DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
150 S. Independence Mall West
Suite 216, The Public Ledger Building
Philadelphia, Pennsylvania 19106-3499

Region III/Division of Medicaid and Children's Health Operations

SWIFT # 070620164051

June 26, 2017

Cynthia B. Jones, Director
Department of Medical Assistance Services
Commonwealth of Virginia
600 East Broad Street, Suite 1300
Richmond, VA 23219

Re: Final Quality Review Report – Virginia's Home & Community-Based Services Day Support Waiver, CMS Control Number 0430

Dear Ms. Jones:

Enclosed is the Final report and the Commonwealth's original evidence for the Centers for Medicare & Medicaid Services' (CMS) quality review of Virginia's Home and Community-Based Services (HCBS) Day Support (DS) Waiver. This report assessed data for the DS Waiver provided by the Commonwealth for State Fiscal Years 2014, 2015, and 2016. As of September 1, 2016, the DS Waiver was renamed the Building Independence (BI) Waiver, CMS control number 0430. The DS/BI Waiver was designed to provide a choice of home and community-based services to individuals with developmental disabilities and related conditions who meet the level of care criteria for an Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID) or Related Conditions and who choose to remain in the community instead of placement in an ICF/IID. The report is releasable to the public under the Freedom of Information Act. The CMS would like to thank the Commonwealth for its response to the draft report. The Commonwealth's responses to the CMS' findings and recommendations have been incorporated in the appropriate sections of the Final Report.

We found the Commonwealth to be in compliance with three of the six HCBS Assurances. The assurances related to Qualified Providers, Service Plans and Health and Welfare were not fully compliant. The Commonwealth has indicated that it intends to develop new performance measures which will be submitted as an amendment. The proposed performance measures will be reviewed by CMS as part of the amendment review process. The Commonwealth has also submitted corrective action plans.

The Commonwealth must show compliance at the time of renewal for CMS to approve the waiver renewal. We encourage the Commonwealth to take appropriate action to design and implement processes to improve performance and maximize the quality of the waiver program.

Finally, we would like to remind the Commonwealth to submit its renewal application on this waiver to CMS via the Waiver Management System at least 90 days prior to the expiration of the waiver, June 30, 2018. Your waiver renewal application should address any issues identified in

the Final report as necessary for renewal and should incorporate the state's commitments in response to the report.

We want to extend our sincere appreciation to the Virginia Department of Medical Assistance Services, Long Term Care Division staff, and the Department of Behavioral Health and Developmental Services who assisted in the process and provided information for this review. If there are any questions, please contact Ellen Reap at (215) 861-4735.

Sincerely,

Francis T. Mccullough -S

Digitally signed by Francis T. Mccullough -S
Date: 2017.06.26 09:21:39 -04'00'

Francis T. McCullough
Associate Regional Administrator

Enclosure

cc: Karen Kimsey, DMAS, Complex Care and Services
Ann Bevan, Behavioral Health and Developmental Services
Terry Smith, DMAS, Division of Aging and Disability Services
Nichole Martin, DMAS, Division of Long-Term Care
Sabrina Tillman-Boyd, CMS RO3 DMCHO
Daphne Hicks, CMCS

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
Region III

FINAL REPORT

Home and Community-Based Services Waiver Review
Day Support (Building Independence) Waiver Program
Control #0430

6/26/2017

I. Executive Summary

The Day Support (DS) Home and Community-Based Waiver for Persons with Intellectual Disabilities began in 2005 and was renewed for the period of July 1, 2013 to June 30, 2018. The DS Waiver is designed to provide day support, pre-vocational and/or supported employment services.

The Department of Medical Assistance Services (DMAS) is the State Medicaid Agency for the Commonwealth of Virginia and the Department of Behavioral Health and Developmental Services (DBHDS) is the contractually designated state operating agency for the Day Support Waiver. DMAS meets with the operating agency (DBHDS) quarterly and as needed to review performance and discuss how problems identified will be remediated. Follow-up letters are sent by DMAS and reports are requested on the status of remediation and individual problems. DMAS and/or DBHDS may provide training and technical assistance and institute individual corrective action plans to ensure problems that have been identified are resolved.

The Commonwealth has recently implemented a system-wide redesign of its Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions (ICF/IID) level of care Medicaid waivers. This system transformation included the submission and subsequent approval of waiver amendments for the conversion of its three existing waivers, including the DS Waiver, into three new waivers that expand access to individuals with developmental disabilities, across ID and DD populations. Many of the components of the redesigned waivers are intended to address quality assurance issues with standardization of processes and procedures and eligibility tools, to improve accountability, development of new comprehensive provider competencies and a provider rating system, as well as a custom waiver management computer system to assist with tracking of providers.

The Quality Review Report identified that the following Assurances were demonstrated: Administrative Authority, State Conducts Level of Care Determinations Consistent with the Need for Institutionalization, and Financial Accountability. Three Assurances were not demonstrated: Qualified Providers Serve Waiver Participants, Service Plans are Responsive to Waiver Participant Needs, and Health and Welfare. The Commonwealth has submitted corrective action plans for these three Assurances. The data submitted by the Commonwealth was subject to review using the pre-2014 guidance.

II. Summary of Findings and Recommendations

A. Administrative Authority

The state substantially demonstrates the assurance.

B. State Conducts Level of Care Determinations Consistent with the Need for Institutionalization

The state substantially demonstrates the assurance.

C. Qualified Providers Serve Waiver Participants
The state does not demonstrate the assurance.

Two of three sub-assurances were not demonstrated. The Commonwealth has submitted an acceptable plan of correction and implemented revised means to verify provider competency and training.

D. Service Plans are Responsive to Waiver Participant Needs
The state does not demonstrate the assurance.

Three of the five sub-assurances were not demonstrated. The Commonwealth has submitted an acceptable corrective action plan.

G. Health and Welfare
The state does not demonstrate the assurance.

No data was collected for 9 of the 10 PMs addressing this sub-assurance. The Commonwealth has submitted a plan for revision of the approved Performance Measures which will be reviewed upon submittal of a waiver amendment.

I. Financial Accountability
The state substantially demonstrates the assurance.

III. Introduction

Pursuant to section 1915(c) of the Social Security Act, the Secretary of the Department of Health and Human Services has the authority to waive certain Medicaid statutory requirements to enable a state to provide a broad array of home and community-based services (HCBS) as an alternative to institutionalization. The Centers for Medicare & Medicaid Services (CMS) has been delegated the responsibility and authority to approve state HCBS waiver programs. CMS must assess each home and community based waiver program in order to determine that state assurances are met. This assessment also serves to inform CMS in its review of the state's request to renew the waiver.

Waiver Name:	Day Support Waiver
State Medicaid Agency	Department of Medical Assistance Services (DMAS)
State Operating Agency:	Department of Behavioral Health and Developmental Services (DBHDS)
State Waiver Contact:	Terry Smith Director DMAS, Division of Long Term Care 600 East Broad Street, 10th Floor Richmond, Virginia, 23219 (804) 371-8490 terry.smith@dmas.virginia.gov

Local Operating Agencies:	Behavioral Health Authority (BHA) or Community Service Board (CSB)
Target Population:	☐ Aged or Disabled, or Both – General ☐ Aged ☐ Disabled (Physical) ☐ Disabled (Other) ☐ Aged or Disabled, or Both – Specific Recognized Subgroups ☐ Brain Injury ☐ HIV/AIDS ☐ Medically Fragile ☐ Technology Dependent ☒ Intellectual Disability or Developmental Disability, or Both ☐ Autism ☐ Developmental Disability ☒ Intellectual Disability ☐ Mental Illness ☐ Mental Illness ☐ Serious Emotional Disturbance **Additional Criteria:** Individuals who are diagnosed with an ID, meet the level of care criteria for an ICF/IID, and meet Medicaid financial eligibility
Level of Care:	☐ Hospital ☐ Nursing Facility ☒ Intermediate Care Facility for Individuals with Intellectual Disabilities **Additional Criteria** N/A
Effective Dates of Waiver:	July 1, 2013 to June 30, 2018
Actual Annual Per Capita Costs (CMS-372):	$13,843
Actual Unduplicated Number of Waiver Participants (CMS-372):	276
Approved Waiver Services:	1) Day Support 2) Prevocational Services 3) Supported Employment

CMS Contact:	Ellen Reap 215-861-4735 Ellen.Reap@cms.hhs.gov

IV. Detailed Findings

A. Administrative Authority

The state must demonstrate that it retains ultimate administrative authority over the waiver program and that its administration of the waiver program is consistent with the approved waiver application. AUTHORITY: 42 CFR 441.303; 42 CFR 431; SMM 4442.6; SMM 4442.7.

#	Sub-Assurance Description	For Draft Report: CMS Determination	For Draft Report: CMS Justification	For Draft Report: Additional Information Requested	For Draft Report: CMS Recommendations or Required Changes	For Final Report: CMS Determination
A-i	The Medicaid agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.	The state substantially demonstrates the sub-assurance.	Each of three PMs showed 100% compliance in each waiver year.	None.	None	The state substantially demonstrates the sub-assurance. **CMS Additional Comments:**

State Response to the Draft Report:
Instructions to State: Enter State's response here and answer any questions that CMS has posed in the preceding table.

B. State Conducts Level of Care Determinations Consistent with the Need for Institutionalization

The state must demonstrate 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 consistent with care provided in a hospital, NF, or ICF/ID. AUTHORITY: 42 CFR 441.301; 42 CFR 441.302; 42 CFR 441.303; SMM 4442.5

#	Sub-Assurance Description	For Draft Report: CMS Determination	For Draft Report: CMS Justification	For Draft Report: Additional Information Requested	For Draft Report: CMS Recommendations or Required Changes	For Final Report: CMS Determination
B-i	An evaluation for level of care is provided to all applicants for whom there is reasonable indication that services may be needed in the future.	The state does not fully or substantially demonstrate the sub-assurance, though there is evidence that may be clarified or readily addressed.	For PM B.1, Compliance was 100% for 2014 and 2016 and 99% in 2015. The single 2015 instance was rectified. For PM B.2, Compliance was 86% for 2014, 87% for 2015, and 90% for 2016.	The state has identified a general process for remediation. Please confirm that each LOF was completed. Please provide a brief plan to ensure that LOF determinations will be completed timely. Discuss how the new VIDES system will operate to ensure this objective.	CMS Recommendations	The state substantially demonstrates the sub-assurance. **CMS Additional Comments:**
B-ii	The level of care of enrolled individuals is reevaluated at least annually or as specified in the approved waiver. **[This sub-assurance only applies to waiver years regulated by the guidance in place prior to March 12, 2014.]**	The state substantially demonstrates the sub-assurance.	For PM B.3, DMAS' QMR review showed compliance at 100% for 2014, 98% for 2015 and 100% for 2016. The 2015 instances were successfully remediated.	None	None	The state substantially demonstrates the sub-assurance. **CMS Additional Comments:**

#	Sub-Assurance Description	For Draft Report: CMS Determination	For Draft Report: CMS Justification	For Draft Report: Additional Information Requested	For Draft Report: CMS Recommendations or Required Changes	For Final Report: CMS Determination
B-iii	The process and instruments described in the approved waiver are applied appropriately and according to the approved description to determine initial participant level of care.	The state substantially demonstrates the sub-assurance.	The state uses a dual process of both supervisory and QMR reviews for each of the 3 PMs. Where two sets of data were presented, QMR was used if available. Compliance ranged from 98% to 100% for each PM for each year.	None	None	The state substantially demonstrates the sub-assurance. **CMS Additional Comments:**

State Response to the Draft Report:
As part of the amended waivers, the allowable time for LOF evaluation for applicants for whom there is reasonable indication that services may be needed in the future was increased from 45 days to 60 days. This increase in time for LOF evaluation will ensure that LOF determinations are completed timely. The state has also recently completed the functionality upgrade necessary to its new Waiver Management System (WaMS). The determination of need date is captured on Part I of the ISP in WaMS and will be an individual data entry field; in addition, there is a field for date of LOF (VIDES) completion. WaMS includes the name of the support coordinator who entered the LOF (VIDES) and the date. A query of WaMS can be conducted quarterly for dates outside of the 60 day time period, with individual CM's identified for technical assistance and training. Standard remediation activities including case management training and technical assistance, and development and implementation of a corrective action plan (CAP) will continue as part of its systemic remediation activities. The state confirms that each LOF has been completed.

C. Qualified Providers Serve Waiver Participants

The state must demonstrate that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers. AUTHORITY: 42 CFR 441.302; SMM 4442.4

#	Sub-Assurance Description	For Draft Report: CMS Determination	For Draft Report: CMS Justification	For Draft Report: Additional Information Requested	For Draft Report: CMS Recommendations or Required Changes	For Final Report: CMS Determination
C-i	The state verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other state standards prior to their furnishing waiver services.	The state does not fully or substantially demonstrate the sub-assurance, though there is evidence that may be clarified or readily addressed.	PM C.1 demonstrated 100% compliance for each year. PM C2 showed compliance at 99% for 2014, 100% for 2015 and 98% for 2016. The state presented evidence of individual remediation for each instance of non-compliance. For PM C3, the data showed compliance at 99% in 2014, 80% in 2015 and 82% in 2016. There was also a wide fluctuation in the number of providers reviewed.	For PM C3, in 2014 the data showed 7 providers, in 2015 and 2016 there were 87 and 71 providers respectively. The PM requires 100% review. Please identify how many providers were participating in the program each year. If the numbers of providers do not correspond with the PM, please provide the correct denominators. If the numbers are correct, please provide a plan to ensure providers continue to meet licensing/certification requirements. Also, for 2016, please explain why CAPs were approved for only 3 providers and discuss how remediation was accomplished for the remaining instances of non-compliance.	CMS Required Changes	The state does not demonstrate the sub-assurance. **CMS Additional Comments:** Approved Performance Measures should be implemented following the protocol of the approved waiver in terms of data sources and sampling/ review methodologies. Any changes to the PMs should not be implemented prior to approval of a waiver amendment.
C-ii	The state monitors non-licensed/non-certified providers to assure adherence to	The state substantially demonstrates the sub-assurance.	This sub-assurance is not applicable to this waiver. The approved waiver does not contain	None	None	The state substantially demonstrates the sub-assurance.

#	Sub-Assurance Description	For Draft Report: CMS Determination	For Draft Report: CMS Justification	For Draft Report: Additional Information Requested	For Draft Report: CMS Recommendations or Required Changes	For Final Report: CMS Determination
	waiver requirements.		PMs for this sub-assurance.			**CMS Additional Comments:**
C-iii	The state implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.	The state does not demonstrate the sub-assurance.	PM C.4 showed compliance at 100%, 83% and 100% for 2014, 2015 and 2016 respectively. All issues identified in 2015 were remediated. Where QMR and OLIS data were presented, QMR data was used per the approved waiver.	Please provide a plan to ensure improved provider compliance with the training requirements.	CMS Required Changes	The state does not demonstrate the sub-assurance. **CMS Additional Comments:** The Commonwealth has implemented revised policies for verifying provider training under the approved redesigned waiver.

State Response to the Draft Report:

C-i. PM C3- In 2014, the data source for this performance measure was changed. As a result, the low denominator reflects providers reviewed in the last quarter of 2014 and is not representative of the entire year or all providers.

Upon further review the state found that the reported data for 2016 corrective action plans is incorrect. In 2016, there were 13 CAPS approved. Providers not required to complete a CAP completed other remediation activities including training for staff and forwarding training documents to the department of licensing for review. All citations issued to the provider for non- compliance were remedied as documented by the Licensing specialist.

C- iii PM C4- With the implementation of the redesigned waivers all DBHDS licensed providers are required to fulfill new competency requirements for direct support professionals and supervisors. Fulfillment of requirements includes the successful passing of a knowledge-based online test. Direct Support Professional (DSP) and supervisors must maintain the appropriate signed assurance, and also obtain a certificate online through the DBHDS Learning Management System when they successfully pass the test (with a total score of 80% or better). DBHDS Division of Developmental Services provider development staff has conducted extensive training with the provider community during the last quarter of calendar year 2016 and in early 2017 on the new competency requirements and documentation expectations. Supervisors must retain the appropriate assurance and a copy of the LMS certificate of completion during the provision of services under these waivers. DBHDS licensing and DMAS QMR staff review staff records to ensure training has occurred and is documented appropriately. Corrective action plans are required when providers do not meet the requirement.

D. Service Plans are Responsive to Waiver Participant Needs

The state must demonstrate that it has designed and implemented an adequate system for reviewing the adequacy of service plans for waiver participants. AUTHORITY: 42 CFR 441.301; 42 CFR 441.302; 42 CFR 441.303; SMM 4442.6; SMM 4442.7 SECTION 1915(C) WAIVER FORMAT, ITEM NUMBER 13

#	Sub-Assurance	For Draft Report: CMS Determination	For Draft Report: CMS Justification	For Draft Report: Additional Information Requested	For Draft Report: CMS Recommendations or Required Changes	For Final Report: CMS Determination
D-i	Service plans address all individuals' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.	The state does not demonstrate the sub-assurance.	For PM D.1, 2014 compliance was 92%, for 2015 89%, and for 2016 79%. PM D.2 and PM D.3's compliance was at 91% to 100%. PM D.4 which deals with risk mitigation showed compliance at 100% for 2014, 83% for 2015, and	The state reports that each individual deficiency identified was remediated via a corrective action plan. However, the systemic performance indicates that improvement efforts for PM D.1 and PM D.4 have not been effective. Please provide a plan with milestones and timelines to ensure improved service plans are developed, and risk mitigation is conducted. Also, please provide	CMS Required Changes	The state does not demonstrate the sub-assurance. **CMS Additional Comments:** The Commonwealth has submitted an acceptable plan of correction. The PM (D.5) for which data was not collected is not included in

#	Sub-Assurance	For Draft Report: CMS Determination	For Draft Report: CMS Justification	For Draft Report: Additional Information Requested	For Draft Report: CMS Recommendations or Required Changes	For Final Report: CMS Determination
			86% for 2016. PM D.5 had no data collected.	a plan to describe the process to ensure the PM D.5 data is conducted and analyzed.		the approved amended waiver.
D-ii	The state monitors service plan development in accordance with its policies and procedures. **[This sub-assurance only applies to waiver years regulated by the guidance in place prior to March 12, 2014.]**	The state substantially demonstrates the sub-assurance.	PM D.6 showed compliance at 100% in 2014 and 2015 and at 99% in 2016. PM D.7 showed compliance at 100% for 2014 and 2016 and 98% for 2015. All service plans were remediated.	None	None	The state substantially demonstrates the sub-assurance. **CMS Additional Comments:**
D-iii	Service plans are updated/revised at least annually or when warranted by changes in waiver individual needs.	The state does not demonstrate the sub-assurance.	PM D.8, addressing annual revisions, showed compliance of 100% in 2014 and 2015 and 99% in 2016. However, PM D.9 addressing revisions as needed to meet changing needs showed	The state reports that all individual deficiencies have been remediated by corrective action plans. The state should submit a plan to ensure that service plans are updated when warranted by changes in needs.	CMS Required Changes	The state does not demonstrate the sub-assurance. **CMS Additional Comments:** The Commonwealth has submitted an acceptable plan of correction.

#	Sub-Assurance	For Draft Report: CMS Determination	For Draft Report: CMS Justification	For Draft Report: Additional Information Requested	For Draft Report: CMS Recommendations or Required Changes	For Final Report: CMS Determination
			compliance of 100% for 2014 and 2015, but only 30% in 2016.			
D-iv	Services are delivered in accordance with the service plan, including in the type, scope, amount, duration, and frequency specified in the service plan.	The state does not demonstrate the sub-assurance.	The state erred in reporting the data for PM D.10. This was a single PM but was reported as averages among the compliance with the various factors (type, scope, duration, frequency). The various elements showed individual issues as well: scope was found to be complaint by only 73% in 2014, by 63% in 2015, and by 76% in 2016. Services were also not delivered in the amount specified in 21% of the records in 2015 and 22% in 2016. There were additional instances	The state should report on the PM as approved: i.e., the number and percentage of service plans for which ALL services were delivered in accordance with all of the criteria (type, scope, duration, and frequency). Although the state reports that each deficiency was remediated via a corrective action plan, the state should provide a plan to ensure that service plans are implemented as ordered including specific actions, monitoring, timelines and milestones. Additionally, the state should provide a detailed plan to put into place the systems to collect and assess the data for PM D.11 including specific actions, timelines, and milestones.	CMS Required Changes	The state does not demonstrate the sub-assurance. **CMS Additional Comments:** The Commonwealth has submitted an acceptable plan of correction. The Commonwealth is reminded that each Performance Measure should be addressed specifically as approved and an effective data collection plan should be developed and implemented for each approved PM.

#	Sub-Assurance	For Draft Report: CMS Determination	For Draft Report: CMS Justification	For Draft Report: Additional Information Requested	For Draft Report: CMS Recommendations or Required Changes	For Final Report: CMS Determination
			of significant noncompliance in frequency. Data was not collected for PM D.11 which measures individuals/families reporting that the support plan includes all the services and supports the individual needs for 2 of the three years. PM D.12 addressed face to face contacts by the case manager and was 100% in each year.			
D-v	Participants are afforded choice between/among waiver services and providers. **[This sub-assurance only applies to waiver years regulated by the guidance issued March 12, 2014.]**	The state substantially demonstrates the sub-assurance.	PM D.15 showed compliance at 100% for each year.	None	None	The state substantially demonstrates the sub-assurance. **CMS Additional Comments:**

State Response to the Draft Report:

Performance measure *D.5. Number and percent of individuals/family members who reported participating in the development of the individual's support plan* is not in the current BI waiver. It was originally anticipated that data for the measure could be pulled from NCI data. It was later determined that NCI data was not a viable data source for the measure. Since this measure is not included in the current waiver this data will not be formally collected.

The state has a multi-pronged strategy designed to improve overall service plan development and delivery compliance requirements. The strategy for systemic improvement includes implementation of final regulations for the redesign of the DD waiver system including a requirement that providers who are out of compliance with specific service planning elements participate in mandatory TA and training; an updated provider manual with additional information and examples that address key areas of non-compliance; the development and release of training and guidance resources that include online training and resources, in person training and TA, a mechanism for providers to request additional training and implementation of provider competencies; further enhancements of WaMS. The performance measures addressed in the plan are from the current Building Independence Waiver.

BI Waiver Service Plan Development & Risk Mitigation Improvement Plan			
Performance Measure	Action	Milestone	Timeline
D.1. Number and percent of individuals who have service plans that address their assessed needs, capabilities and desired outcomes	• Include in proposed regulations a requirement that providers with a history of noncompliance in key identified areas are required to undergo TA and training • Provider manual includes clear and specific guidance on service plan development including assessing needs, capabilities and desired outcomes • Training on service plan requirements is made available to providers	• Proposed regulations drafted & Final regulations promulgated • Provider manual published • WaMS service plan integration complete • Training resources made available	• 6/2017 & 1/2018 • 1/2018 • ongoing
D.2 Number of individual records that indicate a risk assessment was conducted	• Include in proposed regulations a requirement that providers with a history of noncompliance in key	• Proposed regulations drafted & Final regulations promulgated	• 6/2017 & 1/2018

BI Waiver Service Plan Development & Risk Mitigation Improvement Plan			
Performance Measure	Action	Milestone	Timeline
	identified areas are required to undergo TA and training • Provider manual includes clear and specific guidance on service plan development including assessing needs, capabilities and desired outcomes • Training on completing a risk assessment is made available to providers	• Provider manual published • WaMS service plan integration complete • Training and risk mitigation assessment resources made available	• 1/2018 • ongoing
D.3 Number and percent of individuals whose support plan includes a risk mitigation strategy when the risk assessment indicates a need	• Include in proposed regulations a requirement that providers with a history of noncompliance in key identified areas are required to undergo TA and training • Provider manual includes clear and specific guidance on service plan development including assessing needs, capabilities and desired outcomes • Information and training on risk mitigation resources, strategies and service plan requirements is made available to providers	• Proposed regulations drafted & Final regulations promulgated • Provider manual published • WaMS service plan integration complete • Training on risk mitigation strategies made available	• 6/2017 & 1/2018 • 1/2018 • ongoing
D.9 Number and percent of individuals whose support plan was revised by the case manager as needed, to address changing needs.	• Include in proposed regulations a requirement that providers with a history of noncompliance in key identified areas are required to undergo TA and training • Provider manual includes clear and specific guidance on service	• Proposed regulations drafted & Final regulations promulgated • Provider manual published	• 6/2017 & 1/2018 • 1/2018

BI Waiver Service Plan Development & Risk Mitigation Improvement Plan			
Performance Measure	Action	Milestone	Timeline
	plan development including assessing needs, capabilities and desired outcomes • Training on service plan requirements, to include addressing changing needs, is made available to providers	• WaMS service plan integration complete • Training on service plan requirements made available	• ongoing
D.10 Number and percent of individuals who received waiver services (in the type, amount, frequency, and duration) as delineated in the Individual Support Plan.	• Include in proposed regulations a requirement that providers with a history of noncompliance in key identified areas are required to undergo TA and training • Provider manual includes clear and specific guidance on service plan development including assessing needs, capabilities and desired outcomes • Training on service plan and service delivery requirements - including type, scope, amount, duration and frequency, is made available to providers	• Proposed regulations drafted & Final regulations promulgated • Provider manual published • WaMS service plan integration complete • Training on service plan and service delivery requirements including type, scope, amount, duration and frequency requirements made available to providers	• 6/2017 & 1/2018 • 1/2018 • ongoing

Performance measure *D.11*. **Number and percent of individuals/families reporting that the support plan includes all the services and supports the individual needs is not in the current BI waiver**. It was originally anticipated that data for the measure could be pulled from NCI data. It was later determined that NCI data was not a viable data source for the measure. Since this measure is not included in the current waiver this data will not be formally collected.

G. Health and Welfare (pre-2014)

The state must demonstrate, on an ongoing basis, that it identifies, addresses, and seeks to prevent instances of abuse, neglect and exploitation. AUTHORITY: 42 CFR 441.302; CFR 441.303; SMM 4442.4; SMM 4442.9
[This assurance only applies to the waiver years regulated by guidance that was in place prior to March 12, 2014. There were no sub-assurances for this assurance under the prior guidance.]

#	Sub-Assurance Description	For Draft Report: CMS Determination	For Draft Report: CMS Justification	For Draft Report: Additional Information Requested	For Draft Report: CMS Recommendations or Required Changes	For Final Report: CMS Determination
G-i	On an ongoing basis the state identifies, addresses and seeks to prevent instances of abuse, neglect and exploitation.	The state does not demonstrate the sub-assurance.	No data was collected for 9 of 10 of the PMs addressing this sub-assurance. The state submitted data on 2 additional PMs that were not included in the approved waiver.	The state should submit a comprehensive plan for the collection and analysis of the data for all Health and Welfare PMs. The plan should detail specific actions, milestones, and schedules. If changes to PMs are desired, the state should submit amendments for this purpose.	CMS Required Changes	The state does not demonstrate the sub-assurance. **CMS Additional Comments:** The Commonwealth has submitted a plan of correction. CMS will review changes to the approved PMs upon receipt of a waiver amendment.

State Response to the Draft Report:

Gi PM 1-10, The state's health and welfare data reported by its Department of Licensing, Human Rights Division, and state Mortality Committee do not report critical health and safety incidents by waiver. The state will be submitting amendments to revise performance measures and data sources to report on health and welfare performance measures in aggregate for all three waivers. In addition, during the state's analysis of the reasons for challenges in data collection it was discovered that data reporting entities use different terminology and categories of information collection/data that

have not been adequately aligned with performance measure terminology and information collection needs. Slight variations in terminology and data that is collected versus data that is expected to be reported – e.g. unexpected deaths, unexplained deaths and preventable deaths - have impacted the state's reporting. The following plan is in process to ensure collection and analysis of the data for all Health and Welfare PMs in the waivers.

Plan for Collecting & Reporting Health and Welfare Performance Measure	**Milestones**	**Timeline**
1. DMAS meets with DBHDS Office of Developmental Services, Department of Licensing, Human Rights Division, and state Mortality Committee to review each health and welfare performance measure and data source for validation and identification of measures that need modifications.	✓ Meeting held	May 1, 2017
2. DBHDS Office of Developmental Services, Department of Licensing, Human Rights Division, and state Mortality Committee draft modifications to identified performance measures and validate data source.	Performance measures drafted	May 18, 2017
3. DMAS meets with DBHDS Office of Developmental Services, Department of Licensing, Human Rights Division, and state Mortality Committee to review proposed performance measures and data source. .	Meeting held and performance measures reviewed	May 18, 2017
4. Performance measures are finalized and DBHDS submits a sample quarterly report that includes the collection of data for each revised performance measure validating the efficacy of the measures and data collection.	Performance measures finalized sample report submitted	July 2017
5. DMAS prepares and submits for CMS approval waiver amendment with revised performance measures and requesting aggregate reporting across waivers.	Amendment submitted	September 2017

6. Quarterly review and analysis of each performance measure data and compliance status with appropriate remediation occurring as warranted.	Upon CMS approval	Ongoing

I. Financial Accountability

The state must demonstrate that it has designed and implemented an adequate system for insuring financial accountability of the waiver program. AUTHORITY: 42 CFR 441.302; 42 CFR 441.303; 42 CFR 441.308; 45 CFR 74; SMM 4442.8; SMM 4442.10

#	Sub-Assurance Description	For Draft Report: CMS Determination	For Draft Report: CMS Justification	For Draft Report: Additional Information Requested	For Draft Report: CMS Recommendations or Required Changes	For Final Report: CMS Determination
I-i	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.	The state substantially demonstrates the sub-assurance.	Both of the two PMs reported 100% compliance in each year.		None	The state substantially demonstrates the sub-assurance. **CMS Additional Comments:**

#	Sub-Assurance Description	For Draft Report: CMS Determination	For Draft Report: CMS Justification	For Draft Report: Additional Information Requested	For Draft Report: CMS Recommendations or Required Changes	For Final Report: CMS Determination
I-ii	The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle. **[This sub-assurance only applies to waiver years regulated by the guidance issued March 12, 2014.]**	This sub-assurance does not apply.			None	This sub-assurance does not apply. **CMS Additional Comments:**

State Response to the Draft Report:
Instructions to state: enter state's response here and answer any questions that CMS has posed in the preceding table.

Home and Community-Based Day Support Waiver

Fact Sheet

	[Control #] Waiver Details
Waiver Name:	Day Support Waiver
State Medicaid Agency:	Department of Medical Assistance Services (DMAS)
State Operating Agency:	Department of Behavioral Health and Developmental Services (DBHDS)
State Waiver Contact:	Terry Smith, Director of Long Term Care DMAS (804) 371-8490
Local Operating Agencies:	Behavioral Health Authority (BHA) or Community Service Board (CSB)
Target Population:	Individuals who are diagnosed with an ID, meet the level of care criteria for an ICF/IID, and meet Medicaid financial eligibility
Level of Care:	ICF/IID
Effective Dates of Waiver:	7/1/13 through 6/30/2018
Concurrent Waiver Authority:	1915c of the Social Security Act
Actual Annual Per Capita Costs (CMS-372):	Waiver year #1 2014: $13,806
Actual Unduplicated Number of Waiver Participants (CMS-372):	Waiver Year #1 2014: 249
Approved Waiver Services:	Day Support, Prevocational Service, Supported Employment and Services Facilitation
CMS Contact:	Ellen Reap, 215-861-4735 ellen.reap@cms.hhs.gov

CMS Waiver Program Evidence Standards

CMS Waiver Program Evidence Standards

The Centers for Medicare & Medicaid Services (CMS) conducts evidence reviews, requiring states to demonstrate their use of performance measures to collect home and community-based (HCBS) waiver program data and address how they conduct discovery, remediation, and quality improvement activities.

Performance Measures

The CMS evaluates the state's oversight and monitoring systems according to outcome-based evidence in the form of performance measures. Well-crafted performance measures indicate whether the state is meeting the federal assurances for the approved waiver program. The performance measures drive the state's Quality Improvement Project (QIP) and form the basis of the evidence provided to CMS.

The state's performance measures are assessed by CMS based on the following six criteria:

1. The performance measure is stated as a metric (e.g., number or percent), and specifies a numerator and denominator (i.e., is the performance measure measurable?).
2. The performance measure has face validity (i.e., Does the performance measure truly measure the sub-assurance?).
3. The performance measure data is based on the correct unit of analysis (e.g., waiver participants, providers, claims, etc.). The unit of analysis should be linked to the assurance/sub-assurance measured.
4. The performance measure data is based on a representative sample of the population. The performance measure data should have at least a 95 percent confidence level with a +/- 5 percent margin of error. If the state chooses to stratify a sample to allow for a representative sample of subgroups, the state must "re-weight" the data in order to make estimates for the population as a whole.
5. The performance measure must provide data specific to the waiver program undergoing evaluation.
6. The performance measure data demonstrates the degree of compliance for each period of data collection.

Discovery & Remediation

When a performance measure falls below the threshold, further analysis is required to determine the cause. A QIP must be implemented once the cause is found unless the state provides justification accepted by CMS that a QIP is not necessary. The Evidence Report submitted for each waiver must document QIP(s) including status to date.

Completing This Template

At state option, the following template can be used to provide documentation necessary for the quality review. This template is designed to capture information on all assurances and sub-assurances that apply to the waiver. We have entered all performance metrics approved during the PASSPORT Quality Review time period. However, if you only have partial data or feel that

information contained within is incorrect, please modify as necessary. Please complete the sections identified in blue font.

If the state chooses to populate the template, the evidentiary report below will be the state's submission in response to CMS' Quality Review request to 1) describe the state's Quality Improvement Project and Quality Management Activities, 2) provide background regarding its processes, policies, procedures, etc., related to each Assurance, 3) describe how the state monitors performance in each of the waiver assurances, and 4) provide evidence of discovery, remediation, and improvement activities for all of the waiver assurances.

- Pre-2014 assurances/sub-assurances are highlighted in yellow.
- Post-2014 assurance/sub-assurances are highlighted in green.
- If assurance/sub assurances applies to all years, it must be completed.

Virginia State Medicaid Agency Oversight of the Day Support (DS) Waiver

State Quality Improvement Project
The Day Support (DS) Home and Community-Based Waiver for Persons with Intellectual Disabilities began in 2005. The DS Waiver is designed to provide day support, pre-vocational and/or supported employment services. The Department of Medical Assistance Services (DMAS) is the State Medicaid Agency for the Commonwealth of Virginia and the Department of Behavioral Health and Developmental Services (DBHDS) is the contractually designated state operating agency for the Day Support Waiver. DMAS meets with the operating agency (DBHDS) quarterly and as needed to review performance and discuss how problems identified will be remediated. Follow-up letters are sent by DMAS and reports are requested on the status of remediation and individual problems. DMAS and/or DBHDS may provide training and technical assistance and institute individual corrective action plans to ensure problems that have been identified are resolved. The Commonwealth has recently implemented a system-wide redesign of its Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions (ICF/IID) level of care Medicaid waivers. This system transformation included the submission and subsequent approval of waiver amendments for the conversion of its three existing waivers, including the DS Waiver, into three new waivers that expand access to individuals with developmental disabilities, across ID and DD populations. Many of the components of the redesigned waivers are intended to address quality assurance issues with standardization of processes and procedures and eligibility tools, to improve accountability, development of new comprehensive provider competencies and a provider rating system, as well as a custom waiver management computer system to assist with tracking of providers.

State Quality Management Activities
DBHDS has primary responsibilities in the operations of the DS waiver as well as the quality management program. DMAS provides guidance and oversight of DBHDS activities via joint quarterly operations meetings where issues are discussed and resolved. These meetings include collaborative efforts to develop performance measures, monitor progress toward

those meeting those measures and identify barriers to completion. This group also identifies issues that may need to be addressed through the waiver, regulations or policy and procedure

A primary component of the state's Quality Management process is the Quality Management Review (QMR). Through the QMR process, individual's records are reviewed based on performance measures that are aligned with the six assurances. The QMR process begins with identifying a random sample of active individuals on the DS waiver to determine the percentage of records to be reviewed. A statistically valid sample is generated using the Statistical Analysis System (SAS) to run a report that provides a random selection of individuals and service providers. The review is performed using a QMR tool during onsite visits to capture data specific each performance measure. When deficiencies or instances of non-compliance are found, QMR staff discuss findings with the provider and provides technical assistance. The technical assistance usually consists of provider training and education that focuses on assisting the provider to come into compliance with the program policies and regulations. During the technical assistance session the provider has an opportunity to ask questions and receive clarification on areas of non-compliance. All providers receive technical assistance during the exit interview.

Providers found in noncompliance during site reviews are subject to development, and QMR monitoring, of a corrective action plan. The plan must include methods to remedy the deficient areas including time frames to complete the actions. Corrective action plans must be submitted to DMAS for approval. DMAS approves the plan within 30 days and conducts follow-up with the provider to ensure the area of deficiency has been corrected. The current DMAS policy for follow up on a corrective action plan is within 45 days from the date of implementation identified on the corrective action plan. A final written response is issued to all providers detailing the findings of the QMR and includes recommendations to the provider.

Several DBHDS offices are also involved with DS waiver operations and quality assurance activities. The DBHDS Office of Licensing (OL) is responsible for initial and ongoing licensure of two of the three services available in the DS waiver. Unannounced visits are made at least annually to licensed providers for the purpose of ensuring ongoing compliance with licensing regulation, as well as in response to complaints or incidents related to specific providers. Providers found not to be in compliance with licensing regulations are required by OL to develop and submit corrective actions plants. These must include a description of the remedial actions to be taken and date of completion for each action. A corrective action plan must be submitted within 15 days of the issuance of the licensing report. Unsatisfactory corrective action plans must be rewritten and resubmitted until deemed satisfactory by OL staff. Subsequent to this, OL staff may monitor the provider more closely to ensure implementation. Providers that have demonstrated an inability to maintain compliance with the licensing regulations have violations of human rights or licensing regulations that pose a threat to the health or safety of individuals, or have failed to comply with a previous corrective action plan, may be issued a provisional license. The term of a provisional license may not exceed six months and may be renewed for only an additional six month period.

All providers licensed by DBHDS must comply with DBHDS's Human Rights regulations. Suspected violations of individuals' human rights are typically investigated jointly by OL and OHR staff cited by OL staff and may require corrective action plans.

DMAS and DBHDS staff meet quarterly as a Quality Review Team (QRT) to review data, survey results and information used to monitor progress toward meeting CMS assurances and take steps to conduct remediation where it is indicated. The QRT also identifies trends and areas where systemic changes are needed to collect new data and information or improve quality. The results of Supervisory Record Reviews as well as the actions taken by these staff persons are reviewed by the QRT for appropriateness. Inappropriate actions or failure to take action are referred to DBHDS technical assistance staff to address with the offender. In addition, the QRT monitors, through data collected from DBHDS Offices of Licensing and Human Rights, providers that are cited for abuse as a result of unauthorized use of restraints. The DBHDS Office of Licensing conducts annual reviews and inspections of licensed providers. Unannounced inspections may also occur in response to complaints or reports or serious incidents or events.

Another important component of the Quality Improvement plan is performed in part by the local Community Services Boards/Behavioral Health Authorities (CSBs). These single or multiple jurisdictional entities are established by local government entities and responsible for administering the waivers at the local level. CSB staff are given a certain number of records for each waiver (representative sample based on the number of individuals they support on each waiver) to review annually. The form that they must use includes questions from the performance measures. Each quarter, these staff review approximately one quarter of their total assigned number of records and respond to the questions regarding each record. DBHDS staff reviews and summarizes the information for inclusion in the quarterly report regarding performance measures reviewed by DMAS and DBHDS staff. DBHDS has found that this is an effective means to ensure that CSB supervisors/QA staff are examining individuals' records with an eye to waiver performance measures expectations and providing feedback/remediation to their staff as needed. For each of the measures reviewed by CSB staff, there is typically another source of data (e.g., Quality Management Reviews).

The quality improvement strategy is evaluated on an annual basis. This is accomplished by the QRT through the review of performance indicators and data collected regarding remediation success/failure. During the last QRT meeting of the state fiscal year, the QRT reviews the performance measures, remediation steps that have occurred and outcomes of those remediation steps so a plan can be devised to continue, revise or add any indicators for the upcoming year. A summary of future action steps results from these quarterly meetings.

System Improvement Activities

The Commonwealth has long relied on QMR activities, standard provider training and technical assistance, and communication and outreach activities as the primary means for remediating deficiencies in the waiver quality assurance program. QMR interventions address deficiencies on a provider by provider basis. There are also opportunities for training and technical assistance more broadly applied to all providers in support of systemic remediation.

The recently approved amendments to Virginia's waivers serving individuals with developmental disabilities, including the DS Waiver, introduce comprehensive changes including a single point of entry for services with eligibility for both the ID and DD population determined by the same entity. This streamlines access for individuals and families and promotes consistency. As of 9/1/2016, all individuals with ID and DD access services at their local Community Services Board (CSB). There are forty CSBs throughout Virginia, with each

city or county belonging to the catchment area of one CSB. Individuals may be supported by a CSB-employed or private support coordinator (case manager) contracted with a CSB.
To better ensure that these activities are impactful and that interventions lead to system improvements, a number of the components associated with the waiver system redesign are anticipated to directly impact quality improvement activities.

The waiver changes also consist of the adoption of an updated, more person-centered level of care tool, the Virginia Individual Developmental Disability Eligibility Survey (VIDES). The VIDES is designed to assess an individual's level of functioning according to his or her developmental stage and will be administered to individuals from birth to 3 years, 4-17 years, and 18 years of age and older. The Commonwealth has invested a substantial number of training on this new eligibility tool to staff who will be administering the tool and others who need to understand how it is used. Ongoing training and technical assistance in VIDES administration is available through DBHDS Regional Support Staff. The timelines used for the previous LOF will continue with administration of the VIDES. These changes are expected to promote more consistency and uniformity in LOF determinations.

a. The designation of a single point of entry has established the BHA/CSB as the access point for waiver services, regardless of diagnosis. This single access point will help ensure that information, as well as eligibility determinations are conducted in a uniform and consistent manner.

b. Development of a comprehensive series of training modules and information resources on the new waivers systems and associated elements that are specifically targeted to case managers/support coordinators to ensure they have a consistent understanding of their role in the eligibility determination, case management, and services planning process.

c. Development of a new Waiver Management System (WaMS). The new WaMS system will house individual service plans as well as service authorizations to ensure that timelines and outcomes are being met.

In addition to the waivers system redesign, during this reporting period a significant point of focus was on ensuring the appropriateness of the data being collected for each measure. In several instances, multiple data elements were being collected from different entities; in some instances the data conflicted with other data sources. To address these inconsistencies, DBHDS and DMAS made the following systemic changes:

a. Joined efforts with an existing DBHDS data improvement initiative to retool several DBHDS data reports used with the QRT so that the data collected matched the performance measure. Three new data reports were created in the DBHDS Data Warehouse to specifically address three Health and Welfare Performance Measures.

b. Eliminated data sources that did not directly address the performance measure being targeted. The focus of this effort was to ensure that the data source being used was the most relevant to the measure.

c. Eliminated the use of the NCI as a data source for QRT. The data was proposed to help the Commonwealth assess satisfaction with the level of service delivery. The

annual reporting of the NCI data did not correspond with the reporting timetable for QRT reviews. The state is currently reassessing the use of NCI data for quality improvement to determine if adjustments to the dataset would improve its relevance to state metrics.

d. Added new positions to the QRT to ensure representation of specialists in the development and mining of DBHDS agency data. The intent was that these new members would complement the team to be able to help describe some of the remaining differences in data and work together to explain or resolve differences.

The state is also in the process of including the following in its Quality Improvement Process:

- Standard reporting of key performance metrics during provider and CSB meetings and conferences as a feedback loop back to the provider community to chart progress with the measures

- Investigating use of a case study approach that would link the Quality Service Review (QSR) data to the Supervisory Review process. The intent is to target specific providers who have received a specific quality improvement intervention (technical assistance, training, CAP, etc.) to track that provider's improvement over time and demonstrate the success of specific interventions on individual providers over a period of time.

- Consideration of other sampling methods to ensure that specific cases selected by the Department are being reviewed during the Supervisory Review process.

A. Administrative Authority

The state must demonstrate that it retains ultimate administrative authority over the waiver program and that its administration of the waiver program is consistent with the approved waiver application. AUTHORITY: 42 CFR 441.303; 42 CFR 431; SMM 4442.6; SMM 4442.7.

Background

The Virginia Department of Medical Assistance Services (DMAS) serves as the state Medicaid agency. DMAS exercises administrative discretion in the administration and supervision of the waiver; issues policies, rules and regulations related to the waiver; and makes payment for waiver services provided through the Virginia Medicaid Management Information System (VAMMIS).

The DMAS maintains responsibility for assessing the performance on contracted entities. DMAS employs contract monitors to oversee the daily administrative operations of these contracted entities and to provide evaluation every six months of their outcomes and deliverables. The six month evaluations are submitted to the Office of Contract Management, which are maintained for five years. These evaluations are subject to yearly review by the State's Auditory of Public Accounts. In addition, contract monitors receive regular reports submitted by the contractor/agency, as specified in the contract/IAG.

Virginia DMAS contracts with other entities to perform the following roles:

1) Xerox - Provider Enrollment Services for completion of provider enrollment, execution of provider agreements and management of the Virginia MMIS. Information on their services can be found at www.virginiamedicaid.dmas.virginia.gov.

2) Department of Behavioral Health and Developmental Services (DBHDS) – is the DBHDS the operant agency for this waiver. DBHDS responsibilities include waiver enrollment, managing the waitlist, provider training, and annual level of care reviews.

DMAS contract monitors:

1) Ensure services are delivered in accordance with the contract/IAG and deliverables are in fact delivered;
2) Approve invoices for payment in accordance with the terms of the contract/IAG;
3) Complete and submit a semi-annual report to the DMAS Contract Officer
4) Report any delivery failures or performance problems to the DMAS Contract Officer; and
5) Ensure that the contract /IAG terms and conditions are not extended, increased or modified without proper authorization.

At each semi-annual contract review the DMAS contract monitors track each of the above areas and provide follow up information to address any concerns cited. Satisfactory compliance means checking "yes" in response to areas monitored. DMAS staff review audit findings and submit corrective action plans to contractors to ensure that any deficiencies identified are remediated. Remediation activities generally take the form of corrective action plan.

The daily operation of the Day Support (DS) Waiver is performed by the Department of Behavioral Health and Developmental Services (DBHDS), the designated operating agency which operates under the supervision and authority of the DMAS. Within this authority, the DBHDS is responsible for service authorization, maintaining the statewide waiting list, ensuring appropriate enrollment of individuals into the DS waiver, delivering provider and case management/support coordination training and technical assistance, conducting provider development activities and cooperatively working with DMAS on the waiver application, regulations and policy materials. An interagency agreement (IAG), on file at both agencies, ensures accountability and effective management for all waiver requirements and assurances. It is reviewed annually and updated when needed.

Sub-assurance A-i: The Medicaid agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

Sub-assurance A-i (pre-2014 & post-2014)

Performance Measure:	A.1. Number and percent of Quality Review Team (QRT) meetings held as scheduled each year.
Numerator:	N: # of QRT meetings held each year
Denominator:	D: # of QRT meetings scheduled each year
Description of Data Source:	Meeting notes/QRT tracking grid
Entity Responsible for Data Collection:	DBHDS
Frequency of Data Collection:	Quarterly
Entity Responsible for Data Aggregation:	DMAS DBHDS
Frequency of Data Aggregation:	Quarterly
Sampling Methodology:	100%

State Data	[2014	[2015]	[2016]
Sample Universe: (numerator)	4	4	4
Sample Size:	4	4	4
% Compliant:	100%	100%	100%

State Analysis
The state demonstrates 100% compliance in this measure. In SFY 2014, there was at least one QRT Team meeting scheduled to review information for each quarter, as required, resulting in 100% compliance. In SFY 2015, there was at least one QRT Team meeting scheduled to review information for each quarter, as required, resulting in 100% compliance. In SFY 2016, there was at least one QRT Team meeting scheduled to review information for each quarter, as required, resulting in 100% compliance.
Remediation
Remediation not necessary
Quality Improvement Activities
Quality Improvement Activities not necessary

Performance Measure:	A2. Number and percent of satisfactory Medicaid-initiated contractor (i.e., DBHDS & Xerox) evaluations.
Numerator:	N: Number of satisfactory Medicaid-initiated contractor evaluations
Denominator:	D: Total number of Medicaid initiated contractor evaluations
Description of Data Source:	Records reviewed, onsite
Entity Responsible for Data Collection:	DMAS
Frequency of Data Collection:	Semi-annually
Entity Responsible for Data Aggregation:	DMAS DBHDS
Frequency of Data Aggregation:	Semi-annually
Sampling Methodology:	100%

State Data	[2014]	[2015]	[2016]
Sample Universe: (numerator)	4	4	4
Sample Size:	4	4	4
% Compliant:	100%	100%	100%

State Analysis
For SFY 2014, 2015 and 2016 evidence was gathered for the two following interagency agreements/contract: Xerox Corporation, and DBHDS. The inter-agency agreements/contract evaluations occur every six months resulting in a total of four reviews each SFY. • **Xerox Corporation:** Evaluation findings for SFYs 2014, 2015 and 2016 indicate that the agency consistently complied with all terms of the agreement. The contract monitor 100% of the time indicated overall satisfaction with the agency's performance • **DBHDS**: Evaluation findings for SFYs 2014, 2015 and 2016 indicate that the agency consistently complied with all terms of the agreement. The contract monitor 100% of the time indicated overall satisfaction with the agency's performance.
Remediation
Remediation not necessary
Quality Improvement Activities

Quality Improvement Activities not necessary

Performance Measure:	A3. Number and percent of waiver policies and procedures approved by DMAS prior to implementation by DBHDS.
Numerator:	N: # of policies and procedures implemented by DBHDS that were approved by DMAS prior to implementation
Denominator:	D: total # of policies and procedures implemented by DBHDS
Description of Data Source:	Meeting Minutes
Entity Responsible for Data Collection:	DMAS
Entity Responsible for Data Aggregation:	DMAS DBHDS
Frequency of Data Aggregation:	Quarterly
Sampling Methodology:	100%
Frequency of Data Collection:	Quarterly

State Data	[2014	[2015]	[2016]
Sample Universe: (numerator)	0	0	0
Sample Size:	0	0	0
% Compliant:	100%	100%	100%

State Analysis
In SFY 2014, there were no policies and procedures implemented by DBHDS, therefore there was no need for approval prior to implementation resulting in 0/0. In SFY 2015, there were no policies and procedures implemented by DBHDS, therefore there was no need for approval prior to implementation resulting in 0/0. In SFY 2016, there were no policies and procedures implemented by DBHDS, therefore there was no need for approval prior to implementation resulting in 0/0.
Remediation
Remediation not necessary
Quality Improvement Activities
Quality Improvement Activities not necessary

B. State Conducts Level of Care Determinations Consistent with the Need for Institutionalization

The state must demonstrate 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 consistent with care provided in a hospital, nursing facility, or intermediate care facility for persons with intellectual disabilities. AUTHORITY: 42 CFR 441.301; 42 CFR 441.302; 42 CFR 441.303; SMM 4442.5

Background
Initial and annual level of care evaluations have been performed by case managers/support coordinators at the local Community Services Boards (CSBs) using the Level of Functioning Survey (LOF) for all applicants for whom there is reasonable indication that services may be needed in the future, as well as annually for all individuals receiving DS Waiver services, to ensure continued functional eligibility. DBHDS monitors data from the local CSBs on the length of time between application for screening and notification of determination for each applicant. All LOF evaluations are required to be completed within 30 days from the point at which there is a reasonable indication that services may be needed in the future. The "date of request" by an individual for waiver services is collected on the "Day Support Waiver Enrollment Form" and reported to DBHDS for entry into a centralized database. This date is compared to the date the LOF evaluation is completed for the individual. LOF determinations that are not conducted within a reasonable time frame are remediated through the use of training, education, and technical assistance. Data is collected on the type of remediation required, including outcomes and follow-up. DBHDS has monitored this assurance by collecting data regarding the timeliness and completeness of re-evaluation LOFs. DBHDS receives the "Plan of Care Summary" form annually for each individual receiving waiver services, which includes the date the LOF re-evaluation was completed, and an indication of categories met. The DBHDS monitors the initial completion of the LOF by requiring that case managers submit the date the LOF was completed and the number of LOF categories met. Individuals are then either enrolled in the waiver or placed on the statewide waiting list. The DBHDS also established a qualitative review by case manager supervisors to monitor a number of the DS Waiver performance measures, including the completion and accuracy of LOF re-determinations by case managers. The case management supervisor or quality assurance staff is responsible for addressing problems related to the LOF and reporting their resolution to the Quality Review Team (QRT) through DBHDS on a quarterly basis.

Sub-Assurance B-i: An evaluation for level of care is provided to all applicants for whom there is reasonable indication that services may be needed in the future.

Sub-assurance B-i (pre-2014 & post-2014)

Performance Measure:	B.1. Number and percent of all new enrollees who have a level of care indicating a need for institutional/waiver services.
Numerator:	N: # of new enrollees who have level of care indicating institutional/waiver eligibility
Denominator:	D: total # of new enrollees
Description of Data Source:	Enrollment Request Form
Entity Responsible for Data Collection:	DBHDS
Frequency of Data Collection:	Quarterly
Entity Responsible for Data Aggregation:	DBHDS
Frequency of Data Aggregation:	Quarterly
Sampling Methodology:	100%

State Data	[2014	[2015]	[2016]
Sample Universe: (numerator)	3	30	32
Sample Size:	3	31	32
% Compliant:	100%	97%	100%

State Analysis
Data for this measure is reported through the Receipt of Enrollment Request Form from the DBHDS Data Warehouse. Data reported during 2014 is from the fourth quarter only. In SFY 2014, the data show that for that quarter, of the three new enrollees, all three had a level of care indicating institutional/waiver eligibility, resulting in 100% compliance. In SFY 2015, the data show that of the 31 new enrollees, 30 had a level of care indicating institutional/waiver eligibility, resulting in 97% compliance. In SFY 2014, the data show that of the 32 new enrollees, all 32 had a level of care indicating institutional/waiver eligibility, resulting in 100% compliance.
Remediation
Data show that the measure falls slightly below the required threshold for 2015, requiring remediation. This measure has historically shown 100% compliance. Serious violations (such as a missing LOF) may be referred to DMAS's Provider Integrity unit for billing retraction. This issue may also be remediated through DBHDS Provider Development training and technical assistance.
Quality Improvement Activities

As described in the Quality Management section of this report, adoption of an updated, more person-centered level of care tool, the Virginia Individual Developmental Disability Eligibility Survey (VIDES), is anticipated to promote more consistency in and timeliness of LOF determinations. When necessary, quality Improvement activities will include training of support coordinator supervisors and quality management staff who will be administering the new VIDES LOC tool, as well as general training and QMR activities.

Sub-Assurance B-ii: The level of care of enrolled individuals is reevaluated at least annually or as specified in the approved waiver.

Sub-assurance B-ii (pre-2014)

Performance Measure:	B.2. Number and percent of Level of Functioning Surveys completed within 45 working days of receipt of application for waiver services.
Numerator:	N: # and % of LOF determinations made within 45 working days for new applicants
Denominator:	D: # of and % of new applicants for whom there is a reasonable indication that services may be needed in the future
Description of Data Source:	IDOLS Report
Entity Responsible for Data Collection:	DBHDS
Frequency of Data Collection:	Quarterly
Entity Responsible for Data Aggregation:	DBHDS
Frequency of Data Aggregation:	Quarterly
Sampling Methodology:	100%

State Data	[2014	[2015]	[2016]
Sample Universe: (numerator)	1330	1390	1406
Sample Size:	1549	1601	1564
% Compliant:	86%	87%	90%

State Analysis

The data shows that the measure falls below the required threshold and requires remediation. Between 2013 and 2014, after the waiver renewal, the reporting format and wording of the performance measures were changed. This assurance is now assessed through case management supervisors and quality assurance staff as well as supervisory and QMR reviews.

In SFY 2014, the data show that out of 1539 LOF determinations for the year, 1330 were within the 45 working day threshold for new applicants, resulting in 86% compliance.

In SFY 2015, the data show that out of 1601 LOF determinations for the year, 1390 were within the 45 working day threshold for new applicants, resulting in 87% compliance.

In SFY 2016, out of 1564 LOF determinations for the year, 1406 were within the 45 working day threshold for new applicants, resulting in 90% compliance.

The screening for the DS and ID waivers are both completed by the CSBs. Individuals requesting waiver services are screened for the ID waiver, only individuals on the ID waiver waitlist are eligible for the DS waiver. CSB would offer a DS waiver slot to appropriate individuals on the ID waiver waiting list in their catchment area. Therefore the numbers above represent the number of individuals who were screened for the ID waiver in a timely manner, which is why the numbers are so high.

Remediation

The data show that the performance measures related to this assurance are below the required threshold, resulting in a need for systemic remediation. Remediation activities include correction as soon as the discovery is made, along with follow up training and technical assistance delivered by DBHDS Provider Development staff. Instances of non-compliance reported through the supervisory reviews are typically remediated within thirty days.

Quality Improvement Activities

As described in the Quality Management section of this report, adoption of an updated, more person-centered level of care tool, the Virginia Individual Developmental Disability Eligibility Survey (VIDES), is anticipated to promote more consistency in and timeliness of LOF determinations. Quality improvement activities include targeted training and technical assistance conducted by DBHDS Provider Development staff, QMR monitoring activities, and the ability to relook at capturing this information in the new waiver management system (WaMs). The state will also reexamine and clarify the starting point that providers should be using to start the 45 day period to ensure that all providers are using the same timeframe for more accurate comparison.

Sub-Assurance B-iii: The process and instruments described in the approved waiver are applied appropriately and according to the approved description to determine initial participant level of care.

Sub-assurance B-iii (pre-2014 & post-2014)

Performance Measure:	B.3. Number and percent of individuals who received an annual LOF re-evaluation of eligibility within 12 months of their of their last LOF evaluation.
Numerator:	N: # of individuals who had an annual LOF reevaluation within 12 months of their last LOF evaluation.
Denominator:	D: total # of LOF re-determinations
Description of Data Source:	Supervisory Review QMR
Entity Responsible for Data Collection:	DMAS/DBHDS
Frequency of Data Collection:	Quarterly
Entity Responsible for Data Aggregation:	DMAS/DBHDS
Frequency of Data Aggregation:	Quarterly
Sampling Methodology:	Representative Sample

State Data	[2014	[2015]	[2016]
Sample Universe: (numerator)	Supervisory review 180 QMR 35	Supervisory Review 140 QMR 63	Supervisory Review 110 QMR 93
Sample Size:	Supervisory Review 181 QMR 35	Supervisory Review 152 QMR 64	Supervisory Review 114 QMR 93
% Compliant:	Supervisory Review 99% QMR 100%	Supervisory Review 92% QMR 98%	Supervisory Review 96% QMR 100%

State Analysis

In SFY 2014, for the Supervisory Review, 180 out of 181 received their annual LOF reevaluation within 12 months of their last LOF evaluation, resulting in 99.45% compliance. For QMR, 35 out of 35 received their annual LOF reevaluation within 12 months of their last LOF reevaluation, resulting in 100% compliance.

In SFY 2015, for the Supervisory Review, 140 out of 152 received their annual LOF reevaluation within 12 months of their last LOF evaluation, resulting in 92.5% compliance. For QMR, 63 out of 64 received their annual LOF reevaluation within 12 months of their last LOF reevaluation, resulting in 98% compliance.

In SFY 2016, for the Supervisory Review, 110 out of 114 received their annual LOF reevaluation within 12 months of their last LOF evaluation, resulting in 96% compliance. For QMR, 93 out of 93 received their annual LOF reevaluation within 12 months of their last LOF reevaluation, resulting in 100% compliance.

Remediation

Although the majority of LOF reevaluations are completed within the required timeframe in 2015 and 2016 compliance was under expectation. Providers who are non-compliant with this assurance are addressed through follow up training and technical assistance delivered by DBHDS Provider Development staff, and a development of a corrective action plan through QMR.

Quality Improvement Activities

As described in the Quality Management section of this report, adoption of an updated, more person-centered level of care tool, the Virginia Individual Developmental Disability Eligibility Survey (VIDES), is anticipated to promote more consistency in and timeliness of LOF determinations. Quality improvement activities include targeted training and technical assistance conducted by DBHDS Provider Development staff, and QMR monitoring activities will continue.

Performance Measure:	B.4. Number and percentage of LOF determinations made by a qualified evaluator.
Numerator:	N: # of LOF determinations made by a qualified evaluator
Denominator:	D: total # of LOF determinations
Description of Data Source:	Supervisory Review QMR
Entity Responsible for Data Collection:	DMAS/DBHDS
Frequency of Data Collection:	Quarterly
Entity Responsible for Data Aggregation:	DMAS/DBHDS
Frequency of Data Aggregation:	Quarterly
Sampling Methodology:	Representative Sample

State Data	[2014	[2015]	[2016]
Sample Universe: (numerator)	Supervisory Review 58 QMR 35	Supervisory Review 169 QMR 64	Supervisory Review 141 QMR 97
Sample Size:	Supervisory Review 58 QMR 35	Supervisory Review 170 QMR 64	Supervisory Review 143 QMR 97
% Compliant:	Supervisory Review 100% QMR 100%	Supervisory Review 99% QMR 100%	Supervisory Review 99% QMR 100%

State Analysis

In SFY 2014, the data show that for the Supervisory Review, 58 out of 58 LOF determinations were made by a qualified evaluator, resulting in 100% compliance. For QMR, 35 out of 35 LOF determinations were made by a qualified evaluator, resulting in 100% compliance. In SFY 2015, the data show that for the Supervisory Review, 169 out of 170 LOF determinations were made by a qualified evaluator, resulting in 99% compliance. For QMR, 64 out of 64 LOF determinations were made by a qualified evaluator, resulting in 100% compliance. In SFY 2016, the data show that for the Supervisory Review, 141 out of 143 LOF determinations were made by a qualified evaluator, resulting in 99% compliance. For QMR, 97 out of 97 LOF determinations were made by a qualified evaluator, resulting in 100% compliance.
Remediation
Remediation not necessary In the three instances in which the evaluator was not qualified technical assistance was provided through the supervisory review process previously described.
Quality Improvement Activities
Quality Improvement Activities not necessary

Performance Measure:	B.5. Number and percentage of LOF determinations made on the state's approved form.
Numerator:	N: # of LOF determinations made on state's approved form
Denominator:	D: total # of LOF determinations
Description of Data Source:	Supervisory Review QMR
Entity Responsible for Data Collection:	DMAS/DBHDS
Frequency of Data Collection:	Quarterly
Entity Responsible for Data Aggregation:	DMAS/DBHDS
Frequency of Data Aggregation:	Quarterly
Sampling Methodology:	Representative Sample

State Data	[2014	[2015]	[2016]
Sample Universe: (numerator)	Supervisory Review 58 QMR 35	Supervisory Review 150 QMR 54	Supervisory Review 150 QMR – no data
Sample Size:	Supervisory Review 58 QMR 35	Supervisory Review 162 QMR 54	Supervisory Review 153 QMR – no data
% Compliant:	Supervisory Review 100% QMR 100%	Supervisory Review 93% QMR 100%	Supervisory Review 98%

State Analysis

In SFY 2014, for QMR, 35 out of 35 LOF determinations were made on the state's approved form, resulting in 100% compliance. For Supervisory Review data, 58 out of 58 LOF determinations were made, also resulting in 100% compliance. In SFY 2015, for QMR, 54 out of 54 LOF determinations were made on the state's approved form, resulting in 100% compliance. For Supervisory Review data, 150 out of 162 LOF determinations were made, resulting in 93% compliance. In SFY 2016, this was removed as a performance measure under the assurance. For Supervisory Review data, 150 out of 153 LOF determinations were made, resulting in 98% compliance.
Remediation
Although the majority of LOF determinations were made on the state's approved form, in 2015 compliance was under expectation. Providers who are non-compliant with this assurance are addressed through follow up training and technical assistance delivered by DBHDS Provider Development staff, and a development of a corrective action plan through QMR.
Quality Improvement Activities
Systemic quality improvement activities include targeted training and technical assistance conducted by DBHDS Provider Development staff, QMR monitoring activities, and implementation of an improved, more consistent level of care tool.

Performance Measure:	B.6. (2014) Number and percent of LOF determinations that use criteria appropriately to enroll or maintain a person in the waiver.
Numerator:	N: # LOF determinations that use criteria appropriately
Denominator:	D: total # LOF determinations
Description of Data Source:	Supervisory Review QMR
Entity Responsible for Data Collection:	Community Service Boards' Support Coordination Supervisors or Quality Assurance Staff DMAS
Frequency of Data Collection:	Quarterly
Entity Responsible for Data Aggregation:	DMAS/DBHDS
Frequency of Data Aggregation:	Quarterly
Sampling Methodology:	Representative sample

State Data	[2014	[2015]	[2016]
Sample Universe: (numerator)	Supervisory Review: 55 QMR: 35	Supervisory Review 169 QMR 64	Supervisory Review 113 QMR 97
Sample Size:	Supervisory Review: 58 QMR: 35	Supervisory Review 170 QMR 64	Supervisory Review 114 QMR 97
% Compliant:	Supervisory Review 95% QMR: 100%	Supervisory Review 99% QMR 100%	Supervisory Review 99% QMR 100%

State Analysis

In SFY 2014, the data show that for the Supervisory Review, 55 out of 58 LOF determinations used criteria appropriately to enroll or maintain a person in the waiver, resulting in 95% compliance. For QMR,35 out of 35 LOF determinations used criteria appropriately to enroll or maintain a person in the waiver, resulting in 100% compliance In SFY 2015, the data show that for the Supervisory Review, 169 out of 170 LOF determinations used criteria appropriately to enroll or maintain a person in the waiver, resulting in 99% compliance. For QMR, 64 out of 64 LOF determinations used criteria appropriately to enroll or maintain a person in the waiver, resulting in 100% compliance. In SFY 2016, the data show that for the Supervisory Review, 113 out of 114 LOF determinations used criteria appropriately to enroll or maintain a person in the waiver, resulting in 99% compliance. For QMR, 97 out of 97 LOF determinations used criteria appropriately to enroll or maintain a person in the waiver, resulting in 100% compliance.
Remediation
Remediation activities include targeted training and technical assistance conducted by DBHDS Provider Development staff, and continued QMR monitoring activities.
Quality Improvement Activities
Systemic quality improvement activities include adoption of an updated, more person-centered level of care tool, the Virginia Individual Developmental Disability Eligibility Survey (VIDES), is anticipated to promote more consistency in and timeliness of LOF determinations. The data show that for 2014, the performance measure falls below the required threshold. However, data for 2015 and 2016 show improvement.

C. Qualified Providers Serve Waiver Participants

The state must demonstrate that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers. AUTHORITY: 42 CFR 441.302; SMM 4442.4

Background
The DMAS assures the availability of qualified providers to meet the needs of individuals receiving DS Waiver services. In doing this, DMAS assures that all agency providers who enroll with Medicaid possess the appropriate license or other qualifications prior to provider enrollment and the provision of services. Providers of day support services and some prevocational services providers are licensed by DBHDS. The licensing process requires submission and approval of policies and procedures that demonstrate compliance with licensing regulations, affiliation with a Local Human Rights Committee, the employment or contracting of a Qualified Intellectual Disabilities Professional for staff supervision, individual assessment and plan development, and demonstration of the completion of criminal record checks for all staff. During the period of this report, DMAS contracted with the provider enrollment contractor, Xerox Corporation. The vendor verifies provider qualifications and ensures that all providers meet required licensure and accreditation standards, as well as adhere

to all other standards prior to enrollment and furnishing DS Waiver services. Once enrolled, the provider is entered into Virginia's Medicaid Management Information System (VaMMIS), which verifies at the time of authorization of any service that the provider is enrolled by Medicaid to perform the requested service. System edits will prevent a service authorization or claims payment for a DS Waiver service if the provider does not have a current provider agreement at the time of service provision. DMAS screens all applicants for inclusion on the List of Excluded Individuals and Entities (LEIE). The screening is an automated process conducted by the Division of Program Operations for Medicaid enrolled providers.

Data collected includes verification that providers seeking a DBHDS license meet all regulatory requirements prior to issuance of their license and that QMR staff verify the possession of a current license during their onsite reviews.

The DBHDS issues provider licenses initially for a six-month "conditional" period. At some point during that time frame, DBHDS staff visits the provider to assure they are following their policies and procedures and are in compliance with licensing regulations. Following that initial period, new providers are typically issued a one-year license, at the end of which they are reviewed again.

Virginia performs the majority of its monitoring of the provision of services and health and welfare standards through quality management reviews. DMAS continues to enhance the quality monitoring review process by fully automating the QMR tool used by the analysts. Input and feedback shared during QRT meetings may results in additions to or adjustment of information collected by QMR during reviews.

The QMR is performed by DMAS Long Term Care (LTC) Division staff who conduct on-site record reviews with providers. The analyst uses a QMR tool designed to capture data specific to each performance measure. When deficiencies or instances of non-compliance are found, the analyst discusses the findings with the provider and provides technical assistance. Technical Assistance is provider training and education that focuses on assisting the provider to come into compliance with program policies and regulations. During the technical assistance session, the provider has an opportunity to ask questions and receive clarification on areas of non-compliance. All providers receive technical assistance during the QMR exit interview.

The QMR analyst may require the provider to develop a corrective action plan. The plan includes methods to remedy the deficient areas including time frames to complete the actions. Corrective action plans must be submitted to DMAS for approval. DMAS approves the plan within 30 days and conducts follow-up with the provider to ensure the area of deficiency has been corrected. The current DMAS policy for follow-up on corrective action plans is within 45 days from the date of implementation identified on the approved plan. A final written response is issued to all providers detailing the findings of the QMR and includes recommendations to the provider.

The DMAS QMR staff examine personnel records to ensure that provider agency staff have passed the required criminal record/background checks.

The QMR staff ensure during their onsite reviews that providers have a current

Department of Rehabilitative Services (DRS) vendor agreement and Commission on Accreditation of Rehabilitation Facilities (CARP) accreditation. The DMAS and DBHDS monitor direct support professionals' receipt of training in accordance with requirements under the waiver. DMAS QMR staff confirm that this documentation is present in provider personnel records.

Sub Assurance C-i: The state verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other state standards prior to their furnishing waiver services.

Sub-assurance C-i (pre-2014 & post-2014)

Performance Measure:	C 1. Number and percent of licensed/certified waiver agency provider enrollments for which the appropriate licensure/certification was obtained in accordance with waiver requirements prior to service provision.
Numerator:	N = # of new waiver provider enrollments with lic./certif. in accordance with requirements prior to service provision
Denominator:	D = total # of new enrolled waiver providers
Description of Data Source:	Xerox
Entity Responsible for Data Collection:	Xerox
Frequency of Data Collection:	Continuous and Ongoing
Entity Responsible for Data Aggregation:	DMAS
Frequency of Data Aggregation:	Quarterly
Sampling Methodology:	100%

State Data	[2014]	[2015]	[2016]
Sample Universe: (numerator)	696	516	554
Sample Size:	696	516	554
% Compliant:	100%	100%	100%

State Analysis
In SYFY 2014, 2015 and 2016 the state demonstrated 100% compliance with this quality performance measure.
Remediation
Remediation not necessary
Quality Improvement Activities

Quality improvement activities not necessary

Sub-Assurance C-ii: The state monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

Sub-assurance C-ii (pre-2014 & post-2014)

Performance Measure:	C2. Number and % of licensed/certified provider direct support staff who have had criminal background checks as specified in policy/regulation with satisfactory results.
Numerator:	N = # licensed/certified provider direct support staff who have criminal background checks as specified in policy/regulations with satisfactory results.
Denominator:	D = total # licensed/certified provider direct support staff records reviewed
Description of Data Source:	Onsite Record Reviews
Entity Responsible for Data Collection:	DMAS
Frequency of Data Collection:	Continuous and Ongoing
Entity Responsible for Data Aggregation:	DMAS
Frequency of Data Aggregation:	Quarterly
Sampling Methodology:	Representative sample=95/5confidence level

State Data	[2014	[2015]	[2016]
Sample Universe: (numerator)	36	23	84
Sample Size:	37	23	86
% Compliant:	99%	100%	98%

State Analysis
In SFY 2014, QMR data show that 36 out of 37 licensed/certified provider direct support staff had a criminal background check as specified in policy/regulation with satisfactory results, resulting in 99% compliance. In SFY 2015, QMR data show that 23 out of 23 licensed/certified provider direct support staff had a criminal background check as specified in policy/regulation with satisfactory results, resulting in 100% compliance. In SFY 2016, QMR data show that 84 out of 86 licensed/certified provider direct support staff had a criminal background check as specified in policy/regulation with satisfactory results, resulting in 98% compliance.

Remediation
The data shows that the measures for 2014, 2015 and 2016 are within the required threshold. As an outreach to providers, in the last quarter of 2016 DMAS distributed a targeted Medicaid Memo and a blast email to all providers about the requirement for criminal background checks. Remediation activities included reiterating during provider trainings and provider roundtable meetings, that DSP staff are required to undergo criminal background checks and cannot deliver services until they do so. Individual remediation efforts included: FY 2014-approval of 1 CAPs FY2015-none required FY2016-approval of I CAP
Quality Improvement Activities
Quality Improvement Activities not necessary

Sub-Assurance C-iii: The state implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.

Sub-assurance C-iii (pre-2014 & post-2014)

Performance Measure:	C3. Number and percent of licensed/certified providers continuing to meet applicable licensure/certification following initial enrollment.
Numerator:	N = # licensed/certified providers continuing to meet applicable licensure/certification following initial enrollment
Denominator:	D = total # licensed/certified agencies
Description of Data Source:	Office of Licensing Reviews (OLIS)
Entity Responsible for Data Collection:	DBHDS
Frequency of Data Collection:	Annually, Continuously and Ongoing
Entity Responsible for Data Aggregation:	DMAS/DBHDS
Frequency of Data Aggregation:	Quarterly
Sampling Methodology:	100% review

State Data	[2014	[2015]	[2016]
Sample Universe: (numerator)	6	70	58
Sample Size:	7	87	71
% Compliant:	99%	80%	82%

State Analysis
In SFY 2014, the data show that, 6 out of 7 licensed/certified providers continuing to meet applicable licensure/certification following initial enrollment, resulting in 99% compliance. In SFY 2015, the data show that, 70 out of 87 licensed/certified providers continuing to meet applicable licensure/certification following initial enrollment, resulting in 80% compliance. In SFY 2016, the data show, 58 out of 71 licensed/certified providers are continuing to meet applicable licensure/certification following initial enrollment, resulting in 82% compliance.
Remediation

This measure falls within the required threshold in 2014. During the three year time period, Individual remediation activities included: FY2014: OLIS approved CAP for provisional license violations FY 2015: OLIS requested and approved CAPS from 16 providers with provisional licenses; two provider CAPS were not approved. FY2016: OLIS approved CAPS from 3 providers
Quality Improvement Activities
As part of the amended waivers, DBHDS has developed new provider competencies. All providers will be required to meet the minimum competencies with some providers demonstrating proficiency and expertise in specific competencies allowing them to be designated with certain advanced provider rating levels.

Performance Measure:	C4. Number and percent of providers meeting provider training requirements.
Numerator:	N: # providers meeting provider training requirements
Denominator:	D: total # provider s
Description of Data Source:	OLIS QMR
Entity Responsible for Data Collection:	DBHDS DMAS
Frequency of Data Collection:	Continuously and Ongoing
Entity Responsible for Data Aggregation:	DMAS
Frequency of Data Aggregation:	Quarterly
Sampling Methodology:	100% Review & Representative Sample

State Data	[2014	[2015]	[2016]
Sample Universe: (numerator)	QMR 38	QMR 10	OLIS 67 QMR 72
Sample Size:	QMR 38	QMR 12	OLIS 71 QMR 72
% Compliant:	QMR 100%	QMR 83%	OLIS 94% QMR 100%

State Analysis

In SFY 2014, QMR data shows that 38 out of 38 providers are meeting provider training requirements, resulting in 100% compliance.

In SFY 2015, QMR data shows that 10 out of 12 providers are meeting provider training requirements, resulting in 83% compliance.

In SFY 2016, OLIS was added as a data source for this measure. The OLIS data shows that 67 out of 71 providers are meeting provider training requirements, resulting in 94% compliance. QMR data shows that 72 out of 72 providers are meeting provider training requirements, resulting in 100% compliance.

Remediation

The data show that for years 2015 and 2016, measures fall below the required threshold and will require remediation. This assurance will continue to be remediated via targeted technical assistance training and general training delivered during provider meetings and conferences and by QMR monitoring.

Individual remediation activities include:

FY2014: No remediation required

FY2015: One CAP was given and corrected at the time of follow-up by QMR.

FY2016: All CAPS approved with the exception of one provider by OLIS.

Quality Improvement Activities

As part of the amended waivers and as a systemic enhancement to quality DBHDS developed new provider competencies. All providers will be required to meet the minimum competencies with providers demonstrating proficiency and expertise in specific competencies being designated with certain advanced provider rating levels. Information on the new competencies and requirements will be outlined in the new DD waiver provider manual with training and technical assistance delivered to providers during standard meetings and trainings.

Areas of underperformance are used as focus areas for DBHDS Community Resource Consultants for their provider outreach and training activities.

D. Service Plans are Responsive to Waiver Participant Needs

The state must demonstrate that it has designed and implemented an adequate system for reviewing the adequacy of service plans for waiver participants. AUTHORITY: 42 CFR 441.301; 42 CFR 441.302; 42 CFR 441.303; SMM 4442.6; SMM 4442.7 SECTION 1915(C) WAIVER FORMAT, ITEM NUMBER 13

Background

Individuals in the DS Waiver participate in a person-centered planning process in developing the service plan, the Individual Support Plan (ISP). The CSB case manager facilitates the completion of the plan, working with provider agency staff and any other significant persons the individual chooses. The ISP includes five elements:

1. Essential Information - basic identifying information, emergency contacts, health information, clinical and social history and other information about the individual that may

not change significantly from year to year;

2. Personal Profile - completed by the individual and his/her planning partner; includes a description of the individual's idea of a good life, as well as what works/doesn't work for the individual in the various areas of his/her life, such as home, relationships, work, money, transportation, health and safety;

3. Shared Planning - details the individual's desired outcomes for the year, target completion dates and names of those who will assist in the achievement of each outcome;

4. Agreements - indicates by signature the planning meeting participant's agreement with the plan; and

5. Plan for Support -documents the specific supports the individual will receive by provider.

The DBHDS reviews data from case manager supervisors regarding ISPs inclusion of the needs and risk factors of the individual and whether these are appropriately addressed by planned outcomes in the ISP. In addition, DBHDS staff review ISPs when they conduct their regular provider monitoring visits.

The State strives to develop ISPs for individuals in accordance with policies and procedures outlined in the DS Waiver regulations and provider manual. Individual Support Plans are to be updated at least annually or more frequently, if needed.

The DBHDS' staff review documentation of service delivery to ensure that individuals are receiving services and supports as described by their ISPs.

The choice between waiver services and institutional care and choice of waiver services are documented on the "Documentation of individual Choice between Institutional Care or Home and Community-Based Services" form, which the case manager reviews with the individual as one of the first steps upon determining diagnostic and functional eligibility.

As with all participating providers, the case manager outlines his/her supports to the individual in a "Plan for Supports" (a component of the overall ISP). All supports agreed to during the meeting are further defined by each provider following the meeting in their Plan for Supports. Support instructions, for each activity aimed at achieving desired outcomes and keeping the individual healthy and safe are developed specific to the individual's preferences. Descriptions of what is needed to consider each activity accomplished and the frequency of delivery are included. These Plans for Supports outline who is responsible, how often/by when and how long, and include a schedule of services.

Providers of residential support, personal assistance, day support, and supported employment services have the option of initially developing a "60-day assessment plan," an interim plan for the first 60 days that the individual is with a new provider or service. This is designed to permit the provider to gather some situational information about the individual, as well as to give the individual the opportunity to "try out" the provider/service. Towards the end of the 60-day period, a decision is made by both provider and individual to maintain or terminate the relationship. If the individual will be remaining with the provider, an "annual plan" addressing identified needs and preferences is developed and implemented.

The implementation of the Plans for Support are monitored by the case manager who receives quarterly reviews from each provider regarding the status of each outcome, changes to the support needs and preferences as more is learned about the individual, and changes needed to the plan as desired by the individual.

At a minimum, the case manager must review each provider's quarterly review every three months to determine if the individual's outcomes and activities are being met, determine if any modifications are necessary, confirm the status of the individual's health and welfare, and assess the individual's satisfaction with services. The case manager is also required to have a face-to-face contact with the individual at least every 90 days. The purpose of the face-to-face contact is to observe the individual, to verify services are being provided as described in the service plan, assess the individual's satisfaction and choice of services/providers, ensure his/her health, safety and welfare.

Whenever an individual requests a change, the individual and each provider work together to develop an addendum to the plan, which is then sent to the case manager for approval. In addition, the Plan for Supports is reviewed at least quarterly by all providers, who must forward the results of their reviews to the case manager [per 12 VAC 35-105-660 (licensing regulations)]. The individual's or legal guardian's signature must be obtained for all changes to the plan.

The case manager also has the responsibility for linking the individual to needed services and monitoring their receipt, regardless of funding source. Examples of common nonwaiver-funded services are medical services, therapies, camps and other vacation opportunities, and post-secondary education opportunities. Once the case manager has linked an individual to these supports, they should be included in the case management plan and monitored with a frequency appropriate to their provision.

If there is evidence of serious problems revealed upon case management review including 1) the individual, family, or primary caregiver is dissatisfied with services, 2) services are not delivered as described in the service plan, or 3) the individual's health and safety are at risk, the case manager must take necessary actions and document in the individual's appropriate record(s). Actions may include: requesting a written response from the provider; reporting the information to the appropriate licensing, certifying, or approving agency; reporting the information to DBHDS or DMAS; informing the individual of other providers of the service in question; and as a last resort, after all other options have been exhausted, informing the individual that eligibility may be in jeopardy should he or she choose to continue receiving services from a provider who cannot ensure health and safety or other requirements. Any time abuse or neglect is suspected, the case manager is required to inform Adult Protective Services or Child Protective Services, as appropriate (and DBHDS if it involves a DBHDS-licensed provider).

Information about monitoring results is conveyed to DBHDS quarterly via an on-line submission of case management supervisory review data. Data submitted (for a sample of each CSB's individuals receiving waiver services) include items such as (1) were all needs in the following areas addressed by planned outcomes in the Individual Support Plan: health/medical, home/daily living, leisure/recreation, relationships/social supports, financial/insurance/transportation, employment/education, legal/guardianship,

advocacy/empowerment? (2) was the Individual Support Plan updated/revised when the individual's needs changed? (3) were waiver services delivered as delineated in the Individual Support Plan? If the answer to any of these questions is no, the reason and action taken to remediate the situation must be detailed in the information submitted to DBHDS.

Sub-Assurance D-i: Service plans address all individuals' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.

Sub-assurance D-I (pre-2014 & post-2014)

Performance Measure:	D.1. Number and percent of waiver individuals who have support plans that are adequate and appropriate to their needs, capabilities and desired outcomes, as indicated in the assessment.
Numerator:	N: # of individuals who have support plans that are adequate and appropriate to their needs, capabilities, and desired outcomes, as indicated in the assessment
Denominator:	D: total # of individuals' reviewed
Description of Data Source:	Supervisory Review QMR
Entity Responsible for Data Collection:	DMAS
Frequency of Data Collection:	Quarterly Ongoing and Continuous
Entity Responsible for Data Aggregation:	DMAS
Frequency of Data Aggregation:	Continuous and Ongoing Quarterly
Sampling Methodology:	Representative Sample

State Data	[2014	[2015]	[2016]
Sample Universe: (numerator)	57	75	108
Sample Size:	62	84	137
% Compliant:	92%	89%	79%

State Analysis

In SFY 2014, 57 out of 62 individual plans reviewed met this measure with 92% compliance. In SFY 2015, 75 out of 84 individual plans reviewed met this measure with 89% compliance. In SFY 2016, 108 out of 137 individual plans reviewed met this measure with 79% compliance.
Remediation
Individual remediation activities include: FY2014: 4 CAPS approved FY2015: 3 CAPS approved FY2016: 12 CAPS approved
Quality Improvement Activities
As discussed during the Quality Improvement Activities section, the QRT is currently examining ways to review records to track provider improvement over time (possibly in concert with the DelMarva Quality Service Review (QSR) process) for certain identified providers, to monitor improvement following targeted interventions. The QRT team is reviewing ways to include individual and family input on their satisfaction with services/service plan elements addressed and will investigate providing some of this detail to the Quality Improvement Committee. Ongoing interventions will include identification of specific areas of challenge in performance measures during standard provider meetings and conferences. QRT discussion also includes ensuring that the measures are able to account for those instances when an individual may have an assessed need for something but do not want to have an associated outcome (i.e., non-mandatory ISP areas). This would allow for person centeredness and choice in the process. The state has introduced the option for a more comprehensive survey instrument that would also include information relevant for DOJ reporting that has been met with substantial support from CSB's.

Sub-Assurance D-ii: The state monitors service plan development in accordance with its policies and procedures.

Sub-assurance D-ii (pre-2014)

Performance Measure:	D.2. Number and percent of individuals/family members stating that they have no unmet service needs
Numerator:	N: total # of respondents reporting no unmet service needs
Denominator:	D: total # of respondents
Description of Data Source:	NCI Data Quality Management Reviews
Entity Responsible for Data Collection:	DMAS
Frequency of Data Collection:	Continuous and Ongoing
Entity Responsible for Data Aggregation:	DMAS/DBHDS
Frequency of Data Aggregation:	Quarterly

State Data	[2014	[2015]	[2016]
Sample Universe: (numerator)	NCI: No data QMR 6	NCI Data (family survey):- 238 NCI Data (Adult family survey): 89	NCI: No data QMR 26
Sample Size:	NCI: No data QMR 6	NCI Data (family survey): 261 NCI Data (Adult family survey): 107	NCI:No data QMR 28
% Compliant:	NCI: No data QMR: 100%	NCI Data (family survey): (91%) NCI Data (Adult family survey): (83%)	NCI: No data QMR: 93%

State Analysis

The state had considered utilizing the NCI data to assess participation satisfaction with services with the question "Does the service plan include all the services and supports your family needs?" However the annual reporting timeframe of the release of the NCI data did not correspond with the QRT reporting. The data was provided on a six month reporting schedule and when the state received the full year data, the questions did not align with the measures because the cohort was split into two separate surveys with slightly different wording of the questions. The state is reviewing how it can better use this important information with revising the questions or other changes.

In SFY 2014, the data was not reported because the NCI survey results are aggregated yearly. QMR data shows that 6 out of 6 individuals/family members responding that they have no unmet service, resulting in 100% compliance.

In SFY 2015, the data show that for the NCI Family Survey data, 238 out of 261 respondents reported that they were satisfied with their services, resulting in 91% compliance. For the NCI Adult Family Survey, 89 out of 107 respondents reported that they were satisfied with their services, resulting in 83% compliance. No QMR data was reported.

In SFY 2016, QMR data was added for this measure and results show that 26 out of 28 individuals/family members responding that they have no unmet service, resulting in 93% compliance.

Remediation

Data collected shows that during 2015 and 2016, the results fell below the threshold and require systemic remediation. Remediation was not provider specific given the data came from the family survey. Remediation activities were systemic and include training providers to review ISPs to assess for needs that are unmet. This information will also be emphasized in the new provider training manual.

Quality Improvement Activities

Effective 9/1/2016 the DS waiver transitioned to the Building Independence Waiver as amended and approved by CMS. This performance measure is no longer in the waiver.

Sub-assurance D-iii (pre-2014 & post-2014)

Performance Measure:	D3. Number and percent of individual records that indicate that an appropriate risk assessment) was conducted.
Numerator:	N: # of individual records that indicate that an appropriate risk assessment was conducted
Denominator:	D: total # of individual records reviewed
Description of Data Source:	Quality Management Reviews
Entity Responsible for Data Collection:	DMAS
Frequency of Data Collection:	Continuous and Ongoing
Entity Responsible for Data Aggregation:	DMAS/DBHDS
Frequency of Data Aggregation:	Quarterly

State Data	[2014	[2015]	[2016]
Sample Universe: (numerator)	69	28	159
Sample Size:	69	30	145
% Compliant:	100%	93%	91%

State Analysis
Risk assessments (SIS supplemental questions) are due annually for each individual as the risk assessment measure. This requirement has been misunderstood and there has been some confusion with providers not understanding the difference between the risk assessment and the supplemental questions. Providers are required to complete the supplemental questions annually for every individual. In SFY 2014, the QMR data shows that 69 out of 69 individual records indicate that an appropriate risk assessment) was conducted, resulting in 100% compliance. In SFY 2015, the QMR data shows that 28 out of 30 individual records indicate that an appropriate risk assessment was conducted, resulting in 93% compliance. In SFY 2016, QMR data shows that 145 out of 159 of individual records indicate that an appropriate risk assessment) was conducted, resulting in 91% compliance.
Remediation

Data collected shows most of the results within the required threshold with the exception of one data source for 2015 and 2016, which falls below the threshold and will require remediation. Remediation activities include DBHDS training in this area, which was delivered January through July of 2015. In addition, because many providers did not understand what was being asked, the wording of the question for this measure was changed to specifically note that this is the annual risk assessment demonstrated by the SIS supplemental questions. The QRT also discussed requiring CSB's to pull specific cases that have demonstrated this problem to ensure that this requirement is well understood. Individual remediation activities include: FY 2014: None FY 2015: 2 CAPS approved FY 2016: 3 CAPS approved
Quality Improvement Activities
The new ISP and associated training has reiterated this requirement. In future reporting, QRT discussions have also focused on directing CSB Quality Management staff to review specific cases each quarter, rather than allowing them to decide which cases to pull.

Sub-Assurance D-iii: Service plans are updated/revised at least annually or when warranted by changes in waiver individual needs.

Sub-assurance D-iv (pre-2014 & post-2014

Performance Measure:	D.4. Number and percent of individuals whose support plan indicates a risk mitigation strategy when the risk assessment indicates a need.
Numerator:	N = # of individuals whose support plan includes a risk mitigation strategy when the risk assessment indicates a need
Denominator:	D = total # of individuals reviewed whose risk assessment indicates a need for a risk mitigation strategy.
Description of Data Source:	Quality Management Reviews
Entity Responsible for Data Collection:	DMAS
Frequency of Data Collection:	Continuous and Ongoing
Entity Responsible for Data Aggregation:	DMAS/DBHDS
Frequency of Data Aggregation:	Quarterly

State Data	[2014	[2015]	[2016]
Sample Universe: (numerator)	69	25	136
Sample Size:	69	30	159
% Compliant:	100%	83%	86%

State Analysis
The data demonstrate that in 2015 and 2016, the performance measure fell below the required threshold. If a risk is identified for an individual, the individual's plan should show a risk mitigation strategy. Providers cited for this measure did not include a strategy in the plan to address the risk cited. In SFY 2014, the QMR data show that 69 out of 69 support plans indicate a risk mitigation strategy when the risk assessment indicates a need, resulting in 100% compliance. In SFY 2015, the QMR data show that 25 out of 30 support plans indicate a risk mitigation strategy when the risk assessment indicates a need, resulting in 83% compliance. In SFY 2016, the QMR data show that 136 out of 159 support plans indicate a risk mitigation strategy when the risk assessment indicates a need, resulting in 86% compliance.
Remediation

Remediation in this area has incorporated targeted training and technical assistance and general provider training during standard provider meetings and conferences, including QMR monitoring activities. Individual remediation activities: FY2014: No remediation required FY2015: approval of 3 CAPs FY2016: approval of 5 CAPs
Quality Improvement Activities
The new ISP and associated training has reiterated this requirement.

Sub-Assurance D-iv: Services are delivered in accordance with the service plan, including in the type, scope, amount, duration, and frequency specified in the service plan.

Sub-Assurance D-v: Participants are afforded choice between/among waiver services and providers.

Sub-assurance D-v (post-2014)

Performance Measure:	D.5. Number and percent of individuals/family members who reported participating in the development of the individual's support plan.
Numerator:	N = # of individuals/family members who reported participating in the development of the individual's support plan
Denominator:	D = total # of respondents
Description of Data Source:	NCI Survey
Entity Responsible for Data Collection:	DBHDS
Frequency of Data Collection:	Continuous and Ongoing
Entity Responsible for Data Aggregation:	DBHDS
Frequency of Data Aggregation:	Quarterly

State Data	[2014	[2015]	[2016]
Sample Universe: (numerator)	NCI: No data	NCI: No data	NCI: No data
Sample Size:	NCI: No data	NCI: No data	NCI: No data
% Compliant:	No data	No data	No data

State Analysis

In 2014, the state made the decision to transition to utilizing the NCI data to assess participation satisfaction with services; however the annual reporting timeframe of the release of the NCI data did not correspond with the QRT reporting as the NCI data was reported annually. Upon review of the aggregate survey data, the state determined that the questions did not exactly match the performance measures with enough fidelity to continue to use it as a data source for QRT reporting. After the first full year review of the data, it was discontinued as a QRT data source. Therefore, there is no data for this measure at this time.
Remediation
No data
Quality Improvement Activities
Effective 9/1/2016 the DS waiver transitioned to the Building Independence Waiver as amended and approved by CMS. This performance measure is no longer in the waiver.

Sub-assurance D-v (pre-2014)

Performance Measure:	D6. Number and percent of support plans developed in accordance with policies and procedures
Numerator:	N = # of support plans developed in accordance with policies and procedures
Denominator:	D = total # of service plans reviewed
Description of Data Source:	Supervisory Review
Entity Responsible for Data Collection:	CSB Support Coordination Supervisors or Quality Assurance Staff
Frequency of Data Collection:	Quarterly
Entity Responsible for Data Aggregation:	DMAS/DBHDS
Frequency of Data Aggregation:	Continuously and Ongoing
Sampling Methodology:	Representative Sample=95% confidence interval

State Data	[2014	[2015]	[2016]
Sample Universe: (numerator)	Supervisory Review 58	Supervisory Review 172	Supervisory Review 156
Sample Size:	Supervisory Review 58	Supervisory Review 172	Supervisory Review 157
% Compliant:	Supervisory Review 100%	Supervisory Review 100%	Supervisory Review 99%

State Analysis
In SFY 2014, the Supervisory Review data shows that 58 out of 58 support plans were developed in accordance with policies and procedures, resulting in 100% compliance. In SFY 2015, the Supervisory Review data shows that 172 out of 172 support plans were developed in accordance with policies and procedures, resulting in 100% compliance. In SFY 2016, The Supervisory Review data shows that 156 out of 157 support plans were developed in accordance with policies and procedures, resulting in 99% compliance.
Remediation
Remediation not necessary

Quality Improvement Activities
Quality Improvement Activities not necessary

Performance Measure:	D7. Number and percent of required assessments completed prior to the service planning meeting
Numerator:	N = # of required assessments completed prior to the service planning meeting
Denominator:	D = total # of records reviewed
Description of Data Source:	Quality Management Reviews
Entity Responsible for Data Collection:	DMAS
Frequency of Data Collection:	Continuous and Ongoing
Entity Responsible for Data Aggregation:	DMAS/DBHDS
Frequency of Data Aggregation:	Quarterly
Sampling Methodology:	Representative sample=95% confidence interval

State Data	[2014	[2015]	[2016]
Sample Universe: (numerator)	69	81	26
Sample Size:	69	84	26
% Compliant:	100%	98%	100%

State Analysis
In SFY 2014, the QMR data shows that 69 out of 69 required assessments were completed prior to the service planning meeting, resulting in 100% compliance. In SFY 2015, the QMR data shows that 81 out of 84 required assessments were completed prior to the service planning meeting, resulting in 98% compliance. In SFY 2016, the QMR data shows that 26 out of 26 required assessments were completed prior to the service planning meeting, resulting in 100% compliance.
Remediation
Remediation activities not necessary
Quality Improvement Activities

Quality Improvement Activities not necessary A systemic enhancement as part of the amended waivers, assessments will be uploaded to the new Waiver Management System (WaMs) and should be accessible to state staff to review as needed. Additionally, the combined ID and DD populations being overseen by the CSB should introduce more consistency in assessments being completed in time for the convening of the ISP meeting.

Performance Measure:	D8. Number and percent of support plans reviewed and revised by the case manager by the individual's annual review date
Numerator:	N = # of support plans reviewed and revised by the case manager by the individual's annual review date
Denominator:	D = total # of service plans reviewed
Description of Data Source:	Supervisory Review
Entity Responsible for Data Collection:	CSB Support Coordination Supervisor/Quality Assurance Staff
Frequency of Data Collection:	Quarterly
Entity Responsible for Data Aggregation:	DMAS/DBHDS
Frequency of Data Aggregation:	Continuously and Ongoing Quarterly
Sampling Methodology:	Representative Sample=95% confidence interval

State Data	[2014	[2015]	[2016]
Sample Universe: (numerator)	Supervisory Review 58	Supervisory Review 158	Supervisory Review 156
Sample Size:	Supervisory Review 58	Supervisory Review 158	Supervisory Review 157
% Compliant:	Supervisory Review 100%	Supervisory Review 100%	Supervisory Review 99%

State Analysis

In SFY 2014, the data show that for the Supervisory Review, 58 out of 58 support plans were reviewed and revised by the case manager by the individual's annual review date, resulting in 100% compliance. In SFY 2015, the data show that for the Supervisory Review, 158 out of 158 support plans were reviewed and revised by the case manager by the individual's annual review date, resulting in 100% compliance. In SFY 2016, the data show that for the Supervisory Review, 156 out of 157 support plans were reviewed and revised by the case manager by the individual's annual review date, resulting in 99% compliance.
Remediation
Remediation not necessary
Quality Improvement Activities
Quality Improvement Activities not necessary

Performance Measure:	D9. Number and percent of individuals whose support plan was revised by the case manager, as needed, to address changing needs.
Numerator:	N = # of individuals whose support plan was revised by the case manager, as needed, to address changing needs
Denominator:	D = total # of individual service plans reviewed that needed to be revised due to changing needs
Description of Data Source:	Supervisory Review QMR
Entity Responsible for Data Collection:	DMAS CSB Support Coordination Supervisor/Quality Assurance Staff
Frequency of Data Collection:	Continuously and Ongoing Quarterly
Entity Responsible for Data Aggregation:	DMAS/DBHDS
Frequency of Data Aggregation:	Quarterly Annually
Sampling Methodology:	Representative Sample

State Data	[2014	[2015]	[2016]
Sample Universe: (numerator)	Supervisory Review 58	Supervisory Review 158	Supervisory Review 156 QMR 6
Sample Size:	Supervisory Review 58	Supervisory Review 158	Supervisory Review 157 QMR 20
% Compliant:	100%	100%	Supervisory Review 99% QMR 30%

State Analysis
Data collected shows most of the results within the required threshold with the exception of one data source for 2016, which falls well below the threshold and will require systemic remediation. In SFY 2014, the data show that for the Supervisory Review, 58 out of 58 support plans were revised by the case manager, as needed, to address changing needs, resulting in 100% compliance. No QMR data reported. In SFY 2015, the data show that for the Supervisory Review, 156 out of 156 support plans were revised by the case manager, as needed, to address changing needs, resulting in 100% compliance. No QMR data reported. In SFY 2016, the data show that for the Supervisory Review, 156 out of 157 support plans were revised by the case manager, as needed, to address changing needs, resulting in 99% compliance. For QMR, 6 out of 20 plans were revised to address changing needs, resulting in 30% compliance.
Remediation
The data demonstrate that the QMR data is below the required threshold and in need of systemic remediation. Remediation in this area will continue to incorporate targeted training and technical assistance and general provider training during standard provider meetings and conferences, including QMR monitoring activities. In 2016, a total of 4 CAP were developed and approved within 30 days as required.

Quality Improvement Activities
As part of the amended waivers, individual ISP's are able to be uploaded to the new Waiver Management System (WaMs) allowing state staff the ability to access ISP information for quality reviews.

Performance Measure:	D10. Number and percent of individuals who received waiver services in the type, amount, frequency, and duration specified in the support plan.
Numerator:	N: # individuals who received services in the type, scope, amount, duration, and frequency specified in the support plan
Denominator:	D = total # of records reviewed
Description of Data Source:	Quality Management Reviews
Entity Responsible for Data Collection:	DMAS
Frequency of Data Collection:	Continuous and Ongoing
Entity Responsible for Data Aggregation:	DMAS/DBHDS
Frequency of Data Aggregation:	Quarterly
Sampling Methodology:	Representative Sample=95% confidence interval

State Data	[2014	[2015]	[2016]
Sample Universe: (numerator)	Supervisory Review Type: 76 Scope 76 Amount 76 Duration 76 Frequency 76 QMR Type 82 Scope 61 Amount 77 Duration 84 Frequency 75 Average: 76	QMR Type 81 Scope 53 Amount 66 Duration 83 Frequency 71 Average: 71	QMR Type 139 Scope 113 Amount 116 Duration 146 Frequency 123 Average: 127
Sample Size:	Supervisory Review Type 76 Scope 76 Amount 76 Duration 76 Frequency 76 QMR Type 84 Scope 84 Amount 84 Duration 84 Frequency 84	QMR Type 84 Scope 84 Amount 84 Duration 84 Frequency 84	QMR Type 149 Scope 149 Amount 149 Duration 149 Frequency 149
% Compliant:	Supervisory Review: Type 100% Scope 98% Amount 100% Duration 100% Frequency 97% QMR: Type 98% Scope 73% Amount 92% Duration 100% Frequency 89% Average: 90%	QMR: Type 96% Scope 63% Amount 79% Duration 99% Frequency 85% Average: 84%	QMR: Type 93% Scope 76% Amount 78% Duration 98% Frequency 83% Average: 85%

State Analysis
This measure incorporates violations from providers in the type, scope, amount, duration and frequency of services delivered as required. The results were averaged to represent and average compliance ratio among each service plan element. Each individual instance of non-compliance was remediated through training, technical assistance and/or corrective action plan. In SFY 2014, the Supervisory Review data showed that on average, 76 out of 76 individuals received waiver services in the type, amount, frequency, and duration specified in the support plan, resulting in 100% compliance. For QMR, on average, 76 out of 84 individuals received waiver services in the type, amount, frequency, and duration specified in the support plan, resulting in 90% compliance. In SFY 2015, the Supervisory Review was removed as a data source for this measure. For QMR, on average 71 out of 84 individuals received waiver services in the type, amount, frequency, and duration specified in the support plan, resulting in 84% compliance. In SFY 2016, the Supervisory Review was removed as a data source for this measure. For QMR, on average, 127 out of 149 individuals received waiver services in the type, amount, frequency, and duration specified in the support plan, resulting in 85% compliance.
Remediation
This measure continues to require systemic remediation by the state. Provider non-compliance is addressed primarily through the QMR process. Individual remediation activities included: SFY 2014: 19 CAPS were approved SFY 2015: 13 CAPS were approved SFY2016 : 15 CAPS were approved
Quality Improvement Activities
Quality improvement activities for systemic remediation include educating Provider Development staff of the areas of deficiency and in particular those that fall under scope and amount (the most commonly occurring citation areas). Provider Development staff will use this information to enhance provider training using specific examples. Also discussed was developing a method to examine the data for citation trends that can be presented graphically to providers as feedback on waiver performance measures

Performance Measure:	D.11. Number and percent of individuals/families reporting that the support plan includes all the services and supports the individual needs.
Numerator:	N: # of individuals/families reporting that the support plan includes all the services and supports the individual needs
Denominator:	D: total number of individuals/families surveyed
Description of Data Source:	NCI
Entity Responsible for Data Collection:	DBHDS
Frequency of Data Collection:	Continuous and Ongoing
Entity Responsible for Data Aggregation:	DBHDS
Frequency of Data Aggregation:	Quarterly
Sampling Methodology:	Representative Sample

State Data	[2014	[2015]	[2016]
Sample Universe: (numerator)	NCI - No data	NCI data Family survey: 218 NCI data Adult family survey 76	NCI - No Data
Sample Size:	NCI - No data	NCI data Family survey: 261 NCI data Adult family survey 107 Out of 107, 76 responded Yes, 18 responded No and rest stated 'Doesn't apply' Or 'Don't know'	NCI - No Data
% Compliant:		NCI data Family survey: (84%) NCI Data Adult family survey (71%)	

State Analysis

The state had considered utilizing the NCI data to assess participation satisfaction with services; however the annual reporting timeframe of the release of the NCI data did not correspond with the QRT reporting. Because the questions asked in the NCI survey questionnaire did not exactly match the performance measures it was discontinued as a QRT data source. In SFY 2014, NCI data was not used in the reporting for the measure. In SFY 2015, the NCI data show that 218 out of 264 individuals/families responding to the Family Survey, report that the support plan includes all the services and supports the individual needs, resulting in 84% compliance. 76 out of 107 of individuals responding to the Adult Family Survey, report that the support plan includes all the services and supports the individual needs, resulting in 71% compliance. In SFY 2016, NCI data was not reported for the measure
Remediation
Where data is recorded, results fall below the required threshold and will require systemic remediation. Remediation was not provider specific given the data was NCI data. Remediation activities were systemic and include training providers to review ISPs to assess for needs that are unmet. This information will also be emphasized in the new provider training manual.
Quality Improvement Activities
Effective 9/1/2016 the DS waiver transitioned to the Building Independence Waiver as amended and approved by CMS. This performance measure is no longer in the waiver.

Performance Measure:	D12. Number and percent of individuals who received face-to-face contacts completed by the case manager, as specified in the waiver application.
Numerator:	N = # of individuals who received face-to-face contacts completed by the case manager, as specified in the waiver application
Denominator:	D = total # of records reviewed.
Description of Data Source:	Onsite Record Reviews
Entity Responsible for Data Collection:	DMAS
Frequency of Data Collection:	Continuous and Ongoing
Entity Responsible for Data Aggregation:	DBHDS
Frequency of Data Aggregation:	Quarterly
Sampling Methodology:	Representative Sample

State Data	[2014	[2015]	[2016]
Sample Universe: (numerator)	QMR 35	QMR 47	QMR 97
Sample Size:	QMR 35	QMR 47	QMR 97
% Compliant:	100%	100%	100%

State Analysis
In SFY 2014, the QMR data show that 35 out of 35 individuals received face-to-face contacts completed by the case manager, as specified in the waiver application, resulting in 100% compliance. In SFY 2014, the QMR data show that 47 out of 47 individuals received face-to-face contacts completed by the case manager, as specified in the waiver application, resulting in 100% compliance In SFY 2014, the QMR data show that 97 out of 97 individuals received face-to-face contacts completed by the case manager, as specified in the waiver application, resulting in 100% compliance
Remediation
Remediation not necessary
Quality Improvement Activities
Quality Improvement Activities not necessary

Performance Measure:	D13. Number and percent of individuals whose case management records contain an appropriately completed and signed form that specifies choice was offered between institutional and waiver services.
Numerator:	N = # of individuals whose records contain an appropriately completed and signed form that specifies choice was offered between institutional and waiver services
Denominator:	D = total # of records reviewed
Description of Data Source:	Quality Management Reviews Intellectual Disability Online System
Entity Responsible for Data Collection:	DMAS DBHDS
Frequency of Data Collection:	Continuously and Ongoing Quarterly
Entity Responsible for Data Aggregation:	DBHDS
Frequency of Data Aggregation:	Quarterly
Sampling Methodology:	Representative Sample=95% confidence interval 100% Sample

State Data	[2014	[2015]	[2016]
Sample Universe: (numerator)	IDOLS: No data QMR 35	IDOLS 31 QMR 47	IDOLS 30 QMR 97
Sample Size:	IDOLS: No data QMR 35	IDOLS 31 QMR 47	IDOLS 30 QMR 97
% Compliant:	QMR 100%	IDOLS 100% QMR 100%	IDOLS 100% QMR 100%

State Analysis

In SFY 2014, No IDOLS data was reported. The QMR data shows that 35 out of 35 case management records contained the appropriate documentation showing that choice was offered between institutional and waiver services, resulting in 100% compliance. In SFY 2015, IDOLS data shows that 31 out of 31 case management records contained an appropriately completed and signed form that specified that choice was offered between institutional and waiver services, resulting in100% compliance. The QMR data shows that 47 out of 47 individuals' case management records contained the appropriate documentation showing that choice was offered between institutional and waiver services, resulting in 100% compliance. In SFY 2016, IDOLS data shows that 30 out of 30 case management records contained an appropriately completed and signed form that specified that choice was offered between institutional and waiver services, resulting in 100% compliance. The QMR data shows that 97 out of 97 case management records contained the appropriate documentation showing that choice was offered between institutional and waiver services, resulting in 100% compliance.
Remediation
Remediation not necessary
Quality Improvement Activities
Quality Improvement Activities not necessary

Performance Measure:	D14. Number and percent of individuals whose case management records contain an appropriately completed and signed form that specifies choice was offered among waiver services.
Numerator:	N = # of case management records that contain documentation of choice among waiver services
Denominator:	D = total # of records reviewed
Description of Data Source:	Intellectual Disability Online system Quality Management Review
Entity Responsible for Data Collection:	DBHDS/DMAS
Frequency of Data Collection:	Continuous and Ongoing Continuous and Ongoing
Entity Responsible for Data Aggregation:	DBHDS/DMAS
Frequency of Data Aggregation:	Quarterly
Sampling Methodology:	100% Review Representative Sample=95% confidence interval

State Data	[2014	[2015]	[2016]
Sample Universe: (numerator)	IDOLS 28 QMR 35	IDOLS 31 QMR 47	QMR 93
Sample Size:	IDOLS 28 QMR 35	IDOLS 31 QMR 47	QMR 93
% Compliant:	IDOLS: 100% QMR 100%`	IDOLS: 100% QMR 100%	QMR 100%

State Analysis

In SFY 2014, IDOLS data shows that 28 out of 28 case management records contained an appropriately completed and signed form specifying that choice was offered among waiver services, resulting in 100% compliance. The QMR data shows that 35 out of 35 individuals' case management records contain an appropriately completed and signed form that specified that choice was offered among waiver services, resulting in 100 % compliance. In SFY 2015, IDOLS data shows that 31 out of 31 case management records contained an appropriately completed and signed form specifying that choice was offered among waiver services, resulting in 100% compliance. The QMR data shows that 47 out of 47 individuals' case management records contain an appropriately completed and signed form that specified that choice was offered among waiver services, resulting in 100% compliance. In SFY 2016, IDOLS was removed as a data source. The QMR data shows that 93 out of 93 individuals' case management records contain an appropriately completed and signed form that specified that choice was offered among waiver services, resulting in 100 % compliance.
Remediation
Remediation not necessary
Quality Improvement Activities
Quality Improvement Activities not necessary

Performance Measure:	D15. Number and percent of individuals whose case management records documented that choice of waiver providers was provided to and discussed with the individual.
Numerator:	N = # of case management records that contain documentation that choice of waiver providers was provided to and offered to the individual
Denominator:	D = total # of records reviewed
Description of Data Source:	Supervisory Review QMR
Entity Responsible for Data Collection:	DBHDS
Frequency of Data Collection:	Continuously and Ongoing
Entity Responsible for Data Aggregation:	DBHDS
Frequency of Data Aggregation:	Quarterly
Sampling Methodology:	100% Review Representative Sample=95% confidence interval

State Data	[2014]	[2015]	[2016]
Sample Universe: (numerator)	Supervisory Review: 53 QMR: 35	Supervisory Review: 152 QMR: 57	Supervisory Review: 156 QMR:57
Sample Size:	Supervisory Review: 58 QMR: 35	Supervisory Review: 158 QMR: 57	Supervisory Review: 160 QMR: 57
% Compliant:	Supervisory Review: 91% QMR: 100%	Supervisory Review: 96% QMR: 100%	Supervisory Review: 98% QMR:100%

State Analysis

In SFY 2014, the QMR data shows that 35 out of 35 case management records documented that choice of waiver providers was provided to and discussed with the individual, resulting in 100% compliance. The Supervisory Review data shows that shows that 53 out of 58 case management records documented that choice of waiver providers was provided to and discussed with the individual, resulting in 91% compliance.

In SFY 2015, the QMR data shows that 57 out of 57 case management records documented that choice of waiver providers was provided to and discussed with the individual, resulting in 100% compliance. The Supervisory Review data shows that shows that 152 out of 158 case management records documented that choice of waiver providers was provided to and discussed with the individual, resulting in 96% compliance.

In SFY 2016, the QMR data shows that 57 out of 57 case management records documented that choice of waiver providers was provided to and discussed with the individual, resulting in % compliance. The Supervisory Review data shows that shows that 156 out of 160 case management records documented that choice of waiver providers was provided to and discussed with the individual, resulting in 98% compliance.

Remediation

The data show that the performance measure is slightly below the required threshold and requires systemic remediation. As remediation, this area was addressed in scheduled ISP training and also emphasized in RST meetings about documenting choice.

Quality Improvement Activities

Future quality improvement activities will be to inform Provider Development of the areas that are consistently being cited for noncompliance so that they can train providers and use specific examples to enhance training. Also discussed was developing a method to examine the data for citation trends that can be presented graphically to providers as feedback on waiver performance measures

G. Health and Welfare [pre-2014]

The state must demonstrates, on an ongoing basis, that it identifies, addresses, and seeks to prevent instances of abuse, neglect and exploitation. AUTHORITY: 42 CFR 441.302; CFR 441.303; SMM 4442.4; SMM 4442.9

Background

The Virginia Department of Social Services (VDSS) and the Department of Aging and Rehabilitative Services (DARS) are the state agencies responsible for receiving and investigating all reports of critical incidents of abuse, neglect or exploitation for children and adults. Both agencies have staff dedicated at the local and state level for these programs. Any person may voluntarily report suspected "abuse, neglect and exploitation" (in various forms) to DARS offices of Adult Protective Services (APS) or VDSS Child Protective Services (CPS). The Code of Virginia requires those designated as mandated reporters, including Medicaid service providers, to immediately report any suspected instances of abuse, neglect, or exploitation of adults and children (§ 63.2-1606 and §63.2-1509, respectively) to the local department of social services, VDSS, DARS or the protective services hotline. There is a civil penalty for failure to report at first suspicion. Other state agencies having licensing responsibilities also monitor allegations of abuse, neglect or exploitation, including the Virginia Departments of Health, the Department of Behavioral Health and Developmental Disability Services, and the Department of Health Professions.

There are multiple mechanisms in place to protect the health and safety of the individuals receiving waiver services. Individuals must have a case manager in order to access services in the waiver. The case manager not only links individuals to resources and services, but also serves as a first level safeguard to monitor the individual's health and safety through required monthly contacts and quarterly face-to-face visits. The case manager is tasked with the responsibility to assess the individual on an on-going basis to ensure that the individual has the necessary supports to remain safely in the community.

The DMAS staff also plays a role in monitoring the health and safety of the waiver individual. All DMAS LTC staff is required to complete a standardized annual training on identifying and reporting adult or child abuse and neglect.

DBHDS has used an electronic database for the reporting, storage and maintenance of community provider human rights data including abuse/neglect/exploitation and human rights investigations, provider violations and related monitoring visits. This system is known as the Computerized Human Rights Information System (CHRIS), has been used for community providers and is tied to the development of a statewide, cross-departmental critical information management reporting system. When the state put into practice the use of CHRIS for quality performance reporting purposes it was realized that the measures were not effective and CHRIS did not contain needed data and information to appropriately and correctly report on performance measures where CHRIS was the identified data source.

The DMAS's current approach to monitoring this assurance is through QMR review of service plans and case management monitoring of individuals, addressing prevention of abuse, neglect and exploitation and individual risk management, and verification that appropriate actions were taken. The state deferred to these measures as approved in other applications for reporting on Health and Welfare.

Sub-Assurance G-i: On an ongoing basis the state identifies, addresses and seeks to prevent instances of abuse, neglect and exploitation.

Sub-assurance G-i (pre-2014)

Performance Measure:	G.1. Number and percent of reported critical incidents by type
	G.2. Number and percent of reported serious injury by type
	G.3. Number and percent of reported deaths by type.
	G.4. Number and percent of critical incidents requiring investigation by type.
	G.5. Number and percent of critical incidents substantiated by type.
	G.6. Number and percent of critical incidents for which corrective actions were verified as being completed.
	G.7. Number of substantiated critical incidents per individual.
	G.8. Number and percent of reported deaths by type in licensed programs.
	G.10. Number and percent of providers cited for unauthorized use of restraints.
Description of Data Source:	CHRIS Data Warehouse
Entity Responsible for Data Collection:	DBHDS
Entity Responsible for Data Aggregation:	DMAS DBHDS

State Data	[2014	[2015]	[2016]
Sample Universe: (numerator)	No data	No data	No data
Sample Size:	No data	No data	No data
% Compliant:	No data	No data	No data

State Analysis

When the state put into practice the use of CHRIS for quality performance reporting purposes it was realized that the measures were not effective and CHRIS did not contain needed data and information to appropriately and correctly report on the performance measures where CHRIS was the identified as the data source (G – 1,2,3,4,5,6,7,8,10). Due to the absence of date, these measures are not being reported in this report. The DMAS's current approach to monitoring this assurance is through QMR review of service plans and case management monitoring of individuals, addressing prevention of abuse, neglect and exploitation and individual risk management, and verification that appropriate actions were taken. The state deferred to these measures as approved in other applications for reporting on Health and Welfare in this report.
Remediation
Data source(s) to be reviewed
Quality Improvement Activities
In 2016, DBHDS synthesized several existing CHRIS and IDOLS reports into the Data Warehouse System as part of an agency wide initiative to centralize key agency data. It is from this expanded Data Warehouse functionality that new reports will created specifically for tracking waiver performance measures related to Health and Welfare. Ongoing work is being done to ensure that the correct data is being collected for the relevant performance measures.

Sub-assurance G-iii (post-2014)

Performance Measure:	G.9. Number and percent of licensed Ds Waiver providers with an effective emergency plan in place
Numerator:	N: # licensed DS waiver providers with an emergency plan in place
Denominator:	D: total # licensed DS waiver providers reviewed
Description of Data Source:	Onsite Record Reviews
Entity Responsible for Data Collection:	DBHDS Office of Licensing
Frequency of Data Collection:	Continuous and Ongoing
Entity Responsible for Data Aggregation:	DMAS DBHDS
Frequency of Data Aggregation:	Quarterly
Sampling Methodology:	100% Review

State Data	[2014	[2015]	[2016]
Sample Universe: (numerator)	OLIS 72	OLIS 87	OLIS 85
Sample Size:	OLIS 72	OLIS 85	OLIS 85
% Compliant:	100%	98%	100%

State Analysis
In SFY 2014, the OLIS data shows that there were 72 out of 72 licensed DS waiver providers with an effective emergency plan in place, resulting in 100% compliance. In SFY 2015, the OLIS data shows that there were 85 out of 87 licensed DS waiver providers with an effective emergency plan in place, resulting in 98% compliance. In SFY 2016, the QMR data shows that there were 85 out of 85 licensed DS waiver providers with an effective emergency plan in place, resulting in 100% compliance.
Remediation
In 2015, two providers did not have an emergency plan in place as required. This was remediated by the Office of Licensing. No other remediation activities were required.
Quality Improvement Activities
Quality Improvement Activities not necessary

Performance Measure:	2. Number and percent of waiver individual's records with indications of safety concerns or risk in the physical environment documenting appropriate actions taken
Numerator:	N: # of individual's records with indications of risk in the physical environment documenting appropriate actions taken
Denominator:	D: Total # of individual's records with indications of risk in the physical environment.
Description of Data Source:	QMR Record Reviews
Entity Responsible for Data Collection:	DMAS
Frequency of Data Collection:	Continuous and Ongoing
Entity Responsible for Data Aggregation:	DMAS
Frequency of Data Aggregation:	Quarterly
Sampling Methodology:	Representative Sample=95% confidence level

State Data	**[2014]**	**[2015]**	**2016**
Sample Universe: (numerator)	1	6	0
Sample Size:	1	6	0
% Compliant:	100%	100%	100%

State Analysis
Due to CHRIS data difficulties DMAS used its current approach to monitoring this assurance through QMR review of service plans and case management monitoring of individuals, addressing prevention of abuse, neglect and exploitation and individual risk management, and verification that appropriate actions were taken. The state deferred to these measures as approved in other applications for reporting on Health and Welfare. In SFY 2014 1 record was reviewed with an indication of risk in the physical environment and appropriate action was taken 100% of the time. In SFY 2015 6 records were reviewed with an indication of risk in the physical environment and appropriate action was taken 100% of the time. In SFY 2016 0record was reviewed with an indication of risk in the physical environment.
Remediation
Remediation not necessary
Quality Improvement Activities
With the amended waivers, quality management for the DD population will be integrated into existing processes for QA monitoring of the ID population, resulting in more consistent data and more ready access by state staff.

Performance Measure:	1. Number and percent of waiver individual's records with indications of abuse, neglect or exploitation documenting appropriate actions taken
Numerator:	N: # of individual's records with indications of abuse, neglect or exploitation documenting appropriate actions taken ;
Denominator:	D: Total # of individual's records with indications of abuse, neglect or exploitation.
Description of Data Source:	QMR Record Reviews
Entity Responsible for Data Collection:	DMAS
Frequency of Data Collection:	Continuous and Ongoing
Entity Responsible for Data Aggregation:	DMAS
Frequency of Data Aggregation:	Quarterly
Sampling Methodology:	Representative Sample=95% confidence level

State Data	**[2014]**	**[2015]**	**2016**
Sample Universe: (numerator)	0	2	0
Sample Size:	0	2	0
% Compliant:	100%	100%	100%

State Analysis
Due to CHRIS data difficulties DMAS used its current approach to monitoring this assurance through QMR review of service plans and case management monitoring of individuals, addressing prevention of abuse, neglect and exploitation and individual risk management, and verification that appropriate actions were taken. The state deferred to these measures as approved in other applications for reporting on Health and Welfare. In SFYs 2014 and 2016 no records reviewed indicated abuse, neglect or exploitation. In SFY 2015 2 records had an indication of abuse, neglect or exploitation and appropriate action was taking representing 100% compliance.
Remediation
Remediation not necessary
Quality Improvement Activities
Quality Improvement Activities not needed

I. Financial Accountability

The state must demonstrate that it has designed and implemented an adequate system for insuring financial accountability of the waiver program. AUTHORITY: 42 CFR 441.302; 42 CFR 441.303; 42 CFR 441.308; 45 CFR 74; SMM 4442.8; SMM 4442.10

Background

The Virginia Medicaid Management Information System (VaMMIS) has built in controls (system edits) to ensure provider billings are in accordance with state and federal regulations prior to claims being approved for payment. System edits assure that, when claims are paid, the individual receiving waiver services is Medicaid eligible at the time the services were rendered and the services being billed are approved services for that individual.

All services must be pre-authorized by the contracted service authorization entity, which includes a review of the VaMMIS eligibility file to ensure the individual is enrolled in the DS Waiver prior to service authorization. Prior to payment, all claims are processed using automated edits in the VaMMIS that:

- Checks for a valid service authorization
- Verifies there is no duplicate billing
- Verifies that the provider submitting the claim has a valid participation agreement with DMAS
- Checks for valid service coding and any service limits
- Verifies individuals' eligibility

DMAS ensures financial integrity and accountability through multiple processes occurring across several divisions. The Fiscal and Purchases Division is responsible for timely and accurate processing and recording of financial transactions to include collection of provider and recipient overpayments.

DMAS undergoes an annual independent audit through the Virginia Auditor of Public Accounts, to ensure compliance with state and federal accounting practices. The Virginia Auditor of Public Accounts is the entity responsible for conducting the periodic independent audit of the waiver program under the provisions of the Single Audit Act. DMAS is also subject to audits from CMS through the medical integrity audits.

The Internal Audit Division reviews claims for correct billing performing tests on claims in the MMIS for patterns that are anomalies across provider types. The Division focuses on the accurate processing of claims through MMIS to identify possible patterns of fraud, waste abuse. This division uses concurrent auditing of claims to uncover any problems in the waiver, using over 300 checks on a continuous basis before claims are paid. They also review claims after they are paid to identify irregularities in payment patterns.

The Division of Program Integrity conducts financial reviews utilizing internal staff as well as contractors acquired through a competitive procurement process. The Provider Review Unit (PRU) in the Division of Program Integrity investigates allegations of provider fraud and abuse that result in overpayments of Medicaid benefits. The PRU receives allegations from providers, state agencies, law enforcement agencies, individuals, and other DMAS units. These allegations typically involve misspent funds involving fee-for-service provider issues such as: billing for a service using a code that the provider has previously been instructed not

to use, billing for more expensive services or procedures than were actually provided or performed (commonly known as up-coding), billing for services that were never rendered, performing medically unnecessary services, and misrepresenting non-covered treatments as medically necessary covered treatments.

The PRU could potentially review any provider group. The unit monitors provider activity; to identify potentially fraudulent or abusive billing practices; develop corrective action plans; and when necessary recommend policy changes to prevent abusive billing practices; and to refer abusive providers to other state agencies. Cases are referred to Medicaid Fraud Control Unit (MFCU) when potentially egregious abuse is identified. The PRU supervisor serves as the liaison to the MFCU and referrals when is responsible for reviewing and submitting the referral. The MFCU determines if the case warrants further investigation as fraud.
The PRU conducts on-site and desk reviews of medical and personnel records to determine if services were provided as billed. These reviews also determine if the services were provided by qualified staff members.

The provider has four opportunities to provide input to the audit: Request for Reconsideration, Request for an Informal Fact Finding Conference (IFFC), Formal Evidential Hearing, and Circuit Court. All are dictated by State regulations and handled by the Department's Appeals Division.

DMAS and DBHDS undergo an annual independent audit through the Virginia Auditor of Public Accounts, which includes a review of the waiver, to ensure compliance with state and federal accounting practices. The Virginia Auditor of Public Accounts is the entity responsible for conducting the periodic independent audit of the waiver program under the provisions of Single Audit Act. DMAS is also subject to audits from CMS through the medical integrity audits.

Sub assurance I-i: 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.

Sub-assurance I-i (pre-2014 & post-2014)

Sub assurance I-ii: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Sub-assurance I-ii (post-2014)

Performance Measure:	2. Number and percent of claims adhering to the approved rate in the waiver application
Numerator:	N: # of claims adhering to the approved rate
Denominator:	D: total # of claims
Description of Data Source:	Financial records
Entity Responsible for Data Collection:	Xerox
Frequency of Data Collection:	Monthly
Entity Responsible for Data Aggregation:	DMAS DBHDS
Frequency of Data Aggregation:	Quarterly
Sampling Methodology:	100%

State Data	[2014	[2015]	[2016]
Sample Universe: (numerator)	5508	19886	15053
Sample Size:	5508	19886	15053
% Compliant:	100%	100%	100%

State Analysis
In SFY 14 the Xerox data show that 5508 out of 5508 claims adhered to the approved rate in the waiver application, resulting in 100% compliance. In SFY 15, the Xerox data show that 19886 out of 19886 claims adhered to the approved rate in the waiver application, resulting in 100% compliance. In SFY 15, the Xerox data show that 15053 out of 15053 claims adhered to the approved rate in the waiver application, resulting in 100% compliance.
Remediation
Remediation not necessary
Quality Improvement Activities
Quality Improvement Activities not necessary

Performance Measure:	F.2. Number and percent of claims paid that are for authorized services
Numerator:	N = # of claims paid that are for authorized services;
Denominator:	D = total # of claims paid
Description of Data Source:	Financial records
Entity Responsible for Data Collection:	Xerox
Frequency of Data Collection:	Monthly
Entity Responsible for Data Aggregation:	DMAS DBHDS
Frequency of Data Aggregation:	Quarterly
Sampling Methodology:	100%

State Data	[2014	[2015]	[2016]
Sample Universe: (numerator)	5508	19886	15053
Sample Size:	5508	19886	15053
% Compliant:	100%	100%	100%

State Analysis
In SFY 14 the Xerox data show that 5508 out of 5508 claims were paid for authorized services, resulting in 100% compliance. In SFY 15 the Xerox data show that 19886 out of 19886 claims were paid for authorized services, resulting in 100% compliance. In SFY 16 the Xerox data show that 15053 out of 15053 claims were paid for authorized services, resulting in 100% compliance.
Remediation
Remediation not necessary
Quality Improvement Activities
Quality Improvement Activities not necessary

Performance Measure:	F.3. Number and percent of claims paid within required time frames.
Numerator:	N = # of claims paid within required time frames;
Denominator:	D = total # of claims paid
Description of Data Source:	Claims Data
Entity Responsible for Data Collection:	Xerox
Frequency of Data Collection:	Monthly
Entity Responsible for Data Aggregation:	DMAS DBHDS
Frequency of Data Aggregation:	Quarterly
Sampling Methodology:	100%

State Data	[2014	[2015]	[2016]
Sample Universe: (numerator)	5508	19886	15053
Sample Size:	5508	19886	15053
% Compliant:	100%	100%	100%

State Analysis
In SFY 14 the Xerox data show that 5508 out of 5508 claims were paid within required time frames, resulting in 100% compliance. In SFY 15 the Xerox data show that 19886 out of 19886 claims were paid within required time frames, resulting in 100% compliance. In SFY 16 the Xerox data show that 15053 out of 15053 claims were paid within required time frames, resulting in 100% compliance.
Remediation
Remediation not necessary
Quality Improvement Activities
Quality Improvement Activities not necessary

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