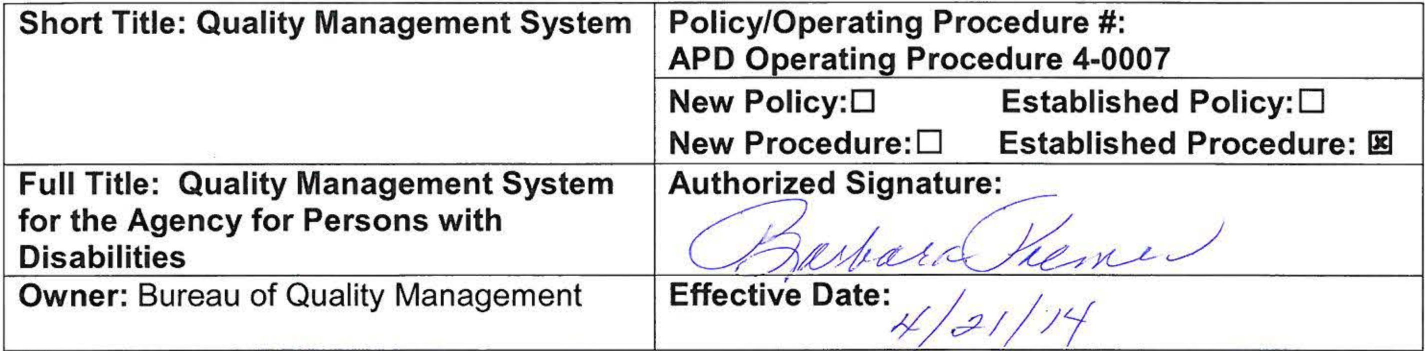
agency for persons with disabilities

State of Florida



Short Title: Quality Management System	Policy/Operating Procedure #: APD Operating Procedure 4-0007
	New Policy: ☐ Established Policy: ☐ New Procedure: ☐ Established Procedure: ☒
Full Title: Quality Management System for the Agency for Persons with Disabilities	Authorized Signature: Barbara Palmer
Owner: Bureau of Quality Management	**Effective Date:** 4/21/14

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I. Purpose:

It is the responsibility of the Agency for Persons with Disabilities (APD) to oversee the delivery of services to individuals with developmental disabilities. The APD service system must be effective, efficient, and meet both individual expectations for improving quality of life and compliance with regulations. This responsibility shall be carried out through quality management activities coordinated at the APD State Office, Regional/Field Offices, the contracted

Quality Improvement Organization (QIO), the Agency for Health Care Administration (AHCA), and others as detailed in this operating procedure.

II. Reference(s):

This operating procedure establishes an internal process for establishing a quality management system by the Agency for Persons with Disabilities.

a) Florida Medicaid Developmental Disabilities Waiver Services Coverage and Limitation Handbook
b) Developmental Disabilities Individual Budgeting (iBudget) Medicaid Waiver Coverage and Limitation Handbook
c) CDC+ Coverage and Limitation Handbook
d) Medicaid 1915(c) Home and Community Based Services Waiver Assurances and Sub-assurances
e) Licensing & Oversight of Residential Facilities Operating Procedure 10-008
f) Licensure of Residential Facilities (F.A.C. 65G-2)
g) Oversight of Medicaid Programs F.S. 409.913
h) Medicaid Integrity (F.A.C. 59G-9.070)
i) Medical Case Management Operating Procedure (in development)
j) Medication Administration (F.A.C. 65G-7)
k) Background Screening, F.S. 393.0655, F.S. 393.0657, F.S. 435.04
l) Incident Reporting Operating Procedure 10-002
m) Provider Enrollment Operating Procedure 04-011
n) Behavioral Services Operating Procedure (in development)
o) Reactive Strategies (F.A.C. 65G-8)
p) Zero Tolerance Operating Procedure (in development)
q) Questionnaire for Situational Information (QSI) Training Materials.

III. Authority:

Under Chapters 287, 393, 402 and 409 F.S., and any applicable State and Federal law and regulation, APD is obligated to ensure that the rights of individuals with developmental disabilities are upheld and that individuals meeting eligibility criteria receive appropriate and timely assessment and services that are rendered effectively and efficiently by qualified and competent providers. There is an Interagency Agreement between AHCA and APD as required by Centers for Medicare and Medicaid Services (CMS), which delineates the agencies respective responsibilities as follows: APD is responsible for administering all applicable Home and Community Based Services/ Developmental Disabilities (HCBS/DD) waivers (iBudget and CDC+), tracking and addressing provider remediation and developing improvements to the

system as a whole. AHCA ensures the administration of the waiver is in compliance with federal and state regulations.

IV. Scope:

This procedure establishes quality management responsibilities of the APD State Office and each Regional/Field Office. These procedures shall be uniformly applied statewide. The quality management activities described in this procedure shall be coordinated by the Bureau of Quality Management within the APD State Office. The procedures describe herein are applicable to services rendered to APD clients through the Medicaid waiver program, contract, or licensure.

V. Policy:

Not applicable.

VI. Definitions:

A shared understanding of the language and terms used in this operating procedure is necessary to ensure uniformity in its implementation. For that reason, an extensive list of terms and definitions is provided in Attachment A as a common reference source.

VII. Procedures:

APD's quality management process has three distinct functions which are (1) Discovery, (2) Remediation, and (3) Improvement. The operating procedure defines APD's Regional/Field Office and State Office requirements to be followed for each of these functions.

Primary responsibility for all quality management activities in the Regional/Field Offices rests with each Regional Operations Manager (ROM). The ROM shall designate staff to carry out the quality management function for each workstream. Regional/Field Offices are responsible for quality management, remediation, and quality improvement activities associated with Medicaid Waiver providers and licensed residential facilities.

The quality management activities described within this operating procedure shall be deployed in response to a variety of events involving APD clients, including but not limited to:

a) QIO Reports and Alerts
b) Protective Services Investigations
c) Incident Reports (Critical & Reportable)
d) Medication Errors
e) Death Reports
f) Complaints
g) Use of Reactive Strategies

The primary quality management monitoring of services funded through the Medicaid waiver and CDC+ programs is rendered through an independent, nationally recognized Quality Improvement Organization (QIO). Pursuant to Chapter 409, F.S. and waiver regulations, the Agency for Health Care Administration (AHCA) manages the quality management contract with the QIO. The QIO is contracted to review provider performance to discover the level of compliance with the Medicaid Waiver Services Handbooks and discover the extent to which quality of life issues including, but not limited to, personal expectations, service satisfaction, health, safety, and well-being of people supported by APD. The QIO furnishes a variety of compliance reports and data to APD to implement remediation and quality improvement activities. APD coordinates with AHCA to guide the QIO contractor to carry out its responsibilities and makes sure that deficiencies found during the QIO discovery process are remediated. APD is also responsible for monitoring waiver services that are beyond the scope of the QIO contract. See Attachment B for greater detail of both the Federal and State requirements for quality management activities and the evidence needed to demonstrate system correction and data used for improvement.

See Attachment C for the required list of reports produced by the QIO.

The following section outlines the discovery, remediation, and improvement functions. Each function has a section devoted to its description with specific processes and procedures APD staff are to follow in implementing the quality management process.

1. Discovery

QIO Discovery

As part of the quality management process, the QIO shall conduct both Person Centered Reviews (PCRs) and Provider Discovery Reviews (PDRs). A detailed description of its processes, its Operational Policies and Procedures Manual, and the Florida Statewide Quality Assurance Program (FSQAP), along with review tools, scoring methods, and related resources, can be accessed on the current QIO's website.

The QIO shall furnish the Regional/Field Offices with a list of scheduled reviews on a monthly basis (or more often as dictated by APD). Notification to APD of upcoming reviews for the month shall include the name of the lead reviewer, the provider being reviewed, and the scheduled review date. APD Regional/Field Office staff shall provide the QIO with the following information involving service providers prior to the scheduled review. The QIO shall use this information to determine how to proceed with the review. Information to be shared includes:

- Complaints or Grievances
- Incident Reports
- DCF & AHCA Investigation Findings
- Other Regional/Field Office Concerns

The QIO shall notify the designated Regional/Field Office staff member following two (2) unsuccessful attempts to schedule a review with a provider. Following such notification, APD Regional/Field Office staff shall attempt to contact the provider by both phone and email to instruct the provider to make contact with the QIO to schedule their review within three (3) business days. APD Regional/Field Office staff shall document contact attempts in the provider's enrollment file. If an APD staff member is successful in contacting the provider, the provider shall notify the QIO and the review shall proceed. If the provider does not respond to APD, does not make records available for review, or fails to participate in a scheduled review, the provider/CDC+ Representative shall be scored "Not Met" in all areas of the discovery tool. Providers who fail to participate in a scheduled QIO review or scores "Not Met" in all areas of the discovery tool, shall be recommended by APD for termination review (see Noncompliance, Section B.3).

A. The PDR Process

The Provider Discovery Review (PDR) process evaluates each provider's/CDC+ Representatives' performance and compliance with regulations. It consists of on-site monitoring reviews, including observation, record review, and interviews for the purpose of discovering the level of quality services rendered by providers and the quality of life experienced by people receiving supports and services. The operational policies and procedures manual and tools specific to the PDR process may be found on the QIO's website.

Unless the provider has earned Deemed Status, each provider identified as eligible per the QIO contract, will receive an onsite PDR review. A provider shall correct all deficiencies noted in the discovery review by completing a Plan of Remediation (POR), assigned by APD Regional/Field Office staff (see Remediation Section) as required per Medicaid 1915C Home and Community Based Services Waiver Assurances and Sub-assurances.

For Consumer Directed Care Plus (CDC+) Participants selected for a Person Centered Review (PCR), a corresponding PDR shall be conducted with their Representative and Consultant. The CDC+ Representative's PDR will occur regardless of whether the CDC+ individual participates or declines participation in the PCR process. The CDC+ Representative's PDR is not required annually unless the CDC+ Participant is selected for a PCR.

The tools specific to the CDC+ process may be found on the QIO's website. Refer to Attachment D for the letter sent to active CDC+ Participants that describes the CDC+ process for PCR and PDR.

Before exiting an on-site review, the QIO reviewer shall leave the provider a Preliminary Findings Worksheet that identifies standards related to any potential Billing Discrepancies and Alerts that are scored Not Met. For Alerts, instructions shall include the provider's responsibility to contact their APD Regional/Field Office within twenty-four (24) hours of the QIO notification. The Preliminary Finding Worksheet includes notification of Billing Discrepancies (i.e. Recoupment), any related details, and Reconsideration instructions. Reconsiderations are only available for Billing Discrepancy citations. A final report by the QIO shall be mailed to the provider and posted on the QIO's website for APD access within thirty (30) days of the PDR.

B. The PCR Process

PCRs begin with a face-to-face interview with individuals receiving services under one of the Medicaid Waivers (i.e. iBudget or CDC+) and includes a review of supports and services specific to that individual, including a review of the support plan, cost plan, implementation plan and service records from each provider rendering services to the individual. The PCR provides information about personal goals and expectations in areas such as health, safety, rights, choice, community involvement, and satisfaction with supports and services.

Deficiencies found in the Service Specific Record Review (SSRR) component of PCRs are integrated into the provider's PDR for subsequent remediation. PCR findings shall be reviewed and monitored by Regional/Field Office staff to identify trends and assign PORs as required.

The PCR tools include the National Core Indicators (NCI), an Individual Interview Instrument (referred to as III or I cubed), and a health summary. It includes:

- Observations of residential and day training facilities (if applicable)
- Interviews with family members (if available)
- An interview and record review with the individual's WSC

- Record reviews of other providers rendering services to that person

The process also includes analysis of claims data and a medical peer review when health or behavioral concerns are present. The operational policies and procedures manual and tools specific to the PCR process may be found on the QIO's website.

The QIO shall provide PCR reports to the APD Regional/Field Office, the WSC, and, by request, to the individual reviewed, and their legal representative. PCR findings shall be reviewed and monitored by Regional/Field Office staff to identify trends and Discovery concerns. The Regional/Field Offices are responsible for addressing issues that adversely impact quality services. POR shall be initiated by APD staff within ten (10) business days for the following:

- A need for a QIO medical peer review (in which the original QIO review indicates the need for medical case management team involvement)
- Less than half of the standards are met on the Individual Interview Instrument (III or I cubed)
- Billing Discrepancy
- Discovery citations related to health and safety

In the event an Alert is identified through the PCR review, the protocol outlined under "Responding to Alert Citations" (Section B.4) in this operating procedure shall be followed.

C. Other Discovery Sources

The identification of deficiencies or concerns related to the provision of quality services is not limited to QIO review activities. Other discovery issues shall be fully researched and may require remediation (i.e. POR assignment). Below are some examples of such (non-QIO) discovery sources:

- **APD Audits**: Financial and/or Administrative Audit reviews conducted by APD Regional/Field Office and/or Inspector General's Office staff.

- **AHCA Medicaid Program Integrity (MPI) & Medicaid Fraud Control Unit (MFCU) Audits/Inspections**: Audits and investigates providers suspected of overbilling or defrauding Florida's Medicaid program, recovers overpayments, issues administrative sanctions, and refers cases of suspected fraud for criminal investigation.

- **Abuse Investigations**: In accordance with the Zero Tolerance protocol, all DCF investigations into allegations of abuse, neglect, or exploitation involving APD clients shall be reviewed by APD staff and

follow-up actions shall be taken to address any health and safety concerns as a result of investigation findings.

- **Incident Reports**: In accordance with CFOP 10-002, all incident reports (Critical and Reportable) shall be reviewed to determine if remediation and/or quality improvement actions as described within this operating procedure are required. For this reason, multiple incident reports involving the same provider or client should be closely examined as part of ongoing trend analyses.

- **Medication Errors**: In accordance with the Medication Administration, F.A.C. 65G-7, medication error reports and MCM reviews may reveal the need for follow-up actions by APD staff.

- **Complaints**: Complaints filed by clients, family members, service providers, Waiver Support Coordinators, or others (e.g. APD staff, other state agencies, etc.) represent an important discovery source in cases where APD researches and determines whether there is validity to such complaints. Examples of complaint sources that require an assignment of a POR are:

1. **Cost Plan Reviews**: Cost plan reviews by APD staff may reveal issues necessitating remediation and improvement. An example of such an issue may involve the lack of fading behavioral services over time (which could be indicative of ineffective behavioral services).

2. **Expenditure Analysis**: Analyses of claims data by APD's Inspector General or Office of Medicaid Program Integrity may reveal billing anomalies requiring follow-up by APD staff.

3. **Licensing and Monitoring**: Any deficiencies discovered during licensing/monitoring inspections that are Medicaid Waiver Handbook related shall be logged as a "Complaint" on the Remediation Tracker.

4. **Reactive Strategies**: Providers are required by statute to report all instances of reactive strategy utilization to APD. Examples of complaints to be filed concerning Reactive Strategies may include a provider who fails to complete the monthly report timely/accurately or Reactive Strategy reports that indicate failure to follow established procedures.

Discovery Responsibilities

A. Quality Improvement Organization (QIO) Responsibilities:

1. Notify Regional/Field Offices of providers scheduled for review
2. Notify providers of scheduled review date
3. Notify Regional/Field Offices of unresponsive providers
4. Conduct Discovery Reviews (PCRs & PDRs)
5. Furnish preliminary findings to providers on the final day of the review
6. Immediately notify Regional/Field Offices of Alerts and other issues needing attention including, but not limited to, potential fraud and noncompliance
7. Submit report to provider and notify Regional/Field Offices of review posting within thirty (30) days
8. Post findings and scores on the QIO's website within thirty (30) days of a provider review

Deemed Status

Deemed Status is a process utilized and applied by the QIO to any provider (with the exception of Waiver Support Coordinators) with an overall score of 95% or higher on their PDR with no identified Alerts and/or Billing Discrepancies. If a provider achieves Deemed Status, it will not be reviewed until the following contract year. The implementation of Deemed Status is at the discretion of APD State Office and AHCA.

In the event that a provider who has Deemed Status for PDRs has any Alerts and/or Billing Discrepancies identified during a PCR that provider shall lose its Deemed Status and a PDR shall be scheduled immediately at the direction of APD State Office and AHCA. APD Discovery review citations may result in a provider losing its Deemed Status. If Deemed Status is revoked, a PDR will be scheduled.

If a provider is in Deemed Status, it does not exempt them from other APD Discovery reviews, audits, and/or licensing/monitoring inspections.

B. APD Regional/Field Office Responsibilities:

1. Collect and analyze provider specific data from a variety of sources as described within the Discovery Sources section of this operating procedure.

2. On a regularly-scheduled and ongoing basis, APD Regional/Field Office staff shall provide the QIO with information regarding concerns or deficiencies involving specific service providers (to include incident reports, complaints, etc.).

3. To initiate a discovery review of any identified provider, a request for QIO review, outside the regular review cycle, shall be made by the ROM (or their designee) contacting the State Office's Bureau of Quality Management. State Office will contact AHCA and the QIO to schedule the review.

4. Provide the QIO with updated contact information as requested for non-responsive/noncompliant providers.

5. Upon receiving an Alert from the QIO, the Regional/Field Office shall immediately follow-up with the provider on the citation to ensure resolution and to validate completion as outlined in this operating procedure.

6. Prior to scheduled reviews, staff shall ensure that WSCs have verified accuracy of the following information:

   - Demographics
   - Contact information for Guardian/Legal Representative/Next of Kin
   - People served on individual caseload (home "district worker assignment")

7. Notify State Office Bureau of Quality Management of any inconsistencies noted in the QIO's performance.

C. APD State Office Responsibilities: APD State Office provides a data report to the QIO and AHCA to assist in scheduling QIO discovery reviews and NCI surveys. Such reports are to include the following information:

   1. Regional/Field Office
   2. WSCs that Provide Services Within the Regional/Field Office
   3. List of Individuals Served by WSCs
   4. The Individuals'/Guardians'/Legal Representatives' Contact Information
   5. Individuals' Demographics

   The APD Bureau of Quality Management shall follow up with the QIO and/or AHCA to address any inconsistencies or concerns related to the QIO's performance.

2. Remediation

In order to ensure the ongoing provision of quality services to APD clients, it is required that all identified deficiencies, regardless of the discovery source, shall be sufficiently addressed in a timely manner. Staff from the Regional/Field Offices and the APD State Office shall work in accordance with the responsibilities outlined below.

Regional/Field Office Responsibilities

Each APD Regional/Field Office Quality Management workstream is responsible for directing and tracking remediation of all violations from a discovery review or other discovery source to a verifiable resolution. ROMs or designees shall ensure that data from QIO reviews or other sources are shared with Regional/Field Office Quality Management staff. The Regional/Field Office QA staff shall ensure that providers have corrected deficiencies cited by the QIO, APD, or any other source.

Regional/Field Offices shall work directly with providers who have cited deficiencies to submit a Plan of Remediation (POR) addressing each item cited. Regional/Field Offices shall use the required Remediation Tracker as an aggregate of all deficiencies identified by the QIO, APD, or other sources for provider follow-up and reporting purposes.

A. Remediation Tracker

The Remediation Tracker shall be used to track all citations identified through the QIO discovery process, as well as deficiencies discovered by APD or any other source. The Remediation Tracker and Instructions are found in Attachments E and F.

Plans of Remediation (PORs)

APD Regional/Field Office Responsibilities:

1. Plan of Remediation Process

   All providers with identified deficiencies, including CDC+ Representatives, are required to complete a POR. Within ten (10) business days of a report from the QIO or other source, the Regional/Field Office shall send a letter or email of notification to the provider or CDC+ Representative (copy Consultant) requiring a POR. The letter is to include the APD-approved POR format to be completed by the provider to identify planned actions, timeframes, and responsibilities to remedy all items cited as deficient. The POR and Instructions are found in Attachments G and H.

Providers/CDC+ Representatives scoring at or below the APD established performance level of 85% on a PDR or contains identified Alerts or Billing Discrepancies are required to meet face-to-face with the designated Regional/Field Office staff to complete a POR. Providers with a trend of two or more PDR reviews with cited Alerts, Billing Discrepancies, and/or scoring less than 85% shall be forwarded to the State Office Operations Department and copied to the Bureau of Quality Management for termination review.

On a case-by-case basis, the ROM or QA Supervisor may approve the use of web-based conferencing in lieu of conducting a face-to-face meeting at the Regional/Field Office. The APD IT standard software is Lync. The use of any other web-based conferencing software is not permitted.

Providers with identified deficiencies scoring above the 85% criteria on a PDR, without an Alert or Billing Discrepancy citation, are required to complete a POR, but will <u>not</u> be required to meet face-to-face with APD staff.

For Alerts, the timeframe for completion of a POR is seven (7) calendar days or less. For all other deficiencies, the POR deadline, set by the Regional/Field Office, shall not exceed ninety (90) calendar days from the APD letter/email notification date.

The ROM or designee shall:

a) Review the POR and sign, if approved.
b) Schedule a follow-up meeting with the provider or CDC+ Representative for technical assistance or other action, as needed.
c) If not approved, forward APD's recommendations for POR improvements to the provider or CDC+ Representative and require a POR resubmission within five (5) business days. The rejected POR may serve as evidence for subsequent disciplinary actions.

When the POR is completed and the remediation is verified by the Regional/Field Office Provider Liaison, the POR form is to be signed by the Provider/CDC+ Representative, the APD Provider Liaison, and the APD QA Supervisor.

Providers with cited Billing Discrepancies shall be advised by APD staff to contact AHCA to pay in full or enter into a written repayment agreement. A copy of the repayment agreement and/or receipt of payment in full shall be attached to the completed POR and maintained by APD at the Regional/Field Office for audit purposes. For provider repayment instructions see <u>Attachment L</u>.

Regional/Field Offices shall maintain files of all correspondence and documentation associated with the provider and/or CDC+ Representative's POR that demonstrates that the remediation is completed.

2. POR Follow-up Activities

   Regional/Field Offices are required to conduct follow up activities with the providers to verify evidence of remediation on all deficiencies cited including:

   (a) Technical assistance meetings

   (b) Unannounced on-site visits
   (c) Financial and/or Administrative Audits
   (d) Reviews of Remediation Documentation

   As part of the Remediation process, Regional/Field Office staff are expected to render technical assistance to individual providers whenever necessary and appropriate in order to prevent subsequent instances of similar violations. In certain cases, a provider's Plan of Remediation may include requirements for additional training or re-training of specific staff members.

3. Noncompliance

   Failure of a provider to comply with required QIO reviews and/or assigned PORs shall result in termination of their Service Agreement and/or other disciplinary actions. Within two (2) business days APD staff shall forward provider termination recommendations to the Bureau of Quality Management and Operations Department for termination review at APD's Interdisciplinary Provider Meetings. Examples include providers identified as:

   - Noncompliant with QIO reviews
   - Noncompliant with PORs
   - Having a trend of two or more PDR reviews with cited Alerts, Billing Discrepancies, and/or scoring less than 85%

   CDC+ Representatives, who fail to complete a corrective action required on a POR within the established timelines, shall be required to enter into a Corrective Action Plan (CAP) as set forth in the CDC+ Handbook. If the CDC+ Representative remains non-compliant for sixty (60) calendar days after implementing the CAP, APD may (at its discretion) recommend involuntary disenrollment of the consumer from the CDC+ program. The consumer would then be returned to the HCBS Waiver. The CDC+ Plan of Remediation (POR) is separate and distinct from the CDC+ Corrective Action Plan. The CDC+ Corrective Action Plan is a federal requirement to address non-compliance with program and finance rules related to the CDC+ program.

4. Responding to Alert Citations

Alerts are identified when review items related to issues of health, safety, rights, abuse, neglect, or exploitation are detected by the QIO. All Alerts require immediate action and substantial improvement on the part of the responsible service provider. The QIO reviewers immediately notify the ROM or designee of any Alerts. Within two (2) business days, QIO management submits further details to the ROM or designee, APD State Office, and AHCA.

APD Regional/Field Office staff shall contact the provider immediately following receipt of the Alert in order to ensure the issues (which prompted the Alert) are appropriately addressed (e.g. remove staff for direct service, etc.). Support Coordinators shall be notified immediately by Regional/Field Office staff to make arrangements to resolve the issue (e.g. obtain another qualified provider). The ROM or designee is to immediately notify APD staff responsible for topics identified in an Alert and ensure prompt resolution on the part of the provider through the completion of a POR not to exceed seven (7) calendar days.

Alerts involving abuse, neglect or exploitation requires the Regional/Field Office to verify that a report was made to the DCF Florida Abuse Hotline to ensure timely reporting of events and that the person at the focus of the report is no longer in an unsafe or harmful situation. In instances where the Abuse Hotline or law enforcement will not accept a report, the Regional/Field Office shall not consider the incident closed. The Regional/Field Office shall follow the situation until it has evidence that the conditions related to the alleged abuse, neglect, or exploitation is no longer a concern. The Regional/Field Office shall maintain files of evidence clearing any such Alerts.

Regional/Field Offices are to receive and log Alerts on the Remediation Tracker and notify the provider or CDC+ Representative & Consultant of the need for immediate action. APD Regional/Field Office staff shall immediately forward all Alerts involving APD licensed residential facilities to staff that are responsible for conducting licensure and/or monitoring visits as well as those responsible for initiating disciplinary action against residential providers. If it is suspected that the health, safety, and welfare of residents are at risk, APD Regional/Field Office staff shall be dispatched to conduct an unannounced site visit within twenty-four (24) hours following notification of any Alert involving an APD licensed home.

Based upon the results of an Alert finding, a provider shall be directed by the APD Regional/Field Office to take immediate corrective action on any significant health and safety issue. Deficiencies reported as Alerts require immediate remediation and development of a required POR.

The QIO provides a written notification via email within two (2) business days to the ROM or their designee and State Office. When an Alert is received, the ROM or their designee is to ensure that the appropriate staff members are immediately notified (e.g., Quality Management staff in collaboration with licensure staff, behavioral, nursing, CDC+ Liaison, etc.) to take appropriate action and track remediation to its completion.

When Background Screening and/or Medication Administration Alerts are identified, the APD Regional/Field Office shall require providers to conduct self-audits by completing APD's Provider Background Screening Self- Audit Form (Attachment I) or Provider Medication Administration Self-Audit Form (Attachment J) of all employees within seven (7) calendar days as a Corrective Action component of the Plan of Remediation. This is not applicable to CDC+ QIO discoveries. This action is to confirm that all employees possess current background screening documentation and meet the requirements for medication administration training and validation (per F.A.C. 65G-7). Providers are required to comply with the protocol set forth in their Plan of Remediation. The self-audit summary documents submitted by the providers are to be validated by the Regional/Field Office Quality Management staff who are to record the information in the APD Remediation Tracker. At a minimum, the content of the self-audit shall include the following information for each employee:

(a) Employee Name
(b) Hired Date
(c) Screening Results for FBI, FDLE, Local Law, Affidavit of Good Moral Character, and proof of Five Year Rescreening, if applicable.
(d) Documentation of Compliance with Medication Administration Training and Validation Requirements, if applicable

For CDC+ Alerts related to background screening violations, Regional/Field Office staff shall immediately notify the Regional/Field Office CDC+ Liaison and CDC+ State Office staff to end the direct care provider authorization until required background screening clearance is obtained and "new hire" paperwork is received by State Office to create a new authorization. Staff identified in an Alert shall end all direct care service immediately until the Alert has been remediated.

If findings of the self-audit reveal direct care staff provided service without meeting mandatory Background Screening and/or Medication Administration requirements, the Regional/Field Office staff shall refer findings to MPI. Providers having a trend of two or more PDR reviews with validated Alert citations shall be forwarded to State Office's Operations Department and copied to the Bureau of Quality Management for termination review (as described in Section B.3, Noncompliance).

5. Medicaid Waiver Services Agreement Terminations and Licensure Actions

   In cases where Regional/Field Office staff believe that a service provider is either unwilling or unable to render quality services to APD clients in accordance with established laws, administrative rules, and applicable Handbooks, the service provider shall be referred to the Bureau of Quality Management and Operations Department for termination review at APD's Interdisciplinary Provider Meeting within two (2) business days.

   The following types of terminations of Medicaid Waiver Service Agreements include:

   - Without Cause Termination
   - With Cause Termination
   - Voluntary Termination
   - Loss of Contact

   In cases involving APD-licensed homes, disciplinary actions should be taken in accordance with s. 393.0673, F.S., Licensing and Oversight of Residential Facilities Operating Procedure 10-008, and 65G-2, F.A.C.

   APD Regional/Field Office staff are required to notify CDC+ State Office when a CDC+ employee is to be terminated due to noncompliance with background screening requirements.

   All recommended terminations presented by the APD Regional Offices are to be reviewed by State Office for final approval. For "With Cause" terminations and licensure actions, the APD General Counsel is to be consulted. State Office staff shall notify AHCA and the QIO of all provider terminations and licensure actions.

6. Provider Expansion Requests

   Regional/Field Offices shall consult APD Provider Enrollment Operating Procedure 04-011 for providers who request expansion of services or geographic area.

   A. Providers <u>without</u> a QIO review history who request an expansion:

      Before the APD Regional/Field Office approves a provider for expansion, the Regional/Field Office must determine that the provider meets the specific service requirements stipulated in the Developmental Disabilities Individual Budgeting Medicaid Waiver Coverage and Limitation Handbook. If a provider does not have a history of a QIO review, this <u>does not</u> prevent consideration for expansion. Factors such as demand for service specific providers within a geographic area may be considered.

APD staff shall check with the provider's home Regional/Field Office to see if there is a history of complaints filed and logged on the Remediation Tracker, any open investigations and/or referrals to AHCA's Medicaid Program Integrity (MPI) or the Attorney General's Medicaid Fraud Control Unit (MFCU), and/or the Department of Children & Families (DCF).

B. Providers with a QIO review history requesting expansion:

Before the APD Regional/Field Office approves a provider for expansion, the Regional/Field Office shall determine that the provider meets the respective Handbook requirements for expansion to occur. The Regional/Field Office shall ensure that the provider has:

(1) 85% or higher on their last QIO Report

(2) No identified Alerts (i.e., Background Screening, Medication Administration and Validation, etc.)

(3) No outstanding Billing Discrepancies or Plan of Remediation

(4) No adverse performance history in their Home Region

(5) No open investigations or referrals to AHCA and/or DCF

APD staff shall check with the provider's home Regional/Field Office to see if there is a history of complaints filed and logged on the Remediation Tracker, any open investigations and/or referrals to AHCA's Medicaid Program Integrity (MPI) or the Attorney General's Medicaid Fraud Control Unit (MFCU), and/or the Department of Children & Families (DCF).

The Regional/Field Office has thirty (30) calendar days to review and determine if a provider is in good standing to permit the expansion.

Regional/Field Office shall submit any intended denial for expansion to the Deputy Director for Operations or designee for approval and copy the Bureau of Quality Management.

APD State Office Responsibilities:

1. Track Alert activities and their resolution that are to be performed by the Regional/Field Offices, ensuring that the relevant data to be tracked is entered into the Remediation Tracker.

2. Interact with Regional/Field Offices on Alert issues to ensure accurate and timely completion.

3. Conduct data analysis on trends related to provider performance. Work with the Regional/Field Offices to prioritize and develop an action plan to promote improvement (i.e., provider training on systems' issues related to background screening, etc.).

4. Follow up on concerns presented by the Regional/Field Offices regarding QIO performance, including informing the AHCA contract manager of these situations in order to coordinate resolution with the QIO.

5. Provide oversight and technical assistance to the Regional/Field Offices regarding quality management.

6. Assist in processing requests for termination or other disciplinary actions in response to identified deficiencies and/or the inability of a provider to remediate deficiencies.

7. Submit Regional/Field Office Remediation Tracker to AHCA for review and oversight, as requested.

8. Collaborate with AHCA and Medicaid Program Integrity on potential and confirmed Billing Discrepancies.

3. Quality Improvement

The quality improvement component of the APD Quality Management system requires the establishment of an infrastructure to review and communicate overall trends in the processes managed by APD. APD in partnership with AHCA and stakeholders are to review data results from QIO discovery reports and their remediation outcomes on an ongoing basis. The focus is to ensure that all people are:

1) Receiving quality services
2) Provided choice
3) Free from abuse, neglect, and exploitation
4) Satisfied with services received
5) Assured health & safety

The QIO's discovery process is the primary source of data for Regional/Field Offices and State Office Quality Management activities for CDC+ and HCBS Waiver services. APD shall utilize the following data sources:

1) QIO reports
2) Reportable/Critical Incidents
3) Medication administration error reports
4) Reactive Strategies reports
5) Residential licensing and monitoring
6) Complaints and/or grievances

A key component of the Quality Improvement process involves the provision of aggregated data and information (related to identified deficiencies) to all providers on an ongoing basis. Regional/Field Office staff shall discuss trends related to identified deficiencies during regularly scheduled provider meetings to include data topics referenced in Section A.8 entitled "Required Provider Meetings."

These provider meetings are intended to ensure that attendees are made aware of Regional/Field Office specific quality assurance issues and trends. This is also an opportunity to provide technical assistance/training and share best practices with providers to aid in the prevention of future similar incidents/violations.

A. Standing Quality-Related Meetings

1. The Quality Council

The Quality Council (QC) consists of members with leadership skills, and a strong interest in driving quality for the Florida Statewide Medicaid Waiver program. Quality Council members assist in enhancement of service delivery in Florida. Members include those receiving Developmental Disabilities services, also known as self-advocates, family members, Medicaid Waiver Providers, Waiver Support Coordinators, and other stakeholders. The Quality Council performs the following functions:

- Provides oversight of Quality Management activities conducted by the QIO;
- Monitors compliance with contractual obligations;
- Contributes feedback to the QIO, AHCA and APD on their implementation of quality management reviews of Home and Community-Based Services Waiver providers;
- Furnishes a forum for discussion and development of recommendations that results in practical, useful, and easily understood information for stakeholders which can be used to facilitate meaningful quality improvement activities; and
- Recommends awareness of available community resources and community partnerships, in order to expand resources for persons with developmental disabilities.

The QC identifies areas for practical and realistic improvement based on the data generated by QIO Discovery Reviews, APD and AHCA initiatives, and information gathered from other stakeholders. The QC utilizes a variety of formats for areas of idea generation, including presentations by QIO, APD, and AHCA staff as well as presentations from community organizations.

The contracted QIO and AHCA facilitate QC meetings which are held several times each year in various locations around the state. QC meetings are attended by Quality Management staff and Regional/Field Office staff when the meetings are held near their location.

2. State Office Quarterly Quality Management & Training Conference Calls

   On a quarterly basis, Quality Management staff within the APD State Office shall conduct conference calls with all Regional/Field Office staff who are involved in quality assurance functions at the local level. These calls shall serve as the primary means to provide information, instruction, and technical assistance related to the implementation of the activities described within this operating procedure.

3. Quarterly QIO Regional Meetings

   On a quarterly basis, QIO and Regional/Field Office staff shall meet to review and discuss the findings from the most recently-conducted QIO reviews. APD State Office staff shall also participate in the meetings (either via telephone or in person) and provide technical assistance/policy clarification as needed.

4. QIO Monthly Status Meeting

   On a monthly basis, APD State Office and AHCA staff shall meet with the QIO to review and analyze QIO-reported data. This meeting provides the opportunity to discuss a variety of issues of mutual concern and interest impacting quality performance.

5. Quarterly Questionnaire for Situational Information (QSI) Conference Calls

   On a quarterly basis, Quality Management staff within the APD State Office shall conduct conference calls with all Regional/Field Office staff who are involved in QSI assessments at the local level. These calls shall serve as the primary means to provide information, instruction, and technical assistance related to the QSI and to the certification/recertification of QSI Assessors, QSI Trainers and Master Trainers.

6. AHCA/APD Monthly Policies and Procedures Meeting

   On a monthly basis, AHCA and APD State Office staff shall meet to discuss issues of concern and interest related to quality management, policy clarifications, and/or the performance of the QIO.

7. APD Interdisciplinary Provider Meetings

   On an as needed basis, Quality Management staff within State Office shall meet with staff from Operations, Inspector General's Office, and other departments as needed to discuss service providers with quality-related issues. Meetings shall include discussion of providers with negative trends consisting of:

   - Noncompliant with QIO reviews
   - Noncompliant with PORs (e.g. missed deadlines)
   - Trends of two or more PDR reviews with cited Alerts, Billing Discrepancies, and/or scoring less than 85%

   This meeting shall serve as a forum to discuss potential provider terminations. In addition, technical assistance and support will be identified to address any systemic issues regarding Regional/Field Office performance and/or compliance.

8. Required Provider Meetings

   Regional/Field Office management and staff shall conduct provider meetings intended to ensure that attendees are made aware of specific quality management issues and trends. This forum is to serve as an opportunity to provide technical assistance/training, policy clarifications, and share best practices with providers to aid in the prevention of future similar incidents, violations, or citations.

   The information shared during these forums shall include the following data:

   a) QIO Reviews
   b) Incident Reports
   c) Abuse, Neglect, & Exploitation
   d) Medical & Behavioral
   e) Licensing/Monitoring
   f) Provider Training
   g) Other quality management related information

Required meetings include:

a) Monthly Waiver Support Coordinator
b) Quarterly Licensed Residential Provider Meeting
c) Quarterly Provider Meeting

B. Provider Scorecards:

Provider Scorecards are used to measure, evaluate, and recognize provider performance. Provider Scorecards are posted on the APD website. Data for the scorecards are generated from QIO data, as well as data from the Regional/Field Offices. The Bureau of Quality Management is responsible for developing the scoring criteria as well as compiling the data to be utilized for the scorecard.

C. Data and Trend Analysis

On an ongoing basis, designated staff members within the State Office shall review aggregated data and conduct trend analysis related to QIO reported information, medication errors, deaths, reactive strategies, critical/reportable incidents, and protective services investigations, etc. Follow-up activities from the analysis results may include:

- Plans of Remediation
- CDC+ Corrective Action Plan
- Technical Assistance
- Training
- Disciplinary Action
- Policy Changes

The Bureau of Quality Management shall have responsibility for ensuring that follow-up actions are initiated. In cases where these activities reveal the need for corrective action on the part of a particular Regional/Field Office, the ROM or designee shall be responsible for ensuring that such actions are implemented in a timely manner.

D. Oversight and Monitoring of Regional/Field Office QA Activities

At least once per year, designated staff within the Bureau of Quality Management shall conduct reviews of each Regional/Field Office to ensure staff are carrying out QM functions in accordance with CMS requirements and established agency policies and procedures. Such reviews shall involve a combination of desk reviews (utilizing the data sources described within this operating procedure) and on-site visits. The Bureau of Quality Management shall develop and utilize standardized tools for conducting and reporting on Regional/Field Office performance:

- Regional/Field Office internal system reviews (i.e. performance and/or compliance issues identified during the APD Interdisciplinary Provider Meetings)
- Incident Report Tracking and follow-up
- Audits of Plans of Remediation and related activities
- Provider Enrollment Tracking database
- Protective services investigations and follow-up
- Regional/Field Office Residential Monitoring compliance with rules and regulations
- Initiation of provider disciplinary actions
- Timely completion of QSI assessments along with certification/recertification of QSI Assessors, QSI Trainers and Master Trainers

Review findings shall be shared and discussed during APD Interdisciplinary Provider Meetings described within this operating procedure. Findings will be shared with members of the Agency's Executive Management Team. It is the ROM's responsibility to ensure that any and all issues of concern identified during the review process are addressed in a timely manner.

E. Provider Compliance/Enrollment Tracking

As part of the Provider Enrollment tracking process, Regional/Field Office staff shall track enrolled providers on the approved Provider Enrollment Tracking database which contains basic demographic information, enrolled services, Handbook required documentation, etc. Regional/Field Office staff shall use the Provider Enrollment Tracking database (Attachment K) as a Quality Management tool to ensure provider compliance with Handbook standards and CMS requirements such as:

- Provider Demographic Info. (Address, Phone, Email, etc.)
- Eligible Services
- Medicaid Waiver Services Agreement Expiration Date
- Level 2 Background Screening
- Required Training
- Liability Insurance Expiration Date
- Required Documentation for Transportation
- License Renewal Dates for Professional Services (i.e. Licensed Nurses and Therapies)

F. Questionnaire for Situational Information (QSI) Compliance

The Questionnaire for Situational Information (QSI) is an assessment tool used by the Agency for Persons with Disabilities (APD) that gathers key

information about a consumer's life and their need for services and supports. The QSI is divided into four main life areas:

- Life Changes and Community Inclusion
- Functional Status
- Behavioral Status
- Physical Status

ROMs are responsible for ensuring that Region/Field Offices complete assessments within required timeframes. State Office Bureau of Quality Management is responsible for monitoring Regional/Field Offices compliance with assessment deadlines and ensuring all certification/recertification of QSI Assessors, QSI Trainers and Master Trainers are completed timely. The Bureau shall also provide data, instruction, technical assistance, training materials, and standardized tools for tracking QSI compliance within the Region/Field Offices.

G. Training

Training is an essential component to delivering quality services. State Office Quality Management training staff is responsible for assuring that the Agency either creates or identifies standardized curricula for all required training and establishes methods to expand course access: classroom and web-based. The State Office's training staff is also responsible for supporting Regional/Field Office training staff to meet statewide provider training needs in the most cost effective method possible.

A key element of the discovery review process is to determine whether a provider and their staff have completed all required trainings and are applying the principles and best practices shared with them during such training. Depending on the outcome of discovery reviews, remediation may need to include certain staff repeating existing training courses and/or the development of a training tracking system. Based upon discovery trend analysis, APD may identify the need to modify, offer, or develop a new course to address deficiencies found during discovery reviews.

VIII. Attachments:

Attachment A: Definitions
Attachment B: CMS Quality Framework
Attachment C: Summary of Reports Generated by QIO
Attachment D: Letter – CDC+ POR Letter dated 3-26-2013
Attachment E: Remediation Tracker
Attachment F: Instructions for Remediation Tracker
Attachment G: Plan of Remediation (POR) Form
Attachment H: Plan of Remediation Instructions
Attachment I: Provider Background Screening Self-Audit Form
Attachment J: Provider Medication Administration Self-Audit Form
Attachment K: Provider Enrollment Tracker
Attachment L: AHCA Alert DD Waiver Providers Recoup Overpayments

IX. Enforcement:

Any employee found to have violated this policy may be subject to disciplinary action, up to and including termination of employment.

X. Revision/History:

March 2014: Ed DeBardeleben, Quality Management
2010 DRAFT – Update 18.001 QA OP: Steve Dunaway, Quality Assurance
2006 Initial QA OP 18.001: Steve Dunaway, Quality Assurance

Attachment A

Definitions

The following definitions clarify terms associated with implementation of this operating procedure:

Agency for Health Care Administration (AHCA): The Agency responsible for health care licensing, inspection and regulatory enforcement as well as administering the Medicaid program. AHCA administers the Developmental Disabilities waivers and the Medicaid claims process.

Agency for Persons with Disabilities (APD): The Agency responsible for ensuring the delivery of quality services to eligible individuals with Developmental Disabilities, and determining who is an eligible provider. APD is responsible for the operation of the HCBS/DD and CDC+ waivers within the State of Florida.

Billing Discrepancy: A finding of quality assurance reviews, investigations or audits indicating: (1) required documentation was not found to justify expenditure of waiver funding for a specific service, (2) a service was billed in excess of what was authorized, (3) a service was billed and reimbursement received without appropriate authorization, (4) a provider billed for and received reimbursement beyond the limitations of the Handbook, (5) billed and received reimbursement for services not rendered, and/or (6) a provider does not make records available for review purposes.

Bureau of Quality Management: Agency for Persons with Disabilities State Office Unit responsible for Quality Assurance activities and compliance with CMS requirements.

Consumer Directed Care Plus (CDC+): A Medicaid funded option that empowers individuals receiving benefits under the HCBS/DD waiver to hire their own employees and pay for services with a monthly budget they manage. Authorized through the 1915(j) Medicaid State Plan Amendment, CDC+ is a long-term care program alternative to Home and Community Based Services (HCBS) Medicaid Waivers. The CDC+ program is based on the principles of self-determination and person-centered planning.

CDC+ Consultant: A Medicaid Waiver Support Coordinator, as defined in section 393.063(36), F.S., who has received specific training in participant self direction to assist recipients enrolled in CDC+ and their families or Representatives in identifying and choosing supports and services through the CDC+ program. A consultant

provides technical assistance to recipients or their Representatives in meeting their responsibilities under the CDC+ program, as defined in section 409.221 (4)(c)2. F.S.

CDC+ Liaison: The CDC+ Liaison is an APD employee in the APD Region/Field Office who is the primary contact person for that Region's CDC+ program.

CDC+ Representative: An uncompensated individual designated by the Participant served to assist in managing their budget allowance and needed services [s. 409.221 (4) (c) (6), F.S.]. The Representative advocates, manages, or assists in managing, the CDC+ program for the Participant.

Centers for Medicare and Medicaid Services (CMS): The Federal agency responsible for regulation and administration of the Home and Community Based Services Medicaid Waiver programs operated in the State of Florida.

Developmental Disabilities Home and Community-Based Services Waiver (HCBS/DD): The Developmental Disabilities (DD) Waivers are Medicaid programs that provide home and community-based supports and services to eligible persons with developmental disabilities living at home or in a homelike setting. The DD waivers are funded by the Federal Centers for Medicare and Medicaid Services (CMS) with matching State of Florida funds. The Waiver is operated by the Agency for Persons with Disabilities (APD), under the authorization of the Agency for Health Care Administration (AHCA), Division of Medicaid.

Developmental Disabilities Individual Budgeting (iBudget) Waiver: A Home and Community Based Medicaid Waiver for people with developmental disabilities. iBudget Florida gives APD customers more control and flexibility to choose services that are important to them, while helping the agency to stay within its Medicaid Waiver appropriation. The iBudget implementation was authorized in s. 393.0662, Florida Statute in 2010. APD Rule 65G-4.0210 to 65G-4.0218 describes the iBudget algorithm and budget approval process. iBudget Medicaid Coverage and Limitation Handbook (Rule # 59G-13.070 – provider Handbook).

Discovery: A finding that resulted from a Quality Improvement Organization (QIO) review or other source.

Florida Medicaid Developmental Disabilities Waiver Services Coverage and Limitations Handbooks: Administrative rules that explain covered services, their limits, provider enrollment procedures, qualifications, responsibilities and place of services delivered under the Developmental Disabilities (DD) Waivers.

III-Individual Interview Instrument: An Individual Interview Instrument (III) used to gather information on service satisfaction. This instrument is developed and administered by the QIO.

Licensure: A process performed by Agency Regional/Field Office staff to license and monitor residential facilities. The Agency's responsibilities for licensure are defined in Chapter 65G-2, Florida Administrative Code (F.A.C.)

Medicaid Waiver Services Agreement: The agreement between APD and a provider of Medicaid Waiver services.

Medical Peer Review: A process designed to identify the physical, functional and behavioral health care status and needs of individuals currently receiving services on the Medicaid Waiver or participating in the CDC+ program.

National Core Indicators (NCI): Conducted by the QIO, an assessment tool used to gather information from people receiving waiver services to be used at a State level for comparison of the quality of waiver services.

Person Centered Review (PCR): A process of discovery conducted by the QIO beginning with an interview of the person and a subsequent review of all of the services and supports specific to that person, as established in the QIO contract.

Provider: Any agency or solo provider enrolled in the Medicaid waiver program that renders services to Medicaid waiver recipients.

Provider Discovery Review (PDR): Provider Discovery Review is a process of discovery conducted by the QIO focusing on provider compliance and accountability in delivering appropriate supports and services to people and meeting their needs as established in the QIO contract.

Plan of Remediation (POR): A plan submitted by the provider to address all QIO "Not Met" citations, Alerts, Complaints, Incident Reports, Audits, and other items cited as out of compliance during provider reviews. The POR is the action plan used by APD to track and ensure all citations and complaints identified are being addressed and resolved by the provider.

Provider Reviews: Medicaid Waiver providers receive quality assurance reviews conducted by the QIO, APD, and/or AHCA. The reviews are used to determine a provider's success in meeting outcomes for an individual and/or the provider's ability to meet minimum service and/or rule requirements, as stipulated in the Medicaid Waiver DD Handbooks.

Quality Assurance Reviews: The process used by the Agency for Persons with Disabilities or its authorized agent, for determining the level of performance and compliance with program requirements for contracted service providers, and satisfaction of individuals receiving services.

Quality Council: Council of self-advocates, families, AHCA, APD and service providers who provide direction for the Florida Statewide Quality Assurance Program.

Quality Improvement: The use of data or other information to understand the causes of identified problems and the development of solutions, or revision of policy and practices to enhance supports, services, and outcomes.

Quality Improvement Organization (QIO): Is an agency contracted by the State of Florida's Agency for Health Care Administration (AHCA) to provide quality assurance for the State's Developmental Disabilities Services system.

Questionnaire for Situational Information (QSI): An assessment tool used by the Agency for Persons with Disabilities (APD) that gathers key information about a consumer's life and their need for services and supports.

Reconsideration Process: The process allowing providers to request a change in scoring of Billing Discrepancy elements/citations only.

Regional/Field Office: The office having operational and administrative responsibility for services in counties comprising a particular geographic region.

Remediation: The act of correcting cited deficiencies identified during provider reviews.

Regional Operations Manager (ROM): Administrator responsible for the oversight of Regional/Field Office activities within their geographic regional.

Service Specific Record Review (SSRR): A review of a provider's documentation to verify compliance with Medicaid Waiver Handbook standards and Agency rules.

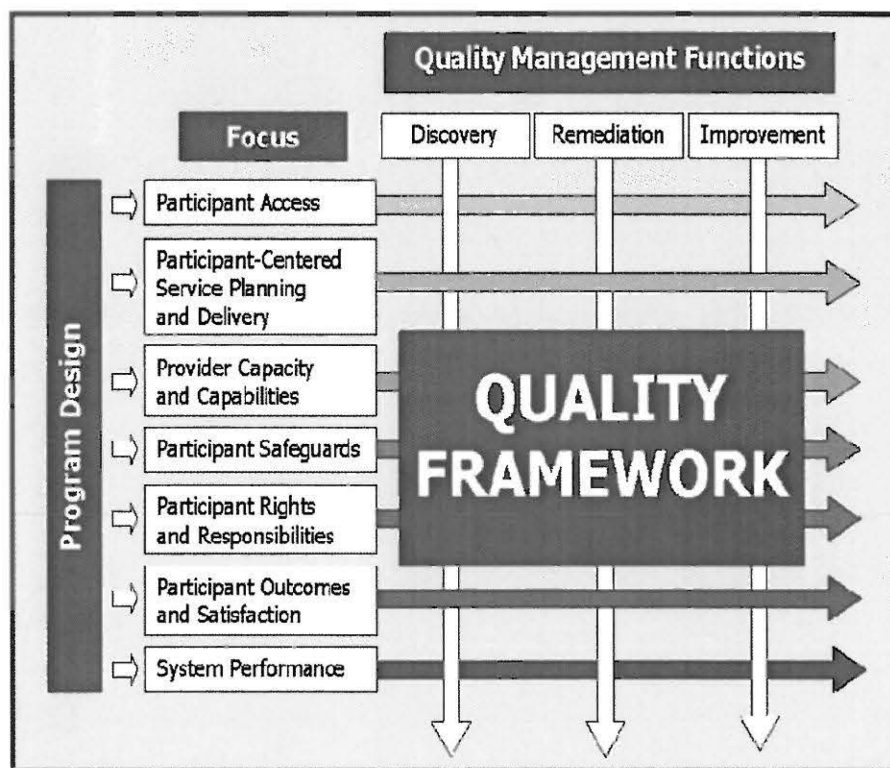
Waiver Support Coordinator (WSC): A provider who acts as the case manager for individuals on the HCBS/DD Waivers. Support Coordination is the service of advocating for the individual and identifying, developing, coordinating and accessing supports and services on his/her behalf, regardless of funding source. Support Coordination may also involve assisting the individual or family to access supports and services on their own.

Attachment B

Centers for Medicare and Medicaid Services (CMS) Quality Framework

Quality management is a broad system of activities focused on continuous review of an organization's goals and objectives, polices and processes for achieving them, and resulting performance. The structure includes quality assurance activities to discover process efficiency and effectiveness or where it is lacking, and implementing remediation or correction activities to improve system flaws and outcomes. It also includes quality improvement processes to review available data sources for analysis of performance and systematic efforts to improve it. Quality Management (QM) is based on the analysis of data for determining trends, diagnosing problems and identifying strengths for management decisions on implementing improvement plans. Finally, plans are reevaluated to measure the impact of changes in achieving desired outcomes.

The chart below shows the quality management functions prescribed by the national Centers for Medicare and Medicaid Services (CMS) for state operation of the Medicaid waiver programs. The Agency for Persons with Disabilities is using the CMS quality framework as the model for its quality management processes.



Down the left side of the box above, under "Focus," are seven elements or assurances for the design of programs and services required by CMS for state implementation of the Medicaid waivers. These include "Participant Access, Participant-Centered Service Planning and Delivery, Provider Capacity and Capabilities, Participant Safeguards, Participants Rights and Responsibilities, Participants Outcomes and Satisfaction, and System Performance." Quality measures are provided by Florida as assurances to CMS that the state will collect data as evidence needed to demonstrate compliance with federal and state rules and regulations related to providing services consistent with the intent of the Medicaid waiver program.

Under the box at the top, titled "Quality Management Functions," are three distinct quality management functions, including "Discovery" of problem areas under each assurance, the short-term "Remediation" of those deficiencies, and system "Improvement" for long-term prevention and maintenance. The responsibility for each of these discrete functions is outlined in this operating procedure.

Attachment C

Summary of Reports Generated by QIO

PCR Report

A report which is generated within thirty (30) calendar days of a Person Centered Review and includes results from the Individual Interview Instrument (III or I^3) and the Service Specific Record Reviews (SSRR). It is available to APD Regional/Field Offices, State Office, and Waiver Support Coordinator/CDC+ Consultants.

PDR Report

A report which is generated within thirty (30) calendar days of a Provider Performance Review and includes results from the PDR components: Administrative Policy and Procedures, Training, Background Screening, Observations, and Service Specific Record Reviews.

Preliminary Findings Worksheet

A document given to providers at the completion of the PDR and includes preliminary results of the review documenting information that was not present at the time of the review. It is signed by the provider and reviewer. The Preliminary Findings Worksheet captures Alerts, Billing Discrepancies, and other missing documentation, not results of every element.

Monthly Report

These are "at a glance" production reports completed by the 15th of the month for the previous month's production, and presented by APD area. It includes PCR and PDR information and is available to APD staff with approved access.

- For the PCR, the names of individuals who participated in a PCR, date, the WSC/CDC+ Consultant, SSRR score, and for CDC+, the representative's score are displayed. Waiver and CDC+ are presented separately. The report also lists the individuals who declined to participate and the reason for the decline.
- For PDR, all providers who had a PDR are listed—provider name, date, and PDR score. The report also lists the providers who were noncompliant and did not complete the PDR process.

Quarterly/Annual Reports

Quarterly Reports shall be completed by May 15th, August 15th, and November 15th. The Annual Report is completed by February 28/29th. These reports include contract activity and aggregate data presentation statewide and across various demographics, including trends when possible. Interpretation of results, discussion, and discovery sections shall be included. Quarterly and Annual reports are made available to APD and AHCA on a secure portal managed by the QIO. Excerpts from Quarterly/Annual reports are presented at Status meetings upon request. Upon approval, reports are posted to the QIO website.

ADHOC Report

An ADHOC report is a special information report that is requested of the QIO by AHCA or APD.

agency for persons with disabilities
State of Florida

Rick Scott
Governor

Barbara Palmer
Director

State Office

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Toll Free:
(866) APD-CARES
(866-273-2273)

March 26, 2013

Dear CDC+ Participant/Representative:

Thank you to those who participated in the Delmarva Foundation CDC+ quality assurance reviews last year. This is to provide you with helpful information regarding the review process and statistics related to last year's results.

The Delmarva Foundation is contracted by the Agency for Health Care Administration (AHCA) to provide quality assurance for the State's Developmental Disabilities Service system. They work in partnership with the Agency for Persons with Disabilities (APD), AHCA and the CDC+ program.

The Delmarva review process is comprised of two major components: Person Centered Reviews (PCR) and Provider Discovery Reviews (PDR). The PCR includes an interview with the CDC+ participant to determine the quality of the participant's service delivery system from the participant's view. The PDR focus is on the consultant and the representative in relation to compliance with standards set forth in the 1915(j) State Plan Amendment. In the year 2012, 304 PCRs were completed with CDC+ participants with an average score of 84.2%. For the same time period, 302 Consultant PDR record reviews were conducted with an overall consultant score of 93.1%; and, 356 Representative PDRs were conducted with an average compliance score of 92.9%. In comparison to the previous year, the average Consultant scores went up from 89.1% in 2011 to 93.1% and Representative scores went up from an average of 88.5% to 92.9%.

The CDC+ quality assurance review process is intended to help ensure that individuals participating in CDC+ are receiving the services they need and they are effectively self-directing their budgets and services in accordance with local, state and federal rules.

Please remember that consumers selected for PCRs are not required to participate in the interview process. However, cooperation with the PDRs is required for selected representatives and consultants. Following a PDR, the reviewer will give the consumer/representative a Preliminary Findings Worksheet which lists the areas of noncompliance that need to be corrected. A PDR Report will be mailed out within 30 days of completion of the review and will include the final findings. The report may also include "Alerts" if a threat to the consumer's health, safety, or wellbeing was observed.

http://apdcares.org

If the consumer/representative's PDR score is 85% or less, the local APD Regional Office will contact the consumer/representative to complete a Plan of Remediation (POR). The POR is a helpful tool to address the areas that need improvement so that the consumer can correct those areas and continue to participate successfully in the CDC+ Program.

In the event that a POR is required, it must be submitted to the local APD Regional Office within 10 calendar days after receiving notification from the regional office. However, the consumer/representative must respond to the local APD Regional Office for all "Alerts" within 24 hours. The local APD Regional Office is responsible for following up with each consumer/representative 30 days after receiving the POR to ensure its compliance.

If the consumer/representative refuses to participate in a PDR or submit a POR to the APD Regional Office in the established timeframes, the consumer/representative will be required to develop a CDC+ Corrective Action Plan (CAP). Consumers/representatives who remain out of compliance with the CAP for 60 days from the date it was initially required, may be disenrolled from the CDC+ program and returned to the DD/HCBS waiver.

Thank you again for your participation with the quality assurance review process. If you need additional information regarding the CDC+ tools or have questions about the process, please visit the Delmarva web site at www.dfmc-florida.org or call their toll-free number at 1-866-254-2075. You may also contact your local APD Regional Office Quality Assurance lead for additional information.

Sincerely,

Liesl Ramos
CDC+ Program Administrator
Consumer Directed Care Plus Program

cc: APD Regional Offices
CDC+ Consultants
Danielle Reatherford, AHCA, CDC+ Analyst
Delmarva Foundation

Attachment E

Remediation Tracker

Remediation Tracker (Revised 4 Apr 2014)

The Remediation Tracker can be accessed as follows:

J:\Quality Management SharePoint\Quality Assurance\Forms\Remediation Master Templates

Instructions for Remediation Tracker (Revised 6 Feb 2014)

See Quality Assurance OP 4-0007 - Attachment F

Note:

Region/Field Offices shall follow the Instructions for Remediation Tracker.

The Remediation Tracker will be regularly reviewed by Region/Field Office and State Office staff to ensure that progress is made toward completion of provider Plans of Remediation (POR).

Region/Field Offices will maintain documented evidence of each provider's POR as well as documentation of action taken when PORs are not completed timely.

Attachment F

Instructions for Completing the Remediation Tracker

(Revised 6 Feb 2014)

The **Remediation Tracker** will be used to track all citations identified in the **QIO** (Quality Improvement Organization, currently Delmarva) review process, as well as any deficiencies discovered by any other means by APD. Providers scoring 100% on their Provider Discovery Review (PDR) will not need to be entered on the Remediation Tracker. If a provider has one or more "Not Met" standards, a Plan of Remediation (POR) is required and the POR must be entered onto the Remediation Tracker.

PORs for PCRs are required when a need for a QIO medical peer review (in which the original QIO review indicates the need for medical case management team involvement) has been identified, when less than half of the standards are met on the Individual Interview Instrument (III or I cubed), when a Billing Discrepancy has been identified, and/or when Discovery citations related to health and safety have been identified.

All PORs shall be initiated by APD staff within ten (10) business days with the exception of Alerts, which must be initiated immediately upon notification.

A. The purpose of the **Tracking Number** is to relate the POR to the Remediation Tracker. There are three types of Modifiers:

   - A – Alerts Identified by the QIO
   - B – QIO PDRs or PCRs
   - C – All Other Discovery Sources Specific to APD

   IMPORTANT: All Alerts must be assigned a Tracking Number when received and immediately entered on the Remediation Tracker.

   A single QIO report may generate two Tracking Numbers. The "A" modifier will be entered into the Remediation Tracker based on the notification to the Regional Operations Manager (or their designee) that an Alert has been identified by the QIO. The subsequent report (PDR) containing the Alert (and other "Not Met" standards) will be referenced using the same Tracking Number followed by a "B" rather than an "A". For example: "12-0001A" for the Alert and "12-0001B" for when the PDR containing that same Alert, and other "Not Met" standards, is posted.

   a. The Tracking Number will always start with a two numeral Field Office identifier followed by a dash (01-, 12-, 23-, etc.)
   b. The second part of the Tracking Number is a five digit rolling numeric entry
   c. The Tracking Numbers will carry over to the Plan of Remediation
   d. All other **Discovery Sources** in Column I (other than QIO Reports) will be coded "C"

B. Enter the **Modifier** – Select A, B, or C from the dropdown box. This allows sorting by type of modifier, if required.
C. Enter the **QIO Report Number**, if applicable.
D. Enter the **Overall PDR Score**, if applicable.
E. Enter the **Provider Agency / Name** as listed on the QIO report. Include "DBA" name, if applicable.

F. Enter the **Provider Medicaid or CDC+ Number**.
G. [redacted]
H. **Program Funding Type** – Select from the dropdown option box.
(Options include – iBudget, CDC+, or GR)
I. **Discovery Source** – Select from options in dropdown box.
J. Enter **Date of Discovery** – The QIO review date or date of an APD review.
K. Enter **Date Information Received in Field Office** – Either the date the PDR/PCR was posted by QIO or the date the Field Office received information from field staff that warrants a POR.
L. Enter **Date Provider Contacted (Regarding Remediation)** – The date Field Office contacts the Provider to begin the remediation process.
M. **Citations Identified in Programmatic Areas** – For each of the boxes N – AD enter a whole number indicating the number of "Not Met" items per type of citation in this report. For example, a single QIO report may contain two (2) "Not Met" citations for Administrative items, five (5) for Residential Habilitation, and one (1) for Behavior Assistant Services. If the citation(s) identified is/are an APD Discovery (from any source other than the QIO), indicate a "1" in the APD Discovery box (column P) and explain the reason for the Plan of Remediation in the Notes (column BK).
AE. [redacted]
AF. **Remediation Required by QIO ALERT** – Select either Yes or No from the drop down box.
AG. **Background Screening Alerts** – For each of the boxes **AH – AL,** enter a whole number indicating the number of citations for those items. This applies to Alerts reported by the QIO.
AM. **Administrative and Training Alerts** – For each of the boxes **AN – AQ,** enter a whole number indicating the number of citations for those items. This applies to Alerts reported by the QIO.
AR. **Personal Security Alerts** – For each of the boxes **AS – AY,** enter a whole number indicating the number of citations for those items. This applies to Alerts reported by the QIO.
AZ. [redacted]
BA. **Billing Discrepancies Cited by QIO** – Select either Yes or No.
BB. **Provider Reconsideration Requested** - Select either Yes or No to indicate if the provider has requested a reconsideration.
BC. **AHCA Recoupment Agreement Received** – Select either Yes, No, or N/A. Providers with valid Billing Discrepancies must enter into a written repayment agreement with AHCA and provide a copy to APD to be maintained in the provider's file attached to the completed POR.
BD. **AHCA Final Billing Discrepancies Dollar Amount** – Enter final validated Billing Discrepancies dollar amount noted on AHCA's written repayment agreement. Enter zero (0) if the Billing Discrepancies amount is zero, do not enter N/A.
BE. [redacted]
BF. **Referred to MPI or MFCU** – Select either Yes or No. Valid deficiencies on Background Screening and Medication Administration Self-Audits shall be referred to MPI by APD staff.
BG. **Referred for Termination Review** – Select either Yes or No.
BH. **Termination Date** – Enter the date the provider has been terminated in FMMIS and ABC.
BI. [redacted]
BJ. **Date POR Due** - Enter the negotiated provider due date for the POR, not to exceed ninety (90) days from the date the report is posted by QIO. Seven (7) days for an Alert.
BK. **Date POR Closed** – For this Tracking Number, enter the actual date the POR is verified, signed off and closed by APD. Repayment of Billing Discrepancies may still be pending.
BL. **Notes** - Enter all important information that applies to this Tracking Number. This includes all terms of Billing Discrepancies (total Billing Discrepancies amount, number of payments, etc.).
- If Billing Discrepancies were reconsidered by QIO, explain in this area.
- If APD Discovery (column P), enter reason for POR.

- If POR is for a QIO Alert, enter immediate action taken to address the Alert in this area, including findings from Self-Audit.
- If Provider is terminated, enter the termination type (voluntary, without cause, etc.).
- Or any other important information regarding the POR.

IMPORTANT: This information is provided to AHCA at the beginning of each month.
All open PORs are to be color coded in Yellow Highlight in the Tracking Number box **ONLY** (Column A) until the POR is closed and a completion date is entered (Column BJ). Remove Yellow Highlight when POR is closed. **DO NOT use any other colors, fonts, or change the formatting on the Remediation Tracker.**

Attachment G

Plan of Remediation

Plan of Remediation Form (Revised 11 Apr 2014)

The Plan of Remediation blank form can be accessed as follows:

J:\Quality Management SharePoint\Quality Assurance\Forms\Remediation Master Templates

Instructions for Creating a Plan of Remediation (Revised 3 Dec 2013)

See Quality Assurance OP 4-0007 - Attachment H

Note:

Region/Field Offices and Providers shall follow the Instruction for Creating a Plan of Remediation.

Plans of Remediation will be regularly reviewed by the Region/Field Offices to ensure that progress is made toward completion of remediated items.

Region/Field Offices will maintain documented evidence of each item remediated as well as documentation of action taken when remediation is not completed.

Attachment H

AGENCY FOR PERSONS WITH DISABILITIES

Instructions for Creating Plan(s) of Remediation

(Revised 6 Feb 2014)

Providers will complete a **Plan of Remediation (POR)** form to address any "Not Met" standards cited by the QIO (Quality Improvement Organization, currently Delmarva), APD discovery or any other source. Providers scoring 100% on their Provider Discovery Review (PDR) are not to complete a POR. A provider who has one or more "Not Met" standard(s), a Plan of Remediation is required. The provider must type all information on the POR form. No handwritten forms will be accepted. A provider completed POR must be submitted to the designated APD Regional/Field Office staff. Providers who score 85% or better with no Alerts or Billing Discrepancies have the option of sending their signed final POR copy via US Mail or hand deliver to the designated APD Regional/Field Office. Providers who score 84% and below, have Alerts or Billing Discrepancies are required to meet face to face upon completion of the POR. Provider must sign and date the POR regardless of PDR score or circumstance. Original ink signature is required by all parties. The APD Regional/Field Office will maintain the original signed copy POR and documented evidence of each item remediated, as well as documentation of action taken when remediation is not completed.

PORs for PCRs are required when a need for a QIO medical peer review (in which the original QIO review indicates the need for medical case management team involvement) has been identified, when less than half of the standards are met on the Individual Interview Instrument (III or I cubed), when a Billing Discrepancy has been identified, and/or when Discovery citations related to health and safety have been identified.

All PORs shall be initiated by APD staff within ten (10) business days with the exception of Alerts, which must be initiated immediately upon notification.

The top of the POR form must be completed by the APD Regional/Field Office staff and include the **Provider Name, Provider Medicaid or CDC+ Number**, all applicable **Tracking Number(s)** from the Remediation Tracker, the **Date Provider Contacted Regarding Remediation**, **QIO Score** and **Terms of Billing Discrepancies.** The Plan of Remediation must be completed by the APD Regional / Field Office and provider as follows:

Action Item Number (sequential) - Enter the number for each item in sequence starting with "1", up to the total number of citations contained in a single QIO review or other APD discovery. This column is to be completed by the Regional/Field Office staff.
Discovery Source – The Regional/Field Office staff will select from the dropdown box, the discovery source type from the Remediation Tracker.
QIO Programmatic Item – Select the QIO category from the dropdown box. See list below: Select "N/A" to indicate if the item is any source other than QIO.

Administrative
CDC+
Life Skills – Level 1 (Companion)
Life Skills – Level 2 (Supported Employment)
Life Skills – Level 3 (ADT)
Personal Supports
Respite
Specialized Medical Homecare
Standard Residential Habilitation
Behavioral-Focused Residential Habilitation
Intensive-Behavioral Residential Habilitation
Live-in Residential Habilitation
Supported Living Coaching
Support Coordination
Behavior Analysis Services
Behavior Assistant Services

QIO Deficiency Number Related to Programmatic Item – Enter the number associated with the QIO Programmatic Item from the PDR. If this is an APD Discovery Item (i.e."C" modifier), enter N/A.
Description of Deficiency or Citation – Enter the QIO or other source description identified as the deficiency. It is recommended that the Regional/Field Office complete this column.
Corrective Action Required – The provider will enter the corrective action process required to successfully remediate their deficiency. The corrective action shall include the following:

1. Steps taken to correct the standard cited.
2. Steps taken to prevent future citations (creation of systems or tools).
3. Indicate any update to provider's policies or procedures.

Billing Discrepancies Cited by QIO – Select Yes or No to answer if this particular deficiency or citation is a billing discrepancy cited by QIO.
Provider Reconsideration Requested – Select Yes or No to answer if this particular deficiency or citation has been requested for reconsideration by the provider.
Billing Discrepancy Dollar Amount – Enter the required billing discrepancy dollar amount for each Not Met standard. All billing discrepancy amounts in this column will automatically calculate and post the total value in the Sum Total Billing Discrepancies box (upper right hand corner). If no repayment is required, enter value zero (0). Do not enter N/A.
Deficiency Due Date – Enter the anticipated completion date of the corrective action. Due dates are negotiated with APD. Corrective actions are required to be completed in ninety (90) days or less. An Alert citation is required to be completed in seven (7) days or less including the completion of the required Self-Audit.
Date Deficiency Remediated – Enter the date the corrective action is completed and verified by APD.
Evidence of Completion – Enter the documentation evidence provided to APD that corresponds with the Corrective Action Required and demonstrates that the remediation has been successfully completed. Documentation of evidence of completion must be maintained by APD at the Regional/Field Office for future audit purposes.
Sum Total Billing Discrepancies – This dollar amount is the sum total amount from each Billing Discrepancy Dollar Amount.

Providers with cited Billing Discrepancies shall be advised by APD staff to contact AHCA to pay in full or enter into a written repayment agreement. A copy of the repayment agreement and/or receipt of payment in full shall be attached to the completed POR and maintained by APD at the Regional/Field Office for audit purposes.

When the Plan of Remediation is complete and signed by all parties, the POR document must be scanned in PDF format and stored in the Quality Management Remediation Field Office specific folder.

All file names must be saved in the following format:

Tracking Number_Provider Name (*Example:* 12-0001b_ABC Company)

IMPORTANT: Do not change the Plan of Remediation format or cells. The preferred default printer setting is legal size. Additional rows can be added to the document, if needed. A second page will be created including provider identification headings.

Attachment I

Agency for Persons with Disabilities
Provider Background Screening Self-Audit Instructions

Pursuant to the Medicaid Waiver Service Agreement, Section A. Monitoring, Audits, Inspections, and Investigations, APD is requesting a self-audit to be conducted of all direct care staff. Results and supporting documentation shall be forwarded to APD within the given timeframe defined on your **Plan of Remediation (POR)**. This action is to confirm that all employees possess current Background Screening documentation. Failure to account for direct care staff shall result in a provider termination review by APD State Office.

Background Screening:

1. Complete a summary of the self-audit to include the following:
   a. A breakdown of all your employees and/or subcontractors to include: Name, Date of Hire, Social Security Number (SSN), and Date of Birth.
   b. Screening details for FBI/FDLE, Local Law, and Affidavit of Good Moral Character
2. For each type of screening identify the date of the previous and most current screening; if a new screening is scheduled indicate the date.
   a. Use the following self-audit form to capture all required information. Each page must be signed and dated.
3. In the POR indicate what will be done to correct any deficiencies found. For example, through this audit you discover an employee was not re-screened timely, then set a date for the staff to be re-screened. When screening is completed provide a copy of the screening as evidence for the POR.
4. Do not send the results of the background screening(s) for you/staff. If they are needed they will be requested as part of the POR.

Provider Background Screening Self-Audit Form

Staff Name (as listed on screening)	Date of Hire (MM/DD/YYYY)	Staff SSN (XXX-XX-XXXX)	Staff Date of Birth (MM/DD/YYYY)	FBI/FDLE (last two screening dates) (MM/DD/YYYY)		Local Law (last two screening dates) (MM/DD/YYYY)		Affidavit of Good Moral Character (MM/DD/YYYY)	
				Previous	Most Current	Previous	Most Current	Previous	Most Current
Sample	*01/01/2007*	*123-45-6789*	*05/01/1975*	*01/13/2007*	*01/10/2013*	*01/20/2007*	*01/15/2013*	*01/05/2007*	*01/05/2013*

Provider Name & Title: Click here to enter text.

Provider Medicaid ID: Click here to enter text.

Provider Signature: ______________________ Date Completed: Click here to enter text.

Staff Name (as listed on screening)	Date of Hire (MM/DD/YYYY)	Staff SSN (XXX-XX-XXXX)	Staff Date of Birth (MM/DD/YYYY)	FBI/FDLE (last two screening dates) (MM/DD/YYYY)		Local Law (last two screening dates) (MM/DD/YYYY)		Affidavit of Good Moral Character (MM/DD/YYYY)	
				Previous	Most Current	Previous	Most Current	Previous	Most Current

Provider Name & Title: Click here to enter text.

Provider Medicaid ID: Click here to enter text.

Provider Signature: ______________________ Date Completed: Click here to enter text.

Attachment J

Agency for Persons with Disabilities
Provider Medication Administration Self-Audit Instructions

Pursuant to the Medicaid Waiver Service Agreement, Section A. Monitoring, Audits, Inspections, and Investigations, APD is requesting a self-audit to be conducted of all direct care staff. Results and supporting documentation shall be forwarded to APD within the given timeframe defined on your **Plan of Remediation (POR)**. This action is to confirm that all employees possess current Medication Administration and Validation documentation. Failure to account for direct care staff shall result in a provider termination review by APD State Office.

Medication Administration:

1. Self-audit, based on 65G-7, provide information on staff training and validation by an Agency approved source and assure that the validation requirements of 65-G7.004 are followed.
    a. Use the following self-audit form to capture all required information. Each page must be signed and dated.
2. In the POR you will need to indicate what will be done to correct any deficiencies found. For example, if an employee was not validated on a route and you discovered it through this audit you must set a date for them to be validated, then provide evidence that the validation was completed for the POR.
3. Do not send the results of the training and validation for you/staff. If they are needed they will be requested as part of the POR.

Provider Medication Administration Self-Audit Form

		Medication Administration Training		Medication Validation		
Staff Name (as listed on screening)	Date of Hire (MM/DD/YYYY)	Date Training Completed (MM/DD/YYYY)	Expiration Date (MM/DD/YYYY)	Validation Date (MM/DD/YYYY)	Expiration Date (MM/DD/YYYY)	Route

Provider Name & Title: Click here to enter text.

Provider Medicaid ID: Click here to enter text.

Provider Signature: ____________________ Date Completed: Click here to enter text.

		Medication Administration Training		Medication Validation		
<u>Staff Name</u> (as listed on screening)	<u>Date of Hire</u> (MM/DD/YYYY)	Date Training Completed (MM/DD/YYYY)	Expiration Date (MM/DD/YYYY)	Validation Date (MM/DD/YYYY)	Expiration Date (MM/DD/YYYY)	Route

Provider Name & Title: Click here to enter text.

Provider Medicaid ID: Click here to enter text.

Provider Signature: ______________________________ Date Completed: Click here to enter text.

Attachment K

Provider Enrollment Tracker

Provider Enrollment Tracking (Revised 4.11.2014)

The Provider Enrollment Tracker can be accessed as follows:

J:\Quality Management SharePoint\Quality Assurance\Forms\Provider Enrollment Tracker Template

Note:

As part of the Provider Enrollment tracking process, Regional/Field Office staff shall track enrolled providers on the approved Provider Enrollment Tracking database which contains basic demographic information, enrolled services, Handbook required documentation, etc. Regional/Field Office staff shall use the Provider Enrollment Tracking database as a Quality Management tool to ensure provider compliance with Handbook standards and CMS requirements such as:

- Provider Demographic Info. (Address, Phone, Email, etc.)
- Eligible Services
- Medicaid Waiver Services Agreement Expiration Date
- Level 2 Background Screening
- Required Training
- Liability Insurance Expiration Date
- Required Documentation for Transportation
- License Renewal Dates for Professional Services (i.e. Licensed Nurses and Therapies)

etter Health Care for All Floridians

FLORIDA MEDICAID

A Division of the Agency for Health Care Administration

Provider Type(s): 67

Subject: Alert for Developmental Disabilities Waiver Providers Regarding Recoupment of Overpayments

Message:

In June 2013, the Agency issued a provider alert about the Delmarva Review Process. That alert was intended to serve as a resource for providers about the reviews themselves. Additionally, the alert advised providers that if they are selected for review they are obligated to fully cooperate in the review process.

This notice is intended to remind Medicaid providers of their obligation to promptly refund moneys due to the Agency, regarding any moneys received in error or in excess of the amount to which the provider is entitled from the Medicaid program, or any moneys due as a result of the imposition of a fine or other fees or costs. (See, Section 409.907(3)(g), Florida Statutes and paragraph 5(g) of the Non-institutional Medicaid provider agreement).

If you have received a Delmarva review with claims identified as non-compliant, you are obligated to repay those amounts to the Agency. Failure to pay moneys due to the Agency in full, or have a written repayment agreement in place with the Agency and comply with its terms, is grounds for termination from the Medicaid program. (See, Rule 59G-9.070 (2)(s), Florida Administrative Code, and Sections 409.913(25)(c) and 409.913(30), Florida Statues).

In the upcoming months the Agency will increase its efforts to ensure that providers are complying with the obligation to repay these overpayments. Providers who wish to avoid these increased efforts, including the sanctions and/or investigative costs that may be associated with these efforts, who have not reimbursed overpayments should immediately void the non-compliant claims or submit a check to the Agency for the amount of any overpayments as a result of non-compliant findings. To ensure proper credit, be certain you legibly record on your check your Medicaid provider number and the review i.d. numbers related to the Delmarva audits. Please ensure the checks are made payable to the Agency for Health Care Administration and are sent to: Will Smeltzer, Agency for Health Care Administration, 2727 Mahan Drive, Mail Stop #8, Tallahassee, Florida 32308

If you have any questions about these increased compliance efforts, please feel free to contact Kelly Bennett at 850-412-4000 or via email Kelly.Bennett@ahca.myflorida.com.

Effective Date: 11/22/2013

Sent Date: 11/22/2013

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