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**CHAPTER 9: ADULT DAY HEALTH CARE WAIVER**

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### **PROGRAM OVERSIGHT AND REVIEW**

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 rules and regulations. Oversight is conducted through licensure compliance and program monitoring. The Louisiana Department of Health's (LDH) Health Standards Section (HSS) staff conducts on-site reviews to assure state licensure compliance for the providers they license. The Office of Aging and Adult Services (OAAS) staff conducts reviews to monitor compliance with Medicaid policy, waiver participation requirements, and the presence of personal outcomes as defined by beneficiaries served.

The OAAS regional office staff conduct on-site reviews of support coordination agencies. Details about the support coordination monitoring process are provided to support coordination agencies at the time of enrollment.

#### **Health Standards Section Reviews**

HSS reviews include an examination of administrative records, personnel records, and a sample of beneficiary records. In addition, ADHC providers are monitored with respect to:

- Beneficiary access to needed services identified in the Plan of Care (POC) and Individualized Service Plan (ISP);
- Quality of assessment and service planning;
- Appropriateness of services provided including content, intensity, frequency and beneficiary input and satisfaction; and
- Internal quality improvement.

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

#### **On-Site Reviews**

HSS on-site review with a provider is unannounced to ensure licensure compliance. The on-site review is comprised of the following:

- Administrative Review;
- Personnel Record Review;

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- Interviews; and
- Beneficiary Record Reviews.

**Administrative Review**

The Administrative Review includes:

- A review of administrative records;
- A review of other agency documentation; and
- Provider staff interviews as well as interviews with beneficiaries 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 staff interviews to ensure that direct care staff and all supervisors meet the following staff qualifications:
  - Education;
  - Experience;
  - Skills;
  - Knowledge;
  - Employment status;

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- Hours worked;
- Staff coverage;
- 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 employee;
- Members of the beneficiary's network of support, which may include family and friends;
- Direct care staff; and
- Other members of the beneficiary'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 ADHC center.

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

**Beneficiary Record Review**

Following the interviews, the HSS staff may review the case records of a representative sample of beneficiaries served. The records will be reviewed to ensure that the activities of the provider are associated with the appropriate services of intake, ongoing assessment, care planning, and transition/closure.

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

- Identified in the POC and ISP (if applicable);
- Provided to the beneficiary;
- Documented properly; and

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- Are appropriate in terms of frequency and intensity.

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

**Report of Review Findings**

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 ADHC provider. 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.

The review report includes:

- Identifying information;
- A statement of compliance with all applicable regulations; or
- Deficiencies requiring corrective action by the ADHC provider.

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 and requests immediate resolution of the deficiencies in question.

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

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**Informal Dispute Resolution (Optional)**

In the course of the review process, providers may request an informal hearing with HSS staff. 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 the providers' 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 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 Division of Administrative Law.

**Fraud and Abuse**

When HSS staff detects patterns of abusive or fraudulent Medicaid billing, the provider will be referred to the Program Integrity Section for investigation and sanctions, if necessary. Investigations, recoupments and sanctions may also be initiated from reviews conducted by the Surveillance and Utilization Review System (SURS) and/or Program Integrity Section. LDH 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 the Centers for Medicare and Medicaid Services (CMS) also conduct investigations of Medicaid fraud.

**Support Coordination Monitoring**

The OAAS regional staff conducts annual monitoring of each support coordination agency as a means of monitoring compliance with Medicaid policy, waiver participation requirements, and the presence of personal outcomes as defined by beneficiaries served. The results of the monitoring process are reported to the support coordination agency along with any required follow-up actions and timelines. Recurrent problems are to be addressed by the support coordination agency through

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systemic changes resulting in improvements. Support coordination agencies who do not perform all of the required follow-up actions according to the specified timelines are subject to sanctions.

Support coordination agencies are responsible for the following in the monitoring process:

- Offering full cooperation with OAAS;
- Providing policy and procedure manuals, personnel records, case records, and other documentation, as requested;
- Providing space for documentation review and support coordinator interviews;
- Coordinating with agency support coordinator interviews; and
- Assisting with scheduling beneficiary interviews.

Providers may refer to Appendix B of this manual chapter for further information regarding the Support Coordination Monitoring process.