PROGRAM MONITORING

Services offered through the Adult Day Health Care (ADHC) waiver are closely monitored to assure compliance with Medicaid's policy as well as applicable state and federal regulations. Medicaid's Health Standards Section (HSS) staff conducts on-site reviews of each provider agency. These reviews are conducted to monitor the provider agency's compliance with Medicaid's provider enrollment participation requirements, continued capacity for service delivery, quality and appropriateness of service provision to the waiver group, and the presence of the personal outcomes defined and prioritized by the individuals served.

The HSS reviews include an examination of administrative records, personnel records, and a sample of recipient records. In addition, provider agencies are monitored with respect to:

- Recipient access to needed services identified in the Plan of Care and Individualized Service Plan,
- Quality of assessment and service planning,
- Appropriateness of services provided including content, intensity, frequency and recipient input and satisfaction,
- The presence of the personal outcomes as defined and prioritized by the recipient/guardian, and
- Internal quality improvement.

A sample of recipient records will also be reviewed to assure appropriate services are documented and delivered.

A provider's failure to follow state licensing standards and Medicaid policies and practices could result in the provider's removal from Medicaid participation, federal investigation, and prosecution in suspected cases of fraud.

On-Site Reviews

On-site reviews with the provider agency are unannounced and conducted by HSS staff to:

- Ensure compliance with program requirements, and
- Ensure that services provided are appropriate to meet the needs of the recipients served.

Administrative Review

The Administrative Review includes:

- A review of administrative records,
- A review of other agency documentation, and
- Provider agency staff interviews as well as interviews with recipients sampled to determine continued compliance with provider participation requirements.

Failure to respond promptly and appropriately to the HSS monitoring questions or findings may result in sanctions or liquidated damages and/or recoupment of payment.

Personnel Record Review

The Personnel Record Review includes:

- A review of personnel files,
- A review of time sheets,
- A review of the current organizational chart, and
- Provider agency staff interviews to ensure that support coordinators, direct service providers, and all supervisors meet the following staff qualifications:
    - Education,
    - Experience,
    - Skills,
    - Knowledge,
    - Employment status,
    - Hours worked,
    - Staff coverage,
    - Supervisor-support coordinator ratio,
    - Caseload/recipient assignments,
    - Supervision documentation, and
    - Other applicable requirements.

Interviews

As part of the on-site review, the HSS staff will interview:

- A representative sample of the individuals served by each provider agency employee,
- Members of the recipient's network of support, which may include family and friends,
- Service providers, and
- Other members of the recipient's community. This may include support coordinators, support coordinator supervisors, other employees of the support coordination agency, direct service providers and other employees of the direct service provider agency.

This interview process is to assess the overall satisfaction of recipients regarding the provider agency's performance, and to determine the presence of the personal outcomes defined and prioritized by the recipient/guardian.

Recipient Record Review

Following the interviews, the HSS staff may review the case records of a representative sample of recipients served. The records will be reviewed to ensure that the activities of the provider agency are associated with the appropriate services of intake, ongoing assessment, planning (development of the Plan of Care and Individualized Service Plan, transition/closure, and that these activities are effective in assisting the individual to attain or maintain the desired personal outcomes.

The case record must indicate how these activities are designed to lead to the desired personal outcomes, or how these activities are associated with organizational processes leading to the desired personal outcomes of the recipients served.

Recorded documentation is reviewed to ensure that the services reimbursed were:

- Identified in the Plan of Care and Individualized Service Plan,
- Provided to the recipient,
- Documented properly,

- Appropriate in terms of frequency and intensity, and
- Relate back to personal outcomes on the Plan of Care and Individualized Service Plan.

The HSS staff will review the intake documentation of the ADHC waiver recipient's eligibility and procedural safeguards, support coordination and professional assessments/reassessment documentation, service plans, service logs, progress notes and other pertinent information in the recipient record.

Quality Enhancement Plan

The provider agency's approved annual Quality Enhancement Plan (QEP) is reviewed to ensure that the agency is providing quality services and is responsive to the needs of recipients, including the personal outcomes defined and prioritized by the recipients. In addition, the following is also reviewed:

- The current approved QEP, any internal corrective action plans and documentation of QEP meetings of the provider agency.
- Recipient input into service planning and timeliness of response to recipient requests in a sample of recipient records.
- The support coordination or direct service provider agency's use of recipient input in the improvement of service provision.

Monitoring Report

Upon completion of the on-site review, the HSS staff discusses the preliminary findings of the review in an exit interview with appropriate staff of the support coordination or ADHC provider agency. The HSS staff compiles and analyzes all data collected in the review, and a written report summarizing the monitoring findings and recommended corrective action is sent to the provider agency.

The monitoring report includes:

- Identifying information,
- A statement of compliance with all applicable regulations or,

- Deficiencies requiring corrective action by the support coordination or ADHC provider agency.

The HSS program managers will review the reports and assess any sanctions as appropriate.

Corrective Action Report

The provider is required to submit a Plan of Correction to HSS within **10 working days of receipt of the report**.

The plan must address *how each cited deficiency has been corrected* and *how recurrences will be prevented*. The provider is afforded an opportunity to discuss or challenge the HSS monitoring findings.

Upon receipt of the written Plan of Correction, HSS program managers review the provider's plan to assure that all findings of deficiency have been adequately addressed. If all deficiencies have not been addressed, the HSS program manager responds to the provider requesting immediate resolution of those deficiencies in question.

A follow-up monitoring survey will be conducted when deficiencies have been found to ensure that the provider has fully implemented the plan of correction. Follow-up surveys may be conducted on-site or via evidence review.

Informal Dispute Resolution (Optional)

In the course of monitoring duties, an informal hearing process may be requested. The provider is notified of the right to an informal hearing in correspondence that details the cited deficiencies. The informal hearing is optional on the part of the provider and in no way limits their rights to a formal appeal hearing. In order to request the informal hearing, the provider should contact the program manager at HSS. (See Appendix A for contact information.)

This request must be made within the time limit given for the corrective action recommended by the HSS.

The provider is notified of time and place where the informal hearing will be held. The provider should bring all supporting documentation that is to be submitted for consideration. Every effort will be made to schedule a hearing at the convenience of the provider.

The HSS program manager convenes the informal hearing and will conduct the hearing in a non-formal atmosphere. The provider is given the opportunity to present its case and to explain its disagreement with the monitoring findings. The provider representatives are advised of the date that a written response will be sent and are reminded of its right to a formal appeal.

There is no appeal of the informal hearing decision; however, the provider may appeal the original findings to the DHH Bureau of Appeals.

Fraud and Abuse

When HSS staff detects patterns of abusive or fraudulent Medicaid billing, the provider will be referred to the Program Integrity Section of the Medicaid Program for investigation and sanctions, if necessary. Investigations and sanctions may also be initiated from reviews conducted by the Surveillance and Utilization Review System (SURS) of the Medicaid Program. DHH has an agreement with the Attorney General's Office which provides for the Attorney General's office to investigate Medicaid fraud. The Office of the Inspector General, Federal Bureau of Investigation (FBI), and postal inspectors also conduct investigations of Medicaid fraud.