COMMONWEALTH of VIRGINIA

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November 1, 2023

TO: The Hon. Janet D. Howell, Co-Chair, Senate Finance and Appropriations Committee
The Hon. George L. Barker, Co-Chair, Senate Finance and Appropriations Committee
The Hon. Barry D. Knight, Chair, House Appropriations Committee

FR: Nelson Smith, Commissioner

RE: DBHDS 2023 Combined Study Workgroup

The Department of Behavioral Health and Developmental Services (DBHDS) convened the DBHDS 2023 Combined Study Workgroup in accordance with HB2255 (Hodges)/SB1155 (Mason) and SB1544 (Rouse). This report presents a review of the regulations that impact providers and consideration of possible ways to reduce administrative burden on providers licensed by the department to provide mental health, developmental, and substance abuse services while maintaining high quality services and protecting the rights of individuals receiving services.

I hope that you find the information in this report helpful. Please do not hesitate to contact me if you have any questions.

CC: The Hon. T. Montgomery Mason, Member, Senate of Virginia
The Hon. Aaron R. Rouse, Member, Senate of Virginia
The Hon. M. Keith Hodges, Member, Virginia House of Delegates
The Hon. John Littel, Secretary, Health and Human Resources
Susan E. Massart, House Appropriations Committee
Mike Tweedy, Senate Finance and Appropriations Committee

DBHDS

Virginia Department of Behavioral Health and Developmental Services

2023 Combined Study Workgroup HB2255 (Hodges)/SB1155 (Mason) and SB1544 (Rouse)

November 1, 2023

DBHDS Vision: A Life of Possibilities for All Virginians

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Report of the DBHDS 2023 Combined Study Workgroup

Preface

This report is submitted in accordance with the combined requirements of HB2255 (Hodges)/SB1155 (Mason) and SB1544 (Rouse), related to reviewing regulations that impact providers that deliver (i) services to individuals with mental illness, developmental disabilities, or substance abuse or (ii) residential services for persons with brain injury (12VAC35-46 and 12VAC35-105), and regulations that protect the rights of individuals receiving services from service providers in Virginia (12VAC35-115). Specifically, the legislation required:

> HB2255 (Hodges)/SB1155 (Mason)
> *§ 1. That the Department of Behavioral Health and Developmental Services (the Department) shall review its regulations that impact providers licensed by the Department in order to identify reforms to increase efficiency, reduce redundancy, and decrease regulatory burdens on providers. This review shall include consideration of how relief from licensing requirements may be authorized for providers that are accredited by recognized national accreditation bodies. The Department shall also consider adjustments to the frequency of licensing inspections for providers with triennial licenses that have had no health or safety violations or complaints for the previous year. The Department shall collaborate with stakeholders to conduct this review and shall report its recommendations to the Chairmen of the Senate Committee on Education and Health and the House Committee on Health, Welfare and Institutions by November 1, 2023.*
>
> SB1544 (Rouse):
> *§ 1. That the Department of Behavioral Health and Developmental Services (the Department) shall review its regulations that require providers licensed by the Department to report allegations of abuse, neglect, and exploitation and incidents classified as Level II and Level III. The Department shall collaborate with stakeholders to develop solutions to reduce administrative burdens on licensed providers. The Department shall report its recommendations to the Chairmen of the Senate Committee on Education and Health and the House Committee on Health, Welfare, and Institutions by November 1, 2023.*

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Executive Summary

In 2023, the General Assembly passed Section 1 legislation (HB2255 (Hodges)/SB1155 (Mason) and SB1544 (Rouse)) directing DBHDS to collaborate with stakeholders to review regulations that impact providers licensed by the Department of Behavioral Health and Developmental Disabilities (DBHDS) to identify reforms to increase efficiency, reduce redundancy, and decrease regulatory burdens on providers. The bills specifically required DBHDS to seek stakeholder input to consider:

1) how relief from licensing requirements may be authorized for providers that are accredited by recognized national accreditation bodies (this process is known as "deemed accreditation");
2) adjustments to the frequency of licensing inspections for providers with triennial licenses that have had no health or safety violations or complaints for the previous year; and
3) requirements of providers licensed by DBHDS to report allegations of abuse, neglect, and exploitation, and incidents classified as Level II and Level III.

DBHDS extensively researched deemed accreditation programs operating in other states, sought stakeholder input through a broadly distributed survey (see Appendix B), convened workgroup meetings, facilitated extensive workgroup member discussion at each meeting, and provided time for written and oral public comment at each meeting.

Discussion of alleviating provider burden included a consideration of the timeframe of serious incident and abuse/neglect complaint reporting, the frequency of inspections, and how deemed accreditation works in other states and how such a program might be implemented within the Commonwealth. The workgroup considered additional suggestions for reducing administrative burden that included leveraging inspections from multiple state agencies to reduce the number of inspections and creating a shared document portal to reduce the number of document requests. The workgroup received presentations from DBHDS regarding the results of the stakeholder survey, how deemed accreditation works within other states, and how DBHDS currently uses provider reports to help ensure the health and safety of individuals receiving services, including information about oversight provided by other state agencies. The workgroup also received a presentation by the Commission on Accreditation of Rehabilitation Facilities (CARF). CARF is a nationally recognized accreditation body recognized in 48 states. Finally, the members worked together to draft recommendations and draft recommendations were circulated to members (see Appendix C). The recommendations were in three main categories: reporting requirements, annual inspections, and accreditation.

Importantly, there is significant interest from both the provider population, DBHDS, and the Administration to reduce the existing administrative burden. However, the Commonwealth is currently under a Settlement Agreement with the U.S. Department of Justice (DOJ) which includes provisions that stipulate reporting and inspection requirements. DBHDS cannot make regulatory changes to these requirements while the related Settlement Agreement provisions are in effect. In addition, because the Settlement Agreement requires annual inspections, it is not clear if implementing an accreditation process could reduce provider burden without conflicting with provisions in the Agreement.

Regulatory Review

Review of the Current System

Licensing

The DBHDS Office of Licensing (OL) licenses providers which are defined by 12VAC35-105-20 of the *Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services* ("Licensing Regulations") as: "any person, entity, or organization, excluding an agency of the federal government by whatever name or designation, that delivers (i) services to individuals with mental illness, developmental disabilities, or substance abuse (substance use disorders) or (ii) residential services for persons with brain injury. The person, entity, or organization shall include a hospital as defined in § 32.1-123 of the Code of Virginia, community services board, behavioral health authority, private provider, and any other similar or related person, entity, or organization. It shall not include any individual practitioner who holds a license issued by a health regulatory board of the Department of Health Professions or who is exempt from licensing pursuant to §§ 54.1-2901, 54.1-3001, 54.1-3501, 54.1-3601, and 54.1-3701 of the Code of Virginia."

In the exercise of its administrative oversight responsibility, the OL licenses providers; monitors provider compliance with regulations through inspections and investigations of complaints and incidents as needed; makes determinations of regulatory compliance; provides training and regulatory technical assistance; and collects, tracks, and trends data. The OL also conducts statutorily required annual inspections, reviews, and triages serious incidents to determine if technical assistance or further action is warranted, and tracks and trends data to determine areas for quality improvement initiatives. Currently, statutory requirements mandate the department make at least one annual unannounced inspection of each licensed service. Further, regulations for the licensing of providers by DBHDS (12VAC35-105) and (12VAC35-46, *Regulations for Children's Residential Facilities*) require serious incidents be reported using the department's 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.

Additionally, the Commonwealth and the United States Department of Justice entered into a settlement agreement in 2012 regarding the Commonwealth's system of services for individuals with developmental disabilities ("Settlement Agreement" or "Agreement").[1] The Settlement Agreement contains provisions affecting DBHDS's regulation and oversight of private providers. Specifically, DBHDS is required to i) monitor compliance with the serious incident reporting requirements of the Licensing Regulations as specified by DBHDS policies during all investigations of serious injuries and deaths and during annual inspections; and ii) require corrective action plans for 100 percent of providers who are cited for violating the serious incident reporting requirements of the Licensing Regulations. Additionally, DBHDS must demonstrate at least 86 percent of reportable serious incidents are reported within the timelines set out by DBHDS policy and that providers that fail to report serious incidents, deaths, or

[1] In January 2020, the Parties, at the direction of the Court, filed a list of compliance indicators that would guide the Court's determination of the Commonwealth's compliance. The Court adopted those compliance indicators and incorporated them into the consent decree in December 2021. Subsequent references in this document to the Settlement Agreement are inclusive of the Settlement Agreement and compliance indicators.

allegations of abuse or neglect as required by the Licensing Regulations receive citations and are required to develop and implement DBHDS-approved corrective action plans. The Settlement Agreement also includes requirements for annual inspections of providers, including that the Office of Licensing assesses provider compliance with serious incident reporting requirements as part of the annual inspection process. Additionally, the Agreement requires that at least 86 percent of licensed providers of developmental disability (DD) services are assessed for their compliance with the risk management regulations and with the quality improvement regulations during their annual inspections.

The Settlement Agreement is a court order and, as such, the Commonwealth must comply with and implement these requirements as long as these provisions of the Settlement Agreement are in effect. Therefore, some initiatives suggested by HB2255/SB1155 and SB1544 and some recommendations of this work group cannot be implemented while pertinent provisions of the Settlement Agreement are in effect. Additionally, some recommendations would require statutory and regulatory changes.

As part of the system transformation, the provider system has been moving from institutionalized care to community-based services. Since FY 2012, there has been a 92 percent increase in the number of licensed providers, a 96 percent increase in the number of licensed services and an 80 percent increase in the number of DBHDS licensed locations. This monumental increase in providers and administrative strategies required the department to focus on efficiency and have required that the department allocate a majority of its resources towards providers requiring more technical assistance.

Triennial Licenses - Currently, 45 percent of licensed providers hold a triennial license. Providers holding a triennial license:

- Provide a service that has demonstrated full compliance with all applicable regulations;
- If they had violations during the previous license period, those violations did not pose a threat to the health or safety of individuals receiving services;
- The provider or service demonstrated consistent compliance for more than a year; and
- The provider has a process in place that provides sufficient oversight to maintain compliance.

Annual Licenses - Thirty-six percent of licensed providers hold an annual license. Providers holding an annual license demonstrated compliance with all the applicable regulations but have not met the threshold of compliance for a triennial license.

Conditional Licenses - A conditional license is issued to a new provider to permit the provider to demonstrate compliance with all regulatory requirements. The maximum term of a conditional license is six months; if at the end of that time a provider has still not demonstrated compliance with all licensing standards, a second conditional license may be issued. The total period for a conditional license may not exceed 12 successive months.

Eighteen percent of providers are on a conditional license; 61 percent of these providers on a conditional license have been issued a first conditional license, and 39 percent have been issued a

second conditional license because they have not yet been able to demonstrate full compliance with the regulations. This often occurs when a provider has not admitted anyone to its service during the first period of conditional licensure.

Provisional Licenses - Less than one percent of license holders have a provisional license, which is issued to a provider that has previously been licensed, has demonstrated an inability to maintain compliance with applicable regulations, has violations of human rights or licensing regulations that pose a threat to the health or safety of individuals, has multiple violations of human rights or licensing regulations, or has failed to comply with a previous corrective action plan. The OL focuses its available resources (those not required to maintain the department's statutory purview) on providing additional technical assistance to those providers who have been cited for health and safety violations, who hold a provisional license, or hold a second conditional license.

Human Rights

The administrative authority of the Office of Human Rights (OHR) is to: monitor providers ongoing compliance with regulations; investigate and examine all conditions or practices that may interfere with the free exercise of individuals' rights; provide training and regulatory technical assistance to individuals, family members, and providers; represent individuals making a complaint that their rights have been violated by a provider; offer oversight, training, and technical assistance to local and state human rights committees; track and trend data to determine areas for quality improvement initiatives; review reports of alleged violations; and ensure due process for individuals who seek resolution of a human rights complaint.

Currently, the *Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded, or Operated by the Department of Behavioral Health and Developmental Services*, 12VAC35-115 ("Human Rights Regulations"), require providers of services licensed, funded, or operated by the department to report each complaint alleging abuse or neglect via Computerized Human Rights Information System (CHRIS) within 24-hours of receipt of the complaint. Moreover, the Settlement Agreement requires that providers report allegations of abuse and neglect in accordance with both the Licensing and Human Rights regulations. This means each complaint that involves abuse, neglect, or exploitation must be reported via CHRIS within 24 hours of receipt the complaint.

Providers are also required by the Human Rights Regulations to take specific actions immediately to include: 1) contacting the individual about the complaint; 2) taking immediate steps necessary to protect the individual from retaliation and harm; 3) notifying the local Child Protective Services (CPS) or Adult Protective Services (APS) agency; 4) notifying the legal guardian or authorized representative, if applicable; and 5) initiating an impartial investigation as soon as possible. If a crime is suspected, the provider is responsible for notifying law enforcement. Providers must also cooperate with any abuse, neglect, or exploitation investigation conducted by the local Department of Social Services (DSS).

Therefore, to the extent initiatives suggested by HB2255/SB1155 and SB1544 and recommendations of this work group related to reporting allegations of abuse, neglect, or exploitation would be inconsistent with the Settlement Agreement, they cannot be implemented

while the pertinent provisions of the Settlement Agreement are in effect. Additionally, some recommendations would require statutory and regulatory changes.

Reports to the OHR are triggered by a complaint and serve to provide the department with assurance about immediate health, safety, and rights-protective actions taken by the provider in direct response to the compliant, These CHRIS reports also document the entirety of the complaint resolution process. A provider's initial CHRIS report, required within 24 hours, must include information about the type of abuse or neglect, the individual(s) and provider staff involved, evidence that the provider made the required notifications, whether the individual was injured and if so, what type of medical treatment was provided. The provider has 10 business days to investigate and determine whether the abuse or neglect occurred. The CHRIS report includes space for the provider to enter the rationale for the finding and the results of the complaint resolution process.

OHR managers review CHRIS reports during business hours and triage them to local advocates to monitor. The OHR advocate ensures the CHRIS report accurately reflects the complaint, the providers investigation and decision, any identified human rights violations, any corresponding corrective actions, and the outcome of the complaint resolution process. Triage of CHRIS reports include assessment based on the OHR "A.I.M." protocol for high priority complaints. The A.I.M. protocol was established by the OHR in March 2019 to ensure high priority and substantiated complaints alleging abuse and neglect receive a prompt response. "A.I.M" represents the advocate response of:

- **A**ssessing and Assuring safety for the identified individual, as well as other individuals receiving services;
- **I**nitiating the department's complaint resolution process pursuant to 12VAC35-115-175; and
- **M**onitoring provider follow up through verification that the provider has completed an investigation, implemented appropriate corrective actions(s) and finished the complaint resolution process.

High priority complaints are defined as any allegation of sexual assault, restraint with serious injury, or physical abuse with serious injury. High priority complaints receive an advocate response that includes an onsite visit within one business day of notification to ensure that the individual is safe and received necessary medical care and protection from retaliation, the provider investigation was initiated, and all required notifications were made. Substantiated complaints result in an onsite review and verification of corrective action(s). This includes returning on site to include interviews with staff and individuals, observation of environmental modifications, and other forms of record and documentation reviews. Through these steps, OHR helps to ensure providers are doing what they have attested to doing in their CHRIS reports and that the actions have the desired effect.

In FY 2023, licensed community providers reported 9,447 complaints involving abuse, neglect, or exploitation in CHRIS. Of those complaints, 119, or 1.26 percent, were identified as a priority and resulted in an A.I.M. response. These statistics and information show the importance of the CHRIS reporting system and a prompt response.

Accreditation

Review of Other States Deemed Accreditation Programs

In preparation for the workgroup meetings, DBHDS conducted an environmental scan of public information on state websites to evaluate the use of deemed accreditation within other states and the effect such a program has on the frequency of licensing inspections. Of note within this research is that DBDHS discovered that a number of other states license providers either by disability or by service type. Therefore, a provider may need to be licensed by multiple state agencies, requiring multiple inspections per year. In Virginia, all clinically-based behavioral health and developmental disability services are licensed by one office in one agency, the Office of Licensing within DBHDS. Therefore, the inspection burden of providers in other states may be greater than it is in the Commonwealth due to the spread of regulatory oversight.

DBHDS reviewed deemed accreditation programs within several states and found a variety of methods utilized in administering these programs, ranging from some states which require both accreditation and licensing for certain programs (Maryland, Indiana) to states that recognize deemed accreditation may be utilized in lieu of receiving routine onsite licensure surveys (Connecticut, Florida, Indiana). Below is a summary of the findings:

Connecticut:	Connecticut Department of Public Health allows for deemed status for certain hospitals and health care services. Examples of some of the accreditation bodies the state recognizes includes the Commission on Accreditation of Rehabilitation Facilities (CARF), Council on Accreditation (COA), the Joint Commission (JCO) or the National Association for the Education of Young Children (NAEYC). The department may waive, for deemed status license or certification renewals, the inspection and investigation that would otherwise be required for standard renewals. This does not limit authority to inspect providers, suspend or revoke a license or certification, or take any other legal action to address complaints or non-compliance under the law.
Florida:	Accreditation is not required but is recognized. Accreditation does not preclude monitoring by the agency and compliance with regulatory requirements. However, programs may ask the agency to accept accreditation in lieu of receiving routine onsite licensure surveys, by submitting the required documentation from a recognized or approved accreditation organization.
Illinois:	Adult day services are considered to meet licensing standards if accredited by a nationally recognized entity. Surveyors do not review the rule sections for which deemed status has been granted. Deemed status may be nullified if the department finds the agency is in substantial noncompliance with one or more of the department's rules. The department shall, at least quarterly, review the services being provided to assure compliance with the standards.
Indiana:	Community mental health centers, opioid treatment programs, and private mental health institutions are all considered to meet licensing standards if accredited by a nationally recognized entity. However, the state is not currently accepting new applicants for community mental health centers or opioid treatment programs. Further, the state requires accreditation for addiction treatment services.
Maryland:	Requirements may be waived for agencies providing behavior support services if accredited. The state requires certain services to be both licensed and accredited. In a hospital setting, with accreditation and appropriate DEA and statutory standards, opioid treatment and withdrawal management do not need to be licensed. Those same services, not in a hospital setting, must be accredited AND licensed.
Missouri:	The state grants certification upon application of an organization with CARF, COA, or JCO accreditation. The state currently has a moratorium (from March – September 2023) on its application process while working through a backlog of applications and incorporating additional monitoring requirements. The moratorium does not apply to opioid treatment programs. Note: DBHDS also had a call with Missouri to gain additional understanding of the structure there.
North Carolina:	Facilities are awarded "deemed status" and licensed if accredited, though inspections are still required.
Ohio:	The following national accreditation organizations are recognized: CARF, COA, and JCO. Deemed status

	means "evidence of compliance." When deemed status is granted, the licensing body is accepting the agency's appropriate national behavioral health accreditation compliance with the state standards. Incident reporting and risk management are not exempt from deemed status, which means a provider granted deemed status must continue to report incidents to the state agency. The department also maintains authority to conduct follow up surveys of a random sample of agencies in order to validate the accrediting body's continued ability satisfactorily address requirements.
Tennessee:	Accreditation streamlines the licensure process, though site visits are still required.

CARF International

The workgroup heard a presentation from the senior managing director of behavioral health and CARF International, including an overview of who CARF is and how they accredit providers.

CARF is an independent, nonprofit organization that accredits programs within the human services sector, including aging, behavioral health, employment and community services, child and youth services, and opioid treatment programs. CARF also offers a certification program in the ASAM levels of care for residential providers. The CARF presenter shared with the group how CARF is recognized for quality and discussed how deemed accreditation programs can be used to strengthen and add value to the health care system. He noted that currently there are 48 states[2] that utilize CARF for deemed accreditation of at least some regulatory standards; however, he also noted that the focus of CARF accreditation is on quality of services as opposed to specific regulatory requirements. He noted that there are differences in the way that accreditation organizations accredit providers. Some will accredit the entire provider organization, while others, such as CARF accredit specific programs, so a provider could be accredited for some, but not all their programs. Examples of the types of programs that CARF accredits include Assertive Community Treatment. Case Management, Community Integration, Crisis Programs, Day Treatment, Inpatient Treatment, Intensive Outpatient Treatment, and others.

Because CARF is not a regulatory body and does not assess the full range of requirements that might be included in regulation, it is possible that a provider could be accredited by CARF but fails to meet state regulatory requirements. The presenter noted that an initial step to determining how accreditation could be implemented in Virginia could include a comprehensive survey of the CARF standards and the licensing regulations to determine where they overlap, and where there are regulations not included in the CARF standards. The Commonwealth would then need to determine how important those requirements are and whether they would be evaluated separately by licensing in addition to accreditation. He noted that some states have accepted CARF accreditation as the only requirement to provider services within that state, whereas others have identified the specific licensing regulations that must be met by accredited providers, and those that are waived.

[2] § 51.5-116 specifies that an Employment Services Organization, approved by the Department of Aging and Rehabilitative Services, is an organization accredited by the Commission on Accreditation of Rehabilitation Facilities

Stakeholder Input

Survey

As stated earlier, in preparation for convening the workgroup, the department administered a survey from July 7 - 16, 2023. The survey was distributed via listservs comprised of individuals receiving services, licensed providers, advocacy organizations, and others interested stakeholders, and was posted on Virginia's Regulatory Town Hall as a general notice. The department received 298 total responses. 86 percent of the respondents identified as DBHDS providers.

The survey asked respondents which elements of the Licensing Regulations or Human Rights Regulations require the most effort or administrative burden for the respondent's agency. Based on the responses, the following represents a ranking of what the respondents consider the most burdensome requirements: 1) annual inspections, 2) reporting of serious incidents, 3) quality improvement and risk management provisions, 4) developing and implementing corrective action plans, 5) reporting abuse and neglect, 6) provider investigations of abuse or neglect, 7) submissions of requests for service modifications, 8) submissions of seclusion and restraint data annually, and 9) other requirements. The survey allowed respondents to elaborate on what other requirements they felt were administratively burdensome to which respondents noted: having multiple audits on the behalf of multiple organizations, 24-hour reporting requirements for serious incidents particularly over holidays and weekends, detailed root cause analysis requirements, competency requirements within required trainings, and mortality reviews, among other responses.

The survey also asked respondents to rank how impactful certain OL activities are in helping to ensure the health, safety, and welfare of individuals accessing services. The respondents ranked provider investigation of abuse or neglect as having the highest impact on ensuring the health, safety, and welfare of individuals accessing services. This was followed by reporting abuse and neglect, reporting serious incidents, quality improvement and risk management, developing and implementing corrective action plans, with submission of seclusion and restraint data ranking the lowest on the list of responses.

The survey also asked respondents how quickly they believed that reported allegations of abuse, neglect, and exploitation, and incidents classified as Level II and Level III should be reported to DBHDS. The department received a range of responses ranging from 24 hours to a week, with 49 percent recommending reporting on the next business day, and 28 percent favoring reporting within 24 hours.

Provider respondents noted if their organization is accredited and by which organization. The following accrediting organizations were noted: JCO (21 respondents), COA (six respondents), and CARF (62 respondents).

The survey also asked what strategies the respondents would support to reduce the administrative burden associated with requirements of the Licensing Regulations and Human Rights Regulations. The most respondents (165) noted that they would support reducing the frequency of inspections for triennial license holders, followed by the requiring reports of allegations and

incidents by the next business day (159 respondents), then reducing the frequency of inspections for accredited providers (126 respondents), and, finally, utilizing desk reviews instead of onsite inspections of home and non-center-based services (103 respondents). However, when looking only at those respondents who did not identify themselves as providers, 29 percent stated that they would not support any reductions to licensing or human rights requirements, followed by 23 percent supporting reporting serious incidents and abuse and neglect allegations the next business day.

DBHDS asked respondents to provide suggestions for additional administrative changes that the survey had not suggested. The respondents suggested:

1. **Streamlining audits across offices and agencies:** Such as having all agencies aligning review items and methods of auditing, having one central location where all audit documents can be uploaded and accessible to all appropriate offices and agencies, having agencies accept other agencies' audits, and alternating which agencies completes audits during any given year.
2. **Replacing or revamping CHRIS[3]:** Such as looking at creating an alternative application; providing 24-hour application support; using the CONNECT interface to submit abuse, neglect, and serious incident reports; or reducing duplication of efforts by allowing providers to enter information into one part of CHRIS regardless of whether the information is related to an abuse or neglect allegation or a serious incident report.
3. **Revising reporting requirements:** Such as revising reporting requirements for Level III incidents that occur outside of the provision of services or revising reporting requirements for abuse and neglect allegations.
4. **Reducing risk management and quality improvement documentation; and**
5. **Reducing the number of corrective action plans (CAPs) a provider must respond to:** Providers currently have multiple agencies they must provide CAPs to and may have multiple licensing reports or human rights citations.

DBHDS also collected from respondents other considerations or recommendations related to licensing requirements. The department is undergoing several regulatory reform initiatives that seek to streamline the department's Licensing Regulations and reduce administrative burden, which will allow the department the opportunity to address these issues, if appropriate.

Workgroup Discussion

The workgroup convened three meetings in July-August 2023. As noted earlier, the workgroup received presentations from the department regarding the results of the stakeholder survey, how deemed accreditation works within other states, and a presentation by CARF. Ample discussion time was provided at each meeting in addition to opportunities for written and public comment from interested stakeholders not on the workgroup.

Reporting Requirements

There was extensive discussion and interest among the workgroup members in extending the reporting requirements for reports of complaints alleging abuse, neglect, or exploitation and Level I and Level II serious incidents from 24 hours to within the next business day. There was

[3] DBHDS issued an RFP to replace the CHRIS system on 6/30/2023.

specific discussion about the fact that department staff are not charged to routinely have offices staffed outside of state business hours. During this discussion, some workgroup members noted the different roles of different state and local agencies, i.e., DBHDS, APS/CPS, and law enforcement, in providing protection to individuals. When there are allegations of abuse or neglect, APS or CPS is directly involved to ensure protection of a specific individual. This may involve physically removing an individual from a situation where abuse or neglect has been alleged or substantiated and placing them in a safe environment. Additionally, law enforcement may be involved in removing or detaining someone who has allegedly perpetrated abuse. In contrast, DBHDS investigations of serious incidents are primarily required to focus on ensuring that provider organizations are complying with regulations, including making appropriate notifications to APS/CPS and law enforcement. While DBHDS requires providers to implement corrective actions when violations of the Licensing Regulations or Human Rights Regulations are identified and takes action against a provider's license as warranted, the department's actions are generally less immediate than that of APS/CPS or law enforcement. Thus, the group questioned the benefit of requiring providers to report these incidents outside of regular Department business hours.

There was additional discussion about the impact of extending the length of time between when the incident occurs and when reporting to DBHDS is required, particularly with respect to incidents that occur on weekends. A concern was raised that, as more time passes between an incident and the report, staff memories about the incident may fade and thus important details may be lost. Some providers responded that each incident is reported in real time by direct service staff on their internal incident reports, so all essential details known at the time are captured. Some raised the concern that the administrative staff who then report that information to DBHDS must be available on weekends to provide that information to DBHDS within 24 hours. Some providers also noted that a potential benefit of extending report times is that more information is often known and, therefore, a more thorough report can be submitted to DBHDS.

Providers within the group also expressed frustration with the fact that if a report is submitted later than 24-hours they universally receive a citation which requires a corrective action plan, even if all (or a majority of their previous reports were within the 24-hour time frame). They stated that ideally DBHDS would look at their overall timeliness in reporting, perhaps establishing a threshold of a certain percentage of reports that must be timely before corrective action is required. DBHDS noted that due to the requirements outlined in the Settlement Agreement, the OL requires corrective action plans for 100 percent of providers cited for violating the serious incident reporting requirements of the Licensing Regulations.

Annual Inspections

The workgroup discussed the potential for making changes to requirements for each service to have an annual inspection. While providers may receive either an annual or a triennial license, the code requires that they all receive an annual inspection. Provider members suggested that it would make sense that those providers who have been issued a triennial license do not have a need to be inspected every year and that it would make better use of resources to focus annual inspections on those providers who have an annual license. Some advocates expressed strong concerns that a provider might go three years without anyone from licensing visiting them.

It was noted that the Office of Licensing currently makes determinations of which providers are

issued a triennial based upon the language in code (37.2-410):

> *"…The Commissioner shall issue a triennial license to a provider that has demonstrated full compliance with all applicable regulations of the Board related to health and safety of individuals receiving services during the previous licensing period and has demonstrated consistent compliance with all regulations of the Board during the previous 12-month period and the provider has taken steps satisfactory to the Department to prevent future violations and maintain full compliance with all applicable regulations during the three-year period."*

Some members of the workgroup noted that they would be more comfortable with exempting providers on a triennial license from an annual review, if more specific criteria for issuing a triennial license were developed and made public. It was also noted that in addition to onsite visits from licensing specialists, providers may also have onsite visits from OHR, DMAS, and for providers of developmental disability services, quality service reviews conducted by an external vendor contracted through DBHDS.

Accreditation

Workgroup members were generally favorable of consideration of deemed accreditation as a method of reducing administrative burden, while perhaps increasing the quality of services. However, members generally stated that they thought further study would be needed before definitive recommendations could be made. In addition, some members noted that the cost and administrative overhead that would be required for a provider to become accredited could be prohibitive (particularly for smaller providers). Therefore, allowing reduced inspections for triennial license holders might be a more efficient way to reduce administrative burden. The workgroup noted that additional study should include a more thorough assessment of each of the national accreditation bodies and how well they align with requirements for licensed providers. This would involve an analysis of the accreditation standards and creating a crosswalk with licensing requirements to determine where there is overlap and which regulations would not be covered. Additionally, the workgroup stated that it would be important to have a more detailed understanding of what had worked well and what had not worked in states that have adopted deemed accreditation, including an understanding as to whether there are different quality outcomes between accredited and non-accredited providers. This would likely require additional funding to accomplish this review.

U.S. Department of Justice Settlement Agreement with Virginia

DBHDS identified current requirements in the Settlement Agreement that would prevent certain regulatory mandate reductions. There are compliance indicators filed with the court referencing requirements to report incidents within 24 hours and to conduct inspections at least annually.

Related to incident reporting, the compliance indicators state:

- *The Office of Licensing assesses provider compliance with the serious incident reporting requirements of the Licensing Regulations as part of the **annual inspection process**. This includes assessing whether: i. Serious incidents required to be reported under the*

*Licensing Regulations are reported within **24 hours of discovery**.*

- *DBHDS requires all DBHDS-licensed providers to report deaths through the incident reporting system within **24 hours of discovery.***

The compliance indicators also require the following related to annual inspections:

- *The Office of Licensing assesses provider compliance with the serious incident reporting requirements of the Licensing Regulations as part of the **annual inspection process**. This includes assessing whether:*
  - *Serious incidents required to be reported under the Licensing Regulations are reported within **24 hours of discovery**.*
  - *The provider has conducted at least quarterly review of all level I serious incidents, and a root cause analysis of all level II and level III serious incidents;*
  - *The root cause analysis, when required by the Licensing Regulations, includes i) a detailed description of what happened; an analysis of why it happened, including identification of all identifiable underlying causes of the incident that were under the control of the provider; and iii) identified solutions to mitigate its reoccurrence.*
- *DBHDS monitors compliance with the serious incident reporting requirements of the Licensing Regulations as specified by DBHDS policies during all investigations of serious injuries and deaths and during annual inspections.*
- *At least 86 percent of DBHDS-licensed providers of DD services have been assessed for their compliance with risk management requirements in the Licensing Regulations during their **annual inspections.***
- *On an annual basis at least 86 percent of DBHDS licensed providers of DD services have been assessed for compliance with 12 VAC 35-105-620 during their **annual inspections**.*
- *At least 86 percent of DBHDS licensed providers receiving an **annual inspection** have a training policy meeting established DBHDS requirements for staff training…*
- *The DBHDS Office of Licensing uses the checklist during all **annual unannounced inspections** of DBHDS-licensed DD service providers, and relevant items on the checklist are reviewed during investigations as appropriate. Reviews are conducted for providers at least annually pursuant to 12VAC35-105-70.*

As noted above, the Settlement Agreement is a court order and, as such, the Commonwealth must comply with and implement these requirements as long as these provisions of the Settlement Agreement are in effect. This means that there is not an immediate clear path to modifying either the reporting requirements or requirements related to annual inspections without violating some aspects of the Settlement Agreement.

This led to discussion as to whether the department could create different reporting requirements for different disability populations as the Settlement Agreement is specifically targeted to the treatment of individuals with intellectual and developmental disabilities. Provider members of non-DD services of the workgroup tended to express concern that they are unnecessarily subject to stricter requirements required of DD service providers. Members speaking on behalf of individuals receiving services generally would opt for requirements that are standardized across all disability populations served by providers.

The workgroup was very interested in the department's research regarding deemed accreditation but felt further research would be necessary prior to creation of a Virginia model. Specifically,

the workgroup strongly advocated for the development of a crosswalk of the standards of applicable accreditation bodies compared to the department's licensing regulations. There was concurrent agreement that such a research project, while highly valuable, would require significant time and resources including additional funding. Additionally, the workgroup expressed interest in the effect of accreditation on patient outcomes and the cost of accreditation, particularly among smaller providers for whom accreditation is less accessible due to cost. Certain members of the workgroup reminded the group that recommendations should be made for all providers and that the needs of individuals are the priority.

Workgroup Recommendation Matrix: Points of Consensus

RECOMMENDATION 1: Changes to reporting requirements.

Policy Option	Panelist Support (Y/N)
Option A: Amend regulations to change requirements to report allegations of abuse, neglect, and exploitation and level I and level II serious incidents from 24 hours to within the next business day.	Six panelist organizations agreed with this option. Two panelist organizations did not agree with this option.
Option B: Amend regulations to change the definition of what types of incidents are required to be reported within 24-hours.	Four panelist organizations agreed with this option. Three panelist organizations did not agree with this option.
Option C: Amend regulations to require different time frames for residential vs other services.	No panelist organizations agreed with this option. Seven panelist organizations did not agree with this option.
Option D: Amend guidelines for issuing citations to allow consideration of the provider size, and number of late reports as a percentage of all reports.	Five panelist organizations agreed with this option. Two panelist organizations did not agree~~d~~ with this option.
Option E: Make no change to reporting requirements.	No panelist organizations agreed with this option. Seven panelist organizations did not agree with this option.

RECOMMENDATION 2: Changes to inspection requirements.

Policy Option	Panelist Support (Y/N)
Option A: Amend the Code of Virginia to allow providers with triennial licenses, without significant or unresolved health and safety violations, to be inspected once during their license period.	Five panelist organizations agreed with this option. Three panelist organizations did not agree with this option.
Option B: Leverage inspections and	Three panelist organizations agreed with this option.

investigations from other agencies to reduce the number of reviews that occur.	Four panelist organizations did not agree with this option.
Option C: Create central repository for documents that can be shared across different agencies and review entities.	Five panelist organizations agreed with this option. Two panelist organizations did not agree with this option.
Option D: Make no change to inspection requirements.	No panelist organizations agreed with this option. Seven panelist organizations did not agree with this option.

RECOMMENDATION 3: Accreditation.

Policy Option	Panelist Support (Y/N)
Option 1: Amend the Code of Virginia to deem certain licensing requirements as met (e.g., annual inspection, compliance with quality improvement regulations, etc.) for providers that are accredited by a recognized national accreditation body.	Four panelist organizations agreed with this this option. Four panelist organizations did not agree with this option.
Option 2: Conduct further study to determine how to best utilize accreditation status to minimize the administrative burden associated with licensing. This would include evaluating outcomes in other states that utilize deemed accreditation and conducting a crosswalk of accreditation organization standards with licensing requirements. This would include a request for funding.	Eight panelist organizations agreed with this option. No panelist organizations did not agree with this option.
Option 3: Make no change; do not include a consideration of accreditation status in licensing oversight.	No panelist organizations agreed with this option. Seven panelist organizations did not agree with this option.

Requirements of DOJ Settlement Agreement

Virginia is operating in a changed landscape. Since entering into the Department of Justice (DOJ) Settlement Agreement in 2012, there has been a significant increase in the number of community-based providers. Related widespread impacts on the system include increased scrutiny through reporting requirements, as well as additional requirements for providers to implement quality and risk management programs. The Commonwealth must report certain criteria to the Court which requires DBHDS to collect data from providers. While there has been tremendous build-out of the services system in the past 11 years, the pressures on the system, including workforce shortages and lingering pressures from the pandemic, are pushing a further evolution of the system.

Administrative burden is a symptom of this larger change. There is significant interest from both the provider population as well as the Administration to reduce the existing administrative burden. Initiatives to increase efficiency, reduce redundancy, and allow resources to be targeted to providers requiring additional technical assistance will help to improve care and create a more collaborative system.

The workgroup expressed interest in a deemed accreditation program in reducing the frequency and burden of licensing inspections; adjustments to the frequency of licensing inspections for triennial license holders; and reducing the burden of reporting allegations of abuse, neglect, and exploitation and serious incidents classified as Level II and Level III. These initiatives would require either statutory changes to the Code of Virginia, or amendments to the Licensing and Human Rights Regulations. Additionally, any changes that would conflict with the Settlement Agreement cannot be implemented while pertinent provisions of the Settlement Agreement are in effect. Any changes to the system should be undertaken carefully and incrementally to avoid unintended consequences to Virginia's most vulnerable citizens and the pitfalls that other states have experienced, such as entering into a deemed accreditation program too quickly that resulted in an unintended consequence such as a backlog of accreditation applications.

The workgroup evaluated and made recommendations related to three areas of regulatory requirements: requirements for reporting serious incidents and abuse/neglect allegations, the frequency of annual inspections, and implementation of accreditation as method of deeming compliance with licensing regulations. Each of these are addressed below.

Reporting Requirements

The workgroup was generally in agreement with making changes to reporting requirements, with many noting the inconsistency in requiring reporting on weekends, even though agency staff are not available to review them until the next business day. There were no members who voted to leave the reporting regulations as they are.

The two policy options with the strongest support were to either: a) amend regulations that require reporting within 24 hours, to the next business day; or b) amend the regulations to change the definition of what types of incidents must be reported within 24 hours. Discussion noted that the system for the protection of individuals is spread across various agencies, including, but not limited to DBHDS. In addition to notifying DBHDS, depending on the incident, providers may also be required to notify protective services or law enforcement. Unlike protective services, DBHDS does not have authority to directly intervene with individuals but is generally monitoring to ensure that providers are taking appropriate actions. Workgroup members supporting a change to next business day reporting noted that it would reduce the administrative burden of having specific staff on call to file a report, without increasing the risk of harm to individuals. Immediate actions to protect individuals, such as staff re-assignments, obtaining medical treatment, and making emergency notifications would still be expected to occur.

In the absence of eliminating the 24-hour reporting requirement, several workgroup members endorsed a change that would define only specific types of incidents (such as level III serious incidents) as requiring a report within 24 hours. However, there was some concern that this option could lead to some confusion as to whether a specific incident met the criteria for 24-hour

reporting. Regarding either option, it was also noted that providers offering services to individuals covered by Medicaid managed care organizations must also report incidents to those organizations and that any change to DBHDS regulations should be aligned with the contract requirements for DMAS health plans.

There was also consensus that DBHDS should consider other factors, such as provider size or the number of late reports as a percentage of all reports, prior to issuing a citation, as opposed to the current guidelines that state a provider will receive a citation for every late report.

As noted above, the Settlement Agreement includes some provisions that stipulate that providers report incidents within 24 hours and that 100 percent of late reports receive a citation. DBHDS cannot make regulatory changes to these reporting requirements while the related Settlement Agreement provisions are in effect. Any request to change these provisions would likely need to be accompanied by clarification as to how the entire service system works together to ensure that individuals receiving 24-hour care remain protected from harm.

Annual Inspections

The two policy options with the greatest support from the workgroup were: a) amending the Code of Virginia to require that providers with a triennial license to be inspected once during their license period; and b) create a central repository for documents that could be shared across different agencies and review entities.

There was strong support from provider workgroup members to allow a single inspection during the three-year license period for those providers that have been issued a triennial license. It was noted that there did not appear to be a reason to have a triennial license if those license holders are treated the same as providers with an annual license. Reducing the frequency of inspections for providers with a strong track record of compliance would reduce administrative burden on those providers and allow licensing staff to focus their resources on providers that had not yet demonstrated substantial compliance. It would also create additional incentives for providers to meet the threshold for a triennial license.

However, there was some concern among advocacy organizations and other state agencies about reducing the frequency of inspections. The primary concern seemed to be that three years seemed too long a time between inspections and that it was not clear what impact this might have on the safety of individuals receiving care. Some workgroup members indicated that they would be less concerned about reducing the frequency of inspections if the criteria for a triennial license were more clearly defined and publicly available.

There was also support for the idea of creating a central repository of non-PHI documents that are reviewed by different agencies or review entities as an additional means of reducing administrative burden. However, it was noted that such a system would only be effective if there was agreement from all agencies and review entities to use the documents uploaded to the system and not make separate document requests. A pilot system (MART) has been developed by DBHDS and is being used with some CSBs. The outcome of this project may inform the feasibility of such a system on a larger scale.

As with reporting requirements, there are provisions in the Settlement Agreement that require

annual inspections of providers. DBHDS cannot make regulatory changes to these requirements while the related Settlement Agreement provisions are in effect. A central document repository could be implemented without any changes to the Settlement Agreement.

Accreditation

There was a strong general interest among workgroup members about utilizing accreditation as a means of deeming certain licensing requirements as met. Some members noted that in many areas, the requirements and the review conducted by accrediting bodies was more thorough than current licensing requirements and could serve to increase provider quality. Coupled with reduced licensing inspections, this could alleviate administrative burden for public and private community providers. In addition, the DBHDS Office of Licensing have been attempting to increase staff to keep up with demand for additional community provider capacity. Adding accreditation would decrease the administrative burden and ease the need to add more staff.

While there was strong consensus to consider this, there was universal consensus that further study is required before moving to implement such a process. Among the questions that would need to be addressed:

- What are the differences between accreditation bodies, and which ones would be allowed to offer deemed accreditation?
- What criteria should be used to identify appropriate accreditation bodies?
- How do the licensing requirements (as well as requirements of other agencies, for example, DMAS) compare (crosswalk) with each of the accreditation bodies?
- What are the outcomes in other states that have implemented a deemed accreditation process?
- Given the costs of becoming accredited, how would implementing this process, even if voluntary, impact smaller providers?
- Is there a benefit to providing financial support for providers to become accredited?
- To what degree would accreditation offset the administrative burden of licensing?

Such a study would need to be comprehensive and involve a consideration of all the relevant regulatory authorities in Virginia, the relevant national accreditation bodies, and a study of other states' experiences. This is beyond the existing resources of DBHDS and would require additional funding, or direction to a capable entity such as the Joint Legislative Audit and Review Committee, to complete.

While there are no specific provisions in the Settlement Agreement that would prohibit the use of accreditation as a means of determining a provider's ability to provide services, as noted above, there are provisions that require annual inspections; thus, it is not clear at this time if implementing an accreditation process could reduce provider burden without conflicting with provisions of the Settlement Agreement.

Appendices

Appendix A: Workgroup Member List

Organization	Member
Department for Aging and Rehabilitative Services	Paige McCleary
Department of Health Professions	Jaime Hoyle; Erin Barrett
Department of Medical Assistance Services	Lisa Jobe-Shields; Emily McClellan; Laura Reed
Department of Social Services	Jennifer Phillips; Shannon Hartung
Virginia Board for People with Disabilities	Jen Krajewski; Teri Morgan
The Arc of Virginia	Tonya Milling
Centers for Independent Living	Maureen Hollowell
DisAbility Law Center of Virginia	Colleen Miller; John Cimino
Loudoun County (SB1544)	John Freeman: Hannah Hirschland; Carlinda Kleck; Karin Addison
Mental Health America-Virginia	Barbara Barlow
National Alliance on Mental Health-Virginia	Kathy Harkey
Pinnacle (Provider)	Lori Ryland
VaACCSES	Karen Tefelski
Virginia Association of Community Services Boards	Circe Black; Nicole Lewis
Virginia Association of Community-based Providers	Mindy Carlin
Virginia Coalition of Private Provider Associations	Michael Triggs; Bill Elwood
Virginia Hospital and Healthcare Association	Jennifer Wicker
Virginia Network of Private Providers	Meneika Chandler; Deanna Rennon
VOCAL	Heather Orrock; Martin Mash

Appendix B: Survey

Draft Survey to Providers

Developing strategies to provide relief for DBHDS-licensed providers

Earlier this year, the General Assembly passed two bills that require the Department of Behavioral Health and Developmental Services (DBHDS) to examine regulatory requirements for DBHDS-licensed providers and provide recommendations on ways to reduce administrative burden on providers. The first, HB2255/SB1155, specifically requires DBHDS to review its regulations that impact licensed providers and consider ways to reduce the regulatory requirements on providers, including consideration of reducing the frequency of inspections for accredited providers. The second, SB1544, requires DBHDS to review regulations specific to the reporting of allegations and serious incidents.

DBHDS plans to convene a workgroup of interested parties representing licensed providers as well as individuals in the behavioral health and developmental disability services system later this summer. This survey will help to inform the workgroup's discussion, any necessary research that should be conducted, and will help to initiate ideas for recommendations the workgroup may put forward in a final report.

If you have any questions, do not hesitate to reach out to Ruth Anne Walker at ruthanne.walker@dbhds.virginia.gov.

1. *Information –
    a. First and last name
    b. Organization or company name
    c. Email address

2. If you work for a DBHDS-licensed provider, which of the following licensing or human rights requirements require the most effort or administrative burden for your agency? Please rank the options.
    a. Annual inspections
    b. Reporting abuse/neglect
    c. Reporting serious incidents
    d. Investigations
    e. Developing/implementing corrective action plans
    f. Quality improvement and risk management provisions
    g. Submission of seclusion/restraint data annually
    h. Service modifications
    i. Other
    j. Other
    k. Other

3. *In your opinion, how impactful are the following licensing or human rights requirements to ensuring the health, welfare, and safety of individuals accessing services? Please rate each option on a scale from 1 to 5 where 1 indicates minimal impact and 5 indicates a significant impact.

- Annual inspections
- Reporting abuse/neglect
- Reporting serious incidents
- Investigations
- Developing/implementing corrective action plans
- Quality improvement/risk management provisions
- Submission of seclusion/restraint data annually
- Other (from previous q)

4. *In your opinion, how quickly do you believe that reported allegations of abuse, neglect, and exploitation and incidents classified as Level II and Level III should be reported to DBHDS?
    a. Within 24 hours
    b. Next business day
    c. Other

5. [Using skip logic for those who respond with b. or c. to #4]
*What other agencies or safety mechanisms (internal or external to your organization) exist to ensure the safety of individuals until a report is submitted?

6. If you are a provider, is your organization accredited by any of the following organizations? Please check all that apply.
7. The Joint Commission
8. Council on Accreditation (COA)
9. Commission on Accreditation of Rehabilitation Facilities (CARF)
10. Other
11. None of the above
12. I am not a provider

13. What strategies would you support to ease DBHDS-licensed providers' compliance with licensing or human rights requirements? Please check all that apply.
    a. Reduce frequency of inspections for triennial license holders
    b. Reduce frequency of inspections for accredited providers
    c. Require reports of allegations and incidents next business day
    d. Desk reviews for inspections of home and non-center-based services
    e. I would not support any reductions of licensing or human rights requirements
    f. Other

14. On a scale from 1-5, with 1 being the least helpful and 5 being the most helpful, how helpful have the following Office of Licensing administrative changes been in reducing administrative burden on providers?
    a. Therapeutic Day Treatment project
    b. Honoring the sponsored provider certification process
    c. New applicant and new provider training (coming in June)

15. Are there any other issues, considerations, or recommendations related to licensing requirements you would like the workgroup to address?

Appendix C: Draft Recommendations

(as presented to the Workgroup on July 27, 2023)

RECOMMENDATION 1: CHANGES TO REPORTING REQUIREMENTS.

1. Amend regulations to change requirements to report allegations of abuse, neglect, and exploitation and level I and level II serious incidents from 24 hours to within the next business day.
2. Amend regulations to change the definition of what types of incidents are required to be reported within 24 hours.
3. Amend regulations to require different time frames for residential vs other services.
4. Amend guidelines for issuing citations to allow consideration of the provider size, and number of late reports as a percentage of all reports.
5. Make no change to reporting requirements

RECOMMENDATION 2: CHANGES TO INSPECTION REQUIREMENTS.

1. Amend the Code of Virginia to allow providers with triennial licenses, without significant or unresolved health and safety violations, to be inspected once during their license period.
2. Leverage inspections and investigations from other agencies to reduce the number of reviews that occur.
3. Create central repository for documents that can be shared across different agencies and review entities.
4. Make no change to inspection requirements

RECOMMENDATION 3: ACCREDITATION.

1. Amend the Code of Virginia to allow providers that are accredited by a recognized national accreditation body, to have reduced frequency of inspections.
2. Conduct further study to determine how to best utilize accreditation status to minimize the administrative burden associated with licensing. This would include evaluating outcomes in other states that utilize deemed accreditation; conducting a crosswalk of accreditation organization standards with licensing requirements. This would include a request for funding.
3. Make no change - do not include a consideration of accreditation status in licensing oversight.