person-Centered Planning 1. Opportunities for choice in the person's current environment are described	Met is determined if: — There is a specific description of the person's opportunities to make meaningful choices in their daily life. If there are areas in which opportunities for choice are limited, these are listed. (Need to mention "choice" or a similar word) OR — Opportunities to make choices are identified, but not described. (Need to mention "choice" or a similar word) Not Met will be determined as follows: — The issue of opportunities to make choices is not addressed (there is not mention of "choice" or other similar words)	From LTCC form 3428: Section E , items in F related to meal choices, and care plan

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18	Person-Centered Planning 2. Current rituals and routines are described (quality, predictability, preferences)	Met is determined if: — There is a general description of the person's daily rituals and routines, which includes quality, choice, preferences, and predictability, in general OR — There is some information provided regarding regularly scheduled activities but there is no mention of how predictable they are or how enjoyable they are or if they relate to a person's preference Not met will be determined as follows: — There is no information provided regarding the person's daily activities, rituals or routines	From LTCC form 3428: Section E , items in F related to meal choices, and care plan
18	Person-Centered Planning 3. Social, leisure, or religious activities the person wants to participate in are described	Met is determined if: — Specific social, leisure, or religious activities the person wants to participate in are clearly described and there is a statement regarding how this information was gathered OR — The social, leisure, or religious activities the person wants to participate in are mentioned but not described in enough detail and/or there is no information about how the activities were gathered Not met will be determined as follows: — The social, leisure, or religious activities the person wants to participate in are not identified	From LTCC from 3428: Section E. and care plan

	Desired outcome	Method for measuring outcome achievement	Contract Citation
18	Person-Centered Planning 4. Goals or skills to be achieved are described and are related to the person's preferences and how the person wants to live their life	Met will be determined if: — The goals or skills to be achieved are clearly described and are related to the person's preferences OR — The goals or skills to be achieved are listed but are not clearly described and/or not related to the person's preferences Not met will be determined as follows: — There is no mention about the goals or skills to be achieved	From care plan Also item F.9a related to training on assistive devices
18	Person-Centered Planning 5. Action steps describing what needs to be done to assist the person to achieve the goals or skills are documented	Met will be determined if: — Actions steps documenting what needs to be done to assist the person achieve his/her or goals are clearly identified and described with dates for completion and people responsible for assisting the person in completing each step OR — Action steps describing what needs to be done to assist the person achieve his/her goals are identified but not described (simply listed), the description of the actions are unclear, and/or no dates for completion and people responsible for completing step are documented Not met will be determined as follows: — Action steps of what needs to be done to assist the person achieve his/her action steps or goals are not addressed	From care plan

	Desired outcome	Method for measuring outcome achievement	Contract Citation
18	Person-Centered Planning 6. The plan includes a method for the individual to request updates to the plan, as needed	Met will be determined if: — The Care Plan includes how the individual can request changes to the plan Not met will be determined as follows: — The care plan does not include how the individual can request changes to the plan	On care plan.
18	Person-Centered Planning 7. The plan records the alternative home and community-based settings and services that were considered by the individual	Met will be determined if: — The LTCC assessment items related to housing choices are completed, including all follow-up questions AND — Services offered are indicated in the Care Plan Not met will be determined as follows: — The LTCC items related to housing choices are not completed OR — The follow up questions related to housing choices are not completed OR — Services offered are not indicated in the Care Plan	On care plan. Note: it could be that all offered services are accepted in the care plan.

	Desired outcome	Method for measuring outcome achievement	Contract Citation
18	Person-Centered Planning 8. The plan is distributed to the individual and other people involved in the plan	Met is determined if — The Care Plan reflects the person's choice of individuals who are to receive the plan AND — The Care Plan has required information about the date the plan was sent/delivered to the person Not met is determined as follows: — The Care Plan does not reflect the person's choice of individuals who are to receive the plan OR — The Care Plan does not include required information about the date the plan was sent/delivered to the person	From Care Plan.
18	Person-Centered Planning 9. The person decision about employment/volunteer opportunities has been documented	— Met is determined if: — The LTCC items related to employment opportunities are completed AND — The LTCC items related to volunteer opportunities are completed Not met is determined as follows: — The LTCC items related to employment opportunities are not completed OR — The LTCC items related to volunteer opportunities are not completed	From LTCC form 3428 D.13 and D.14

18	Person-Centered Planning Transition Planning 10. Has the individual chosen a different living arrangement than their current living arrangement? If so, is a plan in place on how to help that individual move to their preferred setting, identifying barriers and steps that need to be taken before the move happens? Present in LTCC, requires revision to CCP In addition, for people who have been identified as having a transition, the following are transition related items: 10.a. The essential elements of the transition summary and follow-up plan has been completed for an individual who has transitioned 10.b. During transition planning, there is evidence that the person was provided information and options to make informed choices that were meaningful to them	Met is determined if: — The LTCC assessment items related to housing choices and support are completed, including follow-up questions AND — If the person indicates they want assistance in exploring housing options, the plan reflects a goal, steps to be taken (transition plan), potential barriers Not met will be determined as follows: — The LTCC assessment items related to housing choices and support are not completed, including follow up questions OR — If the person indicates they want assistance in exploring housing options, and the plan does not reflect a goal, steps to be taken (transition plan), potential barriers	From LTCC form 3428: Section E., items E.12, E.13, and E.13a. Preparation of transition plan. Will provide DHS eDoc template for this that meets transition plan requirements (action steps). The transition plan is expected to be an attachment to the Care Plan.