Maryland
DEPARTMENT OF HEALTH

Developmental Disabilities Administration

Self-Direction Utilization/Qualified Staff Review

Standard Operating Procedure Guidance

Issue Date: 1/29/24

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All text in red indicates added/revised language since the prior release date

Contents

Audience

- Liberty Healthcare Corporation staff
- Developmental Disabilities Administration (DDA) staff
- Fiscal Management and Counseling Services (FMCS)
- People who self-direct their services and their support teams including Support Brokers, Coordinators of Community Services (CCS);family members and natural supports

Purpose

This guidance outlines the Liberty Healthcare Corporation process to conduct Utilization reviews of the Self-Directed service delivery model to evaluate compliance with DDA standards related to billing, service delivery and staff qualifications.

The purpose of this guidance is to set forth applicable procedures for oversight and verification of provision of DDA funded services by qualified staff and obtain insight into overall claims management by service category of self-directed paid claims.

The DDA is committed to fiscal integrity and responding proactively to identify and address systemic deficiencies and therefore ensure a stable, transparent, and accountable billing and utilization process.

Definitions

A. “Claim” means a paid amount for a day of service on a particular date of service, for a particular participant and particular service (i.e., a claim covers all units paid for the date of service)

B. “Documentation Requirements Checklist” means a document listing all necessary information required by service type from a Financial Management and Counseling Services (FMCS) agency to complete a Utilization Review.

C. “Financial Accountability” means the assurance that DDA payments are made only for eligible participants, for authorized services on a date of service and follow all billing documentation requirements.

D. “Findings Report” means the resulting summary of findings and determinations rendered at the end of a Utilization Review. There are two types of findings reports, (1) Initial findings reports – gives FMCS’s an opportunity to submit appropriate supplemental or corrected documentation to substantiate a proper payment and (2) Finalized findings

reports that provide the final determinations on whether a claim(s) met criteria for proper payment.

E. "Financial Management and Counseling Services (FMCS)" means an organization that supports individuals who choose to self-direct. With the help of a Coordinator of Community Service (CCS) and other team members, participants choose a FMCS agency. FMCS assists participants with employer and budget related hiring, accounting, and payroll activities. For example, FMCS:
   - Help check that employees/vendors meet requirements to work
   - Remind participants and their teams when employee/vendor certifications are due
   - Pay employees/vendors and purchase goods and services at the request of participants
   - Provide reports and monthly statements to help participants keep track of spending of their budget
   - Complete tax reporting for the participants, their employees, and vendors

F. "LTSS*Maryland*" means an electronic information system, developed, and supported by the Maryland Department of Health, used by DDA, the CCS, and DDA Providers to create, review, and maintain records regarding an individual's eligibility status for DDA-funded services, the participant's person-centered plan, and services and funding authorized by the DDA.

G. "Liberty Reviewer" means a qualified professional trained in conducting utilization and qualified provider reviews remotely and on site on behalf of Liberty Healthcare Corporation.

H. "LibertyTraks" - is a web-based software application developed by Liberty Healthcare Corporation that will be used to track the initiation, completion and results of each review conducted by Liberty Healthcare reviewers.

I. "Participant" means an individual enrolled in, and receiving, DDA-funded services.

J. "Pending" means that an Unmet finding can be remediated with supplemental/corrective documentation.

K. "Person-Centered Plan" or "PCP" means a written plan that is developed by a planning process driven by the individual with a developmental disability to:

a. Identify the goals and preferences of the individual to support the individual in pursuing the individual's personally defined outcomes in the most integrated community setting.
b. Direct the delivery of services that reflect the individual's personal preferences and choice; and
c. Identify the individual's specific needs that must be addressed to ensure the individual's health and welfare.

L. "Self-directed service providers" are support brokers, employees, vendors or traditional providers who rendered services to a self-directed participant for a claim.

M. "Utilization reviews" are post-payment reviews designed to ensure financial accountability of DDA paid services and ensure qualified staff provided the services.

Overview

The Maryland Department of Health (MDH) is the single state agency for Medicaid. The MDH's Office of Long-Term Services and Supports (OLTSS) is responsible for ensuring compliance with federal and state laws and regulations related to the operation of the Waivers. The MDH's Developmental Disabilities Administration (DDA) is the Operating State Agency (OSA) and funds community-based services and supports for people with developmental disabilities. The state must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver programs and the state only funded programs.
AUTHORITY: 42 CFR 441.302; 42 CFR 441.303; 42 CFR 441.308; 45 CFR 74; SMM 4442.8; SMM 4442.10.

The Developmental Disabilities Administration (DDA) has contracted with Liberty Healthcare Corporation to conduct a series of post-payment reviews (utilization reviews outlined below) to ensure the integrity of payments made across all Home and Community-Based Waiver and state only funded services (see Appendix I Financial Accountability in the approved Waiver applications).

- Review of randomly selected paid claims of self-directed services
- Review of staff qualifications for staff/vendors who provided services for the selected paid claims

As stated in the Waivers, Utilization Reviews are designed to verify that the hours of service and the actual service for which the DDA has contracted and/or paid for were provided to the participant. The reviews will consist of reviewing FMCS furnished documentation to justify that the service was rendered and that the provider's support hours were utilized as described in the participant's Person-Centered Plan (PCP), Service Funding Plan (SFP) or Detailed Service Authorization (DSA) in LTSS*Maryland*. The reviews also will include examination of staff qualifications that provided the service by reviewing documentation provided by the FMCS.

The scope of the post-payment utilization reviews is limited to a sampling of paid claims for services rendered during the quarterly review period from self directed participants included in Liberty's quarterly participant sample. Participants included in the quarterly sample are based on the participant's annual Person-Centered Plan date falling within the review quarter and being selected through a random 95% confidence interval sampling process.

Liberty Healthcare reviewers will be requesting and reviewing information from FMCSs as part of the Utilization Reviews.

The documentation requirements include the following:

- **Employee Timesheet documentation** for the person that provided the service for the claim; or **vendor invoice** for services rendered by a contractor/vendor/provider [Documentation should include the date of service, participant name and/or LTSS ID, Service delivered and start and end times of the service when applicable]
- **Staff (e.g., Employee or Vendor) Training Records** for DDA Required Trainings specific to staff providing self-directed services [documentation should include Staff Date of Hire and verifies required trainings (First Aid/CPR and Individualized trainings listed in the PCP) are current on the date of service].
- **Staff (e.g.,Employee/vendor) qualifications** as listed in the Waiver(s) [Documentation verifying completion of the background check prior to service delivery]

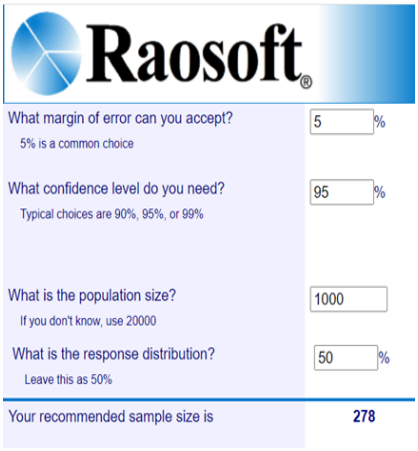
Liberty reviewers will follow a detailed process outlined below in the section titled **Self-Direction Utilization Review Process**. The process includes information related to notifications, documentation requests, findings reports and the process for participant interviews if applicable.

APPLICABILITY

This guidance applies to all information documented and uploaded into the participant's record in LTSS*Maryland* related to their person-centered plan and service authorization as well as billing documentation in LTSS*Maryland* . It also pertains to the service documentation submitted to the FMCS for the selected claims under review. Each claim is reviewed using a detailed step by step instructional guide by Liberty Healthcare Corporation reviewers.

UTILIZATION REVIEW SAMPLE SELECTION PROCESS

The scope of the post-payment utilization reviews is limited to a sampling of paid claims for services rendered during the quarterly review period from self directed participants included in Liberty's quarterly participant sample. Participants included in the quarterly sample are based on the participant's annual Person-Centered Plan date falling within the review quarter and being selected through a random 95% confidence interval sampling process.



A sampling methodology of 95% confidence interval (+/- 5% error margin), using the following automatic sampler, will be used to determine the sample size for Participants included in the sample (Raosoft software, http://www.raosoft.com/samplesize.html). It will generate the total number of participants that must be randomly selected annually and then divided by 4 for the quarterly sample. The minimum sample size will be generated when the total number of participants for the chosen review is entered into the population field.

The table below provides examples of when self directed claims for a specific quarterly review period will be included in Utilization Reviews conducted by Liberty.

Quarterly Review Period [Dates of Service For Paid Claims]	**Liberty Reviewers will Conduct Utilization Reviews**
July 1, 2023 - September 30, 2023	January 1, 2024 - March 31, 2024
October 1, 2023 - December 31, 2023	April 1, 2024 - June 30, 2024

SELF-DIRECTION UTILIZATION REVIEW PROCESS

PRE-REVIEW ACTIVITIES:

Step 1: Quarterly claim sample will be pulled and uploaded into LibertyTraks.

Step 2: Claims will be assigned to Liberty reviewers. The reviewer will then be able to access the case and build the record in preparation for the review. For all cases, this will include demographics of the participant that we have captured from data imports (e.g., imports from LTSS*Maryland*) or from previous reviews.

Step 3: During the first week of each quarterly review period, the reviewer will send an email notification to the primary contact at the FMCS organization informing them of the review of the specified claim(s), which will include the date of service, service type and participant who received the service. The reviewer will request required service documentation as well as staff training and qualification documentation as listed below. The email notification will request confirmation of receipt. If confirmation is not received within three (3) business days, the reviewer will call the FMCS to verify primary contact information.

The email notification for FMCS agencies will list the documents needed to complete the utilization review, which includes:

- **Employee Timesheet documentation** for the person that provided the service for the claim; or **vendor invoice** for services rendered by a contractor/vendor/provider [**Documentation should include the date of service, participant name and/or LTSS ID, Service delivered and start and end times of the service when applicable**]
- **Staff (e.g., Employee or Vendor) Training Records** for DDA Required Trainings specific to staff providing self-directed services [documentation should include Staff Date of Hire and verifies required trainings (**First Aid/CPR and Individualized trainings listed in the PCP) are current on the date of service**].
- **Staff (e.g.,Employee/vendor) qualifications** as listed in the Waiver(s) [**Documentation verifying completion of the background check prior to service delivery**]

UTILIZATION REVIEW ACTIVITIES:

Step 4: FMCS agencies will have fifteen (15) business days to respond to documentation requests. LibertyTraks will provide reviewers with alerts of when documentation is due. If a FMCS fails to submit requested documentation, the review will be initiated with the documentation that is available in LTSS*Maryland*.

Step 5: The Lead Reviewer will upload the documentation submitted by the FMCS to LibertyTraks within three (3) business days of receiving it. Reviewers will begin reviews in the order they receive requested documentation and will complete reviews within three (3) business days of starting a review. All initial reviews will be completed by week eight (8) of the quarterly review process. Results will be communicated to FMCSs after all initial reviews are completed.

Step 6: Reviewers will complete initial reviews to determine if the services outlined in the individual's Person-Centered Plan have been delivered, documented, billed, and paid as required, as well as provided by qualified providers and staff when applicable. (**See attached Appendix B, Indicator Questions/Authority Table**).

Step 7: Quality control checks on at least 10% of reviews will be conducted by Liberty supervisors to ensure each step of the review was conducted as outlined in the instructional guide. Assignment of cases for quality control checks will be randomly selected at the time the sample is loaded into LibertyTraks. Follow-up coaching and training will be provided to reviewers not meeting the 85% or higher accuracy threshold. Findings will be adjusted accordingly to accurately reflect the correct finding and evidence.

Step 8: **Initial Findings Reports will be generated from LibertyTraks and sent to FMCS agencies**. Met and Unmet findings will be included in the **Initial Findings Report**.

A. Unmet Findings consist of:
    a. Less services provided than billed.
    b. Services provided did not match the definition of the services billed.
    c. Payments cannot be substantiated by appropriate service record documentation.
    d. Required staff/vendor training could not be verified prior to service delivery
    e. Required staff/vendor background checks could not be verified prior to service delivery

B. An Initial Review summary report will be sent in Week nine (9) of the quarterly review period.

C. If unmet findings are identified in the initial reviews, the FMCS's Initial Review summary report will highlight each unmet finding, indicating which claims are "pending remediation" and request supplemental/corrective documentation to remediate the unmet finding.

Step 9: The FMCS will have five (5) business days to provide supplemental documentation for the purposes of remediating any unmet findings highlighted in the Initial Findings summary report.

Step 10: Upon receipt of supplemental documentation from the FMCS, the reviewer will determine if additional documentation is acceptable. If allowable, a remediation determination will be included in the Finalized Findings Report.

Step 11: Finalized Findings Reports will be sent via email to the FMCS within 15 business days following the end of the quarterly review period.

Step 12: Based on the extent of unmet findings, it will be determined if a participant interview will be requested. The following criteria will be utilized to determine if an interview with the participant and/or proxy is recommended:

- No service documentation submitted for any of the claims reviewed
- More than one staff with training and/or qualification discrepancies

The determination of whether or not a participant interview will be requested will be included with the finalized findings report. The communication with the finalized findings report will be sent to the point of contact of the FMCS, the participant, DDA Statewide Coordinator of Self-Directed Services and the DDA contract monitor in writing within fifteen (15) business days of the end of the fiscal quarter. If a participant interview will not occur, the review will be considered closed.

Step 13: The reviewer will make up to three (3) attempts to contact the participant and/or representative to request a remote or in-person interview. At least one of the contacts will be through the participant's Coordinator of Community Service if the reviewer is unable to contact the participant directly. The brief (less than 30 minute) interviews are for the purpose of ensuring

services are being delivered in the type, scope, amount, duration and frequency specified in the PCP and to better understand the potential causes of unmet findings. The information from the participant interviews will be used to support the development of further guidance and technical assistance to reduce systemic issues causing unmet findings. The reviewer shall obtain verbal consent from participants or their legal guardian to conduct the interview. If desired by the participant, family members, guardians, and important others will be included in the interview.

Step 14: A summary of the interview(s) will be completed by the Reviewer and will be used with the Finalized Findings report to provide technical assistance to the FMCS administrative team during an exit conference. Technical assistance at the Exit Conference will focus on assisting the FMCS to develop a Corrective Action Plan. The Exit Conference will be scheduled within five (5) business days of the completion of the interview and will be conducted virtually.

Step 15: Corrective Action Plans

Liberty will request the submission of a Corrective Action Plan at the conclusion of the Exit Conference if unmet findings remain for the following:

- Documentation did not verify proper payment of the service, and/or
- Staff providing the service did not meet qualifications on the date of service

If a CAP is required, the FMCS will submit the CAP to the Liberty reviewer for approval within thirty (30) business days of the request and will have thirty (30) business days from approval to submit evidence the CAP was initiated and/or fully implemented.

Liberty will continue to monitor the implementation of the CAP until completion. At the time of completion, Liberty will provide the finalized CAP and evidence of implementation to the DDA QIO contract monitor and the DDA Statewide Coordinator for Self-Directed Services. Liberty will then send an acceptance letter for the implemented CAP within five (5) business days to the FMCS.

Corrective Action Templates

Corrective Action Plan Request Summary

Baltimore Provider

Quick View Information

Main

Date:
10/02/2023

Organization Name:
Baltimore Provider

Liberty Reviewer:
Jennifer Mettrick

Reviewed Service(s):
Community Development Services Group (1-4)

Deficiencies:
Category: Policies and Procedures; Area of Deficiency: Missing documentation

Corrective Action Plan Requirements:

For each area of deficiency, create a corrective action plan that addresses the following:

What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?

Who, by job title, and how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?

Acceptance of Liberty's Corrective Action Plan or submittal of a Corrective Action Plan must be returned to Liberty Healthcare by (30 business days of the exit conference)

Evidence the Corrective Action Plan has been implemented within your organization must be submitted 30 business days after approval **an official due date will be sent once Corrective Action Plan has been approved**

Deficiency Requiring Corrective Action

Baltimore Provider

Quick View Information

Deficiency Details:

Record ID
432397

Corrective Action Category
Policies and Procedures

Area of Deficiency:
Missing documentation

Description:
Documentation did not include start and end times for the service and timesheet documentation to verify staff worked on the date of service was not submitted.

Indicator Questions Related to Deficiency:
UR1a: If applicable, was the date of service with start and end times included in service documentation?

Factors:

Possible Internal Contributing Factors:
Quality oversight process not in place for reviewing service documentation prior to billing submissions.

Possible External Contributing Factors:
Provider not receiving regular communications from DDA and was not using the Service Authorization and Billing guidance issued by DDA.

Plan

Recommended Corrective Actions:
Develop and implement a quality oversight process to review service documentation prior to billing.

Corrective Action Status
In Progress

Link to Documentation Evidence

Medicaid Fraud

If there are systemic or alleged **intentional** billing issues, the DDA may refer the FMCS, employee, vendor, or team member to the Office of Inspector General for Health.

Appendix A. COMMUNICATION

Communication is an essential component of a successful review. Below is a list of communications that will be used to ensure FMCS/self-directed service provider and participant engagement in the review process.

Outreach			
Document	Definition/Purpose	Timing	Audience
Notification and Initial Checklist of Requested Documents	List of documents sent notifying of required documents needed to complete the review.	Emailed at the start of the review. Provides a specific list of documents that are required from the FMCS to begin the Utilization Review.	FMCS
Findings Report	Communication sent with finalized results of the SDS Review(s)	Completion of the review period.	FMCS

Appendix B : Indicator Question/Authority Table

Indicator Question	Sub-Question	Justifications	Authority
Is the claim supported by documentation that services were delivered?	Did service documentation exist to support the paid claim?	Met = a **timesheet** with the service name, date, start and end times, as well as the employee providing the service and the participant identified or **Vendor Invoice**	HCBS 1915 (C) Waiver Appendix D: Participant-Centered Planning and Service Delivery

Indicator Question	Sub-Question	Justifications	Authority
		with service name, date, start and end times, as well as the vendor name who provided the service and participant identified; Unmet= any missing documentation listed above	
Was the person eligible on the date of service and was the service authorized in the PCP?	*** Both responses to the two sub questions below must be 1=Met in order for the response to this indicator question to be 1=Met.***		HCBS 1915 (C) Waiver Appendix D: Participant-Centered Planning and Service Delivery
	Was the person eligible on the date of service?	Met= participant was eligible on the date of service. Unmet= date of service falls outside of the eligibility span.	HCBS 1915 (C) Waiver Appendix D: Participant-Centered Planning and Service Delivery

Indicator Question	Sub-Question	Justifications	Authority
	Was the service authorized in the PCP?		HCBS 1915 (C) Waiver Appendix D: Participant-Centered Planning and Service Delivery
Was the claim coded and paid for in accordance with the reimbursement methodology specified in the approved waiver?		Met= claim was coded and paid for accurately as evidenced by use of an accurate waiver code, billing rate, and billing unit. Unmet= claim was not coded and/or paid correctly	HCBS 1915 (C) Waiver Appendix I: Financial Accountability; Quality Improvement: Financial Accountability
Did the staff who delivered services meet all required training & qualifications on the date of service?		Met= submitted documentation indicates services were delivered by qualified staff on the date of service. Unmet= submitted documentation does not verify that services were delivered by qualified staff on the date of	HCBS 1915 (C) Appendix C: Participant Services, C-1/C-3: Provider Specifications for Service

Indicator Question	Sub-Question	Justifications	Authority
		service.	

Appendix C: REFERENCES

RELEVANT DOCUMENTATION:

Authorized HCBS 1915 (C) Waivers (Appendix C, D and I)

REFERENCE MATERIALS

COMAR Title 10 Subtitle 22 Developmental Disabilities