Quality Review Team (QRT) End of Year Report SFY 2025

DMAS, Division of High Needs Support

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

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

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

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

The mission of the Virginia Medicaid agency is to improve the health and well-being of Virginians through access to high-quality health care coverage.

The Virginia Department of Medical Assistance Services (DMAS) plays an essential role in the Commonwealth's health care system by offering health care coverage to more than one in five Virginians through our Medicaid program, known as Cardinal Care. Cardinal Care covers over 2 million Virginians; the largest populations being low-income adults and children. Other groups covered include people with disabilities, older adults, and pregnant women.

A key priority of the HCBS waivers program is to provide needed services to more Virginians with developmental disabilities. Virginia's Developmental Disabilities Waiver program currently provides a variety of supports with medical care, employment, community living, behavioral interventions, and other services that support employment.

Background Continued:

States submit Waiver Assurance Evidentiary Reports to CMS on performance under each of the assurances with remediation shown for performance measures with less than 86% compliance. Ongoing demonstrated compliance is necessary to maintain federal financial participation in the waiver program. The DMAS Division of High Needs Supports and DBHDS Division of Developmental Services, collaboratively oversee waiver performance under these assurances on a quarterly basis using data derived from both DMAS and DBHDS through Quality Review (QRT) reporting. The QRT uses data from provider and CSB reviews to monitor waiver performance and demonstrate compliance to CMS through triennial evidentiary reporting. The data is used to ensure remediation occurs where it is indicated, identify trends and areas where systemic changes are needed, and identify the need to collect different data or improve its quality. CMS reviews QRT data to ensure the state has sufficient evidence to demonstrate compliance with waiver assurances.

The DBHDS Quality Management Plan links the various quality improvement mechanisms in DBHDS and DMAS within a framework that ensures accountability of quality improvement through monitoring of performance indicators. These indicators are directly tied to requirements set forth by the DOJ settlement agreement (now permanent injunction) and the CMS waiver assurances. The DBHDS Quality Improvement Committee (QIC) is the highest-level quality committee for the agency and provides overall oversight of the quality management program. All other quality committees, excluding the Quality Review Team (QRT), report to the QIC, which in turn provide cross functional, cross disability data and triage to sub-committees. The QIC ensures a process of continuous quality improvement and maintains responsibility for prioritization of needs and work areas and resource allocation to achieve intended outcomes for the agency and the Commonwealth. While not falling under direct oversight of the DBHDS QIC, the QRT committee structure and its data reporting is aligned with the overall DBHDS Quality Management Plan, with an annual summary of waiver performance made available to the public via this End of Year report and other data posted to the DBHDS website.

This report provides an overview of waiver performance for state fiscal year (SFY) 2025. The data presented represents the average across all three waivers per PM, as CMS permits states to report data in aggregate when HCBS waivers support the same population.

QRT Data Summary SFY 2025:

For FY 2025, the Commonwealth did not meet compliance (threshold of 86% of total sample) for seven performance measures. *This is a noted improvement from SFY 2024 in which the Commonwealth did not meet compliance for eight performance measures and SFY 2023 in which the Commonwealth did not meet compliance for ten performance measures.

Performance Measures not met during FY 2025:

C4: Number and percent of non-licensed/non-certified provider agencies that meet waiver provider qualifications.

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

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

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

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

G2: Number and percent of substantiated cases of abuse/neglect/exploitation for which the required correction action was verified by DBHDS as being implemented.

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

The Commonwealth attempts to include a variety of provider types in its sample per fiscal year to address compliance with the CMS performance measures. The overall data analysis for FY 2025 is consistent with information noted in previous reporting years with the bulk of non-compliance noted in areas of "Person-Centered Planning and Service Delivery [Category C]" and "Qualified Providers [Category D]."

Remediation Strategies for Non-Compliant Performance Measures:

As required by CMS, all non-compliant performance measures received some level of remediation and/or action planning during the fiscal year 2025.

First level remediation for all PM's reported below compliance includes targeted training and technical assistance in the specific area of noncompliance delivered by various DBHDS departmental units. Group training, FAQ documents, training videos, newsletters, written provider guidance and memoranda have also been developed and distributed as supplemental resources. In addition, on-demand recorded training has been utilized with the intent to secure resources to expand this capability. Systemic remediation in the form of quality improvement initiatives (QII) either informal or following the DBHDS QIC QII approval process and root cause analysis (RCA), may also be implemented.

Demonstrable improvement in provider compliance is contingent on several factors. Since the 2022 report, the following factors have remained constant:

- The degree and extent to which state staff have access to correct contact information for all providers of DD waiver services in the Commonwealth in order to deliver information, resources, and training on waiver requirements.
- The sampling methodology used to review some provider records.
- Provider accountability for demonstrating quality and related sanctions.
- Workforce sustainability.

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

Second, the sampling methodology utilized in some reviews has the potential to indirectly impact compliance reporting. Quality Management Reviews (QMRs) conducted by DMAS are the data source for multiple performance measures. Each quarter, a sample of service providers is selected and individuals receiving services from those providers are identified for inclusion in the record review. A proportionate stratified sample is used to determine the number of records to be reviewed within each waiver. The methodology for review of records ensures different providers and provider types are sampled each quarter. Smaller providers who do not participate in training or review regular state notices or large providers, which may have many records showing noncompliance in the same area, can adversely impact a PM. Additionally, small sample sizes also affect compliance. If there are not enough providers delivering an authorized service to review a particular service during the quarter or if the PM incorporates a subset of the population (when an additional condition has to be met within the total number of records under review for the record to be included), the smaller numbers cause a larger impact to the compliance percentage.

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

Continuing throughout SFY 2025 (also noted in SFY 2024 and 2024), all of the above factors remain important considerations to improve quality; however, an additional barrier that is well documented nationwide, is the workforce shortage. The workforce crisis persists throughout all industries, including the DD and Human Service profession overall. Staffing shortages not only impact the ability of providers to support individuals receiving services, but have also impacted state agencies that perform a critical role in reviewing provider functions and quality management/improvement.

In conclusion, SFY 2025 in many ways mirrors SFY 2024 to include comparable QRT recommendations. Generalized provider knowledge and information to ensure each provider is being reached and trained on the waiver regulations and documentation requirements, developing the capacity within the state for more innovative/on-demand training resources focused on individual, provider-specific remediation, modernization of QRT processes and tools for improved reporting of systemwide performance, exploring provider accountability through financial penalties and solutions for addressing workforce shortages.

Overview: Quality Review Team Charter (June 2024):

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

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

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

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

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

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

The team identifies barriers to attainment and the steps needed to address them. The QRT re-examines data in the following quarter to determine if remediation was successful or if additional action is required. If remediation and/or improvement is not recommended for a performance measure that falls below 86%, the justification for that decision will be documented in the meeting minutes.

The QRT was established in August 2007 in response to CMS's expectations that states implement a Quality Improvement Strategy for HCBS waivers. The charter shall be reviewed by DBHDS and DMAS on an annual basis or as needed.

Model for Quality Improvement:

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

- Design
- Discovery
- Remediation
- Improvement

Structure of Committee:

DBHDS:

- Director of Waiver Operations or designee
- DD Policy and Compliance Manager or designee
- Director of Provider Development and/or designee
- Director of Office of Licensing and/or designee
- Director of Office of Human Rights and/or designee
- Director of Office of Community Quality Management and/or designee
- Director, Mortality Review Committee and/or designee
- Settlement Agreement Advisor

DMAS:

- Director of DMAS Division of High Needs Supports and/or designee
- Developmental Disabilities Program Manager and/or designee
- QMR Program Administration Manager
- Sr. Policy Analyst, Division of High Needs Supports
- Office of Community Living Quality Analyst or designee

A quorum shall be defined as 50% plus one of the voting membership. The committee will, at a minimum, meet four times a year. The QRT review cycle is scheduled with two quarters' lag time to accommodate the 90-day regulatory requirement to successfully investigate and close cases reportable under the Appendix G Health and Welfare measures.

Leadership and Responsibilities:

The DMAS Office of Community Living Quality Analyst shall serve as chair and will be responsible for ensuring the committee performs its functions including development of meeting agendas and convening regular meetings. The standard operating procedures include:

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

Documentation of PM performance during the quarter, a meeting agenda, and summary of the previous meeting is prepared and distributed to committee members prior to the meeting and shall reflect the committee's review and analysis of data and any follow up activity.

The QRT shall produce an End of Year (EOY) Report for public review at the end of the previous state fiscal year within no more than 6 months of end of fiscal year. The QRT EOY report will include an analysis of findings; including quality improvements, trend longevity; and recommendations based on review of the information regarding each performance measure. Each Community Service Board will be solicited annually for feedback on the QRT EOY Report. The report shall be presented to the DBHDS Quality Improvement Committee on the findings from the data review with recommendations for system improvement.

QRT Data Provenance for Health and Safety Measures:

Performance Measures Using DMAS Quality Management Reviews:

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

The following is noted with regard to determining the sample:

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

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

2. All forty (40) of the CSBs are sampled within a three (3) year period. Individual service providers are selected for review. Service providers are not randomly chosen; instead, a non-probability sampling method is utilized. Once a non-CSB has been reviewed, that provider is filtered out of the SAS run for at least two years. Providers are selected based on the following factors:
    - Whether the individual CSB's review is due within the current three-year period.
    - Whether the service provider has been reviewed recently
    - Whether the service provider has been reviewed in the past
    - The type of service provided (if targeted reviews are being completed)
    - If there are existing concerns/complaints regarding a provider
    - If there is a history of non-compliance
    - The geographic location of the provider. Due to staffing constraints, a large provider supporting many individuals who is closer geographically may be reviewed over a smaller provider supporting fewer individuals who is farther away.
    - The number of individuals served. A provider supporting many individuals who is providing services for all three waivers, may be prioritized over a smaller provider supporting fewer individuals who may only be providing services under one waiver.

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

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

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

Step 4.	CL Waiver	FIS Waiver	BI Waiver	Total
#1 Determine #of recipients enrolled in each waiver (subgroup)	11,695	3,572	351	15,618
#2 Determine what % each waiver (subgroup) is of the whole	75%	23%	2%	100%
#3 Determine sample size using noted parameters	375 rounded up to 400			
#4 Determine the number of recipient records to be reviewed in proportion to the percentage of enrolled recipients	300 75%of 400 =300	92 23% of 400 =92	8 2% of 400 = 8	400

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

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

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

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

- Claims records are included for each selected member.
- Unduplicated records are selected from all random samples (from Step 4) and merged.

Performance Measures for Appendix G: Health and Safety:

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

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

Providers are required to report all Level II and Level III serious incidents using DBHDS' web-based reporting application, CHRIS, and by telephone or email to anyone designated by the individual to receive such notice and to the individual's authorized representative within 24 hours of discovery. Upon review, the Incident Management Unit (IMU) makes a determination as to whether further follow-up is needed. The Specialized Investigation Unit (SIU) completes all death and complaint investigations for individuals with developmental disabilities. The overall goal of the SIU is to improve processes relating to investigations, promote consistency, allow for specialized training of investigators, and to ensure the overall safety of all individuals served throughout the Commonwealth. Any incidents for which there are concerns that the individual or others are at imminent risk are referred for immediate investigation. Other concerns are forwarded to the provider's licensing specialist for follow-up.

Population:

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

Acronym Guide:

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

CHRIS Comprehensive Human Rights Information System

CMS Centers for Medicare and Medicaid Services

DBHDS Department of Behavioral Health and Developmental Services

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

DMAS Department of Medical Assistance Services

DW Data Warehouse

ISP Individual Supports Plan

KPA Key Performance Areas (DOJ Settlement Agreement)

MRC Mortality Review Committee

OHR Office of Human Rights

OL Office of Licensing

PM Performance Measure

QRT Quality Review Team

RST Regional Support Teams

QSR Quality Service Review

RST Regional Support Team

SC Support Coordinator

Data Source Index:

DMAS:

DMAS Contract Evaluations:	A1
DMAS:	A2
DMAS QMR:	B3, B4, C2, C3, C4, C5, C8, C9, D1, D2, D3, D4, D5, D6, D7, D8, D9, D10, D11, D12, D13, G4
DMAS Conduent:	C1
DMAS Fiscal Agency Reports:	C6, C7
DMAS Training Verification:	C10
DMAS NCQA:	G9, G10
DMAS Billing/Claims Data:	I1, I2, I3

DBHDS:

RSS Slot Allocation Process:	A3
Level Of Care Reporting:	B1
Data Warehouse Reporting:	B2
Office of Human Rights:	G1, G2, G8
Office of Licensing:	G5, G6
Mortality Review Committee:	G3
Quality Service Reviews:	G7

APPENDIX: STATE FISCAL YEAR 2025 (JULY 1, 2024-JUNE 30, 2025) QUALITY TEAM REPORTING

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

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

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

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

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

The aggregate total for this PM in SFY 2025 was 100%. No remediation was needed.

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

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

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

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

The aggregate total for this PM in SFY 2025 was 100%. No remediation was needed.

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

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

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

This PM seeks to demonstrate that state-facilitated Waiver Slot Assignment Committees assign slots according to statewide critical needs ranking and priority criteria. DBHDS operational processes require that all rankings for slot assignment are routinely reviewed and confirmed by DBHDS state staff as a quality check prior to enrollment. This PM typically demonstrates 100% compliance.

The aggregate total for this PM in SFY 2025 was 100%. No remediation was needed.

B. Level of Care

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

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

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

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

D: Total number of new enrollees

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

The aggregate total for SFY 2025 was 99%.

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

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

D: Total number of new enrollees

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

The aggregate total for SFY 2025 was 94%, which is above the required threshold and an improvement from the 93% noted in SFY 2024. No remediation is needed.

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

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

N: Number of VIDES determinations that followed the required process

D. Total number of VIDES forms reviewed.

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

For review of this PM, QMR reviewers require the provider to show proof that the review was conducted face to face with signatures showing all others present during the evaluation. Evidence of a face to face visit has traditionally included documentation in the Electronic Health Record or written in progress notes. If the QMR reviewer is unable to locate the documentation in their records, the provider is requested to locate it for the reviewer. If documentation is unable to be located, then the provider will receive a corrective action.

The aggregate total percentage for this PM in SFY 2025 was 100%. No remediation is required.

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

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

D: Total number of VIDES forms reviewed

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

The aggregate total for this PM in SFY 2025 was 100%. No remediation is needed.

Appendix C. Participant Services - Qualified Providers

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

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

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

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

D: Total number of waiver agency provider enrollments

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

The aggregate total for this PM in SFY 2025 is 100%. No remediation is needed.

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

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

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

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

The aggregate total percentage for all waivers for SFY 2025 is 96%. No remediation needed.

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

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

D: Total number of licensed/certified provider agencies

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

The aggregate total for this PM in SFY 2025 is 100%. No remediation is needed.

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

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

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

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

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

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

The aggregate total for this PM in SFY 2025 is 83%.

Discussion: As noted in the previous EOY [SFY 2024], it is critical to note that sample size limitations may create potential barriers where limited to no data may be available to determine compliance. SFY 2023 was deemed in compliance due to the 0 records reviewed and SFY 2024 was at 100% compliance with a sample size of 5 records. For this reporting cycle, the sample size was 12 – with 10 demonstrating compliance.

The performance measure came in at 100% for three of four reporting quarters, including Q4. The QRT members will continue to monitor and engage in active dialogue but the need for systemic remediation has not been demonstrated clearly.

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

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

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

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

The aggregate total for this PM in SFY 2025 is 95%, which is above the 86% threshold for compliance.

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

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

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

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

The aggregate total for this PM in SFY 2025 is 100%. No remediation is needed.

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

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

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

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

The aggregate total for this PM in SFY 2025 is 100%. No remediation is needed.

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

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

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

D: Total number of provider agency staff reviewed

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

The aggregate total for all waivers for SFY 2025 is 97%, a noted increase from SFY 2022 (73%) and SFY 2023 (88%) and SFY 2024 (91%). No remediation needed.

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

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

D: Total number of provider agency DSP records reviewed

This PM seeks to ensure that all provider agency DSPs completed competency training requirements and that completed documentation indicating that provider staff were observed demonstrating competencies, is present in the provider's record.

The aggregate total for all three waivers for SFY 2025 is 75%. This is a noted increase from the previous reporting period, SFY 2023 at 59% but a slight decrease from SFY 2024 at 78%.

The measure will require systemic remediation.

Discussion: As background, the QRT reviews compliance through an assessment of records using the initial hiring AND annual date for a year. Compliance with the PM is based primarily on written documentation produced during QMR reviews. Common issues identified during SFY 2025 include verification of competency forms located in agency records, competency forms not completed/updated annually, and proficiency boxes not checked appropriately.

The likely primary reason for noncompliance continues to be limited engagement of some providers in staying up to date on DD waiver requirements. This measure has been consistently low for a number of years, with the primary issues identified relating to poor recordkeeping.

In addition to provider engagement, DBHDS is addressing concerns in this area as part of the DSP Competency QII. This QII is focused on improving the percent of DSPs completing training and competencies requirements to 95% by SFY27. It uses QSR PQR and PCR results. DBHDS QSR Round 7 data in this area presents the following: DSP training/documentation at 93% and DSP observed competence at 82%.

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

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

D: Total number of services facilitators reviewed

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

The aggregate data for SFY 2025 is 83%, which is below the 86% threshold for compliance.

Discussion: The total sample size for SFY 2025 was 6 records, with 5 records demonstrating compliance. Data for three of the four quarters (including Q4) demonstrated 100% compliance. While the SFY data came in below the 86% needed for CMS compliance, this does not necessarily indicate a systemic issue. The QRT will continue to monitor this performance to determine if a trend of noncompliance is noted and if systemic remediation will be needed.

D. Service Plan

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

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

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

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

D: Total number of individuals' records reviewed

This PM seeks to ensure that service plans address all needs/desires of the individual receiving services. If the plan identifies a need, a measurable outcome should be included in the plan, to be provided through

waiver services or other means (natural supports, etc.). QMR reviewers are determining whether the individual's needs (i.e., via risk awareness tools) and desires (i.e., measurable outcomes) are addressed in the ISP. Both the identification of risks through the risk assessment and the strategy for mitigating risks must be included.

The aggregate total for SFY 2025 is 67%. This is a notable increase from SFY 2024 of 51% and SFY 2023 of 57%. This remains below the compliance threshold of 86%.

The measure will require systemic remediation.

Discussion: This PM will continue to be added as a reminder in notices to providers and included as an agenda item for the Provider Roundtable (PRT). During SFY 2025, DBHDS implemented the WaMS ISP 4.0. with a key element being the RAT TO ISP QII with DBHDS. This QII is part of the WaMS ISP 4.0 automation process.

Data assessed over the state fiscal year 2025 has been trending in a positive direction and is likely attributed to successful results from the RAT to ISP QII and WaMS ISP 4.0. Quarter 4 of this reporting cycle presented an 80% compliance rate. The QRT team will continue to monitor and assess this trend to determine if additional systemic measures are necessary to further improve compliance.

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

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

D: Total number of individual records reviewed.

This PM seeks to demonstrate that individuals receiving waiver services who have a documented risk or potential risk factor are following the instructions outlined in the DBHDS Risk Awareness Tool (RAT) to mitigate the risk, as required.

The aggregate total for SFY 2025 is 99%, which is well above the required threshold. No remediation is necessary.

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

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

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

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

The aggregate total for SFY 2025 is 67%. This is a notable increase from SFY 2024 of 49%. The PM remains below compliance. *Systemic remediation is required.*

Discussion: The QRT suspects that the primary reason for noncompliance is related to PM #D1. During SFY 2025, DBHDS implemented the WaMS ISP 4.0. with a key element being the RAT TO ISP QII with DBHDS. This QII is part of the WaMS ISP 4.0 automation process.

Data assessed over the state fiscal year 2025 has been trending in a positive direction and is likely attributed to successful results from the RAT to ISP QII and WaMS ISP 4.0. Quarter 4 of this reporting cycle presented an 82% compliance rate. The QRT team will continue to monitor and assess this trend to determine if additional systemic measures are necessary to further improve compliance.

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

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

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

The PM seeks to demonstrate that service plans for the following DD waiver services included a back-up plan as required: In-home Supports, Personal Assistance, Respite, Companion, and Shared Living. This PM is monitored through review of Services Facilitator records for CD services. CD services are available in the CL and FIS waivers only. There will be corresponding data for the BI waiver with planned initiation of QMR reviews of the Shared Living service.

The aggregate total for SFY 2025 is 91%. No remediation needed at this time.

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

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

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

D: Total number of service plans reviewed

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

The aggregate total for this PM in SFY 2025 is 100%. No remediation is needed.

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

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

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

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

The aggregate total for SFY 2025 is 98%. This is a significant increase from SFY 2024 of 81% and SFY 2023 of 71%. This performance measure is now above threshold of 86%. While no additional systemic remediation is necessary, the QRT will continue to monitor this PM closely. It is likely closely connected to improvement noted in PMs D1 and D3.

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

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

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

D: Number of service plans reviewed

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

The aggregate percentage for this PM in SFY 2025 is 89%. No remediation needed at this time.

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

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

D: Service plans reviewed

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

The aggregate total for SFY 2025 is 99%. No remediation is needed.

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

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

D: Service plans reviewed

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

The percentage for this for SFY 2025 is 99%. *No remediation is required.*

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

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

D: Service plans reviewed

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

The aggregate total for SFY 2025 is 99%. No remediation is needed.

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

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

D: Service plans reviewed

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

The aggregate total for SFY 2025 is 90%. No remediation is needed at this time.

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

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

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

D: Total number of records reviewed

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

The aggregate total for SFY 2025 is 99%. Systemic remediation is not needed.

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

N: Number of case management records that contain documentation of choice among waiver services
D: Total number of records reviewed

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

The aggregate total for SFY 2025 is 100%. Systemic Remediation is not needed.

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

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

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

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

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

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

The aggregate total for SFY 2025 is 88%, which brings the measure into compliance. The aggregate total for SFY 2024 was 80%. The QRT will continue to monitor this performance measure consistent with discussion below due to the history of noncompliance.

Discussion: The DBHDS Office of Human Rights has successfully implemented remediation plans to address this PM. The active strategies implemented to ensure trained investigators include:

- Implemented a process for advocates validating that investigators are trained at the time of report entry (within 24 hours) in CHRIS.
- increased number of ANE Investigator trainings offered from 4 in 2024 to 6 in 2025; and
- increased capacity to train upwards of 250+ participants per session; and
- developed and implemented orientation for new and newly licensed providers, offered every 4th Wednesday; and
- developed a training and tool for OHR staff on how to document verification activities; and
- added a question on Waiver Validation checklist; and
- revised the Human Rights Compliance Verification Checklist (which is the tool providers who are seeking to be licensed must complete prior to being licensed. It includes attesting to establishing a trained investigator).

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

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

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

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

The aggregate total for SFY 2025 is 84%, which is a reduction of 92% for SFY 2024. While this performance measure has fallen below threshold, it is critical to note Q4 data reflected a 93% compliance rate, which was consistent with SFY 2024's final outcome. QRT will continue to monitor this performance measure to determine if any systemic remediation is needed.

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

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

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

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

The aggregate total for SFY 2025 is 100%. No remediation is required.

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

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

D: Total number of records received

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

The aggregate total for SFY 2025 is 90%. This is an improvement from SFY 2024 of 82% - and a noted improvement from SFY 2023 of 66%. This performance measure is now in compliance with CMS requirements.

Discussion: While additional remediation is no longer necessary, the team will continue to monitor this measure to ensure ongoing compliance. Training and outreach from DBHDS, as discussed under remediation for PM G1, has likely contributed to improvement in this area as well.

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

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

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

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

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

The aggregate total for SFY 2025 is 95%. No remediation is necessary.

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

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

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

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

The aggregate total for SFY 2025 is 88%. No remediation is required.

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

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

D: Number and percent of individuals reviewed

This PM seeks to demonstrate that DBHDS verified that providers were not using unauthorized restrictive interventions (including restraints and time out) via review of the number of HSAG PCR alerts that were issued to the OHR that were NOT due to unauthorized restrictive interventions.

The aggregate total for SFY 2025 is 100%. No remediation is required.

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

N: Number of individuals who did not have unauthorized seclusion

D: Number of abuse allegations + complaints submitted via CHRIS

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

The aggregate total for SFY 2025 is 100%. No remediation is required.

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

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

D: Number of participants 20 years and older

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

The aggregate total for SFY 2025 is 95%. No remediation required.

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

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

D: Number of participants 19 and younger

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

The aggregate total for SFY 2025 is 61%, which is comparable to SFY 2024 of 63% and SFY 2023 of 65%. Remediation is required.

Discussion: This PM has been measured using aggregated data from insurance billing codes from the state Managed Care Organizations (MCOs), through which the state's medical benefits covered by Medicaid, are administered. This data is only available at the end of the state fiscal year, which makes it difficult for the QRT to assess how the PM is progressing throughout the year.

The current data is pulled from DMAS claims information – which includes individuals with alternative payors/Third Party Liability coverage. This may be adversely impacting the aggregate data being produced. DMAS is planning to complete a root cause analysis of this performance measure during SFY 2026 to develop a better understanding of barriers impacting compliance.

I. Financial Accountability - State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.

Sub-assurance a). The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.

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

N: Number of adjudicated claims reimbursed using the approved rate

D: Total number of adjudicated claims

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

The aggregate total for SFY 2025 shows 100% compliance with this measure. No remediation required.

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

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

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

D: Total number of adjudicated claims.

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

The aggregate total for SFY 2025 shows 100% compliance with this measure. No remediation required.

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

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

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

D: Total # of claims

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

methodology.

The aggregate total for SFY 2025 shows 100% compliance with this measure. No remediation required.

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