oppaga
OFFICE OF PROGRAM POLICY ANALYSIS & GOVERNMENT ACCOUNTABILITY

August 2008 **Report No. 08-49**

Agency for Persons with Disabilities Has Made Several Changes to the Prior Service Authorization Process

at a glance

In response to our 2006 report, the Agency for Persons with Disabilities has taken steps to address communication problems in its prior service authorization process. The agency revised the notices provided to clients and their guardians to better inform them about the quasi-judicial nature of the process used to appeal service determinations. To reduce state costs, the agency recently consolidated prior service authorization with a single provider. The agency also modified the role of waiver support coordinators and transferred some of their responsibilities to agency staff. Given that the prior service authorization process has been in transition, it is too soon to determine how consolidating contracts, changing the role of waiver support coordinators, and dividing their responsibilities among different staff will affect communication, how long it takes to identify client needs and approve services, and the cost of these processes.

Scope

In accordance with state law, this progress report informs the Legislature of actions taken by the Agency for Persons with Disabilities (APD) in response to a 2006 OPPAGA report. [1, 2] This report presents our assessment of the extent to which the department has addressed the findings and recommendations included in our report.

Background

The primary purpose of the Agency for Persons with Disabilities is to support persons with developmental disabilities in living, learning, and working in all aspects of community life, and to ensure their safety, well-being, and self-sufficiency. To be eligible for program services, an individual must be three years of age or older and have a confirmed diagnosis of a developmental disability. [3] For Fiscal Year 2008-09, the Legislature appropriated $1.06 billion and 3,716 positions for the agency.

The agency often provides support in community settings including a person's home, a family home, a supported living arrangement or a group home setting utilizing services from the Developmental Disabilities Home and Community-Based Services Medicaid Waiver and Family and Supported Living Waiver. This waiver allows the state to receive federal Medicaid matching payments for community-based services, such as personal care, physical therapy, residential habilitation, and training. As of March 1, 2008, 31,098 individuals were enrolled in the waiver programs.

[1] Section 11.51(6), *F.S.*

[2] *MAXIMUS's Prior Service Authorization Process Meets Contract Requirements, But Improvements Are Needed,* OPPAGA Report No. 06-17, February 2006.

[3] Persons with developmental disabilities have or are at risk of having mental retardation, autism, cerebral palsy, spina bifida, or Prader-Willi syndrome.

The services received by waiver clients vary based on their specific needs. Waiver support coordinators, who are chosen by clients when they enroll in the waiver, act as advocates for the clients. Wavier support coordinators develop support plans and agency staff develop cost plans that describe client needs and the frequency, intensity, duration, and cost of services for addressing these needs.

Before clients can receive services under the Developmental Disabilities Home and Community-Based Services Waiver, their support and cost plans must undergo a prior service authorization review. These reviews are intended to ensure that the services are medically necessary and that their duration and scope are within established waiver service limitations. Once plans are approved, providers must receive a service authorization before beginning service.

The agency contracted with private vendors to conduct most prior authorization reviews. MAXIMUS, Inc., conducted the reviews for all support and cost plans that met certain criteria, including requests for residential habilitation services in settings such as group homes, and cost plans that equal or exceed $80,275. From January 2003 to June 2008, MAXIMUS conducted 47,927 prior service authorizations for the agency. Another contractor, APS Healthcare, and local Agency for Persons with Disabilities offices conducted prior service authorization reviews for clients whose service needs did not meet the criteria for a review by MAXIMUS.

Clients may appeal prior service authorization determinations. To do so, they must file a request for a hearing through the Division of Administrative Hearings within 30 days of receiving the agency's decision.

Current Status

Consistent with our recommendations, the agency has taken steps to better inform clients about the quasi-judicial nature of the appeals process. The agency has also recently consolidated prior service authorization with one vendor and has modified the role of waiver support coordinators by reassigning some of their former responsibilities to various agency staff. Given that the process is in transition, it is too soon to determine how the combination of these changes will affect communication during prior service authorization reviews and the timeliness and cost of the process.

The agency has revised the information it provides to clients on the appeals process

Our 2006 report concluded that agency notices regarding the fair hearing process did not adequately inform clients and their guardians about the quasi-judicial nature of the proceedings. Correspondence sent to clients did not specify that the agency would be represented by an attorney at the hearing, and did not provide clients with information on how they could obtain legal representation. As a result, some stakeholders asserted that the clients were at a disadvantage at the hearings.

To address this problem, the agency revised the information it provides to clients to state that the agency will be represented by an attorney. This information, which is also posted on the agency's website, also includes links to a guide to hearings and a list of pro bono legal resources. The agency reports that this information was accessed by 695 visitors between January 2008 and June 2008. [4]

[4] Since the time of our prior review, the appeals process has changed. Prior service authorization review appeals were previously handled by the Department of Children and Families Office of Appeals Hearings. However, since October 1, 2006, all new appeals have been conducted through the Division of Administrative Hearings (DOAH). DOAH is a state agency that conducts administrative hearings to resolve conflicts between private citizens and state agencies. The transfer of appeals from the Department of Children and Families Office of Appeals Hearings was mandated by a Florida District Court ruling that required the agency to offer another avenue for appeals outside DCF. For more information, see J.M v. Florida Agency for Persons with Disabilities (938 So.2d 535).

The agency has made recent changes to the prior service authorization process and needs to monitor effect of these changes on communication, timeliness, and cost

Our 2006 report noted that there was insufficient communication between MAXIMUS reviewers and waiver support coordinators. MAXIMUS reviewers did not directly contact waiver support coordinators to discuss concerns about the information provided in support plans or to obtain more information. As a result, problems were not resolved as quickly as possible, and waiver support coordinators did not have timely feedback on the status of their prior authorization requests.

The agency recently ended its contract with MAXIMUS and consolidated prior service authorization reviews with one provider. The agency and MAXIMUS partially addressed these communication problems. In December 2007, the agency implemented a web-based system that enabled waiver support coordinators to electronically submit support plans and view case status. However, this system did not allow direct contact with MAXIMUS reviewers.

To reduce costs and streamline the prior service authorization process, the agency has ended its contract with MAXIMUS and has consolidated all prior service authorization activities into one contract. The agency solicited requests for proposals on May 1, 2008, and awarded a contract for all prior service authorization reviews to APS Healthcare, Inc., in May 2008. APS Healthcare had previously conducted prior service authorization reviews for clients whose service needs did not meet the criteria for a review by MAXIMUS. [5]

The agency's Fiscal Year 2007-08 contracts with MAXIMUS and APS Healthcare totaled $4,804,345 and it estimates that consolidating the contracts will yield a savings of $2 million in Fiscal Year 2008-09. [6] Agency administrators anticipate that they will achieve additional savings in Fiscal Year 2009-10 because Florida has received federal approval to reduce the frequency of prior service authorizations from annually to once every three years.

APS Healthcare allows agency staff and waiver support coordinators direct contact with its reviewers. Reviewers, agency staff, and waiver support coordinators may contact each other by phone and e-mail to discuss and resolve any problems that arise during the prior service authorization process. APS Healthcare is also planning to implement a web-based document submission tool similar to MAXIMUS's system by April 2009. This system will allow the agency to request services and provide support plan documentation online. Waiver support coordinators will be able to check the status of reviews at any time and receive electronic notification of missing documentation.

The agency has modified the role of waiver support coordinators by reassigning some of their responsibilities. As a part of the state's Fiscal Year 2007-2008 budget reductions, the agency proposed and the Legislature approved reassigning some of the waiver support coordinators' duties to agency employees. Agency administrators indicate that modifying the role of waiver support coordinators allows these persons to continue to act as client advocates while limiting potential conflicts of interest. Previously, waiver support coordinators developed support and cost plans that described client needs and the frequency,

[5] APS Healthcare, Inc., conducted prior service authorization reviews for clients in the Family and Support Living Waiver, and those in the Developmental Disabilities Home and Community-Based Services (HCBS) Waiver with cost plans and amendments that cost less than $80,275 and did not include residential habilitation services in a residential setting.

[6] The agency's contract with APS Healthcare, Inc., for all prior service authorization reviews will be $2,804,059 in Fiscal Year 2008-09 and $1,892,681 in Fiscal Year 2009-10.

intensity, duration, and cost of services for addressing these needs. These staff were also responsible for entering this information in the agency's data system, the Allocation, Budget and Contract Control database, and submitting the information for prior service authorization review. The staff were also responsible for working with prior service authorization reviewers as needed to obtain provider service authorizations so that clients could begin receiving services.

The agency modified the role of the waiver support coordinators to focus on advocating on behalf of the client in identifying natural and community supports, developing support plans, and assisting individuals in choosing providers. The waiver support coordinators are no longer conducting the agency approved needs assessment, developing cost plans, and submitting support plans directly for prior service authorization review. Instead, these functions have been reassigned to agency staff. The agency began hiring temporary staff in January 2008 to conduct client needs assessments using a recently-developed needs assessment instrument. Using information from these assessments, waiver support coordinators develop support plans with clients and submit either an electronic or paper version of the plan and supporting documentation to local agency staff. Using information from the assessments, along with information from waiver support coordinators, local agency staff develop cost plans outlining allowable service amounts and enter this information into the agency's Allocation, Budget and Contract Control database. Local agency staff are then responsible for submitting the support plan information to APS Healthcare for prior service authorization review. When the prior service authorization review is finished, APS Healthcare will send out all provider service authorizations for clients.

Given that the prior service authorization process is in transition, it is too soon to determine how consolidating contracts, changing the role of waiver support coordinators, and dividing their responsibilities among different staff will affect communication, how long it takes to identify client needs and approve services, and the cost of these processes. Accordingly, the agency should monitor these changes and provide a status report to the Legislature.

OPPAGA supports the Florida Legislature by providing evaluative research and objective analyses to promote government accountability and the efficient and effective use of public resources. This project was conducted in accordance with applicable evaluation standards. Copies of this report in print or alternate accessible format may be obtained by telephone (850/488-0021), by FAX (850/487-3804), in person, or by mail (OPPAGA Report Production, Claude Pepper Building, Room 312, 111 W. Madison St., Tallahassee, FL 32399-1475). Cover photo by Mark Foley.

Florida Monitor: www.oppaga.state.fl.us

Project supervised by Claire Mazur (850/487-9211)
Project conducted by James Dervin
Becky Vickers, Staff Director (850/487-1316)
Gary R. VanLandingham, Ph.D., OPPAGA Director