Quality Review Team (QRT) End of Year Report

7/1/2019-6/30/2020

DBHDS Division of Developmental Services, Waiver Operations Unit

EXECUTIVE SUMMARY

Virginia operates three Home and Community-Based (HCB) §1915 (c) Medicaid Waivers designed as an alternative to an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) "institutional" setting for individuals with developmental disabilities. Waiver services supplement the services available to individuals through other funding authorities or provided by individual families and local communities. The three waivers include the Community Living (CL) Waiver, the Family and Individual Supports (FIS) Waiver, and the Building Independence (BI) Waiver. These three waivers are collectively referred to as the "DD Waivers." Each waiver has a target population based upon the support needs of the individuals. Individuals access services at the local level via the Community Services Board (CSB) system, as the single point of entry. There are forty CSBs throughout Virginia, with each city or county belonging to the catchment area of one CSB.

The VA Department of Behavioral Health and Developmental Services (DBHDS) is the operating agency for these waivers with the broad oversight of the state Medicaid Agency, the Virginia Department of Medical Assistance Services (DMAS). As directed by the Centers for Medicare and Medicaid Services CMS, the federal Medicaid authority, each waiver must have its own quality assurance system. The quality assurance system requires that states demonstrate performance in six overarching assurance areas. The assurances include the following:

1. Administrative Authority -The State Medicaid agency is involved in the oversight of the waiver and is ultimately responsible for all facets of the program.
2. Evaluation/Reevaluation of Level of Care - Individuals enrolled in the waiver have needs consistent with an institutional level of care.
3. Person-Centered Planning and Service Delivery - Service Plan-Participants have a service plan that is appropriate to their needs, and services/supports specified in the plan are received.
4. Qualified Providers - Waiver providers are qualified to deliver services/supports.
5. Health and Welfare - Participants' health and welfare are safeguarded and monitored.
6. Financial Accountability - Claims for waiver services are paid according to state payment methodologies.

All Medicaid HCB waiver programs must operate in accordance with CMS required waiver assurances. The assurances and related sub-assurances are built upon the statutory requirements of the §1915(c) waiver program with related state-specific performance measures (PMs) tied to each assurance/sub-assurance. States report on performance under each of the assurances with remediation shown for performance

measures with less than 86% compliance. Ongoing demonstrated compliance is necessary to maintain federal financial participation. The DMAS Division of High Needs Supports and DBHDS Division of Developmental Services Waiver Operations Unit, collaboratively oversee waiver performance under these assurances on a quarterly basis using data derived from both DMAS and DBHDS through Quality Review Team (QRT) reporting. The QRT uses data from provider and CSB reviews to monitor waiver performance and demonstrate compliance to CMS through annual and triennial reporting. The data is used to ensure remediation occurs where it is indicated, identify trends and areas where systemic changes are needed, and identify the need to collect different data or improve its quality. CMS reviews QRT data to ensure the state has sufficient evidence to demonstrate compliance with the waiver assurances. QRT data is provided annually to the state Quality Improvement Committee (QIC) and made available to the public on the DBHDS website

This report provides an overview of waiver performance for state fiscal year 2020. The data presented represents the average across all three waivers, as CMS permits states to report data in aggregate when the three waivers support the same population. Due to the ongoing COVID-19 pandemic, some onsite state operations were temporarily suspended, resulting in a delay of data reporting for several PM's and the subsequent delay in release and publication of this report. Missing data has since been incorporated into this final version.

Waiver assurance performance in the Commonwealth for FY2020 is comparable to FY2019 performance, with eight PM's reported below the 86% minimum annual average. All noncompliant measures for FY2019 were resolved to compliance in FY2020, with the exception of two PMs **#C9** *Number and percent of provider agency direct support professionals (DSPs) meeting competency training requirements*, and **#D7** *Number and percent of individuals who received services in the frequency specified in the service plan,* ensuring that individuals receive services in the frequency outlined in the Individual Support Plan (ISP). (See Figure 1A below).

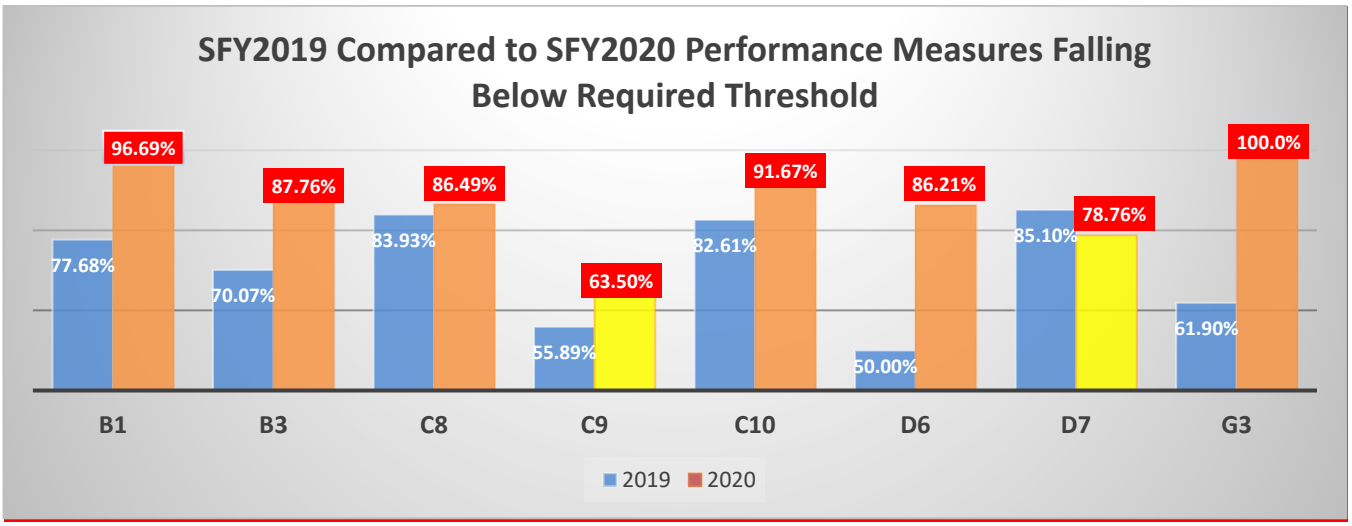

Figure 1A

The eight 8 PM's that fell below 86% in 2020 include the following:

C9: Number and percent of provider agency direct support professionals (DSPs) meeting competency training requirements.

D1: Number and percent of individuals who have Plans for Support that address their assessed needs, capabilities and desired outcomes.

D3: Number and percent of individuals whose Plan for Supports includes a risk mitigation strategy when the risk assessment indicates a need.

D4: Number and percent of service plans that include a back-up plan when required for services to include in-home supports, personal assistance, respite, companion, and Shared Living.

D7: Number and percent of individuals who received services in the frequency specified in the service plan.

D11: Number and percent of individuals who received services in the amount specified in the service plan.

G4: Number and percent of individuals who receive annual notification of rights and information to report abuse, neglect, and exploitation (ANE).

G10: Number and percent of participants 19 and younger who had an ambulatory or preventative care visit during the year.

All FY 2020 non-compliant PM's shown below were remediated during 2020 and 2021, with activites described throughout this report.

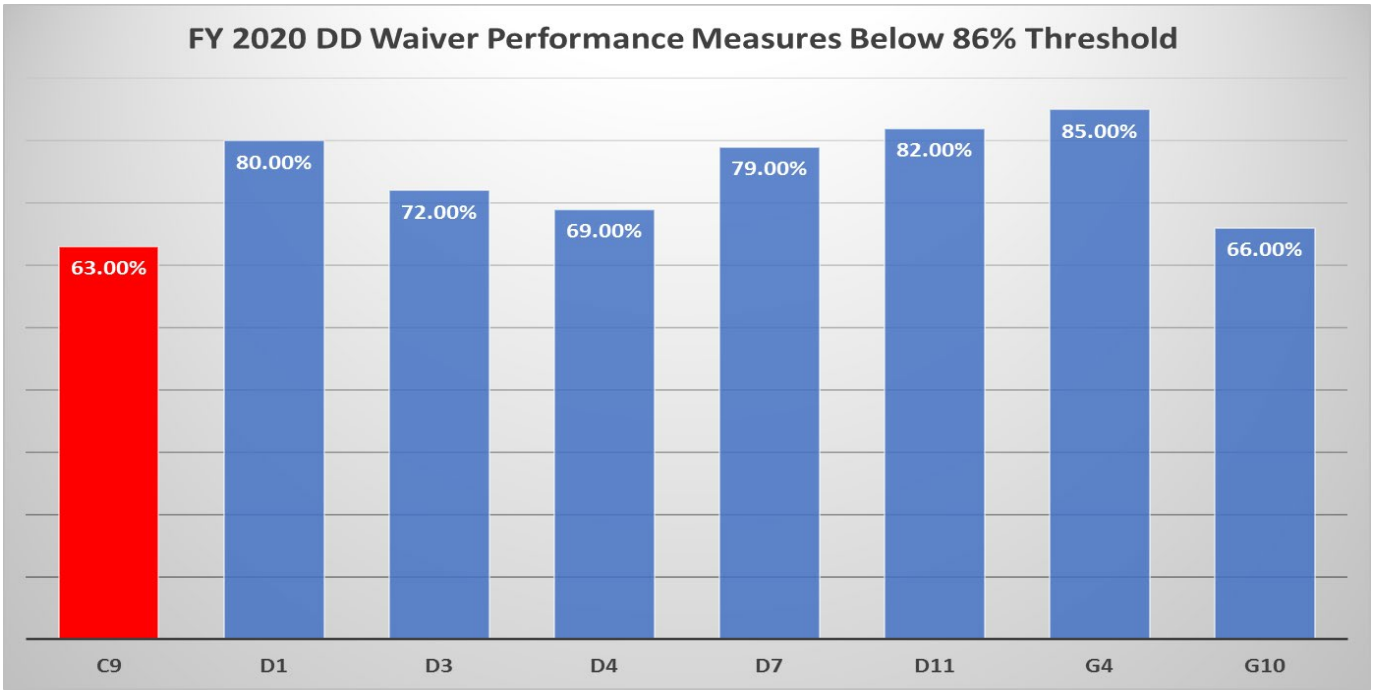

Figure 1B

First level remediation for all PM's below compliance includes targeted training and technical assistance in the specific area of noncompliance delivered by various DBHDS departmental units. Group training, FAQ documents, training videos, and newsletters have also been developed and distributed as supplemental resources. In addition, on-demand recorded training has been utilized with the intent to secure additional resources to expand this capability. For specific areas of non-compliance that persist for more than two quarters despite intervention, additional remediation activities are developed and targeted to the area of challenge. For PM's related to assuring individual health and safety, several new risk tools were created which are expected to have an impact on waiver performance over time. Systemic remediation in the form of statewide quality improvement initiatives (QII), may also be implemented. All of the waiver PM's are tracked for compliance with CMS requirements as well as the statewide DBHDS Quality Management plan, reportable under the DOJ Settlement Agreement.

Demonstrable improvement in provider compliance statewide is contingent on several factors. These include:

1.) The degree and extent to which state staff have access to contact information for all providers of DD waiver services in the Commonwealth in order to deliver timely information, resources, and training on waiver requirements.
2.) The sampling methodology used to review some provider records.
3.) Improvements in data collection, reporting, and remediation tracking via modernized data tools

First, comprehensive provider contact information is not readily accessible. Provider lists are often generated via a combination of DBHDS licensing data, DMAS billing data, and information voluntarily submitted through other electronic systems and platforms. Further, there is no universal location for acessing provider contact information or statewide mandate or regulatory requirement for providers to update their contact information in any statewide system. In addition, provider contact information may be reported differently in each department or electronic platform. Therefore, essential information delivered by the state is reaching only a fraction of the intended population. These DD waiver providers disengaged from the system are less likely to be familiar with requirements, resulting in an increased likehood of noncompliance.

Second, the sampling methodology utilized in some reviews may indirectly impact compliance reporting. Quality Management Reviews (QMR's) conducted by DMAS are the data source for the majority of the PM's. Each quarter, a sample of service providers is selected and individuals receiving services from those providers are identified for inclusion in the record review. A proportionate stratified sample is used to determine the number of records to be reviewed within each waiver. The methodology for review of records allows for differerent providers to be sampled each quarter (see DMAS data provenance discussion in Section II). Smaller providers who do not participate in training or review regular state notices, or large providers, like a CSB, which may have many records showing noncompliance in the same area, can adversely impact a PM. Additionally, small sample sizes also affect compliance. If there are not enough providers delivering an authorized service to review a particular service during the quarter, or if the PM

incorporates a subset of the population (when an additional condition has to be met within the total number of records under review for the record to be included), the smaller numbers in the sample cause a larger impact to the compliance percentage.

Thus, data reviewed presents only a snapshot of the system; a descriptive interpretation of compliance for a particular PM, within a particular service, during a particular quarter. Only when downward trending PM data persists over multiple quarters and/or over multiple years, can it be determined that systemwide noncompliance exists. When widespread noncompliance is identified, systemic quality improvement initiatives targeted to areas of continued noncompliance are developed, implemented, and evaluated for impact. Improvements in performance resulting from provider remediation and targeted interventions are typically demonstrated, at minimum, over the course of 2-3 quarters or even a full year's review.

Third, the QRT leadership has also identified improved data reporting capability through an electronic data solution, as an ongoing critical need. The ability to review aggregate data collected at its source, as well as integrate historical information via a database solution, will allow for analysis of patterns and trends in noncompliance and improve the ability to determine the effectiveness of interventions. Design and implementation of an electronic data reporting solution is expected to be complete by the fourth quarter of 2021.

QRT process improvements are also underway. Though the QRT sampling methodology is tied to Virginia's approved waivers application and thus not easily changed, an investment in documenting all processes for collecting and reporting QRT data is in progess to ensure data fidelity and confidence in data reported. Overall QRT process improvements include changes made beginning in the third quarter of FY2020 to improve follow up of QRT PM's and remediation activities, such as restructuring the meeting agenda and meeting summary to allow for improved tracking of remediation activities. Further, the new DD waiver regulatory requirement mandating provider remediation can be the catalyst for developing statewide, intra-agency processes to help expand the reach to all providers so that existing first line remediation is more effective.

In conclusion, there are multiple factors which impact compliance for a given PM. The extent to which compliance is able to be realized across Virginia's DD Waivers system, is tied to generalized provider knowledge and information. Therefore, it is imperative that a system be in place to ensure each provider, large or small, DBHDS-licensed or not, is being reached and trained on the waiver regulations and documentation requirements. Further, developing the capacity within the state for more innovative/on-demand training resources will free up staff time to be able to focus on individual, provider-specific remediation, and modernization of QRT processes and tools will allow for improved reporting of systemwide performance over time as well as efficiency in operations.

OVERVIEW: QUALITY REVIEW TEAM CHARTER (MAY 2021)

The Quality Review Team (QRT), a joint Department of Behavioral Health and Developmental Services (DBHDS) and Department of Medical Assistance Services (DMAS) committee, is responsible for oversight and improvement of the quality of services delivered under the Commonwealth's Developmental Disabilities (DD) waivers as described in the waivers' performance measures.

Authorization / Scope of Authority

The QRT is responsible for reviewing performance data collected regarding the Centers for Medicare and Medicaid Services' (CMS) Home and Community Based Services waiver assurances:

- Waiver Administration and Operation: Administrative Authority of the Single State Medicaid Agency
- Evaluation/Reevaluation of Level of Care
- Participant Services - Qualified Providers
- Participant-Centered Planning and Service Delivery: Service Plan
- Participant Safeguards: Health and Welfare
- Financial Accountability

The work of the QRT is accomplished by accessing data across a broad range of monitoring activities, including those performed via DBHDS licensing and human rights investigations and inspections; DMAS quality management reviews and contractor evaluations (QMR); serious incident reporting; mortality reviews; and DBHDS level of care evaluations.

Each DD waiver performance measure is examined against the CMS standard of 86% or above compliance. Those measures that fall below this standard are discussed to identify the need for provider specific as well as systemic remediation. The committee may make recommendations for remediation such as:

- Retraining of providers
- Targeted technical assistance
- Information Technology system enhancements for the collection of data
- Change in licensing status
- Targeted QMR
- Referral for mandatory provider remediation
- Payment retraction or ceasing referrals to providers
- Review of regulations to identify needed changes
- Review of policy manuals for changes.

The team identifies barriers to attainment and the steps needed to address them. The QRT reexamines data in the following quarter to determine if remediation was successful or if additional action is required. The QRT was established in August 2007 in response to CMS's expectations that states implement a quality

review process for HCBS waivers. This charter shall be reviewed by DBHDS and DMAS on an annual basis or as needed and submitted to the Quality Improvement Committee for review.

Model for Quality Improvement

The activities of the QRT are a means for DMAS and DBHDS to implement CMS's expected continuous quality improvement cycle, which includes:

- Design
- Discovery
- Remediation
- Improvement

Structure of Workgroup / Committee:

Membership DBHDS:

- Director of Waiver Operations or designee
- Senior DD Program Staff
- Director of Provider Development and/or designee
- Director, Office of Integrated Health, and/or designee
- Director of Office of Licensing and/or designee
- Director of Office of Human Rights or designee
- Director of Office of Community Quality Improvement or designee
- Director, Mortality Review Committee and/or designee
- Settlement Agreement Director

DMAS:

- Director of Division of Developmental Disabilities or designee
- Program Advisor
- Developmental Disabilities Program Manager or designee
- QMR Program Administration Supervisor or designee
- Sr. Policy Analyst

Meeting Frequency: The committee will, at a minimum, meet four times a year. The QRT review cycle is scheduled with two quarters' lag time to accommodate the 90-day regulatory requirement to successfully investigate and close cases reportable under the Appendix G Health and Welfare measures.

Leadership and The DBHDS: The Senior DD Policy Analyst shall serve as chair and will be responsible for ensuring the committee performs its functions including development of meeting agendas and convening regular meetings. The standard operating procedures include:

- Development and annual review and update of the committee charter
- Regular meetings to ensure continuity of purpose
- Maintenance and distribution of quarterly reports and/or meeting minutes as necessary and pertinent to the committee's function
- Maintenance of QRT data provenance
- CMS Evidentiary and state stakeholder reporting
- Quality improvement initiatives consistent with CMS's "Design, Discover, Remediate, Improve" model.

A meeting summary is prepared and distributed to committee members prior to the meeting and shall reflect the committee's review and analysis of data and any follow up activity.

The QRT shall produce an annual report (QRT End of Year (EOY Report) to the DBHDS Quality Improvement Committee on the findings from the data review with recommendations for system improvement. The QRT's report will include an analysis of findings and recommendations based on review of the information regarding each performance measure.

CMS has indicated that reporting on the performance measures can be consolidated if all of the following requirements are met.

1.) Design of the waivers is same/very similar
2.) Sameness/similarity determined by comparing waivers on approved Waiver Application Appendices:
    - C: Participant Services
    - D: Participant-Centered Planning and Service Delivery
    - G: Participant Safeguards
    - H: Quality Management
3.) Quality management approach is the same/very similar across waivers, including:
4.) Methodology for discovering information (e.g., data systems, sample selection)
5.) Manner in which individual issues are remedied
6.) Process for identifying & analyzing patterns/trends
7.) Majority of Performance Measures are the same
8.) Provider network is the same/very similar
9.) Provider oversight is the same/very similar

Additionally, the sampling method must be proposed in the Waiver application and approved by CMS and various sampling methods are acceptable. It is noted that, for the Commonwealth's DD waivers:

- All services are the same but not all are offered under each waiver.
- All individuals go through the same slot selection process.
- All waiver service providers use the same enrollment process as delineated by DMAS.
- All providers for the three waivers that are required to be licensed are done so through the DBHDS.

- All participants' service needs are determined through the Person Centered Planning process.
- All three waivers will have the same performance measures with the approval of the amendment for the CL Waiver.

Therefore, QRT data across the CL, FIS, and BI waivers is consolidated for annual and triennial reporting to CMS. However, individual waiver level data may be reported and reviewed for internal quality management monitoring across waivers where feasible and necessary.

I. QRT DATA PROVENANCE FOR HEALTH AND SAFETY MEASURES

Background

Performance Measures Using Quality Management Reviews (DMAS)

The data source for specifically identified performance measures is data collected during the Quality Management Reviews completed by the Health Care Compliance Specialists in the QMR Division of High Needs Supports at DMAS. These reviews monitor provider compliance with DMAS participation standards and policies to ensure an individual's health, safety, and welfare and individual satisfaction with services, and includes a review of the provision of services to ensure that services are being provided in accordance with DMAS regulations, policies, and procedures. A representative sample of the participants in all three DD waivers is employed as the sampling methodology. There are two subsets of the population that are sampled; private providers and CSB's. Information demonstrating the level of compliance with the performance measures is gathered from CSB case management records and from the Plans for Supports from service providers.

The following is noted with regard to determining the sample:

A. A Statistical Analysis System (SAS) run is completed at the beginning of each quarter and yields a list of individuals with the following characteristics:

- The individual has received services, and
- DMAS has paid the provider's claim for services.

B. All forty (40) of the CSBs are sampled within a three (3) year period. Individual service providers are selected for review. Service providers are not randomly chosen; instead, a non-probability sampling method is utilized. Once a non-CSB has been reviewed, that provider is filtered out of the SAS run for at least two years. Providers are selected based on the following factors:

- Whether the individual CSB's review is due within the current three-year period.
- Whether the service provider has been reviewed recently
- Whether the service provider has been reviewed in the past
- The type of service provided (if targeted reviews are being completed)
- If there are existing concerns/complaints regarding a provider
- If there is a history of non-compliance
- The geographic location of the provider. *Due to staffing constraints, a large provider with many records who is closer geographically may be reviewed over a smaller provider with less records who is farther away.*

- The number of individuals served. *A provider with a larger number of records who is providing services for all three waivers, may be prioritized over a smaller provider with less records who may only be providing services under one waiver.*

C. Once the service provider is selected, the recipients receiving services from that provider are identified for inclusion in the record review. A proportionate, stratified sample is used to determine the number of records to be reviewed within each waiver. Using a sample size calculator such as Raosoft, a sample size is determined based on the total number of enrolled recipients using the following parameters and rounded up to the nearest 100:

- 5% margin of error
- 95% confidence level
- 50% distribution

The total number of individuals enrolled in the three (3) waivers is used as the population size. This method is used for both data subsets: case management records and individual plans for supports provided by enrolled service providers. The table below shows and example of the proportionate sample stratified by waiver subgroups.

Step	CL Waiver	FIS Waiver	BI Waiver	Total
#1 Determine #of recipients enrolled in each waiver (subgroup)	11,204	1,723	296	13,223
#2 Determine what % each waiver (subgroup) is of the whole	85% 84.7%	13% 13.03	2% 2.2	100%
#3 Determine sample size using noted parameters	374 rounded up to 400			
#4 Determine the number of recipient records to be reviewed in proportion to the percentage of enrolled recipients	340 85%of 400 =340	52 13% of 400 =52	8 2% of 400 = 8	400

The number of records to be reviewed at each CSB is determined at the beginning of each fiscal year. The number of records selected for review is in proportion to the overall percentage of recipients receiving case management services for that fiscal year. For other (non-CSB) service providers, a minimum number of records will be reviewed based on the following SAS program:

- Claim records are sorted by provider and individual
- The number of members with claims by a provider is determined
- The percentage of members that will be selected for each provider is determined according to the chart below:

# Members		Between	Sample %
0	-	15	100
16	-	24	70
25	-	39	60
40	-	50	50
51	-	61	40
62	-	75	35
76	**-**	**90**	**31**
90	**-**	**No Limit**	**25**

Members are randomly selected based on the assigned percentage for each provider:

- Claims records are included for each selected member.
- Unduplicated records are selected from all random samples (from Step d) and merged.

Performance Measures for Appendix G: Health and Safety

The Offices of Licensing and Human Rights jointly coordinate, communicate, consult and monitor the investigation of abuse and neglect allegations and critical incidents in DBHDS licensed programs. The Mortality Review Committee reviews recent deaths of individuals with a developmental disability who received services in a state-operated facility or in the community through a DBHDS-licensed provider to provide ongoing monitoring and data analysis to identify trends/patterns, system level quality improvement initiatives, and make recommendations that promote the health, safety, and well-being of individuals, in order to reduce mortality rates to the fullest extent practicable.

The data for the majority of the performance measures evaluating compliance with the CMS Appendix G waiver assurances, which serve to assure the waiver participant's health and safety, are collected by DBHDS during Office of Licensing site visits, retrospective Office of Human Rights reviews, and retrospective case reviews completed by the Mortality Review Committee. Additionally, three performance measures that fall under Appendix G of the CMS Waiver Application utilize DMAS QMR reviews as the data source.

Population

For DBHDS performance measures using data from the Computerized Health Record Information System (CHRIS), the waiver population is defined below. Measures not using data from CHRIS include a description of the population. The population consists of individuals receiving DD services as reported by the provider in the "incident service type." This was chosen based on the consistency of providers entering the service type into CHRIS as compared to the waiver type. This method relies on the assumption that those receiving DD services are on a waiver. DBHDS acknowledges this is not a 100% match; however, it is consistent with other reporting to DMAS from CHRIS.

Reporting Schedule

Data is reported on the following delayed schedule unless otherwise noted:

Period of Occurrence	**Data review and submission date (approximately)**
Q1 SFY 2020 (July 1 - Sept. 30, 2019)	February (March) 2020
Q2 SFY 2020 (Oct. 1 - Dec. 31, 2019)	May 2020
Q3 SFY 2020 (Jan. 1 – March 31, 2020)	August 2020
Q4 SFY 2020 (April 1 – June 30, 2020)	November 2020

II. STATE FISCAL YEAR 2020 (JULY 1, 2019-JUNE 30, 2020) QUALITY TEAM REPORTING

A. Administrative Authority:
Assurance: The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program exercising oversight of the performance of waiver functions by other

Performance Measure A1: Number and percent of satisfactory Medicaid-initiated operating agency and contractor (i.e. DBHDS, Conduent & CDCN) evaluations. (DMAS)

N: Number of satisfactory Medicaid–initiated operating agency & contractor evaluations.

D: Total number of Medicaid initiated operating agency & contractor evaluations

This PM seeks to demonstrate that Medicaid-initiated contractor evaluations show satisfactory performance. Measurement of the PM requires the initiation of an operating agency contract evaluation during the quarter. IF this is not initiated then results for the quarter will be reported as 0/0. Contracts potentially reviewable include DBHDS, CDCN, and Conduent. Question #6 of the evaluation "satisfaction with contractor performance" is the standard for evaluating contractor performance. If results of any DBHDS evaluation are below compliance, aggregate results will first be shared with the state DD agency for resolution. This PM typically demonstrates 100% compliance.

The aggregate total for this PM in FY2020 is 100%. No remediation is needed.

Performance Measure A2: Number and percent of DBHDS provider memorandums pertaining to the waiver approved by DMAS prior to being issued by DBHDS.

N: Number of satisfactory Medicaid–initiated operating agency & contractor evaluations.

D: Total number of Medicaid initiated operating agency & contractor evaluations

DBHDS memoranda incorporated into this category include waiver educational guidance and policy interpretations targeted to the overall DD community and system stakeholders. Any DBHDS memoranda falling into these categories must first be reviewed by DMAS prior to distribution or posting externally.

The aggregate total for this PM in FY 2020 is 100%. No remediation is needed.

Performance Measure A3: Number and percent of slots allocated to CSB's in accordance with the standardized statewide slot assignment process (DBHDS).

N: Number of waiver provider memorandums issued by DBHDS that were approved by DMAS prior to being issued.

D: Total # of waiver provider memorandums issued by DBHDS.

This PM seeks to demonstrate that state-facilitated Waiver Slot Assignment Committees assign slots according to statewide critical needs ranking and priority criteria. DBHDS operational processes require that all rankings for slot assignment are routinely reviewed and confirmed by DBHDS state staff as a quality check prior to enrollment.

The aggregate total for this PM in FY2020 is 100%. No remediation is needed.

B. Level of Care

Assurance: The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care

Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.

Performance Measure B1: Number and percent of all new enrollees who have a level of care evaluation prior to receiving waiver services (DBHDS)

N: Number of new enrollees who have a level of care evaluation prior to receiving waiver services

D: Total number of new enrollees

This PM seeks to demonstrate that all individuals newly enrolled in the waiver had a recent level of care evaluation completed confirming eligibility for waiver services, prior to receipt of services. For individuals on the DD waivers waiting list, the Virginia Intellectual and Developmental Disabilities Eligibility Survey (VIDES) is completed once to determine eligibility and again, no more than 6 months prior to active DD waiver enrollment.

The aggregate total for FY2020 is 94%. This is an improvement from 74% in FY2019. No remediation is required.

Discussion: No remediation was required in 2020, as changes made in 2019 continued to facilitate compliance throughout 2020. Low compliance demonstrated in 2019 resulted from a different standard being used to measure compliance which was built into existing standardized reports. To improve

consistency in reporting, DMAS and DBHDS agreed that the reporting standard should match the regulatory requirement that the "level-of-care determination through the VIDES appropriate to the individual according to his age, be completed no more than six months prior to waiver enrollment." The state further addressed the issue by developing a method to tabulate VIDES manually to ensure that the VIDES was administered appropriately prior to receiving waiver services. This manual tabulation methodology included comparing information in the Waiver Management System (WaMS) to information submitted in the DMAS Virginia Medicaid Management Information System (VAMMIS). Since this change, all VIDES have been reported within required criteria. Because the manual tabulation is labor-intensive, there is a continued need for an electronic solution through automated reporting from WaMS.

Performance Measure B2: The number and percent of VIDES (LOC) completed within 60 days of application for those for whom there is a reasonable indication that service may be needed in the future.

N: Number of new enrollees who have a level of care evaluation prior to receiving waiver services

D: Total number of new enrollees

This PM seeks to demonstrate the timeliness of evaluations conducted via Virginia's Level of Care Tool, the VIDES (within 60 days for individuals requesting services.)

The aggregate total for FY 2020 is 93%, which is above the required threshold. No remediation is needed.

a. Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine the initial participant level of care.

Performance Measure B3: Number and percent of VIDES determinations that followed the required process, defined as completed by a qualified CM, conducted face-to-face with the individual and those who know him (if needed).

N: Number of VIDES completed within 60 days for new applicants

D. Total number of new applicants for whom there is a reasonable indication that services may be needed in the future.

This PM seeks to demonstrate that the results of the level of care evaluations determining eligibility for waiver services (VIDES), were determined by following the appropriate process. In order to demonstrate compliance with the required VIDES process, the survey should: 1.) be completed by a qualified case manager (CM) 2.) Include evidence that the evaluation was conducted face to face with the individual and, 3.) Include supporting evidence demonstrating that the individual and someone who knows the individual

well were included. Evidence supporting all three requirements must be present to demonstrate compliance with the measure.

For review of this PM, QMR reviewers require the provider to show proof that the review was conducted face to face (i.e., progress notes or other designation in the record which includes language indicating that the VIDES was conducted in person) and signatures showing all others present during the evaluation. Evidence of a face to face visit has traditionally included documentation in the Health Electronic Record or written in progress notes. If the QMR reviewer is unable to locate the documentation in their records, the provider is requested to locate it for the reviewer. If documentation is unable to be located, then the provider will receive a corrective action. In July of 2020, a drop down selection was added to the state Waiver Management System (WaMS) as a universal mechanism to document that the review was conducted face to face.

The aggregate total for this PM in FY2020 is 88%, an increase from 70% in FY2019. No remediation is required.

Discussion: The first quarter of FY2020 continued to show lower compliance. Discussion during QRT meetings proposed the reason for noncompliance as case managers not knowing or either forgetting to document a "virtual" visit allowable under Appendix K flexibilities due to COVID, as a "face to face" visit. Virtual face to face visits, including those conducted via Skype, Zoom, etc. and in-person visits outside of the individual's home, in a park, etc. and a telephone conversation (if individual or family refuses an in person visit), may be documented as a face to face visit. Reminders about this flexibility were shared during various provider communications and trainings and as a result, the annual average percentage for the PM increased to compliance for FY2020.

Performance Measure B4: Number and percent of VIDES determinations for which the appropriate number of criteria were met to enroll or maintain a person in the waiver.

N: Number of VIDES determinations that use criteria appropriately to enroll or maintain a person in the waiver

D: Total number of VIDES forms reviewed

This PM seeks to demonstrate that individuals were appropriately screened and meet the required eligibility criteria to receive waiver services prior to being enrolled or maintained in the DD Waivers program. The VIDES is required to be completed within 12 months of the previous VIDES and any time there is a significant change in the individual's life that would potentially affects the results of the survey.

The aggregate total for this PM in FY2020 is 100%. No remediation is needed.

Appendix C. Participant Services - Qualified Providers

Assurance: The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

Sub-Assurance a) The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.

Performance Measure C1: Number and percent of licensed/certified waiver provider agency enrollments for which the appropriate license/certificate was obtained in accordance with waiver requirements prior to service provision.

N: Number of licensed/certified waiver agency provider enrollments for which the appropriate license/certification was obtained in accordance with waiver requirements prior to service provision

D: Total number of waiver agency provider enrollments

This PM seeks to demonstrate that waiver provider agencies had the appropriate license prior to providing services to individuals on the DD Waivers.

The aggregate total for this PM in FY2020 is 100%. No remediation is needed.

Performance Measure C2: Number & percent of licensed/certified waiver provider agency staff who have criminal background checks as specified in policy/regulation with satisfactory results.

N: Number of licensed/certified waiver provider agency DSPs who have criminal background checks as specified in policy/regulation with satisfactory results.

D: Total number of licensed/certified provider agency DSP records reviewed.

This PM seeks to demonstrate that licensed and/or certified waiver provider agency staff completed criminal background checks, with satisfactory results, according to regulatory requirements.

The aggregate total for all waivers for FY FY2020 is 88%, which is within the required threshold for compliance. No remediation is needed.

Performance Measure C3: Number & percent of enrolled licensed/certified provider agencies, continuing to meet applicable licensure/certification following initial enrollment.

N: Number of enrolled licensed/certified providers, continuing to meet applicable licensure/certification following initial enrollment

D: Total number of licensed/certified provider agencies

This PM seeks to demonstrate that waiver provider agencies continued to maintain their license/certification after initial enrollment.

The aggregate total for this PM in FY2020 is 100%. No remediation is needed.

Sub-Assurance b) The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

Performance Measure C4: Number and percent of non-licensed/noncertified provider agencies that meet waiver provider qualifications. (DMAS)

N: Total number of non-licensed/non-certified provider agencies that meet waiver provider qualifications.

D: Total number of non-licensed/non-certified provider agencies

This PM seeks to demonstrate that non-licensed/non-certified provider agencies meet the appropriate provider qualifications prior to providing services to individuals on the DD Waivers. Non-licensed, non-certified provider agencies include those that provide services which are not licensed by DBHDs or another statewide licensing agency or Board. These include the following services

- Community Guide
- Employment and Community Transportation
- Peer Mentor Supports when a Center for Independent Living (CIL) is the provider
- Therapeutic Consultation
  - Behavior Consultation when the provider is an endorsed PBSF
  - Rehabilitation Consultation when the provider is a rehabilitation engineer

The aggregate total for this PM in FY2020 is 100%. No remediation is needed

Performance Measure C5: Number & percent of non-licensed/noncertified provider agency DSPs who have criminal background checks as specified in policy/regulation with satisfactory results. (DMAS)

N: Number of non-licensed/non-certified provider agency DSPs who have criminal background checks as specified in policy/regulation with satisfactory results.

D: Total number of non-licensed/noncertified provider agency DSP records reviewed.

This PM seeks to demonstrate that non-licensed and/or non-certified provider DSP staff completed criminal background checks, with satisfactory results, according to regulatory requirements.

The aggregate total for this PM in FY2020 is 88% which is within the required threshold. No remediation is needed

Discussion: Prior QRT discussion focused on achieving agreement on which services should be included in the sample for this PM. The number of services initially included in the DMAS sample of non-licensed/non-certified providers was very small. Due to the relatively small number of individuals enrolled in these services, the ability to review the referenced services for each waiver and for each quarter has been challenging. Since this time, DMAS agreed to review providers of the following identified services: Therapeutic Consultation, Respite, Assistive Technology, Environmental Modifications, Group Supported Employment Services, and Community Guide. Employment and Community Transportation and Peer Mentor Services will be added once there are individuals authorized for those services.

Performance Measure C6: Number of new consumer-directed employees who have a criminal background check at initial enrollment.

N: Number of new consumer-directed employees who have a criminal background check at initial enrollment

D: Total number of new consumer-directed employees enrolled.

This PM demonstrates that consumer-directed employees have completed a criminal background check upon initial enrollment.

The aggregate total for this PM in FY2020 is 98%. No remediation is needed.

Performance Measure C7: # of consumer-directed employees who have a failed criminal background who are barred from employment (DMAS)

N: Number of consumer-directed employees who have a failed criminal background who are barred from employment

D: Total number of consumer-directed employees who have a failed criminal background check

This PM seeks to ensure that consumer-directed employees who failed their criminal background check were not able to be employed as consumer-directed staff.

The aggregate total for this PM in FY2020 is 100%. No remediation is needed.

sub-Assurance: c) The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.

Performance Measure C8: Number and percent of provider agency staff meeting provider orientation training requirements (DMAS)

N: Number of provider agency staff meeting provider orientation training requirements

D: Total number of provider agency staff reviewed

This PM seeks to demonstrate that provider agency staff have completed the annual DSP orientation training and documentation of the training is present in the provider's record.

The aggregate total for all waivers for FY2020 is 86% which is just within the required threshold. This is an increase from FY2019 (83.96%) No remediation necessary.

Discussion: When DBHDS initiated the core competencies in 2016, some providers were of the mistaken impression that the DSP competencies (C9) replaced the annual staff orientation training/testing requirement. Aggressive training and technical assistance, and reminder notifications were distributed to providers for this PM in concert with PM C9 during FY2020/2021.

Performance Measure C9: Number and percent of provider agency direct support professionals (DSPs) meeting competency training requirements.

N: Number of provider agency DSP's who meet competency training requirements as specified in regulation

D: Total number of provider agency DSP records reviewed

This PM seeks to ensure that all provider agency DSPs completed competency training requirements and that completed documentation indicating that provider staff were observed demonstrating competencies, is present in the provider's record. DSPs and DSP Supervisors must be deemed as proficient in the basic competencies and, if a DBHDS-licensed provider, applicable advanced competencies within 180 days of hire (or within 180 days of supporting a person with related needs) and reconfirmed annually.

The aggregate total for all waivers for FY2020 is **63%** which is increased slightly from FY2019 (55.89%) but still well below the required threshold.

Discussion: As background, two population subgroups comprise the denominator for this PM. To assess which subgroup data reporting would be used moving forward, throughout FY2020 the QRT reviewed compliance using two options a.) Assessing staff competency records using only the initial hiring date and b.) Assessing records using the initial hiring AND annual date for a year. During FY2020 dual reporting, review of the data did not reveal a significant difference between the numbers; therefore, the QRT determined that reporting Option B, which included new employees and those who have had at least one annual update, would be used as the option most reflecting regulatory requirements.

This measure has been consistently low for a number of years and of all the PMs shown as below compliance for 2020, this is one of only two PMs that has carried over from 2019. The primary issues identified with this PM have been related to poor recordkeeping and misunderstanding/confusion about

the competency requirements. During QMR reviews, providers cited under the PM have been unable to produce the competency documentation for staff, are missing pages from the packet, missing signatures, and missing the documentation of observation of demonstrated competencies via checkmark, that staff have been observed demonstrating the competencies. Providers cited include very large provider agencies as well as CSB's. This PM has been an area of concern for both CMS and DOJ Settlement Agreement reporting.

Remediation activities have focused on both group and targeted trainings, as well as provider reminder notifications. In response to QRT EOY feedback from CSB's in 2019, the DBHDS Provider Development team developed regional and targeted provider trainings as a formal Quality Improvement Initiative (QII) approved by the DBHDS QIC (the QII was formally implemented in FY 2021). Those providers who received a CAP in this area in FY 2020 were identified and invited to attend training on provider orientation and competencies requirements in FY 2021. Other resources were developed and made available on the DBHDS website, including a training video, slides, and an FAQ on the competencies. It should be duly noted that provider contact information for the Provider Listserv and Provider Roundtable meetings, the primary DBHDS communication and information vehicles targeted to providers, are opt-in only. This means that DBHDS is not reaching 100% of waiver providers with its messaging. This is an area of deficiency noted statewide that is noted in the introduction to this report and is being further discussed. Other remediation now permissible with statewide regulatory authority, will soon include financial sanctions for providers with multiple corrective action plans (CAPS) in specific areas who do not participate in Mandatory Training and Technical Assistance/Remediation in the area of noncompliance. Nevertheless, variation in compliance is likely continue to some degree as different providers are sampled each quarter.

Performance Measure C10: Number of services facilitators meeting training requirements and passing competency testing.

N: Number of services facilitators meeting training requirements and passing competency testing.

D: Total number of services facilitators reviewed

This PM seeks to demonstrate that service facilitators for consumer-directed services (CL and FIS waiver only) met provider training requirements and passed the competency test with at least the minimum score.

The aggregate total for all waivers for FY2020 is (92.60%). No remediation required.

Discussion: Although the PM is within compliance for 2020, the QRT has continued to discuss specific information vehicles that can be used to share information with service facilitators (SF's). These communication vehicles should target SF's with similar information sent to the general provider population regarding the new regulatory provision of referring noncompliant providers to Mandatory Technical Assistance and Training/Remediation, as well as PM information specifically targeted to the SF population.

D. Service Plan

Assurance: The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

Sub-assurance a) Service plans address all participants assessed needs including health and safety risk factors and personal goals, either by the provision of waiver services or through other means.

Performance Measure D1: Number and percent of individuals who have Plans for Support that address their assessed needs, capabilities and desired outcomes. (DMAS)

N: Number of individuals who have Plans for support that address their needs, capabilities, and desired outcomes

D: Total number of individuals' records reviewed

This PM seeks to ensure that service plans addressed all needs/desires of the individual receiving services. If the plan identifies a need, a measurable outcome should be included in the plan, to be provided through waiver services or other means (natural supports, etc.).

The aggregate total for FY2020 is **80%** which is decreased from FY2019 (87%). The measure will require systemic remediation.

Discussion: QMR reviewers are determining whether the individual's needs (i.e. via risk assessment) and desires (i.e. measurable outcomes) are addressed in the ISP. Both the identification of risks through the risk assessment and the strategy for mitigating risks must be included in the ISP. Providers cited typically have not developed any kind of strategy to address risks. The QRT discussion focused on several new risk mitigation tools developed by DBHDS to address risk mitigation across DBHDS quality management areas and resolve low compliance with this PM. Instructions about the need to identify risks and risk mitigation in ISPs were issued by DBHDS in the form of a targeted memorandum distributed to providers on 6/15/2020. Providers also received notice about this PM during provider roundtable meetings and other technical assistance and training opportunities. The committee discussed allowing follow-up and review of the PM during the first few quarters of FY2021 to allow time for the new risk mitigation tools to impact compliance.

Performance Measure D2: Number and percent of individual records that indicate that a risk assessment was completed as required.

N: Number of records that indicate that a risk assessment was completed as required.

D: Total number of individual records reviewed.

This PM seeks to demonstrate that individuals receiving waiver services received a risk assessment, as required.

The aggregate total for FY2020 is 96%, which is well above the required threshold. No remediation is necessary.

Performance Measure D3: Number and percent of individuals whose Plan for Supports includes a risk mitigation strategy when the risk assessment indicates a need.

N: Number of individuals whose Plan for Supports includes a risk mitigation strategy when the risk assessment indicates a need.

D: Total number of individuals' records reviewed whose risk assessment indicates a need for a risk mitigation strategy.

This PM seeks to ensure that a risk mitigation strategy was included in the provider's Plan for Supports, if the completed risk assessment identified a risk factor for the individual.

The aggregate total for FY2020 is **72%.** Systemic remediation is required.

Discussion: A downward trend for the PM continued for 2020 as it has for the past several years. To address this area, DBHDS developed and implemented several new tools devoted to identification and remediation of risk. There is a new Risk Awareness Tool (RAT) that was developed to comply with the DOJ indicators, a new onsite visit tool designed to assess change of status and whether or not he ISP was implemented appropriately, and a new crisis risk awareness tool that was recommended to fill in the gaps between Supports Intensity Scale® assessment years. These tools are more comprehensive and require a referral and change in the ISP.

- The Risk Awareness Tool (RAT) is used in ISP planning to develop health outcomes and support instructions for qualified professionals, to ensure that a discussion occurs between the individual and their support system about potential indicators of risk of a fatal event or adverse outcome. Since implementation, the RAT has since been updated with some revisions made to increase utility. In order to make implementation easier and reduce redundancy, the state has discontinued use of the Annual Risk Assessment.
- The QRT discussed follow-up and review of this PM and the previous PM to occur over several quarters in 2021, to allow time for the new risk assessment tools to become an effective resource for improving compliance.

Performance Measure D4: Number and percent of service plans that include a back-up plan when required for services to include in-home supports, personal assistance, respite, companion, and Shared Living.

N: Number of service plans that include a back-up plan when required for services to include in home supports, personal assistance, respite, companion, and shared living.

D: Total number of service plans reviewed that require a back-up plan

The PM seeks to demonstrate that service plans for the following DD waiver services included a back-up plan as required for the following services: In-home Supports, Personal Assistance, Respite, Companion, and Shared Living. This PM is monitored through review of Services Facilitator records for CD services. CD services are available in the CL and FIS waivers only. It should be noted that there is no data for the BI waiver for this PM as Shared Living is the only option available and that service is under- utilized by individuals in the BI waiver.

The aggregate total for FY020 is **at 69%.** Systemic remediation is required.

Discussion: This PM has periodically demonstrated low compliance. QRT discussion included the need for reminders/guidance to DBHDS Service Authorization (SA) staff to ensure that they closely examine these services for inclusion of back-up plans. Standard remediation activities have occurred for this PM, including providers receiving notice during standard e-mail distributions, reminders at provider roundtable meetings and other technical assistance and training opportunities. PM instructions were included in a memorandum distributed to providers on the provider distribution list 6/15/2020 and SA staff received more in-depth training and follow up by Lead Service Authorization staff.

Discussion also included SA staff being trained on new online training modules which include the specific services that require a back-up plan, the requirements, and where staff should expect to find this information recorded. The requirement for a back-up plan for specific services will be highlighted in the forthcoming provider manual.

Sub-assurance: c) Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.

Performance Measure D5: Number and percent of service plans reviewed and revised by the case manager by the individual's annual review date.

N: Number of service plans reviewed and revised by the case manager by the individual's annual review date

D: Total number of service plans reviewed

This PM seeks to demonstrate that service plans were reviewed by the individual's annual review date and revised by the case manager (as needed).

The aggregate total for this PM in FY2020 is 99%. No remediation needed.

Performance Measure D6: Number and percent of individuals whose service plan was revised, as needed, to address changing needs.

N: Number of individuals whose service plan was revised as needed, to address changing needs

D: Total number of individual service plans reviewed that needed to be revised due to changed needs

This PM seeks to ensure that the ISP was updated/revised by the case manager, whenever an individual's needs or desires change (irrespective of annual review dates). QMR reviews include first, the determination of a change in need demonstrated in documentation and then the addition of a new support activity or outcome to address the change in need.

The aggregate number for this PM in FY2020 is just within the required threshold at 86%.

Discussion: Although the PM is demonstrated within compliance for 2020, it is an area of continued challenge. First line remediation continues to be provider education through targeted instructions for providers on how to make changes in WaMS, recorded webinars, and a guidance document with instructional content on how to document changes to plans when needed. Performance with regard to this measure will also be addressed with approval and implementation of a new waiver regulatory requirement for mandatory provider training and technical assistance for those providers with multiple citations in an identified area.

Sub-assurance d: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the physician of waiver services or through other means.

Performance Measure D7: Number and percent of individuals who received services in the frequency specified in the service plan

N: Number of individuals who received services in the frequency specified in the individual service plan

D: Number of service plans reviewed

This PM seeks to demonstrate that services were delivered to the individual in the required frequency as outlined in the service plan and evidenced by documentation in the provider record (indicating how often services were being delivered to the individual and the presence of a support activity). The PM is assessed during QMR reviews to determine if the provider is providing the service (s) as required (outlined in the ISP). If the individual is sick, chooses not to participate, or otherwise deviates from the scheduled activity as described in the ISP, this should be documented in the record.

The aggregate number for this PM in FY2020 is below the required threshold at **79%** which is decreased from FY2019 (85%). Systemic remediation is required

Discussion: This PM was also reported as non-compliant in 2019. During reviews, DMAS QMR is looking for documentation showing how often services were delivered to the individual *and* the presence of a support activity. For example, if a support activity is to occur 3x weekly, barring the existence of a documented reason why the individual could not participate in the activity, the documentation should show that the individual was receiving the support activity in the frequency specified in the plan. Cited providers could not show the reason why the service was not provided as noted on the plan. Compliance with this PM varies by service or the actual support activity. Refusals do not count towards DMAS's attempt to document an overall pattern of noncompliance.

As remediation, DMAS developed written guidance to providers distributed to providers via the Provided Distribution Listserv in the form of a TSADF Criteria Grid, which depicts expectations under the Type, Scope, Amount, Duration, and Frequency of waiver supports provided per the ISP and reviewed during QMR audits. If there are extenuating circumstances for why services were not delivered in the required frequency, this should be documented in the record. If there are extenuating circumstances as to why services were not delivered in the required frequency, this should be documented in the record and there should be a review of the plan for needed modifications.

Provider documentation will continue to be addressed via provider training and technical assistance.

Performance Measure D8: Number and percent of individuals who received services in the duration specified in the service plan

N: Number of individuals who received services in the duration specified in the service plan

D: Service plans reviewed

This PM seeks to ensure that services were delivered to the individual in the required duration as outlined in the service plan, and evidenced by documentation in the provider record.

The aggregate total for FY2020 is 98%, which is well above the required threshold. No remediation is needed.

Performance Measure D9: Number and percent of individuals who received services in the type specified in the service plan

N: Number of individuals who received services in the type specified in the service plan

D: Service plans reviewed

This PM seeks to ensure that the appropriate type of services were delivered to the individual as outlined in the service plan and evidenced by documentation in the provider record.

The aggregate total for 2020 is 99%, which is well above the required threshold. No remediation is needed.

Performance Measure D10: Number and percent of individuals who received services in the scope specified in the service plan

N: Number of individuals who received services in the scope specified in the service plan

D: Service plans reviewed

This PM seeks to ensure that services were delivered to the individual in the required scope (plan included all services needed by the individual) as outlined in the service plan and evidenced by documentation in the provider record.

The aggregate total for FY2020 is 97%, which is well above the required threshold. No remediation is needed.

Performance Measure D11: Number and percent of individuals who received services in the amount specified in the service plan

N: Number of individuals who received services in the amount specified in the service plan

D: Service plans reviewed

This PM seek to ensure that services were delivered to the individual in the amount required (correct amount of time/number of hours individual received services daily) as outlined in the service plan and evidenced by documentation in the provider record.

The aggregate total for FY2020 is **82%.** Systemic remediation is required.

Discussion: As remediation, DMAS developed written guidance to providers in the form of the TSADF Criteria Grid. See PM D7 for discussion.

Sub-assurance e: Participants are afforded choice between/among waiver services and providers.

Performance Measure D12: Number and percent of individuals whose case management records documented that choice of waiver providers was provided to and discussed with the individual. (DMAS)

N: Number of case management records that contain documentation that choice of waiver providers was offered to the individual

D: Total number of records reviewed

The PM seeks to ensure that individual case management records reviewed by QMR, contained the form used by the state to document that choice of waiver providers was offered to the individual receiving services.

The aggregate total for FY2020 is within the required threshold (99%).

Performance Measure D13: Number and percent of individuals whose case management records contain an appropriately completed and signed form that specifies choice was offered among waiver services

N: Number of case management records that contain documentation of choice among waiver services

D: Total number of records reviewed

The PM seeks to ensure that individual case management records reviewed by QMR, contained the form used by the state to document that choice was provided among waiver services.

The aggregate total for 2020 is within the required threshold (99%).

G. Participant Safeguards: Health and Welfare - The state demonstrates that it has designed and implemented an effective system for assuring waiver participant health and welfare.

Sub-assurance: a) The State demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.

Performance Measure G1: Number and percent of closed cases of abuse/neglect/exploitation for which DBHDS verified that the investigation conducted by the provider was done in accordance with regulations.

N: Number of closed cases of abuse/neglect/exploitation verified that the investigation was conducted in accordance with regulations

D: Number of closed cases of abuse/neglect/exploitation that were reviewed

This PM seeks to demonstrate that fact-finding in reported cases of abuse, neglect, and exploitation (ANE), once closed, were verified as properly investigated according to Office of Human Rights (OHR) regulations. The OHR retrospective review uses a random sample of closed cases of abuse, neglect, and exploitation for individuals receiving DD services drawn from allegations in CHRIS. The specific question from the look-behind that addresses this performance measure is "Did the facts of the provider investigation support the Director's finding?"

The aggregate total for 2020 (93%) is within the required threshold. No remediation required.

Performance Measure G2: Number and percent of closed cases of abuse/neglect/exploitation for which the required corrective action was verified by DBHDS as being implemented

N: Number of substantiated cases of abuse/neglect/exploitation for which the required corrective action was verified as being implemented within 90 days

D: Number of substantiated cases of abuse/neglect/exploitation

This PM seeks to demonstrate that DBHDS has verified that providers who had substantiated cases of ANE implemented corrective actions. The OHR retrospective review uses a random sample of closed cases of ANE for individuals receiving DD services. This sample is drawn from allegations in CHRIS. The OHR Advocates follow protocols to verify the implementation of the corrective action. By designating the case as closed, the advocate has therefore received verification of the approved corrective action. This measure uses 90 days as the maximum amount of time that a substantiated case should be open.

The aggregate total for 2020 (99%) is within the required threshold. No remediation required.

Performance Measure G3: Number and percent of unexpected deaths where the cause of death/a factor in the death, was potentially preventable & some intervention to remediate was taken. (DBHDS)

N: Number of unexpected deaths where the cause of death/a factor in the death, was potentially preventable & some intervention to remediate was taken

D: Number of substantiated cases of abuse/neglect/exploitation

This PM seeks to demonstrate that the DBHDS Mortality Review Committee (MRC), recommended interventions for all unexpected deaths identified as potentially preventable (where the cause of death, or a factor in the death, was potentially preventable). It ensures that the MRC has documented that the recommended interventions to remediate were taken within 90 days of the closed review date.

The aggregate total for 2020 is 100%. No remediation required.

Discussion: After low percentages were reported at the beginning of fiscal year 2019, a new process for tracking and remediating cases of preventable death to prevent recurrence was initiated. This process involved directing follow-up remediation activities to appropriate DBHDS departments with resolution reported back to the MRC within 90 days. This resulted in significantly improved results with compliance demonstrated consistently since this time.

Performance Measure G4: Number and percent of individuals who receive annual notification of rights and information to report ANE

N: Number of records containing documentation confirming notification of rights and how to report ANE

D: Total number of records received

This PM seeks to demonstrate that individuals were notified annually of their human rights and how to report ANE information to appropriate authorities. QMR reviewers are looking for a copy of an ANE form that has been signed annually by the individual. For the providers cited, DMAS recommends technical assistance in these cases versus a formal CAP. Because technical assistance only is given to the provider, there is no follow-up of remediation delivered.

The aggregate total for 2020 is (**85%)** which is below the required threshold. Individual and systemic remediation is required.

Discussion: For 2020, this PM is below compliance for the first time. For the providers cited, DMAS QMR recommended technical assistance (TA) in these cases versus a formal CAP, which is typically done by QMR reviewers. To document annual notification of rights and how to report ANE, the DBHDS OHR reviews providers under a single related regulation (HR citation 150.4) with authority to cite for a violation, and completion of the CAP is monitored by Licensing. Remediation for the Licensing CAP is that the provider participate in training within 15 business days. Documentation of completion of the CAP is retained by Licensing. The QRT discussed capturing providers issued Human Rights citations (via Licensing CAP) as a data source for future PM reporting. DBHDS continues its discussions with Licensing on the feasibility of developing an aggregate report summarizing the remediation provided in these individual cases.

Sub-assurance: b) The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible as determined by the number and percent of critical incidents reported to the Office of Licensing within the required timeframes as specified in the approved waiver.

Performance Measure G5: Number and percent of critical incidents reported to the Office of Licensing within the required timeframes as specified in the approved waiver.

N: Number of critical incidents reported to the Office of Licensing within the required timeframe.

D: Number of critical incidents reported to the Office of Licensing regarding individuals receiving DD waiver services

This PM seeks to demonstrate that an incident management system was in place to ensure that incidents are reported to the DBHDS Office of Licensing within the required timeframes, as well as to help resolve and prevent similar incidents to the extent possible.

The aggregate total for 2020 is 91% which is within the required threshold. No remediation necessary.

Discussion: In 2020, the DBHDS Office of Licensing (OL) instituted a new reporting methodology for this PM that it believes is a more accurate representation of this measure. The new DBHDS Data Warehouse report used for this measure counts licensed congregate settings owned by a provider under one license and one inspection. With this change, Licensing Specialists will be able to explain the reason why percentages are low. The new report was developed based on new priorities under the Settlement Agreement and will replace the previous report. The change will also help lower the number of inspections required during the pandemic and help ensure completion of annual inspections by the end of the calendar year. As a result of the new methodology, the compliance percentage dropped slightly and continued to

show lower numbers through subsequent quarters. Licensing worked with the DBHDS Office of Integrated Health (OIH) to develop targeted training and TA to address the education needed for the provider community and distributed a memo as guidance to providers. Despite early lower compliance, the PM is within the range of compliance for 2020 EOY reporting

Performance Measure G6: Number and percent of licensed DD providers that administer medications that were not cited for failure to review medication errors at least quarterly.

N: Number of licensed DD providers that administer medications not cited for failure to review medication errors at least quarterly

D: Number of licensed DD providers that administer medications that were reviewed by Office of Licensing in the quarter

This PM seeks to demonstrate that providers were reviewing medication errors at least quarterly, with documentation of these reviews available in the provider record. Citations are issued to providers who did not meet this standard.

The aggregate total for 2020 is 88%, which is within the required threshold. No remediation is required.

Discussion: This PM is also impacted by the new Licensing reporting protocol implemented in FY2020. As a result of the new reporting, the compliance percentages dropped during the first two quarters of FY2020. Remediation was provided in the form of training and technical assistance delivered by the Office of Integrated Health and Licensing and educational materials developed by the Office of Licensing. Noncompliance was resolved during the final two quarters of FY2020.

Performance Measure G7: Number and percent of individuals reviewed who did not have unauthorized restrictive interventions.

N: Number of individuals reviewed who did not have unauthorized restrictive interventions

D: Number and percent of individuals reviewed

This PM seeks to demonstrate that DBHDS verified that providers were not using unauthorized restrictive interventions (including restraints and seclusion).

The aggregate total for 2020 is 99.7%, which is within the required threshold. No remediation is required.

Performance Measure G8: Number and percent of individuals who did not have unauthorized seclusion.

N: Number of individuals who did not have unauthorized seclusion

D: Number of abuse allegations + complaints submitted via CHRIS

This PM seeks to demonstrate that DBHDS verified that providers were not using unauthorized seclusion. The OHR reads the case descriptions of staff activity scanning for use of words that may indicate that an instance of seclusion occurred. By design, the dataset to be screened by OHR includes false positives to decrease the probability of missing potential instances.

The aggregate total for this PM in 2020 is 100%. No remediation is needed.

Performance Measure G9: Number and percent of participants 20 years and older who had an ambulatory or preventive care visit during the year.

N: Number of participants 20 years and older who had an ambulatory or preventive care visit during the prior year.

D: Number of participants 20 years and older

The PM seeks to demonstrate that individuals receiving waiver services received a doctor's visit (either a primary care visit or identified preventive care/wellness visit) at least once a year.

The aggregate total for 2020 is 94% compliance, which is within the required threshold. No remediation required.

Discussion: This PM is measured using aggregated data from insurance billing codes from the state Managed Care Organizations (MCOs), through which the state's medical benefits covered by Medicaid, are administered. This data is only available at the end of the state fiscal year, which makes it difficult for the QRT to assess how the PM is progressing throughout the year. The QRT previously discussed the insurance billing codes included in this reporting. The intent is to determine what constitutes an ambulatory or preventive care visit to ensure that the PM is meeting the assurance that individuals on the waiver are receiving annual preventative medical care from a primary provider. A performance indicator for the DOJ Settlement Agreement specifies that individuals should receive "an annual visit and annual screening." Although this is a different standard than the PM, it may be necessary in the future to tease out more detail in this area. Since a "preventive care visit" has yet to be defined for this purpose (neither in practice nor in the regulations for provider adherence); the most important next step would be to gain an understanding of how the information is received and prepared by DMAS staff. Although this measure currently demonstrates compliance, the QRT will look to recommendations from the DBHDS Office of Integrated Health (OIH) as it continues to research this issue for a similar DOJ performance indicator.

Performance Measure G10: Number and percent of participants 19 years and younger who had an ambulatory or preventive care visit during the year.

N: Number of participants 19 and younger who had an ambulatory or preventive care visit during the prior year.

D: Number of participants 19 and younger

This PM seeks to demonstrate that children and young adults receiving waiver services received a doctor's visit (either a primary care visit or identified preventive care/wellness visit) at least once a year.

The aggregate total for 2020 is **66%,** which is well below the required threshold and markedly decreased from 2019 (87%). Systemic remediation is required.

Discussion: This PM is measured using aggregated data from insurance billing codes from the state Managed Care Organizations (MCOs), through which the state's medical benefits covered by Medicaid, are administered. This data is only available at the end of the state fiscal year, which makes it difficult for the QRT to assess how the PM is progressing throughout the year. The state's MCOs have attributed 2020 low compliance with the PM overwhelmingly to COVID-19, as many individuals with serious medical conditions chose to forfeit medical appointments to avoid risk of social exposure to the coronavirus. Prolonged shelter-in-place orders may have also contributed to the drop in doctor visits. This measure will continue to be observed in 2021 to determine if numbers improve with mass vaccinations and the lifting of some restrictions.

I. Financial Accountability - State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.
Sub-assurance a). The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.

Performance Measure I1: Number and percent of adjudicated waiver claims that were submitted and reimbursed using the correct rate in accordance with the approved DMAS rate schedule.

N: Number of adjudicated claims reimbursed using the approved rate

D: Total number of adjudicated claims

The PM seeks to demonstrate that waiver claims are paid according to regulatory criteria using the CMS approved rate methodology.

The aggregate total for 2020 shows 100% compliance with this measure. No remediation required.

This PM is always in compliance due to the process that DMAS uses to resolve reimbursement and billing issues prior to QRT review.

Performance Measure I2: Number and percent of adjudicated waiver claims that were submitted using the correct procedure codes

N: Total number of adjudicated claims that were submitted using the correct procedure codes.

D: Total number of adjudicated claims.

This PM is a quality check for DMAS to ensure that provider claims are submitted using the correct code so that proper attribute is given for data reporting.

The aggregate total for 2020 shows 100% compliance with this measure. No remediation required.

This PM is always in compliance due to the process that DMAS uses to resolve reimbursement and billing issues prior to QRT review.

Performance Measure I3: Number and percent of claims adhering to the approved rate/rate methodology in the waiver application

N: Number of claims adhering to the approved rate/rate methodology

D: Total # of claims

The PM seeks to demonstrate that waiver claims are submitted according to the CMS approved rate methodology.

The aggregate total for 2020 shows 100% compliance with this measure. No remediation required.

This PM is always in compliance due to the process that DMAS uses to resolve reimbursement and billing issues prior to QRT review

Appendix A:

Acronym Guide

ANE Abuse, neglect, and exploitation (allegations of human rights violations)

CHRIS Comprehensive Human Rights Information System

CMS Centers for Medicare and Medicaid Services

DBHDS Department of Behavioral Health and Developmental Services

DD Developmental Disability (inclusive of individuals with an intellectual disability)

DMAS Department of Medical Assistance Services

DW Data Warehouse

ISP Individual Supports Plan

KPA Key Performance Areas (DOJ Settlement Agreement)

MRC Mortality Review Committee

OHR Office of Human Rights OL
Office of Licensing

PM Performance Measure

QRT Quality Review Team

RST Regional Support Teams

QSR Quality Service Review

RST Regional Support Team

SC Support Coordinator

Appendix B

Data Source Index

DMAS

DMAS Contractor Evaluations: **A1**

DMAS: **A2**

DMAS QMR: **B3, B4, C2, C3, C4, C5** (Provider Enrollment Form), **C8, C9, D1, D2, D3, D4, D5, D6, D7, D8, D9, D10, D11, D12, D13, G4**

DMAS Conduet: **C1**

DMAS Fiscal Employer Agency Reports: **C6, C7**

DMAS Training Verification Records: **C10**

DMAS National Committee on Quality Assurance (NCQA) Data: **G9, G10**

DMAS Medicaid Management Information System Claims Data: **I1, I2, I3**

DBHDS Regional Supports Unit

DBHDS RSS Slot Allocation Process: **A3**

DBHDS Service Authorization

Hand-Tallied LOC (VIDES) reporting: **B1**

DBHDS WaMS Report

DBHDS Data Warehouse Report: **B2**

DBHDS Office of Human Rights

Office of Human Rights Retrospective Reviews: **G1**

Office of Human Rights CHRIS Report: **G2**

Office of Human Rights CHRIS Critical Incident Report: **G8**

DBHDS Office of Licensing -

Office of Licensing CHRIS Report: 12 VAC35 105-780 (5): 12 VAC35 105-620 **G5**

Office of Licensing CHRIS Report: **G6**

DBHDS Mortality Review Committee

Mortality Review Committee Data Tracking: **G3**

DBHDS HSAG/QSR

Quality Service Review (QSR) Contractor Alerts: 12 VAC35 115, 100, 12 VAC35 115, 105 **G7**