# PROGRAM MONITORING

Services offered through the Residential Options Waiver (ROW) program 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 or its designee conducts on-site reviews of the home and community based waiver (HCBS) provider agencies. 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 a review of administrative records, personnel records, and a sample of beneficiary records. In addition, provider agencies are monitored with respect to the following:

1. Beneficiary's access to needed services identified in the service plan;

2. Quality of assessment and service planning;

3. Appropriateness of services provided including content, intensity, frequency and beneficiary input and satisfaction;

4. The presence of the personal outcomes as defined and prioritized by the beneficiary and/or responsible representative; and

5. Internal quality improvement.

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:

1. Ensure compliance with program requirements; and

2. Ensure that services provided are appropriate to meet the needs of the beneficiaries served.

### Administrative Review

The Administrative Review includes the following:

1. A review of administrative records;

2. A review of other provider agency documentation; and

3. Provider agency staff interviews, as well as interviews with a sampling of beneficiaries, 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, liquidated damages, and/or recoupment of payment.

### Interviews

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

1. A representative sample of the individuals served by each provider agency employee;

2. Members of the beneficiary's circle or network of support, which may include family and friends;

3. Service providers; and

4. Other members of the beneficiary's community. This may include support coordinators, support coordinator supervisors, other employees of the support coordination agency, and direct service providers and other employees of the direct service provider agency.

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

### Personnel Record Review

The Personnel Record Review includes the following:

1. A review of personnel files;

2. A review of electric visit verification record/time sheets; and

3. A review of the current organizational chart.

## Beneficiary Record Review

A representative sample of beneficiary records are reviewed to ensure the services and supports delivered to beneficiaries are rendered according to the beneficiary's approved plan of care (POC). 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 beneficiaries served.

Beneficiary records are reviewed to ensure that the activities of the provider agency are correlated with the appropriate services of intake, ongoing assessment, planning (development of the POC), transition/closure, and that these activities are effective in assisting the beneficiary to attain or maintain the desired personal outcomes.

Documentation is reviewed to ensure that the services reimbursed were:

1. Identified in the POC;

2. Provided;

3. Documented properly;

4. Appropriate in terms of frequency and intensity; and

5. Relate back to personal outcomes on the POC.

## Provider Staff Interviews

Provider agency staff is interviewed as part of the on-site review to ensure that staff meets the following qualifications:

1. Education;

2. Experience;

3. Skills;

4. Knowledge;

5. Employment status;
6. Hours worked;
7. Staff coverage;
8. Supervisor to staff ratio;
9. Caseload/beneficiary assignments;
10. Supervision documentation; and
11. Other applicable requirements.

## 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 provider staff. 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 the following:

1. Identifying information;
2. A statement of compliance with all applicable regulations; or
3. Deficiencies requiring corrective action by the 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 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 the right of the provider to a formal appeal hearing. In order to request the informal hearing, the provider should contact the program manager at HSS. (See Appendix C 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 the time and place of the informal hearing. 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 providers are given the opportunity to present their case and to explain their disagreement with the monitoring findings. The provider representatives are advised of the date to expect a written response and are reminded of their right to a formal appeal.

There is no appeal of the informal hearing decision; however, the provider may appeal the original findings to the Louisiana Department of Health (LDH) 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. LDH has an agreement with the Office of the Attorney General to investigate Medicaid fraud. The Office of the Inspector General, Federal Bureau of Investigation (FBI), and postal inspectors also conduct investigations of Medicaid fraud.

## Quality Management

Direct service providers and support coordination agencies must have a quality enhancement process that involves the following:

1. Learning;
2. Responding;
3. Implementing; and
4. Evaluating.

Agency quality enhancement activities must be reviewed and approved by the local governing entity (LGE) as described in the *Quality Enhancement Provider Handbook*. (See Appendix D for information on this handbook).