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

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

SWIFT# 112320154096

June 23, 2016

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

Re: Final Quality Review Report – Virginia's Home & Community-Based Services Elderly or Disabled with Consumer Direction Waiver, CMS Control Number 0321

Dear Ms. Jones:

Enclosed is the Final Report of the Centers for Medicare & Medicaid Services' (CMS) quality review of Virginia's Home and Community-Based Services (HCBS) Elderly or Disabled with Consumer Direction (EDCD) Waiver, CMS control number 0321. The EDCD Waiver was designed to provide a choice of home and community based services for individuals choosing to remain in the community instead of placement in a nursing facility. The report is releasable to the public under the Freedom of Information Act. The CMS would like to thank the Commonwealth for its response to the draft report. The Commonwealth's responses to the CMS' findings and recommendations have been incorporated in the appropriate sections of the Final Report.

We would like to commend the Commonwealth for initiating actions to improve quality including revising pertinent regulations and the Provider Policy Manual for the EDCD waiver. We found the Commonwealth was compliant with four of the six HCBS assurances but does not fully demonstrate sub-assurance III-C of the Qualified Provider assurance and sub-assurance IV-A of the Health and Welfare assurance. For these assurances, the Commonwealth should implement corrective action to ensure compliance prior to waiver renewal. Recommendations for program improvement have been provided.

We would like to remind you to submit a renewal package for this waiver to CMS Central and Regional Offices at least 90 days prior to the expiration of the waiver, June 30, 2017. Your waiver renewal application should address issues identified in the final report and should incorporate the Commonwealth's commitments in response to the report.

Please note the Commonwealth must provide CMS with ninety (90) days to review the submitted waiver application. If we do not receive your renewal request ninety days prior to the waiver expiration we will contact you to discuss termination plans. Should the Commonwealth choose to abbreviate the ninety day timeline, 42 CFR 441.307 and 42 CFR 431.210 require the Commonwealth to notify recipients of service thirty (30) days before expiration of the waiver and termination of services. In this instance, we also request that you send CMS the draft beneficiary notification letter sixty (60) days prior to the expiration of the waiver.

We would like to express our appreciation to the Virginia Department of Medical Assistance Services, Division of Long Term Care staff, who assisted in this process and provided information for this review. If you have any questions, please contact Ellen Reap at (215) 861-4735.

Sincerely,

Francis T. Mccullough -S

Digitally signed by Francis T. Mccullough -S
Date: 2016.06.23 16:46:32 -04'00'

Francis McCullough
Associate Regional Administrator

Enclosure

cc: Terry Smith, Division of Long-Term Care
Nichole Martin, Division of Long-Term Care
Daphne Hicks, CMCS

U.S. Department of Health & Human Services

Centers for Medicare & Medicaid Services

Region III

FINAL REPORT

Virginia Elderly or Disabled with Consumer Direction Waiver
CMS Control # 0321

June 23, 2016

EXECUTIVE SUMMARY

The Virginia Home and Community-Based Services (HCBS) Elderly or Disabled with Consumer Direction (EDCD) Waiver, CMS Control Number 0321, was approved for the period July 1, 2012 to June 30, 2017. The EDCD Waiver was designed to provide a choice of home and community based services for individuals with a nursing facility level of care who choose to remain in the community instead of placement in a nursing facility. Based on the CMS 372 Report for the State's Fiscal Year (FY) 2013, the waiver served 30,178 unduplicated individuals at an average annual per capita cost of $16,852.

The operating state agency (OSA) is the Virginia Department of Medical Assistance Services (DMAS).

The Centers for Medicare & Medicaid Services (CMS) conducted the review of this waiver in accordance with 42 CFR 441.304 and instructions from the Procedural Guidance for Conducting Reviews of HCBS waiver programs. In response to the CMS request for specific evidence to review and determine if the State is meeting the required assurances in the approved waiver, the DMAS submitted an evidence report. Following a review of the evidence provided, CMS finds that additional information is needed and necessary rectification actions should be implemented to be in compliance prior to waiver renewal.

The report findings for each assurance are as follows:

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

The State substantially meets the assurance.

II. Service Plans are Responsive to Waiver Participant Needs

The State demonstrates the assurance but CMS recommends improvements that should be implemented prior to waiver renewal.

III. Qualified Providers Serve Waiver Participants

The State does not fully demonstrate the assurance. Subassurance III-C: "The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver" was not fully met. CMS recommends improvements and program actions that should be implemented to be in compliance prior to waiver renewal.

IV. Health and Welfare of Waiver Participants

The State does not fully demonstrate the assurance. CMS recommends improvements and necessary rectification action that should be implemented to be in compliance prior to waiver renewal.

V. State Medicaid Agency Retains Administrative Authority Over the Waiver Program

The State substantially meets this assurance. CMS recommends improvements that should be implemented prior to waiver renewal.

VI. State Provides Financial Accountability for the Waiver

The State substantially meets this assurance.

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 and Medicaid Services (CMS) has been delegated the responsibility and authority to approve State HCBS waiver programs.

The 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.

State's Waiver Name:	Elderly or Disabled with Consumer Direction Waiver
State Medicaid Agency:	Virginia Department of Medical Assistance Services (DMAS)
Operating Agency:	Virginia Department of Medical Assistance Services (DMAS)
State Waiver Contact:	Terry Smith Long Term Care Division Director Virginia Department of Medical Assistance Services (DMAS)
Target Population:	Waiver services are available to individuals who are aged, or disabled. Services are available to the aged 65 years or older and to disabled individuals regardless of age. There are no maximum age limits for any waiver participants.
Level of Care:	Nursing Facility
Number of Waiver Participants:	30,178 from the WYE 2013 CMS 372 Report
Average Annual per capita costs:	$16,852 from the WYE 2013 CMS 372 Report
Effective Dates of Waiver:	July 1, 2012 to June 30, 2017
Approved Waiver Services:	There are nine services available to eligible individuals including: personal assistance services, Consumer Directed personal assistance services, services facilitation, adult day health care, respite care, Consumer Directed respite care, personal emergency response systems (PERS) medication monitoring, transition coordination, and transition services.
CMS Contact:	Ellen Reap Virginia HCBS Waiver Coordinator (215) 861-4735

Background

The Elderly or Disabled with Consumer Direction (EDCD) Waiver began in February 1, 2005 and was renewed for the period July 1, 2012 to June 30, 2017. The EDCD Waiver was designed to provide a choice of home and community based services for individuals choosing to remain in the community instead of placement in a nursing facility.

EDCD Waiver services are available to eligible individuals who:

1. Meet the nursing facility level of care criteria, i.e., functionally dependent and require medical and nursing supervision or care;
2. Are determined to be at risk of nursing facility placement and without services are reasonably expected to enter a nursing facility; and
3. For whom community-based care services under the waiver are the critical services that enable the individual to remain at home.

The EDCD Waiver includes a variety of services that support individuals living in the community. Services available to eligible individuals include: personal care services (agency and consumer-directed), adult day health care, respite (agency and consumer-directed), personal emergency response systems (PERS), services facilitation, transition coordination, and transition services.

For a number of years, the EDCD Waiver experienced significant growth, however for the past three years the number of individuals served has been relatively static. In SFY 2013, total individuals served were 31,178; in SFY 2014, 30,003 and SFY 2015 enrollment was 31,153.

The waiver has experienced steady growth in the number of individuals choosing to utilize the consumer direction (CD) model of service delivery. In January 2013, 10,795 individuals receiving EDCD Waiver services selected the CD model for personal care or respite services; increasing to 13,242 in 2015. Virginia's annual consumer satisfaction survey of individuals using the CD model revealed that in 2013 99.1% and in 2014 99.7% were satisfied with the ability "to choose who I want as my attendant". The flexibility and individualized nature of the CD model of services and supports continues to be a valuable option for individuals and families in their choice to remain in their home and community.

Beginning July 1, 2015 DMAS implemented a mandatory electronic pre-admission screening process (ePAS) for submission and claims processing for these screenings. ePAS is considered the cornerstone for enhancements to Virginia's Pre-Admission Screening (PAS) process to reduce PAS processing time, enhance business processes and remain budget neutral. Use of ePAS enables DMAS to track and monitor requests and timeliness of screenings performed as well as generate a claim for payment to the hospital or public health office associated with the individual's PAS.

Monitoring Process

The Department of Medical Assistance Services (DMAS) is committed to meeting all of the requirements from the Centers for Medicare and Medicaid Services (CMS) including the identified quality assurances. DMAS utilizes a quality management review (QMR) process as the main component of the quality assurance plan. Through this process, waiver individual's records are reviewed based on performance measures that are aligned with the six assurances. The QMR process begins with identifying a random sample of active waiver individuals to determine the percentage of records to be reviewed. A statistically valid sample is generated using the Statistical

Analysis System® (SAS) to run a report that provides a random selection of individuals and service providers.

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

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

During the review period, DMAS has taken action to enhance the quality monitoring review process. The QMR tool has been fully automated and provides objective reviews based on quantifiable measures that are consistently applied across all reviews and reviewers. The tool provides the analyst prompts for standard actions based on the information entered during the review. The tool instructs the analyst when to remediate deficiencies with technical assistance and corrective action plans based on the pre-determined standard for each performance measure. The new tool increases inter-rater reliability and standardizes reviews.

Other DMAS divisions also contribute to the quality monitoring process for the EDCD Waiver. The Division of Operations ensures that standards for provider participation are met, and oversees provider enrollment. The Division of Program Integrity provides post payment audits and is responsible for recoupment of funds when necessary and for referring cases to the Medicaid Fraud Control Unit as appropriate.

Virginia's quality improvement process of discovery, remediation and action ensures continuing improvement. This evidence report includes data from state fiscal year (SFY) 2013 to SFY 2015.

I. 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 chronic hospital or NF.
*Authority: 42 CFR 441.301; 42 CFR 441.302; 42 CFR 441.303; SMM 4442.*5

The State substantially meets the assurance.

Background

All individuals enrolled in the EDCD Waiver must meet the nursing facility level of care (LOC). Prior to enrollment into the waiver, individuals for whom there is a reasonable indication that services may be needed in the future may request and receive an individual LOC evaluation. This initial evaluation is part of the pre-admission screening (PAS) that is conducted by community or hospital based teams. The community-based team is composed of personnel from the local jurisdiction of the Department of Social Services and the Department of Health and includes a social worker, a registered nurse (RN) and a physician. Hospital-based screenings are performed by hospital staff, which may include a nurse, discharge planner and attending physician. All pre-admission screenings include a face-to-face assessment with the individual and family or caregivers, as appropriate, to determine the individuals' needs based on functional criteria, medical and nursing needs, and the risk for placement into an institution in the absence of waiver services. This standardized assessment is documented on the Virginia Uniform Assessment Instrument (UAI), which guides the team in identifying the individual's appropriate LOC requirements based on medical needs and circumstances. The documentation of the face-to-face screening is reviewed by the physician. If services are needed, each member of the PAS team must sign the Medicaid Funded Long-Term Care Service Authorization form that identifies the LOC of the individual and deems the information valid for enrollment into the EDCD Waiver.

There are multiple mechanisms in place to ensure that prior to enrollment into the waiver that all individuals meet the appropriate LOC. After the PAS team makes the determination that the individual is appropriate to receive waiver services, the information is then entered into the ePAS electronic portal, which transmits the information to the DMAS Medicaid Management Information System (MMIS). From there, it is electronically validated to ensure that the information entered meets the required LOC. Once the individual chooses a service provider, that provider conducts a basic assessment of the individual and ensures that the individual meets the LOC required for the waiver.

In the event that the screening data entered does not pass the electronic system validation check to confirm that the waiver individual meets the criteria for the EDCD Waiver, the PAS team reviews the information inputted. In instances when the screening team determines that the information was incorrectly completed, appropriate corrections are made and the screening is resubmitted for processing. If the corrections validate that the waiver individual does indeed meet the criteria for services under the EDCD Waiver, then the individual is enrolled into the waiver. If the screening team determines that the individual does not meet the criteria for services under the waiver, no services are authorized and the individual or his or her representative is provided notification of the individual's right to appeal.

DMAS conducts annual LOC reviews to ensure all individuals enrolled in the EDCD Waiver continue to meet the appropriate LOC for waiver services. During this review, the service provider completes the Level of Care Eligibility Review Instrument (LOCERI), an assessment designed to document functional status, medical or nursing needs, and the physical health of the individual. This information is then entered into the secure LOCERI web portal. The LOCERI web portal is set up to validate that the individual continues to meet the criteria for services through the EDCD Waiver. In the event that this electronic validation check determines that the individual no longer meets the criteria for services, the individual is referred to a RN in the DMAS Division of Long-Term Care for a higher level review and re-determination. If it is determined that the waiver individual does not meet the criteria, the individual is removed from the waiver and notified of his or her right to appeal.

Sub-Assurance I-A: 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.

Performance Measure: Number and percent of all new waiver enrollees who had a level of care (LOC) indicating need for institutional (nursing facility) level of care prior to the receipt of services.
Numerator (N) = New waiver enrollees who had a LOC indicating need for institutional services.
Denominator (D) = New waiver enrollees.

Waiver Year	Numerator/ Denominator	% of Compliance	% of Noncompliance
2013	10,573/10,573	100%	0%
2014	14,999/14,999	100%	0%
2015	15,553/15,553	100%	0%

Findings/Remediation/Improvement:
100% compliance; no remediation required.

CMS Findings and Recommendation
The evidence provided demonstrates that this sub-assurance was met.

Sub-Assurance 1-B: The level of care of enrolled individuals is re-evaluated at least annually or as specified in the approved waiver.

Performance Measure: Number and percent of waiver participants who received an annual LOC evaluation of eligibility within 365 days of their initial LOC evaluation or within 365 days of their last annual LOC evaluation using the states approved forms.
N = Participants who received a LOC review within required timeframe.
D = LOC reviews completed.

Waiver Year	Numerator/ Denominator	% of Compliance	% of Noncompliance
2013	16,306/16,755	97%	3%
2014	14,859/14,859	100%	0%
2015	16,524/16,524	100%	0%

Findings/Remediation/Improvement:
In SFY 2013, 16,306 individual required a LOC review, a total 97% individuals received an annual LOC review. For SFY 2014 and 2015, 100% of waiver individuals received an annual LOC review. Of those receiving the annual LOC review, DMAS found that all of individuals participating in the EDCD Waiver met appropriate LOC criteria.

CMS Findings and Recommendations
The evidence provided demonstrates that this sub-assurance was met. However, please provide a discussion of the remediation steps taken in FY 2013 to ensure that all waiver participants received an annual LOC.

Sub-Assurance 1-C: The process and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.

Performance Measure 1: Number and percent of completed EDCD LOC forms entered into LOCERI system for standardized LOC review.
N = Number of completed EDCD LOC forms entered into LOCERI system for standardized LOC review.
D = LOC reviews completed.

Waiver Year	Numerator/ Denominator	% of Compliance	% of Noncompliance
2013	16,755/16,755	100%	0%
2014	14,859/14,859	100%	0%
2015	16,524/16,524	100%	0%

Findings/Remediation/Improvement:
100% compliance; no remediation required.

Performance Measure 2: Number and percent of LOC reviews that LOCERI indicate do not meet LOC criteria sent for higher level review (HLR).
N = Number of LOC reviews that LOCERI indicate do not meet LOC criteria sent for higher level review (HLR).
D = Total number of LOC reviews that LOCERI indicate do not meet LOC criteria.

Waiver Year	Numerator/ Denominator	% of Compliance	% of Noncompliance
2013	646/646	100%	0%
2014	401/401	100%	0%
2015	951/951	100%	0%

Findings/Remediation/Improvement:
100% compliance; no remediation required.

Performance Measure 3: Number and percent of waiver individuals who did not meet LOC criteria after HLR who were terminated from the waiver after completion of appeal process (if any).
N = Number of waiver individuals who did not meet LOC criteria after HLR who were terminated from the waiver after completion of appeal process (if any).

D = Total # of waiver individuals who did not meet LOC criteria after HLR.

Waiver Year	Numerator/ Denominator	% of Compliance	% of Noncompliance
2013	36/36	100%	0%
2014	39/39	100%	0%
2015	26/26	100%	0%

CMS Findings and Recommendation

The evidence provided demonstrates that this subassurance was met. CMS notes that the current PMs for this sub-assurance could be improved as part of the waiver renewal. As currently stated, the numerators and denominators for several of these PMs are essentially the same data. This limits the utility of the PMs as a tool for clearly identifying potential improvement areas. These three PMs could be refocused to identify program issues more clearly.

II. 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*

The State demonstrates the assurance but CMS recommends improvements that should be implemented prior to waiver renewal.

Background

A service plan is developed prior to the start of care for each individual enrolled in the EDCD Waiver. The service plan is developed by the registered nurse from the provider agency or the services facilitator when consumer directed services are chosen. The provider completes a comprehensive assessment of the waiver individual's support needs with the individual and their family/caregivers as applicable as active participants. This comprehensive assessment includes, information taken from the Uniform Assessment Instrument (UAI) that was previously completed by the Pre-Admission Screening (PAS) team, an in-depth evaluation of the individual's functional status and support needs, medical and health status, support system and other relevant social, psychological information. The assessment also explores the individual's goals and preferences. The assessment is documented on the Community-Based Care Recipient Assessment form (DMAS 99).

With the information from the comprehensive assessment, the service plan is developed and documented on the Agency or Consumer Direction Provider Plan of care form (DMAS-97A/B). The service plan identifies the service needs agreed upon with the individual and their family/caregivers as appropriate.

The service plan takes into consideration the following items:

- a summary of, or reference to, the assessment completed by the PAS Team;
- goals and measurable objectives for addressing each identified need of the individual;
- the services, supports, frequency and amount, duration and scope of services to accomplish the goals and objectives;

- target dates for accomplishment of goals and objectives;
- estimated duration of service;
- the role of other agencies or responsible parties if the plan is a shared responsibility; and
- staff responsible for coordination and integration of services, including the staff of other agencies if the plan is a shared responsibility.

Time is allocated for four main service categories:
- activities of daily living (ADLs)
- special maintenance items;
- supervision time; and
- instrumental activities of daily living (IADLs).

The service plan must be signed by the individual or their caregiver, a parent/guardian of a child when appropriate, and the RN or services facilitator. Once established, the service plan must be updated at least annually or more often when necessary to meet the needs of the waiver individual.

Sub-Assurance II-A: **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.**

Performance Measure 1: The number and percent of Waiver individuals who have a service plan in the record.
Numerator: Waiver individuals who had service plan in the record.
Denominator: Records reviewed.

Fiscal Year	Numerator/ Denominator	% of Compliance	% of Noncompliance
2013	1,631/1,806	90%	10%
2014	2,031/2,242	91%	9%
2015	1,705/1,906	89%	11%

SFY 2013Remediation:
- Technical assistance was provided during the exit interview to educate the provider of the importance of maintaining the service plan in the record.
- Corrective action plans were requested from 36 providers and approved by DMAS.

SFY 2014Remediation:
- Technical assistance was provided during the exit interview to educate the provider of the importance of maintaining the service plan in the record.
- Corrective action plans were from 57 providers and approved by DMAS.

SFY 2015Remediation:
- Technical assistance was provided during the exit interview to educate the provider of the importance of maintaining the service plan in the record.
- Corrective action plans were requested from 39 providers and approved by DMAS

Performance Measure 2: *Number and percent of waiver individuals who have service plans that are adequate and appropriate to their needs and personal goals, as indicated in the assessment.*
N = The number and percent of waiver individuals who have service plans that are adequate and

appropriate to their needs and personal goals, as indicated in the assessment.
D = Total number of service plans reviewed.

Fiscal Year	Numerator/ Denominator	% of Compliance	% of Noncompliance
2013	1,610/1,631	99%	1%
2014	2,022/2,031	99.6%	0.4%
2015	1,650/1,705	97%	3%

Findings/Remediation/Improvement:

SFY 2013Remediation:

- Technical assistance was provided during an exit interview to educate the provider of the importance of addressing all of the assessed needs of the individual and retaining the documentation in the individual's records.
- Corrective action plans were requested from nine providers and approved by DMAS.

SFY 2014Remediation:

- Technical assistance was provided during an exit interview to educate the provider of the importance of addressing all of the assessed needs of the individual and retaining the documentation in the individual's records.
- Corrective action plans were requested from four providers and approved by DMAS.

SFY 2015Remediation:

- Technical assistance was provided during an exit interview to educate the provider of the importance of addressing all of the assessed needs of the individual and retaining the documentation in the individual's records.
- Corrective action plans were requested from three providers and approved by DMAS.

CMS Findings and Recommendation

Although the State appears to substantially meet this subassurance, PM 1 reports the percentage of the Service Plans which were not present in the record and PM 2 reports the service plans present in the record which did not adequately address the participants' needs. The waiver contains only one PM for this subassurance: "Number and percent of waiver individuals who have service plans that are adequate and appropriate to their needs and personal goals, as indicated in the assessment. N: # of waiver individual's records who have service plans that are adequate and appropriate to their needs and personal goals, as indicated in the assessment D: total # of waiver individual's records reviewed." The State has collected data that looks at the individual elements of the approved PM. But by doing so has made it more difficult to assess the approved PM. By definition, a plan which is not existent could not adequately address the beneficiary's needs. Therefore, PM 2 as reported is underreporting service plan issues by approximately 10%. We request that if the data exists, that the State report the PM as it appears in the waiver rather than truncating the elements of the approved PM. Please ensure that in the future, approved performance measure are assessed and reported exactly as they appear in the waiver rather than modifying them in any way.

State Responses to Findings and Recommendations

DMAS recognizes the importance of the service plan in assuring that an individual's need are met therefore service plans are, closely monitored and reviewed for compliance. When a service plan is not found in the record, a Corrective Action Plan (CAP) is requested. Once the CAP for

this issue is received and accepted, a follow-up visit is made to the provider in order to ensure the CAP is being implemented as submitted. Analysts review the records that were missing service plans and may ask for additional records to further ensure compliance.

While the service plans that were initially missing are not included in subsequent performance measure calculations, these plans are reviewed by the analyst on follow-up. It has been a long-standing DMAS policy that no new citations are made if there are new deficiencies found in these service plans as the original CAP addressed the missing records. This policy is based on from information received from the DMAS Appeals Division. Should deficiencies be found in the service plans that are reviewed during a follow up visit, analyst provide technical assistance is provided to the provider and documented in the quality management review letter for that follow-up visit. If a provider is found to be out of compliance during the follow-up visit for the service plan not being in the record, another CAP is requested and another follow-up visit is conducted. If, at the conclusion of the second follow-up the provider is still not in compliance, they are referred to the Program Integrity Unit at DMAS.

We understand the concerns presented by CMS and work to revise the procedures for this assurance upon renewal of the waiver.

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

Performance Measure 1: *The number and percent of service plans developed in accordance with the State's regulations policies.*
N = Service plans developed in accordance with State's regulations and policies.
D = Total service plans reviewed.

Fiscal Year	Numerator/ Denominator	% of Compliance	% of Noncompliance
2013	1,527/1,631	94%	6%
2014	1,888/2,031	93%	7%
2015	1,501/1,705	88%	12%

Findings/Remediation/Improvement:
SFY 2013 Remediation:

- Technical assistance was given during an exit interview to educate the provider of the importance of developing the individual's service plan according to regulations & policies.
- Corrective action plans were requested from 24 providers and approved by DMAS.

SFY 2014 Remediation:

- Technical assistance was given during an exit interview to educate the provider of the importance of developing the individual's service plan according to policies and procedures.
- Corrective action plans were requested from 37 providers and approved by DMAS.

SFY 2015 Remediation:

- Technical assistance was provided during an exit interview to educate the provider of the importance of developing the individual's service plan according to policies and procedures.
- Corrective action plans were requested from 38 providers and approved by DMAS.

CMS Findings and Recommendation
The trend shown by this PM is that non-compliance is growing and we recommend that the QIT address this with technical assistance or training for providers. From the reported PM 1 of subassurance II-A, we know that approximately 10% of beneficiary records had missing service plans. CMS recommends that this PM be revised during renewal to also report those service plans which were missing altogether in addition to those which were not prepared in accordance with State regulations and policy. By definition, a plan which is not existent could not be in accordance with regulations and policy. The PM as written and approved is underreporting overall service plan issues by approximately 10%. We recommend that in the waiver renewal, the Denominator be changed to "all records reviewed" rather than all service plans reviewed.

State Responses to Findings and Recommendations
As part of the remediation, QMR analysts provide technical assistance on site at the time non-compliance is discovered. The remediation efforts includes individualized training on the areas in which the provider was non-compliant.

The records that did not contain the service plan were not included in the sub-assurance reported numbers, however during the follow-up visits the service plans were in the records and reviewed. While these plans were ultimately reviewed, any additional findings were not included in the overall evidence presented.

Sub-Assurance II-C: Service plans are updated/revised at least annually or when warranted by changes in waiver participant's needs.

Performance Measure 1: The number and percent of EDCD Waiver individuals with a service plan in the record that is updated/revised annually.
N = Waiver individuals whose service plan was updated/revised at least annually.
D = Total service plans reviewed.

Fiscal Year	Numerator/ Denominator	% of Compliance	% of Noncompliance
2013	1,573/1,631	96%	4%
2014	1,956/2,031	96%	4%
2015	1,604/1,705	95%	5%

Findings/Remediation/Improvement:
- Technical assistance was given during an exit interview to educate the provider of the importance of updating/revising the individual's service plan annually.
- Corrective action plans were requested from non-compliant providers and approved by DMAS. In SFY 2013, there were 22 such providers, in SFY 2014 40 providers, and in SFY 2015, 40 providers.

CMS Findings and Recommendation
While the State has demonstrated that this sub-assurance was substantially met, the current and approved PM only addresses one of two elements of the sub-assurance and does not address updates needed to the service plans when participants' needs change. The State should consider adding a second PM such as: "Number and percent of participants' plans of service that were updated when the waiver participants' needs changed" as a part of the renewal process.

State Responses to Findings and Recommendations
A new PM will be added upon renewal as recommended.

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

Performance Measure 1: Number and percent of individuals who received services of the type specified in the service plan.
N = Number of individuals who received services of the type specified in the service plan.
D = Total number of records reviewed.

Fiscal Year	Numerator/ Denominator	% of Compliance	% of Noncompliance
2013	1,527/1631	94%	6%
2014	1,861/2,031	92%	8%
2015	1,548/1,705	91%	9%

Performance Measure 2: Number and percent of individuals who received services in the scope specified in the service plan.
N = Number of individuals who received services in the scope specified in the service plan.
D = Total number of records reviewed.

Fiscal Year	Numerator/ Denominator	% of Compliance	% of Noncompliance
2013	1,533/1631*	94%	6%
2014	1,906/2,031	94%	6%
2015	1,616/1,705	95%	5%

Performance Measure 3: Number and percent of individuals who received services in the amount specified in the service plan.
N = Number of individuals who received services in the amount specified in the service plan.
D = Total number of records reviewed.

Fiscal Year	Numerator/ Denominator	% of Compliance	% of Noncompliance
2013	1,520/1631*	93%	7%
2014	1,904/2,031	94%	6%
2015	1,603/1,705	94%	6%

Performance Measure 4: Number and percent of individuals who received services for the duration specified in the service plan.
N = Number of individuals who received services for the duration specified in the service plan.
D = Total number of records reviewed.

Fiscal Year	Numerator/ Denominator	% of Compliance	% of Noncompliance
2013	1,553/1631	95%	5%
2014	1,963/2,031	97%	3%
2015	1,678/1,705	98%	2%

Performance Measure 5: Number and percent of individuals who received services in the frequency specified in the service plan.
N = Number of individuals who received services in the frequency specified in the service plan.
D = Total number of records reviewed.

Fiscal Year	Numerator/ Denominator	% of Compliance	% of Noncompliance
2013	1,347/1,631*	83%	17%
2014	1,819/2,031	90%	10%
2015	1,603/1,705	94%	6%

Findings/Remediation/Improvement:
SFY 2013: DMAS reviewed 1,631 individual's service plans and identified 104 (6%) instances in which individuals did not receive the type of service specified in the plan, 98 (6%) did not receive the scope of services in accordance to the plan, 111 (7%) did not receive the amount of services identified in the plan, 78 (5%) did not receive services for the specific duration indicated in the plan, and 284 (17%) did not receive services based on the frequency specified in the plan.
Remediation:

- Technical assistance was provided during an exit interview to educate the provider of the importance of insuring that services are delivered in the type, scope, amount, duration, and frequency as specified in the service plan.
- DMAS requested and approved corrective action plans from 42 providers.

SFY 2014: DMAS reviewed 2,031 individual's service plans and found identified 170-(8%) instances in which individuals did not receive the type of service specified in the plan, 125 (6%) did not receive the scope of service in accordance to the plan, 127 (6%) did not receive the amount of services identified in the plan, 68 (3%) did not receive services for specific duration indicated in the plan, and 212 (10%) did not receive services based on the frequency specified in the plan.
Remediation:

- Technical assistance was provided during an exit interview to educate the provider of the importance of insuring that services are delivered in the type, scope, amount, duration, and frequency as specified in the service plan.
- DMAS requested and approved corrective action plans from 63 providers.

SFY 2015: DMAS reviewed 1,705 individual's service plans and found identified 157 (9%) instances in which individuals did not receive the type of service specified in the plan, 89 (5%)

did not receive the scope of service in accordance to the plan, 102 (6%) did not receive the amount of services identified in the plan, 27 (2%) did not receive services for specific duration indicated in the plan, and 102 (6%) did not receive services based on frequency specified in the plan.

Remediation:

- Technical assistance was provided during an exit interview to educate the provider of the importance of insuring that services are delivered in the type, scope, amount, duration, and frequency as specified in the service plan.
- DMAS requested and approved corrective action plan for 46 providers.

CMS Findings and Recommendation

The State substantially meets the subassurance.

Sub-Assurance II-E: Individuals are afforded choice between waiver services and institutional care and between/among waiver services and providers.

Performance Measure 1: The number and percent of individuals whose records contain an appropriately completed and signed form that specifies choice was offered between institutional care and home and community based services.
N = Total number of records that contain documentation of choice between institutional care and waiver services.
D = Total number of records reviewed.

Fiscal Year	Numerator/ Denominator	% of Compliance	% of Noncompliance
2013	1,773/1,806	98%	2%
2014	2,143/2,198	97%	3%
2015	1,839/1,908	96%	4%

Remediation:

- Technical assistance was provided during an exit interview to educate the provider of the importance of ensuring that choice between waiver and institutional care is appropriately documented.
- Corrective action were requested from 11 providers and approved by DMAS in SFY 2013. Corrective action plans were requested from 25 providers and approved by DMAS in SFY 2014. Corrective action plans were requested from 31 providers and approved by DMAS in SFY 2015.

Performance Measure 2: The number and percent of individuals whose records contain an appropriately completed and signed form that specifies choice was offered among waiver services.
N =Total number of records that contain documentation of choice among waiver services.
D = Total number of records reviewed.

Fiscal Year	Numerator/ Denominator	% of Compliance	% of Noncompliance
2013	1,772/1,806	98%	2%
2014	2,142/2,198	97%	3%
2015	2,091/2,189	95%	5%

Remediation:

- Technical assistance was provided during an exit interview to educate the provider of the importance of ensuring that choice waiver services are appropriately documented.
- Corrective action plans were requested from six providers and approved by DMAS in 2013. In SFY 2014, corrective action plans were requested from 22 providers and approved by DMAS and in SFY 2015, from 28 providers.

Performance Measure 3: The number and percent of individuals whose records documented that choice of waiver providers was provided to the individual.
N = Number of records that contain documentation that choice of the waiver providers was offered to the individual.
D = Total number of case management records reviewed.

Fiscal Year	Numerator/ Denominator	% of Compliance	% of Noncompliance
2013	1,772/1,806	98%	2%
2014	2,142/2,198	97%	3%
2015	2,091/2,189	96%	4%

Remediation:

- Technical assistance was provided during an exit interview to educate the provider of the importance of ensuring that choice of waiver provider is documented.
- In SFY 2013, corrective action plans were requested from 12 providers and approved by DMAS. In SFY 2014, corrective action plans were requested from 20 providers and approved by DMAS and in SFY 2015, corrective action plans were requested from 26 providers and approved by DMAS.

CMS Findings and Recommendation

In PM 1 for SFY 2015, the data submitted show that a total of 1,908 records were reviewed. PMs 2 and 3 for SFY 2015 each show that a total of 2,189 records were reviewed. For all other years, the total number of records reviewed was consistent across all years. Please confirm that the data submitted for SFY 2015 for PM 1 was correct or, if that data is incorrect, please submit the corrected data.

State Responses to Findings and Recommendations

PM 2 REVISION:

Fiscal Year	Numerator/ Denominator	% of Compliance	% of Noncompliance
2013	1,772/1,806	98%	2%
2014	2,142/2,198	97%	3%
2015	*1836/1908*	*96%*	*4%*

PM 3 REVISION:

Fiscal Year	Numerator/ Denominator	% of Compliance	% of Noncompliance
2013	1,772/1,806	98%	2%
2014	2,142/2,198	97%	3%
2015	***1851/1908***	***97%***	**3%**

This has been corrected. A total of 1,908 records were reviewed in 2015. The charts have been updated for PM 2 and PM 3.

Improvement – Service Plans

The State's Quality Improvement Strategy for this waiver states: "Each performance measure has a DMAS Long-Term Care Division staff assigned to monitor it on an assigned frequency. The responsible staff members participate in quarterly Quality Improvement Team (QIT) meetings. As deficiencies are discovered, remediation is implemented as specified. If a compliance threshold of 98% is not met for a performance measure, it is brought for discussion to QIT. The team reviews trends, particularly in relation to remediation efforts. The QIT determines if system improvements are indicated and identifies strategies for implementation."

Given that the 98% threshold was not met, the Commonwealth should present an Improvement Plan for inclusion in the final QRR.

State Response

DMAS promulgated revised regulations for this waiver that included recommendations from the Quality Improvement Team. These regulations became effective February 2015. Subsequently, the EDCD waiver Provider Manual was revised to reflect changes in the waiver regulations and clarified the requirements. A training is being developed that will include detailed information on service plan development and requirements. This training is expected to be available in the fall of 2016.

III. 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*

The State does not fully demonstrate the assurance. Subassurance III-C: "The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver" was not fully met. CMS recognizes the improvements made and recommends continued improvements and program actions that should be implemented to be in compliance prior to waiver renewal.

Background

DMAS assures that all providers of EDCD Waiver services meet the needs of the individuals in the community. In doing this, DMAS makes sure that all providers that enroll with Medicaid possess the necessary skill, knowledge, competencies and qualifications prior to enrollment and the provision of services to the individuals. Providers whose services require licensure must

hold a valid license issued by the appropriate authority. Individuals who do not require licensure are assessed to assure that all requirements are met prior to participation.

During the period of the report, DMAS contracted with Xerox Corporation to conduct provider enrollment functions. The vendor's role is to verify provider qualifications and ensure that provider applicants meet all required licensure and certification standards. Only those applicants meeting all the qualifications will be given a provider agreement to sign which is required in order to enroll as a Medicaid provider.

DMAS screens providers for inclusion on the List of Excluded Individuals and Entities (LEIE). In addition, all agency providers must demonstrate the completion of criminal record checks conducted by the Virginia State Police for all direct support staff as part of the waiver regulatory requirements. Providers are also required to conduct a search of the Child Protective Services Registry (CPS) with the Virginia Department of Social Services when the individual being served is a minor.

Individuals utilizing services through the EDCD Waiver may choose to self-direct certain services (personal care, respite) by assuming the role of employer. The Fiscal/Employer agent for consumer directed services requests criminal background checks on behalf of the employer (waiver individual) for all attendants and ensures that all attendants meets basic qualifications.

Sub Assurance III-A: 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.

Performance Measure 1: The number and percent of licensed/certified waiver agency provider enrollments for which appropriate licensure/certification were obtained in accordance with law and waiver requirements prior to service provision.
N = Number new waiver agency provider enrollments with licensure/certification requirements meeting all requirements before service provision.
D = Newly enrolled providers with licensure/certification requirements.

Fiscal Year	Numerator/ Denominator	% of Compliance	% of Noncompliance
2013	444/444	100%	0%
2014	471/471	100%	0%
2015	448/448	100%	0%

Findings/Remediation/Improvement:
100% compliance; no remediation required.

Performance Measure 2: *The number and percent of licensed/certified provider agencies continuing to meet applicable licensure/certification following initial enrollment.*
N = Enrolled providers continuing to meet applicable licensure/certification requirements following initial enrollment.
D = Total number licensed/certified providers reviewed.

Fiscal Year	Numerator/ Denominator	% of Compliance	% of Noncompliance
2013	66/66	100%	0%
2014	86/86	100%	0%
2015	59/59	100%	0%

Findings/Remediation/Improvement:
100% compliance; no remediation required.

Performance Measure 3: *Number and percent of licensed/certified provider agency direct support staff who have criminal background checks as specified in policy/regulation with satisfactory results following initial enrollment.*
N = Licensed/certified provider direct support staff with documented satisfactory criminal background records.
D = Total number licensed/certified provider agency direct staff records reviewed.

Fiscal Year	Numerator/ Denominator	% of Compliance	% of Noncompliance
2013	392/437	90%	10%
2014	669/735	91%	9%
2015	493/537	92%	8%

Findings/Remediation/Improvement:
Remediation:

- Technical assistance was provided during an exit interview to educate the provider of the importance of ensuring documentation of criminal background checks with satisfactory results.
- Corrective action plans were requested from 15 providers and approved by DMAS in SFY 2013. Corrective action plans were requested from 10 providers and approved by DMAS in SFY 2014 and from 19 providers in SFY 2015.

CMS Findings and Recommendations

CMS requires additional information regarding PM 3 to determine if the sample size meets the waiver criteria for a 95% confidence level and 5% confidence interval. Please identify how many total staff providing services under the waiver were employed by licensed/certified providers in SFYs 2013 and 2015 who require criminal background checks.

State Response to Findings and Recommendations
We are unable to utilize the sampling methodology indicated as we do not capture data on the number of staff employed by licensed/certified providers. The current methodology utilized is to review ten (10) personnel records per provider when available. In some cases, such as with service facilitators who normally work independently, there is only one personnel record to review. While reviewing the waiver individual's records, the analysts create of list employees, who provided care to those individuals, and request the personnel files for those identified. The analysts ensure there are personnel files reviewed for each service reviewed at the time of the QMR visit. The sampling methodology will be updated in the waiver application upon renewal.

Sub-Assurance III-B – The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

Performance Measure 1: Number and percent of new non-licensed/non-certified individual provider enrollments, who initially met waiver provider qualifications.
N = Number new non-licensed/non-certified individual provider enrollments, who initially met waiver provider qualifications.
D = Total number new non-licensed/non-certified individual provider enrollments.

Fiscal Year	Numerator/ Denominator	% of Compliance	% of Noncompliance
2013	211/211	100%	0%
2014	131/131	100%	0%
2015	151/151	100%	0%

Findings/Remediation/Improvement:
100% compliance; no remediation required.

Performance Measure 2: *Number and percent of new non-licensed/non-certified attendants working in the consumer-directed model of service delivery who meet qualifications.*
N = New consumer-directed attendants who meet requirements.
D = Total number new consumer-directed employees.

Fiscal Year	Numerator/ Denominator	% of Compliance	% of Noncompliance
2013	7,183/7,183	100%	0%
2014	8,564/8,564	100%	0%
2015	9,402/9,402	100%	0%

Findings/Remediation/Improvement:
100% compliance; no remediation required.

Performance Measure 3: *Number and percent of new consumer-directed (CD) attendants who have a criminal background check at initial enrollment.*
N = Number of new CD employees who have criminal background check at initial enrollment.
D = Total number new CD employees enrolled.

Fiscal Year	Numerator/ Denominator	% of Compliance	% of Noncompliance
2013	7,183/7,183	100%	0%
2014	8,564/8,564	100%	0%
2015	9,402/9,402	100%	0%

Findings/Remediation/Improvement:
100% compliance; no remediation required.

Performance Measure 4: *Number and percent of consumer-directed (CD) attendants with a failed criminal background check that are barred from employment.*
N = CD attendants who have failed criminal background checks who are barred from employment.
D = Total CD attendants who have failed criminal background check.

Fiscal Year	Numerator/ Denominator	% of Compliance	% of Noncompliance
2013	438/438	100%	0%
2014	373/373	100%	0%
2015	276/276	100%	0%

Findings/Remediation/Improvement:
100% compliance; no remediation required.

CMS Findings and Recommendations

The evidence provided demonstrates that this sub-assurance was met.

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

Performance Measure 1: *Number and percent of provider agencies meeting provider staff training requirements.*
N = Number of provider agencies meeting provider staff training requirements.
D = Total number provider agencies records reviewed.

Fiscal Year	Numerator/ Denominator	% of Compliance	% of Noncompliance
2013	414/470	88%	12%
2014	731/768	95%	5%
2015	605/632	96%	4%

Findings/Remediation/Improvement:

- Technical assistance was provided during an exit interview to educate the provider of the importance of ensuring staff meet the training requirements.
- Corrective action plans were requested from 21 providers and approved by DMAS in FY 13. Corrective action plans were requested from 33 providers and approved by DMAS in FY 14. Corrective action plans were requested from 10 providers and approved by DMAS in FY 15.

Performance Measure 2: *Number and percent of consumer-directed (CD) employers trained, as required, regarding employee management and training.*
N = Number of CD employers trained as required regarding employee management and training.
D = Total CD employer training records reviewed.

Fiscal Year	Numerator/ Denominator	% of Compliance	% of Noncompliance
2013	19/25	76%	24%
2014	82/102	82%	18%
2015	134/189	71%	29%

Findings/Remediation/Improvement:

- Technical assistance was provided during an exit interview to educate the SF provider of the importance of training requirements being met when enrolling new consumer-directing employers.
- Corrective action plans were requested from 4 providers and approved by DMAS in FY 13. Corrective action plans were requested from 8 providers and approved by DMAS in FY 14. Corrective action plans were requested from 43 providers and approved by DMAS in FY 15.

CMS Findings and Recommendations
CMS finds that the sub-assurance was not met and requests that the state develop a comprehensive plan to ensure that providers of the CD services meet training requirements prior to renewal of the waiver. Although the evidence shows non-consumer directed providers did not meet the training requirements, further analysis of the detailed data showed that there has been consistent improvement in this area. However, there has been no such improvement among the consumer directed (CD) employers in meeting training requirements. CMS requires additional information as to why so few employers were reviewed in State FY 13 and evidence that the number reviewed meet the waivers statistical sampling requirements. CMS also recommends that the State monitor the providers cited for the staff training omissions to ensure that the organizations have implemented effective processes to ensure that these lapse in staff training does not reoccur.

State Response to Findings and Recommendations
This PM was initiated at the time of waiver renewal (FY13). Initially, it was unclear to analyst on how to clearly measure this PM during record reviews. This difficulty was addressed during QIT meetings and a process was established. Because of this, the records reviewed for FY13 were lower than expected.

All SF providers found non-compliant with this PM were asked to develop CAPs. Upon follow-up analyst ensured that the CAP had been implemented and missing documentation was present.

This PM measures the documentation present in an individual's record to determine if the employer (the individual receiving services or another person designated by the individual) received the initial comprehensive training for consumer directed services. These employers are not direct service providers and the training addresses duties related to employee management. Upon waiver renewal, DMAS will develop a more appropriate PM that more adequately addresses provider training.

Improvement – Qualified Providers
DMAS developed a comprehensive web-based training for services facilitator (SF) providers in an effort to enhance the quality of services received by waiver individuals choosing to consumer-direct services. This modular training developed in partnership with the Virginia Commonwealth

University's Partnership for People with Disabilities outlines the waiver provider requirements based on state regulations and policies.

The State's Quality Improvement Strategy for this waiver states: "Each performance measure has a DMAS Long-Term Care Division staff assigned to monitor it on an assigned frequency. The responsible staff members participate in quarterly Quality Improvement Team (QIT) meetings. As deficiencies are discovered, remediation is implemented as specified. If a compliance threshold of 98% is not met for a performance measure, it is brought for discussion to QIT. The team reviews trends, particularly in relation to remediation efforts. The QIT determines if system improvements are indicated and identifies strategies for implementation."

Given that the 98% threshold was not met, the Commonwealth should present a more comprehensive Improvement Plan for inclusion in the final QRR.

State Response

The QIT recognized the deficiencies present and worked with stakeholders to enhance the quality of services. This resulted in emergency regulations being established that 1.) required training for all current and new services facilitators and 2.) enhanced qualifications for new services facilitators that specified educational requirements and experience requirements. All services facilitators are required to complete the modular based training and demonstrate competency by scoring a minimum of 80% on each of the modules. These regulations became effective January 11, 2016.

In addition to the changes noted above, the Employer of Record Manual was revised in 2015 to streamline and clarify information provided to the employers by the services facilitators. This change also included separating required DMAS forms from the Employer of Record Manual and placing them on the DMAS portal with all other required forms; this includes forms that document required initial training for employers. Additionally, a provider policy manual update that contained sections that were more clearly identified listing services facilitation expectations.

IV. Health and Welfare

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

The State does not fully demonstrate the assurance. CMS recommends improvements and rectification action that should be implemented to be in compliance prior to waiver renewal.

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 respectively. Both agencies have staff dedicated at the local and state levels 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. The Virginia Departments of Health, and Health Professions are other state entities responsible for the licensure of Medicaid enrolled providers of EDCD Waiver services.

There are multiple mechanisms in place to protect the health and safety of the individuals receiving EDCD Waiver services. Individuals work with an agency provider or a services facilitator (for CD services) to access services in the waiver. Registered nurses and consumer-directed services facilitators not only link individuals to resources and services, but also serve as a first level safeguard to monitor the individual's health and safety through required quarterly face to face visits. The service provider is tasked with the responsibility to assess the individual's on-going needs to ensure that the individual has the necessary supports to remain in the community safely.

DMAS staff also play a role in monitoring the health and safety of individuals receiving waiver services. All DMAS LTC staff are required to complete a standardized annual training on identifying and reporting adult or child abuse and neglect. QMR analysts conduct home visits from a random sampling of the waiver population. These visits permit the analysts to assess for safety hazards and signs of abuse, neglect and exploitation.

Sub-Assurance IV-A: On an ongoing basis the State identifies, addresses and seeks to prevent instances of abuse, neglect and exploitation.

Performance Measure 1: Number and percent of waiver individual's records with indications of abuse, neglect, or exploitation documenting appropriate actions taken.
N = Number of individual's records with indications of abuse, neglect or exploitation documenting appropriate actions taken.
D = Total number of individual's records with indications of abuse, neglect or exploitation.

Fiscal Year	Numerator/ Denominator	% of Compliance	% of Noncompliance
2013	6/6	100%	0%
2014	30/30	100%	0%
2015	20/23	87%	13%

Findings/Remediation/Improvement:
Technical assistance was provided during an exit interview to educate the provider of the importance of ensuring appropriate actions are taken when there is indication of abuse, neglect, or exploitation. The importance of documenting the actions was also discussed. Corrective action plans were requested from two providers that were subsequently received and approved by DMAS.

State Response to Findings and Recommendations
In the original report, there were three separate instances of non-compliance reported in 2015. At the request of CMS, DMAS further examined each instance in order to provide additional information related to the non-compliance. DMAS found that one instance was a duplicated count of the same incident. This happened because the analyst reviewing the individual record for both personal care and respite services cited the incident for each service reviewed. Because of this finding, we have adjusted the compliance in the chart above. This instance involved documentation found in the record of unsafe (unhygienic) living conditions, however; there was no evidence present in the documentation that a report was made to Adult Protective Services

(APS). The provider verbally stated that a report was made to APS. At the time of review, there was no current evidence of unsafe living conditions in the home; the analyst informed the Agency RN of the finding and requested a corrective action plan from the provider.

The second instance involved suspected financial exploitation by the provider. DMAS staff reported this to APS appropriately. The provider agreement was ended by DMAS as a result of the finding and the individual was supported by DMAS staff in choosing a new provider for services.

PM 1 REVISION:

Fiscal Year	Numerator/ Denominator	% of Compliance	% of Noncompliance
2013	6/6	100%	0%
2014	30/30	100%	0%
2015	***21/23***	***91%***	***9%***

Performance Measure 2: Number and percent of waiver individual's records with indications of safety concerns document appropriate actions taken.
N: Number of individual's records with indications of safety concerns documenting appropriate actions taken.
D: Total number of individual's records with indications of safety concerns.

Fiscal Year	Numerator/ Denominator	% of Compliance	% of Noncompliance
2013			
2014			
2015			

No evidentiary data was presented.

State Response to Findings and Recommendations
Data is presented below.
PM 2 REVISION:

Fiscal Year	Numerator/ Denominator	% of Compliance	% of Noncompliance
2013	***1/1***	***100%***	***0%***
2014	***2/2***	***100%***	***0%***
2015	***6/10***	***60%***	***40%***

Technical assistance was provided during an exit interview to educate the provider of the importance of ensuring appropriate actions are taken when there are indications of safety concerns or risk in the physical environment. The importance of documenting the actions was also discussed. Corrective action plans were requested from two providers that were subsequently received and approved by DMAS.

Performance Measure 3: Number and percent of waiver individual's records with indications of safety concerns or risk in the physical environment documenting appropriate actions taken.
N = Number of individual's records with indications of risk in the physical environment documenting appropriate actions taken.
D = Total of individual's records with indications of risk in the physical environment.

Fiscal Year	Numerator/ Denominator	% of Compliance	% of Noncompliance
2013	1/1	100%	0%
2014	2/2	100%	0%
2015	6/10	60%	40%

Findings/Remediation/Improvement:
Technical assistance was provided during an exit interview to educate the provider of the importance of ensuring appropriate actions are taken when there are indications of safety concerns or risk in the physical environment. The importance of documenting the actions was also discussed. Corrective action plans were requested from two providers that were subsequently received and approved by DMAS.

State's Revision to PM3
PM 3 REVISION:

Fiscal Year	Numerator/ Denominator	% of Compliance	% of Noncompliance
2013	*0/0*	*100%*	*0%*
2014	*0/0*	*100%*	*0%*
2015	*0/0*	*100%*	*0%*

Findings/Remediation/Improvement: None Required

CMS Findings and Recommendation
Performance measure 1 was not fully met in 2015. The Commonwealth should consider training or targeted assistance for providers under the waiver. For performance measure 2, no data was presented. The state should ensure that data is collected and reported for each performance measure. Performance measure 3 was not met in FY 2015. The Commonwealth should consider training or targeted assistance for providers under the waiver. Additionally, the State should plan on adding performance measures for each of the subassurances in the Health and Welfare area at the time of waiver renewal.

State's Response to Findings and Recommendations
Data for PM 2 and PM3 were combined in the original report. As a result of the CMS Findings, this data has been separated and reported as requested in the tables above. All previously reported instances were issues of safety concerns in the environment and have been reported as such. DMAS will add additional performance measures for each sub-assurance in the Health and Welfare area at the time of waiver renewal.

Revised CMS Findings and Recommendations
In the revised submittal, the data indicate that PM2 was not met and PM3 was met. CMS recommends that the Commonwealth implement provider training and also monitor providers cited for program omissions.

Improvement – Health and Welfare
The State's Quality Improvement Strategy for this waiver states: "Each performance measure has a DMAS Long-Term Care Division staff assigned to monitor it on an assigned frequency. The responsible staff members participate in quarterly Quality Improvement Team (QIT) meetings. As deficiencies are discovered, remediation is implemented as specified. If a compliance threshold of 98% is not met for a performance measure, it is brought for discussion to QIT. The team reviews trends, particularly in relation to remediation efforts. The QIT determines if system improvements are indicated and identifies strategies for implementation."

Given that the 98% threshold was not met, the Commonwealth should present an Improvement Plan for inclusion in the final QRR.

State Response
The Quality Improvement Strategy in this area involves the development of EDCD waiver provider training that will re-iterate the mandated reporter responsibilities of each provider. The training will also include resources available from the VDSS that further enhances provider knowledge of identifying abuse, neglect, and exploitation.

Revised CMS Findings and Recommendations
CMS recommends that the Commonwealth develop and conduct EDCD waiver provider training that emphasizes the importance of prevention, monitoring, detection, and reporting of abuse, neglect or exploitation as well as training on the implementation of appropriate actions in instances of abuse, neglect or exploitation prior to waiver renewal.

V. 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.

With the revised submission, the State demonstrates that the assurance was substantially met.

Background
DMAS contracts with the following entities related to the respective roles:

1) Virginia Departments of Health and Social Services are contracted, through interagency agreements, to complete pre-admission screenings, including the dissemination of materials to potential waiver enrollees and assistance to individuals enrolling in the EDCD Waiver.
2) Keystone Peer Review Organization (KEPRO) is the DMAS services authorization (SA) contractor completing authorizations for all participants in the EDCD Waiver. Services requests are reviewed in relation to all waiver participants' plans of care to ensure that services are authorized within regulation and policy.
3) Xerox corporation, a contract agency, to perform all provider enrollment functions and for the management of the Virginia Medicaid Management Information System.

4) PCG, Public Partnerships LLC (PPL), a contract agency, provides fiscal employer/agent functions for the consumer-direction model of service delivery.

DMAS maintains administrative authority over the waiver program's contracted functions. DMAS employs contract monitors to oversee the daily administrative operations of these contracted entities and to provide periodic evaluation of the outcomes and deliverables. Contract monitors are responsible for coordinating and overseeing the day-to-day delivery of services under the contract.

DMAS contract monitors:

- ensure that services are delivered in accordance with the contract and that deliverables are in fact delivered;
- approve invoices for payment in accordance with the terms of the contract;
- complete and submit a semi-annual report to the DMAS Contract Officer;
- report any delivery failures or performance problems to the DMAS Contract Officer; and,
- ensure that contract terms and conditions are not extended, increased, or modified without proper authorization.

In addition, contract monitors receive monthly, quarterly, and annual reports submitted by the contractor in the format and timeframe specified in the contract.

DMAS contract monitors complete an evaluation of the contracted entity every six months. The six-month evaluations are submitted to the Office of Contract Management, which are maintained by the Office for five years. These evaluations are subject to yearly review by the State's Auditor of Public Accounts.

The contract monitors respond to each of the following evaluation measures in the six-month evaluation:

- Has the contractor complied with all terms and conditions of the contract/interagency agreement during the period of this evaluation?
- Have deliverables required by the contract/interagency agreement been delivered on a timely basis?
- Has the quality of services required by the contract/interagency agreement been satisfactory during the evaluation period?
- From an overall standpoint, are you satisfied with the contractor's/agency's performance?
- Where applicable, have all of the required Business Associate Agreement forms been completed and forwarded to the Office of Contract Management?

DMAS contract monitors, at each semi-annual contractor review, answer each of the questions and provide follow up information to address any concerns cited.

DMAS contract monitors at any time during the contract period may issue requests for corrective actions when a contractor does not meet contract deliverables as stated in the contract. These action plans ensure that any identified deficiencies are remediated.

The DMAS Long-Term Care Division has contract oversight responsibility for Public Partnerships LLC (PPL). This contractor has the unique responsibility of acting as the fiscal employer/agent for EDCD Waiver participants, and other waiver participants, using the consumer directed model.

On-going monitoring is conducted through review of weekly and monthly reports, which are discussed with the vendor during Operations Meetings. LTC Division staff monitor on-site at PPL on a weekly rotating schedule to observe vendor practices and make recommendations for enhancing performance. An annual Consumer Recipient Satisfaction Survey is conducted by PPL as a component of the quality management process.

Sub-assurance V-A - 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.

Performance Measure 1: Number and percent of satisfactory Interagency Agreement/Contract evaluations.
N: Total number of satisfactory Interagency Agreements/Contract evaluations;
D: Total number of Interagency Agreements/ contracts with entities performing functions related to the waiver.

Virginia Department of Social Services
Findings: Evidence was gathered for FY 14 and FY 15. The inter-agency agreement evaluations indicated that the agency consistently complied with all terms of the agreement with the exception of providing published policy and training materials to DMAS prior to release. The contract monitor 100% of the time indicated overall satisfaction with the agency's performance.

Virginia Department of Health
Findings: Evidence was gathered for FY 14 and FY 15. The inter-agency agreement evaluations indicated that the agency consistently complied with all terms of the agreement. The contract monitor 100% of the time indicated overall satisfaction with the agency's performance.

Xerox Corporation
Findings: Evidence was gathered for FY 14 and FY 15. The inter-agency agreement evaluation indicated that the agency consistently complied with all terms of the agreement for provider enrollment and claims services functions. The contract monitor 100% of the time indicated overall satisfaction with the agency's performance.

KEPRO
Findings: Evidence was gathered for FY 14 and FY 15. The contract evaluation indicated that the contractor consistently complied with all terms of the contract. The contract monitor 100% of the time indicated overall satisfaction with the agency's performance.

PCG, Public Partnerships, LLC (PPL)
Findings: Evidence was gathered for FY 14 and FY 15. The contract evaluations indicated that the contractor consistently complied with all terms of the agreement. The contract monitor 100% of the time indicated overall satisfaction with the agency's performance.

Findings/Remediation/Improvement:
No remediation was presented.

CMS Findings and Recommendations
The evidence provided by the State does not demonstrate that the assurance was met. While the evidence presented for each contracting agency states: "The contract monitor 100% of the time indicated overall satisfaction with the agency's performance" appears to indicate that the performance measure was met in 2014 and 2015, the State did not present the evidentiary data called for in the performance measure in terms of the numbers of evaluations conducted during each annual period as the performance measure specifies that these evaluations are "Continuously and Ongoing." The evidence presented also indicate that no evaluations were conducted in 2013. The State should have practices in place to ensure that data is collected for each performance measure on an ongoing basis. Additionally, no Remediation was presented addressing the lack of data for 2013 or the problems referenced for the Virginia Department of Social Services' failure in providing "published policy and training materials to DMAS prior to release." CMS requests the State to provide the specific data called for in the performance measure as well as describing the remediation provided or planned. The State should also provide an improvement plan for the Assurance prior to release of the final report.

State Response to Findings and Recommendations
Evidence for FY 2013 has been included in the table below. Remediation addressing VDSS was also added to the findings reported: "To remediate this, the agency was alerted to this fact and requested written assurances that VDSS would conform with the requirements of the inter-agency agreement. The agency was in full compliance beginning in FY 15."

PM 1 REVISION:

Fiscal Year	Numerator/ Denominator	% of Compliance	% of Noncompliance
2013	***10/10***	***100%***	***0%***
2014	***10/10***	***100%***	***0%***
2015	***10/10***	***100%***	***0%***

Improvement - Administrative Authority
No plan provided.

State Response to Findings and Recommendations
Evidence for FY 2013 has been included in the table above. Remediation addressing VDSS was also added to the findings reported above.

VI. Financial Accountability

The State must demonstrate that it has designed and implemented an adequate system for assuring 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

The State demonstrates that this assurance has been met.

Background
The Virginia Medicaid Management Information System (VaMMIS) system 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 waiver

individual is Medicaid-eligible at the time the services were rendered and the services being billed are approved services for that waiver individual. A summary of the process follows. 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 EDCD Waiver and is a Medicaid waiver individual 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 claims has a valid participation agreement with DMAS;
- Checks for valid service coding and any service limits; and,
- Verifies individual eligibility.

DMAS ensures financial integrity and accountability through multiple processes occurring across several divisions. The Fiscal and Purchases Division are responsible for the 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 VI-A*:* State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.

Performance Measure 1: Number and percent of adjudicated waiver claims that were submitted using the correct rate as specified in the waiver application.
N = Number of adjudicated waiver claims that were submitted using the correct rate.
D = Total number of adjudicated waiver claims

Fiscal Year	Numerator/ Denominator	% of Compliance	% of Noncompliance
2013	1,933,102/1,933,102	100%	0%
2014	2,353,877/2,353,877	100%	0%
2015	2,146,964/2,146,964	100%	0%

Findings/Remediation/Improvement:
100% compliance; no remediation required.

CMS Findings and Recommendations
The State demonstrates that this assurance has been met. However, CMS recommends that the State consider additional performance measures to demonstrate the assurance beyond the use of the automated VaMMIS. We particularly recommend with the renewal the addition of a performance measure related to the subassurance: “The State provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.”

State Response to Findings and Recommendations

Additional performance measures will be considered and added upon renewal as recommended by CMS.