Please Reference the Desk Review Procedures (effective 4/1/20) on our website as they currently supersede certain sections of this Operational Policies and Procedures Manual, due to COVID-19

Operational Policies and Procedures Manual

Florida Statewide Quality Assurance Program

Mission: *To deliver quality, clarity, and opportunity.*

Vision: *To deliver the most innovative solutions and unrivaled results with an agile, expert workforce and trusted strategic relationships.*

This manual describes the policies and procedures used to implement the Florida Statewide Quality Assurance Program. AHCA maintains review/revision oversight of this document. This document is considered current until otherwise notified by the Contractor.

Note: **This is a controlled document. Master document is the on-line version.** It supersedes all previous updates. Users shall not make unauthorized alterations. Users must determine the current version and completeness prior to use. The user must discard obsolete documents.

Contents

List of Acronyms and Terms

AHCA – Agency for Health Care Administration is the single state agency responsible for administering the Medicaid program in Florida and administers the Developmental Disabilities Individual Budgeting (iBudget) Waiver.

Agency – A business or organization enrolled to provide waiver services that has two or more employees to carry out the enrolled service(s), including the agency owner.

Alert – An alert is triggered when the Quality Assurance Reviewer determines a person's health, safety and /or rights are in jeopardy and immediate corrective action is needed.

APD – **Agency for Persons with Disabilities** is the state agency specifically tasked with serving the needs of Floridians with intellectual and developmental disabilities.

Regional Office – Agency for Persons with Disabilities 's Regional office responsible for managing one of six service Regions around the state.

CDC+ – The **Consumer Directed Care+ Program** operates under the authority of section 1915(j) Medicaid State Plan Amendment of the Social Security Act. This program permits individuals to self-direct their own personal assistance services, hire and pay legally liable relatives directly for personal assistance services identified in the service plan and budget through a monthly budget the individual manages. For the purpose of this program, individuals must be enrolled in the 1915(c) iBudget Waiver.

CDC+ Consultant – A Waiver Support Coordinator specifically trained to assist Consumer Directed Care + Participants with program administration and care management.

CDC+ Representative – An individual selected by the participant to assist in managing the budget allowance and services. Representatives advocate for and act on behalf of the program participant in all CDC+ matters.

DSP - Direct Support Professional is a person that works directly with people with physical and/or intellectual disabilities with the aim of assisting the person to become integrated into his/her community or the least restrictive environment. This person may be directly hired as an employee or brought in as a sub-contractor by the provider.

Discovery Process – Process of collecting data and direct participant experiences in order to assess the ongoing implementation of the service delivery program.

Discovery Tools – Instruments used to capture information gleaned from specific review processes.

FSQAP – The **Florida Statewide Quality Assurance Program** is the program under which providers rendering services and billing to the Developmental Disabilities Individual Budgeting Waiver are reviewed for quality assurance purposes.

HSRI – **Human Services Research Institute** is the organization that developed the National Core Indicators, together with the National Association of State Directors of Developmental Disabilities Services (NASDDDS).

iBudget Handbook – **Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook** The purpose of the Handbook is to educate the iBudget Waiver provider about policies and procedures needed to receive reimbursement for covered services provided to eligible waiver recipients. The Handbook provides descriptions and instructions on how and when to complete required documentation and contains minimum education/experience requirements for each service.

iBudget Waiver – **Developmental Disabilities Individual Budgeting Home and Community-Based Services Waiver** authorized under section 1915(c) of the Social Security Act and governed by Title 42, Code of Federal Regulations (CFR), Parts 440 and 441. Section 409.906, Florida Statutes (F.S.), and Rule 59G-13.070, Florida Administrative Code (F.A.C.). The iBudget Waiver is referenced in Chapter 393, F.S., and the Agency for Person's with Disabilities' Rule 65G- 4.0213, F.A.C. The iBudget Waiver provides home and community-based supports and services to eligible persons with developmental disabilities living at home or in a home-like setting.

QC – **Quality Council** is a council of self-advocates, families, Agency for Health Care Administration, Agency for Persons with Disabilities and service providers who provide direction for the Florida Statewide Quality Assurance Program.

MPR – **Medical Peer Review** process is designed to identify the physical, functional and behavioral health care status, and needs of individuals currently receiving services on the Developmental Disabilities iBudget Waiver or participating in the Consumer Directed Care + program.

NCI – **National Core Indicator Adult In-Person Survey** - Assessment tool used to gather information from people 18 years of age or older receiving waiver services to be used at a state level for comparison of the quality of waiver services.

ORC – **Observation Review Checklist** is used to gather information about specific locations (licensed residential homes and day training facilities).

PCR – **Person Centered Review** is a process of discovery beginning with the person and reviewing the services and supports provided to the person by the Waiver Support Coordinator.

PDR – **Provider Discovery Review** is a process of discovery focusing on provider compliance and accountability in delivering appropriate supports and services to people and meeting their needs.

Provider – A provider is any entity, facility, person (solo), agency or group who is enrolled in the Developmental Disabilities iBudget Waiver program rendering services to Medicaid Waiver recipients and billing for Medicaid Waiver services.

QAR – **Quality Assurance Reviewer**s are employed and trained by Qlarant to conduct Discovery Reviews.

Reconsideration Review – Process allowing providers to request a change in scoring of standards related to identified potential billing discrepancies.

SSRR – The **Service Specific Record Review** is a review of the person's service record maintained by the provider. It is used to evaluate the extent to which providers incorporate a person centered approach in their service delivery systems, and maintain compliance and accountability to applicable laws, Agency for Persons with Disabilities expectations, and standards.

WSC – **Waiver Support Coordinator** is the provider who acts as the case manager for people receiving services through the Developmental Disabilities Individual Budgeting Waiver.

Policies and Procedures

Confidentiality

All medical data and individual specific information are confidential and are only shared by Qlarant with agencies that have legal authority to receive such information. Qlarant complies with all federal and state laws governing confidentiality, including electronic treatment of records, facsimile mail, and electronic mail, in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Discovery Process inputs are gathered via a customized, secure web-based application consisting of various modules. This application is continuously available to our Quality Assurance Review staff (except for pre-determined and approved maintenance windows) via the Internet, protected by Extended Validation SSL (EVSSL) encryption. All modules are accessible from a single point-of-entry. Access to the modules will be role-based and limited to only those persons who require access.

All Qlarant staff is required to take a Security Awareness training session annually.

Customer Service

A dedicated Customer Service Representative (CSR) is located in the Tampa, Florida office. The CSR serves as a liaison between Qlarant, iBudget Waiver service providers and recipients, the APD Regions, and the business community. The person in this position is trained in all review processes in order to better communicate with all stakeholders. If unable to answer an inquiry or respond to a grievance, the CSR forwards the call to the person best able to address the issue. In addition, the CSR is bi-lingual, fluent in English and Spanish. When the need for interpreter services for a Quality Assurance Review (QAR) arises, the CSR arranges for such services. Qlarant does not allow communication to be a barrier to providing excellence in services, including Customer Service. The CSR may be reached by the toll free number (866-254-2075) or by fax at (888-877-5526).

Complaints

Qlarant strives to provide the best service possible in all aspects of business. We take every step possible to ensure expectations are met and exceeded when possible. Through our rigorous training and staffing processes, we make certain QARs understand what is expected of them when interacting with individuals receiving services, family members, providers, state of Florida personnel, and other community members. We set high standards for our employees, and expect them to maintain ethical business practices, i.e. honesty, integrity, respect, trust, responsibility and to be helpful and courteous to our stakeholders at all times.

Qlarant consistently strives to exhibit the following key customer service qualities:

- Timeliness of response;
- Accuracy of information;
- Thoroughness of approach;
- Respectful interactions.

If Qlarant falls short of meeting these requirements and a complaint is made, we make every effort to resolve the complaint quickly. The following steps can be followed to lodge a complaint:

- Contact our Customer Service Representative at our toll free number 866-254-2075 and explain your concern;
- If you are not satisfied with the explanation/resolution ask to speak with a Regional Manager;
- If you are still not satisfied with the resolution please ask to speak with the Program Director;
- Calls are returned within 24 hours or by the next business day;
- Responses to written inquiries are returned within 30 days;

Non-Compliance with the Discovery Review Process

According to 2019 Florida Statutes (409.907 and 409.913) and 1915j, the provider is required to participate in quality improvement activities conducted by the state of Florida. This includes the release of Medicaid patient information when requested. According to 1915j, "The State assures that there are necessary safeguards in place to protect the health and welfare of individuals provided services under this State Plan Option, and to assure financial accountability for funds expended for self-directed personal assistance services".

Non-Compliant providers are those:

- Who do not respond to at least two attempts to schedule a review,
- Who do not make individual records available for review purposes,
- Who is a “no-show” after a review has been scheduled.

Procedure for Providers who do not respond to scheduling efforts:

Immediately after the second failed attempt to schedule an annual Provider Discovery Review, the Qlarant QAR notifies Regional Agency for Persons with Disabilities (APD) staff of the difficulty scheduling the review with the provider/Consumer Directed Care+ (CDC+) Representative. The provider/CDC+ Representative is given three business days to respond to APD Regional staff. If Regional staff succeeds in getting the provider/CDC+ Representative to comply, the review is scheduled and conducted accordingly. If there continues to be non-

compliance from the provider/CDC+ Representative despite efforts from APD staff, the provider/CDC+ Representative is scored "Not Met" in all areas of the discovery tool.

Procedure for Providers who do not make individual records available for the review process:

During the scheduling phase of the Discovery Review Process providers/CDC+ Representatives are made aware of time frames for making records available. The QAR informs each provider/CDC+ Representative involved in the Person Centered Review (PCR) and Provider Discovery Review (PDR) which records need to be available and when. If the provider/CDC+ Representative does not make all records available for review within the designated time frame, the provider/CDC+ Representative is scored "Not Met" for all standards pertaining to the record review. The QAR notifies Regional APD staff by phone.

Procedure for providers who are a "no-show" after a review has been scheduled:

Should a provider fail to appear at the scheduled time and location for a PDR the QAR will wait thirty minutes while continuing to try to reach the Provider/CDC+ Representative. If the Provider/CDC+ Representative does not respond, we will notify the APD Region and score "Not Met" for all standards pertaining to the PDR.

Discovery Review Procedures

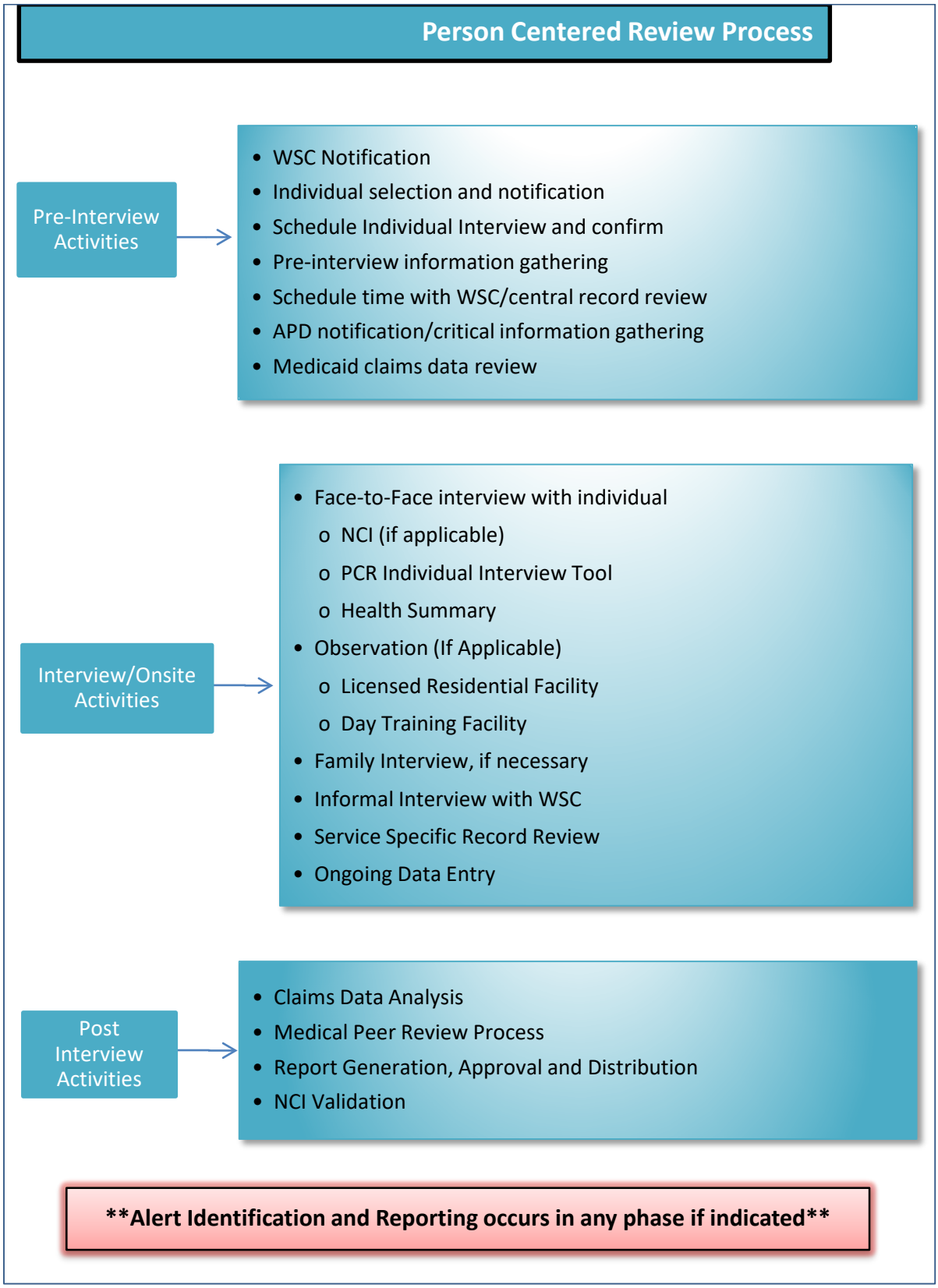
Quality Framework

The Quality Assurance System developed by Qlarant, in collaboration with the Agency for Health Care Administration (AHCA) and APD, is used to determine whether current systems to support individuals are efficient, effective, and rendered to their satisfaction. The Quality Assurance System Discovery Process has the goal of discovery, with two key processes being the PCR and PDR.

Person Centered Reviews

The Person Centered Review process embodies the philosophy commonly characterized by many self-advocates of "Nothing About Me, Without Me". It is designed to determine the effectiveness of the Waiver Support Coordinator (WSC) in rendering services to individuals, as specified by the person. Question areas include: Is there a consistent person centered approach used that allows individuals to direct their own lives, choose their own services and providers, participate in the development of their own support plans, and determine their own goals and objectives? Is the support plan deployed appropriately? The PCR sample is designed to allow results to be generalized to each APD Region and to the state system as a whole.

The Discovery Process begins with PCRs to assess the efficiency and quality of supports, services, planning and delivery from the person's perspective. PCRs begin with Face-to-Face interviews with persons receiving services and include a review of the supports and services rendered by the WSCs specific to that person, including a review of the Support Plan. The following flow chart describes the PCR process.



Notification to Waiver Support Coordinator

All WSCs and Consultants rendering services to persons are informed of the PCR process. A review schedule is submitted to AHCA and APD for approval. WSCs are sent a letter describing the PCR and PDR processes and the expectations of their participation in the process. The letter includes a web address for the Florida Statewide Quality Assurance Program (FSQAP) Web site where the PCR tools and procedures can be accessed online. The WSC/Consultant is directed to the Qlarant Website to access this operating policy and procedure manual explaining the PCR process. The letter also includes a list of potential documents the WSC must make available for the PCR process. These include but are not limited to person's central record, Service Authorizations, Progress Notes, medical information, and provider information (Implementation Plans, Quarterly/Reports etc.).

Selecting the Sample for Person Centered Reviews

Solo WSCs and Consultants who rendered and billed for services over the previous 6 month period, as identified through claims data, are eligible for a PCR/PDR. WSCs within existing agencies are eligible for review after rendering services for 3 months. On a quarterly basis WSCs and Consultants rendering services receive a letter notifying them they are scheduled for a review within the next 90 days. The names of two individuals served by each WSC/Consultant are randomly selected. The Qlarant QAR calls the WSC/Consultant and notifies them regarding the selection of individuals for a PCR.

A list of individuals for each WSC/Consultant is generated from APD's iConnect database or it is provided by the WSC onsite if needed. Claims data from Florida Medicaid Management Information System may also be used to further identify all individuals who receive services from the WSC/Consultant.

Scheduling the Face-to-Face Individual Interview/Sending a Confirmation Letter

The WSC/Consultant is tasked with contacting the person selected for a PCR. If the person chooses not to participate the PCR is concluded though the QAR may follow-up with the person to determine if there were any questions about the process; however for persons participating in the CDC+ program a PDR still occurs with the CDC+ Representative. Demographic information such as

waiver type and residential setting, along with the reason for declining, is captured for those persons who decline.

If there is a decline, the WSC/Consultant will be given the next name from the randomly ordered list and asked to contact the next person. This process continues until the required number of interviews are scheduled. If the person chooses to participate, the WSC/Consultant schedules the date, time and location for the interview based on the person's preferences. QARs maintain contact with WSCs to gather information on interview locations, dates and times. Once the interview has been confirmed, the QAR enters the information into the scheduling component of the web based application. This triggers the mailing of a confirmation letter to the person, outlining the purpose of a PCR, tools used and examples of questions the Qlarant QAR may ask. If the interview replaces a last minute cancellation a letter will not be sent.

Information covered by the QAR during the initial phone call with the WSC/Consultant will include the following at a minimum:

- Sharing the names of persons sampled for PCRs.
- Coordinating with WSC to assist with contacting and scheduling PCRs.
- Confirming with the Agency the number of WSCs employed, hire dates, gather caseload information, sample PCRs for any WSCs not in original sample.

Pre-Interview Information Gathering for the Individual Interview

Prior to conducting the National Core Indicator Adult In-Person survey, PCR Individual Interview and the Health Summary it is important for the QAR to collect information from the WSC that may be beneficial to the person and the QAR to help ensure the interview is successful. This information could include the person's communication style; if the person needs assistance from specific supports during the interview or uses a communication device; or if the person's primary language is different than spoken English. It is important for the QAR to have this information before the interview. If the person chooses, Qlarant obtains an interpreter to assist during the interview, e.g. sign language, Spanish, or Creole.

Review of information from the Agency for Persons with Disabilities

Qlarant notifies APD of the upcoming PCR reviews for the month, including the name of the QAR. A request is made for information pertaining to incidents, concerns, complaints or grievances associated with the WSC. This information is discussed with the WSC during the PDR if applicable.

Scheduling Waiver Support Coordinator/Consultant participation in Person Centered Review

Prior to the date of the actual PCR, the QAR calls the WSC/Consultant to discuss the review process and the date of the PCR. Once a date for the Individual Interview has been confirmed, the QAR establishes firm dates and times for the WSC interview, to follow up on information gathered from the Individual Interview and complete the WSC central record review.

Confirmation with Waiver Support Coordinator/Consultant

Once the QAR and WSC have determined the actual dates of the WSC follow-up and record review, this information is entered into the web based application. A phone call or e-mail is made to the WSC to confirm date, location and time of review, and includes a list of documents that need to be available for review such as the Cost Plan, Support Plan, Medicaid Waiver Eligibility Worksheet, and Progress Notes as noted in the notification letter. Subsequent calls to the WSC will be initiated by the QAR to:

- Finalize and confirm PCR dates, times and locations
- Gather background information for NCI
- Schedule time with the WSC
- Schedule WSC PDR to include Administrative/Personnel record and Service Specific Record Review (SSRR)

Claims Data Pull

QARs access Medicaid claims data prior to the Face-to-Face interview. Claims data are used to compare the WSC documentation of services rendered to the person with actual billed claims to demonstrate whether the documentation matches what the WSC billed with what was paid. The comparison will also show whether the WSC billed according to the specific service(s) requirements and according to the approved rate on the approved cost plan. The comparison of claims data and service records will occur while meeting with the WSC to review the person's records.

Face-to-Face Interviews (NCI, PCR Interview Tool and Health Summary)

The interview with the person takes place at a date, time and location of the person's choosing. During the initial Face-to-Face contact with the person the QAR confirms the person's willingness to participate in the interview, and confirms the person has approved the participation of any

other people in attendance. Ideally interviews are conducted with as few people present as possible to ensure the voice of the person is the focus of the interview. The QAR may gather additional information related to service delivery and satisfaction from family, guardian/legal representative, and/or support personnel. These interviews may be needed to corroborate information or if there are significant gaps in information provided by the person. If the person no longer chooses to participate in the process, the PCR concludes; however for persons on the CDC+ program a PDR occurs for the person's CDC+ Representative. For those who choose to participate, the PCR consists of the National Core Indicators Adult In-Person Survey (NCI), Individual Interview and Health Summary.

The QAR explains the two distinct components of the interview: 1) gathering information for the NCI; 2) gathering additional information using the PCR Interview Tool and Health Summary. Required NCI protocol is followed while administering the NCI survey to ensure the data are suitable for inclusion in the Human Services Research Institute (HSRI) national database of information.

NCI - The NCI Adult In-Person Survey covers specific areas and consists primarily of choosing the most appropriate response. The purpose of the Survey is to identify and measure core indicators of performance of state developmental disabilities service systems, such as satisfaction with services, community integration, and choice.
The survey consists of five parts:

- Pre-Survey - Information to help set up the meeting
- Background Information - Person's demographic and personal characteristics
- Section 1 - Subjective questions, only the person receiving services may answer
- Section 2 – Objective questions, Preferably completed by person receiving services, but a proxy can be used
- Surveyor Feedback Form - Details about survey and flag issues with specific questions

The Adult In-person Survey is conducted with people 18 years of age or older receiving waiver services. People may have someone present who knows them best, to assist during specific sections of the survey; however section 1 must be answered by the person independently. After the Survey is conducted, the QAR informs the person of the survey's conclusion, the confidential nature of the survey, and then begins the PCR Interview Tool and Health Summary.

PCR Interview Tool - Data specific to a person's desired goals and outcomes and supports, are collected through the PCR Interview Tool. The Interview Tool covers six key tenets: Choice and

self-direction, rights, satisfaction, stability, future, and safety. The domains include My service life, My home life, My work/day activity life, My social life, My health, and My safety.
The interview consists of open-ended questions such as:

- What services and supports are you receiving?
- How did you have input into deciding which services you receive?
- How are you offered options of services and supports?
- Who is providing your supports and services?
- How did you have input into choosing who provides your services?
- How were your service providers selected?
- What do you know about your rights as a citizen?
- How does your WSC provide you with information about your rights?
- What rights are most important to you?

The QAR ultimately determines within each domain if certain expectations/findings need to be reported as applicable for each person interviewed. The actual questions asked may vary from interview to interview depending on the needs of the person being interviewed and the person's communication style.

Health Summary - Data specific to the person's health and safety in all settings are collected using the Health Summary tool. The Health Summary is incorporated into the interview tool and consists of a series of questions related to medications taken, medical personnel involved in providing care, hospitalizations, adaptive equipment, environmental conditions, behavioral needs, and safety. The Health Summary is used to assist in identifying any health and behavioral issues/concerns. Discoveries are generated when applicable, and these are shared with the WSC and APD via the PCR Report.

If the Face-to-Face PCR interview occurs at a location where the person receives Residential Habilitation or Life Skills Development 3 services, the QAR may conduct an observation of that environment if the provider is projected to have a PDR between then and the end of the contract year. The observation may be announced or unannounced. If it is announced, it is scheduled by the QAR with the provider with the intent that the information gathered during the observation is included in the provider's PDR results. Although observations may be conducted following the PCR interview with the person, the information becomes a part of the providers PDR report.

Informal Waiver Support Coordinator/CDC+ Consultant Interview

While there is no formal interview process with the WSC, following the Face-to-Face interview with the person, the QAR will talk with the WSC to obtain follow up information related to the Individual

Interview and observation (if conducted). This is the opportunity for the QAR to learn about person centered planning processes used by the WSC.

Waiver Support Coordinator/CDC+ Consultant Central Record Review

The final component of the PCR is a review of the person's record maintained by the WSC using the Support Coordinator or CDC+ Consultant service specific record review tool (SSRR). In addition to the two PCR records, the QAR will select one unannounced record for inclusion in the WSC's PDR. Review of records covers the prior 12-month period preceding the PDR and determines whether:

- Support Plans are based on identified needs and preferences of the person;
- The person's preferences were taken into consideration;
- The person is supported to choose services;
- The person is supported to choose service providers;
- The person is supported to drive service delivery including when and where services are rendered;
- The person's satisfaction with supports and services is addressed.
- The person's health and safety needs were addressed;
- There is collaboration between service provider and the WSC;

The WSC is expected to be a part of and participate in conducting the record review, allowing the WSC an opportunity to locate required documentation and explain anything that may be unclear.

The record review also helps to ensure the WSC is meeting the minimum standards listed below:

- Documentation verifying service delivery;
- The current Support Plan is in the central record;
- Services are delivered in accordance with the person's Cost Plan;
- Billing requirements are met;
- Incident report requirements are met;
- Provider documentation is in the central record.

Medicaid Claims Data Analysis

Documentation in the Person's central record is compared with Medicaid claims data. The QAR determines if billing requirements and documentation specifications were met as identified in the

iBudget Handbook. If documentation is determined to be Not Met this is included in the report and is identified as a potential billing discrepancy to the State.

Data entry into the web based application

QARs ensure data collected from the WSC, record reviews and interviews with persons are entered into the web based application within 10 days of completion of the PCR process.

The Medical Peer Review Process

The Medical Peer Review (MPR) process is designed to identify the physical, functional and behavioral health care status and needs of people currently receiving services on the Florida HCBS iBudget waiver. The focus of the MPR process is on person's safeguards as identified in the HCBS Quality Framework Focus Area IV. It captures health risk and safety concerns and will identify interventions designed to promote the health and safety of the person. The process allows for the identification and reporting of critical incidents and potentially life threatening situations. It identifies environmental risks and recommendations, as needed, for modifications that promote safety and independence.

The process will identify:

- Use/misuse of chemical and/or physical restraints as defined in Florida Statute 65G-8.
- Medication management concerns and recommendations as defined in Florida Statute 65G-7;
- And, information on the current provision of healthcare services for each person.

The MPR is conducted with established methods by the Qlarant Nurse Reviewer and includes:

1. Observation – real time, actual events/behaviors that occur in the person's natural context based upon real time observations conducted by the QAR.
2. Interview – targeted, direct questions that allow for the person's perspective based upon the PCR Individual Interview Tool.
3. Documentation Review – stable and precise review of the person's Medical Information, Health Summary, Medicaid Claims Data and Medical Record Review (as indicated)

The Medical Peer Review process begins at the time of the PCR interview with the availability of the Nurse Reviewer for real time consultation with the QARs, people interviewed, families and providers as health and safety questions or concerns arise. Subsequent to the PCR on-site activity, the following activities occur for the MPR, for each person interviewed:

a. Medicaid (FMMIS) Claims Data review of Institutional, Medical and Pharmacy claims by the Nurse Reviewer, for the 12 month period prior to the review
b. Review of the comprehensive Health Summary data by the Nurse Reviewer
c. Review of the observational data collected through the PCR by the Nurse Reviewer
d. Review of information collected from the person's Central File and Medical File through the PCR on each person by the Nurse Reviewer.

The MPR process is completed as a Level One, Two or Three – Focused Review as follows:

a. Level One Review
    i. Components of a Level One Review include review of the PCR report, Health Summary, NCI, and Medicaid claims data. If no questions or need for additional follow-up is indicated the MPR is concluded and closed at Level One.

b. Level Two Review
    i. If any of the following Triggers are identified in Level One the PCR is automatically elevated for Level Two Review
        - Three or more Emergency Room visits
        - Two or more hospitalizations
        - Two or more Baker Acts within 6 months
        - 2 or more falls
        - Skin breakdown
        - Unplanned weight change "greater or less than 10 lbs.
        - Concurrent use of Anti-Epileptic/psycho therapeutic medications
        - Non-psych physician prescribing psychotropic medication
        - Use of Reactive Strategies
        - No medical care/preventative treatment for past year
        - Other
    ii. A Level Two review could be triggered when discrepancies are noted between the Health Summary, Institutional, Medical or Pharmacy claims data review and other document reviews that indicate the need for additional information.
    iii. Qlarant Nurse Reviewer will follow up on all identified triggers. Every attempt will be made to obtain additional information necessary for clarification by phone or secure email. This could include calls to any of the following; Qlarant Reviewer, Person/Family/Caregiver, WSC, Providers, Regional/State APD Medical Case Manager, Regional/State APD Senior Behavior Analyst.
    iv. Components of a Level Two Review may include a request for and review of the person's medical record.

v. If inquiries satisfy concerns, Qlarant Nurse Reviewer will forward any follow-up items and/or recommendations if applicable to the Regional/State APD Medical Case Manager and/or Regional/State APD Behavior Analyst. The MPR is concluded and closed at Level Two.

c. Level Three – Focused Review
   i. If Qlarant Nurse Reviewer inquiries do not produce a satisfactory result and concerns persist the PCR is elevated to a Level Three – Focused Review.
   ii. For trigger items not resolved in Level 2 and/or any new concerns brought on through Qlarant Nurse Reviewer inquiries in Level 2, Nurse will continue to follow up with contacts made during the Level Two review and expand contacts to include physicians, therapists and other licensed professionals as necessary as well as formal written requests for medical records.
   iii. Qlarant Nurse Reviewer may also consult with the Qlarant Medical Director and/or Regional/State APD Nurse Case Manager as needed.
   iv. If significant concerns persist and/or the level of complexity of the concern, warrants further in-depth review a referral will be sought from person's primary care physician to follow-up with a board-certified specialist (in the area of concern).
   v. As part of a Focused Review, Nurse Reviewer will document the concerns/triggers that elevated the PCR to a Focused Review, findings and recommendations. A Focused Review Report including this information will be generated and posted to the Qlarant portal/secure website. APD Regional Nurse Case Manager, APD State office and AHCA are notified that a Focused Review report is posted for review. The MPR is concluded and closed at Level Three –Focused Review.

Report Approval and Distribution

Qlarant Quality Assurance Managers approve 100% of reports prior to dissemination.

Reports are mailed to the WSC, distributed to people participating in the PCR process upon request, and made available electronically to APD and AHCA for authorized users through the FSQAP Reporting System within 45 days of completion of the review. Reports include specific information for each person sampled as part of the PCR process as well as information about the degree to which the WSC successfully meets the needs of the person.

Provider Discovery Reviews

The Provider Discovery Review (PDR) process is an integral component of the discovery process, used to evaluate the extent to which providers incorporate a person centered approach in their service delivery systems as well as their compliance and accountability to Medicaid, Medicaid Waiver, AHCA and APD standards. The PDR process uses a well-rounded approach where information is gathered from interviews with persons receiving services, informal interviews with provider/Direct Support Professional, review of agency policies and procedures where applicable, review of required qualifications and training for services provided, review of general provider practices, review of person's service records and Observations of Licensed Residential and Day Training Facilities. The PDR process:

- ✓ Centers around the provider's service delivery system
- ✓ Evaluates performance in delivering appropriate services and supports to assist the person in achieving personal goals/outcomes and meeting identified needs
- ✓ Assesses quality, billing and compliance with iBudget Handbook, Florida Statute, Florida Administrative Code, and other state/federal requirements, rules, and policy

This holistic approach ensures information is gathered directly from people receiving services while allowing providers the opportunity to demonstrate their adherence to person-centered planning and compliance with standards as set forth by Centers for Medicare and Medicaid Services (CMS) and the iBudget Handbook.

The PDR takes place where the records are maintained. This could be an office, group home or the provider's home office. Any deviation from the provider's office location must be approved through AHCA.

Unannounced records will be sampled once onsite.

Eligibility Criteria

Each provider identified as meeting eligibility criteria is required to participate in an annual PDR at least once each contract year. However, with the exception of WSCs, those providers whose overall PDR score in the previous year meets "deemed status" criteria may skip a year of review. WSCs who meet WSC deemed status criteria are still reviewed, but may only be sampled for one

PCR. The contract year is defined as the period from July to June. Deemed status criteria are determined on an annual basis by AHCA and APD and can be revoked statewide or for a given provider at the discretion of either entity. It should be noted the annual PDR schedule is driven by the volume of providers eligible for a PDR review each year. Annual PDRs may not always be exactly 12 months apart.

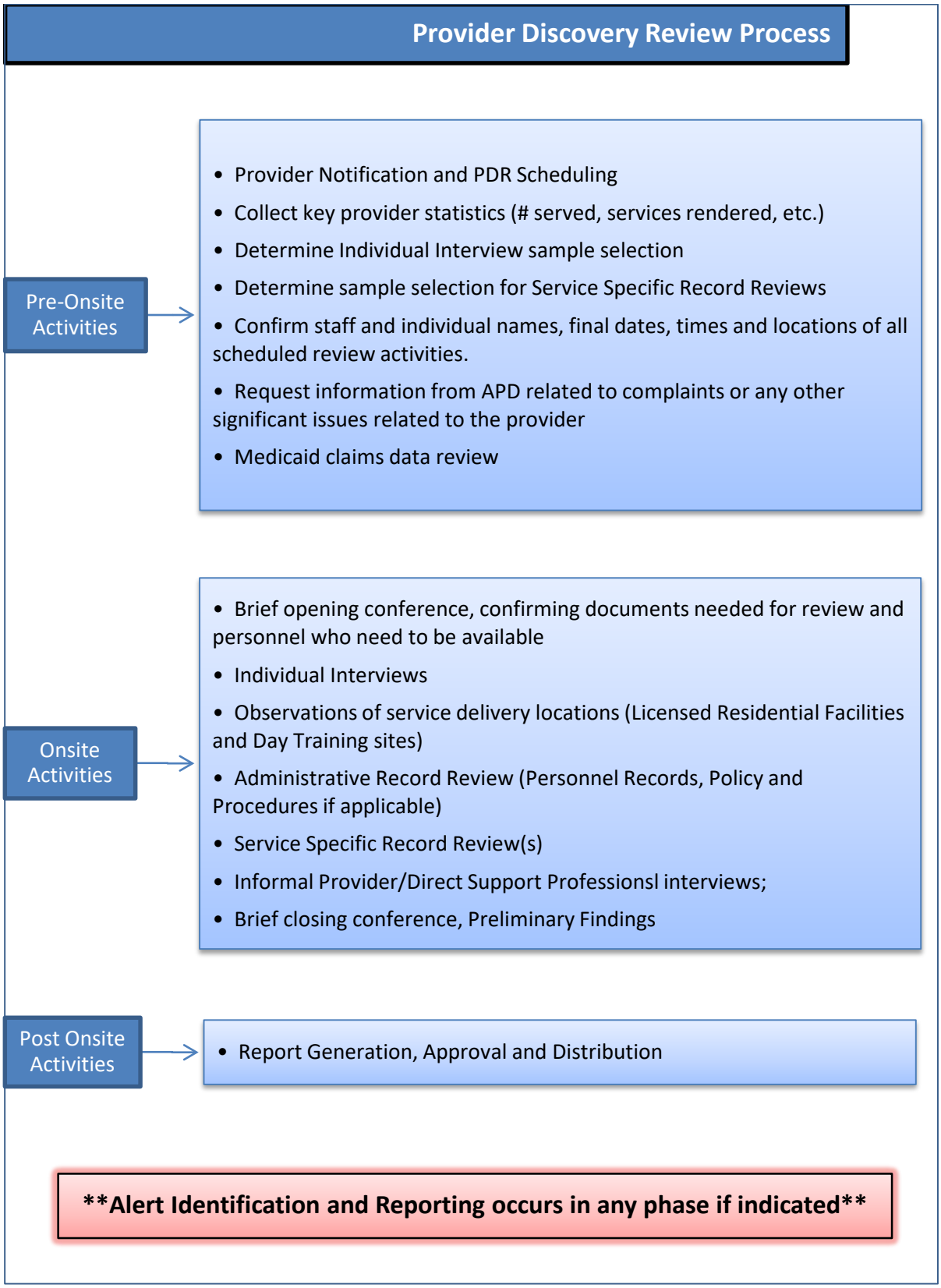
A provider becomes eligible for a PDR when services have been rendered and billed for at least 6 months for one or more of the following services:

- Behavior Analysis Services
- Behavior Assistant Services
- Residential Habilitation Standard
- Residential Habilitation Behavior Focus
- Residential Habilitation Intensive Behavior
- Residential Habilitation Enhanced Intensive Behavior
- Life Skills Development 1 (Companion)
- Life Skills Development 2 (Supported Employment)
- Life Skills Development 3 (Adult Day Training)
- Personal Supports
- Respite Care (under 21)
- Supported Living Coaching Services
- Specialized Medical Home Care
- Waiver Support Coordination/CDC+ Consultant

At the time of the PDR, **all** services provided within the previous 12-month review period will be included in the review. A PDR is conducted for each APD Region.

Procedures and Methods for Reviews

The PDR process is comprised of several activities including pre-onsite, onsite and post-onsite activities, all of which are completed by QARs. The following table outlines each primary activity and related responsibilities:



Provider Notification and Scheduling

Prior to May 15th of each year Qlarant Regional Managers develop annual PDR and PCR schedules for the following contract year, identifying the quarter a provider will receive an onsite visit. All providers meeting eligibility criteria will receive an onsite visit unless otherwise requested by APD and AHCA.

On a quarterly basis, Qlarant ensures providers scheduled for a PDR in the coming quarter receive a notification letter informing them they will be receiving a review within the next 90 days. Additionally this letter informs the provider that a QAR will contact the provider up to 30 days prior to the date of the review. Up to 30 days prior to the review the QAR contacts the provider by phone and sets a firm date(s) for the review. The QAR will also direct the provider to the FSQAP website location to access this Operational Policies and Procedures manual and the current Discovery Review tools. Providers who do not have internet access are directed to contact our CSR. The relevant sections of the manual and Discovery Review tools will be mailed to providers at their request. The QAR documents all calls/contact efforts to the provider in a contact log.

Collect key provider statistics (# served, services rendered, etc.)

During this initial phone call the QAR introduces themselves and explains the purpose of the call. The QAR describes the process to the provider, including the provider's role in scheduling interviews with persons served, and takes the opportunity to answer any questions the provider may have. The following is information that will be requested and discussion topics the QAR will cover during the initial contact with the provider:

- Does the provider operate in any other APD Regions(s)?
- What services are provided?
- Is the provider an agency or solo provider?
- If the provider is billing the agency rate for services rendered, inform the provider payroll documentation covering the previous twelve months must be available on the day of the review.
- When applicable how many Licensed Residential Facilities and/or Day Program locations does provider have?
- Request a list of persons served by service
- Request a list of DSPs by service (including date of hire)
- Inform provider information will be used to determine Individual Interview and record review selections

- Select a PDR review date within the next 30 days
- Explain a person may decline to participate in a PDR Individual Interview; another name will be randomly selected.
- Discuss provider role and responsibility with scheduling interviews.
- Explain number of persons randomly selected to be interviewed is based on number of people served and number of services rendered.
- Explain informal interview process for provider/ Direct Support Professionals (DSPs)
- Confirm primary provider contact information, address, and ensure the provider has QAR contact information
- Inform provider there will be a short opening and closing meeting component to the PDR process
- Provide the https://florida.qlarant.com web address and refer the provider to this Operational Policies and Procedure Manual and the Discovery Review tools on the website
- Answer any additional provider questions

Subsequent QAR calls to the provider will be made in order to:

- Provide names of persons sampled to be interviewed
- Enlist provider assistance with scheduling interviews
- Reiterate to the provider the person may decline to participate in a PDR interview. If this happens another name will be randomly selected.
- Finalize and confirm Interview times with people, dates and locations
- When applicable confirm addresses, dates and times for Day Training and/or Licensed Residential Facility observations
- Confirm PDR review date, location and time to include Administrative, personnel and Service Specific Record Reviews

This information also allows for planning on the part of the provider to ensure DSP availability during the review timeframes, including agencies making other personnel available to assist in the review process if the administrator/owner is not available.

Individual Interview sample selection

The PDR includes Face-to-Face interviews with people receiving services to capture the person's perspective regarding the effectiveness of supports and services in meeting stated goals and needs. In keeping with the expectations of CMS, interviews with people are designed to assess the efficiency and quality of supports, services, planning and delivery—the support delivery system—from the person's perspective. The number of people sampled per provider is based on

the number of people served by the provider and the number of services the provider renders. Using a combination of names of people served and services provided gathered from the provider along with claims data the QAR will randomly select the names. See "PDR Individual Interview Sample Matrix" below. If necessary, when a person's communication style limits information the QAR can gather from the person, proxies may be used to gather necessary information. If proxies are used, the use of a proxy will be captured in the web based application for purposes of data analysis.

PDR Individual Interview Sample Matrix	
Individuals Served Per Provider	**Number Individuals Sampled**
1 - 29	At least 1 per eligible service, minimum of 1 per provider
30 - 59	At least 1 per eligible service, minimum of 2 per provider
60 - 99	At least 1 per eligible service, minimum of 3 per provider
100 +	At least 1 per eligible service, minimum of 5 per provider

Individual record review sample selection

Based upon claims data, individual records are selected to ensure all eligible services rendered in the previous 12 months are represented in the sample. The person's records are chosen from the eligible services and the sample size is based on the total number of people receiving eligible services and the total number of people served by the provider. People that are sampled to be interviewed will have a full file review. A person receiving more than one service counts for those services. Additional records will be reviewed as needed to cover all services and meet the unannounced record requirement. The matrix below describes sample selection for PDR individual record reviews.

PDR Individual Record Review Sample Matrix		
Individuals Served Per Provider	**Individuals Full Records**	**Unannounced Service Records**
1 - 29	At least 1 per eligible service, minimum of 2 per provider	1
30 - 99	At least 1 per eligible service, a minimum of 3 per provider	2
100 - 199	At least 1 per eligible service, a minimum of 5 per provider	3

200 +	At least 1 per eligible service, a minimum of 7 per provider	4

The matrices above do not apply to WSCs. Each WSC will have two people sampled from their caseload to be interviewed unless the WSC/Agency has been approved for a modified deemed status. The WSC is informally interviewed related to each of the two people sampled. A third unannounced record will be selected once onsite.

For WSCs, two record reviews will be completed as part of the PCR process. The WSC knows in advance the names of the people receiving a PCR and which records need to be provided. Therefore in addition, at least one other record per WSC is randomly selected for an "unannounced" record review, with up to a total of three record reviews per WSC (treating provider) reviewed as part of the PDR. For example, WSC agencies with five treating providers have a total of 15 record reviews completed as part of the PDR, with at least five unannounced. A solo WSC has at least three individual records reviewed, with at least one unannounced.

Note: there are circumstances in which a WSC could be pulled into more than 2 PCRs. Examples of these circumstances include:

* WSCs working for large agencies where caseloads shift around could result in one WSC serving more than 2 people who are in the original PCR sample.
* Individuals changing WSCs due to personal choice, or a WSC discontinuing services results in a WSC who has already been drawn into 2 PCRs now serving another person in the PCR sample.

A stratified random sample of people is included in the record review component of the PDR.

Request information from the Agency for Persons with Disabilities related to complaints or any other significant issues about the provider

Current PDR and PCR schedules are sent to each APD Region on a weekly basis. Specific APD Regional staff has access to current schedules via the FSQAP Reporting System for authorized viewers. This serves as formal notification and request for information pertaining to complaints or grievances against the provider. This information is discussed with the provider during the onsite review to determine how the provider has addressed any complaints and grievances.

Medicaid Claims Data Review

QARs access and review Medicaid claims data prior to the review to confirm services rendered by the provider and to assist in selecting the sample of s for record reviews.

Opening conference, confirming documents needed for review and personnel who need to be available

Once onsite, the QAR will conduct a brief opening conference with the provider. The purpose of the opening conference is to establish the framework for the PDR process and outline expectations for both Qlarant and the provider. This initial meeting includes introductions and an opportunity to confirm:

- The name of the primary contact identified by the provider for all aspects of the PDR process and other personnel who need to be available
- PDR Individual Interview schedules including names, addresses, times, locations, contact numbers
- Lists of all DSPs rendering services eligible for review
- Documents needed for review

Individual Interviews (Provider Discovery Review)

A PDR Interview Tool is used to gather information as part of Face-to-Face interviews with people receiving services. The purpose of this interview is to gather information specific to the person's desired goals, outcomes and satisfaction with services from the person's perspective.

The interviews also help the QAR determine whether services are effectively implemented in accordance with the person's unique needs, expressed preferences and decisions concerning his/her life.

If family members or others close to the person are present during the Individual Interview, the QAR, with the permission of the person, may gather additional information related to service delivery and satisfaction. This information may be needed to corroborate information if there are significant gaps in information provided by the person.

The Interview will cover six key tenets:

- Choice and self-direction, rights, satisfaction, stability, future, and safety. The domains include My service life, My home life, My work/day activity life, My social life, My health, and My safety.

Quality tenets reviewed and questions asked will be driven by the specific service(s) the provider renders to the person being interviewed. For example questions related to where a person lives will vary based on the role of the provider in the living situation. Additional detail outlining what questions will be asked based on service(s) rendered is written into the header of each Quality domain within the tool.

Informal Provider/Direct Support Professional Interviews

The QAR will informally speak with the provider/DSP regarding person centered planning and to follow up on specifics from Individual Interviews, observations, or record reviews.

Observation of Licensed Residential Facilities and Day Training Service Locations

Observations are conducted by the QAR at Licensed Residential and Day Training service locations. The focus of these observations is used to make determinations in the following key areas:

- Autonomy and Independence
- Community Opportunity
- Privacy Dignity and Respect
- Physical Environment
- Medication Management
- Restrictive Interventions
- Abuse, Neglect and Exploitation

During the observation component of the PDR, people who agree to participate are informally engaged in conversation to determine how supports and services are being provided and to determine their level of satisfaction with where they live or where they spend their day and the service provider. Provider/DSP on the premises are also included in conversations related to any of the key focus areas.

An Observation Review Checklist is used as a guide and reporting mechanism for the QAR to document any findings. Observations may be announced or unannounced and occur at all day program facilities and up to a maximum of 10 licensed residential facilities per provider. All licensed residential facilities receiving funding for any level of Residential Habilitation and all onsite day training programs receiving funding for Life Skills Development 3 are required to have onsite observations as part of the annual PDR. Observations can occur anytime during the year prior to the annual PDR as either announced or unannounced. Sometimes the observation may be done

when a person chooses to be interviewed at their home. Any facility observation conducted prior to the annual PDR will count in that year and will not need to be done again during the formal scheduled review. However, if the provider has more than 10 licensed residential facilities, a maximum of 10 sites are observed per contract year (July – June). The homes not seen in one year are slotted to participate in an observation the next year until all facilities have been reviewed. Observations are conducted annually at all Day Training Program facilities

The numbers of Licensed Residential Facility locations are selected as follows:

Number of Licensed Residential Facilities	Number of Licensed Residential Facilities receiving an Observation
1 to 10	1 per home
11 or more	A maximum of 10 different homes

Administrative Review

Policy, Procedure and General Practice

Policies and procedures are the foundation of any organization. They are what guide and govern the systems and practices used by a provider organization to render services. If these policies are not in alignment with the expectations of the HCBS Focus Areas, then the provider is not providing services according to CMS standards or the iBudget Handbook. Therefore, the policies and procedures identified in the Discovery Tool to be reviewed as part of the administrative review are reflective of the CMS Focus Areas and are reviewed as applicable.

This section of the Discovery Process is the first phase of learning about how a provider renders services. Policies and procedures are key to begin to understand what the quality of the provider's services may look like. They are reviewed to ensure they meet the required standards. This includes a review of other pertinent documentation including but not limited to incident reporting, follow-up and tracking and grievances.

Solo providers are not required to have formal policies and procedures at this time; however they are expected to make available all incident reports, related follow-up, grievances, etc. at the time of the review. The PDR Administrative review is an opportunity for the provider, whether agency

or solo, to discuss or demonstrate any processes and procedures and their overall approach to service delivery.

All training requirements for all provider types and services are included as part of the administrative review. These requirements include background screening and employee qualifications and training as required in the iBudget handbook.

A sample of DSP records are selected based upon the number of services the provider renders. At least one DSP record is selected per service provided, to include a minimum of three DSP records, where available. For WSC agencies, a maximum of three treating provider records are reviewed.

PDR DSP Record Sample
Minimum of 3 per provider, at least 1 per eligible service

Service Specific Record Reviews

The Discovery Tool component used to collect data for individual record reviews during the PCR is also used for record review during the PDR, and determines compliance and accountability with relevant iBudget Handbook standards.

For support coordination, additional requirements such as caseload size, WSC referrals, and provider changes are included. Data captured provides a means to objectively measure the majority of the focus areas of the HCBS Quality Framework and compliance with iBudget Handbook requirements, to include but not be limited to:

- Information to support choice of community based services and supports in communities;
- Person centered service planning and delivery and effective deployment of the Support Plan;
- Provider capacity and capabilities including provider training and qualifications;
- Participant safeguards to include health, safety and well-being, and freedom from abuse, neglect and exploitation;
- Education on rights and responsibilities, and opportunities for exercising rights;
- Satisfaction with services and achievement of outcomes;
- System support as evidenced by provider collaboration;
- Appropriate billing practices as evidenced by Medicaid claims; and
- Required documentation.

Documentation for services rendered by the provider is reviewed for the 12-month period prior to the review. Medicaid claims data for the same 12-month period are compared to the provider's documentation for evidence of appropriate billing, and for identification of any potential billing discrepancies. At a minimum documentation review includes a review of Support Plans, Implementation Plans, Behavior Plans, Service Authorizations, Agency Approved Assessment, Progress Notes, Service Logs, and other required documentation as specified per service. Documentation is used to determine the provider's compliance with requirements per the iBudget Handbook, State and Federal rules, and to make the determinations identified below.

Provider Discovery Reviews for CDC+ Representatives

The CDC+ Representative PDR may or may not occur in conjunction with a PCR. The CDC+ Representative is required to participate in the PDR even when the CDC+ Participant declines participation in the PCR process.

- A Person/CDC+ Representative record review can include but is not limited to a review of:
    - Employee background screenings
    - Monthly spending procedures and corrective actions if applicable
    - Current Employee job descriptions

The Confirmation letter mailed to CDC+ participants scheduled for a PCR includes information regarding the Record Review of the Participant/CDC+ Representatives files and a list of documents to be available for review such as the Purchasing Plan, time sheets, invoices, Directly Hired Employee and Vendor files.

Alert Reporting

If at any point during the Discovery Process the QAR uncovers any indication of abuse, neglect, exploitation or has any concerns related to medical, behavioral, rights, health, safety, and/or mistreatment the appropriate entity is contacted – the abuse registry if needed – and the Regional APD office is notified by telephone immediately. Every effort is made to safeguard the person should such a situation arise. An Alert Notification showing the details of the alert is provided to AHCA, APD State Office and Regional APD within two business days of the incident. Qlarant QAR Regional Managers take the lead on reporting alerts.

Closing Conference, Preliminary Findings

At the conclusion of the PDR the QAR meets briefly with the provider and/or personnel identified by the administrator/owner to provide a brief overview of the findings associated with the PDR.

The provider is given a Preliminary Findings worksheet, for each SSRR and the Administrative component, which enables the provider to address areas requiring improvement in preparation for remediation activities with APD and to confirm SSRR standards cited by the reviewer. The Preliminary Findings worksheet identifies SSRR service standards reviewed at the time of the onsite visit including the identification of potential billing discrepancy items and alerts that are scored Not Met. It is important to note this information should not come as a surprise to the provider due to interactive sharing and feedback provided throughout the PDR. Both the QAR and the provider sign the Preliminary Findings worksheet and a copy is given to the provider to help ensure all participants have a clear understanding of review findings. If the provider declines to sign the preliminary findings worksheet, the QAR documents this on the worksheet.

Report Development and Distribution

PDR Reports are available within 45 days of the completion of the reviews via the FSQAP Reporting System for authorized viewers. Hard copies are mailed to providers.

The report presents findings of each component of the PDR, including the individual record review results, observations and the administrative records including policy and procedures (if applicable) and training and qualifications of DSPs.

Other Reporting Activities

Data are captured to facilitate reporting on information specifically identified by the state in order to aid in its efforts toward remediation and improvement. Data from the PDR are collected using the Met/Not Met format based on the review procedures described above. Most standards result in a numeric point score, although some standards may be weighted due to their importance. All PDR reports include “How my score is calculated” table at the end of the report to assist providers with understanding their score.

Request for Reconsideration Review Procedures

The Reconsideration Review is the process a provider utilizes to request a change in scoring on the Provider Discovery Review (PDR). An example of when a provider may request a Reconsideration Review is when the provider believes required documentation presented to the reviewer during the review met requirements, but the final report showed the standard identified as "Not Met".

Reconsideration Review Requests are only applicable to standards of performance related to noted potential billing discrepancies. These standards are identified on the Provider Discovery Review report under the heading **Potential Billing Discrepancies.** Additional clarification is under two other headings following results of each individual record review: **Detailed Issues from Record Reviews by Service and Individual** and **Billing Discrepancy Detail**.

* **Important Note:** Documentation not made available at the time of the initial review will not be accepted for a Reconsideration Review. All documents pertinent to the reconsideration request must be sent at the same time. Only one request for reconsideration per PDR will be processed.

If you disagree with the findings related to noted potential billing discrepancies in your Provider Discovery Review (PDR) report, you may request a Reconsideration Review. The Reconsideration Review Request must be made in writing and received within 30 days of the annual PDR report mailing date. If the request is not submitted in the 30 days, it will not be accepted and the request will be deemed ineligible. You have the option of submitting the Reconsideration Review Request by hand delivery, mail or by fax to the Tampa or Tallahassee address/Right Fax number located below. Upon receipt, your Reconsideration Review Request will be entered into a tracking system to ensure Qlarant completes the Reconsideration Review Report within 30 days of receipt of your request.

To submit a Reconsideration Review Request you must fill out the Reconsideration Review Request form located on our website at www.florida.qlarant.com under Provider Resources> FSQAP Discovery Review Tools.

Please carefully follow the procedures outlined below when requesting a Reconsideration Review. All fields must be completed to be eligible for Reconsideration:

- Provider Number

- Provider Name
- Provider Street Address/City/State/Zip
- APD Region
- Provider Location (if applicable)
- Provider Discovery Review date
- Qlarant Reviewer Name
- Billing discrepancy Standards (list service and standard number- example: Respite # 5) for which Reconsideration is requested. List service and standard # on each page submitted.
- Documentation to support Reconsideration (each document submitted must state which service and standard it applies to).
- Name of Person to Contact/Phone number

The completed Reconsideration Review Request form along with documentation to support the Reconsideration Request may be hand delivered, mailed or faxed to either the Tampa or Tallahassee office.

A review of the Reconsideration Request will be processed and a report generated within 30 days. If you do not receive your Reconsideration Review Report shortly after the 30 days, please contact our Customer Service Representative at 1-866-254-2075.

Final Note: Reconsideration Review Request submissions should only include documentation related to the request. Please forward other documents related to APD remediation plans,

corrective action plans or corrected documentation to your Regional APD office if and when requested.

Tampa Office
14025 Riveredge Dr.
Suite 150
Tampa, FL 33637
(866) 254-2075
(888) 877-5993 Fax

Tallahassee Office
2039 Centre Pointe Blvd.
Suite 202
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