Policy Title:	**Delegation Oversight**
Department:	**Markets Growth & Retention**
Business Unit:	**State Public Programs**
Approved By:	**Senior Manager, Regulatory Oversight & Improvement**
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PRODUCTS AFFECTED:

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

DEFINITIONS

Care Coordination: The assignment of an individual who assesses the need for and coordinates the provision of all Medicare and Medicaid health and long-term care services for Members and who assesses the need for and coordinates services to a member among different health and social service professionals and across settings of care.

Care Coordinator (CC): An individual who assesses the member, develops a person-centered care plan, and coordinates and supports delivery of services identified in the care plan.

Care Coordination Products (CCP): Medica Care Coordination products include DUAL Solution (MSHO), Choice Care (MSC+), AccessAbility (SNBC), and AccessAbility Solution Enhanced (SNBC SNP) products.

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

Medicaid and SNP Leadership: The Director of Medicaid and SNP Product & Strategy, the Director of Medicaid and SNP Member Solutions & Innovation and their designated staff.

PURPOSE

This policy guides Delegates and Medica Regulatory Oversight & Improvement staff through the annual review process of contracted care coordination responsibilities.

POLICY

Medica performs a formal review of each Delegate annually. The purpose of the review is to collect information regarding Delegates' care coordination processes to monitor compliance with Medica, DHS and

CMS requirements for care coordination. Examples of topics addressed during the review include but are not limited to:

- Care Coordination Qualifications; Description of use of administrative or non-clinical staff to support Care Coordination
- Case distribution weighting process; PTO/Leave case load coverage; Ongoing Care Coordinator support and supervision
- Timely assignment of members; timely notification of Care Coordinator changes; Monitoring of Medicaid status and renewal assistance; timely completion of assessments and care plans; Timely entry of assessments; Timely submission of requested materials
- Staff onboarding process; DHS training and tracking; HIPPA and Data Privacy training and tracking
- Delegate attestations to their understanding, under Medica contract, that they are in compliance with the administrative requirements and protocols of Medica, including policies and procedures, and use of tools, forms, and letters
- Potential conflicts of interest; Business Disaster Recovery Plan

PROCEDURE

1. All Delegates are reviewed annually.
    a. Content reviewed as part of the Delegation Oversight process is identified by the Regulatory Oversight & Improvement team and Medica Medicaid and SNP Leadership.
    b. Delegation Oversight is the responsibility of the Regulatory Oversight & Improvement team with support and input from Medica Medicaid and SNP Leadership, Clinical Liaisons, and others as identified.

2. The Clinical Improvement Lead notifies each Delegate of the annual review via email and requests the completion and return of the Annual Care Coordination Delegation Oversight Review form and additional supplemental documents.
    a. Materials requested are customized to reflect the populations the Delegate serves. For example, if the entity has a contract for SNBC members, no MSHO-only requirements will be requested.
    b. A review date is established that allows two to three weeks for the Delegate to provide the requested information.

3. The Clinical Improvement Lead works with each Delegate during their review process to resolve any discrepancies or concerns prior to bringing recommendations to Medica Medicaid and SNP Leadership.

4. The Delegate is notified of the findings:
    a. No further action required
    b. Opportunities for improvement (OFI)
    c. Corrective action plan (CAP) required
        i. If a CAP is required the Clinical Improvement Lead will monitor CAP progress and will ensure completion of the CAP.

5. In addition, the Clinical Improvement Lead shares internal audit finding data such as Health Risk Assessment/Care Plan audit, Unable to Reach/Refuser audit results, and Transition of Care audit results.

6. The final Annual Care Coordination Delegate review form and supplementary documentation is filed in the Delegate's electronic folder saved on a secure Medica server.

Annual Medicaid and SNP Leadership Review:

1. Medica Regulatory Oversight & Improvement staff present the findings of the review and recommendations to Medica Medicaid and SNP Leadership annually. Results also are reported to the Medica Delegate & Subcontractor Oversight Committee at least annually.

2. The Medica Medicaid and SNP Leadership meetings are scheduled annually to accommodate organizational and departmental priorities.

3. A list of those Delegates who meet all Medica expectations will be presented to leadership in aggregate for discussion.

4. For Delegates who did not meet all Medica expectations, the Delegate is discussed individually by Medica Medicaid and SNP Leadership.
    a. An action plan is identified, including identification of specific staff who will follow-up with the Delegate to address identified issues.
    b. During resolution of identified issues, an escalating process is pursued:
        i. Meetings to discuss issues/deficiencies
        ii. Request for remediation of the identified issue
        iii. Request for missing or improved documentation
        iv. Discussion of Medica expectations moving forward
        v. Follow-up review and interaction with Delegate to determine if requirements have been met. The time frame for follow-up is determined based on the specific issue(s), including perceived level of potential harm to members.
    c. Electronic, telephonic, or in person reporting is acceptable for follow-up with the Delegate.
    d. The identified Medica staff member working with the Delegate on resolution of identified issues reports back to Medica Medicaid and SNP Leadership with the Delegate's response and indicates whether or not the Delegate now meets Medica's expectations. If the issue/deficiency is not resolved, Medica Medicaid and SNP Leadership determine next steps. Options up to and including termination of the contract are considered.
    e.
    f. Actions for external Delegates are reported to the Medica Delegate & Subcontractor Oversight Committee. Actions related to the internal care coordination team are discussed with Medica Health Services leadership.

Medica Generated Reporting:

1. In accordance with Medica's responsibilities to Delegation Oversight, Medica generates several reports identified on the Care Coordination Reporting Policy to Care Coordination entities. Some of those reports include:
    g. Monthly enrollment report with new members, termed members and current members.
    h. Member Stratification Report: The Member stratification report brings together Demographic and Care System Data with Clinical Markers and Utilization metrics for a given population at the universal person identification (ID) level. The report is based around several data elements per member and built to facilitate Pivot Table reporting in Excel. The report contains a population summary with comparison to the containing product as well as several useful pivot table metrics including enrollment span, inpatient (IP) and emergency room (ER)

utilization, and Coordination Issue highlights. Each row of the pivot tables can be double clicked on to expose the detailed rows of the members making up that category. Additionally, the Medica data analytics team or the care coordination delegate can filter either the source data or create additional pivots to help stratify their population and focus clinical intervention to increase member health.

i. Enhanced Care Coordination Report: this report is sent to delegates quarterly. Medica uses the Johns Hopkins ACG predictive modeling software combined with other selected indicators, including utilization, claims experience, and member diagnostic information. This report utilizes variables including total cost of care, multiple chronic conditions, poly pharmaceuticals or drugs, inpatient use, emergency room utilization and high risk mental health condition indicators. The report uses a rolling 12 months of data to identify each member's risk.

j. Ad hoc reports including but not limited to: Members Missing Assessment Reports, Department of Human Services (DHS) Medicaid Management Information System (MMIS) Timeliness Reports and other financial/cost of care reports.

Delegate Generated Reporting & Documentation:

1. In accordance with the Delegate's responsibilities concerning Delegation Oversight, Medica requires the following reports/documentation from the Care Coordination entities:
    a. Medica Care Coordination HRA Tracking report, which includes completed HRAs, Care Plans and assigned Care Coordinator.
    b. Annual Care Coordination Delegate Oversight Response (includes attestations and required written documentation).
    c. Annual Care Coordinator List, including contact information, degree/training, supervisor, and date of last MOC training.
    d. Requested copies of Medica case files/member records as needed for regulatory and quality purposes such as, but not limited to Unable to Reach/Refuser audits, Transition of Care audits, Minnesota Department of Health audits, Centers for Medicare & Medicaid Services (CMS) audits, Model of Care review, and Part C Validation.

Delegate Input Collection:

1. Additional activities through which Medica monitors Care Coordination Delegates' performance and collects input on Medica's processes may include:
    a. Annual meeting with each Delegate to discuss new requirements and identified issues;
    b. Input from Medica clinical liaisons
    c. Care Coordinator comments and input
    d. Monitoring of missing member assessments
    e. Part C Special Needs Plan (SNP) Care Management Report Validation

Cross References

Annual Delegation Oversight Response Form
Care Coordination Reporting Policy

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