SENIOR & LONG TERM CARE DIVISION
COMMUNITY SERVICES BUREAU

COMMUNITY FIRST CHOICE Policy Manual	Section: ADMINISTRATIVE REQUIREMENTS
	Subject: ➢Quality Assurance Review

Reference: 37.40.1023 and 37.40.1132

PURPOSE

The Community Services Bureau (CSB) conducts comprehensive reviews for compliance of Community First Choice/Personal Assistance Service (CFC/PAS) provider agencies. The compliance reviews are known as a Quality Assurance Review (QAR). The QAR is conducted for every Medicaid enrolled CFC/PAS self-directed provider to ensure compliance with federal assurance standards, collect quality assurance data, and to identify training needs. Corrective action, including sanctions, may occur if a provider agency is unable to demonstrate compliance during the QAR.

CRITERIA

The CSB's QAR process includes two components:

1. Verification of the provider agency's annual Quality Assurance Report; and

2. Member chart reviews.

TIME FRAME

The date of a provider agency's QAR is coordinated between the Regional Program Officer (RPO) and the provider agency. A QAR may occur any time the CSB believes a review is warranted to improve services, but will not exceed three state fiscal year intervals (July-June). The RPO will provide written notification 90 days prior to scheduling the QAR.

PROVIDER AGENCY ACTION

Each provider agency must allow CSB representatives access to provider agency records during the QAR, including staff and worker files and member records. If the provider agency maintains records in an electronic database the provider agency must provide the CSB representatives with database access, electronic file access, or hard-copies of required documentation.

The QAR will include on-site record/documentation review. The provider agency must provide CSB representatives with adequate private work space to conduct the QAR. If a provider agency is able to provide electronic records or remote database access the CSB representatives may conduct aspects of the review from the CSB representative's regional office.

PERFORMANCE STANDARDS

A performance standard is a mechanism to evaluate quality and demonstrate provider agency compliance in the CFC/PAS program. Every performance standard has criteria to measure and evaluate program compliance.

The CSB representatives will evaluate compliance in 14 performance standards. Nine performance standards will be evaluated to provide verification of the information contained in the provider agency's most recent Quality Assurance Report; referred to as the "Verification of the Provider Agency Quality Assurance Report" portion of the QAR. An additional five performance standards will be obtained from the on-site review of member charts; referred to as the "Member Chart Review" portion of the QAR.

Below is a list of the performance standards broken out by the verification of the Provider Agency Quality Assurance Report and the Member Chart Review portions of the QAR.

1. Verification of the Provider Agency Annual Quality Assurance Report includes the following nine performance standards:

    a. Standard 1: Internal Chart Review (ICR) Sample Review;

    b. Standard 2: Intake;

    c. Standard 3: Recertification;

    d. Standard 4: Annual;

    e. Standard 5: Person Centered Planning (PCP);

    f. Standard 6: Health and Safety;

    g. Standard 7: Program Oversight Staff;

h. Standard 8: Plan Facilitator Staff; and

i. Standard 9: Self-Direction Agency Oversight.

2. Member Chart Review portion of the QAR includes the following five performance standards:

a. Standard 10: Services Delivered According to Service Plan;

b. Standard 11: Services Billed Correctly;

c. Standard 12: Services Billed with Supporting Documentation;

d. Standard 13: Plan Facilitator Oversight of Personal Emergency Response System (PERS); and

NOTE: This standard is only reviewed when the CFC/PAS Provider agency is the Plan Facilitator for the member.

e. Standard 14: Health Care Professional Authorization.

REVIEW CRITERIA

Below is a table that includes each review standard along with the criteria and policy reference.

Verification of the Provider Agency Quality Assurance Report:

	Standard	Criteria	Policy
1 a	ICR Sample	Provider agency documentation verifies how internal chart review (ICR) sample was determined.	610, 924
1 b	ICR Sample	Provider agency worksheets for internal chart reviews include a	610, 924

		review for correct standards.	
2	ICR- Intake	Provider agency member chart verifies findings on the agency's ICR form.	610, 924
3	ICR- Recertification	Provider agency member chart verifies findings on the agency's ICR form.	610, 924
4	ICR-Annual	Provider agency member chart verifies findings on the agency's ICR form.	610, 924
5	ICR-PCP	Provider agency member chart verifies findings on the agency's ICR form.	610, 924
6	ICR- Health and Safety	Provider agency member chart verifies findings on the agency's ICR form.	610, 924
7	Program Oversight Staff	Staff member personnel records verify findings on the Provider Prepared Standards.	610, 925
8	Plan Facilitator Staff	Staff member personnel records verify findings on the Provider Prepared Standards.	610, 925
9	Self-Direction Agency Oversight	Provider agency paperwork substantiates policy provided in the Provider Prepared Standards.	610, 925

MEMBER CHART REVIEW:

	Standard	**Criteria**	**Policy**
10	Services Delivered According to Service Plan	Review of member service delivery records verify that services are delivered as identified on the member's Service Plan. When variation occurs documentation supports	421, 703, 911

		agency oversight to resolve the issue.	
11	Services Billed with Supporting Documentation	Review of member service delivery records and mileage forms support units paid to the provider agency.	606, 707, 708, 718, 911, 912
12	Services Billed with Correct Codes and Rates	Claims data review substantiates procedure codes and rates used to bill claims.	606
13	Plan Facilitator Oversight	Review of PERS prior authorization documentation and forms verifies that PERS is being assessed and authorized on an annual basis.	930, 931, 1102
14	Health Care Professional Authorization	Review of the member's Health Care Professional Authorization verifies that the form is consistent with the scope of services identified on the Service Plan	418

PROCESS

The process for conducting and completing a QAR includes the 13 steps outlined below:

1. The RPO will contact the provider agency to schedule the provider agency's QAR. A written confirmation letter with the date of the on-site QAR will be sent to the provider agency at least 90 days prior to the scheduled QAR.

2. The QAR will include a lead RPO. The provider agency shall direct all correspondence and questions related to the QAR to the lead RPO. The QAR may include additional CSB representatives.

3. The RPO will request documentation in writing prior to the QAR to assist with the completion of the QAR. The provider agency will have 30 days to provide the required documentation. The documentation request will include:

    a. List of members in the intake, recertification and annual sample from the provider agency's most recent Quality Assurance Report; and

    b. Worksheet/tracking document for each member's internal chart review.

4. The RPO may request additional documentation in order to conduct portions of the QAR from the CSB representative's office. The decision to provide electronic documentation will be made jointly between the provider agency and the RPO based on the availability of electronic forms. If documentation is not available prior to the QAR review date, the RPO and CSB representatives will require the documentation at the time of the on-site QAR.

5. Prior to the on-site QAR the RPO and CSB representatives will conduct an entrance conference. At the entrance conference the RPO will provide an overview of the QAR process, provide the provider agency with a list of member names that will be reviewed to assess the QAR "Member Chart Review" standards, and request records for the verification of the provider agency's Quality Assurance Report (these may have already been provided to the RPO through electronic means). The provider agency will have an opportunity to ask the RPO questions about the QAR process.

6. The QAR member chart review will consist of a review of member charts from a 5% sample or three members; whichever is greater. Additional charts may be reviewed, when necessary, to determine agency compliance with a standard.

7. During the QAR the RPO and CSB representatives will conduct a review of the QAR standards. Each standard will be evaluated for specific criteria. Findings from the review of standards will be documented in the Quality Assurance Management System (QAMS).

8. The RPO will determine whether each standard has been met. If a standard is not met, the RPO will issue a Quality Assurance Communication (QAC) and outline the reason the standard was not met. The provider agency will be required to respond to the QAC and provide remediation to improve program compliance.

9. Repayments are required when certain criteria is unmet. A recovery QAC will be issued anytime the RPO identifies an overpayment. The provider agency will be required to respond to the QAC and select one of three follow-up options. The options are as follows:

    a. Provide missing documentation to substantiate the payment;

    b. Issue a repayment; or

    c. Request an Administrative Review.

10. The on-site QAR will conclude with an exit conference. The exit conference will occur at the conclusion of the on-site review. The exit conference will include a summary of the findings for each of the performance standards. The provider agency will have an opportunity to ask questions during the exit conference.

11. Within five working days after the exit conference the RPO will submit all of the findings from the review to the provider agency. These findings will be documented in the QAR's QACs. The provider agency will receive an email notification from QAMS when the QAR QACs have been submitted. The provider agency will have 30 days from the date the QAR QACs are submitted to respond and return them in QAMS to the RPO.

12. Within 15 working days from when the provider agency returns a QAC to the RPO the RPO will review and close the QAC.

13. When all of the QAR QACs have been closed, the RPO will issue a closure letter to the provider agency. The CSB will close all QAR within three months from the exit conference. The closure letter summarizes findings from the QAR, including whether each standard was met,

unmet, or not reviewed (N/A) and indicates the timeframe for the next QAR. The timeframe for the next QAR is based on the findings from the QAR. QAR are scheduled in one, two, or three-year cycles.

NOTE: QARs may be scheduled earlier than the cycle indicated in the closure letter when circumstances warrant a more frequent review cycle. Circumstances may include staff turn-over, failure to submit the annual Quality Assurance Report, member complaints, billing errors, change in policy, or other circumstances.

14. Example QAR Timeline:

January 1	Provider Agency Notice Letter *90 days later…*
April 2	On-Site Provider Agency QAR Entrance
April 5	On-Site Provider Agency QAR Exit *Five working days later…*
April 12	QAR Quality Assurance Communications Submitted *30 days later…*
May 12	Provider Agency Returns QAR Quality Assurance Communications *15 working days later…*
June 1	RPO Reviews and Closes QAR Quality Assurance Communications *Three months from QAR Exit*
July 5	CSB Closure Letter sent to Provider Agency