PROGRAM MONITORING/QUALITY ASSURANCE AND IMPROVEMENT

The Louisiana Department of Health (LDH) is responsible for setting the standards for monitoring fiscal/employer agent (F/EA) providers and administering sanctions for failure to meet the minimum standards of participation. Services offered by the F/EA will be are closely monitored on an on-going basis as outlined in the performance agreement to assure compliance with Medicaid's policy as well as applicable state and federal regulations. F/EAs are required to fully cooperation with LDH during the monitoring process.

F/EA responsibilities in the monitoring process include, but are not limited to:

1. Providing policy and procedure manuals;

2. Employer/employee records; and

3. Other documentation as requested.

Failure to follow Medicaid policies and practices could result in the F/EA's removal from Medicaid participation, federal investigation, and prosecution in suspected cases of fraud.

F/EAs shall cooperate with any audit requests from state or federal agencies.

Grievances

The F/EA shall establish and follow a written grievance procedure to be used to process complaints by employers, their family member(s), or a legal representative that is designed to allow employers to make complaints without F/EA of retaliation. The written grievance procedure shall be provided to the employer.

All suspected cases of abuse (physical, mental and/or sexual), neglect, exploitation or extortion must be reported to the appropriate authorities. (See Appendix E for contact information).

If the beneficiary needs emergency assistance, the F/EA shall call 911 or the local law enforcement agency.

Any other circumstances that place the beneficiary's health and well-being at risk should also be reported.

NOTE: It is the policy of LDH, Office for Citizens with Developmental Disabilities (OCDD) and Office on Aging and Adult Services (OAAS) that all critical incidents for home and community-based services (HCBS) be reported, investigated and tracked. Beneficiaries or their responsible party must report such occurrences to their support coordinator. Should the F/EA receive a complaint or a report of abuse, neglect or fraud, it must be reported to the appropriate program office, Medicaid Program Support and Waivers section and the Office of the Inspector General (OIG), if indicated.

Internal Complaint Policy

Beneficiaries must be able to file a complaint regarding his/her services without fear of reprisal. The F/EA shall have a written policy to handle beneficiary complaints. In order to ensure that the complaints are efficiently handled, the F/EA shall comply with the following procedures:

1. Each F/EA shall designate an employee to act as a complaint coordinator to investigate complaints. The complaint coordinator shall maintain a log of all complaints received. The complaint log shall include the date the complaint was made, the name and telephone number of the complainant, nature of the complaint, and resolution of the complaint;

2. The complaint coordinator must thoroughly investigate each complaint. The investigation includes, but is not limited to: gathering pertinent facts from the beneficiary, the personal representative, the worker, and other interested parties. These contacts may be either in person or by telephone. The provider is encouraged to use all available resources to resolve the complaint at this level and shall include the on-site program manager. For issues involving medical or quality of care issues, the on-site program manager must sign the resolution;

3. The provider's administrator or designee must inform the beneficiary and/or the personal representative in writing **within 10 working days** of receipt of the complaint and the results of the internal investigation; and

4. If the beneficiary is dissatisfied with the results of the internal investigation regarding the complaint, he/she may continue the complaint resolution process by contacting the appropriate local governing entity (LGE) in writing, or by telephone.

If the complainant's name and address are known, the LGE will notify the complainant **within two working days** that the complaint has been received and action on the complaint is being taken.

Complainant Disclosure Statement

Louisiana R.S. 40:2009.13-40.2009.21 sets standards for identifying complainants during investigations in nursing homes. The Bureau is mandated to use these standards for use within the home and community-based services waiver programs. When the substance of the complaint is furnished to the F/EA, it shall not identify the complainant or the beneficiary unless he/she consents in writing to the disclosure. If the disclosure is considered essential to the investigation or if the investigation results in judicial proceeding, the complainant shall be given the opportunity to withdraw the complaint.

Definition of Related Terms Regarding Incidents and Complaints

The following definitions are used in the incident and complaint process:

1. Trivial report - an account of an allegation that an incident has occurred to a beneficiary or beneficiaries that causes no physical or emotional harm and has no potential for causing harm to the beneficiary or beneficiaries. (R.S. 40:2009.14);

2. Allegation of noncompliance - an accusation that an event has occurred or is occurring that has the potential for causing no more than minimal harm to a consumer or consumers. (R.S. 40:2009.14);

3. Disabled person - a person with a mental, physical or developmental disability that substantially impairs the person's ability to provide adequately for his/her own care or protection; and

4. Incident - any situation involving a beneficiary that is classified in one of the categories listed in this section or any category of event or occurrence defined by OCDD as a critical event, and has the potential to impact the beneficiary or affect delivery of waiver services.

For additional definitions, refer to Appendix E Glossary of this manual chapter.

Administrative Sanctions for Violations for Violations/Non-Performance

Liquidated Damages

F/EAs that fail to meet the performance standards specified in the provider enrollment documentation and performance agreement may be assessed liquidated damages.

Liquidated damages will be used to reduce the Department's payments to the F/EA for FMS. If liquidated damages exceed the amounts due from LDH, the F/EA will be required to make cash payments for the amount in excess.

If it is in the best interest of LDH, the assessment of liquidated damages may be delayed. LDH may give notice to the F/EA of a failure to meet performance standards but delay the assessment of liquidated damages in order to the F/EA to cure the deficiency. If the F/EA subsequently fails to remedy the deficiency to the satisfaction of LDH, LDH may assess the liquidated damages that have been incurred, even following Medicaid enrollment termination.

Liquidated damages are defined as:

1. **Late submission of any required report:**
   One hundred dollars ($100) per working day, per report;

2. **Failure to maintain all beneficiary files and perform all file updates according to the requirements in the performance agreement:**
   Five hundred dollars ($500) per occurrence; and

3. **Failure to meet performance outcomes as outlined in the performance agreement:**
   Reduce the F/EA's per member per month (PMPM) payments by up to 20 percent.

The decision to impose liquidated damages may include consideration of some or all of the following factors:

1. Duration of the violation;

2. Whether the violation (or one that is substantially similar) has previously occurred;

3. F/EA's history of compliance;

4. Severity of the violation and whether it imposes an immediate threat to the health or safety of the beneficiary(s); and/or

5. "Good faith" exercised by the F/EA in attempting to stay in compliance.

In order to remain in good standing with Medicaid and eligible to continue the provision of services under the Medicaid Provider Agreement, the F/EA must comply with the all requirements listed in Performance Agreement. If the F/EA is determined to be in violation and/or non-compliance with those requirements, Medicaid reserves the right to impose sanctions on the F/EA, with or without prior notice.

Sanctions may be imposed in the following circumstances:

1. Retaliation aimed at beneficiary/family members for complaints against the F/EA;

2. Negligence directly or indirectly caused by failure to comply with mandating reporting requirements resulting in serious harm or death to the beneficiary;

3. Engaging in a pattern of recurring or continuing non-compliance;

4. Failure to implement an emergency preparedness and response plan in the event of a disaster; and/or

5. Failure to cooperate in assisting the beneficiary and the receiving F/EA to assure a smooth transition, by assuring that the receiving F/EA, receives copies of the beneficiary's records.

Sanction Determinations

The following factors will be considered in determining sanctions to be imposed:

1. Seriousness of the violation;

2. Extent of the violation;

3. History of prior violations;

4. Pattern of non-compliance; and

5. Any other factors deemed critical by LDH.

Sanctions may include, but are not limited to, the following which are **binding** and **not subject to appeal**:

1. Written warning;

2. Written mandate for documentation of acceptable remediation plan/demonstration of compliance with rules/regulations/agreement;

3. Impose training and accountability measures;

4. Impose further performance requirements;

5. Moratorium on admissions and/or expansion of services (i.e. Removal from FOC list); and

6. Removal of existing beneficiaries. If Medicaid determines that removal of existing beneficiaries is necessary, the F/EA must cooperate in the transfer of the beneficiaries to a new F/EA or face additional sanctions.

In addition to the measures described above, sanctions may also include, but are not limited to, the following, which are subject to an administrative appeal:

1. Suspension of payments in whole or part for a specific time period;

2. Recoupment;

3. Denial of reimbursement for undocumented services;

4. Impose daily, weekly, or monthly fines;

5. Medicaid provider enrollment suspension/limitation/revocation; and/or

6. Termination of the Medicaid Provider Agreement.

In addition, if action or inaction on the part of the F/EA result in a federal disallowance, the F/EA shall be held liable to recoupment of those amounts.

Due Date of Monetary Sanctions

Impositions of any damage shall not be suspensive. Any and all monetary sanctions/recoupment shall become due and payable upon written notification from LDH. Failure to remit payment within ten (10) working days may result in withholding of payment until all outstanding monetary sanctions/recoupment are paid, unless an administrative appeal is pending.

If LDH should prevail at the administrative appeal, payment is due within ten (10) working days from the date of the decision. Failure to remit payment within ten (10) working days from the date of decision may result in withholding of the F/EA's payments until all outstanding fines are paid, and may result in additional non-monetary sanctions.

Appeals

Specified sanctions administered by Medicaid in accordance with the performance agreement may be appealed. The F/EA has a right to an administrative hearing. A request for an administrative hearing must be received within 30 days from the date of written notice of the sanction. The request must be made in writing and mailed or faxed directly to: