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Quality Review Team (QRT) End of Year Report

7/1/2020-6/30/2021

DBHDS Division of Developmental Services, Waiver Operations Unit

Background

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 submit Waiver Assurance Evidentiary Reports to CMS 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 in the waiver program. 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 (QRT) reporting. The QRT uses data from provider and CSB reviews to monitor waiver performance and demonstrate compliance to CMS through annual and triennial evidentiary 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 waiver assurances.

The DBHDS Quality Management Plan links the various quality improvement mechanisms within DBHDS and DMAS within a framework that ensures accountability of quality improvement through monitoring of performance indicators, directly tied to requirements set forth by the DOJ settlement agreement and the CMS waiver assurances. The DBHDS Quality Improvement Committee (QIC) is the highest-level quality committee for the agency and provides overall oversight of the quality management program. All other quality committees, including the Quality Review Team (QRT), report to the QIC, which in turn provides cross functional, cross disability data and triage to sub-committees. The QIC ensures a process of continuous quality improvement and maintains responsibility for prioritization of needs and work areas and resource allocation to achieve intended outcomes for the agency and the Commonwealth (DBHDS Quality Management Plan 2020). The QRT committee structure and its data reporting is aligned with the overall DBHDS Quality Management Plan, with an annual summary of waiver performance made available to the public via this End of Year report and other data posted to the DBHDS website.

This report provides an overview of waiver performance for state fiscal year 2021. The data presented represents the average across all three waivers per PM, as CMS permits states to report data in aggregate when HCB waivers support the same population. SFY 2021 QRT reporting corresponded to triennial evidentiary reporting in preparation for the waiver renewal in 2023; therefore, recommendations from CMS as a part of that review are incorporated into this report. Due to the ongoing COVID-19 pandemic, some state operations continue to be delayed in SFY 2021, resulting in late data reporting for many PMs. As onsite visits remain restricted, QMR reviews are being conducted exclusively via uploading to an internet portal. As such, providers have been slow to upload documents leading to increased time spent compiling data for reviews. Accordingly, a few scheduled QRT meetings were delayed to accommodate the availability of QMR PM data.

Results Summary

Waiver assurance performance in the Commonwealth for SFY 2021 was comparable to SFY 2020 performance. Approximately 84% of PMs met compliance and nine PMs (16%) did not meet compliance in SFY 2021 (Figure 1).

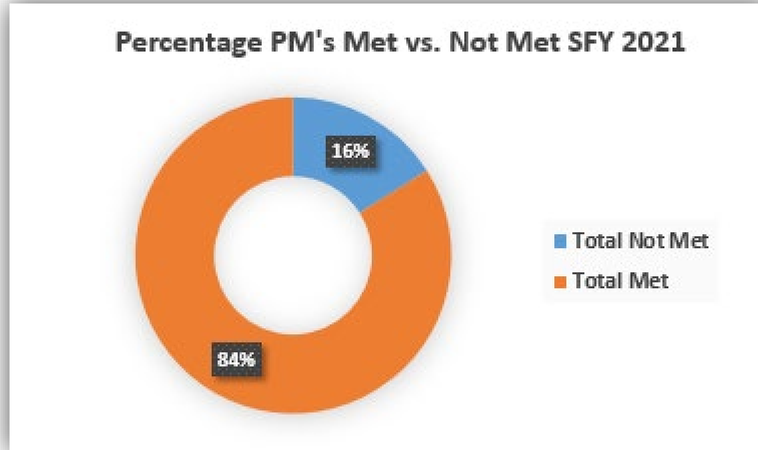

Figure 1

Three PMs that were noncompliant in SFY 2020 met compliance in SFY 2021.

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.

The following five PMs that did not meet compliance in SFY 2020 remain unmet in SFY2021.

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 Plans for Supports includes a risk mitigation strategy when the risk assessment indicates a need.

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.

Four additional PM's that *were* compliant in SFY 2020 did not meet compliance in SFY 2021.

C8: Number and percent of provider agency staff meeting provider orientation training requirements.

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

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

G1 Number and percent of participants 19 years and younger who had an ambulatory or preventive care visit during the year.

Though the specific PM's that did not meet compliance varied during SFY 2020 and SFY 2021, the overall total number of PM's not met was comparable both years. (See Figs. 1A and 1B below)

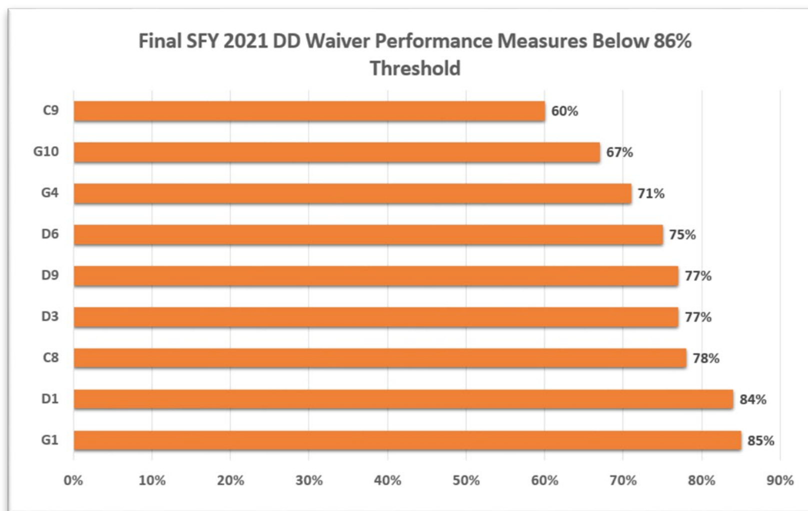

Figure 1A

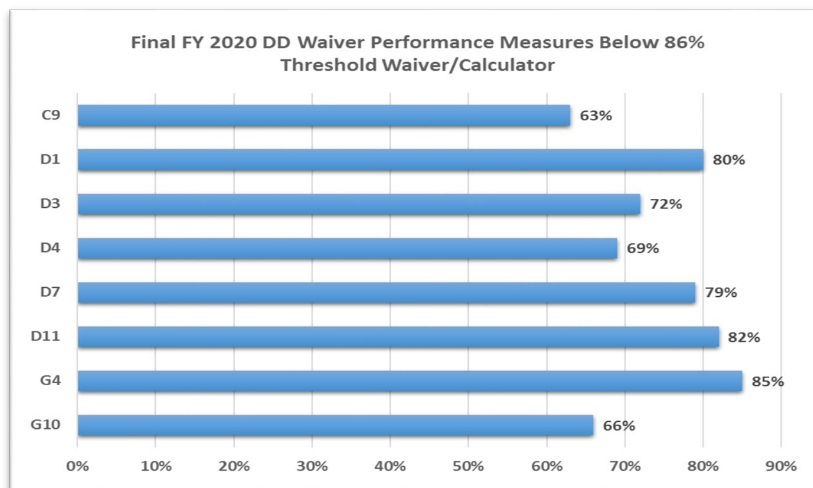

Figure 1B

The overall comparison of waiver PM performance for SFY 2020 and SFY 2021 is shown below in Figure 1C.

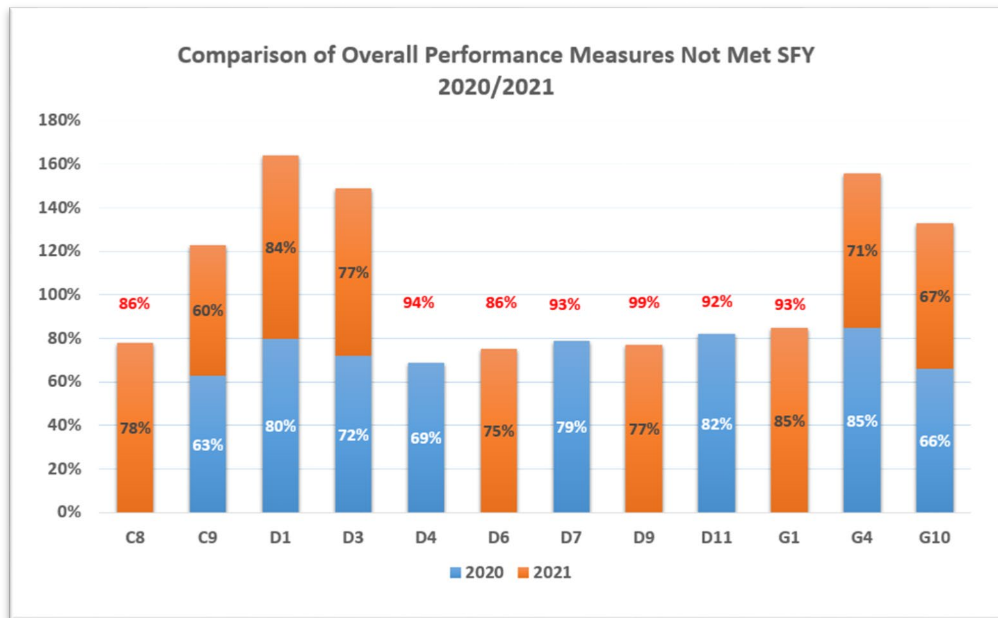

Figure 1C

As required by CMS, all non-compliant PMs received some level of remediation during 2021, with activities described throughout this report.

First level remediation for all PM's reported 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, newsletters, written provider guidance and memoranda have also been developed and distributed as supplemental resources. In addition, on-demand recorded training has been utilized with the intent to secure 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 need. Systemic remediation in the form of quality improvement initiatives (QII) either informal or following the DBHDS QIC QII approval process, may also be implemented. All of the waiver PMs are tracked for compliance with CMS reporting through the QIC committee structure and the statewide DBHDS Quality Management plan.

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

1.) The degree and extent to which state staff have access to correct contact information for all providers of DD waiver services in the Commonwealth in order to deliver 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.
4.) Provider accountability for demonstrating quality and related sanctions.

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. The 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 (QMRs) conducted by DMAS are the data source for the majority of the PMs. 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 cause a larger impact to the compliance percentage.

Thus, data reviewed in any given year represents 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. Original source data is unable to be collected due to barriers outside of the scope of this report; however, design and implementation of an electronic data reporting solution is in development and expected to be completed by the second quarter of 2022. This electronic solution will fully automate the process for capturing and reporting QRT data and allow for review and analysis of historical information.

Continuing throughout SFY 2021, all of the above factors remain important considerations to improve quality; however, a fourth additional barrier to achieving continuous compliance has been the inability of the Commonwealth to ensure that providers are held accountable for performance by imposing consistent, timely, disciplinary action to those with repeated noncompliance. Currently, except in instances of a threat to the health and safety of an individual in services, sanctions are not imposed immediately, and the sanctions fall short of facilitating compliance.

In 2021, the permanent proposed waiver regulations were finalized, which included a regulatory requirement for providers with a history of noncompliance in a specific area to undergo mandatory training and technical assistance in the area of noncompliance. This process is still in development. When fully implemented, it will be an additional measure of quality assurance and a catalyst for developing statewide, intra-agency processes to help expand the reach to all providers so that existing first line remediation is more effective. However, implementation of the Mandatory Provider Remediation process (MPR) will not directly affect QRT reviews of PMs, as providers who receive a corrective action as a result of noncompliance, are typically successfully remediated at a rate close to 100%. The MPR process has been reserved for providers with the most concerning history or aggregious infractions. As a result, QRT discussion has focused on tried and true methods to gain the attention of providers, including development of expanded criteria for referral to DMAS Provider Integrity to institute fiscal penalties for noncompliance. This is an area of ongoing discussion and focus.

Throughout SFY 2021, to better align work undertaken as part of other DBHDS quality initiatives, the QRT also began discussing the review of supplemental data related to CMS-approved PM data sources, that can be monitored as surveillance data. Review of supplemental data can assist the QRT in vetting other potential PM data sources that may be subsituted for existing data in preparation for the upcoming 2023 waiver renewal. The review of supplemental data may also help in the formulation of new waiver performance measures or modifications to existing PMs as needed. For PMs related to assuring individual health and safety, the QRT worked with the DBHDS Office of Integrated Health (OIH) to highlight risk awareness and risk mitigation in reviews across state entities to create a consistent understanding and interpretation of data resulting from new risk awareness tools. Ongoing discussions are occurring between DBHDS and DMAS to identify areas where performance improvement and remediation activities could be implemented.

In conclusion, SFY 2021 in many ways mirrors SFY 2020 to include the same QRT recommendations and one additional recommendation proposed to achieve compliance for a given PM. Generalized provider knowledge and information to ensure each provider is being reached and trained on the waiver regulations and documentation requirements, developing the capacity within the state for more innovative/on-demand training resources focused on individual, provider-specific remediation, modernization of QRT processes and tools for improved reporting of systemwide performance, and exploring provider accountability through financial penalties.

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
- DD Policy and Compliance Manager
- 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 High Needs Supports
- Program Advisor
- Division of High Needs Supports 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 DD Policy and Compliance Manager 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.

Documentation of PM performance during the quarter and a meeting agenda and 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. Information demonstrating the level of compliance with the performance measures is gathered from case management records and from the Plans for Supports from service providers. Subsequently, there are two subsets of the population.

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 supporting many individuals who is closer geographically may be reviewed over a smaller provider supporting fewer individuals who is farther away.*
- The number of individuals served. *A provider supporting many individuals who is providing services for all three waivers, may be prioritized over a smaller provider supporting fewer individuals 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 D	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 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 Human Rights 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 (approximate)**
Q1 SFY 2021 (July 1 - Sept. 30, 2020)	February (March) 2021
Q2 SFY 2021 (Oct. 1 - Dec. 31, 2020)	May 2021
Q3 SFY 2021 (Jan. 1 – March 31, 2021)	August 2021
Q4 SFY 2021 (April 1 – June 30, 2021)	November 2021

II. STATE FISCAL YEAR 2021 (JULY 1, 2020-JUNE 30, 2021) 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 SFY 2021 was 100%. No remediation was 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 falling 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. This PM typically demonstrates 100% compliance.

The aggregate total for this PM in SFY 2021 was 100%. No remediation was 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. This PM typically demonstrates 100% compliance.

The aggregate total for this PM in SFY 2021 was 100%. No remediation was 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 SFY 2021 was 97%. This is an improvement from 94% in FY2020. No remediation is required.

Discussion: No remediation was required in 2021, as changes made in 2019 continued to facilitate compliance via manual tabulation comparing information in the Waiver Management System (WaMS) to information submitted in the DMAS Virginia Medicaid Management Information System (VAMMIS) (now MES). Since this change, all VIDES have been reported within required criteria. Because the manual

tabulation is labor-intensive from a human resource perspective, 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 SFY 2021 was 92%, which is above the required threshold but slightly lower than in SFY 2020 (93%). 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 determinations that followed the required process

D. Total number of VIDES forms reviewed.

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 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 which has contributed to increased compliance.

The aggregate total percentage for this PM in SFY 2021 was 97%, increased from 88% in SFY 2020 and 70% in SFY 2019. No remediation is required.

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 SFY 2021 was 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 SFY 2021 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 percentage for all waivers for SFY 2021 is 90%, which is a slight increase from SFY 2020 (88%) and the PM remains within the required threshold. 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 SFY 2021 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

- Therapeutic Consultation

- Respite
- Assistive Technology
- Environmental Modifications
- Electronic Home-Based Supports
- Group Supported Employment Services
- PERS
- Community Guide
- Employment and Community Transportation
- Peer Mentor Services

The aggregate total for this PM in SFY 2021 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 percentage for this PM in SFY 2021 remains at 88% (as in SFY 2020). No remediation is needed.

Discussion: Prior QRT team 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. The QRT will continue to review the PM to ensure that it does not fall below compliance.

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 had completed a criminal background check upon initial enrollment.

The aggregate total for this PM in SFY 2021 is 100%. 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 SFY 2021 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 SFY 2021 is 78% which is actually a decrease from SFY 2020 (86%) and SFY 2019 (83.96%). *The measure will require systemic remediation.*

Discussion: The QRT has engaged in considerable discussion concerning PM# C8 and PM# C9. The QRT believes that the primary reason for noncompliance continues to be limited engagement of some providers in staying up to date on DD waiver requirements. Aggressive training and technical assistance and reminder notifications were distributed to providers for this PM for both C8 and C9 during SFY 2020/2021. A DBHDS Quality Improvement Initiative was implemented in 2020 which included conducting regional trainings on the required provider orientation and completion of the DSP competencies. Further, any provider who was required to submit a corrective action to QRT during the quarter was invited to attend the training. Although these providers are invited to attend, since the permanent waiver regulations had not been finalized at the time, there was no mechanism to mandate that providers attend

the training. Data reviewed by the QRT throughout SFY 2021 continued to show a lack of improvement in PM reporting.

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.

The aggregate total for all waivers for SFY 2021 is 60% which is lower than SFY 2020 (63%) despite a slight increase from SFY 2019 (55.89%). *The measure will require systemic remediation.*

Discussion: As background, the QRT reviews compliance through an assessment of records using the initial hiring AND annual date for a year. Compliance with the PM is based primarily on written documentation produced during QMR reviews.

The QRT believes that the primary reason for noncompliance continues to be limited engagement of some providers in staying up to date on DD waiver requirements. This measure has been consistently low for a number of years, with the primary issues identified related to poor recordkeeping. Providers cited under the PM have been unable to produce correctly completed competency documentation for staff. Noncompliance with this PM has been an area of particular concern for both CMS and DOJ Settlement Agreement reporting.

As described in the discussion in PM# C8, remediation activities have focused on both group and targeted trainings, as well as provider reminder notifications. In addition to the regional and targeted provider trainings conducted as a part of the formal Quality Improvement Initiative (QII) approved by the DBHDS QIC, other resources were developed and made available on the DBHDS website, including a training video, slides, and an FAQ on the competencies. Toward the end of SFY 2021, a change was instituted in the formal QII which removes DMAS QMR as the data source for DOJ reporting. Instead, Quality Service Review (QSR) data from Health Services Advisory Group (HSAG) reviews is being used. The methodology allows for reviewers to actually interview and observe staff and individuals receiving services, to determine the competency level in the real life environment. The QRT has discussed possibly reviewing this data as surveillance to determine if it would be a more appropriate measure of determining the competency level of provider DSP staff.

Remediation is now permissible with statewide regulatory authority, and QRT discussion has begun focusing on financial sanctions for providers with multiple corrective action plans (CAPs) in specific areas who do not participate in Mandatory Provider Remediation in the area of noncompliance. The QRT

continues to reference the fact that DBHDS does not have consistently reliable contact information for 100% of its waiver providers in order to disseminate alert/training information and this continues to be an area of deficiency noted statewide.

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 waivers only) met provider training requirements and passed the competency test with at least the minimum score.

The aggregate total for all waivers for SFY 2021 is (100%). No remediation required.

Discussion: Although the PM is within compliance for 2021, as in SFY 2020, the QRT has continued to discuss specific information vehicles that can be used to share information with service facilitators to improve their general knowledge of waiver requirements. These communication vehicles should target SFs 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.). QMR reviewers are determining whether the

individual's needs (i.e., via risk awareness tools) 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.

The aggregate total for SFY 2021 is 84% which is an increase from SFY 2020 (80%), though still below the in-compliance percentage reported in SFY 2019 (87%). *The measure will require systemic remediation.*

Discussion: The QRT discussed how to address the downward trend that has continued for the PM the past several years. The QRT believes that the primary reason for noncompliance continues to be lack of understanding in how to develop an awareness of risks, assess the likelihood of risk for each individual, and incorporate risk mitigation into the plan when a risk is identified. Compliance for this PM has been increasingly challenging. Providers cited typically have not developed any kind of strategy to address risks. During QMR reviews, it is reported that the Plans for Support often do not address all of the needs the individual has for health and safety, and also do not address things that the person wants to do, the goals they want to achieve, etc. QRT discussion has included obtaining information related to ongoing interventions/workgroups within DHDS to encourage performance improvement (i.e., the Incident Management Unit (IMU) Care Concerns process within the Office of Licensing where fall information is aggregated to determine which are appropriately categorized as a health and safety care concern, as well as HSAG QSR reviews, and the RQC 2 QII related to falls with injuries). This will be a topic moving forward with regard to changes that could be made to the performance measures and remediation activities for discussion in preparation for the 2023 waiver renewal.

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 who have a documented risk or potential risk factor, are following the instructions outlined in the DBHDS Risk Awareness Tool (RAT) to mitigate the risk, as required.

The aggregate total for SFY 2021 is 100%, 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 awareness tool identified a risk factor for the individual.

The aggregate total for SFY 2021 is 77%. Though increased from SFY 2020 (72%), the PM remains below compliance. *Systemic remediation is required.*

Discussion: A downward trend for the PM continued for 2021 as it has for the past several years. The QRT believes that the primary reason for noncompliance is related to PM #D1. To address this area, DBHDS developed and implemented several new tools devoted to identification and remediation of risk and there are other related workgroups and initiatives within DBHDS designed to identify and mitigate risk. Although the data reviewed by QMR continues to indicate low compliance as discussed in the previous PM, the QRT has been discussing reviewing data from some other DBHDS initiatives (i.e., Risk Management Review Committee) to identify whether interventions are having an impact. This will be a topic moving forward with regard to changes that could be made to the performance measures and remediation activities for discussion in preparation for the 2023 waiver renewal.

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: 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. There will be corresponding data for the BI waiver with planned initiation of QMR reviews of the Shared Living service.

The aggregate total for SFY 2021 is 94% compared to 69% in SFY 2020. No remediation is required.

Discussion: This PM has periodically been shown with low compliance depending on the specific type of provider, the size of the provider, and the length of time they have been in business. QRT discussion in SFY 2020 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. The requirement for a back-up plan for specific services is also included in the new provider manual as a reference.

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 SFY 2021 is 100%. No remediation is 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 percentage for this PM in SFY 2021 is 75% which is a significant decrease from compliance in SFY 2020 (86%). *The measure will require systemic remediation.*

Discussion: The PM has a very long standing history of lower performance.

Although the PM is demonstrated within compliance for 2020, it is an area of continued challenge. The QRT believes that the primary reason for noncompliance continues to be multifactorial, but rooted in the fact that it is easier to review the plan and make changes annually During previous QRT meetings, it had been discussed that these providers should be included in the cohort required to participate in the mandatory provider remediation (MPR) process. QMR is continuing to develop the protocol with the implementation date TBD; however, recent updates indicate that providers needing mandatory remediation will include those that licensing has deemed need increased monitoring (since they see providers more than QMR); not necessarily providers identified through the QMR CAP process.

It was agreed that a full update on the MPR will be provided to the QRT at each meeting. This will be a topic moving forward with regard to changes that could be made to the performance measures and remediation activities for discussion in preparation for the 2023 waiver renewal.

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 percentage for this PM in SFY 2021 is 93% which is higher than in SFY 2020 (85%). No remediation is required.

Discussion:

Compliance with this PM has varied by service or the actual support activity.

There is a separate PM for each CMS required area, assessing whether services are being provided in the required type, scope, amount, duration and frequency outlined in the plan. In SFY 2020, as remediation, DMAS developed written guidance distributed to providers via the Provider Distribution Listserv in the form of a "TSADF Criteria Grid," which depicts expectations under each area of supports provided per the ISP and reviewed during QMR audits. If there are extenuating circumstances for why services were not delivered according to the plan, this should be documented in the record and there should be a periodic review of the plan for needed modifications.

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

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 SFY 2021 is 95%, well within 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 percentage for this PM is typically 100% compliant; however, the aggregate total for SFY 2021 is 77%. *Systemic remediation is required.*

One record was reviewed during the year which was cited as noncompliant. The provider was cited under the FIS waiver, due to the fact that all of the individual plans covered 2 years. Although service authorization is for a two year period, the plans must be reviewed annually.

The service cited was Service Facilitation. Current and previous discussion has focused on the fact that Service Facilitators need supplemental training in areas covered by the waiver assurance PM's. Service Facilitator training is required every five years, which leaves a large knowledge gap.

During QRT discussion, the QRT has considered having some areas of low compliance addressed in the trainings completed by SFs. Both DDS and DMAS have agreed to work together to develop the content to be added to the SF training.

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 SFY 2021 is 99%. 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 SFY 2021 is 99%, increased from 82% in SFY 2020. No remediation is needed.

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 SFY 2021 is 94% which is increased from SFY 2020 (83%). Systemic remediation is not needed.

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 SFY 2021 is 96% which is well within the required threshold**.** No remediation is needed.

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 SFY 2021 is 85% and just below the required threshold. This is a decrease from SFY 2020 (91%). *Individual and systemic remediation is required*.

It was noted that remediation is already occurring which will improve the compliance numbers over time. Human Rights developed a specific ANE training for providers to explain the way that the compliance measures and the investigations are tied into CHRIS. It was also noted that there are several new barriers to achieving consistent compliance with the PM. The community look behind process, which has been operationalized in Human Rights, is used to demonstrate compliance for this PM and other departmental quality assurance. The Office of Data Quality and Visualization identified a data quality issue in the Office of Licensing Information System (OLIS) that extended to CHRIS and the Data Warehouse tables indicating that the way that the sample has been pulled until now does not assure that all of individuals in the sample represent individuals receiving DD waiver services. For this reason, the retrospective community reviews are on pause, and it is not expected that there will be QRT data for PM# G1 for 2022.

Because of the upcoming waiver renewal, other ways of obtaining information on provider compliance with abuse and neglect data were discussed and will be explored. This will be a topic moving forward with regard to changes that could be made to the performance measures and remediation activities for discussion in preparation for the 2023 waiver renewal.

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 SFY 2021 is 98%. No remediation is 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 SFY 2021 is 100%. No remediation is required.

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 individual remediation documented.

The aggregate total for SFY 2021 is 71% which is significantly decreased from SFY 2020 is (85%).
Individual and systemic remediation is required.

Discussion: For SFY 2021, this PM remains below compliance.

During QRT discussion, the primary reason identified for the noncompliance is that different standards are being used for review of the ANE documentation. The QMR review is focused on the presence of the signed ANE form. Human Rights only requires that providers have signed documentation of ANE in the record at the onset and then a conversation to occur thereafter with a case note documenting the discussion. DBHDS OL reviews providers under a single related regulation (OL citation 150.4) with authority to cite with a CAP for a violation. Completion of the CAP is monitored by Licensing with the associated remediation requiring the provider participate in training within 15 business days. DBHDS OHR can recommend citation when made aware of a violation (either by QMR or OL) under 12VAV35-115-40. When a signed ANE form is not found during a QMR review, no citation is given; however, technical assistance is delivered. This TA is documented but there is no follow-up.

The QRT has been discussing utilizing a similar standard between the information that QMR would require of providers to document ANE, and what Human Rights would accept as compliant. This would be another way to demonstrate compliance that would involve Human Rights intervention as remediation and a CAP for noncompliance. Ongoing discussion is needed to reconcile both standards. This will be a topic moving forward with regard to changes that could be made to the performance measures and remediation activities for discussion in preparation for the 2023 waiver renewal.

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 SFY 2021 is 95%. No remediation is necessary.

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 SFY 2021 is 98%. No remediation is required.

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 time out) via review of the number of HSAG PCR alerts that were issued to the OHR that were NOT due to unauthorized restrictive interventions.

The aggregate total for SFY 2021 is 100%. 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. 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 SFY 2021 is 100%. No remediation is required.

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 SFY 2021 is 87% just above the required threshold but decreased from SFY 2020 (94%). No remediation required.

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 SFY 2021 is 67% which is which is well below the required threshold and consistent with SFY 2020 (68%). 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 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 this should be defined.

For the QRT, the MCO data used for the PM serves as a proxy for the waiver populations (both children and adults) receiving an annual, primary care, preventive exam. The QRT discussed data being used within DBHDS for DOJ compliance with a similar measure. There are several DBHDS Quality Improvement initiatives (QII's) developed that build off of a DOJ Performance Measurements Indicator (PMI) which has slightly different language than the QRT PM, but are also intended to measure whether or not individuals on the waiver are receiving an annual physical to identify/prevent health issues. It was suggested that the supplemental data could be viewed as surveillance data to determine if it could be a relevant data

source to include in the waiver renewal application in 2023. It was also noted that since the potential surveillance data originates from WaMS, there would need to be improvement in the information that is entered in WaMS by Support Coordinators, which is a training and enforcement issue.

The OIH proposed to continue to review the data for trends as presented in documentation sources.

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 SFY 2021 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 SFY 2021 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 SFY 2021 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 Conduent: **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**