Minnesota Department of Human Services

2022 Special Needs BasicCare (**SNBC) Care Plan Audit Protocol**
(*As required under 7.1.5, 7.7, 11.5.1 12. 8.2 of the 2022 SNBC contract*)
02/28/2023

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

Description of the protocol:

- The Audit Protocol is organized by element, first presenting outcomes related to assessment and enrollment and followed by outcomes related to care planning. This protocol also incorporates person-centered planning requirements.
- A description of the method used to determine the achievement of each desired outcome is included under each element, and includes acceptable evidence for achieving a "met" or "not met" score is outlined in the protocol heading titled "Method for measuring outcome achievement."
- This protocol applies to care plans developed in Calendar Year (CY) 2022 and audited in CY 2023.
- Conducted annually for all delegates and the work of MCO internal employees who are SNBC care coordinators except those designated as high performers.

MCO sampling instructions:

- The selection of care plans uses the same sampling method for the audit of the work of MCO employees who are SNBC care coordinators and each delegate* under contract with the MCO for care coordination.
- If any of the 8 records produce a "not met" score for any of the outcomes outlined in the Audit Protocol/Data Collection Guide, the remaining 22 records will be examined for the outcome(s) that resulted in "not met" findings.
- For MCO employees who are SNBC care coordinators and delegates with fewer than 30 eligible care plans, then 8 care plans will be pulled from all eligible care plans. If the MCO employees who are SNBC care coordinator or a delegate has

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fewer than 8 eligible care plans, then all eligible care plans will be reviewed for that delegate.

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

Sources of Evidence: Sources of evidence may include:

- Health Risk Assessment (HRA, DHS 3428H),
- Case notes,
- Member Record,
- Service plan or care plan

High Performers:

Per the SNBC and MSHO/MSC+ contracts, the health plans and DHS developed a method to identify delegates with consistently high performance at review and a process that allows these identified delegates to be reviewed on a schedule other than annually.

Delegates must meet the following criteria to be designated as high performers:

- Receive no corrective action (CAP) in care plan audits in two consecutive years for all products (SNBC, MSHO, and MSC+).
- Complete and sign a Delegate High Performer Attestation form, and fulfill the requirements laid out in the form.

Delegates designated as high performers:

- Will not need to participate in the care plan audit in the calendar year following their designation.
- Will continue to participate in the care plan audit every other year as long as they maintain their no CAP status for all products and fulfill the requirements laid out in the attestation form.
- Will lose their high performer designation if they receive a CAP in a care plan audit.
- To regain the high performer designation, they must again meet the criteria outlined above (that is, no CAP in two consecutive years; and complete, sign and fulfill the terms of the attestation form).

This process continues to meet state and federal requirements for review of care plans and the purpose of the review. Health plans report delegates who meet the

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criteria in the annual MCO SNBC Internal Care Coordination and Delegate Review Report.

  - See the attached Addendum for special guidance on designating delegates as high performers based on the audit of 2022 care plans in CY 2023.

Reporting:

MCO reporting to DHS

- MCOs will complete a report via SNAP survey for SNBC for each delegate under contract with the MCO for care coordination or case management and for internal employees who provide SNBC care coordination indicating results of the audit.

- MCOs will prepare a summary of key findings and recommendations from the audit. 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 provided to DHS in such a manner that DHS can determine that corrective actions were implemented, including a plan for monitoring completion of required actions. MCOs will use the "MCO SNBC Internal Care Coordination and Delegate Review Reporting Template" provided by DHS to report additional information collected during the care plan audit.

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1. Member Contact Desired outcome:

Member contact will occur within 10 business days of Care Coordinator/Case Manager assignment or change in SNBC Coordinator/Case Manager.

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

a. Date notification completed is within 10 business days.
b. Notification must include Care Coordinator/Case Manager's name and telephone number.
    - Notification may be via mail or phone call with attempts documented in case notes or member record.

Not met as determined by the following:

- The above stated requirements are not met per each sub-element

Source of Evidence:
- Member Record
- Case Notes
- Electronic Health Record

Contract Citation(s):

6.1.5.8

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2. INITIAL HEALTH RISK ASSESSMENT (HRA)

Desired outcome:

All members new to the MCO will receive a complete Health Risk Assessment (HRA) within required timelines (60 days). **OR**

For all member's changing product[1] within the same MCO documentation exists that the assigned CC reviewed the previously completed and current HRA with the member within 60 calendar days of enrollment into the MCOs new SNBC product.

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

a. Date HRA completed is within 60 calendar days of enrollment date or an explanation is documented if HRA attempted but not completed within 60 calendar days when:
    - Member declined completion of the initial HRA or
    - Member was unable to be contacted.

b. All (100%) of the fields of HRA have been completed with pertinent information or documented as Not Applicable or Not Needed as appropriate.

Not met as determined by the following:

- The above stated requirements are not met per each sub-element

Not applicable:

- If member has been enrolled for more than 12 months.

Source of Evidence

- HRA Assessment (DHS 3428H)
- Case Notes
- Member Record

Contract Citation(s):

6.1.5.2

[1] For example, member moves from SNBC non-integrated to SNBC integrated product.

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3. ANNUAL HEALTH RISK ASSESSMENT (HRA)

Desired outcome:

An annual HRA has been completed for all members who have been a member of the MCO for more than 12 months.

Annual is defined as completing member's health risk assessment within 365 days[2] of the previous health risk assessment.

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

a. Date annual HRA is completed within 365 days of previous HRA **OR**

b. An explanation is documented if the HRA attempted but not completed with 365 days of enrollment when:
    - Member declined completion of the HRA **or**
    - Member was unable to be contacted **or**

c. HRA is completed but not within 365 days, and the explanation for not completing within 365 days is present.

d. All (100%) of the fields relevant to the members are completed with pertinent information or documented as Not Applicable or Not Needed as appropriate.

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

Source of Evidence

- HRA Assessment (DHS 3428H)
- Case Notes
- Member Record

Contract Citation(s):

6.1.5.2

[2] As dictated per MCO model of care- this allows MCOs the flexibility of 12 months verses 365 days

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4. CARE PLAN TIMELINESS

Desired outcome:

Care plan is completed and mailed to member within 30 calendar day, of completion of a HRA and is based on issues and needs identified in the HRA and other sources such as medical records and member and/or family input.

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

a. Care plan is completed and sent to member within 30 calendar days of completion of the HRA; **OR**

b. If completed care plan was not sent or reviewed within 30 days of HRA a member-related explanation of status is documented.

Not met as determined by the following:

- The above stated methods to meet this requirement are documented.

Source of Evidence

- HRA Assessment (DHS 3428H)
- Case Notes
- Care Plan
- Member Record

Contract Citation(s):

6.1.5.4
7.1.5

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5. Care Plan Addresses Assessed Needs

Desired outcome:

The care plan addresses member's assessed needs, preferences and reflects a person-centered interdisciplinary, holistic, and preventive focus.

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

a. Care plan addresses member's health care needs, concerns, primary care, acute care, behavioral health care needs,[3] and chronic conditions as identified in the HRA or a statement as to why an assessed need(s) was not included in the care plan.

b. Care plan is signed by member or authorized representative or, evidence of care coordinator/case manager **attempt** to obtain signature.

c. Action steps, including services or supports needed, are identified and describe what needs to be done to achieve the member's goals or skills. [4]

d. Care Coordinator documents the service provided and member's response to the service including follow-up.[5]

Not met as determined by the following:

- The above stated requirements are not met per each sub-element

Source of Evidence

- HRA Assessment (DHS 3428H)
- Case Notes
- Care Plan
- Member Record

Contract Citation(s):

6.1.5.4
7.1.5.

[3] Behavioral health care includes both mental health and substance use disorders.
[4] Element "5" item 'c' for the 2022 care plan audit is included for training and development purposes.
[5] Element "5" item' d' for the 2022 care plan audit is included for training and development purposes.

6. Care Coordinator/Case Manager Follow-Up

Desired outcome:

Members have a care coordinator/case manager follow-up or contact plan related to identified concerns, needs[6] and referrals, and the plan is implemented.

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

a. Care Coordinator/Case Manager documents their plan for member contact;

AND

b. Care Coordinator/Case Manager documents contact with member according to plan;
or

c. Care Coordinator/Case Manager 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

- Case Notes
- Care Plan
- Member Record

[6] Follow up plan must address:
Identified preventive care concerns including but not limited to annual physical, immunizations, screening exams such as vision and hearing exams, health care (advance) directive, dental care, and tobacco use.

Identified long-term care and community support concerns including but not limited to nursing facility care, home health agency services such as home health aide services, and skilled nurse visits.

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 behavioral health care concerns includes both mental health and substance use disorders.

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Contract Citation(s):
6.1.4
6.1.5
7.1.5

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7. COMMUNICATION OF CARE PLAN SUMMARY – Primary Care Providers

Desired outcome:

The member's Primary Care Provider (PCP) receives a Care Plan Summary.

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

Evidence of Care Coordinator/Case Manager's communication of care plan elements with Primary Care Physician (PCP) or clinic if applicable.

Not met as determined by the following:

- Evidence not present of communication of care plan summary to PCP.

Source of Evidence

- Case Notes
- Care Plan
- Member Record

Contract Citation(s):

6.1.5
7.1.5

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8. ANNUAL PREVENTIVE HEALTH EXAM

Desired Outcome: Member engages in conversation about the need for an annual, age–appropriate comprehensive preventive health exam with Care Coordinator /Case Manager.

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

a. Documentation in member's care plan, case notes, or member record substantiates a conversation was initiated with member 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 member's care plan, case notes or member record.

Source of Evidence:
- Care plan.
- Member Record
- Case Notes

Contract Citation(s):

6.1.4

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9. ADVANCE DIRECTIVE

Desired outcome:

Member has opportunity for annual discussion about resources available for an Advanced Directive.

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

a. **Advance** Directive exists, **OR**

Documentation of conversation about Advance Directive **OR**

Documentation of member's refusal to discuss an Advance Directive, **OR**

Documentation of 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.
- Case Notes
- Member Record

Contract Citation(s):

6.1.5.16

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10. COMMUNICATION AND COORDINATION WITH COUNTIES

Desired outcome:

The Care Coordinator/Case Manager will maintain communication with county social services or public health agencies throughout the year as needed. (Such as with financial workers & case managers).

This may include, but is not limited to, referrals and/or coordination with county service staff for members in need of the following services:

- Pre-petition screening for civil commitment
- Preadmission screening for HCBS waivers.
- County case management for HCBS waivers.
- Child Protection
- Court ordered treatment
- Housing funding resources
- Assessment of medical barriers to employment
- Adult Protection
- Relocation Service Coordination
- State medical review team or social security determination
- Working with Local Agency social service staff or county attorney staff for members who are the victims or perpetrators in criminal cases.

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

a. Evidence of communication, coordination or referrals to other agencies are identified on the HRA as new or ongoing.

    Communication, coordination, or referral may be via letter, fax, email, face to face contact, or phone call.

    Documentation includes attempts at communication, coordination and referral.

b. Evidence the Case Coordinator/Care Manager communicated updates and changes to the member's condition and needs as appropriate.

Not met as determined by the following:

- The above stated requirements are not met per each sub-element.

Source of Evidence

- Care plan
- Case notes
- HRA (DHS 3428H)

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- Member record

Contract Citation(s):

6.1.5.12
6.1.5.11
6.1.5.13

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11. BEHAVIORAL HEALTH

Desired outcome:

Behavioral health concerns[7] will be identified and referrals will be made to qualified behavioral health professionals, as applicable.

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

a. Evidence of communication, coordination, or referral, if appropriate with the member's permission, is included in the case notes
    - Communication, coordination, or referrals may be via letter, fax, email, face to face contact, or phone call.
    - Documentation includes all attempts to communicate, or coordinate services etc.
    - Documentation as to why a referral was not provided is included in the case notes.

b. The Care Coordinator must communicate updates and changes to the member's condition and needs as appropriate, to appropriate professional staff.

Not met as determined by the following:

- The above stated requirements are not met per each sub-element

Source of Evidence

- Care Plan
- Case Notes
- HRA (DHS 3428H)
- Member Record

Contract Citation(s):

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6.1.5.11
6.1.5.12
6.1.5.13
6.1.5.14

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[7] Behavioral health includes both mental health and substance use disorders.

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Addendum Related to Classification of Delegates as High Performers

During the 2021 and 2022 audits of 2020 and 2021 care plans, MCO found that, despite concerns that the performance of delegates would be negatively affected by the COVID pandemic experience, many delegates continued to demonstrate 100% compliance with audit requirements. Based on this finding, it was determined that delegates that accomplished high performance despite COVID-related pressures should be granted credit for that accomplishment as follows:

Scenario 1: Delegates that met high performer requirements in the 2021 audit of 2020 care plans AND met the requirements for high performance in the 2022 audit of 2021 care plans.

- High performance during 2021 audit of 2020 care plans = Y
- High performance during 2022 audit of 2021 care plans = Y

These delegates will be granted high performer status. This means those delegates will not be subject to the 2023 audit of 2022 care plans.

Scenario 2: Delegates that met high performer requirements in the 2022 audit of 2021 care plans will have met the Year 1 condition.

- High performance during 2022 audit of 2021 care plans = Y

These delegates will be subject to the 2023 audit of 2022 care plans to determine if they meet Year 2 requirements to obtain high performer status.

Scenario 3: Delegates that met high performer requirements in the 2021 audit of 2020 care plans but did NOT meet the requirements in the 2022 audit of 2021 care plans.

These delegates will be allowed to retain their Year 1 high performance status and attempt a Year 2 high performance status in the 2023 audit of 2022 care plans. Due to the effects of the COVID pandemic, a delegate’s 2022 audit result will be disregarded.

- High performance during 2021 audit of 2020 care plans = Y
- High performance during 2022 audit of 2021 care plans = N
- High performance during 2023 audit of 2022 care plans = Y

These delegates will be subjected to the 2023 audit of 2022 care plans. If they meet high performer requirements in the 2022 audit, they will be granted high performer status. Delegates granted high performer status based on the 202 audit of 2022 care plans will not be subject to the 2024 audit of 2023 care plans.

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