

Delmarva Foundation
Florida Statewide Quality Assurance Program
Provider Performance Reviews
An Analysis of Desk Review Results
September 2001 – May 2004

Florida DD HCBS Waiver

Florida Statewide Quality Assurance Program Provider Performance Reviews

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Over 31,000 people in Florida with developmental disabilities¹ receive services and supports through the Department of Children and Families, Developmental Disabilities program.² Funding for over 24,000 of these individuals is provided through the Developmental Disabilities Home and Community Based Services (DD HCBS) Medicaid Waiver that is administered by the Florida Agency for Health Care Administration (AHCA). HCBS Waivers provide a mechanism to fund services and supports to eligible populations in community-based settings, as opposed to institutional programs such as Intermediate Care Facilities for the Developmentally Disabled (ICF/DD).

In September 2001, AHCA signed a contract with the Delmarva Foundation to provide a program of quality assurance for persons served through the DD HCBS Medicaid Waiver. As part of this quality assurance oversight, eligible providers under the DD HCBS Medicaid Waiver are subject to annual reviews to ensure compliance with the provisions of the DD HCBS Medicaid Waiver handbook. Provider Performance Reviews are conducted by the Florida Statewide Quality Assurance Program (FSQAP) of Delmarva in collaboration with Joint Commission Resources (JCR), a subsidiary of the Joint Commission on the Accreditation of Healthcare Organizations. Provider Performance Reviews are conducted either on-site or as desk reviews.

Through March 2004, over 5,200 Provider Performance Reviews for 3,342 unique providers of service through the DD HCBS Waiver program have been completed. Each provider, agency or solo entity, is monitored on any of the 30 different services they provide under the DD HCBS Waiver program. Six of these services have been targeted as “core” services and providers of core services are reviewed on-site. The remaining providers who only provide other services are monitored by a desk review. Core services are:

- Adult Day Training
- Non-Residential Support Services
- Residential Habilitation
- Support Coordination
- Supported Employment Services
- Supported Living Coaching

¹ A developmental disability is a severe, chronic disability that begins any time from birth through age 21 and is expected to last for a lifetime. Developmental disabilities may be cognitive, physical, or a combination of both. Chapter 393, Florida Statutes, defines developmental disability as spina bifida, autism, cerebral palsy, Prader-Willi Syndrome and mental retardation

² Effective July 1, 2004, the Florida Legislature created the Agency for Persons with Disabilities (APD) and the Developmental Disabilities program was moved out of the Florida Department of Children and Families to this new agency.

The desk review process involves examination of provider qualifications, training, required documentation and other paperwork. As part of the desk review, reviewers make telephone contact with at least one of the individuals or a representative family member of the recipient of services being monitored to assure that services are being provided as billed and that the person is satisfied with the services.³ The desk review process is limited in scope to basic compliance monitoring for providers of DD HCBS Waiver Services who do not provide core services. Desk reviews are conducted for providers of these services who have delivered services or supports for at least six months, and have served at least one individual during the most recent three months prior to the review. Providers with a performance score of 90 percent or above with no alerts during the review are not reviewed in the following year unless requested by the district. The services subject to a desk review if providers meet the above noted criteria include:⁴

- Adult Dental
- Behavior Analysis and Assessment
- Behavioral Assistant
- Chore
- Companion
- Dietitian
- Homemaker
- In-Home Support
- Medication Review
- Occupational Therapy and Assessment
- Personal Care Assistance
- Personal Emergency Response System
- Physical Therapy and Assessment
- Private Duty Nursing
- Psychological Assessment
- Residential Nursing (if not site-visited)
- Respiratory Therapy and Assessment
- Respite Care
- Skilled Nursing
- Special Medical Home Care
- Specialized Mental Health Services
- Speech Therapy and Assessment
- Therapeutic Massage and Assessment
- Transportation

³ Information that is considered in the provider desk review and sources for the information are included in Appendix A to this report.

⁴ Of these services, two were dropped after the first year: Adult Dental and Personal Emergency Response System. A third, Residential Nursing Services, has had no desk reviews since the first year. These have been excluded from the current analysis.

Methodology and Data

Monitoring Review Procedure

Quality Assurance Reviewers employed by JCR through a subcontract with the Delmarva Foundation are responsible for conducting desk reviews. Upon hire, reviewers complete an extensive training process that includes an overview of the Developmental Services Waiver Services Medicaid Coverage and Limitation Handbook and in-depth training on review procedures, review tools and protocols for all types of Provider Performance Reviews. Training also addresses the use of claims data in the review process, use of previous review reports and techniques for conducting telephone interviews with consumers, representatives or family members. The reviewer participates in the completion of a desk review with the trainer and then conducts a desk review for reliability. Subsequent to the initial training, the reviewer completes a number of desk reviews that are carefully monitored by a Regional Manager who then offers feedback.

The Quality Assurance Coordinator conducts desk review reliability once a year on five randomly selected review reports per reviewer. The selected reviews are limited to similar services, with different services selected each year. A Documentation Evaluation Form is used to conduct the assessment and generate an evaluation report for each of the five reviews per reviewer. Each report is evaluated on the overall content, the elements of performance and the narrative summary. The information is trended and tracked to identify issues such as the need for procedural reinforcement with all reviewers, procedural changes, and elements of performance interpretation issues. A report is generated for each reviewer and given to the regional manager who provides feedback to the reviewer.

Desk Review Process

Based on the claims data, providers receive a letter requesting the submission of documentation for the desk review. Three months of billing information is requested on the individual(s) selected for the review. The provider is also required to submit other documentation related to their qualifications, training, and level 2 background screening. Once the letter is received, the provider has 30 days to submit the necessary documentation to the Delmarva Tampa office. Once submitted, the desk review is recorded into the database and then sent to a reviewer. Providers are given the opportunity to submit missing information during a documentation follow-up review: 10 days to submit information for an alert item (level 2 background screening) and 30 days for any other missing information.

During the review process, service-specific checklists are utilized by reviewers, in conjunction with the service specific monitoring protocol, to identify and monitor each specific requirement contained in the applicable DD HCBS Waiver Checklist. If providers do not agree with the results of the review, they have the opportunity for a Reconsideration Review. Final performance scores for reviews are taken from results of the provider's annual review or the Reconsideration Review report for the provider in that year.

Modifications to the Scoring Process and Review Tool

Providers receive a performance score on each review, based on the services they have provided during the time period being reviewed (Contract Year). Each service has a number of standards that are measured and each standard has a number of elements of performance that are coded by the reviewer as “Met”, “Not Met” or “Not Applicable” based on the requirements specific to that service.⁵ The number of standards varies by service and the number of elements of performance varies by standard. In addition, some elements of performance are weighted more heavily than others, such as having evidence that a Level II Background Screening has been completed on all providers of the service. The provider’s performance score is calculated based on the number of elements “Met”, the weight of the element, and the number of services the provider has administered.

As part of a continuous effort to improve the process, several major modifications have been documented over the first three contract years. Unfortunately, these changes limit the extent of analysis that can be completed at this time. The interview tool was modified in the early part of the second year of the contract (February 2003) to comply with requirements in the DD Waiver Services Medicaid handbook. The number of elements of performance used to score each service was changed such that some services acquired additional elements and others had fewer. Some elements of performance within services were separated into two or more new items and others were combined. Many new elements were added, particularly regarding behavioral factors associated with the services. Finally, some were re-worded for clarification. As a result, comparisons of the calculated performance score for the review between the *original* and *revised* tool are not meaningful. However, only 40 desk reviews were completed in Year Two using the *original* tool. Because these were completed in the early part of the contract year, for analysis purposes they are included in the Year One results. Therefore, in this study, Year One includes desk reviews completed using the *original* tool; July 2001 through June 2002, plus the 40 additional reviews as noted. Year Two and Three reviews were completed using the *revised* tool. Year Two reviews were completed during the 12-month period ending June 2003, and Year Three includes reviews completed and scored from July 2003 through May 6, 2004.

In addition to the modifications made to the review tool, changes were implemented to improve the way the performance score is calculated. On February 24, 2003, the elements were weighted, as discussed above. Up until that time, each element of performance was scored equally. On July 1, 2003, elements scored as “Not Applicable” were removed from the scoring process. Because of the changes made in calculating the review score and also to the tool itself, analyzing performance score trends over the first three contract years is not possible. However, the noted modifications did not affect the way reviewers have scored each element as “Met”, “Not Met”, or “Not Applicable”. Therefore, comparisons in this study are made using the “Percent of Elements of Performance Met” within each service or review.

⁵ Go to http://www.dfmc-florida.org/provider_review_tools_download.htm to review a copy of the tool.

Differences from Original to Revised Tool

The following table shows the change in the number of elements per service from the *original* to the *revised* tool.⁶ The difference in the number of elements ranges from a decrease of 13 for Transportation to an increase of 23 elements for In-home Support. The total number of elements reviewed within each service in the new tool ranges from a low of seven for Medication Reviews to a high of 41 for In-home Support. In total, 80 additional elements are part of the desk review process in the *revised* tool.

Table 1: Difference in Number of Elements
Original Tool v Revised Tool
Change in Tools on 2/24/03

Service	Number of Elements		
	Original	Revised	Difference
Behavior Analysis and Assessment	21	24	3
Behavioral Assistant Services	20	23	3
Chore	17	15	-2
Companion	25	36	11
Dietitian Services	14	18	4
Homemaker	19	18	-1
In-home Support	18	41	23
Medication Review	6	7	1
Occupational Therapy/Assessment	23	25	2
Personal Care Assistance	26	24	-2
Physical Therapy and Assessment	11	25	14
Private Duty Nursing	15	26	11
Psychological Assessment	6	8	2
Respiratory Therapy and Assessment	10	13	3
Respite Care	23	22	-1
Skilled Nursing	12	24	12
Special Medical Home Care	24	26	2
Specialized Mental Health Services	10	18	8
Speech Therapy and Assessment	20	23	3
Therapeutic Massage and Assessment	23	20	-3
Transportation	25	12	-13
Total	368	448	80

⁶ More than one service can be reviewed at each provider review.

The Percent Met per service using the *original* and *revised* tool is displayed in Table 2. Under the *original* tool, scores range from a low of 64.2 percent for Personal Care Assistance, to a high of 100 percent for Respiratory Therapy and Assessment. Using the *revised* tool, the Percent Met ranges from 67.8 percent for Chore to 94.3 percent for Respiratory Therapy and Assessment. It is important to note that many of these are based on only a few reviews, particularly under the *original* tool.

Table 2: Difference in Percent Met
Original Tool v Revised Tool
Change in Tools on 2/24/03

Service	Original Tool		Revised Tool		Difference
	Reviews	% Met	Reviews	% Met	
Behavior Analysis and Assessment	45	82.1%	90	82.0%	-0.1%
Behavioral Assistant Services	22	78.8%	26	73.8%	-5.0%
Chore	8	75.0%	23	67.8%	-7.2%
Companion	312	68.7%	523	77.1%	8.4%
Dietitian Services	9	97.6%	12	89.8%	-7.8%
Homemaker	75	68.9%	165	75.1%	6.2%
In-home Support	37	74.7%	112	74.9%	0.2%
Medication Review	1	66.7%	18	79.8%	13.1%
Occupational Therapy/Assessment	33	70.0%	62	72.0%	2.0%
Personal Care Assistance	431	64.2%	874	74.5%	10.3%
Physical Therapy and Assessment	46	86.1%	73	71.3%	-14.9%
Private Duty Nursing	4	98.1%	14	72.9%	-25.1%
Psychological Assessment	3	94.4%	4	70.0%	-24.4%
Respiratory Therapy and Assessment	1	100.0%	6	94.3%	-5.7%
Respite Care	404	58.7%	746	69.9%	11.2%
Skilled Nursing	24	89.2%	40	76.4%	-12.9%
Special Medical Home Care	4	76.8%	5	85.2%	8.3%
Specialized Mental Health Services	23	90.5%	60	70.9%	-19.6%
Speech Therapy and Assessment	59	62.8%	95	75.0%	12.3%
Therapeutic Massage and Assessment	22	68.2%	55	72.9%	4.7%
Transportation	50	65.3%	101	81.6%	16.3%
Total	1,613	66.4%	3,104	74.3%	7.9%

The difference between the percents within each service is shown in the last column on Table 2. Changes in the percent of elements of performance that met the criteria range from a decrease of 25.1 percentage points (Private Duty Nursing) to an increase of 16.3 percentage points (Transportation). On average, there was nearly an eight percentage point increase in the Percent Met from the *original* to the *revised* tool, from 66.4 percent to 74.3 percent. This is a statistically significant relationship and suggests the efforts to improve the process may have been somewhat successful.⁷ There is a weak negative

⁷ George W. Bohrnstedt and David Knoke. *Statistics for Social Data Analysis*. F. E. Peacock Publishers, Inc. Second Edition. 1988. Difference of Proportions Z-score test. pp. 198-200. Z-score equals 24.5 indicating a high probability this is not due to chance.

correlation between the difference in the number of elements (Table 1) and the difference in the Percent Met (Pearson's Correlation = -.25). Therefore, there is some evidence to suggest that a greater number of changes that were made to the service is associated with a subsequent lower score. However, this is not considered a statistically significant relationship ($p=.277$) so should not be over-interpreted.

There has been some concern that services based on a greater number of elements may be more likely to receive lower scores. Because the review for these services requires more information/documentation, it is more likely that the provider may not be able to "find" the documentation. Also, there is an increased chance that directions may not be clear as to the exact type of documentation needed. We analyzed the data to determine if the number of elements of performance per service is associated with the percent of elements that meet the criteria for that service. This association, when analyzing the original and revised tools combined ($n=42$), suggests that when a greater number of elements are scored (i.e., more information is needed), the Percent Met is lower, and this is a statistically significant association.⁸ However, the relationship disappears when analyzing services using only the revised tool.⁹ A smaller number of cases ($n=21$) is likely a factor.

In addition, because the providers should be improving from year to year, their scores should also improve. They should be correcting the elements scored as "not met" from the previous year's review. Therefore, with time the greater number of elements will have less of an impact. Also, the changes in the tool were designed to assist providers in having a greater understanding of actual documentation required for submission. For example, the original tool combined CPR, HIV/AIDS and Infection Control training into one element and the revised tool has separated these into two elements—CPR in one and HIV/AIDS and Infection Control in another. As mentioned earlier, evidence suggests changes in the tool have successfully enhanced performance on desk reviews.

Annual Trends

Desk reviews for this analysis include only non-core services that were reviewed in the first three years of the contract. Providers who received a 90 percent performance score without any alerts were excluded from the subsequent year's review process.¹⁰ This is an important exclusion to note, particularly when examining trends over time. In Year Two, 590 providers (58.9 percent of the desk reviews that year) were "repeat reviews" or also reviewed in Year One, and in Year Three, 566 providers (46.9 percent of desk reviews) were also reviewed in Year Two.¹¹ Year Three analyses include only reviews that were completed, scored and recorded in the database as of May 6, 2004. The final analysis includes 2,796 desk reviews.

⁸ Pearson's Correlation = -.413, $p=.007$.

⁹ Pearson's Correlation = -.140, $p=.545$

¹⁰ Level 2 background screening on all providers is a mandatory alert item. Alerts are automatically "sounded" when this element is Not Met.

¹¹ Third Annual Report, submitted to AHCA in October 2004, Appendix 1, Exhibit 10.

Table 3: Annual Trends
Average Percent Met

	Jul 01 - Jun 02	Jul 02 - Jun 03	Jul 03 - May 6, 04	Total
Reviews	956	1,122	718	2,796
Percent Met	66.4%	74.1%	74.5%	71.8%

Annual trends are shown in Table 3 for the percent of elements that Met the specific criteria across all services and all districts. The Percent Met increased from Year One to Year Two by over 11 percent, from 66.4 percent to 74.1 percent, and has remained at over 74 percent to date in Year Three. The increase is somewhat more impressive when considering the fact that the “best” performers in Year One were not reviewed again in Year Two. However, because there was a change in the tool, this difference should be viewed with caution. For example, the increase could be due to more clarity in the actual review process and/or improvement in the performance of providers, the intended outcome of an improved quality assurance process.

Agency providers had, on average, a much higher percentage of elements that met criteria in Year One than did solo providers, 76.6 percent compared to 63.3 percent (Table 4). The gap between them, however, disappeared in the subsequent two years of reviews, with solo providers showing a slightly higher percentage. It is interesting that Agency Providers scored higher in Year One, using the *original* tool, than in subsequent years with the *revised* tool. At the same time, Solo Providers scored much lower with the *original* tool than in subsequent years. The resultant increase may in part be the intended/desired result of the revised QA process.

Table 4: Annual Trends by Provider Type
Average Percent of Elements that Met the Standard

Agency Providers				
	Jul 01 - Jun 02	Jul 02 - Jun 03	Jul 03 - May 6, 04	Total
Reviews	167	204	169	540
Percent Met	76.6%	73.9%	73.6%	74.6%
Solo Providers				
	Jul 01 - Jun 02	Jul 02 - Jun 03	Jul 03 - May 6, 04	Total
Reviews	789	918	549	2,256
Percent Met	63.3%	74.2%	74.9%	70.8%

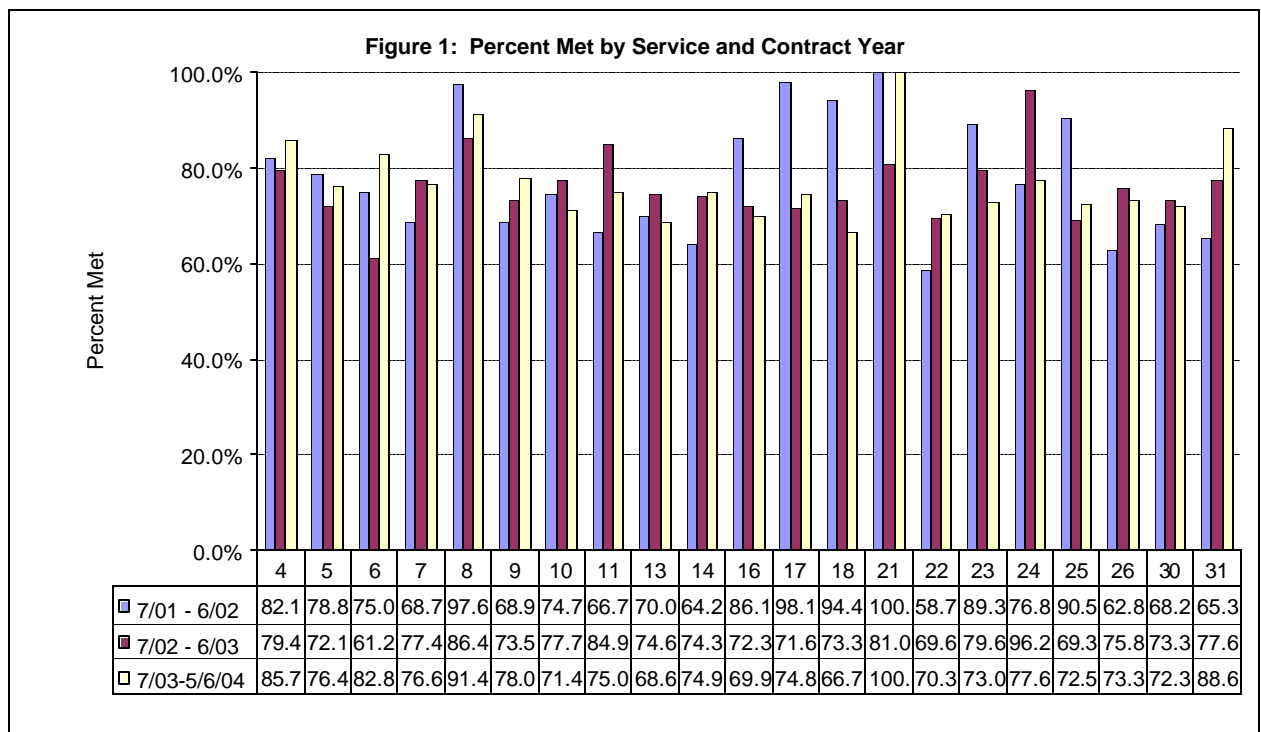
The following table provides the service name and the number of services provided each year for desk-reviewed providers. Personal Care Assistance, Respite Care and Companion services are most often provided. Use the Service ID Number identified on this table when referring to the graph in Figure 1 on the next page.

Service Name and ID Number
Number of Services by Year

Service Name	Service ID Number	Jul 01 - Jun 02	Jul 02 - Jun 03	Jul 03 - May 6, 04
Behavior Analysis and Assessment	4	45	53	37
Behavior Assistant Services	5	22	16	10
Chore	6	8	16	7
Companion	7	312	322	201
Dietitian Services	8	9	4	8
Homemaker	9	75	105	60
In-home Support	10	37	63	49
Medication Review	11	1	9	9
Occupational Therapy/Assessment	13	33	36	26
Personal Care Assistance	14	430	523	350
Physical Therapy and Assessment	16	46	42	31
Private Duty Nursing	17	4	8	6
Psychological Assessment	18	3	2	2
Respiratory Therapy and Assessment	21	1	2	4
Respite Care	22	404	466	279
Skilled Nursing	23	23	21	19
Special Medical Home Care	24	4	2	3
Specialized Mental Health Services	25	23	30	30
Speech Therapy and Assessment	26	59	66	29
Therapeutic Massage and Assessment	30	22	35	20
Transportation	31	50	64	36
Total		1611	1885	1216

Note: One review may monitor more than one service.

Figure 1 displays the trends for each service over the three contract years. The percentage scores range from a low of 58.7 Percent Met (Year 1, Respite Care) to a high of 100 Percent Met for Psychological Assessment (Years 1 and 3). It is possible the interview instrument performs better for some services than it does for others, in particular Respiratory Therapy (#21). However, it is important to note here, again, that some of the services are based upon only a few reviews, particularly Chore (#6), Dietitian Services (#8), Medication Review (#11), Private Duty Nursing (#17), Psychological Assessment (#18), Respiratory Therapy (#21), and Special Medical Home Care (#24).



No discernable pattern exists across the services and years except that a majority of scores lie between 60 and 80 percent. Variation from year to year appears fairly random. The services most often reviewed are Companion (#7), Personal Care Assistance (#14), and Respite Care (#22). Each of these has over 200 reviews each year.

District Trends

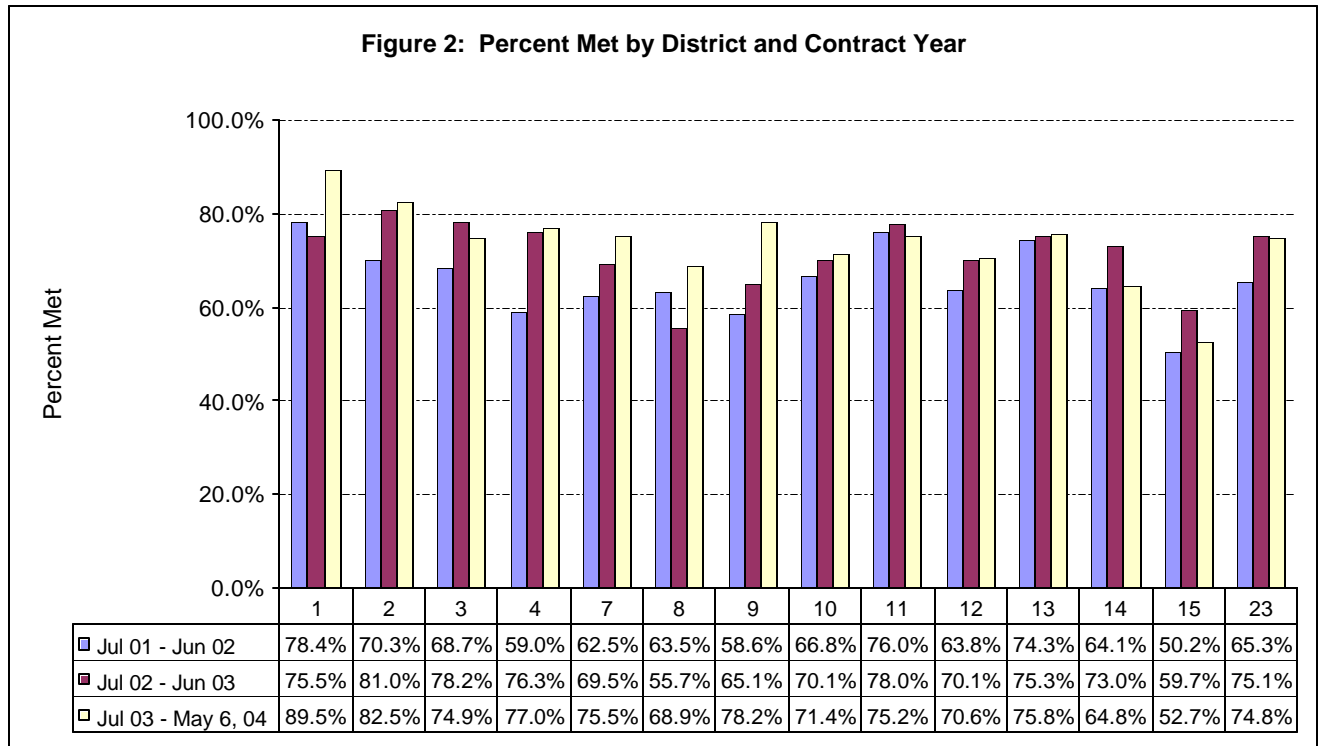
The number of desk reviews completed each year by district is displayed in the following table. District 1 has the fewest number of reviews in the first and third years of the contract. With the exception of District 1 and Year 1 in District 8, all other districts had at least 20 or more reviews completed.

Table 5: Desk Reviews by District

District	Year 1	Year 2	Year 3
1	12	24	12
2	111	129	60
3	61	64	30
4	59	81	72
7	80	101	62
8	19	22	27
9	29	50	26
10	30	35	32
11	81	85	78
12	49	54	40
13	58	68	31
14	27	27	23
15	44	46	33
23	296	336	192
Florida	956	1,122	718

When analyzing the Percent Met by district we find that Districts 4 and 9 show the most improvement over the time period being reviewed (Figure 2). With one exception, District 11 all the districts have a higher percentage of elements met in Year Three (July 2003-May 6, 2004) than during the first year of the contract, and the District 11 difference is less than one percentage point. District 15 exhibited the greatest percent decrease from Year Two to Year Three, with an 11.7 percent drop in the Percent Met on the elements of performance. District 1 demonstrates the highest Percent Met and District 15 is the only district with all three years below 60 percent.¹² District 15 is the only district with a score under 60 percent in Year Three (52.7%). This District may benefit from some targeted intervention. On average, however, performance across the state has improved since the onset of reviews in 2001 - 2002.

¹² District 1 had only 12 desk reviews in the Year One and Three time periods.



Element of Performance Level Analysis

All services provided by the provider are reviewed. As explained earlier, each service has a number of standards that are measured, such as “Provider Qualification and Requirements” or “Service Limits and Times”. Each standard has a number of elements such as “Level 2 background screenings are completed for all direct employees” or “The provider is authorized to render this service.” The reviewer codes the elements as “Met”, “Not Met” or “Not Applicable” based on the requirements specific to that service. Many of the elements reviewed and scored appear in several, if not all, of the different services. The purpose of the following analysis is to determine how well providers do on elements of performance that are common to many of the services. Are providers scoring consistently well on some elements, on average, across all services and consistently not as well on others?

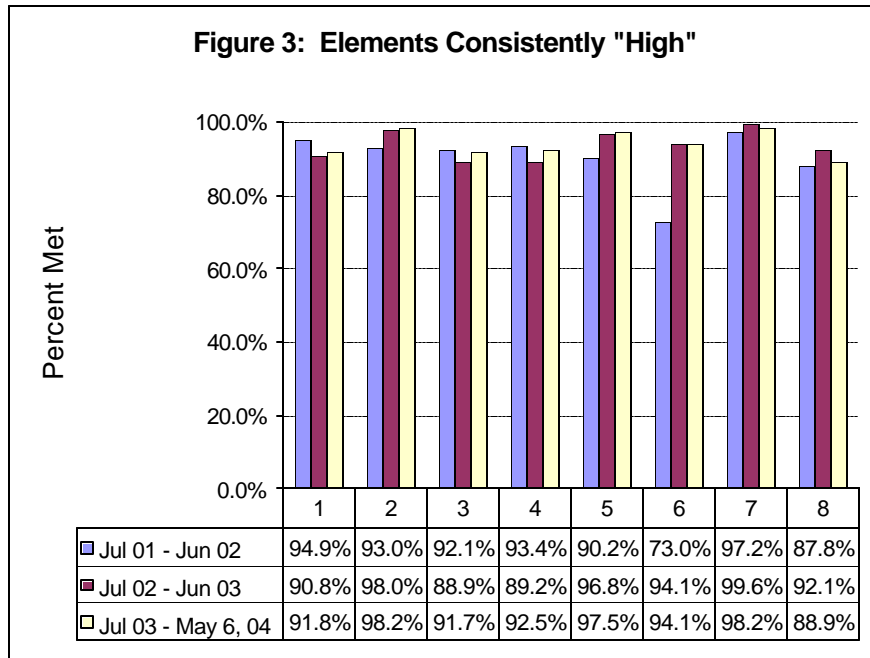
By combining elements across services we analyzed the percentage of times each element met the criteria over the first three years of the contract. They are then combined into three groups: elements consistently “high” in Percent Met; elements consistently “moderate”; and elements consistently “low”.

Elements Consistently High

Elements of performance on which providers are scoring consistently high, with one exception, scored approximately 90 percent or higher over the three years of the contract. Numbers in parentheses below represent the number of services in which the element appears. The elements, displayed in Figure 3, are:

1. Provider has a copy of an assessment report (10);
2. Provider limits service to the appropriate number of units per day (14);
3. Provider has a high school diploma or one or two years of experience (7);
4. The provider and/or facility are properly licensed (15);
5. Service is limited to individuals who are the proper age (7);
6. Provider gives notification of traffic violations or changes in license (3);
7. Provider limits service to appropriate number per year (9);
8. Provider performs work under the proper supervision (7).

Giving notification of any traffic violations or changes in a driver’s license is the only element that was somewhat lower the first year, but improved to close to 95 percent in the subsequent years.¹³ Many of these elements are directly related to licensing and are therefore monitored through additional means and with greater frequency.

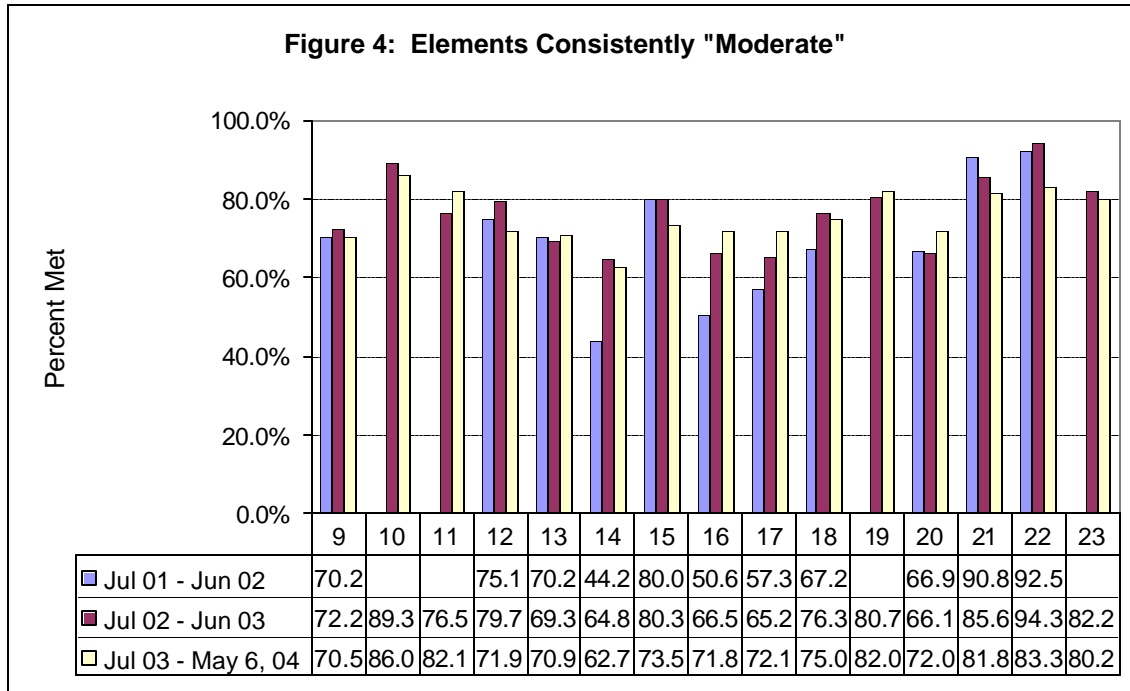


¹³ Providers are not *required* to submit information related to this element, only that they have a proper driver’s license, proof of insurance and vehicle registration.

Elements Consistently Moderate

Elements on which providers fell into the “Moderate” category scored, on average, between 60 and 89 percent over the three study years. The elements displayed in Figure 4 are as follows:

9. Level 2 background screenings are completed for all direct employees (21);
10. Employees undergo Level 2 background re-screening every five years (21);
11. Service is provided at the appropriate frequency and intensity (20);
12. Provider has a copy of the logs relevant to the time being reviewed (19);
13. Providers who transport individuals have a valid driver’s license (7);
14. Provider attends mandatory training and meetings (17);
15. Provider has a copy of monthly summary notes (11);
16. Provider has training in CPR, AIDS and infection control (8);
17. Provider has training in health, safety and wellness (17);
18. Provider receives training specific to the needs and characteristics of the individual (18);
19. The person is authorized to render the specific service (21);
20. Provider has the original prescription (8);
21. Provider has a service/nursing/treatment plan (9);
22. Provider has daily progress notes (4);
23. If driving, the provider conforms to program requirements (4).



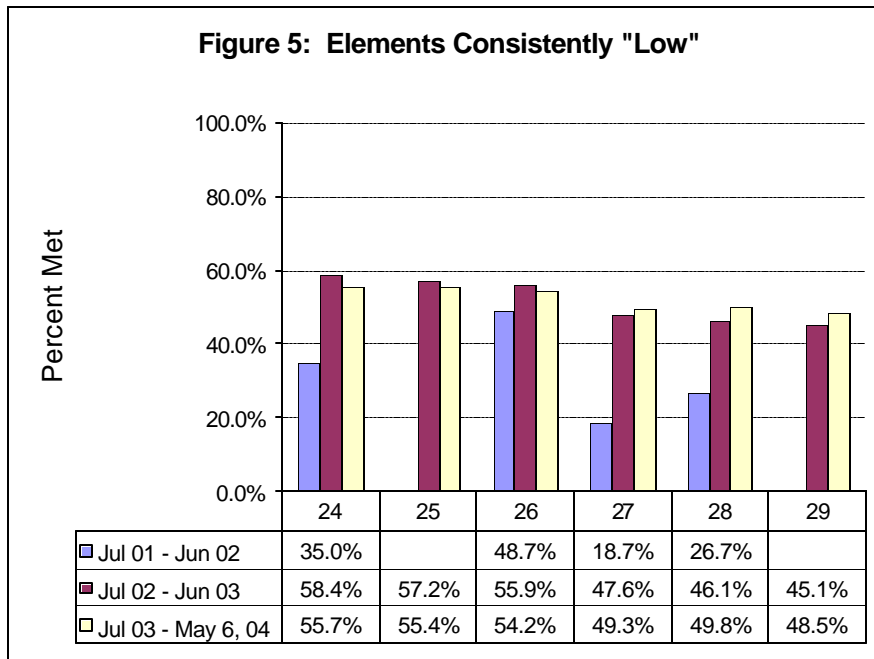
While two of the elements scored over 90 percent in previous years (#21 and #22), in the most recent year the Percent Met has dropped to less than 85 percent. Elements that measure documentation of training, numbers 16, 17 and 18, as well as documentation of attendance at required training and meetings (#14) have all improved over the years.

Elements Consistently Low

Areas of most concern are where documentation has remained fairly low, less than 60 percent. These are all areas regarding training on:

- 24. medication administration (13);
- 25. the responsibilities under the requirements of specific services (16);
- 26. the required documentation for the service being provided (17);
- 27. a person-centered approach to reviews (17);
- 28. Core Assurances (17), and;
- 29. recognition of abuse and neglect (17).

While they are both currently under 50 percent, documentation on training in the person-centered approach and on the Core Assurances has improved dramatically since the first year the desk reviews were conducted, a 163 percent and 86 percent increase respectively. However, all of these areas that document specific training requirements have remained consistently low and compliance may improve with focused interventions.



Discussion and Recommendations

The data in this study indicate that documented provider compliance on average, determined in the desk review process, has remained somewhat low since the first year of the study period. It is important to note, however, that improvement has been demonstrated, with a statewide average Percent Met increasing from approximately 66 percent in Year One to 75 percent by Year Three. This improvement may be due to better compliance by the providers, improvements in written procedures and guidelines for requesting documentation and/or the *revised* review tool that may better delineate the documentation needed to ensure compliance with the standard.

Of particular interest is that when controlling for the type of provider (Agency v Solo), we find the lower scores in Year One with the *original* tool are a reflection of documented compliance of Solo providers only: 63.6 percent compliance for solo providers compared to 76.6 percent for agencies. However, by the third year the compliance scores are much closer, 73.6 percent and 74.9 percent respectively. Many solo providers of services subject to a desk review had never been monitored and were generally unaware of core assurance and service specific requirements. Agency providers, because they often work with many different human service programs and funding sources, were more familiar with requirements and procedures. Solo providers, on the other hand, appeared to have limited knowledge about the requirements. In some districts where solo provider scores were notably lower, targeted training and technical assistance sessions were provided that may have helped improve scores. Because solo providers generally had less experience, it is possible the *original* tool was less effective for them and that use of the *revised* tool has helped them increase compliance. Improvements made to the written procedures and guidelines for providers subject to a desk review resulted in large part from customer service calls from providers confused about the process and required documentation. Therefore the improved process may have had more of an impact on solo providers than agencies.

At the same time there was a small drop in agency scores, from 76.6 percent to 73.9 percent. Because agency providers were generally more experienced in the delivery of social service programs, they were more likely to score 90 percent or higher in the first year. In the first year, over 50% of the agency providers had 90 percent or more elements “Met” compared to only 13 percent of solo providers. Excluding these “best performers” could cause a drop in the subsequent year’s average scores. The current review process is scoring both types of providers at around 75 Percent Met.

Recommendations:

- Additional training targeted for providers of services subject to desk review, especially solo providers, appears to have increased documentation compliance, and should be continued at the district level based on current review results.
- Based on continuing questions about the desk review process and requirements that are received by the FSQAP customer service team, some elements may be scored as “not met” due to written procedures that are unclear. Delmarva is in the process of revising the information that is sent to providers requesting specific

documentation. These revisions should be finalized and implemented as soon as possible.

The element level analysis indicates that while providers are consistently doing quite well with compliance documentation across all services in some areas, they are consistently performing quite poorly on others. Documentation related to licensing issues or eligibility requirements tends to be available: that the provider and/or facility is properly licensed, that the appropriate number of units of service are provided (weekly or annually), and that providers are rendering the service to individuals of the proper age. In several specific areas where documentation is required for proof of training, however, availability of the documentation has remained quite low. We cannot know from these data if the providers are not appropriately trained or if they just did not have documentation of that training. However, because these are vital to the health and welfare of the individual—recognition of abuse and neglect; using a person-centered approach to care; and medication administration—it is vital to determine if providers are adequately trained in these areas.

Recommendations:

- As revisions to the desk review tools and protocols are undertaken, eliminating individual elements of performance that are being made at high rates should be considered.
- The documentation for compliance with training requirements needs to be clearly identified in the revisions to the desk review information and guidelines as well as addressed in any training provided on the desk review process.
- Districts/providers who score well in elements related to training should share their practices on effective provider training and monitoring. This can be accomplished during regularly scheduled meetings or via conference calls.

Compliance has remained quite low documenting that providers have been trained on the Core Assurances. Core Assurances are considered important enough to be monitored for all services and help to determine if providers are treating individuals with dignity and respect; if providers grant individuals personal privacy; and if individuals are free from abuse and neglect. It is imperative that providers receive the proper training in these areas and that they maintain proper documentation of this training. The required training identifies state statutes and rules as well as Federal Laws and regulations to which providers are bound. Participants review the following: program requirements; required training; when to notify the department of infractions; required policies, procedures and practices; guidelines for the provider's self assessment; screening requirements (including background screening and provider qualifications); guidelines for changing provider status; record retention; financial requirements; marketing practices; required documentation for goods and services provided; payment provisions; recoupment of funds; and grievance procedures.

Recommendations:

- Provider enrollment under the DD HCBS Waiver should be contingent upon completion of training in Core Assurances.
- Each district should ensure that an adequate number of training opportunities are available on Core Assurances, especially for solo providers

An element on which providers have consistently scored around 70 percent is verification of Level 2 Background Screening. This item is weighted heavily (factor of 4) in calculating the performance score, indicating a high degree of importance. Because providers in this Medicaid Waiver program work with a very vulnerable population, a Level 2 background screening is a requirement (393 Florida Statutes). Providers have done somewhat better documenting Level 2 Background five year re-screening, with an average compliance rate of 86 percent year to date in Year Three.

Recommendations:

- Because this is an ongoing problem it is imperative that districts continue to address this deficiency. Districts can be proactive in ensuring their providers obtain and maintain documentation related to Level 2 Background Screening and five year re-screenings.
- The training for agency providers should include what should be maintained for Level 2 Background Screening and five year re-screening.
- Prior to certification, agency and solo providers could be trained on the requirements for Level 2 background screenings and/or re-screenings.
- Statewide compliance by the Districts should be enforced to ensure that they are all requiring the same information from providers for level 2 background screenings.
- Provide online training and guidelines for providers to receive needed information related to the Level 2-background screening. Online information could include resources and online links available to access Level 2 Background information.
- Additional links to specific services where providers can access interpretive guides for clarification on what is expected of them should be considered.
- Additional analysis should be completed examining how well providers comply with this requirement during the follow-up documentation review.

Recommendations for additional analysis:

- Is the process helping to improve compliance? It may be of interest to compare the scores for the “repeat providers” each year to the scores for new providers having their first review.
- When providers offer Core as well as “non-Core desk reviewed services”, the non-Core services are reviewed onsite rather than with a desk review. A comparison of the non-Core services reviewed with a desk review to the same services reviewed onsite could provide information as to whether an onsite review would enhance provider performance for these non-Core services.

Conclusion

Overall, the findings demonstrate that providers' performances are improving. As reflected in the recommendation sections, training for providers can play an integral part of this continued increase in scores. This training should focus on the areas identified of most importance to individuals' health and safety. Training can be directly provided on these particular areas or information can be provided on how to access this training. However, not only would it be vital to ensure that providers receive the required training, but also receive instructions on how to maintain training records or the type of documentation needed to verify that the necessary training had been received.

The desk review process currently in place is based upon compliance and ensuring that providers have the foundation needed to provide quality supports and services. Training in areas of basic health and safety, rights, rules and regulations and service specific requirements is recommended. In the future desk review providers could be reviewed using a more person centered and outcome focused approach, similar to the annual reviews for providers who provide one of the six core services, particularly on the services most often provided: Personal Care Assistance, Respite Care and Companion Services. Once their scores improve, demonstrating that they have the foundation needed (including the required training) and that they are providing the service according to the Medicaid Waiver Handbook, the review process for these types of providers could become similar to the new CORE review process.

Before a movement toward a more outcome oriented review process for desk reviews can be implemented successfully, providers must have the necessary foundation. The current statewide scores do not indicate that the necessary foundation is present for many providers. When scores are consistently at 85% - 90% a movement toward a more outcome-oriented review process for desk reviews can be implemented, with confidence that providers have the foundation needed to provide supports and services that result in individual outcomes being achieved.