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 regulations. Oversight is conducted through licensure compliance and program monitoring. The Department of Health and Hospitals'(DHH) 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 review to monitor compliance with Medicaid policy, waiver participation requirements, and the presence of personal outcomes as defined by individuals served.

On-site review of support coordination providers is conducted by the OAAS regional office staff. Details about the support coordination monitoring process are provided to support coordination providers at the time of enrollment.

Health Standards Section Reviews

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, 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

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

- Administrative Review,
- Personal Record Review,

- Interviews, and
- Recipient Record Reviews.

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 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 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, care planning, and transition/closure.

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

- Identified in the Plan of Care and Individualized Service Plan (if applicable),
- Provided to the recipient,
- Documented properly, and
- Are appropriate in terms of frequency and intensity.

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.

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 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 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 DHH 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. 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), the Center for Medicare and Medicaid Services (CMS) and postal inspectors also conduct investigations of Medicaid fraud.

Support Coordination Monitoring

The OAAS regional staff conducts annual monitoring of each support coordination provider as a means of monitoring compliance with Medicaid policy, waiver participation requirements, and the presence of personal outcomes as defined by individuals served. The results of the monitoring process are reported to the support coordination provider along with any required

follow-up actions and timelines. Recurrent problems are to be addressed by the support coordination provider through systemic changes resulting in improvements. Support coordination providers who do not perform all of the required follow-up actions according to the specified timelines, are subject to sanctions.

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

- Offering full cooperation with the 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 recipient interviews.