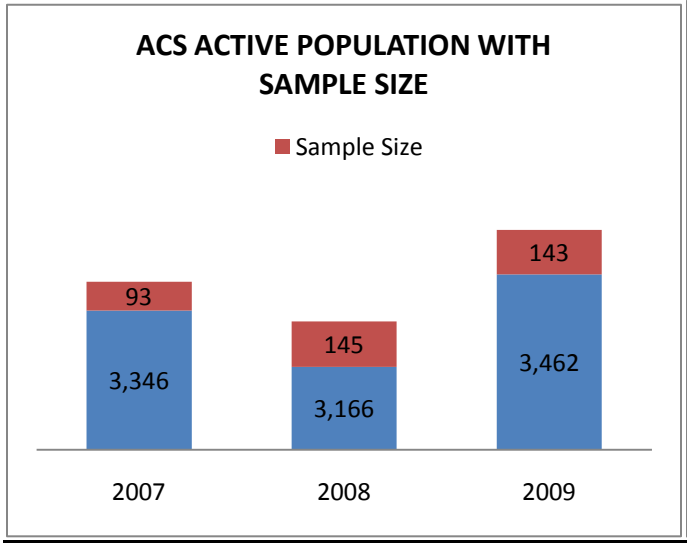
May 13, 2010

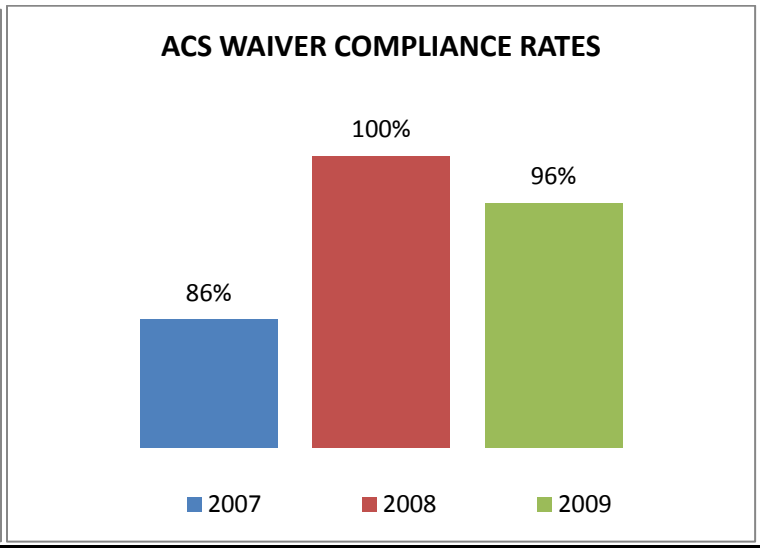
Alternative Community Services Waiver
Division of Medical Services Quality Assurance
2009 Annual Report

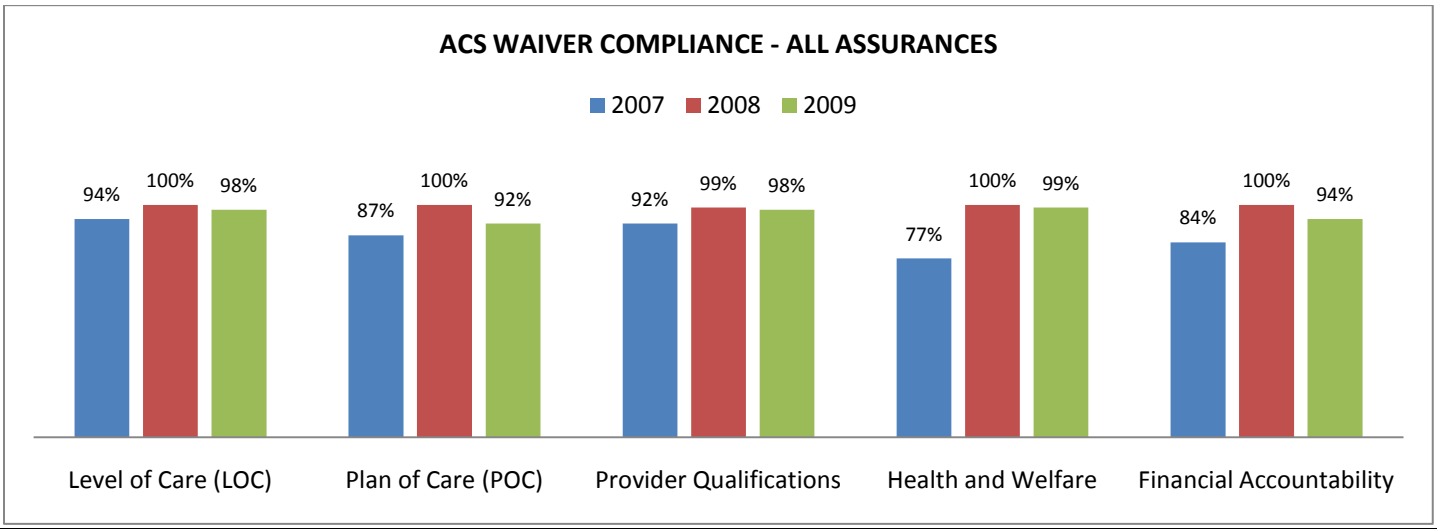
A systematic random sampling of the active case population was drawn. The population size is 3605 with a sample size of 143. For each assurance (level of care, plan of care, provider qualifications, health and welfare, financial accountability) several measures have been identified to determine if the operating agency is in compliance with the approved waiver document.

ASSURANCE	% COMPLIANCE**
Level of Care (LOC)	98%
Plan of Care (POC)	92%
Provider Qualifications	98%
Health and Welfare	99%
Financial Accountability	94%
For all assurances the Division of Developmental Disabilities (DDS) Alternative Community Services (ACS) Waiver was found to be 96% in compliance with all applicable rules, regulations, policies and procedures.	

****The percentages above represent chart reviews performed during the 2009 calendar year only and do not include the results from reviews performed for performance measures relating to the provider certification files, qualified providers (certified and enrolled with Medicaid), freedom of choice, plan of care, and identified reports that monitor other mandates, such as one/no service per month and hospitalizations. While corrective action may have been required of the operating agency to address findings during the 2009 reporting period, specifics will begin to be included in the 2010 quarterly reports and the results of these reviews will be incorporated into the 2010 annual reports.**







Glenda Higgs
Medical Assistance Manager

Rachael Fitzhugh
Waiver Quality Assurance Program Administrator

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Recommended Remediation:

Under utilization of prescribed services continues to be a concern for Division of Medical Services (DMS). It is understood that there are situations that are beyond the control of the provider when contemplating the budget and schedule for the upcoming year. DDS has done a good job of asking providers to explain the under utilization of services in the narrative portion of the plan of care. Generally, the provider's response regarding under utilization falls into one of a few categories – lack of available staff, family not comfortable with staff, and error on the part of the provider in billing. While the staffing issues cannot be controlled, the provider's ability to bill timely and correctly is something that can be monitored and improved upon.

There are several reoccurring concerns that are not part of the assurances but have caused errors to come to light during the reviews:

- There have been a number of errors in changing, cancelling, and issuing prior authorizations.
    - When a change occurs that results in issuing a new prior authorization, not only should the end date change, but the amount authorized should change to accurately reflect the amount of services allowed for that time period.
    - Requests to cancel prior authorizations should be handled timely in order to prevent billing errors.
    - There have been an increasing number of duplicate prior authorizations issued during the reviews this quarter. Extra care should be taken to ensure that only one prior authorization is issued so that billing errors, over billing, and the like do not occur.

Operating Agency's Remediation Plan:

DDS Response: Semi-annually DDS runs a Prior Authorization (PA) Report off Business Objects and looks at PA Utilization. The Manager reviews any underutilization and follows up with the providers regarding whether the services have been provided and are going to be billed. If a revision is submitted requesting to increase/decrease an existing service during the plan year, a utilization review is conducted on the service that is being changed. Also, DDS does quarterly review of reports from DMS showing persons with no services or only one service billed. When these reports are received, DDS staff research the data base and Medicaid Management Information System (MMIS) to see if issue has been resolved. If it has not, the Manager reviews and follows up with the providers to find out whether the approved services have been provided and are going to be billed. In addition to the above, the Specialist does a 100% utilization review of all approved services each year at the continued stay review. DDS does not have sufficient staffing to conduct any further utilization reviews.

DDS can notify all waiver providers of the need for proactive remediation as identified by DMS and advise providers that in the future, subsequent plan of care services will be reduced to the level of the prior plan of care services. Thus requiring that if there is a need for additional services, the provider will have to submit a revision after it is known that the approved service level will be insufficient and prior to the exhaustion of that year's approved service level. It is apparent that training and notification and requirements for justification are insufficient to eliminate this DMS concern and the impact of sanction in the form of following year reduction to the level of the prior year expenditures should serve as sufficient incentive to correct this problem. The only exception to this proactive stance is to be "Provider did not receive prior authorization for services". Specific to this "corrective action in the form of performance evaluation will be initiated".

The DMS Quality Assurance staff will be monitoring all corrective action plans, implementation of any required activities and reporting of findings that continue to require action by the operating agency.

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