DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
801 Market Street
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Philadelphia, Pennsylvania 19107-3134

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

SWIFT # 070320174022

June 19, 2018

Jennifer S. Lee, M.D, Director
Department of Medical Assistance Services
Commonwealth of Virginia
600 East Broad Street, Suite 1300
Richmond, VA 23219

Re: Quality Review – Final Quality Review Report for the Virginia HCBS Intellectual Disability (ID) (CL) Waiver, CMS Control Number 0372

Dear Dr. Lee:

Enclosed is the Final report and the Commonwealth's original evidence for the Centers for Medicare & Medicaid Services' (CMS) quality review of Virginia's Intellectual Disability (ID) Home and Community-Based Services (HCBS) waiver, CMS Control Number 0372. As of September 1, 2016, the ID Waiver was renamed the Community Living (CL) Waiver. The 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.

We found the Commonwealth to be in compliance with five of the six HCBS Assurances. The assurance related to Health and Welfare was not compliant. The Commonwealth has indicated that it is implementing new procedures to ensure that the specific criteria for each Performance Measure are measured and assessed. The Commonwealth has begun the process of implementing specific quality improvement plans for each of the areas where issues were identified.

The Commonwealth must show compliance at the time of renewal for CMS to approve the waiver renewal. We encourage the Commonwealth to continue designing and implementing the processes and tools needed 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, 2019. 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 staff 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
Associate Regional Administrator

Enclosure

cc: Ann Bevan, DMAS
Nichole Martin, DMAS
Sabrina Tillman-Boyd, CMS
Daphne Hicks, CMS

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

FINAL REPORT

Home and Community-Based Services Waiver Review
Intellectual Disability (Community Living) Program
Control # VA.0372

June 19, 2018

I. Executive Summary

The Home and Community-Based Waiver for Persons with Intellectual Disabilities (ID) began in 2005. The ID/CL Waiver is designed to provide services to people in the community rather than in an institutional setting. 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 ID/CL 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 implemented its system-wide redesign of its Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions (ICF/IID) level of care Medicaid waivers on July 1, 2016. This system transformation included the submission and subsequent approval of waiver amendments for the conversion of its three existing waivers 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 were intended to address quality assurance issues with standardization of processes and procedures, eligibility tools, 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 to improve accountability. Although the majority of the waiver redesign components were implemented concurrently, some elements impacting quality management were delayed or are in progress.

II. Summary of Findings and Recommendations

A. Administrative Authority
The state demonstrates the assurance.

B. State Conducts Level of Care Determinations Consistent with the Need for Institutionalization
The state demonstrates the assurance.

C. Qualified Providers Serve Waiver Participants
The state demonstrates the assurance.

D. Service Plans are Responsive to Waiver Participant Needs
The state demonstrates the assurance.

G. Health and Welfare (Post-2014)
The state does not demonstrate the assurance.

None of the four sub-assurance were demonstrated. No evidence was collected for four performance measures across three sub-assurances. CMS requires that the state develop and

implement plans to accurately collect and assess performance measure data at waiver initiation. The state should also identify the root causes of the medication errors and put systems and training into place to effect significant improvements in this area which could endanger the health and safety of program participants. Any proposed new Performance Measures should be addressed through the renewal or amendment processes. The state has developed and begun the process of implementing specific quality improvement plans for each of these areas. Progress on these initiatives will be monitored by CMS via the 372 reports.

I. Financial Accountability

The state 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:	Intellectual Disability/Community Living (ID) (CL)
State Medicaid Agency	Virginia Department of Medical Assistance Services (DMAS)
State Operating Agency:	Department of Behavioral Health and Developmental Services
State Waiver Contact:	Ann Bevan Director, Division of Developmental Disabilities and Behavioral Health DMAS 600 East Broad Street Richmond, VA 23219 (804) 588-4887 ann.bevan@dmas.virginia.gov
Local Operating Agencies:	Community Services Boards(CSBs)/Behavioral Health Authorities(BHAs)

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:** N/A
Level of Care:	☐ Hospital ☐ Nursing Facility ☒ Intermediate Care Facility for Individuals with Intellectual Disabilities **Additional Criteria** N/A
Effective Dates of Waiver:	July 1, 2014 through June 30, 2019
Concurrent Waiver Authority:	N/A
Actual Annual Per Capita Costs (CMS- 372):	Waiver Year 1, SFY 2015 -- $66,967
Actual Unduplicated Number of Waiver Participants (CMS-	Waiver Year 1, SFY 2015 -- 10,140
Approved Waiver Services:	Day Support, Group Home Residential, Individual Supported Employment, Personal Assistance Services, Respite, Consumer-Directed Services Facilitation, Assistive Technology, Center-Based Crisis Supports, Community Coaching, Community Engagement, Community-Based Crisis Supports, Companion Services, Crisis Support Services, Electronic Home-Based Services, Environmental Modification, Group Supported Employment, In-home Support Services, Personal Emergency Response System, Private Duty Nursing, Residential Support Services, Shared Living, Skilled Nursing, Sponsored Residential, Supported Living, Therapeutic Consultation, Transition Services, and Workplace Assistance Services.

	Three services, Prevocational Services, Crisis Stabilization, and Crisis Supervision, were terminated 8/31/16.
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 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.
For Draft Report: CMS Determination	The state demonstrates the sub-assurance.
For Draft Report: CMS Justification	The performance of Virginia on each of three Performance Measures was exemplary with two being 100% each year and the third at 99% or 100% each year.
For Draft Report: Incomplete or Missing Evidence	N/A
For Draft Report: CMS Recommendations or Required Changes	None
For Final Report: CMS Determination	The state demonstrates the sub-assurance. **CMS Additional Comments:** None

State Response to the Draft Report: None required

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 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.
For Draft Report: CMS Determination	The state demonstrates the sub-assurance.
For Draft Report: CMS Justification	For 1 of the 2 PMs, Virginia showed 100% compliance. For PM2 which deals with completion of LOC within 60 days, year 1 was 84% which improved to 90% in year 2 and 92% in year 3 due to the ongoing improvements including the recent deployment of a new tool to aid in compliance. The state's QIP is acceptable.
For Draft Report: Incomplete or Missing Evidence	N/A
For Draft Report: CMS Recommendations or Required Changes	None
For Final Report: CMS Determination	The state demonstrates the sub-assurance. **CMS Additional Comments:** None

Sub-Assurance 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.)**
For Draft Report: CMS Determination	The state demonstrates the sub-assurance.

For Draft Report: CMS Justification	The compliance demonstrated on PM3 ranged was 100% in WY 1 and 2, and 97% in WY3.

Sub-Assurance 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.)**
For Draft Report: Incomplete or Missing Evidence	N/A
For Draft Report: CMS Recommendations or Required Changes	None
For Final Report: CMS Determination	The state demonstrates the sub-assurance. **CMS Additional Comments:** None

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.
For Draft Report: CMS Determination	The state demonstrates the sub-assurance.
For Draft Report: CMS Justification	The compliance demonstrated on PM 4 and 5 ranged from 92% to 100% for each year. The state's QIP is acceptable.
For Draft Report: Incomplete or Missing Evidence	N/A
For Draft Report: CMS Recommendations or Required Changes	None

For Final Report: CMS Determination	The state demonstrates the sub-assurance. **CMS Additional Comments:** None

State Response to the Draft Report: None required

Instructions to state: N/A.

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 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.
For Draft Report: CMS Determination	The state demonstrates the sub-assurance.
For Draft Report: CMS Justification	The compliance demonstrated on each of three PMs ranged from 91% to 100% for all PMs for each year.
For Draft Report: Incomplete or Missing Evidence	PM 2 is missing the sample universe number. In this case, this would be ALL of the licensed or certified provider agency DSPs. However, the sample size is in excess of that required if the universe was over 10,000. For PM3, the State explained some difficulty differentiating waiver specific data for this PM. The State should ensure that there are reliable plans for data collection and analysis for each PM at the start of the waiver.
For Draft Report: CMS Recommendations or Required Changes	CMS Required Changes Please address Quality Improvement related to PM2 related to criminal background checks (WY 1 and 2 were under the 100% standard).
For Final Report: CMS Determination	The state demonstrates the sub-assurance. **CMS Additional Comments:** None

Sub-Assurance C-ii	The state monitors non-licensed/non-certified providers to assure adherence to waiver requirements.
For Draft Report: CMS Determination	The state does not fully demonstrate the assurance, though there is evidence that may be clarified or readily addressed.
For Draft Report: CMS Justification	For PM1 and PM 3, there is 100% compliance. For PM2, data was not provided for WY1 and WY2. The state has indicated it will work to collect and provide the data for the Final Report.
For Draft Report: Incomplete or Missing Evidence	For PM2, data was not provided for WY1 and WY2. The state has indicated it will work to collect and provide the data for the Final Report.
For Draft Report: CMS Recommendations or Required Changes	None
For Final Report: CMS Determination	The state demonstrates the sub-assurance. **CMS Additional Comments**: The State provided the missing information for PM2 for WY1 and 2 which showed 100% compliance.

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.
For Draft Report: CMS Determination	The state demonstrates the sub-assurance.
For Draft Report: CMS Justification	The state demonstrated 88% compliance two years and 89% the final year and has an active QIP of intervening to correct provider shortfalls in training.

For Draft Report: Incomplete or Missing Evidence	For PM 7 in c-iii, please provide the total number of provider agencies for the sample universe row.
For Draft Report: CMS Recommendations or Required Changes	None
For Final Report: CMS Determination	The state demonstrates the sub-assurance. **CMS Additional Comments:** None

State Response to the Draft Report:

Ci PM2:
Remediation: Individual remediation was conducted for each instance of non-compliance. QMR requested 14 corrective action plans and follow ups for WY1 and 8 corrective action plans and follow ups for WY2.

Quality Improvement Activities:
With the implementation of the redesigned waivers, all DBHDS licensed providers are required to fulfill new competency requirements for direct support professionals and supervisors. DBHDS Division of Developmental Services provider development staff 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. DBHDS licensing and DMAS QMR staff review staff records to ensure DSPs meet the requirements and that they are documented appropriately. Corrective action plans are required when providers do not meet the requirements.

Cii PM2: The data for this measure has been revised and added to the report. For each year the state showed 100% compliance with the number of nonlicensed/noncertified provider agencies who met waiver provider qualifications.

C iii PM 7: The state erroneously interpreted the measure in practice differently than written. The data demonstrated in the initial report represents the number of provider staff meeting training requirements based on QMRs. While the data does not align with the approved measure, it does demonstrate that provider staff received training consistent with state requirements. A waiver amendment will be submitted to update the measure to reflect the current interpretation. The amendment will also revise the sampling methodology to adequately address how the sample is captured and to ensure statistical confidence.

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 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.
For Draft Report: CMS Determination	The state demonstrates the sub-assurance.
For Draft Report: CMS Justification	PM1 showed 70% compliance in WY1 but 93% and 90% in WYs 2 and 3 showing effective mitigation. PM2 showed 87 to 93% compliance each year. PM 3 which addressed risk mitigation showed 66% in WY 1, 89% in WY 2, and 85% in WY3 and did not demonstrate the subassurance directly; however, the state implemented risk mitigation as part of their quality improvement initiative and showed improvement in WYs 2 and 3. PM4 ranged from 88% to 94%. Individual remediation was performed.
For Draft Report: Incomplete or Missing Evidence	
For Draft Report: CMS Recommendations or Required Changes	CMS Recommendations The state should continue to refine their risk mitigation strategies as outlined in their quality improvement discussion.
For Final Report: CMS Determination	The state demonstrates the sub-assurance. **CMS Additional Comments:** None

Sub-Assurance 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.)**
For Draft Report: CMS Determination	N/A
For Draft Report: CMS Justification	
For Draft Report: Incomplete or Missing Evidence	
For Draft Report: CMS Recommendations or Required Changes	
For Final Report: CMS Determination	Select one. **CMS Additional Comments:**

Sub-Assurance D-iii	Service plans are updated/revised at least annually or when warranted by changes in waiver individual needs.
For Draft Report: CMS Determination	The state demonstrates the sub-assurance.
For Draft Report: CMS Justification	Each of two PMs were between 94% and 100% for each year. Compliance with PM 9 in this sub-assurance ranged from 100% in WY 1 and 2 and 99% in WY 3.
For Draft Report: Incomplete or Missing Evidence	N/A.

For Draft Report: CMS Recommendations or Required Changes	CMS Required Changes For PM 8 for WY 1, please discuss Quality Improvement for this PM.
For Final Report: CMS Determination	The state demonstrates the sub-assurance. **CMS Additional Comments:** The Draft Report comments on PM8 were the results of a typographic error and can be disregarded.

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.
For Draft Report: CMS Determination	The state demonstrates the sub-assurance.
For Draft Report: CMS Justification	There was an issue with the correlation of the data source to outcomes in the original PM 10 which was replaced by amendment. Although compliance was at 78% for the first year for PM 10 (amendment)/11 (original), performance improved during waiver years 2 to 93% and to 95% in waiver year 3. The state has an active quality improvement program implemented and remediated each instance of non-compliance.
For Draft Report: Incomplete or Missing Evidence	N/A.
For Draft Report: CMS Recommendations or Required Changes	None
For Final Report: CMS Determination	The state demonstrates the sub-assurance. **CMS Additional Comments:** None

Sub-Assurance 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.)**

For Draft Report: CMS Determination	The state demonstrates the sub-assurance.
For Draft Report: CMS Justification	The state achieved 100% compliance on each of two PMs for each year.
For Draft Report: Incomplete or Missing Evidence	N/A.
For Draft Report: CMS Recommendations or Required Changes	None
For Final Report: CMS Determination	The state demonstrates the sub-assurance. **CMS Additional Comments:** None

State Response to the Draft Report:

Di PM#3 – As part of its quality management strategy, the state has convened an internal work group to identify and agree upon a standard risk management tool to be used for waiver assurance reporting in an effort to achieve greater consistency and accountability across providers in the area of risk mitigation.

G. Health and Welfare (post-2014)

The state must demonstrate it has designed and implemented an effective system for assuring waiver participant health and welfare.

AUTHORITY: 42 CFR 441.302; CFR 441.303; SMM 4442.4; SMM 4442.9

[This assurance and all the corresponding sub-assurances (G-i through G-iv) apply to the waiver years regulated by the guidance issued March 12, 2014].

Sub-Assurance G-i	The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect and exploitation and unexplained death.

For Draft Report: CMS Determination	The state does not demonstrate the sub-assurance.
For Draft Report: CMS Justification	While PM 1 demonstrated 100% compliance, data was not collected for PM 2 which addresses unexplained deaths for which there is an identification of opportunities for improvement.
For Draft Report: Incomplete or Missing Evidence	No evidence was collected for PM 2.
For Draft Report: CMS Recommendations or Required Changes	CMS Required Changes The state must put into place systems and tools to collect the evidence for each PM.
For Final Report: CMS Determination	The state does not demonstrate the sub-assurance. **CMS Additional Comments:** The state must put into place systems and tools to collect the evidence for each PM.

Sub-Assurance G-ii	The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.
For Draft Report: CMS Determination	The state does not demonstrate the sub-assurance.
For Draft Report: CMS Justification	For PM 3, dealing with emergency plans, compliance was above 99% each year. However, for PM 4, providers cited for medication errors, compliance was at 80% year 1, 77% year 2, and 74% year 3.
For Draft Report: Incomplete or Missing Evidence	N/A
For Draft Report: CMS Recommendation s or Required	CMS Required Changes The state's systemic remediation efforts have not been effective. The state should identify the root causes of the medication errors and put systems and training into place to effect significant improvements in this area which could endanger the health and safety of program participants.

Changes	
For Final Report: CMS Determination	The state does not demonstrate the sub-assurance. **CMS Additional Comments:** The State should identify the root causes of the medication errors and put systems and training into place to effect significant improvements.

Sub-Assurance G-iii	The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.
For Draft Report: CMS Determination	The state does not demonstrate the sub-assurance.
For Draft Report: CMS Justification	The state did not collect the evidence for one of the two PMs for this sub-assurance.
For Draft Report: Incomplete or Missing Evidence	No evidence was collected for PM 6.
For Draft Report: CMS Recommendations or Required Changes	CMS Required Changes The state must put into place systems and tools to collect the evidence for each PM.
For Final Report: CMS Determination	The state does not demonstrate the sub-assurance. **CMS Additional Comments:** The state must put into place systems and tools to collect the evidence for each PM.

Sub-Assurance G-iv	The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.
For Draft Report: CMS Determination	The state does not demonstrates the sub-assurance.

For Draft Report: CMS Justification	The state did not collect the evidence for either of the two PMs for this sub-assurance.
For Draft Report: Incomplete or Missing Evidence	No evidence was collected.
For Draft Report: CMS Recommendations or Required Changes	CMS Required Changes The state must put into place systems and tools to collect the evidence for each PM.
For Final Report: CMS Determination	The state does not demonstrate the sub-assurance. **CMS Additional Comments:** The state must put into place systems and tools to collect the evidence for each PM.

State Response to the Draft Report:

Gii PM 4 - Medication errors captured in QRT reporting are currently not distinguished by type of error to allow the state to quantify the nature of the error. The state has proposed ways to identify the medication error by type in order to target provider training efforts toward prevention. The DBHDS Provider Development team is planning regular training on medication administration in the form of annual refreshers (based on information provided through QRT reporting). Additionally, proposed waiver regulations include language requiring mandatory technical assistance and training for providers in key areas. Recent changes to the Emergency Licensing regulations include a new three-tiered critical incident reporting system which will improve the state's ability to categorize incidents for remediation and prevention purposes.

Gi, Gii, Giii, Giv PM#2-The state's existing stand-alone data collection systems have created challenges to reporting data for the waiver assurances. Health and welfare data reported by the state's Department of Licensing, Human Rights Division, and state Mortality Committee do not report critical health and safety incidents by waiver type. Further, state data reporting entities used different terminology and categories of information collection/data that were not adequately aligned with performance measure terminology and information collection needs, with multiple data elements collected from different entities resulting in the reporting of conflicting data.

- As part of its quality improvement strategy, the state has committed to internal system improvements and efficiencies that would allow collection of relevant and timely data to address the CMS assurances. This process involved eliminating data sources that did not directly address the performance measures being targeted and developing new measures based on relevant data that is able to be collected, as well as reworking existing processes and data collection methodologies to capture information that will appropriately measure the assurances. A waiver amendment has undergone public

comment and will be submitted in the coming weeks.   Once these changes are approved by CMS, both agencies will be able to collect data to ensure quality assurances are met. .

Sub-Assurance G-i.a	The State demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.
	1. Number and percent of closed cases of abuse/neglect/exploitation for which DBHDS verified that the investigation conducted by the provider was done in accordance with regulations. N = number of closed cases of abuse/neglect/exploitation verified that the investigation was conducted in accordance with regulations D = number of closed cases of abuse/neglect/exploitation that were reviewed.
	2. Number and percent of substantiated cases of abuse/neglect/exploitation for which the required corrective action was verified by DBHDS as being implemented. N = number of substantiated cases of abuse/neglect/exploitation for which the required corrective action was verified as being implemented within 90 days D = number of substantiated cases of abuse/neglect/exploitation
	3. # &% of unexpected deaths where the cause of death/a factor in the death, was potentially preventable & some intervention to remediate was taken. N= # of unexpected deaths where the cause of death/a factor in the death, was potentially preventable & some intervention to remediate was taken D= # of unexpected deaths where the cause of death/a factor in the death, was potentially preventable
Sub-Assurance G-i.b	The State demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.
	1. Number and percent of critical incidents reported to the Office of Licensing within the required time frames as specified in the approved waiver. N = Number of critical incidents reported to the Office of Licensing within the required timeframe. D = Number of critical incidents reported to the Office of Licensing regarding individuals receiving DD waiver services.
	2. Number and percent of licensed DD providers that administer medications that were not cited for failure to review medication errors at least quarterly. N: # of licensed DD providers that administer medications cited for failure to review medication errors at least quarterly D: # of licensed DD providers that administer medications that were reviewed by Office of Licensing in the quarter
Sub-Assurance G-i.c	The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.
	1. Number and percent of individuals reviewed who did not have unauthorized restrictive interventions. N = number of individuals reviewed who did not have unauthorized restrictive interventions. D = number and percent of individuals reviewed
	2. Number and percent of individuals who did not have unauthorized seclusion. N = number of individuals who did not have unauthorized seclusion D = number of abuse allegations + complaints submitted via CHRIS

Sub-Assurance G-i.d	The State establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver
	1. Number and percent of participants 20 years and older who had an ambulatory or preventive care visit during the year. N: Number of participants 20 years and older who had an ambulatory or preventive care visit D: Number of participants 20 years and older
	2. Number and percent of participants 19 and younger who had an ambulatory or preventive care visit during the year. N: Number of participants 19 and younger who had an ambulatory or preventive care visit D: Number of participants 19 and younger

These specific changes include:

- Review and elimination of data sources that did not directly address the performance measure targeted. The focus of this effort was to ensure that the data source used was the most relevant to the measure.

- Revamping of processes within the DBHDS Departments of Licensing and Human Rights, and a refocusing of the efforts of the Mortality Review Committee, to ensure the accurate, relevant and timely collection and reporting of health and welfare data.

New performance measures (listed below) and data sources to capture health and welfare data. The proposed performance measures are below.

- Reporting performance regarding the health and welfare assurances across waivers using aggregated data to more accurately capture data and improve accountability.

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 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.
For Draft Report: CMS Determination	The state demonstrates the sub-assurance.

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.
For Draft Report: CMS Justification	The one PM showed 100% compliance for each of the three years.
For Draft Report: Incomplete or Missing Evidence	NA
For Draft Report: CMS Recommendations or Required Changes	None
For Final Report: CMS Determination	The state demonstrates the sub-assurance **CMS Additional Comments:** None

Sub-Assurance 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.)**
For Draft Report: CMS Determination	The state demonstrates the sub-assurance.
For Draft Report: CMS Justification	The one PM showed 100% compliance for each of the three years.
For Draft Report: Incomplete or Missing Evidence	N/A
For Draft Report: CMS Recommendations or Required Changes	None

Sub-Assurance 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.)**
For Final Report: CMS Determination	The state demonstrates the sub-assurance **CMS Additional Comments:** None

State Response to the Draft Report: None required

Instructions to state: N/A

Home and Community-Based Intellectual Disability (Community Living) Waiver Fact Sheet

	VA.0372 Waiver Details
Waiver Name:	Intellectual Disability/Community Living (ID) (CL)
State Medicaid Agency:	Virginia Department of Medical Assistance Services
State Operating Agency:	Department of Behavioral Health and Developmental Services
State Waiver Contact:	Ann Bevan, DMAS
Local Operating Agencies:	Community Services Boards(CSBs)/Behavioral Health Authorities(BHAs)
Target Population:	Intellectual Disability or Developmental Disability, or Both
Level of Care:	Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)
Effective Dates of Waiver:	July 1, 2014 through June 30, 2019
Concurrent Waiver Authority:	Not Applicable
Actual Annual Per Capita Costs (CMS-372):	Waiver Year 1, SFY 2015 -- $66,967
Actual Unduplicated Number of Waiver Participants (CMS-372):	Waiver Year 1, SFY 2015 -- 10,140

Approved Waiver Services:	Day Support, Group Home Residential, Individual Supported Employment, Personal Assistance Services, Respite, Consumer-Directed Services Facilitation, Assistive Technology, Center-Based Crisis Supports, Community Coaching, Community Engagement, Community-Based Crisis Supports, Companion Services, Crisis Support Services, Electronic Home-Based Services, Environmental Modification, Group Supported Employment, In-home Support Services, Personal Emergency Response System, Private Duty Nursing, Residential Support Services, Shared Living, Skilled Nursing, Sponsored Residential, Supported Living, Therapeutic Consultation, Transition Services, and Workplace Assistance Services. Three services, Prevocational Services, Crisis Stabilization, and Crisis Supervision, were terminated 8/31/16.
CMS Contact:	Ellen Reap, 215-861-4735, Ellen.Reap@cms.hhs.gov

CMS Waiver Program Evidence Standards

CMS Waiver Program Evidence Standards

Pursuant to §1915(f)(1) of the Social Security Act and 42 CFR 441.304(g)(2), 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 Strategy (QIS) 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 Quality Improvement Project (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 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 Strategy 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.

Virginia State Medicaid Agency Oversight of the Intellectual Disability/Community Living Waiver3

State Quality Improvement Strategy
The Home and Community-Based Waiver for Persons with Intellectual Disabilities began in 2005. The ID/CL Waiver is designed to provide services to people in the community rather than in an institutional setting. 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 ID/CL 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 implemented its system-wide redesign of its Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions (ICF/IID) level of care Medicaid waivers on July 1, 2016. This system transformation included the submission and subsequent approval of waiver amendments for the conversion of its three existing waivers 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 were intended to address quality assurance issues with standardization of processes and procedures, eligibility tools, 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 to improve accountability. Although the majority of the waiver redesign components were implemented concurrently, some elements impacting quality management were delayed or are in progress. The Commonwealth will identify these components within the applicable sections of this report.

State Quality Management Activities
DBHDS has primary responsibilities in the operations of the ID/CL 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 meeting those measures and identify barriers to completion. This group also identifies issues that may need to be addressed through the waiver regulations, program policies and

procedures.

The 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 is performed by DMAS staff who conducts on-site record review of providers. The process begins with identifying a random sample of active individuals receiving ID/CL waiver services to determine which records are 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 to each performance measure being reviewed. When deficiencies or instances of non-compliance are found, QMR staff discuss findings with the provider and provides technical assistance. The technical assistance 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 to be non-compliant in any area during site reviews are required to develop a corrective action plan (CAP). The plan must include methods to remedy the deficient areas and includes time frames to complete the actions. CAPs must be submitted to DMAS QMR staff for approval. DMAS approves the plan within 30 days and conducts follow-up with the provider within 45 days from the implementation of the CAP to ensure the area of deficiency has been corrected. 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 ID/CL waiver operations and quality assurance activities. The DBHDS Office of Licensing (OL) is responsible for initial and ongoing licensure of providers for 14 services available in the ID/CL 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 to be non-compliant with licensing regulations are required to develop and submit CAPs. The licensing CAP must include a description of the remedial actions to be taken and the date of completion for each action. The CAP must be submitted within 15 days of the issuance of the licensing report. Unsatisfactory CAPs 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 CAP, 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 also comply with DBHDS's Human Rights regulations. The Office of Human Rights(OHR) has 23 field advocates across the state responsible for ensuring human rights protections to individuals served in state facilities and services offered through over 900 DBHDS licensed community providers. Suspected violations of individuals' human rights are typically investigated jointly by OL and OHR staff cited by OL staff and may

require CAPs as described above. As a proactive measure, advocates visit newly licensed providers within 30 days of service initiation to ensure they have basic knowledge of the human rights system, including review of their human rights policies and training on the requirements and process for utilizing the web-based reporting application (CHRIS). Advocates provide guidance, consultation and on-going technical assistance to community providers, facility staff, individuals, and family members via on-site inspections and reviews. Advocates respond and assist in the complaint resolution process by monitoring provider reporting and reviewing provider investigations and corrective actions. They also respond to reports of abuse by conducting independent or joint investigations with DBHDS partners and/or the Virginia Department of Social Services.

Another component of the quality management process is performed in part by the local Community Services Boards/Behavioral Health Authorities (CSBs) through a Supervisory Review questionnaire. These local government entities provide support coordination for individuals receiving services through the CL/ID waiver. The CSBs participate are required to conduct record reviews based on established performance measures and report the results via an online survey questionnaire. The reviews assist CSBs in identifying and correcting compliance issues through staff feedback and remediation. DBHDS staff monitors the results of the quality reviews and summarizes the information on a quarterly basis. For each of the measures reviewed by CSB staff, there is typically another source of data (e.g., Quality Management Reviews) used.

DMAS and DBHDS staff meet quarterly as a Quality Review Team (QRT) to review and discuss data, survey results and information used to monitor progress toward meeting CMS assurances as well as 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.

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.

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
[State provides detailed background regarding its processes, policies, procedures, etc., related to this Assurance…]

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

Performance Measure: 1	**Number and percent of satisfactory Medicaid-initiated operating agency and contractor (i.e., DBHDS, Xerox and PPL) evaluations.**
Numerator:	**# of satisfactory Medicaid initiated operating agency and contractor evaluations**
Denominator:	**Total # of Medicaid-initiated operating agency and contractor evaluations**
Description of Data Source:	**Annual Medicaid contractor and operating agency evaluation reports**
Entity Responsible for Data Collection:	**State Medicaid Agency**
Frequency of Data Collection:	**Annually and Continuous and On going**
Entity Responsible for Data Aggregation:	**State Medicaid Agency**
Frequency of Data Aggregation:	**Annually**
Sampling Methodology:	**100% review**

State Data	[Year 1]	[Year 2]	[Year 3]
Sample Universe (entire population from which your sample is drawn):	6	6	6
Numerator (# compliant):	6	6	6
Sample Size (denominator):	6	6	6
% Compliant (pre-remediation):	100%	100%	100%

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Performance Measure: 2	**Number and percent of waiver policies and procedures approved by DMAS prior to implementation by DBHDS.**
Numerator:	**# of policies and procedures implemented by DBHDS that were approved by DMAS prior to implementation**
Denominator:	**Total # of policies and procedures implemented by DBHDS**
Description of Data Source:	**Operating agency performance monitoring**
Entity Responsible for Data Collection:	**State Medicaid Agency**
Frequency of Data Collection:	**Quarterly**
Entity Responsible for Data Aggregation:	**State Medicaid Agency**
Frequency of Data Aggregation:	**Quarterly**
Sampling Methodology:	**100% Review**

State Data	[Year 1]	[Year 2]	[Year 3]
Sample Universe (entire population from which your sample is drawn):	0	0	7
Numerator (# compliant):	0	0	7
Sample Size (denominator):	0	0	7
% Compliant (pre-remediation):	100	100	100

Performance Measure: 3	Number and percent of slots assigned in accordance with the standard, statewide slot assignment process
Numerator:	# of slots assigned statewide according to the standardized process
Denominator:	# of slots assigned statewide
Description of Data Source:	Data for each slot assigned submitted to DBHDS staff for review
Entity Responsible for Data Collection:	Operating Agency
Frequency of Data Collection:	Continuous and Ongoing
Entity Responsible for Data Aggregation:	State Medicaid Agency Operating Agency
Frequency of Data Aggregation:	Quarterly
Sampling Methodology:	100% Review

State Data	[Year 1]	[Year 2]	[Year 3]
Sample Universe (entire population from which your sample is drawn):	178	538	349
Numerator (# compliant):	176	530	349
Sample Size (denominator):	178	538	349
% Compliant (pre-remediation):	99%	99%	100%

State Analysis
The data demonstrates that the state maintains authority over waiver operations.
Remediation
No remediation required.
Quality Improvement Activities
None required.

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 are performed by support coordinators at the local Community Services Boards (CSBs) using the Level of Functioning Survey (LOF) or most recently, the Virginia Intellectual and Developmental Disability Eligibility Survey (VIDES) 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 waiver services. DBHDS monitors data from the local CSBs on the length of time between application for screening and notification of determination for each applicant. The CSB support coordinator submits to DBHDS, the completion date of the LOF/VIDES and the number of categories met via the Waiver Management System (WaMS). Individuals meeting the appropriate LOC are either enrolled in the waiver or placed on the statewide waiting list. DBHDS monitors annual re-evaluations through the receipt of the "Plan of Care Summary" form that is completed annually by the support coordinator. The Plan of Care Summary includes the date the reevaluation was completed and the level of functioning categories met. LOF/VIDES evaluations not conducted in a reasonable timeframe are remediated through training, education, and technical assistance. DBHDS collects data on the type of remediation required including outcomes and follow-up. To further ensure the that level of care evaluations are conducted consistent with the processes in the approved waiver application, DBHDS established a qualitative review process to be conducted by the support coordinator supervisors. Support coordinator supervisors review records and address any concerns related to the completion of the LOF/VIDES and reports findings to the Quality Review Team 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

Performance Measure: 1	**Number and percent of all new enrollees who have a level of care prior to receiving waiver services**
Numerator:	**# of new enrollees who have level of care prior to receiving waiver service**
Denominator:	**total # of new enrollees**
Description of Data Source:	**IDOLS**
Entity Responsible for Data Collection:	**Operating Agency**
Frequency of Data Collection:	**Continuous and ongoing**
Entity Responsible for Data Aggregation:	**State Medicaid Agency and Operating Agency**
Frequency of Data Aggregation:	**Quarterly**
Sampling Methodology:	**100% Review**

State Data	[Year 1]	[Year 2]	[Year 3]
Sample Universe (entire population from which your sample is drawn):	178	538	349
Numerator (# compliant):	178	538	349
Sample Size (denominator):	178	538	349
% Compliant (pre-remediation):	100	100	100

Performance Measure: 2	The number and percent of VIDES (LOC) completed within 60 days of application for those for whom there is a reasonable indication that services may be needed in the future.
Numerator:	# of LOF surveys/VIDES completed within 60 days for new applicants
Denominator:	Total # of new applicants for whom there is a reasonable indication that services may be needed in the future.
Description of Data Source:	IDOLS/Waiver Management System
Entity Responsible for Data Collection:	Operating Agency
Frequency of Data Collection:	Continuous and ongoing
Entity Responsible for Data Aggregation:	State Medicaid Agency and Operating Agency
Frequency of Data Aggregation:	Quarterly
Sampling Methodology:	100% Review

State Data	[Year 1]	[Year 2]	[Year 3]
Sample Universe (entire population from which your sample is drawn):	1601	1564	2407
Numerator (# compliant):	1390	1406	2207
Sample Size (denominator):	1601	1564	2407
% Compliant (pre-remediation):	83.6%	89.8%	91.6%

State Analysis
The state ensures that individuals in need of waiver services receive a level of care evaluation prior to receiving services. The state recognizes the need for continued improvement in the timeliness of initial evaluations. The QRT analyzed the data and found discrepancies among CSBs in how timeliness was being captured. The QRT recommended that a process be developed that can be consistently applied across all CSBs.
Remediation
DBHDS Provider Development staff conducted technical assistance and training.
Quality Improvement Activities
To continue to improve the timeliness of evaluations, the state recently implemented a new field in the WaMS to clearly identify the starting point for determination of need. Provider training will focus on this new element to ensure that there is consistent understanding.

Sub-Assurance B-ii: 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-ii

Performance Measure: 3	**Number and percent of individuals who received an annual LOF/VIDES evaluation of eligibility with 12 months of their initial LOF evaluation or with 12 months of their last annual LOF evaluation.**
Numerator:	**# of individual who receive a LOF/VIDES within the required timeframe**
Denominator:	**total # records reviewed**
Description of Data Source:	**On-site/off-site Quality Management Reviews**
Entity Responsible for Data Collection:	**Case Management Supervisors or Quality Assurance staff**
Frequency of Data Collection:	**Continuous and Ongoing**
Entity Responsible for Data Aggregation:	**State Medicaid Agency and Operating Agency**
Frequency of Data Aggregation:	**Quarterly**
Sampling Methodology:	**Representative Sample Confidence Interval = 95%**

State Data	**[Year 1]**	**[Year 2]**	**[Year 3]**
Sample Universe (entire population from which your sample is drawn):	10,060	10,547	11,005
Numerator (# compliant):	672	662	391
Sample Size (denominator):	672	663	402
% Compliant (pre-remediation):	100%	99.8%	97.3%

Performance Measure: 4	**Number and percent of LOF/VIDES determinations that followed the required process, defined as completed by a qualified CM, conducted face-to-face with individual and those who know him (if needed), and at least 3 criteria met**
Numerator:	**# of LOF/VIDES determinations that followed the required process**
Denominator:	**total # of LOF/VIDES forms reviewed**
Description of Data Source:	**On-site/off-site Quality Management Reviews**
Entity Responsible for Data Collection:	**Case Management Supervisors or Quality Assurance staff**
Frequency of Data Collection:	**Continuous and Ongoing**
Entity Responsible for Data Aggregation:	**State Medicaid Agency and Operating Agency**
Frequency of Data Aggregation:	**Quarterly**
Sampling Methodology:	**Representative Sample Confidence Interval = 95%**

State Data	**[Year 1]**	**[Year 2]**	**[Year 3]**
Sample Universe (entire population from which your sample is drawn):	10,060	10,547	11,005
Numerator (# compliant):	672	662	369
Sample Size (denominator):	672	663	402
% Compliant (pre-remediation):	100	99.8	92

Performance Measure: 5	**Number and percent of LOF/VIDES determinations that use criteria appropriately to enroll or maintain a person in the waiver**
Numerator:	**# of LOF/VIDES determinations that use criteria appropriately to enroll or maintain a person in the waiver**
Denominator:	**total # LOF/VIDES forms reviewed**
Description of Data Source:	**Supervisory Reviews**
Entity Responsible for Data Collection:	**Case Management Supervisors or Quality Assurance staff**
Frequency of Data Collection:	**Continuous and Ongoing**
Entity Responsible for Data Aggregation:	**State Medicaid Agency**
Frequency of Data Aggregation:	**Quarterly**
Sampling Methodology:	**Representative Sample Confidence Interval = 95%**

State Data	[Year 1]	[Year 2]	[Year 3]
Sample Universe (entire population from which your sample is drawn):	10,060	10,547	11,005
Numerator (# compliant):	672	662	394
Sample Size (denominator):	672	663	402
% Compliant (pre-remediation):	100	98.4	98

State Analysis
Data indicates that the state consistently ensures that instruments and processes for determining level of care are applied appropriately and in accordance with the approved waiver.
Remediation
Individual remediation was conducted. QMR requested 3 corrective action plans and follow-ups.
Quality Improvement Activities
As part of the waiver redesign, the state implemented a new level of care tool, the Virginia Individual Developmental Disability Eligibility Survey (VIDES). DBHDS Provider Development staff conducted training for CSB support coordinators on the implementation of the tool.

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
DMAS assures the availability of qualified providers to meet the needs of individuals receiving ID/CL Waiver services by ensuring that all agency providers who enroll with Medicaid possess the appropriate license or other qualifications prior to being enrolled and providing services. DMAS contracted with the provider enrollment contractor, which 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 ID/CL 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 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. Providers of 14 ID/CL waiver services 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. 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; upon expiration of that license they are reviewed again.

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

Performance Measure: 1	**# & % of licensed/certified waiver agency provider enrollments for which the appropriate lic./certif. was obtained in accordance with waiver reqmts prior to service provision**
Numerator:	**# of lic./certif. waiver agency provider enrollments for which the appropriate lic./certif. was obtained in accordance with waiver reqmts prior to service provision.**
Denominator:	**total # of waiver agency provider enrollments**
Description of Data Source:	**Xerox**
Entity Responsible for Data Collection:	**Xerox (provider enrollment contractor)**
Frequency of Data Collection:	**Continuous and Ongoing**
Entity Responsible for Data Aggregation:	**State Medicaid Agency**
Frequency of Data Aggregation:	**Quarterly**
Sampling Methodology:	**100% Review**

State Data	**[Year 1]**	**[Year 2]**	**[Year 3]**
Sample Universe (entire population from which your sample is drawn):	333	347	652
Numerator (# compliant):	333	347	652
Sample Size (denominator):	333	347	652
% Compliant (pre-remediation):	100	100	100

Performance Measure: 2	**Number & percent of licensed/certified waiver provider agency direct support staff who have criminal background checks as specified in policy/regulation with satisfactory results**
Numerator:	**# of lic./certif, waiver provider agency DSPs who have criminal background checks as specified in policy/regulation with satisfactory results**
Denominator:	**total # licensed/certified provider agency DSP records reviewed**
Description of Data Source:	**On-site or off-site Quality Management Reviews**
Entity Responsible for Data Collection:	**State Medicaid Agency**
Frequency of Data Collection:	**Continuous and ongoing**
Entity Responsible for Data Aggregation:	**State Medicaid Agency**
Frequency of Data Aggregation:	**Quarterly**
Sampling Methodology:	**Representative Sample Confidence Interval = 95%**

State Data	**[Year 1]**	**[Year 2]**	**[Year 3]**
Sample Universe (entire population from which your sample is drawn):	525	252	437
Numerator (# compliant):	491	237	398
Sample Size (denominator):	525	252	437
% Compliant (pre-remediation):	96	94	91

Performance Measure: 3	**Number & percent of licensed/certified provider agencies, by type, continuing to meet applicable licensure/certification following initial enrollment.**
Numerator:	**# licensed/certified providers, by provider agency type, continuing to meet applicable licensure/certification following initial enrollment**
Denominator:	**total #** **licensed/certified provider agencies**
Description of Data Source:	**Office of Licensing reviews**
Entity Responsible for Data Collection:	Operating Agency
Frequency of Data Collection:	Continuous and Ongoing
Entity Responsible for Data Aggregation:	State Medicaid Agency and Operating Agency
Frequency of Data Aggregation:	Quarterly
Sampling Methodology:	100% Reviews

State Data	**[Year 1]**	**[Year 2]**	**[Year 3]**
Sample Universe (entire population from which your sample is drawn):	100 % of Licensed providers reviewed by QMR	100 % of Licensed providers reviewed by QMR	100 % of Licensed providers reviewed by QMR
Numerator (# compliant):	91	32	42
Sample Size (denominator):	91	32	42
% Compliant (pre-remediation):	100	100	100

State Analysis
The state collected data on the number of licensed/certified provider agencies continuing to meet licensure/certification following initial enrollment based on licensing reviews and found that the information provided does not adequately reflect licensed/certified provider agencies providing waiver services as DMAS has a process that confirms that all enrolled licensed providers continue to meet licensure/certification standards monthly. Any provider found to no longer meet licensing requirements is promptly dis-enrolled as a Medicaid provider. Data reported for this measure was generated as a result of QMR. The QMR sample is derived of the providers of the individuals pulled in the representative sample confidence interval of 95%.
Remediation
No remediation required
Quality Improvement Activities
Click here to enter text.

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

Sub-assurance C-ii

Performance Measure:	**Number & percent of new individual providers under consumer-direction who initially met waiver provider qualifications**
Numerator:	**# of new individual providers under consumer-direction who initially met waiver provider qualifications**
Denominator:	**total # of new individual providers under consumer-direction.**
Description of Data Source:	**Employer information packet**
Entity Responsible for Data Collection:	**PPL (fiscal management services agency)**
Frequency of Data Collection:	**Continuous and ongoing**
Entity Responsible for Data Aggregation:	**State Medicaid Agency**
Frequency of Data Aggregation:	**Quarterly**
Sampling Methodology:	**100% Review**

State Data	**[Year 1]**	**[Year 2]**	**[Year 3]** **7/1/2016 through 8/31/2016**
Sample Universe (entire population from which your sample is drawn):	1432	1310	1046
Numerator (# compliant):	1432	1310	1046
Sample Size (denominator):	1432	1310	1046
% Compliant (pre-remediation):	100	100	100

Performance Measure:	**Number and percent of nonlicensed/ noncertified provider agencies who meet waiver provider qualifications**
Numerator:	**# nonlicensed/noncertified provider agencies who meet waiver provider qualifications**
Denominator:	**total # nonlicensed/noncertified provider agencies**
Description of Data Source:	**Xerox**
Entity Responsible for Data Collection:	**Xerox (provider enrollment contractor)**
Frequency of Data Collection:	**Continuous and Ongoing**
Entity Responsible for Data Aggregation:	**State Medicaid Agency**
Frequency of Data Aggregation:	**Quarterly**
Sampling Methodology:	**100% Review**

State Data	**[Year 1]**	**[Year 2]**	**[Year 3]**
Sample Universe (entire population from which your sample is drawn):	803	863	905
Numerator (# compliant):	803	863	905
Sample Size (denominator):	803	863	905
% Compliant (pre-remediation):	100%	100%	100%

Performance Measure:	**Number & percent of nonlicensed/ noncertified provider agency DSPs who have criminal background checks as specified in policy/regulation with satisfactory results.**
Numerator:	**# of nonlic./noncertif provider agency DSPs who have criminal background checks as specified in policy/regulation with satisfactory results**
Denominator:	**total # nonlic./noncertif. provider agency DSP records reviewed**
Description of Data Source:	**On-site and off-site Quality Management Reviews**
Entity Responsible for Data Collection:	**State Medicaid Agency**
Frequency of Data Collection:	**Continuously and Ongoing**
Entity Responsible for Data Aggregation:	**State Medicaid Agency**
Frequency of Data Aggregation:	**Quarterly**
Sampling Methodology:	**Representative Sample, Confidence Interval = 95%**

State Data	[Year 1]	[Year 2]	[Year 3]
Sample Universe (entire population from which your sample is drawn):	1432	1310	1046
Numerator (# compliant):	1432	1310	1046
Sample Size (denominator):	1432	1310	1046
% Compliant (pre-remediation):	100	100	100

State Analysis
Services facilitators who support individuals in managing their consumer directed services are the only enrolled non-licensed/non-certified provider group specific to this waiver. DMAS ensures that services facilitation providers upon enrollment meet the required standards. There are no non-licensed provider agencies employing direct support staff. The data in the table above reflects the number and percent of consumer directed employees who had criminal background checks as specified in policy/regulation with satisfactory results; the sampling methodology is 100% review. The measures will be updated in the upcoming waiver renewal to accurately reflect the population being reviewed.
Remediation
[Non required]
Quality Improvement Activities

NA

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

Performance Measure: 7	Number and percent of provider agencies meeting provider training requirements.
Numerator:	**# provider agencies meeting provider training requirements**
Denominator:	**total # of provider agencies reviewed**
Description of Data Source:	**Office of Licensing reviews, On-site and off-site Quality Management Reviews**
Entity Responsible for Data Collection:	**Operating Agency /State Medicaid Agency**
Frequency of Data Collection:	**Continuous and Ongoing**
Entity Responsible for Data Aggregation:	**Operating Agency /State Medicaid Agency**
Frequency of Data Aggregation:	**Quarterly**
Sampling Methodology:	**100% Review**

State Data	[Year 1]	[Year 2]	[Year 3]
Sample Universe (entire population from which your sample is drawn):			
Numerator (# compliant):	438	256	224
Sample Size (denominator):	497	288	251
% Compliant (pre-remediation):	88	88	89

State Analysis
The data reported demonstrates the number of provider staff meeting training requirements based on QMRs.
Remediation

The state remediated each instance of non-compliance individually. The following is a breakdown of the number of Corrective action plans requested from providers per waiver year addressing staff training requirements.
FY 15-14 CAPS
FY 16-8 CAPS
FY 17-15 CAPS

Quality Improvement Activities

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

Background

Individuals in the ID/CL Waiver participate in a person-centered planning process for the development of their service plan, which Virginia refers to as the Individual Support Plan (ISP). The CSB support coordinator convenes the ISP meeting and facilitates completion of the plan in collaboration with the individual, their family/chosen representatives, with the 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 Supports -documents the specific services and supports the individual will receive by service provider.

ISPs are required to be developed for individuals in accordance with policies and procedures outlined in the ID Waiver regulations and provider manual. They are also required to be updated at least annually or more frequently, if needed.

The support coordinator discusses with the individual the choice between waiver services and institutional care and choice of waiver services as one of the first steps upon a determination of diagnostic and functional eligibility. This is documented on the "Documentation of individual Choice between Institutional Care or Home and Community-Based Services" form by the support coordinator. All services and supports agreed to during the meeting are incorporated into each provider's Plan for Supports. Instructions for the provision of needed supports for each activity are aimed at achieving desired outcomes, keeping the individual healthy and safe and are developed specific to the individual's preferences.

A Plan for Supports describes what needs to consider for each activity to accomplished and the frequency of needed supports. A Plan for Support also outlines 1) who is responsible, 2) how often/by when and how long, and 3) includes a schedule of services.

Implementation of the Plan for Supports is monitored by the support coordinator who receives required quarterly reviews from each provider on the status of each outcome, changes in support needs and preferences and any changes needed to the plan as desired by the individual. The support coordinator confirms the status of the individual's health and welfare and assesses the individual's satisfaction with services. The support coordinator is also required to have a face-to-face contact with the individual at least every 90 days.

Whenever an individual's support needs change, the provider works with the individual to revise the plan for supports. The support coordinator must review and approval all revised plans. The support coordinator also has the responsibility for linking the individual to needed services and monitoring their receipt, regardless of funding source. This is included in the ISP.

Support coordinator supervisors conduct quality reviews of ISPs and remediates any issues found. This information is sent to DBHDS quarterly. DBHDS staff also review ISPs during provider monitoring visits to ensure that individuals are receiving services and supports as described by their ISPs. DBHDS ensures that any deficiency is documented and includes actions taken to remediate the situation.

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

Performance Measure: 1			**Number and percent of individuals who have service plans that address their assessed needs, capabilities and desired outcomes**
Numerator:			# of individuals who have service plans that address their needs, capabilities, and desired outcomes
Denominator:			Total # of individuals' records reviewed
Description of Data Source:			Supervisory Review and On-site and off-site Quality Management Reviews
Entity Responsible for Data Collection:			Operating Agency and State Medicaid Agency
Frequency of Data Collection:			Quarterly
Entity Responsible for Data Aggregation:			State Medicaid Agency and Operating Agency
Frequency of Data Aggregation:			Continuous and Ongoing
Sampling Methodology:			Representative Sample 95% Confidence Interval
State Data	**[Year 1]**	**[Year 2]**	**[Year 3]**
Sample Universe (entire population from which your sample is drawn):	10,060	10,547	11,005
Numerator (# compliant):	1324	1222	1171
Sample Size (denominator):	1896	1315	1304
% Compliant (pre-remediation):	70	93	90

Performance Measure: 2 (amendment)	Number and percent of individual records that indicate that a risk assessment was completed
Numerator:	# of records that indicate that a risk assessment was completed
Denominator:	total # of individual records reviewed
Description of Data Source:	On-site and off-site Quality Management Reviews
Entity Responsible for Data Collection:	State Medicaid Agency
Frequency of Data Collection:	Continuous and Ongoing
Entity Responsible for Data Aggregation:	State Medicaid Agency and Operating Agency
Frequency of Data Aggregation:	Quarterly
Sampling Methodology:	Representative Sample 95% Confidence Interval

State Data	**[Year 1]**	**[Year 2]**	**[Year 3] 9/1/2016 through 6/30/2017**
Sample Universe (entire population from which your sample is drawn):	10,060	10,547	11,005
Numerator (# compliant):	987	396	1171
Sample Size (denominator):	987	473	1304
% Compliant (pre-remediation):	100%	(84%)	90

Performance Measure: 2 (original)	Number and percent of plans that indicate that the supplemental questions of the VA SIS (i.e., a risk assessment) were completed
Numerator:	# of plans that indicate that the supplemental questions of the VA SIS were completed
Denominator:	Total # of plans reviewed
Description of Data Source:	On-site and off-site Quality Management Reviews
Entity Responsible for Data Collection:	State Medicaid Agency
Frequency of Data Collection:	Continuous and Ongoing
Entity Responsible for Data Aggregation:	State Medicaid Agency and Operating Agency
Frequency of Data Aggregation:	Quarterly
Sampling Methodology:	Representative Sample 95% Confidence Interval

State Data	**[Year 1]**	**[Year 2]**	**[Year 3] 7/1/2016 through 8/31/2016**
Sample Universe (entire population from which your sample is drawn):	10,060	11,005	NA
Numerator (# compliant):	765	1222	NA
Sample Size (denominator):	881	1315	NA
% Compliant (pre-remediation):	87	93	NA

Performance Measure: 3	Number and percent of individuals whose service plan includes a risk mitigation strategy when the risk assessment indicates a need
Numerator:	# of individuals whose service plan includes a risk mitigation strategy when the risk assessment indicates a need
Denominator:	total # of individuals' records reviewed whose risk assessment indicates a need for a risk mitigation strategy
Description of Data Source:	On-site and off-site Quality Management Reviews
Entity Responsible for Data Collection:	State Medicaid Agency
Frequency of Data Collection:	Continuous and Ongoing
Entity Responsible for Data Aggregation:	State Medicaid Agency and Operating Agency
Frequency of Data Aggregation:	Quarterly
Sampling Methodology:	Representative Sample 95% Confidence Interval

State Data	**[Year 1]**	**[Year 2]**	**[Year 3]**
Sample Universe (entire population from which your sample is drawn):	10,060	10,547	11,005
Numerator (# compliant):	259	1078	1103
Sample Size (denominator):	394	1210	1304
% Compliant (pre-remediation):	66	89	85

Performance Measure: 4	**Number and percent of service plans that include a back-up plan when required**
Numerator:	# of service plans that include a back-up plan when required
Denominator:	total # of service plans reviewed that require a back-up plan
Description of Data Source:	On-site and off-site Quality Management Reviews
Entity Responsible for Data Collection:	State Medicaid Agency
Frequency of Data Collection:	Continuous and Ongoing
Entity Responsible for Data Aggregation:	State Medicaid Agency and Operating Agency
Frequency of Data Aggregation:	Quarterly
Sampling Methodology:	Representative Sample 95% Confidence Interval

State Data	**[Year 1]**	**[Year 2]**	**[Year 3]**
Sample Universe (entire population from which your sample is drawn):	10,060	10,547	11,005
Numerator (# compliant):	234	84	200
Sample Size (denominator):	250	95	213
% Compliant (pre-remediation):	94	88	94

State Analysis

The state continues to work to demonstrate that service plans are adequate to meet each individual's needs. The state showed improvement in waiver year 2 and 3 from waiver year 1 where we found that 70% of service plans addressed assessed needs, capabilities, and desired outcomes. *Originally, the state developed a performance measure intended to ensure supplemental questions were completed; our intention was to make sure that risk assessments were being performed. We further clarified this performance measure through an amendment. Data reported for these measure address whether a risk assessment was performed as required. The state demonstrated improvement in the area of risk assessment from year 1 to year 2 as a result of remediation actions.* *The state experienced difficulty initially in measuring effective risk mitigation strategies. As this was a new measure with the renewal of the waiver, QRT members worked to provide clarification for QMR analyst to accurately assess records. As a result, the sample size for WY1 is lower than the standard sampling methodology.*
Remediation
The state remediated each instance of non-compliance individually. The following is a breakdown of the number of Corrective action plans requested from provider per waiver year addressing non-compliance in the adequacy of service plans. *FY 15-66 CAPS* *FY 16-45 CAPS* *FY 17-59 CAPS*
Quality Improvement Activities
The state is implementing a multi-pronged strategy designed to improve the overall service plan development and delivery compliance. The strategy for systemic improvement includes the development of a regulation that will require providers who are out of compliance with specific service planning elements to participate in a mandatory training to reinforce technical assistance being provided by QMR analysts. An updated provider manual is being developed to provide additional information and examples that address the key areas of non-compliance. Online training resources and guidance and a mechanism for providers to request additional training is also under development.

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

Sub-assurance D-ii

Performance Measure: 8	Number and percent of service plans reviewed and revised by the case manager by the individual's annual review date
Numerator:	# service plans reviewed and revised by the case manager by the individual's annual review date
Denominator:	total # service plans reviewed
Description of Data Source:	Supervisory Review / On-site and off-site Quality Management Reviews
Entity Responsible for Data Collection:	CSB Support Coordination supervisor or quality assurance staff / State Medicaid Agency
Frequency of Data Collection:	Quarterly / Continuous and Ongoing
Entity Responsible for Data Aggregation:	State Medicaid Agency and Operating Agency
Frequency of Data Aggregation:	Quarterly
Sampling Methodology:	Representative Sample 95% Confidence Interval

State Data	**[Year 1]**	**[Year 2]**	**[Year 3]**
Sample Universe (entire population from which your sample is drawn):	10,060	10,547	11,005
Numerator (# compliant):	1760	1208	402
Sample Size (denominator):	1896	1209	402
% Compliant (pre-remediati@02885701on):	94	99.9	100

Performance Measure: 9	Number and percent of individuals whose service plan was revised by the case manager, as needed, to address changing needs
Numerator:	# individuals whose service plan was revised by the case manager, as needed, to address changing needs
Denominator:	total # individual service plans reviewed that needed to be revised due to changing needs.
Description of Data Source:	Supervisory Review / On-site and off-site Quality Management Reviews
Entity Responsible for Data Collection:	CSB Support Coordination supervisor or quality assurance staff / State Medicaid Agency
Frequency of Data Collection:	Quarterly / Continuous and Ongoing
Entity Responsible for Data Aggregation:	State Medicaid Agency and Operating Agency
Frequency of Data Aggregation:	Quarterly
Sampling Methodology:	Representative Sample 95% Confidence Interval

State Data	**[Year 1]**	**[Year 2]**	**[Year 3]**
Sample Universe (entire population from which your sample is drawn):	10,060	10,547	11,005
Numerator (# compliant):	679	581	401
Sample Size (denominator):	681	582	407
% Compliant (pre-remediation):	99.7	99.6	98.5

State Analysis
The state demonstrates compliance with ensuring service plans are updated annually and as needed based on changing needs.
Remediation
No remediation required
Quality Improvement Activities
[NA

Sub-Assurance D-iii: 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-iii

Performance Measure: 10 (original)	**Number and percent of individuals and families reporting that their plan meets their needs**
Numerator:	# individuals and families reporting that their plan meets their needs
Denominator:	total # individual and family respondents
Description of Data Source:	National Core Indicators survey
Entity Responsible for Data Collection:	Operating Agency
Frequency of Data Collection:	Continuous and Ongoing
Entity Responsible for Data Aggregation:	State Medicaid Agency and Operating Agency
Frequency of Data Aggregation:	Quarterly
Sampling Methodology:	Representative Sample 95% Confidence Interval

State Data	**[Year 1]**	**[Year 2]**	**[Year 3] 7/1/2016 through 8/31/2016**
Sample Universe (entire population from which your sample is drawn):	10,060	10,547	REMOVED (amendment)
Numerator (# compliant):	143	68	[#Compliant]
Sample Size (denominator):	155	75	[Size]
% Compliant (pre-remediation):	92	91	[%Compliant]

Performance Measure: 10 (amendment)/11 original	Number and percent of individuals who received Waiver services as delineated in the Individual Support Plan
Numerator:	# of individuals who received Waiver services as delineated in the Individual Support Plan
Denominator:	total # of records reviewed
Description of Data Source:	On-site and off-site Quality Management Reviews
Entity Responsible for Data Collection:	State Medicaid Agency
Frequency of Data Collection:	Continuous and Ongoing
Entity Responsible for Data Aggregation:	State Medicaid Agency and Operating Agency
Frequency of Data Aggregation:	Quarterly
Sampling Methodology:	Representative Sample 95% Confidence Interval

State Data	**[Year 1]**	**[Year 2]**	**[Year 3]**
Sample Universe (entire population from which your sample is drawn):	10,060	10,547	11,005
Numerator (# compliant):	1485	1243	364
Sample Size (denominator):	1896	1341	385
% Compliant (pre-remediation):	78	93	95

State Analysis
The state intended to utilize NCI data to assess participant satisfaction however due to the poor correlation between the data and the performance measure, the state was unable to use the performance measure as written. The state was able to capture participant satisfaction in accordance with the measure through QMR. *Improvements can be noted in from WY1 through WY 3 in ensuring that individuals receive services in accordance with their plan.*
Remediation
Each instance of non-compliance was individually remediated through the QMR process.. *WY1- 43 CAPS* *WY2- 32 CAPS* *WY3 – 36 CAPS*

Quality Improvement Activities
The state is implementing a multi-pronged strategy designed to improve the overall service plan development and delivery compliance. The strategy for systemic improvement includes the development of a regulation that will require providers who are out of compliance with specific service planning elements to participate in a mandatory training to reinforce technical assistance being provided by QMR analysts. An updated provider manual is being developed to provide additional information and examples that address the key areas of non-compliance. Online training resources and guidance and a mechanism for providers to request additional training is also under development.

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

Sub-assurance D-iv

Performance Measure: 12	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:	# of case management records that contain documentation of choice among waiver services
Denominator:	total # of records reviewed
Description of Data Source:	On-site and off-site Quality Management Reviews
Entity Responsible for Data Collection:	State Medicaid Agency
Frequency of Data Collection:	Continuous and Ongoing
Entity Responsible for Data Aggregation:	State Medicaid Agency and Operating Agency
Frequency of Data Aggregation:	Quarterly
Sampling Methodology:	Representative Sample 95% Confidence Interval

State Data	**[Year 1]**	**[Year 2]**	**[Year 3]**
Sample Universe (entire population from which your sample is drawn):	10,060	10,547	11,005
Numerator (# compliant):	673	663	400
Sample Size (denominator):	673	663	402
% Compliant (pre-remediation):	100	100	99.5

Performance Measure: 13	Number and percent of individuals whose case management records documented that choice of waiver providers was provided to and discussed with the individual
Numerator:	# of case management records that contain documentation that choice of the waiver providers was offered to the individual
Denominator:	total # of records reviewed
Description of Data Source:	On-site and off-site Quality Management Reviews / Supervisory Reviews
Entity Responsible for Data Collection:	State Medicaid Agency / CSB Service Coordination Supervisors or Quality Assurance staff
Frequency of Data Collection:	Continuous and Ongoing / Quarterly
Entity Responsible for Data Aggregation:	State Medicaid Agency and Operating Agency
Frequency of Data Aggregation:	Quarterly
Sampling Methodology:	Representative Sample 95% Confidence Interval

State Data	**[Year 1]**	**[Year 2]**	**[Year 3]**
Sample Universe (entire population from which your sample is drawn):	10,060	10,547	11,005
Numerator (# compliant):	673	663	400
Sample Size (denominator):	673	663	402
% Compliant (pre-remediation):	100	100	99.7

State Analysis
The data indicates that the state consistently provides individuals choice of services and providers.
Remediation
None required
Quality Improvement Activities
[NA

G. Health and Welfare

The state must demonstrate it has designed and implemented an effective system for assuring waiver participant health and welfare. 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 Services Licensing Department, 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. DMAS staff also play a role in monitoring the health and safety of the individual and all QMR staff must complete a standardized annual training on identifying and reporting adult or child abuse and neglect. QMR staff monitor health and welfare through record reviews and home visits with individuals receiving waiver services. QMR staff identify instances of abuse, neglect and exploitation and individual risk management and ensures the appropriate course of action has been taken. DBHDS uses 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, 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. As a result on ongoing work from both DMAS and DBHDS to remedy data collection challenges, the state will be submitting amendments to revise performance measures and data sources to report on health and welfare performance measures. A corrective action plan is included for

the sub-assurances below.

Sub-Assurance G-i: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect and exploitation and unexplained death.

Sub-assurance G-i

Performance Measure: 1	Number and percent of abuse, neglect and exploitation substantiated cases for which corrective actions were verified by the human rights advocate as being completed
Numerator:	# of abuse, neglect and exploitation substantiated cases forwhich corrective actions were verified asbeing completed
Denominator:	total # of alleged cases
Description of Data Source:	CHRIS
Entity Responsible for Data Collection:	Operating Agency
Frequency of Data Collection:	Continuous and Ongoing
Entity Responsible for Data Aggregation:	State Medicaid Agency and Operating Agency
Frequency of Data Aggregation:	Quarterly
Sampling Methodology:	100% Review

State Data	**[Year 1]**	**[Year 2]**	**[Year 3]**
Sample Universe (entire population from which your sample is drawn):	73	57	114
Numerator (# compliant):	73	57	114
Sample Size (denominator):	73	57	114
% Compliant (pre-remediation):	100	100	100

Performance Measure: 2	Number and percentage of unexplained / unexpected deaths in licensed programs for which there is an identification of opportunities for improvement through training/TA.
Numerator:	# of unexpected deaths in licensed programs for which there is an identification of opportunities for improvement
Denominator:	# of deaths in licensed programs
Description of Data Source:	Mortality reviews
Entity Responsible for Data Collection:	Operating Agency
Frequency of Data Collection:	Quarterly
Entity Responsible for Data Aggregation:	State Medicaid Agency and Operating Agency
Frequency of Data Aggregation:	Quarterly
Sampling Methodology:	Deaths for which families will permit autopsy

State Data	**[Year 1]**	**[Year 2]**	**[Year 3]**
Sample Universe (entire population from which your sample is drawn):	[Universe]	[Universe]	[Universe]
Numerator (# compliant):	[#Compliant]	[#Compliant]	[#Compliant]
Sample Size (denominator):	[Size]	[Size]	[Size]
% Compliant (pre-remediation):	[%Compliant]	[%Compliant]	[%Compliant]

DATA NOT AVAILABLE

State Analysis
The state was unable to obtain adequate information to report data based on Human Rights reviews. The data presented was generated from the Virginia Department of Social Services (VDSS) responsible for investigating and arranging services for individuals with founded cases of abuse, neglect, or exploitation.
Remediation
All instances of founded abuse, neglect, and exploitation were individually remediated by VDSS.
Quality Improvement Activities

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. 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 state developed the following corrective action plan to lead to compliance with the assurance. DMAS and DBHDS Office of Developmental Services in collaboration with Department of Licensing, Human Rights Division, and the state mortality committee are working to revise the performance measures and data sources. This process includes the identification of new measures and the validation of data. The state will seek CMS approval prior to the implementation of the new measures.

Sub-Assurance G-ii: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.

Sub-assurance G-ii

Performance Measure: 3	Number and percent of licensed providers with an effective emergency plan in place that meets the needs of the individuals
Numerator:	# licensed waiver providers with an emergency plan in place
Denominator:	total # licensed waiver providers reviewed
Description of Data Source:	DBHDS Office of Licensing
Entity Responsible for Data Collection:	Operating Agency
Frequency of Data Collection:	Continuous and Ongoing
Entity Responsible for Data Aggregation:	State Medicaid Agency and Operating Agency
Frequency of Data Aggregation:	Quarterly
Sampling Methodology:	100% Review

State Data	**[Year 1]**	**[Year 2]**	**[Year 3]**
Sample Universe (entire population from which your sample is drawn):	465	417	483
Numerator (# compliant):	422	357	482
Sample Size (denominator):	424	357	483
% Compliant (pre-remediation):	99.5	100	99.8

Performance Measure: 4		Number and percent of licensed providers cited for medication errors	
Numerator:		# of licensed providers cited for medication errors	
Denominator:		number of licensed waiver providers reviewed	
Description of Data Source:		DBHDS Office of Licensing	
Entity Responsible for Data Collection:		Operating Agency	
Frequency of Data Collection:		Continuous and Ongoing	
Entity Responsible for Data Aggregation:		State Medicaid Agency and Operating Agency	
Frequency of Data Aggregation:		Quarterly	
Sampling Methodology:		100% Review	
State Data	**[Year 1]**	**[Year 2]**	**[Year 3]**
Sample Universe (entire population from which your sample is drawn):	424	357	547
Numerator (# compliant):	340	275	405
ddSample Size (denominator):	424	357	547
% Compliant (pre-remediation):	80	77	74

State Analysis
DBHDS Office of Licensing conducts reviews of all licensed providers. Providers consistently have effective emergency plans in place however there was growth in non-compliance cited in the area of medication errors.
Remediation
The state individually remediated and provided technical assistance for each cited medication error.
Quality Improvement Activities
The state is reviewing ways to systemically address and prevent medication errors by working with clinical staff at DBHDS. The state is also revising ways to identify the medication error by type in order to target provider training efforts toward prevention.

Sub-Assurance G-ii – Individual Remediation: The state is required to report on individual activities in the instances of substantiated abuse, neglect and/or exploitation. The state must provide via an attachment or in the section below information about the individual instances and the remediation for each. *Note: The state should ensure that where analysis indicates a trend in*

abuse, neglect and/or exploitation, it includes a performance measurement in Sub-Assurance G-ii "The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible".

Individual Instances of Substantiated Abuse, Neglect and/or Exploitation
WY1 – 73 founded reports investigated *WY2- 57 founded reports investigated* *WY3 – 114 founded reports investigated*
Individual Remediation
DMAS receives information from the Virginia Department of Social Services related to reports of abuse, neglect, and exploitation complaints for the waiver population. VDSS workers may offer or arrange a wide variety of health, housing, social, and legal services to stop the mistreatment and prevent further mistreatment. *WY1 – 73 founded reports investigated; 41 was offered and accepted protective services supports; 30 – the need no longer exists (perpetrator no longer has access to the individual or the individual was removed from the situation); 2 individuals refused assistance* *WY2- 57 founded reports investigated; 20 were offered and accepted protective services supports; for 36 individuals, the need no longer exists; 1 individual refused assistance* *WY3 – 114 founded reports investigated; 22 were offered and accepted protective services supports; for 90 individuals, the need no longer exists; 2 individuals refused assistance*
Quality Improvement Activities
NA

Sub-Assurance G-iii: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.

Sub-assurance G-iii

Performance Measure: 5	Number and percent of licensed providers cited for abuse as a result of unauthorized use of restraints		
Numerator:	# of licensed providers cited for abuse as a result of unauthorized use of restraints		
Denominator:	total number of licensed waiver providers		
Description of Data Source:	CHRIS / On-site and off-site Quality Management Reviews		
Entity Responsible for Data Collection:	Operating Agency / State Medicaid Agency		
Frequency of Data Collection:	Continuous and Ongoing		
Entity Responsible for Data Aggregation:	State Medicaid Agency and Operating Agency		
Frequency of Data Aggregation:	Quarterly		
Sampling Methodology:	100% Review/ Representative Sample 95% Confidence Interval		
State Data	**[Year 1]**	**[Year 2]**	**[Year 3]**
Sample Universe (entire population from which your sample is drawn):	Providers of individuals in representative sample	Providers of individuals in representative sample	Providers of individuals in representative sample
Numerator (# compliant):	74	32	48
Sample Size (denominator):	76	36	49
% Compliant (pre-remediation):	97	89	98

Performance Measure: 6	Number and percent of licensed providers cited for serious injury as a result of unauthorized use of restraint
Numerator:	total # of licensed providers cited for serious injury as a result of unauthorized use of restraint
Denominator:	total # of waiver licensed providers
Description of Data Source:	CHRIS / On-site and off-site Quality Management Reviews
Entity Responsible for Data Collection:	Operating Agency / State Medicaid Agency
Frequency of Data Collection:	Continuous and Ongoing
Entity Responsible for Data Aggregation:	State Medicaid Agency and Operating Agency
Frequency of Data Aggregation:	Quarterly
Sampling Methodology:	100% Review/ Representative Sample 95% Confidence Interval

State Data	**[Year 1]**	**[Year 2]**	**[Year 3]**
Sample Universe (entire population from which your sample is drawn):	[Universe]	[Universe]	[Universe]
Numerator (# compliant):	[#Compliant]	[#Compliant]	[#Compliant]
Sample Size (denominator):	[Size]	[Size]	[Size]
% Compliant (pre-remediation):	[%Compliant]	[%Compliant]	[%Compliant]

DATA NOT AVAILABLE

State Analysis
The data presented for PM 5 represents the number of providers cited for use of restraints by DMAS QMR. The state was unable to secure a reliable data source for PM 6.
Remediation
All instances of restraint usage are individually remediated and reported to DBHDS Office of Human Rights.
Quality Improvement Activities
[State discusses whether it implemented a Quality Improvement Project (QIP) or any systemic changes as a result of its review findings and/or whether any improvements or revisions to the state's quality improvement project were required.]

Sub-Assurance G-iv: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.

Sub-assurance G-iv

Performance Measure: 7	Number and percent of individuals prescribed three or more psychotropic medications.
Numerator:	# of individuals prescribed three or more psychotropic medications
Denominator:	total # of individuals receiving waiver services
Description of Data Source:	DMAS billing data
Entity Responsible for Data Collection:	State Medicaid Agency
Frequency of Data Collection:	Quarterly
Entity Responsible for Data Aggregation:	State Medicaid Agency and Operating Agency
Frequency of Data Aggregation:	Monthly
Sampling Methodology:	100% review

State Data	**[Year 1]**	**[Year 2]**	**[Year 3]**
Sample Universe (entire population from which your sample is drawn):	[Universe]	[Universe]	[Universe]
Numerator (# compliant):	[#Compliant]	[#Compliant]	[#Compliant]
Sample Size (denominator):	[Size]	[Size]	[Size]
% Compliant (pre-remediation):	[%Compliant]	[%Compliant]	[%Compliant]

DATA NOT AVAILABLE

Performance Measure: 8	Number and percent of individuals receiving at least one PCP visit annually
Numerator:	Number of individuals receiving at least one PCP visit annually
Denominator:	total number of individuals receiving waiver services
Description of Data Source:	DMAS billing data
Entity Responsible for Data Collection:	State Medicaid Agency
Frequency of Data Collection:	Quarterly
Entity Responsible for Data Aggregation:	State Medicaid Agency and Operating Agency
Frequency of Data Aggregation:	Quarterly
Sampling Methodology:	100% review

State Data	**[Year 1]**	**[Year 2]**	**[Year 3]**
Sample Universe (entire population from which your sample is drawn):	[Universe]	[Universe]	[Universe]
Numerator (# compliant):	[#Compliant]	[#Compliant]	[#Compliant]
Sample Size (denominator):	[Size]	[Size]	[Size]
% Compliant (pre-remediation):	[%Compliant]	[%Compliant]	[%Compliant]

DATA NOT AVAILABLE

State Analysis
The state was unable to secure a reliable data source for these measures.
Remediation
[State discusses its methods for remediation/fixing individual problems, and whether methods match those described in Appendix G: QI-b-i. The state should also discuss whether it implemented any improvements or revisions to the remediation process.]
Quality Improvement Activities
These measures will be reviewed and revised to assure adequate data can be captured to address the sub-assurance. The state will seek CMS approval prior to implementing the new performance measures.

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 TA 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.

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

Performance Measure: 1	**Number and percent of adjudicated waiver claims that were submitted using the correct rate as specified in the waiver application**
Numerator:	# of adjudicated claims submitted using the correct rate
Denominator:	Total # of adjudicated claims
Description of Data Source:	Claims data
Entity Responsible for Data Collection:	PPL and Xerox
Frequency of Data Collection:	Monthly
Entity Responsible for Data Aggregation:	State Medicaid Agency
Frequency of Data Aggregation:	Quarterly
Sampling Methodology:	100% review

State Data	**[Year 1]**	**[Year 2]**	**[Year 3]**
Sample Universe (entire population from which your sample is drawn):	1,161,015	1,206,764	1,409,344
Numerator (# compliant):	1,161,015	1,206,764	1,409,344
Sample Size (denominator):	1,161,015	1,206,764	1,409,344
% Compliant (pre-remediation):	100	100	100

State Analysis
The state demonstrates 100% compliance with this measure
Remediation
NA
Quality Improvement Activities
NA

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

Performance Measure: 2	Number and percent of claims adhering to the approved rate/rate methodology in the waiver application
Numerator:	# of claims adhering to the approved rate/rate methodology
Denominator:	total # of claims
Description of Data Source:	Claims data
Entity Responsible for Data Collection:	PPL and Xerox
Frequency of Data Collection:	Monthly
Entity Responsible for Data Aggregation:	State Medicaid Agency and Operating Agency
Frequency of Data Aggregation:	Quarterly
Sampling Methodology:	100% review

State Data	**[Year 1]**	**[Year 2]**	**[Year 3]**
Sample Universe (entire population from which your sample is drawn):	1,161,015	1,206,794	1,409,344
Numerator (# compliant):	1,161,015	1,206,794	1,409,344
Sample Size (denominator):	1,161,015	1,206,794	1,409,344
% Compliant (pre-remediation):	100	100	100

State Analysis
The state demonstrates 100% compliance with this measure
Remediation
NA
Quality Improvement Activities
NA