Minnesota Department of Human Services

Managed Care (MSHO and MSC+) Elderly Waiver Care Planning Audit
(as required under 7.1.5.4, 7.8.3, and 7.8.4 of the 2021 MSHO/MSC+ contract)

2021 Audit Protocol

Final Draft Revised 4/5/22

(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 of the Protocol

- The Audit Protocol/Data Collection Guide is organized by element, first presenting outcomes related to assessment and enrollment/disenrollment, followed by outcomes related to comprehensive care planning and waiver services. The 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.
- This protocol applies to all care plans completed in Calendar Year (CY) 2021 and sampled for audits conducted in 2022.

Other Background Information

- LTCC and MnCHOICES: Currently, MSHO/MSC+ health plans primarily use the Long Term Care Consultation (LTCC) form DHS 3428 or DHS 3428A for assessment. MnCHOICES is included in the protocol because some MCO county delegates may use that assessment by agreement with an MCO. DHS will inform MCOs when MnCHOICES can be used for all MSHO/MSC+ members.

- "High performers": Per the MSHO/MSC+ and SNBC 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 (MSHO, MSC+ and SNBC).
- 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 criteria in the annual Delegate Review Report.

- See the attached Addendum for special guidance on designating delegates as high performers based on the 2021 audit of 2020 care plans.

- <u>COVID-19 considerations</u>: the audit of CY 2021 care plans will be affected by the COVID-19 national public health emergency, and actions taken by CMS and state government in response to that emergency. These actions are related to:
  - Federal maintenance of effort requirements prohibiting the termination of EW participation throughout the national public health emergency period. Cases where reassessment was recorded in MMIS solely to continue eligibility under COVID requirements when the person was never located should not be included in the sample for care plan auditing.
  - Waiver of certain requirements effective March 20, 2020 under the Governor's Emergency Executive Order 20-12, including:
    - Waiver of certain document and signature requirements. The waiver of the care plan signature requirement initially ended effective August 30th, 2021. However, the 2022 Legislature extended this waiver retroactive to September 1, 2021. In effect, this waiver is in place throughout CY 2021. See the protocol item 11 below for more detail.

- Provision of remote assessments and reassessments.

As a result, some sources of evidence may be changed for some audit items.

There were no changes to required assessment content or other care plan requirements.

For information related to COVID-19 provisions, see:

- Bulletin #20-56-06 – COVID-19: Participation in LTSS Programs Cannot be Terminated
- Bulletin #20-56-10 – LTSS policy amendments related to COVID-19 peacetime emergency

MCO sampling instructions

- The selection of care plans uses the same sampling method for the audit of 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. Cases where reassessment was recorded in MMIS solely to continue eligibility under COVID requirements when the person was never located should not be included in the sample for care plan auditing.

- 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 delegates with fewer than 30 eligible care plans, then 8 care plans will be pulled from all 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 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:
  - The Comprehensive Care Plan (CCP)

- Case notes to supplement the CCP
- MCO Health Risk Assessment (initial assessment conducted at time of enrollment)
- MMIS data from the Long Term Care Screening Document
- LTCC or MnCHOICES Assessment
- HCBS service plan/My Move Plan
- Residential Services Rates Tool and Plan, if applicable.

MCO Reporting to DHS

- MCOs will complete a report via Snap survey for MSHO and MSC+ for each delegate under contract with the MCO for care coordination (MSHO) and case management (MSC+) indicating the results of the audit.

- MCOs will prepare a summary of key findings and recommendations resulting 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.

- Refer to the "MCO 2020 Care Plan Audit Report Instructions" for information about reporting findings in the "MCO Care Plan Audit Report Format" tool.

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 40 total care plans sampled.
- DHS will share the protocols with MDH and discuss which protocol should be used based on the sample provided.

  - 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.

MDH reporting to DHS

- MDH will prepare a summary report for DHS of the findings based on the care plan review. DHS will respond to deficient findings as it determines appropriate.

1. ENROLLEE ASSESSMENT

Desired outcome: All enrollees will receive a complete assessment as applicable within required timelines.

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

1.1 Timeliness:

a. Initial LTCC/HRA completed within 30 calendar days of enrollment **or**

An explanation is documented if HRA was attempted but not completed within 30 calendar days of enrollment date when:
- enrollee refused completion of the initial HRA, or
- enrollee unable to be contacted, or
- enrollee was admitted to a hospital before the 30th calendar day, or
- enrollee was admitted to a nursing facility for a short-term stay of 30 or fewer days before the 30th calendar day after enrollment date **or**

b. Reassessment was completed within 365 days of previous LTCC assessment **or**

   An explanation is documented if completed but not within 365 days of previous assessment **or**

c. LTCC/HRA completed within 20 calendar days of member request; **or**

   An explanation is documented if completed but not within 20 calendar days of the request.

1.2 Complete:

All (100%) of the fields relevant to the enrollee's assessment are completed with pertinent information or noted as Not Applicable or Not Needed as appropriate.

a. All (100%) items within each domain listed below in the assessment are completed, or noted as "Not Applicable" or "Not Needed" as appropriate.

(1) Section A - Assessment Information (Section A)
(2) Section B - Information About Me (Section B)
(3) Section C - Assessment Information (Section C)
(4) Section F - My Health (Section L)
(5) Section G - Taking Care of Myself (Section M)
(6) Section H - My Emotional and Mental Health (Section E)
(7) Section I- My Safety (Section F)
(8) Section J - Assessment Results (Section G)
(9) Section K - Service Plan Summary (Section H)
(10) Section O - Caregiver Assessment (Section P)

1.3 Complete for Person-Centered Domains

a. All (100%) of the fields within each domain listed below are completed with pertinent information or noted as "Not Applicable" or "Not Needed" as appropriate.

(1) Section D - My Everyday Life (Section N)
(2) Section E - Relationships and Community Connections (Section D)

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

Source of Evidence:
LTCC or MnCHOICES assessment
MMIS approved screening document
Sections noted are those found in DHS Form 3428. Sections in ( ) are comparable sections from DHS Form 3428A.

Contract Citation(s):
6.1.4.1 (1)
6.1.5.2(1)
6.1.23.1
6.1.24.3

Citation(s):
Federal waiver reporting requirement
CMS Assurance Performance Measure #21 supported by 1.1 (b)

2. COMPREHENSIVE CARE PLAN - Timeliness

Desired Outcome: Enrollees receive a completed Comprehensive Care Plan (CCP) within 30 calendar days of a completed LTCC/MnCHOICES Assessment.

Method for measuring outcome achievement (met as determined by at least one of the following):

a. A CCP is completed and sent to member within 30 calendar days of the date of a completed LTCC/MnCHOICES assessment, including remote assessment completed under COVID provisions; **or**

The completed CCP was reviewed with member within 30 days of assessment when mail was not available and review is documented; **or**

If completed CCP was not sent or reviewed within 30 days of assessment or reassessment, a member-related explanation of status is documented.

Not met as determined by the following:
None of the above stated methods to meet this requirement are documented.

Source of Evidence:
Comprehensive care plan, care coordinator notes.

Contract Citation(s):
6.1.4.1(2)
6.1.5.2(4)
6.1.24.2

Citation(s)
Federal waiver reporting requirement
CMS Assurance Performance Measure #19

3. COMPREHENSIVE CARE PLAN – Assessed Needs Addressed

Desired Outcome: The Comprehensive Care Plan (CCP) addresses all enrollee assessed needs and preferences, and reflects a person-centered interdisciplinary, holistic and preventive focus.

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

3.1 The CCP addresses assessed needs in areas of life identified for the person.

a. All enrollee's assessed needs and concerns related to primary care, acute care, long-term services and supports, mental health, behavioral, and service needs and concerns are addressed in the care plan; or statement as to why an assessed need(s) was not included on the CCP; **and**

b. The need for services essential to the health and safety of the enrollee is documented; **and**

c. If essential services are included in the plan, a back-up plan for provision of essential services is also documented; **and**

d. There is a description of the plan related to community-wide disasters, such as weather related conditions.

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
LTCC/HRA

Contract Citation(s):
6.1.4.1(2) and (3)
6.1.5.2(4)
6.1.24.2

Citation(s)
Federal waiver reporting requirement
CMS Assurance Performance Measures #12 supported by 3.1 (a) and (b); #14 supported by 3.1 (a); and #31 supported by 3.1 (d)

3.2 The CCP addresses requests for assistance in areas of life identified as important to the person.

a. If the enrollee indicated they want assistance related to social, recreational, leisure or religious activities, this assistance is addressed in the care plan; **and**

b. If the enrollee indicated they want assistance related to social or family relationships, this assistance is addressed in the care plan; **and**

c. If the enrollee indicated they want assistance related to employment or volunteering, this assistance is addressed in the care plan.

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

Source of evidence:
LTCC/MnCHOICES assessment
Care Plan

Citation(s)
Federal HCBS rule requirement related to person-centered planning

4. COMPREHENSIVE CARE PLAN – Goals

Desired Outcome: The enrollee's goals or skills to be achieved are included in plan, are related to the enrollee's preferences and how the enrollee wants to live their life, and there is a plan to achieve their goals.

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

a. Goals and/or skills selected by the enrollee to be achieved are clearly described; **and**

b. Action steps, including services or supports needed, are identified and describe what needs to be done to assist the enrollee to achieve the goals or skills; **and**

c. Monitoring progress towards goals is included; **and**

d. Target dates for goal completion are included (at least month and year); **and**

e. Outcome/achievement dates are included (at least month and year); **and**

f. People/providers responsible for assisting the enrollee in completing each step are identified.

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

Source of Evidence:
Care plan and item F.9a in LTCC related to training on assistive devices.
Provider care plan/summary.

Contract Citation(s):
6.1.4.1 (2) and 3)
6.1.5.2 (4)
6.1.24.2

Citation(s):

Federal waiver reporting requirement
CMS Assurance Performance Measure #15 supported by 4 (a)

5. COMPREHENSIVE CARE PLAN – Choice

Desired Outcome: The enrollee is provided information related to, and makes informed choices about, long-term care services and providers.

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

a. The enrollee was offered choices among HCBS *services*; **and**

b. The enrollee was given information to enable the enrollee to choose among providers of HCBS services.

Not met as determined by the following:
No evidence of choice in each desired outcome is found.

Source of Evidence:
Care plan budget worksheet or equivalent
Care plan signature
Case notes related to review of care plan with member, and member's agreement with care plan, when signature was not obtained.

Notes related to COVID:
The member's signature on a care plan has been the source of evidence used to verify several care plan process and content requirements have been met. The signature requirement was waived as part of COVID-related provisions approved by the state and CMS. The waiver of the care plan signature requirement initially ended effective August 30th, 2021. However, the 2022 Legislature extended this waiver retroactive to September 1, 2021. In effect, this waiver is in place throughout CY 2021. See the protocol item 11 below for more detail. It is expected that CC document review of the plan, including choices between services and providers.

Contract Citation(s):
6.1.5.2(16)(d)
6.1.23.1(10)(a)
6.1.24.2
6.1.25.(3)

Citation(s)
Federal waiver reporting requirement
CMS Assurance Performance Measure #27 supported by 5 (b).

6. COMPREHENSIVE CARE PLAN - Safety Plan/Personal Risk Management Plan

Desired Outcome: The enrollee has been assessed for risk and has a plan to address identified safety issues relating to risks, rights and choice.

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

6.1 Risk discussion and planning:

a. Discussion between care coordinator and enrollee regarding safety concerns/risks is documented; **and**

b. The plan for managing any identified risks is included in the care plan; **or**

it is documented that no plan for managing risks is needed.

6.2 Assessment of need for limitations and planning for members receiving customized living or foster care services:

a. Limitations of choice were identified in the assessment and limitations are reflected in the care plan related to any of the following: *access to food at any time, participation in chosen activities and schedule, privacy, and/or access to visitors.*

Met by one of the following:

Care plan lists modification or limitation of choice due to identified safety concerns/risk and DHS Form 7176H is completed **or**

Care plan lists modification or limitation of choice due to identified safety concerns/risks and a form that contains all of the elements required in DHS Form 7176H has been completed by the care coordinator, member, and provider **or**

If no limitations of choice were identified in the assessment related to any of the following: *access to food at any time, participation in chosen activities and schedule, privacy, and/or access to visitors* **or**,

the member does not receive customized living or foster care services then not applicable.

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

Source of Evidence:
Care plan section.
DHS Form 7176H or equivalent

Contract Citation(s):
6.1.4.1(2)(b)
6.1.24.2

Citation(s)
DHS HCBS Rule- Person-Centered Planning Requirements

7. COMPREHENSIVE CARE PLAN – Informal and Formal Services

Desired Outcome: The enrollee receives a description of their formal and informal services that contains all required elements.

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

The enrollee's comprehensive care plan includes:

a. type of services to be furnished; **and**

b. the amount, frequency, duration and cost of each service; **and**

c. 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 all elements are not completed, an explanation of status must be documented.

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

Source of Evidence:
Care plan

Contract Citation(s):
6.1.24.2

Citation(s)
Federal waiver reporting requirement
CMS Assurance Performance Measure #23 supported by 7 (a), (b), and (c)

8. COMPREHENSIVE CARE PLAN – Caregiver Support
Desired Outcome: Informal caregivers are identified and supported in the plan.

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

If an informal caregiver is identified in the LTCC/MnCHOICES Assessment, then met is determined by the following:

a. A caregiver assessment was completed, and requested caregiver supports are incorporated into the care plan; **or**

   A caregiver assessment was completed but caregiver supports were not requested; **or**

   There is documentation the caregiver declined the caregiver assessment.

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

Source of Evidence:
LTCC Caregiver Interview
DHS-6914
Care Plan.

Contract Citation(s):
6.1.24.1
6.1.24.2

9. COMPREHENSIVE CARE PLAN – Housing and Transition

Desired Outcome: The enrollee has a transition plan to support housing choice.

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

a. If the enrollee indicated they want assistance in exploring housing options, the transition plan (My Move Plan) reflects a goal, steps to be taken, potential barriers; **and**

b. The transition plan (My Move Plan) is attached to the Care Plan; **or**

   A referral was made for Housing Stabilization Supports

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

Source of Evidence:
DHS Form 3428: Section E., items E.12, E.13, and E.13a; or DHS Form 3428A, Section D, items D.12, D.13 and D.13a.
Preparation of transition plan that meets transition plan requirements (action steps).
My Move Plan
Care plan - referral to Housing Support Services

Contract Citation:
6.1.23

Citation(s):
Federal HCBS rule requirement related to person-centered planning

10. COMMUNICATION OF CARE PLAN / SUMMARY - Physician

Desired Outcome: The enrollee's primary care physician receives a Care Plan Summary.

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

a. Evidence of care coordinator communication of care plan elements with Primary Care Physician (PCP).

Not met as determined by the following:
Evidence not present of communication of care plan summary to PCP.

Source of Evidence:
Care plan
Case notes

Contract Citation(s):
6.1.4.1(2)(a)
6.1.24.2

11. COMMUNICATION OF CARE PLAN/SUMMARY -Enrollee and Providers

Desired Outcome: The support plan is signed and dated and disseminated to all relevant parties.

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

Members:

a. The care plan is signed and dated by the enrollee or authorized representative; **and**

b. The care plan reflects the enrollee's choice of providers who are to receive the care plan/summary; **or**

   For support plans created after March 18, 2020, when a signature was not obtained, the care coordinator documented review with and expressed approval by the member of the care plan, including choices related to sharing the plan or portions of the plan with others~~; **or**~~

Providers

c. Documentation, including date and method, indicates the care plan/summary was sent or communicated to the provider(s) agreed to by the member, if any, within 30 days of the completion of the care plan; **and**

d. Documentation, including date and method, indicates that the care plan/summary was sent or communicated again to providers who have not returned the communication tool within 60 days of the completion of the care plan.

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

Notes related to COVID:
The member's signature on a care plan has been the source of evidence used to verify several care plan processes and content requirements have been met. The waiver of the care plan signature requirement initially ended effective August 30th, 2021. However, the 2022 Legislature extended this waiver retroactive to September 1, 2021. In effect, this waiver is in place throughout CY 2021.

Citation:
Federal waiver reporting requirement
CMS Assurance Performance Measure #25 supported by 11 (a), (b), (c), and (d)

12. COMPREHENSIVE CARE PLAN – Enrollee Requests for Updates

Desired Outcome: The care plan includes a method for the individual to request updates to the plan, as needed.

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

a. The care plan provided to a member includes how the individual can request changes to the plan; **or**

The care coordinator has documented all parts of the care plan were reviewed with the member when mail was unavailable

Not met as determined by the following:
The care plan does not include how the individual can request changes to the plan.

Source of Evidence:
Care plan
Case notes

Notes related to COVID:
The member's signature on a care plan has been the source of evidence used to verify several care plan process and content requirements are met. The waiver of the care plan signature requirement initially ended effective August 30th, 2021. However, the 2022 Legislature extended this waiver retroactive to September 1, 2021. In effect, this waiver is in place throughout CY 2021. The signature requirement was waived beginning March 18, 2020 as part of COVID-related provisions approved by the state and CMS.

Contract Citation(s):
6.1.4.2(5)
6.1.5.2(16)(d)

Citation(s):
Federal HCBS rule requirements related to person-centered planning.

13. CARE COORDINATOR FOLLOW-UP PLAN

Desired Outcome: Enrollees have a care coordinator follow-up or contact plan related to identified concerns or needs[1], and the plan is implemented.

[1] Follow-up plan must address based on individual needs:

Identified preventive care concerns including but not 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.

Identified long-term care and community support concerns including but not 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).

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 mental health care concerns including but not limited to depression, dementia, and other mental illness.

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

a. Care Coordinator documents their plan for enrollee contact on the care plan provided to the member; **or**

   The care coordinator has documented the follow-up plan for care coordination was reviewed with the member when mail was unavailable; **and**

b. Care Coordinator documents contact with enrollee according to plan; **or**

   Care coordinator 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:
Care plan
Case notes

Notes related to COVID:
The member's signature on a care plan has been the source of evidence used to verify several care plan process and content requirements have been met. The signature requirement was waived as part of COVID-related provisions adopted to waiver requirements as approved by the state and CMS.

This item is not used for EW performance measurement but may be required by MCOs under other authorities.

Contract Citation(s):
6.1.4.2 (6)
6.1.5.2(16)(e)

14. ANNUAL PREVENTIVE HEALTH EXAM

Desired Outcome: Enrollee engages in conversation about the need for an annual, age–appropriate comprehensive preventive health exam with care coordinator.

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

a. Documentation is present 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.

Source of Evidence:
Care plan

Contract Citation(s):
6.1.4.2(2)
6.1.5.1(2)
6.1.6.2

15. ADVANCE DIRECTIVE

Desired Outcome: Enrollee has opportunity for annual discussion about and/or completion of an Advance Directive

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

a. Advance Directive exists; **or**

   Care coordinator documents annual initiation of conversation about Advance Directive; **or**

   Care coordinator documents enrollee's refusal to complete an Advance Directive; **or**

   Care coordinator documents reason why Advance Directive conversation was not initiated.

Not met as determined by the following:
None of the above stated methods to meet this requirement are documented.

Source of Evidence:
Care Plan

Contract Citation(s):
6.1.4.1 (2)(c)
6.1.5.2(4)

16. APPEAL RIGHTS

Desired Outcome: Enrollee receives information about their appeal rights.

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

a. Completed and signed care plan indicates receipt of appeal rights; **or**

   Other MCO signed documentation in enrollee file indicates receipt of appeal rights; **or**

   When a signature was not obtained under the COVID waiver of this requirement, the care coordinator documented review of appeal rights with the member.

Not met as determined by the following:
No documentation that the enrollee received information about their appeal rights.

Source of Evidence:
Care plan
Other signed documentation
Case notes

Contract Citation(s):
3.8
6.1.24.2

17. DATA PRIVACY

Desired Outcome: Enrollee receives information about data privacy.

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

a. Completed and signed care plan indicates receipt of information about data privacy; **or**

   Other MCO signed documentation in enrollee file indicates receipt of data privacy information; **or**

   When a signature was not obtained under the COVID waiver of this requirement, the care coordinator documented review of data privacy information with the member.

Not met as determined by the following:
No documentation that the enrollee received information about their data privacy.

Source of Evidence:
Care plan
Other signed documentation
Case notes

Contract Citation(s):
6.1.4.2(13)
6.1.5.2(16)(l)
6.1.4.1(2)
6.1.5.2(4)

Addendum Related to Classification of Delegates as High Performers

During the 2021 audit of 2020 care plans, MCOs 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 2020 audit of 2019 care plans AND met the requirements for high performance in the 2021 audit of 2020 care plans.

High performance during 2020 audit of 2019 care plans = Y
High performance during 2021 audit of 2020 care plans = Y

These delegates will be granted high performer status. This means those delegates will not be subject to the 2022 audit of 2021 care plans.

Scenario 2: Delegates that met high performer requirements in the 2021 audit of 2020 care plans will have met the Year 1 condition.

High performance during 2021 audit of 2020 care plans = Y

These delegates will be subject to the 2022 audit of 2021 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 2020 audit of 2019 care plans but did NOT meet the requirements in the 2021 audit of 2020 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 2022 audit of 2021 care plans. Due to the effects of the COVID pandemic, a delegate's 2021 audit result will be disregarded.

High performance during 2020 audit of 2019 care plans = Y
High performance during 2021 audit of 2020 care plans = N
High performance during 2022 audit of 2021 care plans = Y

These delegates will be subject to the 2022 audit of 2021 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 2022 audit of 2021 care plans will not be subject to the 2023 audit of 2022 care plans.