
Commonwealth of Virginia

*Virginia Board for People with Disabilities*

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March 19, 2019

 TO: HCBSComments@dmas.virginia.gov

Department of Medical Assistance Services

FROM: Heidi L. Lawyer 

RE: Comment on Virginia’s Renewal Applications for Amendments to its §1915(c) Home- and Community-Based Waivers for Individuals with Developmental Disabilities—Community Living Waiver

I am writing to provide comments on behalf of the Virginia Board for People with Disabilities (the Board) regarding Virginia’s Request for a Renewal to a §1915(c) Home and Community-Based Services Waiver: Community Living Waiver. The Board appreciates the opportunity to provide input and appreciates that several of its recommendations made in 2016 on the applications for the Community Living, Family and Individual Supports, and Building Independence Waivers were adopted.

The Board continues to support the redesign of Virginia’s Medicaid Waiver System. The Board specifically supports changes included in the Waiver Renewal Application for the Community Living (CL) Waiver that:

1. Change the frequency of the administration of the supports intensity scale (SIS®) for individuals 22 years of age and older from three years to four years or when the individual's needs change significantly; and
2. Allow employment service organizations to be providers of Peer Mentor Supports and Employment and Community Transportation services

The Board offers the following concerns and recommendations to improve the renewal application for the CL waiver, organized by application section:

**Brief Waiver Description**

1. **The statement of goals and objectives should be revised to better reflect the purposes of wavier redesign.**

As it did in February 2016, the Board recommends improving the statement of goals and objectives contained in the waiver renewal application. The stated goals and objectives of the waiver set the tone for what follows, and should provide the benchmarks against which to compare the remainder of the application. They should also be informed by the paradigm shift that prompted and underlies the redesign of Virginia’s waivers for people with developmental disabilities. As written, the goals and objectives do not provide sufficient insight into the purposes of waiver redesign.

The Board recommends that the goal and objectives of the Community Living Waiver be stated as: to provide a comprehensive system of services and supports that empowers individuals with developmental disabilities to live healthy, productive, independent lives in the most integrated setting appropriate to their needs and desires. The objectives should be focused on achieving this goal and should include:

1. Provide a comprehensive array of services and supports to individuals with developmental disabilities that enable them to live independent lives in their communities of choice.
2. Provide the supports and services necessary to strengthen families and enhance natural supports.
3. Provide maximum opportunities for individuals with developmental disabilities to exercise independence, choice, and control over their own lives and their own services and supports.
4. Increase access to waiver services for individuals and families to ensure that individuals with developmental disabilities can remain in the most integrated setting appropriate to their needs and desires.
5. Develop a robust quality assurance system that ensures Medicaid-funded services and supports are person-centered, high quality, and cost-effective.

**Appendix A: Waiver Administration and Operation**

1. **“Use of Contracted Entities,” “Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities,” and “Assessment Methods and Frequency” Sections: References to Public Partnerships, LLC or PPL should be changed to Consumer Direct Care Network, the new fiscal broker.**

**Appendix B-3: Participant Access and Eligibility- Number of Individuals Served**

1. **“Waiver Movement and Emergencies” Section: The Board recommends that data related to past use of reserve slots be included in the application and how this past use relates to the number of reserve slots contained in the application.**

The application states that the “reserve capacity was determined by the amount of reserved waiver slots allocated by the Virginia General Assembly.” While the Board understands that this explanation is technical accurate, in that the General Assembly ultimately determines the number of waiver slots available for individuals in the Commonwealth, some discussion of historical rates of reserve slot usage would aid in determining whether the amount of slots dedicated for this purpose in the future is appropriate and sufficient. Without this data, the reserve capacity contained in the application lacks sufficient context for meaningful evaluation.

1. **“Allocation of Waiver Capacity” Section: The Board recommends that the specific process for determining who is most in need of a slot, as performed by the Waiver Slot Assignment Committee, be specified in the application.**

The application states that “these committees, known as Waiver Slot Assignment Committees (WSACs), review the needs of the highest scoring individuals within that region/sub-region.” For transparency and to ensure that WSACs around the state are operating and making decisions in a uniform manner, the specific scoring rubric should be specified along with the procedures employed by WSAC members in determining these scores.

**Appendix B: Evaluation/Reevaluation of Level of Care - Quality Improvement: Level of Care**

1. **“Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care” Section: The Board recommends adding performance measures regarding the frequency and results of related complaints/grievances and appeals.**

The proposed performance measure, “Number and percent of VIDES determinations that followed the required process as completed by a qualified CM, conducted face-to-face with individuals and those who know him (if needed)” is too narrow. It implies that the only components of an appropriate evaluation are whether the individual conducting it is “qualified” and whether it was conducted face-to-face with the individual and those who know him or her. These two components do not ensure that other components of the administration process, such as appropriately applying the instrument’s instructions and obtaining the appropriate information, are adequate. It is also unclear who is determining whether the appropriate individuals participated in the evaluation, and how they are determining this.

One source of information regarding whether the processes and instruments are applied appropriately is complaints/grievances or appeals. Information on related complaints/grievances or appeals would incorporate important input from the individuals being evaluated and those who know them. While not all complaints/grievances or appeal requests may be valid, the frequency with which complaints/grievances are made or appeals are requested can be an indicator of systematic problems. Furthermore, the frequency of appeals that are resolved in the appellant’s favor is also indicative of potential problems. Therefore, the waiver application should include performance measures regarding the percentage of VIDES evaluations and need prioritizations that are appealed or are the subject of complaints/grievances, and the percentage of appeals regarding VIDES evaluations and need prioritizations that are resolved in the appellants’ favor.

**Appendix C-1: Participant Services - Summary of Services Covered**

1. **The Board recommends re-examining the role of the consumer-directed services facilitator to eliminate unnecessary duplication of functions and more clearly delineate the roles of services facilitators, support coordinators, and CCC Plus care coordinators.**

Service facilitators, support coordinators, and CCC Plus care coordinators are all responsible for monitoring waiver services. This can result in duplication of effort, diffusion of responsibility, confusion, and reduced individual ownership of responsibility. It can also unduly burden individuals who must accommodate multiple home visits and assessments.

When various parties have overlapping roles, DMAS should either distinguish how each party’s contribution to the overall role differs from the others’ contributions or, if the contributions do not differ, consolidate the role under fewer parties. If the majority of the service facilitator’s roles are also shared by other parties, which appears to be the case, DMAS should also consider transferring the remaining roles (such as training employers of record and reviewing timesheets) to the other parties and eliminating the service facilitator position. The cost of this service should be analyzed in relation to the benefit achieved for the funding agency and the consumer.

1. **The Board recommends including dental services as a waiver service.**

Many people with disabilities are in significant need of dental care and are unable to afford this care independently. The failure to cover this service through Medicaid can result in long delays in obtaining much needed care until what could have been addressed through routine dental care has progressed to the point of a medical emergency. In addition, there is significant research relating the lack of dental health to a wide range of medical conditions that could result in more costly expenditures for the Commonwealth. Although some level of preventive dental services is now available from the managed care organization (MCO) health plans, those services are variable by MCO and significantly limited. While it is too early to know the impact of managed care on access to dental care, there have been anecdotal reports of members in CCC Plus still being unable to access basic dental services in their area despite having dental coverage through their MCO. The Board strongly recommends the inclusion of dental services in the Community Living waiver or in the alternative, requiring an enhanced level of dental services in the MCO contracts.

1. **The Board recommends including Individual and Family/Caregiver Training in the Community Living waiver.**

The Family and Individual Supports waiver includes a service called Individual and Family/Caregiver Training. This service includes not only training for family members who care for individuals with disabilities, but also “educational opportunities designed to enable the individual to gain a better understanding of his/her disability or increase his/her self-determination/self-advocacy abilities.” The Board believes that all people who receive waiver services should have opportunities to improve their independence through better understanding their disability and increasing their self-determination and self-advocacy skills. Furthermore, the training for family members or caregivers may be relevant for some individuals enrolled in the Community Living waiver, including those who live with family. The Board, therefore, encourages the Commonwealth to add this service to the Community Living waiver.

1. **The Board encourages the Commonwealth to increase the $5,000 annual cap on environmental modifications, assistive technology, and electronic home based services.**

The caps on assistive technology and on environmental modifications expenditures has remained $5,000 for many year, despite extensive improvements in available technology that can be used to facilitate greater independence for individuals with significant disabilities. The Board is pleased that electronic home based services is also included as a waiver service. The Board believes that the caps on all three of these services are unrealistically low. The Board believes that these amount should be increased to at least $7500 annually.

Absent an increase in the $5,000 cap, which the Board recognizes requires General Assembly approval, the Board recommends that a process for approving amounts greater than $5,000 in cases where there is a substantial need for the requested environmental modification, electronic home based service, or assistive technology in order to maintain community residence status or in order to move to a less restrictive environment. Another alternative would be to allow carryover of unutilized funds for one year in order for the individual to access needed, more expensive goods or services necessary for health, safety, and/or quality of life. The Commonwealth is to be commended for recognizing the value of technology but financial caps should be consistent with the cost of implementing services like Smart Home technology, including monthly monitoring contracts.

1. **The Board recommends a more expansive look at the driving records of those authorized for employment and community transportation.**

This service notes that the driver must “2. Possess a valid driver’s license; 3. Possess and maintain at a minimum (1) proof of general liability insurance coverage in compliance with federal and/or state statutory requirements and (2) a satisfactory driving record defined as no reckless driving charges within the past 24 months.” While the driver may be devoid of a reckless driving charge, the driver could have multiple other offenses, such as speeding, careless driving, accidents caused by failure to yield, etc. The Board recommends that the Commonwealth examine the number of points on a person’s driver’s license and determine an appropriate cap beyond which that driver would not be approved to deliver this service.

1. **The Board recommends clarifying what it means to have “lived independently in the community” as this phrase is used in the Waiver application to describe the individuals who may provide peer mentor supports.**

The application states: “Peer Mentor Supports are provided by an individual with a developmental disability who has lived independently in the community for at least one year and is or has been a recipient of services, including but not limited to, publicly-funded housing, Medicaid waiver services, work incentives, and supported employment.” It is unclear what it means to have “lived independently in the community” for the purposes of determining one’s qualifications to provide peer mentor supports, and the Board is concerned that the phrase is susceptible to interpretations that would exclude a number of people with developmental disabilities who would be well-suited to delivering the allowable activities defined in the application. The phrase could be interpreted, for instance, to mean that an individual must live in his or her own apartment or home, which could exclude individuals in other types of residential settings, such as supported living, who could prove very capable of acting as peer mentors. The Board recommends that DMAS reconsider and/or clarify the standard. In addition, the Board notes that the training for peer mentors will be delivered by the DBHDS Office of Recovery. It is important to ensure that staff in that office have the appropriate knowledge and training themselves to work effectively and train persons with developmental disabilities.

1. **The Board recommends an analysis of how to make Shared Living (Rent and food expenses for live in Caregiver) a viable service**

Shared living is a great addition to services available to people with DD within the redesigned waivers. Unfortunately, the service is not being utilized and providers have expressed concerns about potential liability and other barriers that may prevent individuals from benefiting from the service. A number of questions that have been raised by the provider community remain unanswered: What if the individual does not use the money provided for rent? What is the liability of the provider agency regarding the roommate that is chosen by the individual? Is there an impact on benefits if the rent money is given directly to the individual? What happens if the roommate leaves and there is no one immediately available or acceptable to the individual to move in as a new roommate? The Board recommends that DMAS and DBHDS review how this service has been implemented effectively in other states and make the necessary changes that would increase its use in the Commonwealth as a service that is viable to individuals and to provider agencies.

**Appendix C: Participant Services - Quality Improvement: Qualified Providers**

1. **“Sub-assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements” Section: The Board recommends adding performance measure(s) that speak to waiver requirements for non-licensed/non-certified providers beyond background checks.**

The proposed performance measures address the provision of criminal background checks, but do not address whether other qualifications are met for non-licensed/non-certified providers, with the exception of services facilitation providers. Some services have additional qualifications beyond background checks. For example, the employment and community transportation service requires the administering agency to annually verify that private drivers are at least 18 years old, have a valid driver’s license, have a satisfactory driving record, and have car insurance with certain minimum coverages. The waiver application should include performance measures that speak to the number and percentage of such providers who meet these additional requirements.

1. **“Sub-assurance: The State implements its policies and procedures for verifying that provider training is conducted with state requirements and the approved waiver” Section: The Board recommends adding performance measure(s) that speak to training requirements for additional types of service providers.**

The proposed performance measures address the provision of training for provider agency orientation, services facilitation providers, and direct support professionals. However, there are training requirements for additional types of providers. For example, the shared living service requires that the roommate meet basic training requirements regarding CPR, safety awareness, fire safety and disaster planning, conflict management and resolution, or any other necessary specialized training defined in the individual’s person-centered plan. The waiver application should include performance measures that speak to the number and percentage of such providers who meet their respective training requirements.

**Appendix C-4: Participant Services - Additional Limits on Amount of Waiver Services**

1. **“Additional Limits on Amount of Waiver Services” Section: In view of legislation passed by the 2019 General Assembly which requires explicit authorization of the General Assembly through legislative or budget language prior to implementing Service Packages, the Board recommends that the relevant provision of the waiver application be removed or further clarified with respect to legislative requirements.**

“Budget Limits by Level of Support. Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services. Furnish the information specified above”

There is significant opposition to the implementation of Service Packages, along with the use of a planning and aspirational calendar, by individuals, families, advocates, and providers. At the time of waiver redesign, individuals and families were told that their Supports Intensity Scale (SIS) would not be used to determine the type and amount of services for which they would be eligible, e.g., service caps. This position was reversed by DBHDS, and the SIS, along with other factors, were clearly going to be utilized for budgetary decisions. The application states: “The Commonwealth does not intend for the supports packages limits to be “hard caps” for individuals, but guidelines for case managers to use to facilitate critical conversations with individuals, their families and providers about the typical support needs and related services for individuals of similar support needs levels” DBHDS has made it clear that caps, with an exceptions process, are the ultimate goal, just not at the current time.

The Board was pleased that the Commonwealth delayed implementation of the service packages during the first two years of redesign in order to obtain data on new services, along with modified rates for those services. However, due to underutilization of the new services, resulting from a lack of provider capacity/inability of individuals to find providers, provider concerns regarding certain services (shared living), and the delay of additional services beyond the timeframe originally anticipated (benefits planning, non-medical transportation), valid predictive data remain unavailable. Service usage over the last two years can therefore not be used to predict service usage over the next two to three years.

Furthermore, it should be noted that in presentations regarding service packages, data have been presented that show that about 10 percent of individuals are outliers (those above or beneath the anticipated caps for each package). Developing a complex, bureaucratic process to address such a small number of outliers is an imprudent use of resources and will be unnecessarily intrusive for consumers and families.

In light of General Assembly action and factors noted above, the Board recommends that service packages be removed from the application and, should the General Assembly approve their implementation, an amendment to the application be submitted at that time. In the interim, the Commonwealth should evaluate how the packages would be utilized and their resulting impact in a transparent manner and provide additional opportunities for stakeholders to comment as to their potential impact.

**Appendix C: Participant Services - Quality Improvement: Qualified Providers**

1. **The Board appreciates that the draft DD Waiver regulations require that providers participate in mandatory technical assistance and training when systemic problems are identified. We support the provision that a failure to complete mandatory training or identified technical assistance may result in a referral to DMAS Provider Integrity or termination of the provider’s Medicaid participation agreement. We recommend changing the “may” to “shall” with respect to referral to the Provider integrity Unit.**

With waiver redesign, provider capacity building has necessarily been a priority and will continue to be a priority in order for waiver recipients to have access to services in their ISP. The growth in providers, however, can lead to an increase in unqualified providers or those who do not adhere to the rules and regulations governing their practice.

Poor quality providers are a risk to the health, safety, and welfare of waiver recipients. The Commonwealth has historically been averse to pulling provider licenses and ending participation agreements. In order to have a system of quality providers, there must be consequences for providers who are non-compliant, particularly those who have repeated licensing violations or other findings that result in Corrective Action Plans. Providers should not be allowed to opt out of technical assistance or other training that would facilitate their improved performance and there should be consequences if they do so.

**Appendix D: Participant - Centered Planning and Service Delivery**

1. **The Board encourages the Commonwealth to take additional steps to eliminate organizational conflicts of interest in the developmental disabilities waiver system.**

The Board repeats its 2016 recommendation here. The Board has long advocated for steps to eliminate the conflict of interest created in Virginia as a consequence of a single entity determining eligibility for waiver services, providing case management services to individuals who receive waiver services, and providing direct services to these same individuals. As the Commonwealth is aware, the Centers for Medicare and Medicaid Services (CMS) has required states to provide conflict-free case management to individuals who receive Home- and Community-Based Services since 2014. Ideally, case management and direct services should be provided by separate entities. To the extent that this is impossible or impractical, entities that deliver both case management and direct services must have procedures in place that mitigate the risk of conflicted case management. The Commonwealth has done this to an extent. However, the Board does not believe that the Commonwealth has gone far enough.

CSBs remain the single point of entry for individuals with developmental disabilities, which the Board has supported. CSBs are also allowed to provide both case management and direct services, in addition to evaluating individuals for eligibility for Medicaid waivers, albeit with firewalls in place. Although CSBs will be required to provide choice of case management, CSBs control who can and cannot compete with them in the marketplace, because private providers who wish to provide case management services to Medicaid waiver recipients will have to negotiate contracts with CSBs in order to do so and CSBs determine the rates their competitors receive. For various reasons, the number of private case management providers has dropped precipitously since waiver redesign, leaving even less choice for individuals.

Further, the mitigation standards are inconsistent between private case management entities and CSBs. CSBs can be providers of waiver services as long as there is a separation between the direct service provision and case management units. This is positive mitigation. However, for private providers contracting for case management, the private provider cannot provide any waiver service to an individual other than service facilitation. In reality, this should be the universally applicable standard: case management entities should not provide both direct services and case management. Currently, however, this standard only applies to private case management entities in Virginia, which constitutes inequitable treatment. The same requirements should apply for private and public case management entities.

The Board is concerned that the redesigned waiver system is still not optimal in terms of conflict free case management, and that the system does not provide sufficient choice of case management to waiver recipients. The Board strongly encourages the Commonwealth to consider alternative avenues for approving private case managers and increasing private case management capacity. We also encourage the Commonwealth to consider setting a standard rate of reimbursement for private case managers. The current system that allows CSBs to negotiate rates with private providers, and to determine who can enter the case management market as a competitor, perpetuates potential organizational conflicts of interests. Finally, other conflict mitigation strategies such as enacting a robust monitoring and oversight system and an effective consumer complaint system should also be in place.

**Appendix D: Participant-Centered Planning and Service Delivery - Quality Improvement: Service Plan**

1. **“Sub-assurance: Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by provision of waiver services or through other means” Section: The Board recommends adding performance measures that speak to the satisfaction of the individual and/or their chosen team members with their service plan.**

The proposed performance measures focus on whether the service plans address individuals’ assessed risks, but do not appear to speak to whether the service plans address participants’ personal goals. Absent standard documentation of individuals’ goals against which to compare the service plans, one source of relevant information is the individuals’ and/or chosen team members’ satisfaction level with the service plans. The waiver application indicates that some form of satisfaction information is obtained during and following service plan development. According to the “Service Plan Development Process” section under Appendix D-1, “An evaluation of how the plan achieves the desired outcomes, from the individual’s and responsible partners’ perspectives, is completed prior to final agreements.” The waiver application should include a performance measure that speaks to this information collected regarding satisfaction with the service plan.

1. **“Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan” Section: The Board recommends clarifying the threshold for determining whether an individual received services as specified.**

This section proposes several measures regarding whether individuals received services in the frequency, duration, type, scope, and amount identified in the service plan. The performance measure descriptions do not clarify the threshold for determining whether an individual received services as specified. Performance may vary across services, but a given individual may be set up to receive multiple services. Do all services need to be provided in the specified manner to a given individual? What if 11 out of 12 total services in the service plan were provided in the frequency specified in the service plan? What if only two of 12 total services were provided as specified?

1. **“Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan” Section: The Board recommends adding performance measures that speak to the qualitative aspects of service provision including recipient satisfaction, related complaints/grievances, and outcomes.**

The proposed performance measures address quantitative aspects of service provision, but not qualitative aspects of service provision. One source of information regarding service quality is the recipient. The waiver application indicates that some form of satisfaction information is obtained during and following service plan development. According to the “Service Plan Development Process” section under Appendix D-1, “The case manager meets with the individual (and family/caregiver as appropriate) at least every 90 days to discuss the status of supports received and resulting satisfaction/dissatisfaction.” The waiver application should include a performance measure that speaks to this information collected regarding satisfaction with the service provision.

Another way of determining recipient satisfaction is to consider any complaints/grievances. Information on related complaints/grievances would incorporate important input from the individuals receiving services. While not all complaints/grievances may be valid, the frequency with which complaints/grievances are made is nonetheless an indicator of dissatisfaction and can be an indicator of problems with service provision. Therefore, the waiver application should include performance measures regarding the percentage of recipients who have filed complaints/grievances regarding service provision.

Another source of information regarding service quality is outcomes. It is unclear the extent to which outcome data is readily available, although the waiver application does state that providers develop “descriptions of what is needed to consider each activity accomplished….” However, if any outcome data is readily available or could feasibly be made available, the waiver application should include performance measures that speak to the data.

**Appendix E-1: Participant Direction of Services - Overview**

1. **“Election of Participant Direction” Section: The Board recommends that the wording be changed from “intellectual” disability to “developmental” disability.**

Likely a hold-over from the ID waiver, this language is out of date. There are other developmental disabilities that could affect the individual’s ability to self-direct services in whole or in part. For example, some persons with an Autism Spectrum Disorder or a traumatic brain injury may have challenges that require or would lead them to prefer to designate an Employer of Record rather than undertaking the EOR responsibilities themselves.

1. **“Provision of Financial Management Services” Section: The fiscal agent should be changed from PPL to Consumer Direct Care Network which currently holds the fiscal broker contract.**

**Appendix F-1: Participant Rights - Opportunity to Request a Fair Hearing**

1. **“Procedures for Offering Opportunity to Request a Fair Hearing” Section: The Board recommends reconsideration of two of the items (# 6 and #7) in the exception list for advance notification of adverse action.**

With respect to #6, the individual's physician prescribes a change in the level of care, the individual may not agree with the recommendation of his physician and may seek a second opinion on the appropriateness of care or services. The 10 day advance notice should be afforded to individuals so that they have an opportunity to seek additional information or clarification from their or another physician prior to service termination.

With respect to #7. When the individual's request for admission into a Medicaid-covered service or when the individual's request for an increase in a Medicaid-covered service is denied or not acted upon promptly for any reason, i.e., diagnostic or functional eligibility, funding, no provider¸ there is also no reason that advance notice should not be provided to the individual so that she can seek assistance, particularly with respect to locating a provider.

Unless the situation is an emergency, advance notice of adverse action should always be provided.

**Appendix F-3: Participant Rights- State Grievance/Complaint System**

1. **“Description of System” Section: The Board recommends reviewing the grievance and complaint system verbiage for consistency.**

In 2016, the board recommended that all complaints and grievances be logged. The Board is pleased that this process was undertaken and that complaints are logged within 24 hours into the Waiver Complaint database. It is unclear whether this information is made public (redacted) or if any trend analysis is occurring. The Operational Responsibility states the following: “DMAS will refer all claims to DBHDS, which is “the primary agency that receives complaints and grievances. DBHDS does not have a “formal complaint system” according to the applications, but all complaints are “taken seriously.”

However, the description of the system later states: *DMAS staff must respond to and log the grievance/complaint and resolution as soon as feasible (depending on the nature and extent of the complaint) into the Waiver Complaint Database. The mechanisms for the response may include follow-up by phone, letter, home visit, provider agency visit, QMR, and/or referral to another agency (e.g., DBHDS Office of Licensing, Department of Social Services Child Protective Services, Department of Aging and Rehabilitative Adult Protective Services, Medicaid Fraud Control Unit, Health Department).* This is inconsistent with the statement that all claims are referred to DBHDS. The system and processes should be clarified.

**Appendix G-1: Response to Critical Events or Incidents**

1. **“State Critical Event or Incident Reporting Requirements” Section: The Board recommends updating the language regarding required reporting of deaths and serious injuries to account for recent emergency regulations.**

Emergency regulations effective September 1, 2018, altered the reporting requirements for DBHDS-licensed providers in 12 VAC 35-105-160. Previously, providers were required to collect, maintain, and report each death or serious injury. Now, providers are required to collect, maintain, and report Levels II and III serious incidents. Providers are also required to collect, maintain, and review at least quarterly (but not report) all Level I serious incidents. Definitions of Levels I, II, and III serious incidents, which can be found in the emergency regulations for 12 VAC 35-105-20, should be included in the application. References to “serious injuries or deaths” throughout Appendix G should be changed to “serious incidents” for consistency.

1. **“State Critical Event or Incident Reporting Requirements” and “Responsibility for Review of and Response to Critical Events or Incidents” Sections: The Board recommends adding references, where appropriate, to the roles of the state’s protection and advocacy entity.**

## The state’s protection and advocacy entity receives and reviews complaints, which may or may not involve critical incidents pertaining to waiver recipients. The *Code of Virginia* §37.2-709 also requires reporting of all critical incidents and deaths in facilities and in the community to the state’s protection and advocacy entity, which then reviews the reports and conducts follow-up investigations as needed. The protection and advocacy entity, along with various other entities including the State Long-Term Care Ombudsman, are also entitled to receive Adult Protective Services information per 22 VAC 30-100-50.

## Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions

1. **“Use of Restrictive Interventions” Section: Language should be corrected in the 2nd reference to Provider’s Duties Regarding the Use of Time-Out.**

*Providers shall not use time out as a punishment or reprisal for the convenience of staff.* The word “or” is missing after reprisal. The statement should read, as it does in the previous section, “Providers shall not use time out as a punishment or reprisal or for the convenience of staff.”

**Appendix G: Participant Safeguards: Quality Improvement - Health and Welfare**

1. **”Sub-assurance: 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” Section: The Board recommends adding performance measures regarding verified implementation of corrective action plans, the frequency of repeat incidents, and the frequency of remedial training or technical assistance.**

The waiver application proposes two performance measures to demonstrate a system for effective resolution of incidents and prevention of future incidents, and both of these measures are focused only on detection and review of past incidents. The first performance measure – the percent of critical incidents reported within the required time frames – speaks to the existence and use of a reporting system but not the system’s effectiveness in resolving the incident or preventing recurrence. The second performance measure – percent of licensed providers that administer medications and were not cited for failure to review medication errors at least quarterly – speaks to the review of past incidents, but not the resolution of the past incidents nor the system’s effectiveness in preventing recurrence.

The Board therefore recommends adding a third performance measure that speaks to the verified implementation of corrective action plans. As stated in the “Responsibility for Review of and Response to Critical Events or Incidents” section, DBHDS requires providers to submit corrective action plans within 15 business days of a licensing report that finds noncompliance with any licensing regulations. Corrective action plans are only effective if they are implemented. The waiver application should therefore add a performance measure that addresses whether the plans were implemented. For example, the performance measure could be, “The percentage of critical incidents for which the required corrective action plan was verified by DBHDS as being implemented within the originally required time frame.” A similar performance measure is already proposed for cases of abuse, neglect, and exploitation in the section titled, “Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses, and seeks to prevent instances of abuse, neglect, exploitation, and unexplained death.”

The Board also recommends a fourth performance measure that speaks to the recurrence rates of a given incident by a given provider. For example, the performance measure could be “The percentage of incidents that recur at the same provider within three years.” While some subjectivity may be required in determining whether an incident is similar enough to a prior incident to be considered a recurrence, the Board believes this can be done in a relatively objective manner. In fact, the Board was able to do this type of analysis for violations found through annual re-certifications of intermediate care facilities for individuals with intellectual disabilities (ICF/IIDs).

The Board also recommends a fifth performance measure that speaks to the provision of mandatory training and technical assistance to providers with repeated noncompliance. As stated in the “Responsibility for Review of and Response to Critical Events or Incidents” and “Methods for Remediation/Fixing Individual Problems” sections, providers with a history of noncompliance will be required to undergo mandatory training and technical assistance. The waiver application should include a performance measure like the following, “The percentage of providers who underwent mandatory remedial training and/or technical assistance.” This measure would be an indicator not only of the extent to which providers are repeatedly failing to comply, but also of the extent to which steps are being taken to prevent recurrence.

**Appendix I-2: Financial Accountability- Rates, Billing, and Claims**

1. **“Flow of Billings” Section: References to Public Partnerships, LLC or PPL should be changed to Consumer Direct Care Network, the new fiscal broker.**

**Appendix I-3: Financial Accountability- Payment**

1. **“Method of payments – MMIS” and “Direct payment” Sections: References to Public Partnerships, LLC should be changed to Consumer Direct Care Network, the new fiscal broker.**
2. **“Additional Payment Arrangements” Section and the “Appendix C: Participant Services” Section: The Board recommends adding a requirement that structural modifications be inspected after completion for compliance with all state and federal building codes.** DMAS states that a rehabilitation engineer/CRS may be required if, for example: “The environmental modification involves combinations of systems which are not designed to go together. The structural modification requires a project manager to assure that the design and functionality meet ADA accessibility guidelines. Where structural modifications of the primary residence are requested to ensure the residence is structurally sound for the modifications.” However, there does not appear to be any requirement that the structural modification be inspected after it is complete to be sure it meets all state and federal building codes. This may be an automatic part of the process but the Board recommends including a provision herein. At present, it is simply noted that a meeting takes place with the individual to ensure they are satisfied with the modification.

The Board looks forwarded to continuing to work with DMAS, DBHDS, and other stakeholders as redesign implementation continues. Thank you for the opportunity to provide input.