ILLINOIS
MENTAL HEALTH COLLABORATIVE
FOR ACCESS AND CHOICE

External Protocols for
FY15 Provider Monitoring
Quarter 3 and 4

Scheduling of Reviews

During FY15, all DHS/DMH contracted providers will receive a Post-Payment Review (PPR) and a Clinical Practice and Guidance (CPG) review. Providers that have Community Support Team (CST) and Assertive Community Treatment (ACT) teams will also receive a fidelity review. Each type of review is a separate review with separate reports and scores. Provider monitoring reviews will not be coordinated with Bureau of Accreditation, Licensure and Certification (BALC) certification reviews. The Collaborative Director of Quality Management is responsible for developing the confidential review schedule which is distributed to DHS/DMH staff and Collaborative staff by the Collaborative Training Coordinator.

The review schedule is very tight and it is not possible to change scheduled review dates, with the only exception being an emergency or unusual situation. Providers may contact the Collaborative Director of Quality Management to discuss the situation. If something comes up after the review has been scheduled that would significantly affect the ability to conduct the review, the Collaborative Quality Management Director, must be notified. It will be this person's responsibility to make the final decision as to whether or not the scheduled review dates will be changed and to notify the Regional Liaison Supervisor, the assigned Regional Liaisons, the DHS/DMH Contract Manager and Management Operations Analyst if a change occurs.

Provider Notification

All reviews will continue to be announced. A claim run will be collected and organized prior to PPR's, for use by the review team. Providers will be notified one week prior to an impending review by the Collaborative Training Coordinator. Information pertaining to the upcoming review will be related verbally at this time. The Collaborative Training Coordinator will gather information about the provider for the Regional Liaisons and answer provider questions. Following the phone contact, providers will receive a secure email from the Collaborative Training Coordinator containing a list of consumer names and associated RINs for the records to be reviewed.

For providers receiving fidelity reviews of multiple teams, it is necessary for the Collaborative to obtain reports of all fidelity teams in order to randomly select which teams and which consumers on the randomly selected teams will receive a fidelity review. These providers will be contacted

in advance the fidelity review in order to obtain the rosters. This will be a separate contact and not a part of the provider notification calls.

Provider Monitoring Tools

Provider monitoring tools and ancillary documents are located on the IL Mental Health Collaborative for Access and Choice website. The link to this website is: www.illinoismentalhealthcollaborative.com (then "Provider Information", then "FY15 Provider Monitoring Tools").

A. Post-Payment Review (PPR) Tool:
Provider clinical documentation for a sample of claims approved for payment is reviewed according to a set tool. This tool covers aspects of compliance with 59 Ill. Adm. Code 132.

B. Medicaid CPG Tool:
The purpose of this tool is to measure adherence to clinical standards and assess quality indicators through the provider agency's clinical documentation and practices. This includes a determination of clear and consistent inter-connection among the diagnosis, assessed needs, ITP provisions, and actual services and interventions delivered.

C. Non-Medicaid CPG Tool:
The purpose of this review is to assess two aspects of services to non-Medicaid eligible individuals. DHS/DMH reimburses a limited range of services for non-Medicaid individuals. These items do not create the expectation that providers must provide services that are not reimbursed. The intention of these items is to give feedback and to recognize best practices to share across providers.

D. ACT Fidelity Tool:
The purpose of this tool is to measure a provider's delivery of Assertive Community Treatment services according to the fidelity model. The tool is based on the Dartmouth Assertive Community Treatment Scale (DACTS) developed by Teague, Bond, and Drake (1998). Providers are assessed through interviews, data runs, and documentation reviews.

E. CST Fidelity Tool:
The purpose of this tool is to measure a provider's delivery of Community Support Team services according to the definition and intent of the service.

Sampling Methodology and Claim Review Period

A. Post Payment Review

In order to establish a sampling methodology for PPR for FY15, the Collaborative was given the following guidelines from DHS/DMH:

- The sampling methodology selected must be reflective of the volume of claims each provider has submitted during the specific identified claim period rather than a flat number of claims per provider.
- The claim period will vary from provider to provider, but will begin 12 months prior to the date the claim run is developed and ends with the date the claim run is developed For providers who received a PPR in FY14, the claim period will begin 9-12 months from the last review. The claim run will only include processed and approved claims.
- The sampling methodology must be statistically sound such that findings can be used for recovery and potential extrapolation.
- HHS OIG RAT-STATS, 2007, version 2 Software will be the chosen sampling tool.

Based upon this request, the Illinois Mental Health Collaborative for Access and Choice will provide sample size calculations that are statistically valid for the defined confidence level and margin of error. The Collaborative will utilize the following sampling methodology for FY15:

1. The claim period will vary from provider to provider, but will begin 12 months prior to the date the claim run is developed and ends with the date the claim run is developed. In the event that the provider received a PPR in FY14, the review will be scheduled to occur at least 9-12 months from the date of the last review in order to ensure the largest claim sample possible.

2. A statistically sound random sample of all adjudicated claims per specified provider will be selected for post-payment review using the sample calculator within HHS OIG RAT-STATS, 2007 version 2 Software to reach a 90% confidence level with a 16% desired precision range (margin of error +/- 8%).

    a. To guarantee the 16% desired precision range, an anticipated rate of occurrence of 50% will be used when calculating the number of claims to be reviewed per provider.

    b. The number of claims each provider submitted during the provider's identified unique claim period (universe size) will be determined using ValueOptions' IntelligenceConnect reporting system.

c. Once the sample size has been determined using HHS OIG RAT-STATS, 2007, version 2 Software, a provider specific claim run will be developed using the ValueOptions© IntelligenceConnect reporting application.

d. Claim runs will be developed for each provider approximately two (2) weeks prior to the scheduled review by the Collaborative Training Coordinator.

B. Clinical Practice and Guidance (CPG) Sampling

All DHS/DMH identified contracted providers will receive a CPG review during FY15. For each review, ten Medicaid records and two non-Medicaid records will be randomly selected from the overall PPR claim run using the statistical tool, Random.org.

C. Fidelity Review (ACT/CST) Sampling

The Collaborative runs the CST and ACT Active Authorizations Review Reports within the ValueOptions IntelligenceConnect application. These reports pull twenty active CST or ACT authorizations, for each team being reviewed from the time frame indicated. The first ten records listed on this report will be reviewed. The remaining records are included in this report as alternate records, to be used in the event that a record selected does not contain complete information.

- Development of ACT/CST Review Lists for Providers with **Multiple Teams**

  In order to maintain random sampling for providers with multiple teams, the provider will send team rosters (consumer name and RIN) to the Collaborative Training Coordinator as requested.

  - For Providers with More than Three Teams

    When the Collaborative receives the team rosters, the Collaborative Director of Quality Management will 1) randomly select teams to be reviewed using Random.org and 2) randomly select consumer records for review, by team, using IntelligenceConnect.

  - For Providers with Two or Three Teams

    When the Collaborative receives the team rosters, the Collaborative Director of Quality Management will use the information on the rosters to randomly select the consumer records to be reviewed, by team, using IntelligencConnect.

Policy Pertaining to Conflict of Interest

The Collaborative has a Conflict of Interest policy in place which prevents Collaborative staff from participating in the monitoring of providers for which the staff person has other vested interests or potential conflicts with the provider.

The Collaborative Regional Liaison Supervisor maintains an updated list of providers who would pose a conflict of interest situation for specific Collaborative staff. The Director of Quality Management is responsible for ensuring compliance with this policy, making any adjustments to it and is the final authority in determining whether or not a conflict of interest exists.

Policy Pertaining to Handling Problem Situations While at the Provider Site

In the event that a Regional Liaison encounters a problem situation while at the provider site, he/she will be instructed to contact the Collaborative Regional Liaison Supervisor who will also notify DHS/DMH and the Collaborative Director of Quality Management.

Reviewers' Guidelines While On-site

Reviewers will:

1. Arrange (lead will facilitate) a meeting place and time with other team members and enter the provider site together as a group. Additional reviewers may be required for providers with multiple ACT/CST's. Regional Liaisons may be at different sites during the review, depending upon the locations of the teams. This will be coordinated by the Training Coordinator prior to the review.

2. Carry identification at all times.

3. Maintain the confidentiality of all consumer health care information and provider records, including not leaving consumer or provider records unattended, and ensuring and documenting the return of all records to the provider prior to departure.

4. Document all data on Collaborative forms and/or database.

5. Ensure that handwriting is legible and written in ink when data documentation is done manually.

6. Regional Liaisons document findings on worksheets that are generated through the FY15 Provider Monitoring Access Database. The Regional Liaison Supervisor is responsible for performing a quality check on these worksheets prior to the review. For PPR, there is one worksheet per claim/record being reviewed. Regional Liaisons will

record findings on every item on each worksheet (no items are to be left blank). If the item is substantiated, Regional Liaisons will write a "+" in the findings column for the item. If the item is unsubstantiated, the Regional Liaison will place a checkmark in the findings column for the item with comments explaining why the item is unsubstantiated. Dates of the ITP and MHA that were reviewed specific to the claim will have the date of the LPHA signature recorded on the worksheet. Regional Liaisons are to designate whether the ITP and MHA were initial documents or update/reviews. Regional Liaisons are to note on the worksheet any addendums related to documents that were reviewed. CPG, ACT and CST worksheets and ACT/CST Interview Sheets are used to record information during those reviews.

7. Be responsible for ongoing quality assurance throughout the review, e.g. ensuring that data is being recorded on the most recent and correct document and that reports contain accurate information.

8. Report all mandated abuse and/or neglect allegations immediately to appropriate provider staff, which are then required to file a report with Office of Inspector General, the DCFS Hotline or Department of Aging in conjunction with the Regional Liaison. The Regional Liaison Supervisor needs to be contacted immediately, who will then immediately notify the DHS/DMH Central Office and the Director of Quality Management. If the provider refuses to file a report, the Regional Liaison is required to do so.

9. Immediately consult with the provider Executive Director or designee upon identification of any instance that poses an immediate risk to consumer safety or service delivery, including but not limited to: inadequate staff levels, closure of sites, safety concerns, or non-credentialed staff dispensing medications. Within four hours the Collaborative Regional Liaison Supervisor must be notified by the lead Regional Liaison, who will then contact DHS/DMH Central Office and the Director of Quality Management.

10. Turn cell phones to mute or vibrate throughout the course of the review. All necessary phone calls must be conducted in a private area away from the review area.

11. Present a professional appearance, attire, and demeanor.

12. Ensure that the least amount of disruption to the provider and the provider's services occurs throughout the course of the review.

Entrance Conference

Upon arrival at the site:

- The Lead Regional Liaison will identify him/herself to the provider receptionist and ask to speak with the provider contact person.
- The review team will conduct an Entrance Conference with the provider contact person, Program or Clinical Director, and other staff the provider deems important.
- During this conference the review team will utilize the designated Talking Points.

Final Day

The provider will be given, at minimum, two hours' notice in order to allow the provider time to notify staff and adjust schedules, if necessary. Review team members will take time prior to the Exit Conference to confer about the findings of the reviews. The lead Collaborative Regional Liaison will contact the provider's DHS/DMH Contract Manager to inform them of any identified issues/significant findings and to invite them to the Exit Conference.

The lead Collaborative Regional Liaison is responsible for entering data regarding the reviews, printing the reports and providing the DHS/DMH Contract Manager with a copy of the reports prior to the Exit Conference when possible, or upon availability of encrypted e-mail.

Fidelity reviews for providers with multiple ACT/CST's may occur at separate sites that are specific to each team. Once the fidelity reviews are done, all reviewers will meet up at the main location, to enter data and discuss outcomes prior to the exit conference. As the data is aggregated, there will be one report. Information from all records reviewed can be entered into the database (may be 20 or 30 consumer records instead of 10). When entering comments into the database, comments need to be separated out by team.

In the event that there are significant findings, the lead reviewer should brief the designated provider contact in advance of the Exit to ensure their understanding. Regional Liaisons will notify the provider contact of missing documents during the course of the review and ask him/her to locate them to ensure all needed documents were assessed during the review. It will be noted on the worksheet if the claim/record had missing documents that needed to be located and the name of the staff person involved in the discussion of missing records. In order to ensure that the review team can complete the assessment in a timely manner, the lead Regional Liaison will give the provider contact a final time that documents can be submitted before the exit conference. No documents will be allowed to be submitted to the review team following the specified time.

Exit Conference

At the time designated for the Exit Conference, the lead Regional Liaison will utilize the Exit Conference Talking Points.

- All review reports must be signed by the entire review team and the provider. The original signed reports will be returned to the Springfield Collaborative office by the lead Regional Liaison and placed in the provider file. The lead Regional Liaison will leave a copy of all reports with the provider.

- Explain to the provider that a copy of the reports will be forwarded to DHS/DMH for review and that the assigned DHS/DMH Contract Manager will be following up with the provider on any required Plans of Improvement. The Collaborative will maintain the confidentiality of the review contents.

- Return all provider materials and have the provider sign off that all provider records were returned to provider at the conclusion of the review.

- Distribute the Provider Monitoring Review Questionnaire and stamped envelope to the provider contact person. This is a survey where providers can give their feedback on the process. Envelopes will be addressed to DHS/DMH who will collect and analyze the data.

Transportation of Confidential Records

All Regional Liaisons must comply with the ValueOptions Policy: LC403 - Physical and Electronic Security of Personally Identifiable Information, revised 1/24/14.

PPR Formal Notification to Providers Scoring 50% and Above

Providers will continue to receive preliminary results at the Exit Conference. Providers scoring 50% and above will receive a letter entitled: *Notice of Unsubstantiated Billing* within 30 days following the PPR. The Collaborative writes and sends this Notice to providers as an administrative support function for DHS/DMH.

PPR Follow-Up with Providers Scoring 50% and Above

Providers are required to submit a PPR Plan of Improvement to their DHS/DMH Contract Manager within 30 days of the PPR if established thresholds are not met for each of the eleven items of the PPR Tool. Thresholds for items 1, 5, and 6 are set at 90%. Thresholds for items 2 – 4 and 7-11 are set at 80%. In addition to thresholds for specific PPR Tool items, a threshold of 70% has been established for the total PPR substantiated score. There are no thresholds set for Quality Indicators A and B. Even though the Quality Indicators do not have established thresholds, the DHS/DMH

Contract Manager may request information pertaining to the steps the provider has taken to improve these areas.

The purpose of the Plan of Improvement is to document the steps the provider has taken to correct all issues identified during the recent post-payment review that resulted in scores below threshold. The DHS/DMH Contract Manager is responsible for approving and monitoring compliance of the Plans of Improvement. Additional follow up including a return review may be enacted if a provider has a significantly low overall score. Providers are asked to send a courtesy copy of the Plan of Improvement to the Collaborative. Providers have the option of using their own format for the POI report including all of the specified elements or using the DHS/DMH template.

PPR Formal Notification to Providers Scoring Below 50%

1. DHS/DMH sends the provider a *Notice of Unsubstantiated Billings/Notice of Suspension from Billing* within 30 days of the PPR. This Notice relates information regarding findings, voiding unsubstantiated claims, how to file an appeal, steps needed to be lifted from suspension, required timelines and whether the follow-up review will take place by desk audit or return visit. If the provider is also a DCFS certified provider, this *Notice* is also sent to DCFS.

2. Provider immediately stops billing upon receipt of the *Notice*.

3. Provider submits a Plan of Improvement (POI) to the DHS/DMH Regional Contract Manager within 30 days of the *Notice of Suspension from Billing*. This Plan needs to address all areas that were below threshold on the PPR. In addition, the POI must include a plan for addressing overall issues that resulted in the provider receiving a score below 70%.

4. The DHS/DMH Regional Contract Manager reviews the POI and either approves it as submitted or works with the provider until it is approved. It is his/her responsibility to monitor compliance and progress of the POI.

5. After the Contract Manager has approved the POI, and the provider believes that they have implemented the POI sufficiently for the follow-up review, **the provider must notify** the Collaborative in writing that they are ready for the follow-up review as specified in 59 Ill. Adm. Code 132.42 f) 3).

Desk Audit as Follow-up Review

1. The *Notice of Suspension from Billing* letter specified that the follow-up review will be a desk audit and states that the provider must submit the following items:
   - Written notification that they are ready for the follow-up review.
   - Documents that demonstrate that corrections have been made to address the items that scored below the established threshold during the recent PPR. Sample documents that can be submitted to verify that corrections have been made include, but are not limited to: staff training rosters and training agendas, examples of compliant progress notes, treatment plans and reviews, and mental health assessments dated after implementation of improvement steps, etc. Clinical records need to be actual documents, not blank templates.

2. Provider submits required documents and notification to the Collaborative.

3. Documentation is reviewed by DHS/DMH Central Office and the Collaborative Quality Management department.

4. When DHS/DMH has determined that the provider **has made corrections** and suspension can be lifted, the provider is sent a *Suspension Determination Notice* by DHS/DMH. This *Notice* will inform the provider of the findings of the second review, final determination and appeal process. A copy of this letter is also sent to DCFS (if applicable) and HFS. The provider may submit bills for services provided during the suspension if documentation for those services was compliant with 59 Ill. Adm. Code 132. Clinical records may not be altered.

5. If it is determined that the **provider has not made sufficient corrections** to have the suspension lifted, DHS/DMH Regional and Central Office staff and the Collaborative Quality Management staff will meet to discuss concerns and next steps.

   - A teleconference will occur with the provider to discuss concerns and provide technical assistance regarding documentation and 59 Ill. Adm. Code 132 compliance.

   - If, after this meeting with the provider, it is determined that corrections have not been made so that the suspension can be lifted, the provider is sent a *Suspension Determination Notice* by DHS/DMH. This *Notice* will inform the provider of the findings of the second review, final determination and appeal process. A copy of this letter is also sent to BALC, DCFS (if applicable) and HFS.

Return Visit as Follow-up Review

1. The Collaborative Training Coordinator notifies the provider of the date for a return visit and provides information about the visit. This visit is a focused visit, focusing on the PPR Tool items that did not meet established thresholds. It is not a second PPR.

2. Provider will pull ten clinical records that contain documentation verifying that corrections have been made. Other provider records can also be provided during the review, such as staff training records, that demonstrate the steps taken to meet compliance.

3. Entrance and Exit Conferences will occur during the follow-up review. During the Exit Conference, the Collaborative will not leave a written report with the provider, but will give a verbal report of findings.

4. The Collaborative submits a written report of findings to DHS/DMH Central Office. This is a narrative report, different than PPR reports left during the PPR.

5. DHS/DMH and the Collaborative meet and discuss findings.

6. When DHS/DMH has determined that the provider **has made corrections** and suspension can be lifted, the provider is sent a *Suspension Determination Notice* by DHS/DMH. This *Notice* will inform the provider of the findings of the second review, final determination and appeal process. If the suspension is lifted the provider may submit bills for services provided during the suspension if documentation for those services was compliant with 59 Ill. Adm. Code 132. Clinical records may not be altered.

6. If it is determined that the **provider has not made sufficient corrections** to have the suspension lifted, DHS/DMH Regional and Central Office staff and the Collaborative Quality Management staff will meet to discuss concerns and next steps.

    - A teleconference will occur with the provider to discuss concerns and provide technical assistance regarding documentation and 59 Ill. Adm. Code 132 compliance.
    - If, after this meeting with the provider, it is determined that corrections have not been made so that the suspension can be lifted, the provider is sent a *Suspension Determination Notice* by DHS/DMH. This *Notice* will inform the provider of the findings of the second review, final determination and appeal process. A copy of this letter is also sent to BALC, DCFS (if applicable) and HFS.

    Note: Per 59 Ill. Adm. Code 132.42 (f) (6): "If corrections are not made within 60 days, the Certifying State Agency may suspend the Provider's certification".

    Note: Per 59 Ill. Adm. Code 132.47: "The Certifying State Agency may suspend certification during a certification period for any of the following reasons: b) A provider has less than 50% of its reviewed bills substantiated in a post-payment review and it has not made required corrections within 60 days pursuant to 59 Ill. Adm. Code 132.42 (f) (2)."

CPG, ACT and CST Follow-up

A formal Plan of Improvement is required to be submitted to the DHS/DMH Contract Manager within thirty (30) days from the date on the DHS/ DMH notification letter if established thresholds (scores of "4.0" for CPG and CST, a score of "5" for ACT) are not met for any items of the tools. The purpose of the Plan of Improvement is to document the steps the provider has taken to correct all issues identified during the recent review that resulted in a score below threshold. The DHS/DMH Contract Manager is responsible for approving and monitoring compliance of the Plans of Improvement. Providers must submit all Plans of Improvement to their DHS/DMH Contract Manager with only a courtesy copy going by mail to the Collaborative. Providers have the option of using their own format for the POI report including all of the specified elements or using the DHS/DMH format. DHS/DMH Regional staff may request a revised plan and will monitor progress.

Appeal Process

Providers have the right to appeal findings of the post-payment review. For additional information regarding what an appeal entails, please review 59 Ill. Admin. Code 132.44: Appeal of Post Payment Review Findings.

Appeal hearings are formal hearings conducted in Chicago by the Department of Healthcare and Family Services with attorney representation required. The sole issue at the hearing shall be whether the Provider is in compliance with requirements set forth in 59 IL Admin. Code 132.

If, after reviewing Part 132.44, the provider would like to proceed with a formal hearing, the provider must submit the written request to Collaborative Director of Quality Management within twenty (20) days after the receipt of the *Notice*. The appeal request shall specify the grounds for the appeal.

Upon receipt of an appeal request, the Collaborative Director of Quality Management will forward all documents related to the post-payment review and appeal request to the Illinois Department of Healthcare and Family Services Vendor Hearings Section within five days. A copy of the appeal packet is also sent to the DHS/DMH Medicaid Officer and Management Operations Analyst for review.

An Administrative Law Judge will conduct appeal hearings. If an appeal is filed, claims do not need to be voided until the Administrative Law Judge has made a final administrative decision. The provider will be required to void unsubstantiated claims if the final administrative decision concludes that the provider is not in compliance with 59 Ill. Admin. Code 132.