



Overview of DD Waiver Quality Assurance



Background

- The Centers for Medicare & Medicaid Services (CMS) works with states to assure and improve quality in the Medicaid Home and Community Based Services (HCBS) Waivers Program.
- Strong oversight of waiver programs is critical to:
 - Evaluate and improve the quality of services and outcomes for people who receive HCBS
 - Ensure providers are compliant in meeting requirements necessary to remain in the program
- States must operate their HCBS waiver programs in accordance with certain “assurances” demonstrating that they meet a minimum level of compliance.
- Ongoing compliance with the assurances is necessary to maintain Virginia’s DD Waivers program.

Background

All states operating §1915 Home and Community Based (HCBS) Waivers have a Quality Assurance and Improvement Plan that describes how the state will:

- Demonstrate compliance with CMS waiver assurances/sub-assurances
- Provide quality oversight, monitoring, discovery, remediation and improvement of its the waivers program.
- Develop and implement a quality improvement strategy that measures ongoing waiver performance, assuring the quality of care delivered through services.

Background

- DBHDS and DMAS have the primary responsibility for monitoring waiver assurances through Quarterly Review Team (QRT) meetings .
- The QRT uses data from provider and CSB reviews to monitor waiver performance quarterly and demonstrate compliance to CMS through annual and triennial 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 collect different data or improve its quality.
- CMS reviews QRT data to ensure the state has sufficient evidence to demonstrate compliance with waiver assurances.
- QRT data is provided to the state Quality Improvement Committee (QIC) and made available to the public on the DBHDS website.

Six 1915(c) Waiver Assurances

- **Administrative Authority** - The State Medicaid agency is involved in the oversight of the waiver and is ultimately responsible for all facets of the program.
- **Level of Care** - Persons enrolled in the waiver have needs consistent with an institutional level of care.
- **Service Plan** - Participants have a service plan that is appropriate to their need and that they receive the services/supports specified in the plan.
- **Qualified Providers** - Waiver providers are qualified to deliver services/supports.
- **Health and Welfare** - Participants' health and welfare are safeguarded and monitored.
- **Financial Accountability** - Claims for waiver services are paid according to state payment methodologies.

Compliance with Assurances

Compliance with a **PM** is **considered NOT MET** when:

- Evidence was not submitted for a PM.
- **PM is less than 86% in any waiver year AND** state has not initiated a Quality Improvement (QI) Project.
- **PM is below 86% for 3 or more years**, unless there is increasing *improvement and performance is likely to exceed 85% the following year.*
- Appropriate remediation for any PM associated with any sub-assurance (under the given assurance) did not occur.
- State did not report on individual remediation for substantiated abuse, neglect and exploitation.

Continuous Quality Improvement – (CQI)

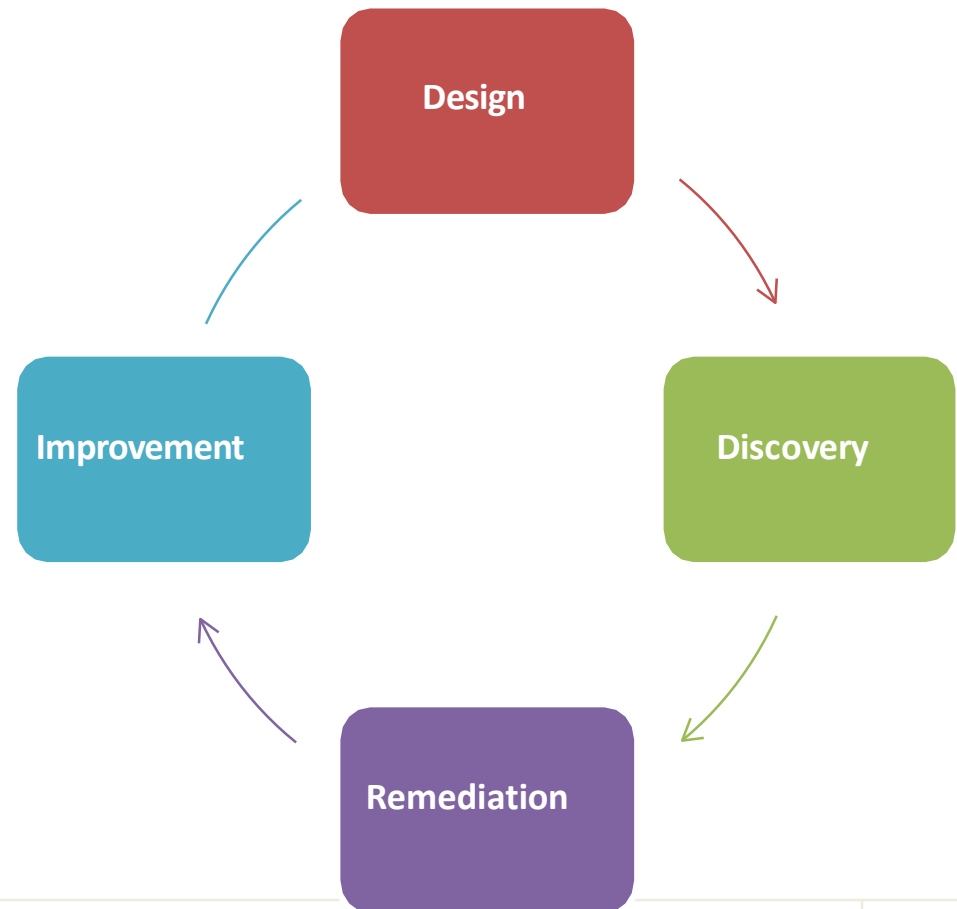
CQI is the foundation of the Home and Community-Based QI strategy. It is an ongoing, (non static) proactive process that evaluates program operations and develops ways to improve processes.

Design—Design of a quality improvement strategy

Discovery— monitoring and data collection

Remediation— plan to address deficiencies

Improvement — measurable change in quality issues system-wide



Quality Improvement Strategy: DESIGN

Each state must **design a Quality Improvement Strategy (QIS)** for each 1915(c) HCBS Waiver:

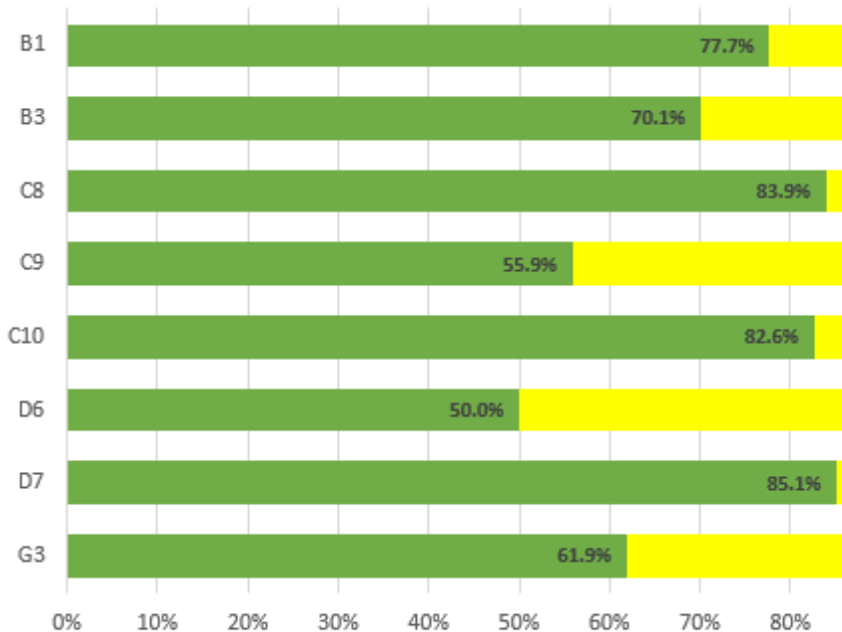
The QIS outlines how the state will meet the waiver assurances

- Describes the sampling approach used: simple, systematic, stratified, or other methodology
- Describes the roles and responsibilities of all state entities in discovery and remediation or systems improvement.
- Outlines PM within assurances that are prescribed by CMS, those specific to the state's own critical need areas, and any additional PMs monitored by the state.
- The QIS must be in place at the time of waiver application; it is expected to change as needed

FY 2019 Non Compliant PM's

FY 2019 Non-Compliant DD Waiver Performance Measures Summary

FY 2019 Non-Compliant Measures



Measure Definition:

B1 - Number and percent of all new enrollees who have a level of care evaluation prior to receiving waiver services

B3 - Number and percent of VIDES (LOC) completed within 60 days of application for those for whom there is a reasonable indication that services may be needed in the future

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

C9 - Number and percent of provider agency direct support professionals (DSP's) meeting competency training requirements

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

D6 - Number and percent of individuals whose service plan was revised, as needed, to address changing needs (Individual Support Plan was updated/revised when individual's needs changed)

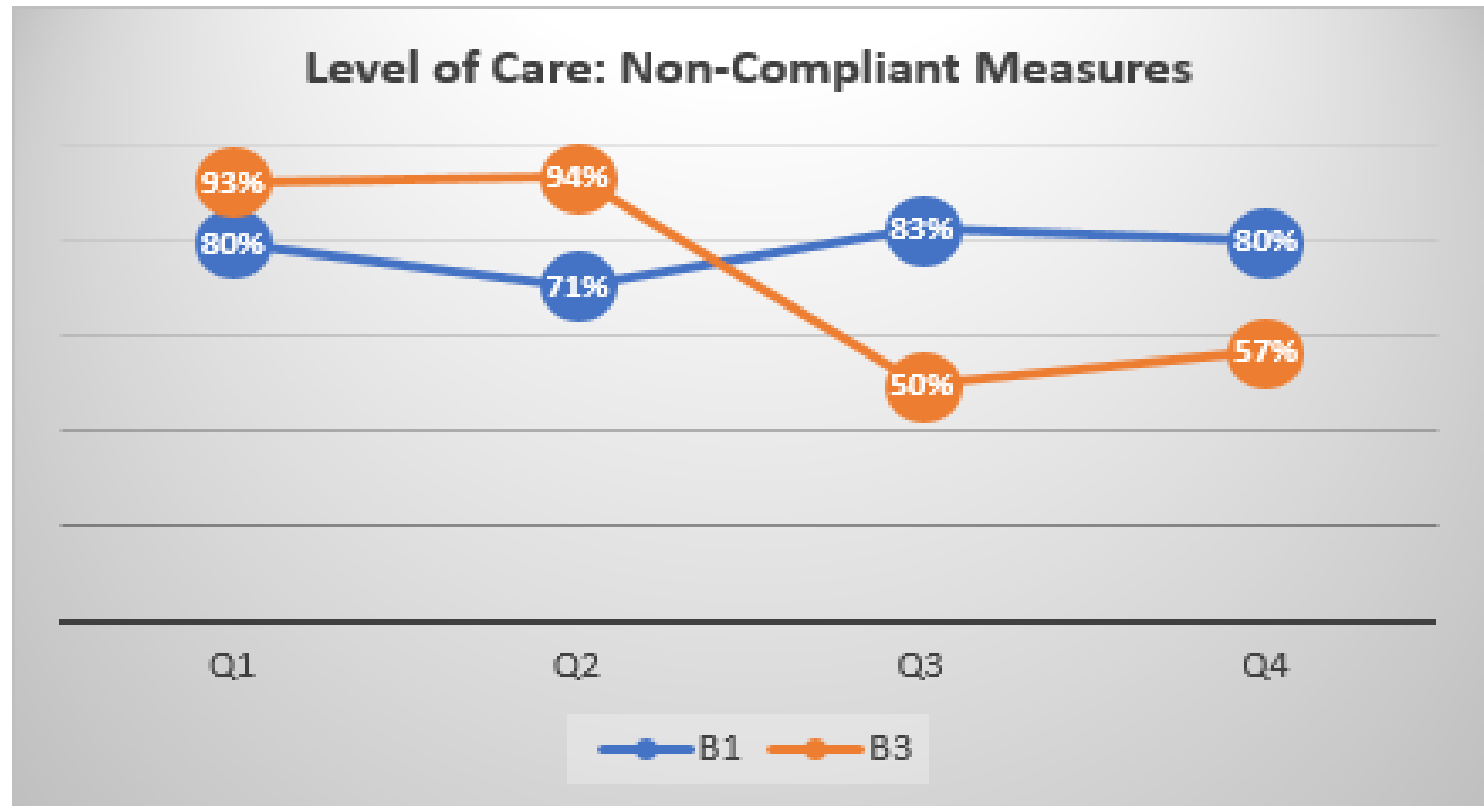
D7 - Number and percent of individuals who received services in the frequency specified in the service plan

G3 - Number and percent of unexpected deaths where the cause of the death/factor in the death, was potentially preventable and some intervention to remediate was taken

Notes:

- While measure C10 is non-compliant for the fiscal year, it is important to note that for the last two quarters of fiscal year 2019, the compliance rate was 100%.

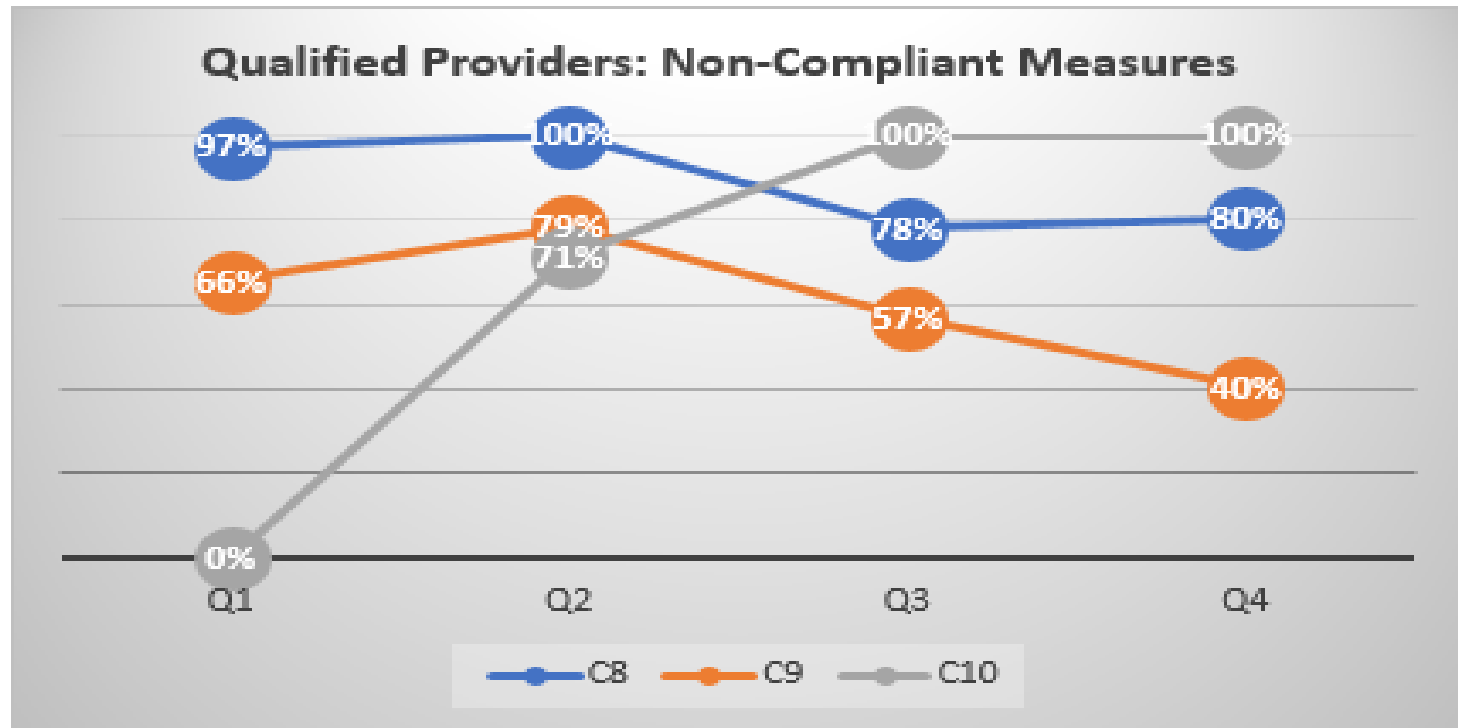
FY 2019 Non-Compliant PM's by Category



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FY 2019 Non-Compliant PM's by Category

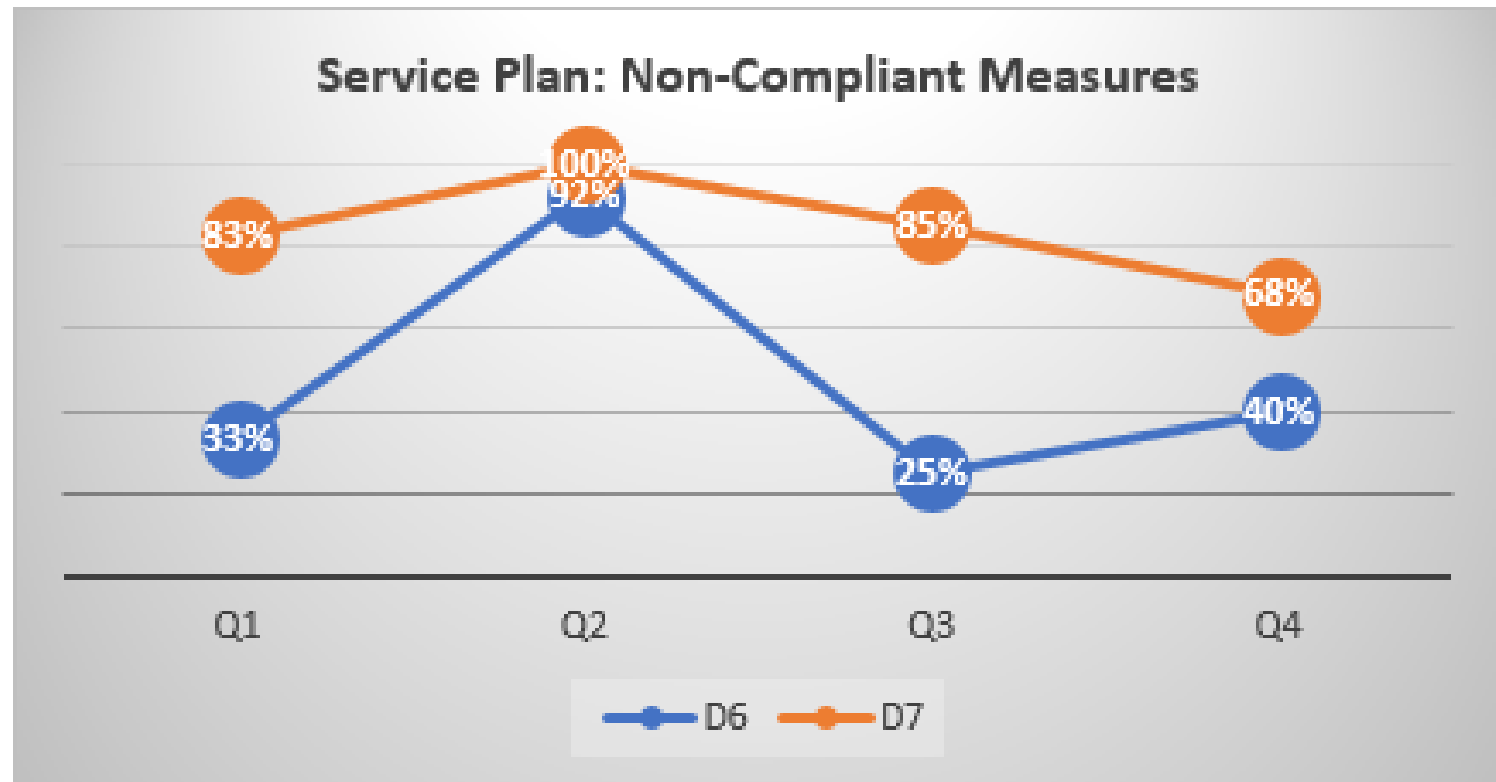


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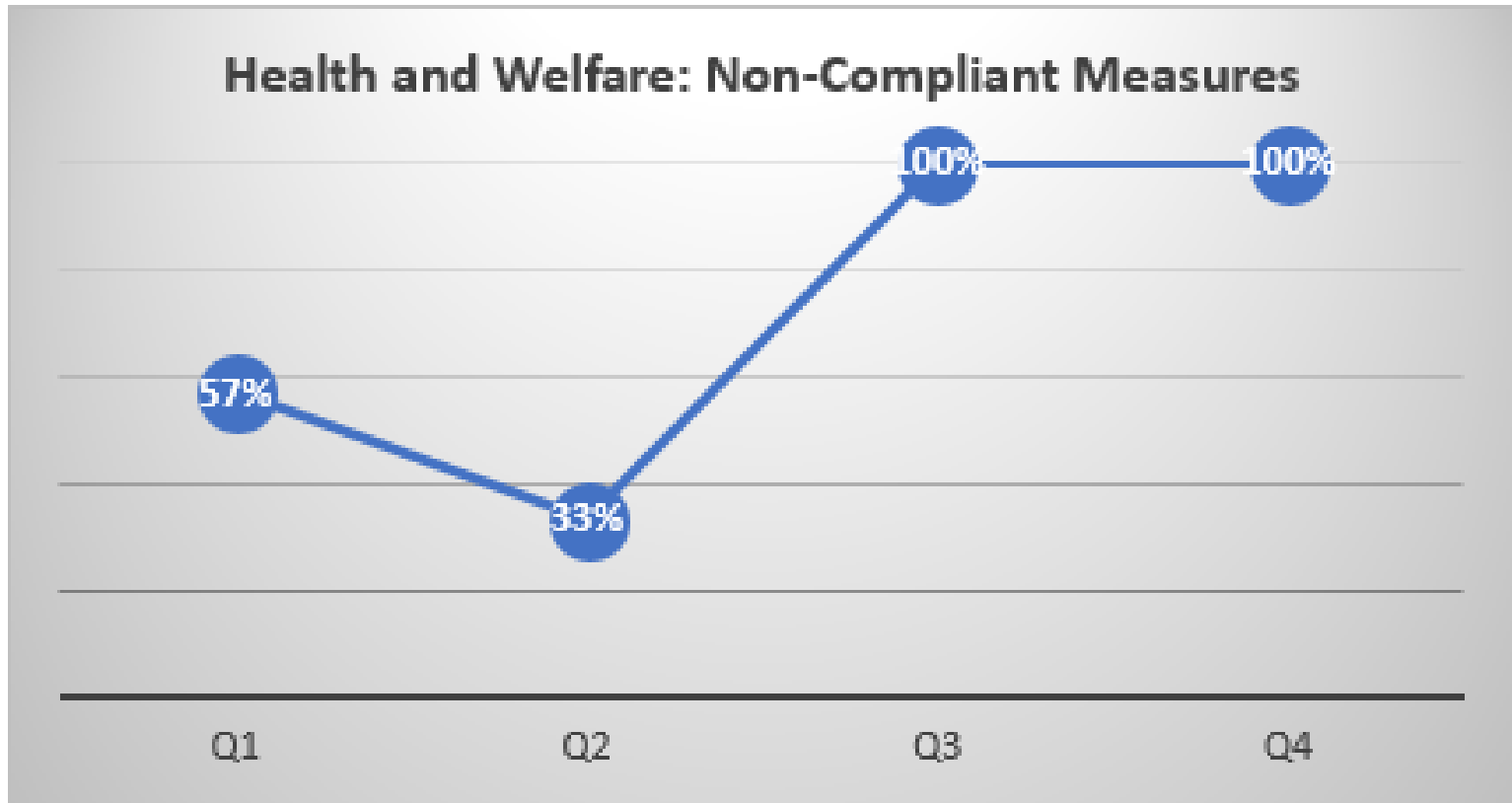
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FY 2019 QRT Annual Report

[Click here to access the FY 2019 QRT Annual Report](#)