

Application for a 1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in 1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for an Amendment to a 1915(c) Home and Community-Based Services Waiver

1. Request Information

- A. The State of Delaware requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of 1915(c) of the Social Security Act.
- B. **Program Title:**
Renewal-DDDS Waiver
- C. **Waiver Number:** DE.0009
Original Base Waiver Number: DE.0009.
- D. **Amendment Number:**
- E. **Proposed Effective Date:** (mm/dd/yy)
10/01/13
Approved Effective Date of Waiver being Amended: 07/01/09

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:
Delaware wishes to amend the DDDS waiver to make the following changes:

1. Add Supported Employment - Small Group as a waiver service and related provider qualifications and reimbursement methodology. Providers will bill in 15 minute units
2. Revise the service definition of "Supported Employment" to call it "Supported Employment - Individual" and to clarify that the staff to consumer ratio must be 1:1
3. Add service utilization estimates for Supported Employment - Small Group to Appendix J
4. Change the current billable unit for Day Habilitation, Supported Employment - Individual and Pre-vocational service from hourly to 15 minutes
5. Change the frequency of the Case Manager review of the plan of care from a monthly face to face visit with the consumer and their family or guardian to monthly "paper" reviews of the plan with documentation and four face to face visits per year to review the plan with the consumer/family/guardian and revise the related Quality Improvement performance measure.

3. Nature of the Amendment

- A. **Component(s) of the Approved Waiver Affected by the Amendment.** This amendment affects the following

component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently (*check each that applies*):

Component of the Approved Waiver	Subsection(s)
<input type="checkbox"/> Waiver Application	
<input type="checkbox"/> Appendix A <input type="checkbox"/> Waiver Administration and Operation	
<input type="checkbox"/> Appendix B <input type="checkbox"/> Participant Access and Eligibility	
<input checked="" type="checkbox"/> Appendix C <input type="checkbox"/> Participant Services	C-1
<input checked="" type="checkbox"/> Appendix D <input type="checkbox"/> Participant Centered Service Planning and Delivery	D-1.b., D-2.a, Quality Improvement PI
<input type="checkbox"/> Appendix E <input type="checkbox"/> Participant Direction of Services	
<input type="checkbox"/> Appendix F <input type="checkbox"/> Participant Rights	
<input type="checkbox"/> Appendix G <input type="checkbox"/> Participant Safeguards	
<input type="checkbox"/> Appendix H	
<input checked="" type="checkbox"/> Appendix I <input type="checkbox"/> Financial Accountability	I-2.a.
<input checked="" type="checkbox"/> Appendix J <input type="checkbox"/> Cost-Neutrality Demonstration	J-2.d

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment (*check each that applies*):

- Modify target group(s)
- Modify Medicaid eligibility
- Add/delete services
- Revise service specifications
- Revise provider qualifications
- Increase/decrease number of participants
- Revise cost neutrality demonstration
- Add participant-direction of services
- Other

Specify:

Application for a 1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The State of Delaware requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of 1915(c) of the Social Security Act (the Act).

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):

Renewal-DDDS Waiver

C. Type of Request: amendment

Requested Approval Period: (*For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.*)

3 years 5 years

Original Base Waiver Number: DE.0009

Draft ID: DE.08.06.20

D. Type of Waiver (*select only one*):

Regular Waiver

- E. Proposed Effective Date of Waiver being Amended: 07/01/09**
Approved Effective Date of Waiver being Amended: 07/01/09

1. Request Information (2 of 3)

- F. Level(s) of Care.** This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (*check each that applies*):

Hospital

Select applicable level of care

Hospital as defined in 42 CFR §440.10

If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR §440.160

Nursing Facility

Select applicable level of care

Nursing Facility As defined in 42 CFR §440.40 and 42 CFR §440.155

If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140

Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150)

If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR level of care:

1. Request Information (3 of 3)

- G. Concurrent Operation with Other Programs.** This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

Not applicable

Applicable

Check the applicable authority or authorities:

Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I

Waiver(s) authorized under §1915(b) of the Act.

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

Specify the §1915(b) authorities under which this program operates (*check each that applies*):

§1915(b)(1) (mandated enrollment to managed care)

§1915(b)(2) (central broker)

§1915(b)(3) (employ cost savings to furnish additional services)

§1915(b)(4) (selective contracting/limit number of providers)

A program operated under §1932(a) of the Act.

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been

submitted or previously approved:

- A program authorized under §1915(i) of the Act.
- A program authorized under §1915(j) of the Act.
- A program authorized under §1115 of the Act.

Specify the program:

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

- This waiver provides services for individuals who are eligible for both Medicare and Medicaid.

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The Division of Developmental Disabilities Services (DDDS) Home and Community Based Services Waiver provides care for eligible individuals in Delaware. The purpose of the DDDS Waiver is to assist individuals in leading healthy, independent and productive lives to the fullest extent possible; promote the full exercise of their rights as citizens of the State of Delaware; and promote their integration into the community to the fullest extent possible. Services are provided with the goal of promoting independence through strengthening the individual's capacity for self-care and self-sufficiency. This waiver creates the fiscal platform for a service system centered on the needs and preferences of the individuals and supports the integration of the participants within their communities. The DDDS serves to provide an on-going opportunity for individuals with developmental disabilities to transition from ICF-MRs or other living arrangements and provide residential and other comprehensive supports for people with complex needs in a non-institutional setting.

The objectives of the DDDS Waiver are to:

1. Promote independence for individuals through the provision of services meeting the highest standards of quality and national best practices, while ensuring health and safety through a comprehensive system of participant safeguards;
2. Offer an alternative to institutionalization through the provision of an array of services and supports that promote community inclusion and independence by enhancing and not replacing existing informal networks;
3. Support individuals and their families to exercise their rights and share responsibility for their programs regardless of the method of service delivery; and
4. Offer access to services that protect the health and safety of the individual if the family or other care giver is unable to continue to provide care and supervision.

The Department of Health and Social Services (DHSS) is the Single State Medicaid Agency that maintains administrative and supervisory oversight of the DDDS Waiver. The DHSS designates the authority for implementing the program(s) and for programmatic oversight of the waiver to the Department of Medicaid and Medical Assistance (DMMA) and DDDS, through a Memorandum of Understanding (MOU).

Services are accessed through entry within DDDS Office of Applicant Services. When the DDDS establishes eligibility for DDDS services and the DDDS Waiver, the participant chooses between ICF-MR and HCBS services. All waiver participants are encouraged to choose their service providers through the Freedom of Choice process. All services are prior authorized and delivered in accordance with an approved Plan of Care.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

- A. Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this

waiver.

- B. Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- D. Participant-Centered Service Planning and Delivery.** Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).
- E. Participant-Direction of Services.** When the State provides for participant direction of services, Appendix E specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. *(Select one):*
- | |
|--|
| <p>Yes. This waiver provides participant direction opportunities. <i>Appendix E is required.</i></p> <p>No. This waiver does not provide participant direction opportunities. <i>Appendix E is not required.</i></p> |
|--|
- F. Participant Rights.** Appendix F specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.
- G. Participant Safeguards.** Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.
- H. Quality Improvement Strategy.** Appendix H contains the Quality Improvement Strategy for this waiver.
- I. Financial Accountability.** Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.
- J. Cost-Neutrality Demonstration.** Appendix J contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

- A. Comparability.** The State requests a waiver of the requirements contained in 1902(a)(10)(B) of the Act in order to provide the services specified in Appendix C that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in Appendix B.
- B. Income and Resources for the Medically Needy.** Indicate whether the State requests a waiver of 1902(a)(10)(C)(i) (III) of the Act in order to use institutional income and resource rules for the medically needy *(select one):*
- Not Applicable
- No
- Yes
- C. Statewideness.** Indicate whether the State requests a waiver of the statewideness requirements in 1902(a)(1) of the Act *(select one):*
- No
- Yes
- If yes, specify the waiver of statewideness that is requested *(check each that applies):*
- Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State. *Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:*

- Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.
Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

- A. Health & Welfare:** The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
 2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
 3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.
- B. Financial Accountability.** The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.
- D. Choice of Alternatives:** The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
 2. Given the choice of either institutional or home and community based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under

the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

- G. Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
- I. Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
- J. Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR §440.160.

6. Additional Requirements

Note: Item 6-1 must be completed.

- A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.
- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1) (ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/MR.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further

bills for that insurer for that annual period.

- G. Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community- based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.
- H. Quality Improvement.** The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.
- I. Public Input.** Describe how the State secures public input into the development of the waiver:
The DDDS is currently renewing the HCBS Residential Waiver. The DDDS has incorporated, where applicable, various advocates and individual's suggestions and ideas gained through committee meetings and survey results.
- The State communicates with advocacy groups, such as the State Council for Persons with Disabilities, on an ongoing basis with regard to the operation of Waivers and other programs. In addition, an announcement about the State's plans to renew the DDDS Residential Waiver is placed in the Delaware Register of Regulations and the public is invited to submit written comments. The comment period is 30 days. Following this comment period, the State reviews, considers, and responds to all comments received.
- J. Notice to Tribal Governments.** The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.
- K. Limited English Proficient Persons.** The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

- A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:**
Last Name:

Chappell

First Name:

Daniel

Title:

Social Services Administrator

Agency:

Division of Medicaid and Medical Assistance

Address:

1901 N Dupont Hwy

Address 2:

Lewis Bldg

City:

New Castle

State:

Delaware

Zip:

19720

Phone:

(302) 255-9625

Ext:

TTY

Fax:

(302) 255-4425

E-mail:

daniel.chappell@state.de.us

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:
Last Name:

Nonnenmacher

First Name:

Marie

Title:

Deputy Director

Agency:

Division of Developmental Disabilities Services

Address:

2540 Wrangle Hill Road, Suite 200

Address 2:

City:

Bear

State:
Delaware
Zip:

19701

Phone:

(302) 836-2138

Ext:

TTY

Fax:

(302) 836-2647

E-mail:

marie.nonnenmacher@state.de.us

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the State's request to amend its approved waiver under §1915(c) of the Social Security Act. The State affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The State further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The State certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature:

State Medicaid Director or Designee

Submission Date:

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name:

First Name:

Title:

Agency:

Address:

.....

Address 2:

.....

City:

.....

State:

Delaware

Zip:

.....

Phone:

..... Ext: TTY

Fax:

.....

E-mail:

.....

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

N/A

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

N/A

Appendix A: Waiver Administration and Operation

- 1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

The waiver is operated by the State Medicaid agency.

Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (*select one*):

The Medical Assistance Unit.

Specify the unit name:

(Do not complete item A-2)

Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

Division of Developmental Disabilities Services

(Complete item A-2-a).

The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency.

Specify the division/unit name:

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

- a. **Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

Delaware Health and Social Services (DHSS) is the state agency with overall accountability for Delaware's public health and social service programs. The DHSS houses both the Division of Medicaid and Medical Assistance (DMMA) and the Division of Developmental Disabilities Services (DDDS). The DHSS is the Single Medicaid Agency and has oversight responsibility via the established reporting relationships on the Division's contained under the Department's umbrella.

DMMA is directly responsible for either the operation or oversight of all Medicaid funded programs (e.g., Managed Care, Waivers). DHSS's Division of Developmental Disabilities Services (DDDS) is responsible for the administration and operation of the DDDS Residential Waiver.

A memorandum of understanding (MOU) between the two agencies spells out the methods used by DMMA to ensure the operating agency (DDDS) performs its assigned operational and administrative functions in accordance with waiver requirements.

DMMA conducts monitoring of the operation of the DDDS Residential Waiver program on an ongoing basis. Monitoring includes, but is not limited to the review of DDDS's provider audits/oversight reviews; quality assurance program data; policies and procedures; provider recruitment efforts; and maintenance of waiver enrollment against approved limits. Specifically, monitoring occurs through three different avenues:

- 1) Delaware Health and Social Services (DHSS) Quality Initiative Improvement (QII) Task Force;
- 2) DMMA Surveillance and Utilization Review (SUR); 3) DMMA's Delegated Services and Medical Management Unit.

QII: DDDS has an internal Quality Assurance system which provides information on an ongoing basis to DMMA via the Department-wide QII Task Force. The QA Unit within DDDS consists of performance and

oversight staff members who work with DDDS's Chief of Administration and Waiver Coordinator to compile and analyze program data.

SUR: DMMA maintains and operates the Medicaid Management Information System (MMIS) in accordance with Federal regulations and is responsible for associated financial and utilization reporting. MMIS includes a SUR system.

On a quarterly basis, the SUR subsystem, produces reports that compare peer ranking of all providers (e.g., comparing providers of a similar type in a similar geographic area) on a variety of dimensions such as service utilization, prior authorizations, invoice payments etc. Providers who deviate from the norm are examined further by the SUR team of auditors. A case under consideration may be resolved at the completion of the desk review and upon receipt of additional documentation from the provider. If it is determined a provider has been overpaid, a letter is sent by the SUR unit to the provider requesting the return of the overpayment.

Desk reviews warranting additional investigation lead to a field audit. The SUR team conducts an onsite review of the provider's records. The SUR unit continues to monitor the case via the subsystem reports each quarter. The SUR Unit Administrator keeps a log of reviews conducted and has the ability to compile trends data that result in the initiation of continued or new reviews.

DMMA Delegated Services and Medical Management Unit: DDDS submits quarterly reports to DMMA documenting results of case file review, participant questionnaires, and provider questionnaires. Other documentation, such as corrective action plans and Fair Hearing reports are submitted to DMMA for review, as described in the Quality Management Strategy.

- b. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

3. **Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.*

Delaware contracts with a provider relations agent to perform specific administrative functions under the waiver, as indicated in Question # 7 of this section. Specific functions performed by this contractor include the ongoing recruitment and enrollment of service providers, executing the Medicaid provider agreement, and the verification of provider licensure on an annual basis.

Provider relations agent functions include:

- enrolling service providers,
- executing the Medicaid provider agreement,
- conducting training, processing claims,
- provider payment
- providing technical assistance to providers concerning waiver requirements
- verifying provider licensure/certification on an annual basis

Contracts are signed by the DMMA Director.

No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).

Appendix A: Waiver Administration and Operation

4. **Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

Not applicable

Applicable - Local/regional non-state agencies perform waiver operational and administrative functions.

Check each that applies:

- Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

- Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:
The Division of Medicaid and Medical Assistance (DMMA) is responsible for assessing the performance of the provider relations agent.

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:
DMMA MMIS Status Group composed of the Chief Administrators, fiscal staff, and contract monitors review provider relations agent performance requirements. This team meets with the provider relations agent account management team twice per month to review performance measures. Performance measures include but are not limited to: timely enrollment of new providers, maintenance of provider enrollment criteria, timely response to provider inquires, billing activities, and all applicable federal and state policies and procedures. Operational policies and procedures are in place to ensure all provider activities are reviewed and approved by DMMA.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check*

each that applies):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Contracted Entity
Participant waiver enrollment	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Waiver enrollment managed against approved limits	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Waiver expenditures managed against approved levels	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Level of care evaluation	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Review of Participant service plans	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Prior authorization of waiver services	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Utilization management	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Qualified provider enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Execution of Medicaid provider agreements	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Establishment of a statewide rate methodology	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Rules, policies, procedures and information development governing the waiver program	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of waiver policies/procedures approved by the Medicaid agency prior to implementation. (Number of waiver policies/procedures approved prior to implementation / total number of waiver policies/procedures that were reviewed.)

Data Source (Select one):

Other

If 'Other' is selected, specify:

Presentation of policies or procedures

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:

Number and percent of unduplicated participants exceeding the maximum enrollment limits. (Number of persons enrolled per DDDS Quarterly Reports/maximum number of persons approved to be served)

Data Source (Select one):

Other

If 'Other' is selected, specify:

Reports to State Medicaid Agency on delegated Administrative functions

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other

	Specify:
--	----------

Performance Measure:

Number & Percent of performance reports reviewed by Medicaid agency (Number of performance reports reviewed by Medicaid agency/total number of performance reports)

Data Source (Select one):

Other

If 'Other' is selected, specify:

Fair Hearing Reports

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

Data Source (Select one):

Other

If 'Other' is selected, specify:

Analyzed collected data (including surveys, focus group, interviews, etc)

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review

<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of Fair Hearing Reports reviewed by Medicaid agency.
(Numerator: Fair Hearing Reports reviewed Denominator: all Fair Hearing reports)

Data Source (Select one):

Other

If 'Other' is selected, specify:

Quarterly DDDS Performance Reports

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

Number and percent of DMMA's Quality Improvement Initiative (QII) Task Force meetings during which E&D Waiver quality assurance and quality improvement activities are discussed. (Numerator: QII meetings during which E&D Waiver quality assurance and quality improvement activities are discussed Denominator: All QII meetings)

Data Source (Select one):

Analyzed collected data (including surveys, focus group, interviews, etc)

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

DMMA instituted a quality improvement strategy to include tools to assess programs and services which is reviewed by DMMA at least annually. Several tools were developed to collect data from the participant & providers to collect data to assess the program, identify strengths and opportunities for improvement. Those tools include participant survey, provider survey, complaint and incident log and fair hearing report. After review of the reported information DMMA requests a corrective action plan when applicable. DMMA follows up in 60 days when corrective action plans are required to assure changes for improvement took place.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

After review of the reported information DMMA may request a corrective action plan. A corrective action plan is to be sent to DMMA within 30 days of notification of problems identified. DMMA follows up with the agency within 60 days to assure corrective measures are implemented to avoid future incidents from re-occurring.

The Division of Medicare and Medicaid Assistance (DMMA) has a Memorandum of Understanding with the Division of Developmental Disabilities Services (DDDS) delegating administrative duties. DMMA receives quarterly reports from the DDDS in advance of a quarterly meeting with administrative and quality assurance staff of DDDS. Findings in the report are discussed and trends noted. DMMA shall request additional information and corrective action based on a review of data reported and discussed. Meeting minutes record discussions and follow-up/remediation required of DDDS by DMMA.

Performance measure related to policy and procedure review: A review of waiver policies and procedures ensure no HCBS Residential Waiver policy/procedure is implemented by the DDDS prior to approval by DMMA.

In addition, the DMMA will, through ongoing review of plans of care, utilization review/quality review processes provided by DDDS, and data obtained through the MMIS monitor to ensure compliance with all assurances and sub-assurances. If the DMMA discovers a policy/procedure was implemented by DDDS without DMMA's approval, DMMA immediately notifies DDDS in writing such policy or policy modification is not effective pending the review and approval of DMMA. The DMMA performs an expedited review of the applicable policy or policy modification, and provides a written response regarding the disposition of the policy or policy modification. If revisions to the policy are needed, DMMA advises DDDS regarding needed revisions, with subsequent review and approval required by DMMA prior to implementation of the policy or policy modification. If approved, the effective date of such policy or policy modification is no earlier than the date of approval by DMMA.

Remaining performance measures: Issues which require individual remediation may come to DMMA's attention through quarterly review of DDDS Quality Management Reports, as well as through day-to-day activities of the DDDS, e.g., review/approval of provider agreements, utilization review and Quality Review processes, complaints from HCBS Residential Waiver recipients related to waiver participation/operation by phone or letter, etc. Remediation activities are reported to DMMA by the DDDS as follow-up to these activities, and aggregated in the DDDS Quality Management Reports.

- ii. **Remediation Data Aggregation**
Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually

	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. **Target Group(s).** Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to a group or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR § 441.301(b)(6), select one waiver target group, check each of the subgroups in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
Aged or Disabled, or Both - General					
	<input type="checkbox"/>	Aged			
	<input type="checkbox"/>	Disabled (Physical)			
	<input type="checkbox"/>	Disabled (Other)			
Aged or Disabled, or Both - Specific Recognized Subgroups					
	<input type="checkbox"/>	Brain Injury			
	<input type="checkbox"/>	HIV/AIDS			
	<input type="checkbox"/>	Medically Fragile			
	<input type="checkbox"/>	Technology Dependent			
Mental Retardation or Developmental Disability, or Both					
	<input checked="" type="checkbox"/>	Autism	4		
	<input checked="" type="checkbox"/>	Developmental Disability	4		
	<input checked="" type="checkbox"/>	Mental Retardation	4		
Mental Illness					
	<input type="checkbox"/>	Mental Illness			

		Serious Emotional Disturbance		
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- b. **Additional Criteria.** The State further specifies its target group(s) as follows:

Waiver eligibility includes the following criteria:

1) A diagnosis of mental retardation and/or of developmental disabilities as delineated in Delaware Administrative Code and is subsequently deemed eligible to receive DDDS Services;

2) Meets level of care and financial eligibility for ICF/MR Services;

3) Is age 4 years or older;

4) Is at risk of needing more intensive supports and needing a residential placement outside of the natural family home as identified in the DDDS' Registry risk assessment component and based on the results of the risk assessment is given an Urgent or High Risk designation. In addition, as promulgated into the Delaware Health and Social Services Policy Memorandum Number 7, titled, "Client Service Waiting List", all services for which a waiting list becomes necessary shall maintain that list in one of the following two fashions:

a. According to the relative need of each participant/potential participant, with those having critical needs being served first. The Division of Developmental Disabilities Services utilizes this method for entrants to this Waiver.

5) Needs a residential placement to remain safely in the community.

6) Individual is a current resident in the Stockley Center ICF/MR and is seeking home and community based services vs. institutional services and request to leave the ICF/MR irrespective of the findings/score of the risk assessment. This provision was signed into law by Governor Ruth Ann Minner in response to Delaware's Olmstead initiatives.

- c. **Transition of Individuals Affected by Maximum Age Limitation.** When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit (*select one*):

Not applicable. There is no maximum age limit

The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

- a. **Individual Cost Limit.** The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual (*select one*) Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

No Cost Limit. The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

Cost Limit in Excess of Institutional Costs. The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

The limit specified by the State is (*select one*)

A level higher than 100% of the institutional average.

Specify the percentage:

Other

Specify:

Institutional Cost Limit. Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*

Cost Limit Lower Than Institutional Costs. The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

The cost limit specified by the State is (select one):

The following dollar amount:

Specify dollar amount: _____

The dollar amount (select one)

Is adjusted each year that the waiver is in effect by applying the following formula:

Specify the formula:

May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.

The following percentage that is less than 100% of the institutional average:

Specify percent: _____

Other:

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

- b. **Method of Implementation of the Individual Cost Limit.** When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

- c. **Participant Safeguards.** When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant (*check each that applies*):

- The participant is referred to another waiver that can accommodate the individual's needs.
- Additional services in excess of the individual cost limit may be authorized.

Specify the procedures for authorizing additional services, including the amount that may be authorized:

- Other safeguard(s)

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

- a. **Unduplicated Number of Participants.** The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	940
Year 2	980
Year 3	1020
Year 4	1060
Year 5	1100

- b. **Limitation on the Number of Participants Served at Any Point in Time.** Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this

way: *(select one)*:

The State does not limit the number of participants that it serves at any point in time during a waiver year.

The State limits the number of participants that it serves at any point in time during a waiver year.

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4	
Year 5	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

- c. **Reserved Waiver Capacity.** The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

Not applicable. The state does not reserve capacity.

The State reserves capacity for the following purpose(s).

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

- d. **Scheduled Phase-In or Phase-Out.** Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

The waiver is not subject to a phase-in or a phase-out schedule.

The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.

- e. **Allocation of Waiver Capacity.**

Select one:

Waiver capacity is allocated/managed on a statewide basis.

Waiver capacity is allocated to local/regional non-state entities.

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

- f. **Selection of Entrants to the Waiver.** Specify the policies that apply to the selection of individuals for entrance to the

Specify percentage: _____

- Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)
- Working individuals with disabilities who buy into Medicaid (TWWIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)
- Working individuals with disabilities who buy into Medicaid (TWWIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)
- Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)
- Medically needy in 209(b) States (42 CFR §435.330)
- Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)
- Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)

Specify:

Special home and community-based waiver group under 42 CFR §435.217 Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed

No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.

Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.

Select one and complete Appendix B-5.

All individuals in the special home and community-based waiver group under 42 CFR §435.217
Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217

Check each that applies:

- A special income level equal to:

Select one:

300% of the SSI Federal Benefit Rate (FBR)

A percentage of FBR, which is lower than 300% (42 CFR §435.236)

Specify percentage: 250

A dollar amount which is lower than 300%.

Specify dollar amount:

- Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)
- Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)
- Medically needy without spend down in 209(b) States (42 CFR §435.330)

waiver:

Waiver eligibility includes the following criteria:

- 1) A diagnosis of mental retardation of developmental disabilities as delineated in Delaware Administrative Code and is subsequently deemed eligible to receive DDDS Services;
- 2) Meets level of care and financial eligibility for ICF/MR Services;
- 3) Is age 4 years or older;
- 4) Is at risk of needing more intensive supports as identified in the DDDS' Registry risk assessment component and based on the results of the risk assessment is given an Urgent or High Risk designation or is a resident of an ICF/MR state institution and seeking services and supports in a home and community-based setting. No waiting list is in place currently. Should a waiting list arise DDDS prioritizes participant's through the use of a risk factor assessment that identifies issues/risk that indicate the probable need for an out of home long term residential placement. Subsequently, placements are not filled on a first come first serve basis.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

- a.
 1. **State Classification.** The State is a (*select one*):
 - §1634 State
 - SSI Criteria State
 - 209(b) State
 2. **Miller Trust State.**
Indicate whether the State is a Miller Trust State (*select one*):
 - No
 - Yes
- b. **Medicaid Eligibility Groups Served in the Waiver.** Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply:*

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- Low income families with children as provided in §1931 of the Act
- SSI recipients
- Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121
- Optional State supplement recipients
- Optional categorically needy aged and/or disabled individuals who have income at:

Select one:

- 100% of the Federal poverty level (FPL)
- % of FPL, which is lower than 100% of FPL.

- Aged and disabled individuals who have income at:

Select one:

100% of FPL

% of FPL, which is lower than 100%.

Specify percentage amount:

- Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 4)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

- a. **Use of Spousal Impoverishment Rules.** Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217 (select one):

Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.

In the case of a participant with a community spouse, the State elects to (select one):

Use spousal post-eligibility rules under §1924 of the Act.

(Complete Item B-5-b (SSI State) and Item B-5-d)

Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)

(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.

(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 4)

- b. **Regular Post-Eligibility Treatment of Income: SSI State.**

The State uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (select one):

The following standard included under the State plan

Select one:

- SSI standard
- Optional State supplement standard
- Medically needy income standard
- The special income level for institutionalized persons

(select one):

- 300% of the SSI Federal Benefit Rate (FBR)
- A percentage of the FBR, which is less than 300%

Specify the percentage: 250
 A dollar amount which is less than 300%.

Specify dollar amount:
 A percentage of the Federal poverty level

Specify percentage:
 Other standard included under the State Plan

Specify:

The following dollar amount

Specify dollar amount: If this amount changes, this item will be revised.

The following formula is used to determine the needs allowance:

Specify:

Other

Specify:

ii. Allowance for the spouse only (select one):

Not Applicable

The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:

Specify:

Specify the amount of the allowance (*select one*):

- SSI standard
- Optional State supplement standard
- Medically needy income standard
- The following dollar amount:

Specify dollar amount: _____ If this amount changes, this item will be revised.
 The amount is determined using the following formula:

Specify:

iii. Allowance for the family (*select one*):

- Not Applicable (see instructions)
- AFDC need standard
- Medically needy income standard
- The following dollar amount:

Specify dollar amount: _____ The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR 435.811 for a family of the same size. If this amount changes, this item will be revised.
 The amount is determined using the following formula:

Specify:

Other

Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR 435.726:

- a. Health insurance premiums, deductibles and co-insurance charges
- b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

Not Applicable (see instructions)*Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*

The State does not establish reasonable limits.

The State establishes the following reasonable limits

Specify:

[Empty box for specifying reasonable limits]

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 4)

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 4)

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan.. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(select one):

- SSI standard**
- Optional State supplement standard**
- Medically needy income standard**
- The special income level for institutionalized persons**
- A percentage of the Federal poverty level**

Specify percentage: _____

The following dollar amount:

Specify dollar amount: _____ If this amount changes, this item will be revised

The following formula is used to determine the needs allowance:

Specify formula:

[Empty box for specifying formula]

Other

Specify:

- ii. **If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.**

Select one:

- Allowance is the same**
Allowance is different.

Explanation of difference:

- iii. **Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR 435.726:**

- a. Health insurance premiums, deductibles and co-insurance charges
 b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

Not Applicable (see instructions)*Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*

The State does not establish reasonable limits.

The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR 441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level (s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

- a. **Reasonable Indication of Need for Services.** In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:

- i. **Minimum number of services.**

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 2

- ii. **Frequency of services.** The State requires (select one):

The provision of waiver services at least monthly

Monthly monitoring of the individual when services are furnished on a less than monthly basis

If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

- b. Responsibility for Performing Evaluations and Reevaluations.** Level of care evaluations and reevaluations are performed (*select one*):

Directly by the Medicaid agency

By the operating agency specified in Appendix A

By an entity under contract with the Medicaid agency.

Specify the entity:

Other

Specify:

- c. Qualifications of Individuals Performing Initial Evaluation:** Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Staff conducting initial ICF/MR Level of Care must be licensed as:

1) Doctor of medicine;

OR

2) Doctor of oteopathy in the State of Delaware.

AND

1) Licensed psychologist;

OR

2), Certified school psychologist;

OR

3) Licensed physician who practices psychiatry in the State of Delaware.

- d. Level of Care Criteria.** Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

Level of Care Criteria:

ICF/MR

1) Individual/applicant has a diagnosis of mental retardation or developmental disabilities and has been deemed eligible for services through the Division of Developmental Disabilities Services (DDDS).

2) Has been recommended for an ICF/MR level of care based on medical evaluation (through the completion of the MAP 25) which is a medical report completed by a doctor of medicine or oteopathy in the State of Delaware. This is sanctioned in Delaware's Administrative Code, Title 16, and includes the relevant medical information necessary to evaluate an individual and his/her need for an ICF/MR level of care designation.

Diagnosis of Mental Retardation or related Developmental Disabilities:

1) The DDDS determines the individual/applicant's diagnosis of mental retardation or related developmental disabilities by meeting the following requirements:

- a. The administration of the Adaptive Behavior Assessment System (ABAS) or Vineland Adaptive Behavior Scale (VABS) by a licensed psychologist, certified school psychologist or a licensed physician who practices psychiatry shall certify that the individual/applicant has significantly sub-average intellectual functioning or otherwise meets the following criteria:
- b. An adaptive behavior composite standard score of 2 or more standard deviations below the mean; or a standard score of two or more standard deviations below the mean in one or more component functioning areas (ABAS: Conceptual, Social; Practical: VABS: Communication; Daily living Skills, Social).
- e. **Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care (*select one*):
 - The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
 - A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

- f. **Process for Level of Care Evaluation/Reevaluation:** Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

The Level of Care is based on a review of the individual/applicant's medical, cognitive and adaptive behavior functioning.

1. A review of the case record is conducted to review diagnoses, educational and work history, social and developmental history, medical history and psychiatric history.
2. Has been recommended for an ICF/MR level of care based on medical evaluation (through the completion of the MAP 25) which is a medical report completed by a doctor of medicine or osteopathy in the State of Delaware. This is sanctioned in Delaware's Administrative Code, Title 16, and includes the relevant medical information necessary to evaluate an individual and his/her need for an ICF/MR level of care designation.
3. If the record contains an educational or psychological evaluation that includes the VABS or ABAS, it is reviewed to determine if the results reflect a valid determination of the individual's functional skills and abilities.
4. If the record does not contain a valid VABS or ABAS assessment, one is conducted. Evaluations are conducted by persons qualified to administer the instrument including a licensed psychologist, certified school psychologist or a licensed physician who practices psychiatry.
5. An adaptive behavior composite standard score of 2 or more standard deviations below the mean; or a standard score of two or more standard deviations below the mean in one or more component functioning areas (ABAS: Conceptual, Social; Practical: VABS: Communication; Daily living Skills, Social).
6. The Level of Care determination conducted is reviewed by a Licensed Psychologist or Registered Psychological Assistant.

Re-evaluations of Level of Care, are based on information provided in case notes, observations, reports from clinicians/doctors, and hospitals. Case Manager's are required to have an Associates degree or higher in a related human services field and conduct a review of all available information in preparation for the annual plan of care (ELP - Essential Lifestyles Plan) meeting with members of the individual's team including the individual and his/her representatives.

1. The review determines if the individual's functioning continues to be validly measured by the current assessments and evaluations in the record. If the record is valid, a determination of ICF/MR Level of Care is completed as described in number 4 above.
 2. If it is determined the current record is not a valid reflection of the individual's functional skills and abilities the processes outlined in Numbers 3 and 4 is followed.
 3. The Level of Care determination conducted is reviewed and a recertification is signed by a Licensed Psychologist or Registered Psychological Assistant.
- g. Reevaluation Schedule.** Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule (*select one*):
- Every three months**
 - Every six months**
 - Every twelve months**
 - Other schedule**
Specify the other schedule:

- h. Qualifications of Individuals Who Perform Reevaluations.** Specify the qualifications of individuals who perform reevaluations (*select one*):
- The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
 - The qualifications are different.**
Specify the qualifications:

The Level of Care reevaluations is signed by a Licensed Psychologist or Registered Psychological Assistant as outlined in State of Delaware Professional Regulation.

- i. Procedures to Ensure Timely Reevaluations.** Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care (*specify*):

A component part of the case manager's role is to ensure completion of a reevaluation of Level of Care (LOC) within twelve months of the previous determination, generally in conjunction with the participant's Annual ELP Conference. In addition, all Level of Care reevaluation forms are submitted to the DDDS Office of Budget, Contracts, and Business Services where relevant information is entered into a database prior to the forms being forwarded to and upon return from Division of Medicaid and Medical Assistance (DMMA).

The data entry process allows for the tracking of the interval between evaluations, the interval between annual conference meetings, and the alert of LOC reevaluations and annual conferences overdue. Moreover, the database enables DDDS to furnish DMMA with periodic statistical reports regarding the timeliness of LOC reevaluation documents to facilitate the agency's oversight of the waiver. Copies of the LOC reevaluation are kept by the case manager, the DDDS Office, and the Health Information Department.

After the Case Manager gathers the necessary documentation the Level of Care reevaluations is signed by a Licensed Psychologist or Registered Psychological Assistant as outlined in State of Delaware Professional Regulation.

- j. Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

The Division of Developmental Disabilities Services, Health Information Management Department (HIM), located on the campus of the Stockley Center, Delaware's only state operated ICF/MR institution.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the

State s methods for discovery and remediation.

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

i. Sub-Assurances:

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

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

B-a-1: The percentage of all new waiver participants for whom an ICF/MR Level of Care has been completed (Number of new participants with an ICF/MR Level of Care completed/Total Number of new participants)

Data Source (Select one):

Other

If 'Other' is selected, specify:

The Division's Office of Budget, Contracts & Business Services data tracking system of completed Level of Care assessments submitted and forwarded for State Medicaid approval.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:

	<input type="checkbox"/> Other Specify:	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

- b. *Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.*

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

B-b-1: The percentage of individuals who have had a Level of Care (LOC) recertification within 365 days. Calculated by: Number of LOC Recertifications done within 365 days of previous one / Total number of individuals on Waiver.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

The Office of Budget Contracts and Business Services' data tracking system of completed LOC assessments submitted for State Medicaid approval. The system will track the timeliness of LOC submissions.

Responsible Party for data	Frequency of data collection/generation	Sampling Approach (check each that applies):
-----------------------------------	--	---

collection/generation <i>(check each that applies):</i>	<i>(check each that applies):</i>	
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

c. **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.*

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

B.c.1 The percentage of Level of Care (LOC) assessment and re-assessments completed using current forms and assessments. (Total LOC's completed using current forms/Total LOC's completed).

Data Source (Select one):

Other

If 'Other' is selected, specify:

The Division's Office of Health Information Management data base.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each)	Frequency of data aggregation and analysis (check each that applies):

<i>that applies):</i>	
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:

**B.c.2 The percentage of LOC's in which the criteria were applied appropriately.
(Number of LOC's in which the criteria were applied appropriately/Total Number of LOC's)**

Data Source (Select one):

Other

If 'Other' is selected, specify:

Division's Office of Quality Management shall use the Office of Budget, Contracts, and Business Services unit data tracking system of completed LOC assessments submitted for State Medicaid approval.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:

<input type="checkbox"/> Other Specify:

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:

B.c.3 The percentage of LOC's where the applicant was found to be ineligible in which the criteria were applied correctly (The total number of individuals found ineligible/Total number ineligible in which criteria was applied correctly)

Data Source (Select one):

Other

If 'Other' is selected, specify:

Actual Level of Care documents in which the individual was deemed ineligible

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe

		Group:
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

To track 100% samples of the initial Level of Care evaluations (new applicants) and the submission of timely reevaluations within 365 days. The DDDS Level of Care tracking system/database ensures all Level of Care evaluations are sent to the State Medicaid Office within the required time frame.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
 - uOn-going data compilation on these measures are conducted by Office of Budget Contract and Business Services (OBCBS) and the Department of Quality Management within the Division of Developmental Disabilities Services. When errors are discovered, information is conveyed to the Regional Program Director (s) by an OBCBS representative requesting remedial, corrective actions and the due date (which must be within 60 days). OBCBS tracks the subsequent corrective actions and compile the data quarterly and annually.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

	Frequency of data aggregation and analysis
--	--

Responsible Party <i>(check each that applies):</i>	<i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. As provided in 42 CFR § 441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:

- i. informed of any feasible alternatives under the waiver; and*
- ii. given the choice of either institutional or home and community-based services.*

- a. Procedures.** Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

When an individual is determined to require a level of care provided in an institutional setting, the individual or his or her legal guardian is informed of any feasible alternative under the waiver prior to enrollment in the waiver. The decision between home and community-based services, such as the DDDS HCBS Residential Waiver, or services provided in an institutional setting is solely that of the applicant or his or her legal guardian and is documented on the recipient's Agreement For Participation In Home And Community-Based Services form. The HIM (Health Information Management) office maintains the original eligibility form and a copy is provided to the recipient, their legal guardian and/or family as well as the service provider (if applicable).

The DDDS assures each individual found eligible for the waiver is given freedom of choice of all qualified providers of each service included in his or her written plan of care including the choice of care provided in an institutional setting.

The individual and his/her family or representative is given these choices through the Intake Coordinator and Case Manager.

- b. **Maintenance of Forms.** Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

The Division of Developmental Disabilities Services, Health Information Management Department (HIM), which is located on the grounds of the Stockley Center.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

The DDDS ensures all DDDS applicants with limited proficiency in English have full access to DDDS services in his primary language, if needed. DDDS entered into an agreement for the purchase of interpretative (oral and written) services with Language Services Associates (LSA). LSA provides language services on a twenty-four hour, seven day a week basis for up 179 languages. They are equipped to provide language experts in all areas of DDDS service need.

For those persons who are deaf or hard of hearing or who are visually impaired, the DDDS, through existing DDDS and local agencies and resources provide full access to DDDS services.

Delaware Health & Social Services, Division of Medicaid & Medical Assistance (DMMA) provides Spanish, Braille, and American sign language translation services for Medicaid enrollees as needed. DMMA staff utilizes the following resources to support Waiver eligible's and participants with interpretation: AT&T's Language Line and independently-contracted language interpreters

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

- a. **Waiver Services Summary.** List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:

Service Type	Service	<input type="checkbox"/>	<input type="checkbox"/>
Statutory Service	Case Management		
Statutory Service	Day Habilitation		
Statutory Service	Prevocational Services		
Statutory Service	Residential Habilitation		
Statutory Service	Supported Employment - Individual		
Statutory Service	Supported Employment - Small Group		
Other Service	Clinical Consultative Services: Behavioral Consultative Services/Nursing Consultative Services		
Other Service	Transportation - Residential Services		

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request

through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

Service Definition (Scope):

Effective 1/1/12, case management is no longer included in the waiver.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Case Manager

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Case Management

Provider Category:

Agency

Provider Type:

Case Manager

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Reference the CMS approved workplan section I.A.1-I.A.18 for additional information and details. The action steps of the work plan spell out the steps the State will be doing to changes from a waiver service to an administrative function.

The minimum qualifications for a case manager are:

Possession of an Associates Degree or higher Behavioral or Social Science or related field.

OR

Experience in health or human services support which includes interviewing clients and assessing

personal, health, social or financial needs in accordance with program requirements; may coordinate with community resources to obtain client services.
 Experience in making recommendations as part of a clients service plan such as clinical treatment, counseling, or determining eligibility for health or human services/benefits.
 Experience in using automated information system to enter, update, modify, delete, retrieve/inquire and report on data.
 Experience in narrative report writing.

Also with the following knowledge, skills, and abilities:

Knowledge of principles, practices, methods and techniques of social work.
 Knowledge of Federal/State eligibility and assistance requirements including Delaware Hospital for the Chronically Ill admission medicare and medicaid.
 Knowledge of agency, hospital, community functions, resources and eligibility requirements.
 Skill in writing, preparing case histories, summaries, logs, reports and records.
 Skill in interviewing applicants and analyzing, assessing and determining needs.
 Skill in counseling clients and establishing effective working relationships with co-professionals.
 Ability to conduct investigations.
 Ability to work in stressful situations.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Developmental Disabilities Services

Frequency of Verification:

Upon hire and annual performance review

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Day Habilitation

Alternate Service Title (if any):

Service Definition (Scope):

Day Habilitation includes assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills which takes place in a non-residential setting, separate from the home or facility in which the individual resides. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, and personal choice. Services are furnished as specified in the participant's service plan. Day Habilitation services can be provided as a full day or hourly. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day).

Day Habilitation services focus on enabling the participant to attain or maintain his or her maximum functional level in completing activities of daily living and instrumental activities of daily living and shall be coordinated with any physical, occupational, or speech therapies in the service plan. In addition, day habilitation services may serve to reinforce skills or lessons taught in other settings. Day habilitation may not be provided to a participant during the same hours that Supported Employment, Work Services or Community Inclusion is provided.

Transportation to and from the day activity may be provided or arranged by the licensed provider. The licensee shall use the mode of transportation which achieves the least costly, and most appropriate, means of transportation for the individual with priority given to the use of public transportation when applicable and/or appropriate. Transportation expenses are included in the Day Habilitation rate during the initial process of determining an individual rate.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:



Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Day Habilitation

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
 Service Name: Day Habilitation

Provider Category:

Agency

Provider Type:

Day Habilitation

Provider Qualifications

License (specify):



Certificate (specify):

Must be a Division of Developmental Disabilities Services Certified Provider.

Other Standard (specify):

Must adhere to all standards, policies, and guidelines in the State of Delaware Day Program Contract including all State of Delaware Day Habilitation Standards included therein.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Developmental Disabilities Services

Frequency of Verification:

Prior to contract approval or renewal (at least annually) or as needed based on service monitoring concerns.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Prevocational Services

Alternate Service Title (if any):

Service Definition (Scope):

Prevocational Services prepare a participant for paid or unpaid employment. Services include teaching such concepts as compliance, attendance, task completion, problem solving and safety. Services are not job-task oriented, but instead, aimed at a generalized result. Services are reflected in the participant's service plan and are directed to habilitative rather than explicit employment objectives. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, and personal choice. Services are furnished or specified in the participant's service plan. Pre-Vocational services can be provided as a full day or hourly. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day).

These services also focus on enabling the participant to attain or maintain his or her maximum functional abilities in completing activities of daily living as well as instrumental activities of daily living and shall be coordinated with any physical, occupational, or speech therapies in the service plan. In addition, Prevocational Services may serve to reinforce skills or lessons taught in other settings. Prevocational services may not be provided to a participant during the same hours that Supported Employment, Work Services or Community Inclusion is provided. Transportation expenses are included in the Prevocational services rate during the initial process of determining an individual rate.

Prevocational services are not available under a program under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401 (16 and 17)).

Documentation is maintained in the file of each individual receiving this service that the service is not otherwise available under a program funding under the Rehabilitation Act of 1973, or P.L. 94-142.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Prevocational Services

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Prevocational Services

Provider Category:

Agency

Provider Type:

Prevocational Services

Provider Qualifications

License (specify):

Certificate (specify):

Must be a Division of Developmental Disabilities Services Certified Provider.

A service site must be certified by the U.S. Department of Labor as a Work Activity Center as defined in Section 14 © of the Fair Labor Standards Act.

Other Standard (specify):

Must adhere to all standards, policies, and guidelines in the State of Delaware Day Program Contract including:

The Contractor agrees to adhere to the requirements of DHSS Policy Memorandum # 46, and divisional procedures regarding the reporting and investigation of suspected abuse, neglect, mistreatment, misappropriation of property and significant injury of residents/clients receiving services, including providing testimony at any administrative proceedings arising from such investigations.

The Contractor, including its parent company and its subsidiaries, and any subcontractor, including its parent company and subsidiaries, agree to comply with the provisions of 29 Del. Code, Chapter 58: Laws Regulating the Conduct of Officers and Employees of the State, and in particular with Section 5805 (d): Post Employment Restrictions.

Contractor shall conduct child abuse and adult abuse registry checks and obtain service letters in accordance with 19 Del. Code Section 708; and 11 Del. Code, Sections 8563 and 8564. Contractor shall not employ individuals with adverse registry findings in the performance of contract. The Contractor agrees that professional staff employed in the execution of this contract shall be state licensed, certified, or registered in their profession as required by state law. In the case of direct care personnel, certification shall be obtained through successful completion of a training program as required by the DDDS.

Must adhere to ALL standards in the DDDS Home and Community Based Waiver Prevocational Standards included and signed with the State of Delaware Contract.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Developmental Disabilities Services

Frequency of Verification:

Prior to contract approval or renewal (at least annually) or as needed based on service monitoring concerns

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Residential Habilitation

Alternate Service Title (if any):

Service Definition (Scope):

Residential services can include assistance with acquisition, retention, or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a

non-institutional community-based setting. These services are individually planned and coordinated through the individual's ELP. These services may include a combination of lifelong-or extended duration-supervision, training and/or support which are essential to daily community living, including assessment and evaluation and the cost of training materials, transportation, fees and supplies.

Payments for residential habilitation are not made for room and board. Payment for residential habilitation does not include payments made, directly or indirectly, to members of the individual's immediate family. Transportation is a component part of Residential Habilitation Services.

Residential Habilitation Services may be in a neighborhood group home setting, a supervised or staffed apartment (community living arrangement), or a shared living arrangement (formerly titled foster care).

Services provided under a shared living arrangement, or foster care, include personal care and supportive services (e.g., homemaker, chore, attendant care, companion, medication oversight (to the extent permitted under State law)) provided in a licensed (where applicable) private home by a principal care provider who lives in the home. A Shared Living Arrangement is furnished to adults who receive these services in conjunction with residing in the home. The total number of individuals (including participants served in the waiver) living in the home, who are unrelated to the principal care provider, cannot exceed four. Separate payment is not made for homemaker or chore services furnished to a participant receiving shared living arrangement services, since these services are integral to and inherent in the provision of shared living arrangement services. Payments for shared living arrangement services are not made for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement. Payment for shared living arrangement services does not include payments made, directly or indirectly, to members of the participant's immediate family. The methodology by which the costs of room and board are excluded from payments for adult foster care is described in Appendix I.

The following items may be performed under Residential Habilitation/Shared Living Arrangement:

Self-advocacy training that may include training to assist in expressing personal preferences, self-representation, individual rights and to make increasingly responsible choices.

Independent living training may include personal care, household services, child and infant care (for parents themselves who are developmentally disabled), and communication skills such as using the telephone.

Cognitive services may include training involving money management and personal finances, planning and decision making.

Implementation and follow-up counseling, behavioral or other therapeutic interventions by residential staff, under the direction of a professional, that are aimed at increasing the overall effective functioning of an individual.

Emergency assistance training includes developing responses in case of emergencies, prevention planning and training and in the use of equipment or technologies used to access emergency response systems.

Community access services that explore community services available to all people, natural supports available to the individual, and develop methods to access additional services/supports/activities desired by the individual.

Supervision services may include a person safeguarding an individual with developmental disabilities and/or utilizing technology for the same purpose.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The frequency, duration, and scope of these services are determined by the individual's care plan. There are no specified limits.

Service Delivery Method (*check each that applies*):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (*check each that applies*):

- Legally Responsible Person

- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Certified Foster Care/Shared Living Arrangement Provider
Agency	Residential Habilitation Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:

Individual

Provider Type:

Certified Foster Care/Shared Living Arrangement Provider

Provider Qualifications

License (specify):

Certificate (specify):

There is a standardized process in place for a person to become a DDDS Certified Foster Care/Shared Living Arrangement Provider. The process includes completing an application, undergoing criminal background & abuse registry checks, attending a required curriculum of classes offered by the Division, and having a home inspection completed to determine that the home will meet the DDDS standards.

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Developmental Disabilities Services

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:

Agency

Provider Type:

Residential Habilitation Agency

Provider Qualifications

License (specify):

Must meet all Delaware Regulations for Neighborhood Homes for Persons with Developmental Disabilities in accordance with 16 Delaware Code §1101.

Certificate (specify):

Must be a Division of Developmental Disabilities Certified Provider Agency

Other Standard (specify):

For Neighborhood Group Homes: Must meet the DDDS Standards for Neighborhood Group Homes as specified in the State of Delaware Residential Contract

For Residential and Staffed Apartments: Must meet the DDDS Standards for Community Living Arrangements as specified in the State of Delaware Residential Contract

Must adhere to all standards, policies, and guidelines in the State of Delaware Residential Contract.

Verification of Provider Qualifications

Entity Responsible for Verification:

For Delaware Regulations for Neighborhood Homes for Persons with Developmental Disabilities: Delaware Division of Long Term Care Residents Protection Agency.

For all other Standards: Delaware Division of Developmental Disabilities Services

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

Supported Employment - Individual

Service Definition (Scope):

Individual Supported Employment Services are provided to participants, at a one to one staff to consumer ratio, who because of their disabilities, need ongoing support to obtain and maintain an individual job in competitive or customized employment, or self-employment position, in an integrated work setting in the general workforce for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals in order to promote community inclusion.

Supported individual employment may also include support to establish or maintain self-employment, including home-based self-employment. Supported employment services are individualized and may include any combination of the following services: vocational/job-related discovery or assessment, person-centered employment planning, job placement, job development negotiation with prospective employers, job analysis, job carving, training and systematic instruction, job coaching, on the job employment supports, social skills training, benefits support, training and planning, transportation, asset development and career advancement services, implementation of assistive technology, and other workforce support services including services not specifically related to job skill training that enable the waiver participant to be successful in integrating into the job setting.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

[Empty box for specifying limits]

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Supported Employment

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Supported Employment - Individual

Provider Category:

Agency

Provider Type:

Supported Employment

Provider Qualifications

License (specify):



Certificate (specify):

Must be a Division of Developmental Disabilities Services Certified Provider.

Other Standard (specify):

Must adhere to all standards, policies, and guidelines in the State of Delaware Day Program Contract including:

The Contractor agrees to adhere to the requirements of DHSS Policy Memorandum # 46, and divisional procedures regarding the reporting and investigation of suspected abuse, neglect, mistreatment, misappropriation of property and significant injury of residents/clients receiving services, including providing testimony at any administrative proceedings arising from such investigations.

The Contractor, including its parent company and its subsidiaries, and any subcontractor, including its parent company and subsidiaries, agree to comply with the provisions of 29 Del. Code, Chapter 58: Laws Regulating the Conduct of Officers and Employees of the State, and in particular with Section 5805 (d): Post Employment Restrictions.

Contractor shall conduct child abuse and adult abuse registry checks and obtain service letters in accordance with 19 Del. Code Section 708; and 11 Del. Code, Sections 8563 and 8564. Contractor shall not employ individuals with adverse registry findings in the performance of contract.

The Contractor agrees that professional staff employed in the execution of this contract shall be state licensed, certified, or registered in their profession as required by state law. In the case of direct care personnel, certification shall be obtained through successful completion of a training program as required by the DDDS.

Must adhere to all standards in the DDDS Home and Community Based Waiver Supported Employment Standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Developmental Disabilities Services

Frequency of Verification:

Prior to contract approval or renewal at least annually or as needed based on service monitoring concerns

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

Supported Employment - Small Group

Service Definition (Scope):

Supported Employment Small Group Employment Support are services and training activities provided in regular business, industry, and community settings for groups of two (2) to eight (8) workers with disabilities. Examples include mobile crews and other employment work groups. Small group employment support must be provided in a manner that promotes integration into the workplace and interaction between participants and people without disabilities in those workplaces. The outcome of this service is sustained paid employment and work experience leading to further career development and individual integrated community based employment for which an individual is compensated, at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Supported employment small group employment supports may be a combination of the following services: vocation/job related discovery or assessment, person center employment planning, job placement, job development, social skills training, negotiation with prospective employers, job analysis, training and systematic instruction, job coaching, benefits supports, training and planning, transportation and career advancements services.

Other workplace support services may include services not specifically related to job skill training that enable the waiver participant to be successful in integrating in to the job setting.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Supported Employment - Small Group

Provider Category:

Agency

Provider Type:

Provider Qualifications**License (specify):****Certificate (specify):**

Must be a Division of Developmental Disabilities Services Certified Provider.

Other Standard (specify):

Must adhere to all standards, policies, and guidelines in the State of Delaware Day Program Contract including:

The Contractor agrees to adhere to the requirements of DHSS Policy Memorandum # 46, and divisional procedures regarding the reporting and investigation of suspected abuse, neglect, mistreatment, misappropriation of property and significant injury of residents/clients receiving services, including providing testimony at any administrative proceedings arising from such investigations.

The Contractor, including its parent company and its subsidiaries, and any subcontractor, including its parent company and subsidiaries, agree to comply with the provisions of 29 Del. Code, Chapter 58: Laws Regulating the Conduct of Officers and Employees of the State, and in particular with Section 5805 (d): Post Employment Restrictions.

Contractor shall conduct child abuse and adult abuse registry checks and obtain service letters in accordance with 19 Del. Code Section 708; and 11 Del. Code, Sections 8563 and 8564. Contractor shall not employ individuals with adverse registry findings in the performance of contract.

The Contractor agrees that professional staff employed in the execution of this contract shall be state licensed, certified, or registered in their profession as required by state law. In the case of direct care personnel, certification shall be obtained through successful completion of a training program as required by the DDDS.

Must adhere to all standards in the DDDS Home and Community Based Waiver Supported Employment Standards.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Division of Developmental Disabilities Services

Frequency of Verification:

Prior to initial enrollment or renewal at least annually or more frequently based on service monitoring concerns.

Appendix C: Participant Services**C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR 440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Clinical Consultative Services: Behavioral Consultative Services/Nursing Consultative Services

Service Definition (Scope):

Clinical Consultative Services consists of two components:

- 1)Behavioral Consultative Services
- 2)Nursing Consultative Services

Behavioral Consultative Services:

Positive behavioral interventions and services are supported by the DDDS waiver; these behavioral interventions

and services are individually designed and provided to waiver participants who have significant behavioral difficulties that jeopardize their ability to remain in the community due to their inappropriate responses to events in their environment.

The contracted Behavioral Consultative Services provider will provide monitoring, assessment and treatment of participants and to support, train, and consult with staff and primary caregivers who support individuals who have been approved to receive behavioral services and exhibit targeted behaviors. This also includes individuals who are on psychotropic medications and receive HCBS waiver services. The behavioral techniques and interventions are to be designed to 1) decrease challenging behaviors while increasing positive alternative behaviors, and 2) assist participants in acquiring and maintaining the skills necessary to live independently in their communities and avoid institutional placement.

The Behavioral Consultative Services include a Performance of a Functional Assessment, Development of a Behavioral Support Plan, and/or Training staff, individuals, families, and service providers in the implementation of the Behavioral Support Plan to enable them to effectively carry out plans designed to meet the individual's needs. The service includes periodic monitoring of the effectiveness of the Behavioral Support Plan with requisite adjustments as indicated.

The Behavioral Consultative Services shall include cognitive therapies, within the Psychological Assistant's scope of practice, when clinically indicated and if desired by the individual and their family.

Specifically, the duties include:

- Provides consultation and direction to ID teams, staff and shared living providers working with individuals displaying challenging or self-limiting behaviors.
 - Completes Functional Assessment of Behavior as needed to better understand the purpose, triggers, and maintaining reinforcers of the behavior.
 - Develops Behavior Support Plans incorporating the principles of Positive Behavior Supports in order to reduce self-limiting and/or destructive behavior and increase incompatible positive behaviors.
 - Monitors Behavior Support Plans incorporating the principles of Positive Behavior Supports in order to reduce self-limiting and/or destructive behavior and increase incompatible positive behaviors.
 - Instructs ID teams, staff and shared living providers on when and how to address self-limiting or inappropriate behavior using the principles of Positive Behavior Support
 - In cases where psychiatric, psychological or counseling or assessment services are needed:
- o Provides the service as allowed under licensing restrictions
 - o Identifies possible doctors or practitioners who are contracted with the Division to provide the service
 - o Acts as a liaison between the individual, his/her ID team and the service provider to insure that the doctor/practitioner receive information necessary to appropriately treat the person and that the team understands and carries out the prescribed treatment plan.
 - o Develops Mental Health Support plans to insure that the individual is supported in accordance with the principles of best practice.
- Monitors progress/treatment for people who have Behavior Support Plans or mental health support Plans
 - Serves as an ID Team member for people who have Behavior Support Plans or Mental Health Support Plans
 - Prepares necessary documentation for oversight committees such as PROBIS and HRC and insures that reviews are completed in accordance with DDDS policies

Nursing Consultative Services:

The Nursing Consultative Services provider furnishes health care coordination and monitoring for the health care needs of individuals. These individuals live in community settings throughout the State of Delaware and have a prescribed medical treatment plan.

Nursing Consultative Services are provided by the Nurse Consultant that are Registered Nurses with a State of Delaware Nursing License. Nursing Consultative Services providers furnishes:

- Primary health care coordination and the development of a Nursing Plan of Care as well as an evaluation of its effectiveness.
- Completes annual ELP nursing assessments, Intake Nursing Assessments, and other assessments as

appropriate.

- In emergency situations may perform a medical procedure that they are licensed to administer.
- Participates as an Interdisciplinary Team member.
- Attends the annual ELP meeting, Transfer Planning Conference meetings, and other meetings as appropriate.
- Provides ongoing health related training for staff of individuals on their caseload.
- Maintains on-going documentation for health care status.
- Communicates to individuals/families/guardians/other service providers about health care issues.
- Assists in obtaining resources and acts as coordinator of health care services.
- Completes record reviews for Neighborhood Homes and Community Living Arrangements (e.g. the monthly medication review as outlined in all applicable DDDS policies and procedures. Findings of all reviews shall be reported to DDDS and the appropriate agency staff for corrective action.
- Assists with individual's transitions for one site to another.
- Acts as an advocate for individuals on their caseloads.
- Completes monthly face-to-face contacts (Home or Day Program) and Quarterly Nursing Reviews for individuals residing with Shared Living Providers.
- Visits all assigned Shared Living Providers at least quarterly and more frequently as indicated.
- Monitors, reviews, and reconciles Shared Living Monthly Medication forms, and takes appropriate action as indicated.
- Adheres to DDDS, State and Federal policies and regulations.
- Ensures all new policies; procedures are read and signed within established time frame.
- Promotes functional independence of individuals during medication administration activities.
- Ensures documentation is accurate, timely, relevant and complete.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
 No duplication may occur under any service.

Service Delivery Method (*check each that applies*):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (*check each that applies*):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Delaware State Merit Consultative Psychological Assistant or Consultative Behavioral Analyst or Contracted Provider Consultative Psychological Assistant or Consultative Behavioral Analyst
Agency	Consultative DDDS State Merit Registered Nurse(s) or Consultative Contracted (non-state) Registered Nurse

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Clinical Consultative Services: Behavioral Consultative Services/Nursing Consultative Services

Provider Category:

Agency

Provider Type:

Delaware State Merit Consultative Psychological Assistant or Consultative Behavioral Analyst or Contracted Provider Consultative Psychological Assistant or Consultative Behavioral Analyst

Provider Qualifications

License (*specify*):

Certificate (specify):

Each Consultative Behavior Analyst must meet the following requirements:
Possession of a Bachelors degree or higher in Behavioral or Social Science or related field.

Each Consultative Psychological Assistant must meet the following requirements:

Official transcript showing earned masters degree based on a program of studies which is psychological in content and specifically designed to train and prepare psychologists.
Registered as a Delaware Psychological Assistant or eligible for registration in Delaware.

Other Standard (specify):

Each Consultative Behavior Analyst and Consultative Psychological Assistant must meet the Delaware personnel requirements for the position as stated in the Delaware Human Resources Job Requirements.

In additional to the above, each individual must also meet the below standards/requirements:

Each Consultative Psychological Assistant or Consultative Behavior Analyst, within his/her area of specialization, ensure all DDDS standards, policies and procedures applicable to Behavioral Services are maintained.

Each Consultative Psychological Assistant or Consultative Behavior Analyst are responsible for providing the following specific services within a consultative model as described in the HCBS Residential Waiver Services Behavioral Consultative Services Policy.

The standards for documentation in the HCBS Residential Waiver Behavioral Consultative Services Policy are adhered to by Psychological Assistant/Behavior Analyst.

Reference workplan changes Section I.B.1-I.B25 to meet free choice of providers requirements

Verification of Provider Qualifications**Entity Responsible for Verification:**

Division of Developmental Disabilities Services

Frequency of Verification:

Annually

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Other Service

Service Name: Clinical Consultative Services: Behavioral Consultative Services/Nursing Consultative Services

Provider Category:

Agency

Provider Type:

Consultative DDDS State Merit Registered Nurse(s) or Consultative Contracted (non-state) Registered Nurse

Provider Qualifications**License (specify):**

The Consultative Registered Nurse provider will be a Registered Nurse (RN) with a Delaware Nursing License as prescribed in Delaware Code, Title 24, Chapter 19, Section 1910. These individuals must be able to work with individuals with Developmental and Intellectual Disabilities with a wide range in the intensity of support needs including cognitive impairments, autism, mobility, dually diagnosed (Developmental and Intellectual Disability & Mental Health support needs), or who have more significant health related challenges.

Certificate (specify):

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:
Division of Developmental Disabilities Services
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Transportation - Residential Services

Service Definition (Scope):

Effective 1/1/12, transportation is no longer included in the waiver.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Day &/or Residential Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transportation - Residential Services

Provider Category:

Agency

Provider Type:

Day &/or Residential Provider

Provider Qualifications**License (specify):**

Valid Delaware driver's license

Certificate (specify):

PUC Certification, when required by Delaware law

Other Standard (specify):

1. At least 18 years of age
2. Have criminal clearances as per Delaware Abuse Registry
3. Automobile insurance for all automobiles owned, leased, and/or hired used as a component of the transportation service.
4. Worker's Compensation Insurance, when required by Delaware law
5. Documentation the individual agrees to carry out transportation responsibilities based on the individual's support plan

Verification of Provider Qualifications**Entity Responsible for Verification:**

Division of Developmental Disabilities Services

Frequency of Verification:

Annually

Appendix C: Participant Services**C-1: Summary of Services Covered (2 of 2)**

- b. **Provision of Case Management Services to Waiver Participants.** Indicate how case management is furnished to waiver participants (*select one*):

Not applicable - Case management is not furnished as a distinct activity to waiver participants.

Applicable - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- As a waiver service defined in Appendix C-3. Do not complete item C-1-c.**
- As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option). Complete item C-1-c.**
- As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management). Complete item C-1-c.**
- As an administrative activity. Complete item C-1-c.**

- c. **Delivery of Case Management Services.** Specify the entity or entities that conduct case management functions on behalf of waiver participants:

The Division of Developmental Disabilities Services (DDDS) provides qualified state Case Managers to individuals who receive services through this Waiver.

Appendix C: Participant Services**C-2: General Service Specifications (1 of 3)**

- a. **Criminal History and/or Background Investigations.** Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (*select one*):

No. Criminal history and/or background investigations are not required.

Yes. Criminal history and/or background investigations are required.

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

Criminal Background Checks (CBC) are required, as a condition of employment, for individuals applying to provide care in DDDS residential homes, day programs, supported employment or prevocational services. This requirement extends to all positions providing direct support or other services to waiver participants such as direct support staff and transportation drivers. Temporary agencies and employment agencies are included in this requirement. In addition, a repeat CBC is required if an existing employee applies for a promotion. The aforementioned requirement is pursuant to Title 16, §1141 and/or the DDDS policy entitled Recruitment and Renewal of Shared Living/Respite Care Providers.

The hiring employer of the applicant or existing employee seeking promotion is the responsible entity for requesting the CBC checks. The process is initiated during the application process, at which the hiring employer ensures the applicant completes the proper authorization forms for State and/or Federal Criminal Background checks completion. The Division of Long Term Care Resident Protection is the State entity responsible for obtaining results of the requested State and Federal CBCs and forwarding the outcome to the hiring employer. If the results of the CBCs do not identify a conviction for a disqualifying crime, the applicant may be considered for employment.

Disqualifying crimes are referenced in Delaware Code, Title 16, §1141 (f), the DDDS policy entitled Recruitment and Renewal of Shared Living/Respite Care Providers and more clearly delineated by the Division of Long Term Care Resident Protection in Delaware's Administrative Code Title 3105, §6.0. Failure to comply with the required CBC as a condition of employment can result in a civil penalty of \$1000-\$5000 per violation. The same civil penalty applies to applicants who fail to make a complete disclosure on his/her application or CBC Request Authorization.

The DDDS Office of Quality Management(OQM) completes Certification of Services reviews for a random sample of participants at the 95% Confidence Level. In addition, the OQM identifies Service Providers and licensed entities that were not captured by the sample selection. For those entities, the OQM completes full certification reviews above and beyond the random sample in order to make evidence based recommendations for contract renewal of all active service Providers. During the certification review process, the OQM Program Evaluators (PEs) complete a staff qualifications & training review checklist. The PEs access the personnel files of each direct contact employee in order to verify the contracted provider agency has implemented the background check process and has received authorized legal documentation testifying to the results of the checks.

The PEs mark on the qualifications checklist, the dates the results of:

- (1) the Delaware Adult Abuse Registry,
- (2) the Delaware Child Abuse Registry,
- (3) State of DE Criminal Background Checks, and
- (4) Federal Criminal Background Checks were received by the contracted provider agency for each direct contact employee.

The requirement for checks is once per employee. DDDS OQM reviews all documents related to the checks for each employee upon initial inspection of a site, and thereafter for employees who have been hired since the last OQM review of the site.

Additionally, Delaware's Division of Long Term Care Residents Protection reviews all Criminal Background and Abuse Registry documentation in Neighborhood Group homes during annual licensing inspections.

The DDDS Office of Resource and Development Management (ORDM) ensures every shared living provider (foster care) applicant includes the completion of State Criminal Background Check, prior to approving the contract. A DDDS review panel is convened to review aspects of each application as well as ensure the completion of all required background checks, prior to approving an application.

- b. **Abuse Registry Screening.** Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

No. The State does not conduct abuse registry screening.

Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

An Adult Abuse Registry (AAR) is maintained by the State's Division of Long Term Care Residents Protection, as required by Delaware Code Title 11, §8564. A Child Protection Registry (CPR) is maintained by the State's Department of Services for Children, Youth and Their Families, as required by Delaware Code, Title 11, §8563.

Both an AAR and CPR check are required as a condition of employment for applicants of DDDS residential homes who may have the opportunity to have personal contact with persons receiving services. This requirement is pursuant to Delaware Code Title 11, §8564, Delaware Code, Title 11, §8563 and the DDDS policy entitled Recruitment and Renewal of Shared Living/Respite Care Providers.

The aforementioned law regarding AAR checks also applies to temporary employment agencies and contractors that place employees or otherwise provide services to individuals in DDDS residential homes.

Hiring employers who are required by either of the aforementioned laws to request an AAR and/or CPR check as a condition of employment are responsible for obtaining written authorization from the applicant for full disclosure from the agencies who maintain the AAR and CPR. Upon receipt of the written authorization, the applicable agency releases information to the hiring employer that indicates if the applicant has been a perpetrator in a substantiated investigation involving adult or child abuse, neglect, mistreatment or financial exploitation. The DDDS residential contracts prohibit the employment of individuals with adverse findings in either the AAR or CPR check.

The DDDS Office of Quality Management(OQM)completes Certification of Services reviews for a random sample of participants at the 95% Confidence Level. In addition, the OQM identifies Service Providers and licensed entities that were not captured by the sample selection. For those entities, the OQM completes full certification reviews above and beyond the random sample in order to make evidence based recommendations for contract renewal of all active service Providers.

During the certification review process, the OQM Program Evaluators (PEs) complete a staff qualifications & training review checklist. The PEs access the personnel files of each direct contact employee in order to verify the contracted provider agency has implemented the background check process and has received authorized legal documentation testifying to the results of the checks.

The PEs mark on the qualifications checklist, the dates the results of:

- (1) the Delaware Adult Abuse Registry,
- (2) the Delaware Child Abuse Registry,
- (3) State of DE Criminal Background Checks, and
- (4) Federal Criminal Background Checks were received by the contracted provider agency for each direct contact employee. The requirement for checks is once per employee.

DDDS OQM reviews all documents related to the checks for each employee upon initial inspection of a site, and thereafter for employees who were hired since the last OQM review of the site.

Additionally, Delaware's Division of Long Term Care Residents Protection reviews all Criminal Background and Abuse Registry documentation in Neighborhood Group homes during annual licensing inspections.

The DDDS Office of Resource and Development Management (ORDM) ensures every shared living provider (foster care) application includes the completion of both an Adult Abuse Registry and Child Protection Registry check, prior to approving the contract.

A DDDS review panel is convened to review aspects of each application as well as ensure the completion of all required background checks.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

- c. **Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:***

No. Home and community-based services under this waiver are not provided in facilities subject to §1616

(e) of the Act.

Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- i. **Types of Facilities Subject to §1616(e).** Complete the following table for each type of facility subject to §1616(e) of the Act:

Facility Type	<input checked="" type="checkbox"/>
Neighborhood Group Home	

- ii. **Larger Facilities:** In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

Neighborhood Group Home - the maximum number of residents allowed in these facilities is five. However, the preferred number is four or less. The structures are single family dwellings located in residential neighborhoods throughout the community. Each resident, more often than not, has their own bedroom designed and decorated to their preferences. The homes have two full size bathrooms, complete kitchen and a dining room or dining areas. Family and friends can privately meet with a resident or individual in a room designated for social gatherings. Furnishings in the home are required to be non-institutional in appearance (unless medically necessary). The outside appearance of the structures are to present in a manner similar to that of neighbors.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Neighborhood Group Home

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Supported Employment - Individual	<input type="checkbox"/>
Transportation - Residential Services	<input type="checkbox"/>
Supported Employment - Small Group	<input type="checkbox"/>
Residential Habilitation	<input checked="" type="checkbox"/>
Clinical Consultative Services: Behavioral Consultative Services/Nursing Consultative Services	<input checked="" type="checkbox"/>
Prevocational Services	<input type="checkbox"/>
Day Habilitation	<input type="checkbox"/>
Case Management	<input type="checkbox"/>

Facility Capacity Limit:

5

Scope of Facility Standards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards	
Standard	Topic Addressed
Admission policies	<input checked="" type="checkbox"/>
Physical environment	<input checked="" type="checkbox"/>
Sanitation	<input checked="" type="checkbox"/>
Safety	<input checked="" type="checkbox"/>
Staff : resident ratios	<input checked="" type="checkbox"/>
Staff training and qualifications	<input checked="" type="checkbox"/>
Staff supervision	<input checked="" type="checkbox"/>
Resident rights	<input checked="" type="checkbox"/>
Medication administration	<input checked="" type="checkbox"/>
Use of restrictive interventions	<input checked="" type="checkbox"/>
Incident reporting	<input checked="" type="checkbox"/>
Provision of or arrangement for necessary health services	<input checked="" type="checkbox"/>

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

- d. **Provision of Personal Care or Similar Services by Legally Responsible Individuals.** A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.

Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of *extraordinary care* by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

- e. **Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.** Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and

above the policies addressed in Item C-2-d. *Select one:*

The State does not make payment to relatives/legal guardians for furnishing waiver services.

The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.

Specify the controls that are employed to ensure that payments are made only for services rendered.

Other policy.

Specify:

- f. **Open Enrollment of Providers.** Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

The Delaware Medicaid (DMMA) provider relations agent provides prospective DDDS Waiver providers access to a comprehensive Delaware Medical Assistance Program (DMAP) web site. This website provides detailed information about the DDDS Waiver program and complete enrollment instructions. In addition to the DMAP web site, the provider relations agent has a toll-free phone line available for general information (800-999-3371).

Current and prospective providers can also access the DMMA/DDDS website where detailed information is outlined on becoming a qualified Provider for the State of Delaware. This information is available through the DMMA or DDDS websites and toll-free phone line available for general information about services as well as becoming a DDDS provider.

The DMMA/DDDS Provider Enrollment Process:

The DMMA/DDDS utilizes a Provider Enrollment Process that assures the open and continuous enrollment of waiver service providers.

The DMMA/DDDS is committed to the participants' freedom of choice to select from enrolled qualified providers. The hallmark of such a service delivery system is the ability of individuals and their families/representatives to self-select the provider of their service(s) from among those that have been qualified through the enrollment process. Prospective service providers have unrestricted 24-hour access to the DDDS Authorized Provider enrollment forms. These may be completed by prospective service providers who believe that they meet the qualifications to provide one or more of the DDDS HCBS Waiver services. The DDDS Website (<http://www.dhss.delaware.gov/dhss/ddds/cps.html>) contains the instructions detailing the process.

The DDDS Authorized Provider Selection Process:

The Division of Developmental Disabilities Services (DDDS) in conjunction with the Delaware Medical Assistance Program has established a continual enrollment process for the initial authorization of a service provider who seeks to offer one or more services contained within the DDDS Home and Community Based Services (HCBS) 1915(c)

Waiver as approved by the Centers for Medicare and Medicaid Services (CMS). These Waiver Services are in the areas of: Residential Habilitation, Day Habilitation, Pre-Vocational, Supported Employment, and /or Clinical Consultative Services.

Prospective providers can be individual proprietors, profit and non-profit business organizations, or limited liability partnerships unless otherwise specified in a Request for Services which shall supersede any information contained within this packet.

Enrollment to become a provider of DDDS HCBS 1915(c) services that enrolls them as a Delaware Medicaid Provider through Delaware's fiscal intermediary, Hewlett Packard (HP). Therefore, all conditions must be successfully met by the prospective provider before authorization is granted by the DDDS/DMMA (HP). The successful completion of the required information shall result in a contract with HP, complete with an assigned provider number, and the DDDS will also issue a separate contract for services and contract items that are non-Medicaid reimbursable.

The terms and conditions in both contracts must be met in order to remain an authorized and enrolled provider. Both of these contracts are available for review at <http://www.dhss.delaware.gov/dhss/ddds/cps.html>. The guidelines for enrolling to become a provider are also listed at the aforementioned web link.

Once a provider has received authorization and is enrolled they shall be added to a Directory of Enrolled Providers which is posted on the DDDS website. The information contained within this Directory shall list the provider name, address and contact information and may also include a link to that provider's website.

Enrolled providers can be selected by individuals eligible for DDDS services and their families, advocates etc. to be their provider of choice. An individual receiving service may select different providers for different services but cannot choose more than one provider for each service (i.e. cannot choose two Behavior Analysts for clinical services).

However, since waiver participants have the right to choose their providers, the State of Delaware and its agents cannot guarantee that an enrolled provider will be selected. Therefore, the DDDS shall host "provider fairs" (at least twice annually) so that service recipients and their families can meet enrolled providers in person. The DDDS also strongly encourages its enrolled providers to market their businesses as much as possible to gain visibility in the community.

Process for Eligible HCBS Waiver Recipients:

After an individual is found to be eligible for DDDS HCBS Waiver Services, a list of enrolled providers is made available to the participant or his or her family, or legal representative (as appropriate). The participant and his or her family may interview prospective providers and ultimately choose to receive services from one or more qualified DDDS providers.

If at any time the participant is unsatisfied or just wants a new provider, the participant has the right to select a different provider or providers and shall communicate this information to their DDDS State Case Manager that shall assist (if requested) with this process.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

i. Sub-Assurances:

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

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance

measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

C-a-1: The percentage of providers in compliance with DDDS certification standards and state licensing regulations by type(number of providers by service type in compliance with licensing and/or certification standards/total number of providers for each service type).

Data Source (Select one):

Other

If 'Other' is selected, specify:

Office of Quality Management **s certification data base.**

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly

<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:

C-a-2: Percent of providers by service type meeting their specific contractual obligations(number of providers by service type fulfilling contractual requirements/total number of providers by service type).

Data Source (Select one):

Other

If 'Other' is selected, specify:

Office of Quality Management **Certification Data Base.**

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:

C-a-3: Percent of providers that receive sanctions by type of sanction. (Total Providers receiving sanction by type/total number of providers)

Data Source (Select one):

Other

If 'Other' is selected, specify:

Database containing all sanctions and all relevant provider data.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:

	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:

C-a-4: The percent of new providers that meet licensing and certification standards (Number of new providers meeting licensing and certification standards/total number of new providers)

Data Source (Select one):

Other

If 'Other' is selected, specify:

The Office of Quality Management Certification Data Base.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =

<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

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

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

N/A: The State of Delaware does not utilize non-certified providers.

Data Source (Select one):

Other

If 'Other' is selected, specify:

N/A: The State of Delaware does not utilize non-certified providers.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:



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

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

C-c-1: the percentage of Provider staff in compliance with DDDS training requirements(number of staff per agency in compliance with state training requirements/number of provider staff reviewed).

Data Source (Select one):

Other

If 'Other' is selected, specify:

Office of Quality Management Certification Review Data Base

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: at least 25% of agency staff per site
	<input type="checkbox"/> Other Specify:	

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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: _____	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: _____

Performance Measure:

C-c-2: The percentage of provider agencies offering in-house training that is in compliance with DDDS requirements (number of provider agencies with DDDS approved training curriculum/number of provider agencies offering in-house training on DDDS required subjects).

Data Source (Select one):

Other

If 'Other' is selected, specify:

The DDDS Training and Professional Development (TAPD) data base

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = _____
<input type="checkbox"/> Other Specify: _____	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: _____

	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The frequency the various discovery processes are employed range from an as needed basis (e.g., incident investigations, placement tracking or mortality reviews) to an annual basis (e.g., certification or licensure of the service provider). More frequently are the routine monthly or quarterly residential program, day program and home visits made by the DDDS Case Managers.

The scope of various reviews include:

People who receive services from DDDS,
 Sites where they are provided day or residential services,
 Providers of those services and
 Service system itself

The discovery methods utilized involve a number of different processes. Visits to where people live or receive daytime services play an important part in monitoring as do observations and interviews with individuals served and those who provide services. These interviews become important when investigating unusual incidents or reports of abuse, neglect, mistreatment, financial exploitation or significant injury, sometimes with involvement from Adult Protective Services, Long Term Care or law enforcement authorities.

A central discovery method used by DDDS professional staff involves a review of the active record of the person surveyed.

Information gathered during the record review includes, among a number of other critical elements:

- Comprehensiveness of the services provided and
- Timely completion of various assessments,
- HCBS Waiver related documents,
- Plans of care,
- Health-related appointments

Monitoring the service providers' compliance to established policy standards and formal regulations is an ongoing function of DDDS staff, including case managers, in their monthly routine or quarterly site visits, as well as the principal duty of the Office of Quality Management (OQM) and Long Term Care staff in their annual certification and licensure surveys.

The DDDS Office of Quality Management (OQM) surveys contracted provider agencies subject to Division contract standards or Department regulations. This is done on a continuous basis as part of the licensing or certification process applied to the providers.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

The remediation process leading to improvement in areas found below expectation varies with the survey and discipline involved in the initial discovery process. After the initial survey or collection of information, the findings of the professionals involved in the discovery process are communicated with the providers or others who are involved in sharing promising practices and taking corrective action when needed. Issues are initially discussed among involved parties to clearly communicate findings and desired outcomes, followed up by a written report noting those areas needing correction and a date by when correction is to be completed. Following the corrections made by the responsible parties, it is the general practice to follow-up verifying the corrections are made and are acceptable. For those surveys done by the Office of Quality Management, verifications usually take the form of an additional look-behind review. With other disciplines, corrections are verified at the time of the next normal review, or through the submission of applicable documentation.

Should the necessary corrections not be performed or still leave room for improvement, further actions are taken. This usually begins with communication of the inadequacy of the response and, in some cases, guidance in making the proper corrections. Higher administrative authorities in the organization are notified of the inadequacy of the response and the possibility of sanctions if improvements are not forthcoming. These sanctions range from the provider being placed on contract probation, the granting of a Provisional License by LTCRP, a freeze on new individuals being placed with the agency, removal of people from the provider's care or, in extreme cases, contract termination. Generally, unless the infractions involve egregious health and safety, rights or criminal violations, much work and effort is made by Division staff to assist the provider to come up to the expected performance before the contract is terminated by the Division.

DDDS departments are tracking the results of their discovery processes in a variety of databases. This tracking serves to provide a number of benefits. It provides a prompt in the remediation process, offers a comparison of results longitudinally or among providers, and is used by the Division in a variety of systems-improvement efforts.

- ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other	<input checked="" type="checkbox"/> Annually

Specify: DDDS staff	
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

- a. **Additional Limits on Amount of Waiver Services.** Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

Not applicable- The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

Applicable - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

- Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

- Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

- 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.*

- Other Type of Limit.** The State employs another type of limit. *Describe the limit and furnish the information specified above.*

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

ELP-Essential Lifestyle Plan

- a. **Responsibility for Service Plan Development.** Per 42 CFR 441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals (*select each that applies*):

- Registered nurse, licensed to practice in the State**
 Licensed practical or vocational nurse, acting within the scope of practice under State law
 Licensed physician (M.D. or D.O)
 Case Manager (qualifications specified in Appendix C-1/C-3)
 Case Manager (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

The Delaware Division of Development Disabilities Services (DDDS) provides Case Management Services through the use of qualified state employees. A workgroup was created consisting of DDDS staff, providers and other stakeholders. An implementation plan for State Case Managers (CM's) being responsible for developing the service plan for all waiver participants was created. The DDDS CM is responsible for monitoring and overseeing the service plan development (known as the Essential Lifestyle Plan (ELP)) have been clarified and defined. Subsequently, the current duties, roles and functions of the State Administrative Case Managers are as follows:

Assessment Activities:

- Level of Care-Annual evaluation and re-evaluation
 Development of the Essential Lifestyle Plan (ELP) for all individuals
 Completes the annual Individual Outcome Satisfaction Assessment(IOSA)with each individual and enters into Therap.
 Completes and reviews annual assessments by assigned discipline(as applicable)within Therap to determine the choice/need for medical, educational, social or other services.
- > Individual Data Form (IDF)
 - > Comprehensive Medical Assessment
 - > BA Support Plans
 - > Individual Plan Of Protection (IPOPs)
 - > Statement of Rights
 - > Release of Information
 - > Health Related Protection Reviews
 - > Human Rights Committee Reviews

The minimum qualifications for a DDDS Case manager are:(C-1-C3)

Possession of an Associates Degree or higher Behavioral or Social Science or related field OR

Experience in health or human services support which includes interviewing clients and assessing personal, health, social or financial needs in accordance with program requirements; may coordinate with community resources to obtain client services.

Experience in making recommendations as part of a clients service plan such as clinical treatment, counseling, or determining eligibility for health or human services/benefits.

Experience in using automated information system to enter, update, modify, delete, retrieve/inquire and report on data.

Experience in narrative report writing.

Monitoring Activities:

Actively ensures that systems and processes of support are in place for disciplines to review the programs and services they provide. In addition the programs and services must coincide with the ELP and preserve the health, safety, and well-being of each individual.

Document monitoring and follow-up of activities. These include activities and contacts which are necessary to ensure that the ELP is effectively implemented and is adequately addressing the person's needs. Follow-up may be with the individual's family members or service providers, or other entities or individuals. Monitoring shall involve face-to-face contact.

Completes visits with each individual (as often as necessary) within the home and/or day program to determine whether: services are being furnished in accordance to the ELP. The services in the ELP must be adequate, and determine if changes are needed in the ELP. This is accomplished during the interview process utilizing the IOSA to assess the individual's satisfaction with the supports and services he/she is receiving. If so, necessary adjustments are made in the ELP and appropriate people notified.

Make referrals to help individuals obtain residential and/or day services/employment.

Coordinates and facilitates the integration of the ELP across all service settings.

Monitors financial resources to maintain individual's eligibility for benefits.

Processes paperwork for all team-approved purchases/transactions.

Responds promptly to individuals requests for changes and documents these changes in the ELP.

Responds promptly to all Office of Quality Management (OQM) contacts (i.e. surveys, certifications, etc.).

Attends team meetings as scheduled and/or needed.

ELP progress reports - reviews all services and supports received by the participant as identified in the ELP.

The DDDS case manager evaluates the requirements of frequency of services, scope, and duration, as well as the participant's satisfaction and progress concerning services and supports provided.

Fire Drill/Emergency Evacuation Drill Logs - reviews on a quarterly basis.

Crisis monitoring and oversight in order to assure appropriate plans and safeguards are provided for the participant.

Survey Tools used by DDDS Case Manager:

Therap-an electronically recording data base system in which case notes, behavioral plans, contact notes and other client information is typed, stored, retained and accessed; specific authorization must be granted to persons with a need to utilize the system for the above mentioned services only, as this is an encrypted, password and firewall protected data storage and retrieval system.

Progress Notes

T-Logs these are daily case notes that are entered into Therap

Level of Care Assessment

Individual Funds Audit Any irregularities in funds require reconciliation and improvement activities. Identified irregularities may initiate an investigation of misappropriation of funds.

IOSA Individual Outcome Satisfaction Assessment

Monthly Home or Day Habilitation Visit

Provision of Choice in Selecting a Case Manager or Agency Program Coordinator:

DDDS continues to recognize the importance of participants being supported to make informed choices from available options. With such recognition, DDDS views the need to support choice with regard to who provides case management services.

If the individual is dissatisfied with his/her case manager, he/she is supported to choose an alternative case manager from available resources.

Refer to workplan for more details

Social Worker.

Specify qualifications:

Other

Specify the individuals and their qualifications:

DDDS has moved to the state DDDS Case Manager being responsible for service plan development for all waiver participants.

The DDDS State Case Manager monitors the implementation of the Essential Lifestyles Plan(ELP)or Plan of Care.

The Clinical or Behavioral Services team members monitor specific outcomes pertaining to participant health and welfare that are specific to these disciplines.

Other members of the person's team may monitor specific outcomes they are assigned during the annual meeting or during any other meetings held periodically throughout the year.

To ensure services are being provided in accordance with the ELP, the DDDS State Case Manager monitors the implementation of the ELP by visiting the participant in their home or day program and by communicating with other service providers as well as the participant's informal supports. This information is documented on progress notes within Therap and T-Logs within the web-based electronic Therap System.

As a part of this process of documentation and monitoring the DDDS State Case Manager will:

1. Assess the extent to which the participant has access to and is receiving services in accordance to his/her ELP. This includes ensuring providers delivered the services at the frequency and duration identified in the ELP, and that participants are accessing all supports and health-related services as indicated in the ELP. Monitoring of the ELP outcomes is governed by the ISP. The plan is finalized at the ELP meeting and identifies services and the person responsible for monitoring the services and the frequency of monitoring;
2. Evaluates whether the services furnished meets the participant's needs and helps the participant to become more independent;
3. Assesses the effectiveness of the plan and determines if changes are necessary;
4. Reminds the participant he/she have free choice of qualified providers;
5. Reminds participants, providers and any other informal caregivers they will need to contact DDDS in the event they believe services are not being delivered as agreed upon in the ELP.
6. Reviews with the participant the progress of the stated goals in the ELP;
7. Observes whether the participant feels and looks healthy and is not in pain or injured;
8. Interviews the participant and others involved in the participant's services to identify any concerns regarding the participant's health and well-being;
9. Stress the importance of notifying the DDDS immediately in the event the participant's health and well-being is in jeopardy;
10. Assesses and reviews the funds of each participant to ensure proper management and safeguards are in place for the participant's funds;
11. The DDDS Case Manager (in these instances) is responsible for reviewing and approving all of the service plans;

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.

Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

The Division of Developmental Disabilities Services (DDDS) has established the Essential Lifestyle Plan (ELP) as its participant-centered planning system. The DDDS developed comprehensive policies and procedures to safeguard the integrity of the ELP so the plan is developed in the best interest of each participant.

According to DDDS Policy, the ELP is a person centered plan, developed with the person receiving services, his/her family or guardian and other individuals providing support, that outlines in detail the individual's preferences, individual support needs, and lifestyle choices.

Before any person can facilitate an ELP, they attend an ELP Facilitator Training and display a basic competency level to the instructor. After competency is established, the instructor issues a certificate of completion. The Training And Professional Development (TAPD) Office maintains documentation of who attends the ELP Facilitator Training and who is certified.

i. Initial ELP developed using the ELP workbook prior to moving into residential placement

ii. 30 days after moving into the residential site, the ELP is reviewed and revised. DDDS Case Manager in shared living and Agency Program Coordinator in other residential sites are the responsible parties.

The participants are currently assigned a DDDS State Case Manager is a government employee in the shared living service area only. The DDDS contracts with provider agencies who are responsible for the service plan development in residential site locations. However, the DDDS is moving towards the DDDS State Case Managers being responsible for all areas of service development. Therefore, since the DDDS State Case Managers do not provide any other direct services, this will ultimately eliminate any potential conflicts of interest. This area has been incorporated into a work plan and will be revised in accordance with the goals, objectives and timeframes identified in the work plan. See Section I.A.1-18 & Section VI.A.1-11 of the approved work plan. DDDS State Case Managers do not provide any other waiver services.

The DDDS State Case Manager ensures the participant is provided with the opportunity to receive comprehensive information about waiver services available and the participant has the right and opportunity to choose from among any of the state's approved Authorized Provider Agencies and change agencies at any time for any reason including for no specific reason at all. While the participant's Team is responsible to support him/her with the identification of and free exercise of his/her personal rights, the DDDS case manager is responsible to assess and address individual rights with each participant. In this role, the DDDS State Case Manager serves as an advocate for waiver participants and monitors the ELP process for any conflicts of interest. A work plan item addresses this issue.

The DDDS State Case Manager monitors the contracted agency's implementation of the participant's plan of care (the ELP) on a monthly basis. In addition to the monthly paper monitoring, this includes a direct interview with the participant four times per year, two of which must be in the participant's home, to review the plan with the participant and his/her family or guardian to assess their satisfaction with the services provided and to review how the participant is progressing with the attainment of his/her state priority outcomes. In effect, the participant has a known advocate with the state, which maintains contractual authority over the provider agency.

When a participant wants to change a service provider(s), the DDDS State Case Manager assists with assuring the provider agency is aware and a transition plan is developed.

The Case Manager assists the participant in filing a Rights Complaint against a provider in instances where a provider is unresponsive to the requests and needs of an individual. In situations where resolution is not provided by the contracted agency, the DDDS State Case Manager assists the participant in identifying alternative providers who may be able to provide the participant with satisfaction.

According to the DDDS Essential Lifestyle Policy, Standard E., the contracted provider agency, in cooperation

with the individual (HCB residential waiver participant) and members of the support team (including the DDDS State Case Manager), complete the appropriate risk assessment tools (i.e., IPOPS) to appropriately plan for safeguards and protective oversight. IPOPS- Individual Plans of Protective Oversight and Safeguards are described in detail in Appendix D, section d. Service Plan Development Process.)

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

- c. **Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

Supports and Information are made available to the participant to direct and be actively engaged in the service plan development process.

Prior to the initiation of services, the DDDS Office of Applicant Services provides individuals and/or families with information and assistance in applying for services from the DDDS. The DDDS makes available for both active and interested HCBS Waiver participants the following training/resource opportunities:

Under the "What's NEW" section of the DDDS Website: there is a section indicating Big News for DDDS recipients and families. The most recent enhancement to this information on the website is the Essential Lifestyle Planning (ELP) forms are now available for anyone interested in developing an ELP. The forms are advertised as being available to help the person design a plan of support that is uniquely individualized. Clicking on the link takes interested persons to the "forms" page.

The ELP Personal Profile form is developed for persons interested in waiver services. The ELP Personal Profile helps the person describe what's important to him/her while at home, at work, and when out in the community. The participant may take this form to his/her next Essential Lifestyle Planning meeting to help guide the plan to incorporate the services and supports that best meet his/her needs.

Posted the DDDS Web-site under the Authorized Provider System section is the DDDS Essential Lifestyle Plan profile. The profile contains a draft copy of an example ELP, a description of what the ELP is, what each section of the ELP means, how it is developed, and how it is used by waiver participants.

Currently, the DDDS Training and Professional Development (TAPD) Unit makes ELP training available to potential participants and their families/guardians or advocates on a regular basis. The training includes a description of the ELP in a power-point presentation. The power-point illustrates each step in the plan development process, and the facilitator takes the time to answer questions as they come up during the training session.

TAPD also offers an Essential Lifestyle Planning Facilitator Training Series. This course is designed to provide detailed instructions on how to gather, organize and format information for the Essential Lifestyle plan. It covers documentation and reporting requirements for the essential lifestyle plan.

Prior to ELP development, the participant is supported to select a qualified ELP facilitator and the facilitator meets with the person to review the ELP workbook and to discuss services and supports available and assists the person in identifying desired personal outcomes, services and supports for inclusion in the plan.

A part of the responsibility of the facilitator is to provide information to the person in such a way as to maximize the person's participation and involvement in the planning process plan.

The ELP User's Manual for Delaware is a resource with the most current Division approved information relative to the development and implementation of ELPs. All staff and contractors comply with the guidelines set forth in this manual.

The ELP Oversight and Curriculum committee are responsible for the development and revision of the ELP User's Manual for Delaware. This committee reviews (and revise as necessary) the ELP User's Manual, at least every six (6) months.

DDDS defines the participant's authority to determine who is included in the ELP process through standard I of the Essential Lifestyle Planning Policy: The person receiving services, with the ELP Facilitator, determines who attends

the ELP meetings, when and where it is held. All support team members or their designee are requested to attend the Annual ELP meeting unless otherwise requested by the individual receiving services.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

- d. **Service Plan Development Process.** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Essential Lifestyle Plans are updated, minimally within 365 days of the previous Annual Conference. Plans are updated whenever there is a change in the participant's needs for services and supports.

DDDS attempts to provide information to the person in a way easy to understand so each person is able to make informed choices. DDDS strives to assure during the assessment, plan development, and review/approval processes, the person is assisted by individuals who: know the person well, have demonstrated care and concern for the person, and are trusted by the person.

With this approach, each participant is assisted in selecting a facilitator for his/her ELP development. The facilitator is an individual who has successfully completed the ELP Facilitator Training offered by the DDDS, and who is responsible for putting information learned about a person receiving services into the person's ELP document. Typically this person is the DDDS State Case Manager or a person selected by the individual (See qualifications in section D-1-a.).

The facilitator begins preparing for the ELP development with information the person communicated important to him/her. That information includes the things the person must have, the person's likes & dislikes, their positive attributes, and significant events or accomplishments of the past year.

Included in the ELP development is information identifying how services and supports will enhance the person's life. This information is obtained from a variety of assessment sources including: the Physical Exam Data from the Person's Primary Care Physician, the Comprehensive Medical Evaluation, the IPOP's, and the IOSA.

This assessment data, including information about services the participant receives through other state and federal programs is coordinated by the DDDS case manager. The case manager's coordination efforts help to assist the participant with plan development, and to ensure the ELP accurately reflects such services or programs.

All support team members or their designee are invited to attend the Annual ELP meeting unless otherwise requested by the individual receiving services. Issues the person does not wish to discuss at the Annual ELP Meeting, are discussed with appropriate team members and outlined in the final draft of the ELP.

All members of the support team have input and review the Essential Lifestyle Plan prior to implementation. During the meeting, the support team with the input of the person identify and assign responsibilities for implementing (the agency) and monitoring (the state) the plan. Each responsible person is identified in writing, the frequency of monitoring is identified, and the reporting/accountability requirements is identified in the ELP.

Approval of the Essential Lifestyle Plan:

At the end of the ELP document is a section with lines for the signatures of either the agency program coordinator or the DDDS Case Manager who reviewed the plan for technical detail, as well as for inclusion of all participant identified services and supports. Signature space is available for; the participant, the participant's family or guardian, an advocate, the contracted provider, the state Case Manager, the Case Manager Supervisor or the DDDS Regional Program Director, and an advocate as selected by the participant. This inclusive list of signatures constitutes the DDDS system for plan approval.

In addition, the Delaware Medicaid Agency- DMMA has the authority and responsibility to "approve" the ELPs and this is done through a sampling approach. See section D-1-g for a discussion of DMMA's role in ELP approval. In the event an ELP is updated prior to the next annual review the approval and review processes outlined above are also required.

However, DDDS recognizes it is the participant who ultimately approves the ELP. This approval is determined through review of the newly developed ELP document, outcome discussions, periodic discussions of the plan, and/or discussions with those who know and care for the person best, or from input with authorized family members or guardians. The implementation of the approved ELP is the primary responsibility of the contracted provider. At a minimum of monthly, the contracted provider summarizes the actions, steps and progress with implementation of the participant's ELP.

The DDDS State Case Manager's review each assigned participant's progress and satisfaction in obtaining his/her desired outcomes, services, and supports. In order to review an ELP, a case manager is designated by DDDS as meeting the requirements for training in, and experience with ELP development. This training and experience requirement to review the technical compliance of ELPs is established in the ELP Users Manual for Delaware.

Given the central role and function of the ELP, the contracted provider agency has the primary responsibility for coordinating waiver service implementation. The contracted provider agency communicates changes/modifications to the ELP and to document the revisions to the primary holders of the person centered plan (i.e., provider, day program, COR). Therefore, revisions, etc. are tracked for the review of anyone with authorization for access.

In order to safeguard against conflicts of interest within the DDDS hierarchy, Appendix D-2, Section b. Monitoring Safeguards addresses systems to reduce the risk of conflict of interest.

This process incorporates the DDDS Office of Quality Management (OQM) evaluators completing comprehensive reviews of Shared Living participant's services, and reporting the discovery results to a variety of advisory groups. Beyond Appendix D-2, these groups are discussed in the QMS sections of Appendix H of this application.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

- e. **Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Individualized risk mitigation strategies are incorporated directly into the Essential Lifestyle Plan (ELP) through the use of Individual Plans of Protection (IPOPS) and done in a manner sensitive to the individual's preferences. To be approved by the DDDS, the individual's ELP must contain a reasonably calculated back-up plan for emergencies. In addition, all DDDS certified/contracted Providers must have a DDDS approved system for providing emergency back-up services and supports.

Provider agencies are contractually bound to provide backup systems which minimally include the following areas:
Administrative Call/Notification Lists,
Hazard Specific Emergency Operations Plans- which include evacuation planning and continuity of operations features.

Such continuity of operations plans include maintaining the flow of communications and transportation in order to safeguard each participant and their identified services and supports- especially as related to health and welfare during emergency conditions.

On an individual level, the Delaware DDDS IPOP was developed to be a resource for individuals with developmental disabilities to use for planning purposes to ensure their health and safety, as well as encouraging individual choice and actions to minimize or prevent of serious types of incidents.

The purpose of the IPOP includes:

Heightens safety planning awareness, to identify and address unreasonable risk in order to prevent potential harm from occurring and to enhance the quality of life of the person;

Directly involve the person, his/her family/legal guardian, and other individuals who know him/her best to describe support services, strategies or interventions necessary in each risk area to keep the person safe from serious harm and promote good health, independence and opportunity to live a satisfying life. Each person's identified support needs vary depending upon his/her life experiences, abilities and environment;

Identify potential areas of risk of serious harm to a person in the following areas: Community Safety, Health/Medical, Sexuality/ Relationships, Abuse, Financial Exploitation, Behaviors, Home Environment, Fire Safety, Personal Care/Daily Living, Mental Health, Police Involvement, Informed Consent, Support Services.

The IPOP addresses a variety of sources for potential risk/safety concerns for serious harm or the vulnerabilities of a person with a developmental disability for an illness, accident or a serious incident.

It is recognized in some instances it may be difficult to prevent harm from occurring involving a person with a disability. However, there are some precautions or interventions identified and implemented in order to minimize the likelihood of any serious harm. The ability of the person to make informed choices is balanced with a reasonably safe environment.

It is the responsibility of the Department of Health and Social Services to assure people with disabilities and their families are provided with access to adequate quality information in order to make appropriate decisions in areas affecting their personal lives.

The IPOP covers various areas and contains a complete description of the concern, a description of interventions or services necessary to address each area, the person responsible for this area along with a timeframe, and an evaluation of effectiveness. The evaluation describes what has worked or didn't historically and how the individual felt about the intervention or area of concern.

The areas incorporated into the IPOP include:

- Community Safety (personal identification, interactions with strangers, ability to use telephone, cell phone, knowledge of emergency numbers, contacts, etc.)
- Health/Medical Care (weight control, nutrition, allergies, dental care, mobility needs, smoking, accessing medical care, etc.)
- Relationships/Sexuality (friendships, dating, sex education, legal or safe social behavior, responsibilities, etc.)
- Abuse (history of child or adult victimization, vulnerabilities, use of internet, caregiver stress, etc.)
- Financial Exploitation (understanding the value of money, credit cards, ability to conduct banking, ATM card, etc.)
- Behaviors (aggressive actions, pica, drug or alcohol abuse, limited communication, fire starting, etc.)
- Home Environment (ability to stay alone, awareness of security, ability to bathe, knowledge of fire appliances, etc.)
- Fire Safety (ability to call 911, fire drills, understanding cooking safety, use of proper extension cords, safe use of medical equipment, etc.)
- Personal Care/Daily Living (hygiene, toileting, dependence on staff for eating, making good choices for personal care, etc.)
- Mental Health (depression, medical counseling, suicidal gestures, psychosocial stressors, problems with substance abuse, etc.)
- Police Involvement (history of criminal behavior, illegal acts, fire setting, causing harm to others, domestic violence, etc.)
- Informed Consent (medical and/or financial decision making, communication skills, ability to understand information)
- Support Services (person signing his/her individual support plan, natural supports, lack of adequate supports, refusal of services, etc.)

Data from the IPOPs are incorporated into the ELP.

IPOPs are developed for General Information(Access Settings), Residential, Day Program, Supported Employment, Work Center, and Individualized services. These are referenced in the Safeguards section of individual plans as the person's individualized support needs are identified.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

- f. **Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

This area has been incorporated into a work plan (section 1.C.1-1.C.5).

The DDDS system to provide people with information to use in making informed choices in selecting services, takes a customer satisfaction approach.

DDDS provides information through three primary modes of communication:

- 1) personal contact,
- 2) provision of a hardcopy of the DDDS' Guide to Services at regular public in-services, and
- 3) electronically on DDDS' Website.

Persons interested in DDDS waiver services select a DDDS Case Manager to assist them through the process of learning about available services. This includes using the DDDS website to become more familiar with the authorized service providers, assisting the individual in setting up meetings with the service providers, and attending those meetings with the service recipient. The DDDS Case Manager is as active in the process as the individual wants and can assist the person in learning about the different providers so that the individual can make an informed choice.

The service recipient, including his/her circle of support, may choose to access the current list of authorized service providers through the DDDS website. The website is maintained and the information is kept current. The website details the services provided in each by county. The section of the website about service providers includes performance measures which are stipulated in the waiver application. The service recipient can compare service providers in the areas he/she may be interested in.

Areas are identified that may assist people in making informed choices. Data reporting is identified and coordinated between the DDDS' data based performance review committees (Committee role and function are detailed in Appendix H-1-a). Suggestions for additional areas of posted performance inquiry results may be stimulated by the Governor's Advisory Council and/or by the Division Director's Quality Council. Both monitoring bodies include a diversified membership of advocates, self-advocates, and stakeholders.

The Authorized Provider System (APS):

The need for DDDS to recruit and maintain a pool of qualified day and residential service providers becomes more acute as the division continues its transition from a prescriptive to a self-determined service delivery system. DDDS commits to establish an effective process for procuring community-based services that facilitates the exercise of consumer choice, supported by an individualized rate system that ensures fairness and equity among certified providers through the use of objective criteria.

The Division's Website provides:

- Performance Indicators (compliance reports): These correspond to areas performance measures provided in the waiver application. The information is received, analyzed, and reviewed by the applicable oversight committee prior to being posted on the website.
- The Performance measures are designed to be inclusive and universal in order to provide systemic information. The service recipient may then look at a particular indicator both across providers and longitudinally for a single provider. He/she can then use this information to determine which provider(s) he/she wishes to interview or as a springboard for conversation with the provider.
- Examples of currently posted data reports include the following:
 - o The number of substantiated abuse, Neglect, Mistreatment, Misappropriation of funds, and Significant Injury (PM-46) cases. Service recipients can review the number and type of cases relative to the number of persons served by that agency. This may be information that is very important for a family or service recipient to review as a part of their selection process.
 - o The contracted providers Staff Turnover Rate: This report includes information about the number of staff leaving each agency compared to the total number of staff positions within the agency. Service recipients may be interested in this information during the selection process for a number of reasons. A Service recipient can make a number of inferences in looking at this data across agencies & longitudinally within a particular agency.
 - o Service Termination: The report indicates the number of persons the service provider has notified they will no longer provide services to.

If a service recipient and his/her Circle of Support cannot access the internet or are not proficient in the use of the internet, they can request a copy of the DDDS Resource Manual(Guide to Services). The guide provides the same information that is available on the website. As a part of the Essential Lifestyle planning process the individual and his/her family receives additional information from DDDS on how to proceed with seeking services and how to obtain more information from providers. They may also receive a hard-copy of the current provider directory.

DDDS provides information through Semi-Annual Provider Fairs . The fairs are announced publicly and operate as meet and greet events. Interested individuals may speak with service providers to get a feel for the services they provide & how they provide them. DDDS representatives are in attendance to assist families in obtaining more information on how to proceed with seeking services & how to obtain more information related to the providers. This venue provides an opportunity to meet a variety of providers and obtain useful information to guide them through the selection process.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

- g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i) through the terms of the Memorandum of Agreement between DMMA and DDDS. DMMA maintains responsibility for service plan approval.

The DMMA Memorandum of Agreement with the Division of Developmental Disabilities Services (DDDS) delineates a division of administrative duties between the Divisions:

- DDDS compiles information and reports on the following areas on an ongoing basis:
 - Participant Enrollment/Expenditure/Rate Methodology
 - Complaint Resolution /Abuse Neglect and Critical Incident Management
 - Fair Hearing Reports
 - Participant Record/ELP Reviews and Satisfaction Surveys which include Level of Care Data, Choice, and Service Plan Implementation
 - Qualified Provider Compliance and Enrollment
 - Policy and Procedure Changes
- DDDS takes immediate steps to assure that any needed corrective action determined by the above reviews and reports information to DMMA on a quarterly/annual schedule. Critical issues are addressed immediately. Provider Agencies and Independent Contractors have 10 days to develop a corrective action plan for less critical problems. DDDS verifies that action has been completed within 30 to 60 days after receipt of improvement plan.
- DMMA completes monitoring on an ongoing basis through the DHSS Quality Initiative Task Force (QII), DMMA Surveillance and Utilization Review (SUR), and DMMA's Delegated Services and Medical Management Unit.
- If a corrective action plan or further action is deemed necessary by DMMA, a request is made to DDDS for an improvement plan.
- DDDS sends a corrective action report to DMMA within 30 days of receipt of request that outlines action already taken and, if necessary, additional improvement plans that outlines timelines for completion.
- DMMA completes follow-up with DDDS within 60 days to assure corrective action measures have been implemented and concerns resolved. DMMA requests further action as needed and if additional investigation is warranted; a DMMA field audit is conducted, with onsite reviews completed. Any needed corrective action is reported to DDDS who takes immediate steps to rectify the problem.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

- h. Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

Every three months or more frequently when necessary

Every six months or more frequently when necessary

Every twelve months or more frequently when necessary

Other schedule

Specify the other schedule:

- i. **Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following (*check each that applies*):

Medicaid agency

Operating agency

Case manager

Other

Specify:

Hard Copies of the plans are maintained by the DDDS in the Division's Health Information Management Archives located at the Stockley Center, in Georgetown, DE. Copies are maintained for a minimum of 3 years and then forwarded for storage to the Delaware Public Archives Department headquartered in Dover, DE, for a period of at least 10 years.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

- a. **Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The Division of Developmental Disabilities Services (DDDS) provides for ongoing monitoring of the implementation of each waiver participant's service plan, which in Delaware is termed the Essential Lifestyle Plan (ELP). The DDDS case manager is the primary person responsible for monitoring the ELP at a minimum of once a month. DDDS has moved to the state Case Manager being responsible for service plan development for all waiver participants.

The purpose of the DDDS State Case Manager is to ensure services meet the participants' needs, are provided in accordance with their ELPs- including reviewing amount, frequency, scope and duration of services, that the ELPs identify the individual's exercise of free choice of providers, back-up plans are present and effective, non waiver services such as health care are accessible, and concerns which require action are identified and remedied promptly.

Special attention and intervention is given when matters arise concerning a participant's health and welfare. The following narrative describes these various monitoring processes.

Evaluation System:

The State DDDS Case Manager monitors the implementation of the ELP. Clinical/Behavioral Consultative Support team members may monitor specific outcomes pertaining to participant health and welfare. This information is documented in progress notes and T-Logs within the web-based Therap System. During this regular monitoring, the State DDDS Case Manager will:

Assess the extent to which the participant has access to and is receiving services according to his/her ELP. This includes monitoring that providers delivered the services at the frequency and duration identified in the ELP, and that participants are accessing all supports and health-related services as indicated on the ELP.

Evaluate whether the services furnished meet the participant's needs and help the participant become more independent.

Assess the effectiveness of plans and determine if changes are necessary.

- Review the participant's progress toward goals stated in the ELP.
- Assess and review the funds of the participant to ensure they are properly managed for the participant's benefit and to maintain waiver eligibility.

During the face to face monitoring of the plan that occurs four times each year, the Case Manager will:

- Remind participants that they have free choice of qualified providers.
- Remind participants, providers, and informal caregivers that they should contact DDDS if they believe services are not being delivered as agreed upon at the most recent ELP meeting.
- Observe whether the participant feels healthy and not in pain or injured.
- Interview the participant and others involved in the participant's services to identify any concerns regarding the participant's health and welfare.

If at any point there is belief that a participant's health and welfare is in jeopardy, actions must be taken immediately to assure the person's safety. In a less serious issue, the team will work with the participant, service providers and/or informal supports to address the issue. Depending on the severity and scope of the issue, the State DDDS Case Manager/Agency Program Coordinator may reconvene the planning team to address the issue.

Required Contracted Provider reports of service monitoring are as follows:

- Monthly ELP Progress Report- Completed by the person's Contracted Provider Agency. The Contracted Provider Agency Monthly ELP Progress report looks at identified priority outcome on the ELP Action Plan, and reports on the status of implementation. What is the status of developing the supports for the individual to attain his/her desired outcomes? Is there a concern or problem supporting the person? The Contracted Provider Agency comments as to what actions or steps are taken to support the person's attainment of identified outcomes.
- Monthly Nursing Audit- Completed by the person's identified Registered Nurse. This tool is used to track and monitor all health related services the person receives, as identified on the ELP. The nurse completes the report and provides findings to the provider agency so any corrections or issues needing follow-up may be addressed by the provider agency. Generally, the residential manager and/or the Support Coordinator receive this review through either a Therap report or a hard copy report in the person's record.
- Quarterly Day Service/Vocational/Work Reports- The providers of such services report on the person's progress as related to identified priority outcomes and goals on a quarterly basis. The reports are entered on the Therap system or hard copies are forwarded to the Support Coordinator for inclusion in the person's record.
- Quarterly Behavioral Reports- For persons who have identified behavioral support needs with active plans to address the issues, the Behavior Analyst or Psychological Assistant provide a quarterly data based report on the person's progress. Frequency of reporting may occur at more frequent intervals for person with intensive behavioral support needs.
- Other progress reports are provided as identified and defined in the person's ELP.

Such reports are based upon the person's support needs and identified priority outcomes.

- All reports are designed to assess the quality of the services and supports the individual receives and to stimulate quality improvement activities with each person's priority outcomes as identified on the ELP.
- Each person/discipline providing the service, support, and monitoring activity is required create annual assessment and progress reports and is used by the person and his/her selected support network for subsequent plan development/update activities.
- DDDS and all authorized service providers use T-Logs within the Therap web-based electronic system to document notes regarding contacts with participants, providers, family members and informal supports. All team members must document their communication and actions regarding the waiver participant in Therap.

Office of Quality Management Oversight:

The DDDS Office of Quality Management (OQM) completes Certification of Services reviews for a random sample of participants at the 95% Confidence Level. In addition, the OQM identifies Service Providers and licensed entities that were not captured by the sample selection. For those entities, the OQM completes full certification reviews above and beyond the random sample in order to make evidence based recommendations for contract renewal of all active service providers.

On an annual basis OQM also completes an interview of the providers- the Provider Questionnaire. The results of these three tools are provided to DMMA on an annual basis for the agency to review waiver operations with DDDS.

OQM uses a variety of other review tools in order to assess compliance with applicable standards and regulations. Identified deficiencies in services are identified in order to stimulate agency provided Improvement Plans. In addition the DMMA tools that are reviewed for quarterly trend analysis, the results of the regulation based certification reports are analyzed for identification of systems deficiencies and the development of systemic improvements.

These OQM reports assess Agreements to Participate, Levels of Care, Choice in Selecting Services, and adequacy of services provided. Negative findings from these reports are used to identify deficient practices and to stimulate agency provided improvement plans.

b. Monitoring Safeguards. *Select one:*

Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.

Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

The case manager is responsible for service plan development for waiver participants.

In order to ensure the Essential Lifestyle Plan (service plan) monitoring conducted by those furnishing direct services is in the best interest of the waiver participant, the DDDS utilizes a variety of service review processes and sources. As indicated in section D-a-1, the State DDDS Case Manager/Agency Program Coordinator is responsible for the implementation of, and reporting on the status of the services and supports the participant has identified- this includes both waived and non-waived services.

The DDDS Case Manager reviews and monitors the implementation of services at least monthly through a direct, person to person meeting and discussion with the participant. The Case Manager reports findings from review activities to the agency for implementation of Improvement Plans or actions to resolve the participant's concerns.

The DDDS Case Manager's role reflects a position of advocacy for the participant to receive satisfaction with his/her desired and identified outcomes. As there are situations in which the DDDS Case Manager may perform supports or services for the participant- such as to serve as the selected ELP Facilitator- DDDS oversight of services includes additional monitoring safeguards.

Primary system wide monitoring is implemented by the DDDS Office of Quality Management (OQM). The DDDS table of organization was structured for the OQM to report directly to the Division Director, as opposed to the Director of Community Services. Therefore, the OQM is accountable to the Division Director to provide accurate and objective data based performance reviews of waived services and programs.

Administratively, the positioning of the OQM under the Division Director protects the OQM from an alleged conflict of interest in reporting survey results. Were the OQM accountable to report directly to any of the DDDS operational units charged with the responsibility for direct waiver monitoring, then it could pose a concern that hard issues would be avoided and/or glossed over.

The OQM has full access to review all pertinent information related to participant in order to review and assess all services and supports provided for the waiver participants. Level of Care Assessments, Incident Reports (General Event Reports on Therap), Individual Plans of Protective Oversight and Safeguards (IPOPS), Nursing Reports and Essential Lifestyle Plans- including medical/psychiatric and behavioral portions, are examples of reports OQM has access to.

Frequency of OQM Reviews:

The DDDS Office of Quality Management (OQM) completes Certification of Services reviews for a random sample of participants at the 95% Confidence Level. In addition, the OQM identifies Service Providers and licensed entities that were not captured by the sample selection. For those entities, the OQM completes full certification reviews above and beyond the random sample in order to make evidence based recommendations for contract renewal of all active service Providers.

OQM is able to verify through observation, interview and thorough record review of required documentation that the plan of care is implemented as specified in the participant's ELP.

OQM utilizes a variety of tools, standards and regulations used for the evaluation of provider performance. The DDDS OQM reports data from such reviews on a quarterly basis to the Delaware Medicaid Unit (DMMA).

In turn DMMA monitors and reviews the DDDS OQM results and requires information on DDDS actions or plans to address issues identified through the data.

As indicated above, OQM completes site visits and conducts record reviews and interviews/discussions with persons receiving services. The interviews and record review findings are compared to the person's Essential Lifestyle Plan in order to assess the effectiveness of the DDDS Case Manager reviews and the agency's implementation of services or supports. Discrepancies between OQM findings and any other reports are forwarded to the provider and to the applicable DDDS Units for resolution.

As discussed in Appendix H, OQM data reports and DDDS Performance Measure- Data Analysis Reports are provided to a series of review committees. Paramount in the report review processes are the DDDS Executive Level- Risk Management Committee, the Governor's Advisory Committee, and the DDDS Director's Quality Council. Each of these two committees is made up of self-advocates (persons with disabilities), independent advocates, parents of waiver participants, and other interested persons. As these committees have memberships of people who have demonstrated advocacy strengths, the Data Analysis Reports are subject to thorough review, as the external committee members have an interest in pushing DDDS to provide excellent programs of supports and services.

In addition to the OQM, service plan monitoring is safeguarded through the monitoring of fundamental program requirements:

□ In licensed facilities such as the Neighborhood Group Homes, the Delaware Division of Long Term Care Residents Protection (DLTCRP) completes annual licensing inspections and reviews. In each site, DLTCRP completes a thorough environmental inspection to identify violations of established codes, and/or laws related to safe environmental practices (infection control/prevention practices, adequate environmental safeguards, condition of facility).

□ The DLTCRP completes a review of staff qualifications each contracted provider agency is to ensure. The qualification documentation includes a review of state and federal criminal background checks, abuse registry results- both adult and child registries, banned substance screenings, PPD screening results, and driver license monitoring.

□ Supplementing the reviews completed by the DLTCRP, the DDDS OQM reviews Emergency Plans, Fire Evacuation Plans, the results of Evacuation Drills, follow-up to issues identified in evacuation drills, environmental/safety reviews- including accessibility issues, and samples employee qualifications reviewing such documentation for each site's newest staff members.

□ Both divisions, the DLTCRP and the DDDS OQM are required to identify deficiencies based upon survey findings. In turn, agencies are required to provide plans of improvement. Such improvement plans are verified through follow up reviews in order to monitor for effective improvements. Failure for contracted agencies to provide effective improvement plans for all deficiencies identified results in the recommendation of a 90-day provisional license for neighborhood homes.

Agencies operating unlicensed sites are still certified annually by the OQM and may be issued notice similar to a provisional license. In both cases, continued non-compliance with providing adequate corrective actions or improvement plans is considered with regards to the agency's contract with DDDS. Sites can be re-assigned to other authorized providers or may be closed.

In settings with required automatic fire suppression, monitoring, and annunciation systems, contracted Fire Service Agencies complete annual system inspection and reviews and report their findings to the Office of the Delaware State Fire Marshal. Corrective actions are documented to the Office of State Fire Marshal.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

i. Sub-Assurances:

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

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

D-a-1: The percentage of Plans of Care (POC) in which individual's services and supports aligned with identified needs. (Number of Plans of Care in which services and supports are aligned with identified needs/number of Plans of Care reviewed.)

Data Source (Select one):

Other

If 'Other' is selected, specify:

The Division of Developmental Disabilities Services' Office of Quality Management (DMMA) Participant Questionnaire.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:

	<input checked="" type="checkbox"/> Continuously and Ongoing	Other Specify:
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:

D-a-2: The percentage of Plan of Care (POC) in which services and supports are aligned with identified preferences. (Number of Plans of Care in which services and supports are aligned with identified preferences/number of plans of care reviewed.)

Data Source (Select one):

Other

If 'Other' is selected, specify:

Office of Quality Management Individual Focused Certification Review.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review

<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

- b. **Sub-assurance:** *The State monitors service plan development in accordance with its policies and procedures.*

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes

are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

D-b-1: The percentage of Plans of Care (POC) developed in accordance with the Division of Developmental Disabilities Services' policies and procedures (Number of POC's developed in accordance within the guidelines of DDDS policies and procedures/Total number of ELP's reviewed)

Data Source (Select one):

Other

If 'Other' is selected, specify:

Office of Quality Management Individual Focused Certification Review Data Base

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually

	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

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

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

D-c-1: The percentage of Plans of Care reviewed and revised before the annual review date. (The number of Plans of Care reviewed and revised before the annual review date/number of Plans of Care reviewed.)

Data Source (Select one):

Other

If 'Other' is selected, specify:

Division's Office of Quality Management's Individual Focused Certification Review Data Base.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input checked="" type="checkbox"/> Continuously and	<input type="checkbox"/> Other

	Ongoing	Specify:
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:

D-c-2: The percentage of Plans of Care indicating services and supports were revised when an individual's needs changed. (The number of Plans of Care indicating services and supports were revised when an individual's needs changed/number of plans reviewed).

Data Source (Select one):

Other

If 'Other' is selected, specify:

The Division s Office of Quality Management's Individual Focused Certification Review Data Base.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval =

		95%
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

- d. **Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.**

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

D-d-1: Percentage of Plans of Care where services were delivered in accordance with service plan with regard to scope, amount and duration/frequency. (Number of Care Plans where services were delivered in accordance with Plan of Care in regard to scope, amount and duration as detailed in the service plan/Total number of Care Plans reviewed.)

Data Source (Select one):

Other

If 'Other' is selected, specify:

The Division's Office of Quality Management's Individual Focused Certification Review Data Base.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually

	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:

D-d-2: The percentage of participants whose Case Manager visited them to review the Plan of Care at least 4 times/year, of which 2 visits must be in the participant's home. (The number of participants whose Case Manager visited with them to review the Plan of Care at least every 4 months (2 of which must be in the home)/the number of participants whose services and supports were reviewed by OQM.)

Data Source (Select one):

Other

If 'Other' is selected, specify:

Office of Quality Management Individual Focused Certification Review-OQM Certification Data Base.

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

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Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:

D-d-3: The percentage of participants whose Residential Program Coordinators have completed at least monthly reviews of the implementation of the Plan of Care. (The number of participants whose Residential Agency Program Coordinators have completed at least monthly reviews of the implementation of the Plan of Care/the number of participants whose services and supports were reviewed).

Data Source (Select one):

Other

If 'Other' is selected, specify:

Office of Quality Management Individual Focused Certification Review-QQM Certification Data Base

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:

	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

- e. **Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.**

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

D-e-1: The percentage of new waiver participants who were presented with a choice of different waiver services including as option to choose institutional (IFC/MR) care. (The number of new waiver participants who were presented with a choice of different waiver services including an option to choose institutional (ICF/MR) care/total number of new waiver participants).

Data Source (Select one):

Other

If 'Other' is selected, specify:

DDDS Health Information Management Data Base

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:

D-e-2: The percentage of participants whose Plans of Care contain documentation that the participant was supported to make an informed choice about their provider(s). (The number of participants whose Plans of Care contain documentation that the participant was supported to make an informed choice about their provider(s)/total number of participants whose plans were reviewed.)

Data Source (Select one):

Other

If 'Other' is selected, specify:

The DDDS Office of Health Information Management Data Source

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually

<input type="checkbox"/> Continuously and Ongoing
<input type="checkbox"/> Other Specify:

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

Delaware's Method for Addressing Individual Problems as Discovered:

The discovery portion of the Division's Quality Management System relies on the survey processes conducted by nearly everyone at DDDS. These oversight functions are built into, and are an integral part of DDDS job duties. The majority of different surveys involving remediation and verification activities are done by staff of the Division's Office of Quality Management. Several other surveys are done by DDDS nurse consultants and case managers.

In addition, there is oversight involvement by family monitoring groups, formal review committees, other DDDS staff or disciplines, day and residential service providers, and the DDDS sister agency- the Division of Long Term Care Residents Protection (DLTCRP- for licensing).

For each step in the Quality Management System, DDDS has identified:

Entities responsible for Discovery (measuring and monitoring),
Frequency of monitoring,
Data Sources,
Party Responsible for Remediation, and
Unit Responsible for Verifying Corrections

Many of the discovery and verification processes are used as data sources to measure the DDDS outcomes and indicators.

The remediation process leading to improvement in areas found below expectation varies with the survey and discipline involved in the initial discovery process.

After the initial survey or collection of information, the findings of the professionals involved in the discovery process are communicated with the providers or others who will be involved in sharing promising practices and taking corrective action when needed. Issues are initially discussed among involved parties so as to clearly communicate findings and desired outcomes, followed up by a written report noting those areas needing correction and a date by when such is to be completed.

The responsible party discuss the issue requiring remediation and develop plans of improvement designed to provide satisfaction for the participant, or programmatic improvements for the areas impacted by the identified finding.

Once the improvement plan is developed by the provider, the applicable unit of DDDS is notified of the plan in writing.

Following notification the corrections were made, it is the general practice of the DDDS to follow-up, verifying the corrections were made and are acceptable.

For those surveys done by the Office of Quality Management, verifications usually take the form of a

documented look-behind review. The documentation includes a letter to the contracted provider agency's director, with copies of the letter to the Division Director and applicable Regional DDDS personnel. With other disciplines, corrections may be verified at the time of the next normally scheduled review, through increased frequency of surveillance, or through the review of provider submitted applicable documentation.

Verifications in these other cases may be documented on the next scheduled discipline specific monitoring report or immediately through the Therap Web-based system.

Local Ongoing Monitoring and Remediation:

With ever increasing frequency, DDDS departments are tracking the results of their discovery processes in a variety of databases. This tracking serves to provide a number of benefits. It provides a prompt in the remediation process, offer a comparison of results longitudinally or among providers, or is used by the Division in a variety of systems-improvement efforts.

Regional Offices have a key role in ongoing monitoring in order to verify issues on an individual and provider level are resolved. Regional Directors have access to reports tracking issues and follow-up, along with monthly summary reports from various discovery processes including PM-46/incident reports, case management visits; nursing visits; OQM provider reviews (e.g., shared living, CLA, NGH, day program), etc. Each office has a Management Team whose members are responsible for oversight of family support, case management, day and residential services for all individuals receiving support in the Region.

In addition to the Regional Program Director, membership includes a Nurse, Behavior Analyst, Case Management Supervisor, and Office of Quality Management staff. Following are the major Regional Resource Team responsibilities:

- Review unresolved and emerging serious individual concerns and provide technical assistance and/or resources to the Essential Lifestyle Planning (ELP) Team
- Review unresolved and emerging provider issues and provide technical assistance, resources, and/or requesting further review, etc.
- Periodically reviewing Regional Office trends and developing local improvement strategies

DDDS response to Continued Inadequate Performance:

Should the necessary corrections not be performed or still leave room for improvement, further actions are taken. This begins with communication of the inadequacy of the response and guidance in making the proper corrections. Higher administrative authorities in the organization are notified of the inadequacy of the response and the possibility of sanctions should improvements not be soon forthcoming. These sanctions range from the provider being placed on contract probation, the granting of a Provisional License by LTCRP, a freeze on new individuals being placed with the agency, removal of people from the provider's care or, in extreme cases, contract termination.

- Generally, unless the infractions involve egregious health and safety, rights or criminal violations, much work and effort is made by Division staff to assist the provider to come up to the expected performance before the contract is terminated by the Division.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: DDDS staff	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing

<input type="checkbox"/> Other Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability (from Application Section 3, Components of the Waiver Request):

Yes. This waiver provides participant direction opportunities. Complete the remainder of the Appendix.

No. This waiver does not provide participant direction opportunities. Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested (select one):

Yes. The State requests that this waiver be considered for Independence Plus designation.

No. Independence Plus designation is not requested.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

APPENDIX E-0 (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The State of Delaware Medicaid Fair Hearing process is promulgated in Delaware Administrative Code, Title 16, §5000-5607.

The State provides an opportunity for a Fair Hearing under 42 CFR Part 431, subpart E, to all individuals who are not given

the choice of home or community-based services as an alternative to institutional care or who are denied the service(s) of their choice, or the provider(s) of their choice. DDDS requires a letter indicating the individual's right to a Fair Hearing be sent to the individual and/or their legal guardian.

When an individual applies for services under this waiver, he or she is assessed to determine medical and financial eligibility. Following the eligibility determination process, written correspondence is mailed to this individual related to his or her eligibility to receive services through this waiver. Included in this information is the Fair Hearing notice. Notices of adverse action and the opportunity to request a Fair Hearing, at the time of entrance to the waiver, are maintained in the DDDS Office of Applicant Services.

The Fair Hearing notice indicates: denial of service, reduction of service, suspension of service, or termination of service can generate a Fair Hearing. The individual has the right to appeal and to be heard in a Fair Hearing if he/she is dissatisfied with the action. The individual must present a written request if he/she wishes to obtain a Fair Hearing. The individual may be represented by legal counsel (referrals are made to Community Legal Aid in instances where private legal counsel is not financially feasible) or other persons of his/her choice at the Fair Hearing. The individual may discuss this action with a member of the agency's staff. Filing a grievance does not interfere with the individual's Fair Hearing rights. The individual's benefits continue during the fair hearing process if the issue in question is not one of state or federal law. If the individual's benefits continue, they may be responsible for repayment, if they lose the Fair Hearing.

In order for Medicaid to continue, the actual receipt of a written request for a Fair Hearing is required within 10 days from the date of the notice/action being disputed. The individual may write directly to the agency or detach a portion of the notice and mail it to his/her local DMMA office.

Fair Hearing notices accompany notification of all other adverse actions and notify the individual of his/her right to a Fair Hearing. Notices are sent by case managers and/or providers by mail to individual. While not all of these actions are typically carried out in this waiver program, any adverse action, including action related to choice of HCBS vs. institutional service; choice of provider of service; and the denial, reduction, suspension or termination of service would be accompanied by the Fair Hearing notice described above. Case managers assist individuals in pursuing Fair Hearings by assisting the individual with the completion of forms or referrals to Community Legal Aid, as needed.

Documentation concerning Fair Hearing notifications are kept on file by DMMA via the quarterly State Fair Hearing Report.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

- a. **Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

No. This Appendix does not apply

Yes. The State operates an additional dispute resolution process

- b. **Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

DDDS operates an appeals process for individuals and/or their guardian or advocate to aggrieve any DDDS decision to which satisfactory resolution cannot be reached. DDDS appeals process is a dispute resolution mechanism requested in conjunction with or in addition to a State Medicaid Fair Hearing request. DDDS sends the individual and/or their guardian or advocate a written explanation of the disputed decision, the reason for such and notification of their right to request a DDDS appeal.

Instructions for requesting the DDDS appeal are provided and includes sending the appeals request form (included with the notification letter) to the Appeals Committee Chairperson.

Significant timelines regarding the request for and processing of a DDDS appeals request are as follows:

- 30 days from receipt of adverse notification letter to request an appeal;
- 5 working days from date of receipt of appeal request to schedule the appeal;

- 30 days from date of receipt of appeal request to conduct the appeal meeting;
- 15 working days from date of appeal meeting to issue a written disposition of the appeal.

Included in the adverse actions that may be appealed through DDDS include those delineated in 42 CFR Part 431, subpart E (action related to choice of HCBS vs. institutional service; choice of provider of service; and the denial, reduction, suspension or termination of service). The written notification of the adverse action presents the right to file a State Medicaid Fair Hearing and/or a DDDS appeal. A DDDS Appeal request does not negate the right to also request a State Medicaid Fair Hearing nor is it a pre-requisite to access the Medicaid Fair Hearing process.

The information regarding DDDS appeals is supported in the DDDS administrative policy entitled Appeal to DDDS Decision(s).

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

No. This Appendix does not apply

Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver

b. Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:

State Grievance/Complaint System:

Operational Responsibility:

DDDS is responsible for the operation of the grievance/complaint system(s).

The DDDS Director of Planning and Policy Development and Constituent Relations liason, was appointed by the DDDS Director to be the Division's Rights Complaint Designee. Individual Rights Complaint forms and instructions for the completion of such is included as an attachment in Rights Complaint Policy. They are prominently placed and accessible in all program and administrative offices and locations throughout the State of Delaware.

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Description of System:

The following grievance/complaint system processes are not a pre-requisite for or substitute for a State Medicaid Fair Hearing:

DDDS operates a toll free 24 hour telephone line at 1-866-552-5758 equipped to receive complaints as well as allegations of abuse, neglect, mistreatment and financial exploitation. This telephone line is publicized on the DDDS website and includes a disclaimer that a complaint filed via the toll free line method is not a pre-requisite nor a substitute for a State Medicaid Fair Hearing.

A more formalized complaint system is authorized through the DDDS administrative policy entitled Rights Complaint(s). Types of complaints addressed are limited to individual rights complaints/violations. Individual Rights Complaint forms and instructions for the completion of such is included as an attachment in Rights Complaint Policy. They are placed in prominent and accessible locations in all program and administrative areas. The address for submitting complaints or violations is included in the instructions attached to the Rights Complaint Form. The process and timeline for filing a rights complaint via the Rights Complaint system authorized by policy are as follows:

Anyone who has reasonable cause to believe a right has been violated may file a complaint with the DDDS Rights Complaint Designee, the DDDS Director of Planning and Policy Development and Constituent Relations liason. This information is provided to each program participant during the annual ELP and through the DDDS Case Manager;

- Upon receipt of the Individual Rights Complaint form, the Director of Planning and Policy Development/Constituent Relations coordinates a review of the reported situation with the applicable DDDS administrator. The Individual Rights Complaint form include the following statement: "The DDDS Individual Rights Complaint Process is not a prerequisite nor a substitute for a State Medicaid Fair Hearing.
- The applicable DDDS administrator responds to the Director of Planning and Policy Development/Constituent Relations with an outcome of the review, and a determination if rights were/were not violated and corrective/preventative actions, as applicable;
- The information in the bullet above is reviewed by the Rights Complaint Designee, and the DDDS Director;
- The Director of Planning and Policy Development/Constituent Relations provides a written response to the complainant within 60 working days of receipt of the complaint. The response includes notification of the outcome of the review as well as completed and planned follow-up.
- The identity of the complainant is protected and the actual complaint is maintained in a confidential file by the Rights Complaint Designee.

Participants or their personal advocate register grievances/complaints with the Rights Complaint Designee by sending a Individual Rights Complaint Form to the Director of Planning and Policy Development. This individual reviews the receipt of all Individual Rights Complaint Forms and coordinates an investigation with the applicable DDDS administrator.

The investigating administrator responds to the Director of Planning and Policy Development/Constituent Relations with the outcome of the investigation, determination if rights were/were not violated and corrective/preventive actions, if applicable. Individual Rights Complaint Designee, the Director of Planning and Policy Development/Constituent Relations reviews the aforementioned information with the Division Director. Within 60 days of having received the complaint/grievance, the Director of Planning and Policy Development contacts the person who filed the grievance/complaint and advises him/her of the outcome and planned follow-up, as applicable.

The aforementioned series of events are documented in the DDDS Rights Complaint policy.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

- a. **Critical Event or Incident Reporting and Management Process.** Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program. *Select one:*

Yes. The State operates a Critical Event or Incident Reporting and Management Process (complete Items b through e)

No. This Appendix does not apply (do not complete Items b through e)

If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

- b. **State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

DDDS has two (2) distinct mechanisms for reporting critical incidents. The first mechanism is to report incidents which cause or could cause injury or which have serious impact on the consumer or others. General Event Reports (GER) are used to communicate and document these reportable incidents. Therap Services is a web-based service organization used by DDDS that allows its users to efficiently communicate an incident (GER), plans of correction

and the tracking of incidents. The following events are reportable incidents via the Therap system of incident reporting, according to the DDDS General Event Report policy:

- Events which violate or have the potential to violate an individual's human rights (ex: person is prevented from practicing their religion, person is expected to work without being paid);
- Any explained or unexplained injury to an individual;
- Accidents requiring non-routine first aid or outside medical attention;
- An individual's unauthorized absence;
- Events which involve or have the potential to involve the legal system/law enforcement;
- Actions of an individual generally viewed as unacceptable social behavior in a community setting (i.e., public display of sexual activity, coerced or exploited sexual behavior, physical aggression, verbal abuse/aggression, self-injurious behavior, criminal activity, property destruction, suicide threat/attempt);
- Events adversely impacting or have the potential to adversely impact the a person receiving services or affect the reputation/integrity of the Division's community based programs;
- Significant destruction or loss of property;
- Any behavior necessitating the use of a physical restrictive procedure (document on MBIS section of the General Event Report form, via Therap, in accordance with DDDS Behavior Support Policy);
- Any situation which necessitates the use of a medical restraint (ex: papoose board used by dentist);
- Any deviation from a physician's plan of treatment including medication errors;
- Errors related to the documentation of a physician's treatment plan (ex: assisted with medications but failed to document such on the MAR);
- Life-threatening or allergic reaction by an individual to medical treatment;
- The death of an individual regardless of cause.

The person who witnessed or discovered the incident initiates the report immediately (as soon as the situation is stabilized and no later than the end of his/her shift). If the initiating person is a contracted residential provider, the incident report is channeled through his/her respective administrative review process.

The second mechanism for reporting critical incidents is via the "PM #46" process. Policy Memorandum 46 is a Department of Health and Social Services Policy Memorandum developed in response to Delaware law for reporting and investigation of abuse allegations. Title 16, Section 1131-1134 of the Delaware Code addresses reporting and investigative requirements and is mirrored in the Delaware Department of Health and Social Services PM #46 and the DDDS Abuse, Neglect, Mistreatment, Financial Exploitation and Significant Injury Policy. Critical incidents requiring immediate reporting and investigating include the following:

1. Abuse;

- a. Physical Abuse - the unnecessary infliction of pain or injury to an individual receiving services. This includes but is not limited to hitting, kicking, pinching, slapping, pulling hair, or any sexual molestation. When any act constituting physical abuse has been proven, the infliction of pain shall be assumed.
- b. Emotional Abuse - ridiculing or demeaning an individual receiving services, making derogatory remarks or cursing directed towards a consumer, or threatening to inflict physical or emotional harm to a consumer.

2. Neglect shall include the following:

- a. Lack of attention to the physical needs of an individual receiving services including but not limited to toileting, bathing, meals and safety (to include supervision).

b. Failure to report health problems or changes in health problems or changes in health condition, of an individual receiving services, that may have the potential to cause adverse effects, to an immediate supervisor or medical professional.

c. Failure to carry out a prescribed treatment plan for an individual receiving services.

d. A knowing failure to provide adequate staffing which results in a medical emergency to an individual receiving services.

3. Mistreatment - the inappropriate use of medications, isolation or physical or chemical restraints on or of an individual receiving services.

4. Financial exploitation - the illegal or improper use of an individual's resources or financial rights by another person, whether for profit or other advantage.

5. Significant Injury - an injury which is life threatening or causes severe disfigurement or significant impairment of bodily organ(s) or function(s) which cannot be justified on the basis of medical diagnosis or through internal investigation.

Immediate (as soon as the situation is stabilized) verbal reports are required to be made to the designated DDDS PM #46 Coordinator by DDDS and contracted agency staff who have reason to suspect any of the aforementioned reportable incidents.

Strategies For Preventing Abuse and Neglect:

The individual's Essential Lifestyle Plan (ELP) must identify any risk factors that make a person more vulnerable to abuse or neglect (more likely to become a victim). Each identified risk factor includes a corresponding support(s) to protect the person from becoming a victim of abuse/neglect. The risk factors and supports are identified by the individual and his/her support team and circle of family and friends. The risk factors are discussed and addressed via the ELP meeting. Some risk factors indicating a person's heightened vulnerability include the following:

- Inability to physically leave the environment or situation
- Unable to change the environment or situation
- Unable to speak or to be heard
- Unable to take action in his/her own behalf
- Physically, socially or psychologically isolated
- Limited or non-existent circle of support (friends and families)
- Easily intimidated or controlled by others

Tracking of Reports

The DDDS reviews all reportable incidents, provides any needed follow-up, files the reports, and aggregates and tracks the trends of these incidents on a quarterly basis. The trend reports are sent to the Division Director each quarter where they are reviewed. Results of trend analysis may result in program changes, including the provision of provider training, based on information received from reports as appropriate. On an annual basis, compiled incident report data are reviewed and linked to systemic performance improvement efforts as part of the waiver quality management plan.

- c. **Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

All persons served in the DDDS residential and day habilitation program(s) are advised of the participant's right to be free of physical, verbal, sexual, psychological/emotional abuse and exploitation and how incidents are reported. This education is provided at the time of the initial contact, following eligibility determination, and yearly thereafter, at the time of the Essential Planning Conference (ELP). The Case Manager is responsible for the development of ongoing teaching and support strategies designed to assist participants to understand and exercise his/her rights.

The ARC of Delaware in collaboration with the Division of Developmental Disabilities Services provides education seminars to families of participants, twice per year in each of the three (3) counties.

The ARC provides verbal and written information to the seminar's participants concerning an individual's right to be free from harm, explanations of what constitutes abuse (both physical and emotional), neglect, mistreatment,

financial exploitation and significant injury and telephone numbers of the Division of Long Term Care Residents Protection and the regional PM #46 Coordinators.

- d. Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

The Incident Management System of General Event Reports is overseen at several levels. The most immediate review and monitoring occur at the team level. Team members, include DDDS, residential agency or shared living provider and day program staff assigned to provide services to the individual, document incidents, develop plans of correction or protection and monitor the effectiveness of such plans.

The Office of Quality Management reviews GER data on an annual basis, prior to Neighborhood Group Home and Community Living Arrangement certifications. Program Evaluators review Therap data to determine if appropriate actions were taken, if such actions were effective and if trends exist. The outcome of the review of the incident management system by the Program Evaluators is incorporated into the certification report, if corrective action is necessary.

Immediately following the receipt of an abuse, neglect, mistreatment, financial exploitation or significant injury allegation, the PM #46 Coordinator directs the initiation of an investigation by State or contracted agency trained investigators and provides oversight and review of the subsequent investigation.

The PM #46 Coordinator ensures applicable law enforcement authorities and/or health care providers are contacted, as necessary. Incidents falling within the realm of the PM #46 are minimally reported to the PM #46 Coordinator to the Division Director, Office of the Secretary of the Delaware Department of Health and Social Services, the Division of Long Term Care Residents Protection and the Attorney General's Office. The individual served, guardian of person (and property if the allegation involves financial exploitation) and primary family contact person is notified an investigation has been initiated, except when the individual communicates he/she does not want such information released or the release of information has the potential to do harm. At the conclusion of the investigation, the same individuals notified at the initiation of the investigation are advised the completed internal investigation is sent to the DLTCRP for their review and further investigation, if necessary, and determination of the status of the allegation(s) investigated. The involved individual(s) is notified the DLTCRP will send them communication at the conclusion of their investigative review.

The DDDS is required to submit comprehensive investigative reports to the Division of Long Term Care Residents Protection (DLTCRP) within ten (10) days of the initial PM #46 notification, unless it is determined there are extenuating circumstances requiring further investigation. Upon completion of the investigation, the DDDS Case Manager/Social Worker notifies the family member the investigation is completed, actions have been taken to protect the individual receiving services and a further level of review is completed by the Division of Long Term Care Residents Protection and possibly the Attorney General/Medicaid Fraud Unit.

If an investigation is not completed within ten (10) days, the DDDS Case Manager/Social Worker notifies family the investigation is on-going and the individual served is safe. Title 29, section 7971 and Title 16, section 1134 of the Delaware Code charge the DLTCRP with the ultimate responsibility of the investigative process, making determinations relative to substantiation/unsubstantiation of allegations and notifying the alleged victim and authorized family/representative of the outcome of the investigation. As required by law, the DLTCRP notifies the individual or his/her guardian, at the conclusion of their investigation, relative to the status (i.e., substantiated or not substantiated) of the case, unless prohibited by law.

- e. Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

DDDS Risk Management Committee reviews data presented by the Performance Analysis Committee to determine if risk reduction strategies are necessary to strengthen the DDDS systems or improve individuals' quality of life.

The Performance Analysis Committee is an administrative committee appointed by the Division Director and charged with the responsibility of collecting, reviewing and analyzing data that measures the Division's adherence to performance measures/indicators. The Performance Analysis Committee subsequently generates analytic reports to the various DDDS quality-related committees on a regularly scheduled frequency or as requested.) The report includes data which correlates with a CMS assurance (i.e., "the state, on an ongoing basis, identifies and addresses and seeks to prevent the occurrence of abuse, neglect and exploitation") an analysis of the data, recommended

improvement strategies and follow up from previous review periods.

The Risk Management Committee issues reports of findings to the Division Director and requests for plans of corrections, as necessary, to the appropriate executive staff person.

The DDDS Office of Quality Management communicates with the State Medicaid office via reports and/or face to face meetings, on a quarterly basis, relative to critical incident data.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 2)

a. Use of Restraints or Seclusion. (Select one):

The State does not permit or prohibits the use of restraints or seclusion

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints or seclusion and how this oversight is conducted and its frequency:

The use of restraints or seclusion is permitted during the course of the delivery of waiver services. Complete Items G-2-a-i and G-2-a-ii.

- i. Safeguards Concerning the Use of Restraints or Seclusion.** Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints or seclusion). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

As outlined in the DDDS Policy on Behavior and/or Mental Health Support, positive supports are the essential foundation upon which all programs and individual plans are developed.

Prohibited procedures:

DDDS Policy on Behavior and/or Mental Health Support policy prohibits the use of mechanical restraints; corporal punishment or threat of corporal punishment; seclusion as defined as placing an individual in a locked room; chemical restraint; physical, verbal, sexual, or psychological abuse or punishment; denial of a nutritionally adequate diet (including the withholding of a meal); physical restraints which cause pressure or weight on the lungs, diaphragm or sternum causing chest compression; physical interventions which cause pain, hyper extend any part of the body beyond normal limits and any technique which puts or keeps a person off balance; individuals receiving services disciplining other individuals receiving services; techniques or procedures used for the convenience of staff, or as a substitute for a support program; intrusive techniques or procedures used in the absence of other relative proactive supports.

Permitted Personal Restraints:

Permitted planned personal restraints are limited to the one and two person side body hug and the one and two arm supporting technique as described in the Mandt Training protocol.

Use of Alternative methods before Instituting Restraints

If the individual's Behavior and/or Mental Health Support Plan (BMHSP), developed by the contracted Behavior Specialist, include an approved restraint, it must describe less intrusive techniques and resources used prior to the implementation of the restraint. Every attempt is made to anticipate and de-escalate the behavior. It is only after these have been tried, and failed, the restraint may be implemented. An approved restraint may not be used as retribution, for the convenience of staff, as a substitute for program or in a way that interferes with the individual's development.

Protocol for When Restraints can be employed

Restraints are always a last resort to protect an individual's health and/or safety. The individual is to be immediately released from the restraint per instructions in the BMHSP, is no longer a risk to themselves or others, or shows signs of distress.

For each restraint procedure developed by the contracted Behavior Specialist, the BMHSP must include the following:

- 1) Specific behavior to be addressed and a description of conditions for which the restraint procedure is used
- 2) Single behavioral outcome desired stated in observable or measurable terms,
- 3) Functional assessment to identify suspected antecedents and functions of the behavior,
- 4) Description of less intrusive techniques which must be used prior to the use of the restraint,
- 5) Methods and target dates for modifying or eliminating the behavior,
- 6) Methods and target dates for replacement behaviors,
- 7) Description of the procedure to be used,
- 8) Risk benefit analysis,
- 9) Medical clearance,
- 10) Consents from relevant parties, and
- 11) Name of the person responsible for monitoring and documenting progress with the plan.

Each BMHSP is reviewed by the Peer Review of Behavior Intervention Strategies committee (PROBIS) for completeness and compliance with best accepted practices consistent with DDDS policies and procedures.

The PROBIS committee is a DDDS committee appointed by the Division Director to review and approve BMHSPs. The BMHSP is reviewed by the Human Rights Committee to the protection of the rights of individuals served by DDDS. This committee is appointed by the Division Director and is made up of non-DDDS employees.

Methods for Detecting Unauthorized use of Restraints

Each provider has access to the web-based Therap database. Every use of a restraint, whether it is planned or emergency, is electronically submitted by the involved parties within 24 hours using the General Event Reports (GER) and the Medical/Behavioral Intervention Strategies (MBIS) report.

These reports describe:

The incident,

Description of the events leading up to the restraint,

Duration of the restraint, and

Follow-up to assure the health and safety of the individual.

Additionally, contracted residential support staff enters individual electronic Inter-Disciplinary Team notes (ID notes) in the Therap database on a daily basis.

Contracted case managers and contracted clinical support staff review this information several times a week. The state Regional Services Coordinator receives electronic notification of the use of a restraint

and reviews the report. The Regional Services Coordinator ensures the individual's health and welfare. Improper or unauthorized use of a restraint is considered abuse and investigated through the PM #46 procedures.

Aggregate individual restraint information is reviewed by the individual's ID team at least bi-monthly or more frequently as indicated in the BMHSP. The Inter-Disciplinary Team (ID team) is comprised of the individual, parent/guardian, contracted case manager, contracted residential support agency staff as relevant, and contracted clinical support staff as relevant. Additional members participate as appropriate or invited. It is charged with the development, oversight and modification of the Individual's Essential Lifestyle Plan and the Behavior and/or Mental Health Support Plan if needed.

Restraint information is reviewed monthly by the PROBIS committee. Restraint information is aggregated bi-annually by type, frequency, agency and geographic region by the Division's Performance Review Committee (PAC) and submitted to the Division's Risk Management Committee for review and action.

The Office of Quality Management conducts Individual Focused Certification Reviews that include record reviews and consumer interviews. Where indicators are identified, individuals are asked about the use of restraints. Any undocumented use of a restraint is reported as a potential case of abuse and investigated through the PM#46 processes. The DDDS submits quarterly reports to the Delaware DMMA which includes the use of restraints.

Education and Training Requirements for Personnel who Administer Restraints

As articulated in the DDDS Training Policy, all state staff and contracted providers have required trainings and timelines which must be completed. Providers submit training compliance information through the Therap Database. The Office of Quality Management monitors training compliance as a part of provider monitoring.

These training requirements are considered to be viewed as minimal expectations to help support the individual and create a structure that prevents restraint. All providers have procedures in place to address how people are supported in emergency situations where an individual's health and welfare may be at risk.

~~All contracted providers are required to have specific trainings within established timelines prior to working alone with individuals. These training requirements include DDDS policies relevant to the use of restraints.~~

All contracted providers are required to participate in the Mandt System crisis intervention training or a DDDS approved equivalent. Contracted providers must be certified in a specific restraint prior to its use with an individual.

The Mandt System includes the following topics:

- 1) Environmental factors and triggers,
 - 2) Positive behavioral support,
 - 3) Person-centered alternatives to the use of restraint, training in body mechanics that illustrates how to avoid hyperextensions and other positions that may endanger individual safety,
 - 4) Awareness of the impact of the individual's health history on the application of a restraint,
 - 5) Training in the use of approved restraints and possible negative psychological and physiological effects or restraints,
 - 6) Monitoring of an individual's physical condition for signs of distress or trauma, and
 - 7) Debriefing techniques with the supported individual as well as staff members.
- ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints or seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

DDDS is responsible for the oversight of the use of restraints. DDDS analyzes restraint data as described above under detecting unauthorized use of restraints.

Each provider has access to the web-based Therap database. Every use of a restraint, whether it is planned or emergency, is electronically submitted by the involved parties within 24 hours using the General Event Reports (GER) and the Medical/Behavioral Intervention Strategies (MBIS) report. These reports describe the incident, a description of the events leading up to the restraint, the duration of the restraint, follow-up to assure the health and safety of the individual.

The State Regional Services Coordinator receives electronic notification of the use of a restraint and reviews the report. The Regional Services Coordinator ensures the individual's health and welfare. Information on the use of restrictive procedures for an individual is reviewed by the individual's ID team at least bi-monthly or more frequently as indicated and Behavioral Support Plans are modified as necessary.

Additionally, the Office of Quality Management conducts annual reviews which include consumer interviews where individuals are asked about their health and welfare. Prior to these interviews the Office of Quality Management reviews the Therap database for any incidences of the use of a restraint for that individual. The Office of Quality Management submits quarterly reports to the Delaware DMMA which includes data on incidents and complaints.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 2)

b. Use of Restrictive Interventions. (Select one):

The State does not permit or prohibits the use of restrictive interventions

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

The use of restrictive interventions is permitted during the course of the delivery of waiver services
Complete Items G-2-b-i and G-2-b-ii.

- i. Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

As articulated in the DDDS Policy on Behavior and/or Mental Health Support, positive supports are the essential foundation upon which all programs and individual plans are developed. Further, the policy discourages the use of restrictive procedures.

A restrictive procedure is defined as a practice which limits an individual's movement, ability to acquire positive reinforcement, results in the loss of valued objects or activities, or requires an individual to engage in a behavior the individual would not engage in given freedom of choice.

Use of Alternative methods before Instituting Restrictive Interventions

If the individual's Behavior and/or Mental Health Support Plan (BMHSP), developed by the contracted Behavior Specialist, include restrictive interventions, it must describe less intrusive techniques and resources which must be used prior to the implementation of the intervention. Every attempt is made to anticipate and de-escalate the behavior. It is only after these have been tried, and failed, the restrictive intervention are implemented.

A restrictive procedure may not be used as retribution, for the convenience of staff, as a substitute for the program or in a way that interferes with the individual's development. The use of aversive conditioning, defined as the contingent application of startling, painful or noxious stimuli is prohibited.

Protocol for When Restrictive Interventions are Employed

For each restrictive intervention procedure developed by the contracted Behavior Specialist, the BMHSP includes the following:

- 1) the specific behavior to be addressed and a description of conditions for which the restrictive intervention is used
- 2) the single behavioral outcome desired stated in observable or measurable terms,
- 3) a functional assessment to identify suspected antecedents and functions of the behavior,
- 4) a description of less intrusive techniques used prior to the use of the restrictive intervention,
- 5) methods and target dates for modifying or eliminating the behavior,
- 6) methods and target dates for replacement behaviors,
- 7) a description of the intervention to be used,
- 8) a risk benefit analysis,
- 9) medical clearance if appropriate,
- 10) consents from relevant parties, and
- 11) the name of the person responsible for monitoring and documenting progress with the plan.

Each BMHSP are reviewed by the Peer Review of Behavior Intervention Strategies committee (PROBIS) for completeness and compliance with best accepted practices consistent with DDDS policies and procedures.

The PROBIS committee is a DDDS committee appointed by the Division Director to review and approve BMHSPs. The BMHSP also is reviewed by the Human Rights Committee (HRC) to ensure the protection of the rights of individuals served by DDDS. This committee is appointed by the Division Director and is made up of non-DDDS employees.

Methods for Detecting Unauthorized use of Restrictive Interventions

Each provider has access to the web-based Therap database. Every use of a restrictive intervention is electronically submitted by the involved parties within 24 hours using the General Event Report (GER) report.

These reports provide information identified in the BMHSP which may include a description of the incident, a description of the events leading up to the restrictive intervention, the duration of the restrictive intervention, follow-up to assure the health and safety of the individual.

Additionally, contracted residential support staff enters individual electronic ID notes in the Therap database on a daily basis. Contracted case managers and contracted clinical support staff review this information several times a week. The State Regional Services Coordinator receives electronic notification of the use of a restrictive intervention and reviews the report. The Regional Services Coordinator ensures the individual's health and welfare. Improper or unauthorized use of a restrictive intervention is considered abuse and investigated through the PM #46 processes.

Aggregate individual restrictive intervention information is reviewed by the individuals ID team at least bi-monthly or more frequently as indicated in the BMHSP. Restrictive intervention information is reviewed by the PROBIS committee as identified by the DMHSP.

The Office of Quality Management conducts Individual/ Focused Certification Reviews that include

record reviews and consumer interviews where indicators are identified concerning the use of restrictive interventions. Undocumented use of restrictive procedures are reported to the Regional Service Coordinator for follow up to:

- 1) Ensure the individuals health and welfare, and
- 2) Determine how to prevent further use of undocumented restrictive interventions.

Any undocumented use of a restrictive procedure which constitutes suspected abuse or neglect is investigated through the PM #46 process. The Office of Quality Management submits quarterly reports to the Delaware DMMA which includes data on incidents and complaints.

Education and Training Requirements for Personnel who Administer Restrictive Interventions.

As articulated in the DDDS Training Policy, all state staff and contracted providers have required trainings and timelines which must be completed. Providers submit training compliance as a part of provider monitoring.

These training requirements are considered to be viewed as minimal expectations to help support the individual and create a structure that prevents restrictive interventions. All providers have procedures in place to address how people are supported in emergency situations where an individual's health and welfare may be at risk.

All contracted providers have specific required trainings within established timelines which must be completed prior to working alone with individuals. These training requirements include DDDS policies relevant to the use of restrictive interventions. All contracted providers are required to participate in the Mandt System crisis intervention training or a DDDS approved equivalent. Contracted providers must be certified in a specific restrictive intervention prior to its use with an individual.

The Mandt System includes the following topics:

- 1) Environmental factors and triggers,
 - ~~2) Positive behavioral support,~~
 - 3) Person-centered alternatives to the use of restrictive intervention, training in body mechanics that illustrates how to avoid hyperextensions and other positions that may endanger individual safety,
 - 4) Awareness of the impact of the individual's health history on the application of a restrictive intervention,
 - 5) Training in the use of approved restrictive interventions and possible negative psychological and physiological effects or restrictive interventions,
 - 6) Monitoring of an individual's physical condition for signs of distress or trauma, and
 - 7) Debriefing techniques with the supported individual as well as staff members.
- ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

The DDDS is responsible for the oversight of the use of restrictive interventions. DDDS analyzes restrictive intervention data as described above under detecting unauthorized use of restrictive interventions

Each provider has access to the web-based Therap database. Every use of a restrictive intervention is electronically submitted by the involved parties within 24 hours using the General Event Reports (GER) report. These reports provide information identified in the BMHSP which may include a description of the incident, a description of the events leading up to the restrictive intervention, the duration of the restrictive intervention, follow-up to assure the health and safety of the individual.

Additionally, contracted residential support staff enters individual electronic ID notes in the Therap

database on a daily basis. Contracted case managers and contracted clinical support staff review this information several times a week. The state Regional Services Coordinator receives electronic notification of the use of a restrictive intervention and reviews the report. The Regional Services Coordinator ensures the individual's health and welfare. Improper or unauthorized use of a restrictive intervention is considered abuse and investigated through the PM #46 processes.

Aggregate individual restrictive intervention information is reviewed by the individual's ID team at least bi-monthly or more frequently as indicated in the BMHSP. Restrictive intervention information is also reviewed by the PROBIS committee as identified by the DMHSP.

The Office of Quality Management conducts annual record reviews and consumer interviews where individuals are asked about the use of restrictive interventions. Undocumented use of restrictive procedures are reported to the Regional service Coordinator for follow up to:

- 1) Ensure the individuals health and welfare, and
- 2) Determine how to prevent further use of undocumented restrictive interventions.

Any undocumented use of a restrictive procedure which constitutes suspected abuse or neglect is investigated through the PM #46 processes.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

No. This Appendix is not applicable *(do not complete the remaining items)*

Yes. This Appendix applies *(complete the remaining items)*

b. Medication Management and Follow-Up

- i. Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

The on-going monitoring of participant medication regimens by contracted provider agencies is made clear by DDDS in the following policy statement:

Contracted agencies have a system, as identified in their policy, whereby they minimally monitor regularly for medication errors, ensure staff who assist with medications have a current certification in Assistance with Self-Administration of Medication, respond to the Delaware State Board of Nursing with required information, provide their staff with necessary training and/or mentoring and apply corrective actions as required.

This responsibility is completed in all Neighborhood Homes and Community Living Arrangements (CLAs) by assigned agency personnel. The first line of monitoring is conducted by the contracted provider agency's House Manager and/or Program Coordinator. In Shared Living settings the DDDS Nurse and the contracted provider work in tandem to complete the monitoring processes.

The scope of monitoring by the provider agency's House Manager and/or Program Coordinator is to review each participant's entire medication regimen, assure adequate documentation, and to observe staff provide direct assistance for participants with taking their medications in accordance with the participant's ELP.

The House Manager is expected to review all participant health related issues including medications during each day in which the House Manager is on duty in the site. The review is to entail a review of upcoming medical appointments for the participants, medication amounts present in the site, proper storage of the

medications, and proper documentation of the medications which have been received by each participant. The role of the Case Manager is to complete on at least a monthly basis, follow up to the issues tracked by the House Manager. This is to assure the House Manager is properly reviewing participants' medication. Both the House Manager and Case Manager assure proper incident reports are completed should a medication error be identified or investigation be required.

□ This monitoring system is designed to detect potentially harmful practices by providing an accountability system. The system compares all components of a Physician's Order for medication (i.e., correct medication, correct dose, correct recipient, correct route, correct time, etc.) to the documentation trail of what was received by the participant, and what the participant's ELP requires for supports.

□ Second-line monitoring is conducted on the use of behavior modifying medications by the same processes as described in the paragraphs above as well as the additional processes described as follows:

The DDDS Peer Review of Behavioral Strategies Committee (PROBIS) reviews and approves multi-component Behavioral/Mental Health or Essential Lifestyle Plans. The committee is responsible for monitoring all plans that include the use medication for the sole purpose of behavior control in the absence of a psychiatric diagnosis. PROBIS also completes an initial review of Mental Health Support Plans for the use of medication for the treatment of a mental illness.

DDDS Policy requires Behavior Support Plans and Mental Health Support Plans show an understanding of and address the individual's behavior / psychiatric symptoms in terms of:

- a. the impact of environmental factors
- b. the impact of social and interpersonal factors
- c. the individual's coping skills
- d. the impact of psychological/psychiatric factors
- e. the individual's ability to understand and produce meaningful communication
- f. any potential medical condition or physical disability

Mental Health Support Plans/Essential Lifestyle Plans outlining the use of psychotropic medication for the treatment of a mental illness is reviewed by the ID Team prior to or at the time of beginning the medication. Additionally, the plan is submitted to PROBIS within 90 days of beginning the medication and shall include the I. D. Team's recommendation relative to the future monitoring of the plan. This recommendation includes the proposed monitoring/review body (I. D. Team or PROBIS) and the suggested frequency of review.

PROBIS monitors and determines the frequency of monitoring of all Level III interventions and plans. Proposed changes are submitted to the PROBIS chair via e-mail/written notification prior to implementation if an intervention is added or deleted.

If PROBIS determines the Interdisciplinary (ID) Team is the monitor for the Mental Health Plan, the team assumes responsibility and no further committee reviews of the plan/program is necessary unless:

1. The diagnosis is changed to one not included in the major diagnostic class of the original diagnosis;
2. The class of medication prescribed is changed to another class;
3. The total daily dosage of the medication exceeds the recommended upper range listed in either the Physician's Desk Reference or the Nursing Drug Handbook.

The contract provider agency's Program Manager reviews the participant's treatment plan involving behavior modifying medications on a monthly basis.

Monitoring includes notation of the participant's response to treatment in comparison to established treatment goals. The ID Team is notified whenever the participant's response to treatment is not meeting established goals or if undesired side effects are identified. The ID Team, then under the leadership of the Psychological Assistant or Behavior Analyst arranges for the participant to meet with the applicable physician for further

- evaluation should the treatment not provide desired outcomes.
- ii. **Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

DDDS is the State Agency responsible for the oversight of participant medication regimens. By contractual agreement, either DDDS or the provider agency Nurse Consultant completes a thorough monthly medication monitoring function with a report generated as to the findings. The nurse leaves a copy of findings in each participant's active record for the House Manager to follow up on. The nurse refers to the previous reviews to assure the House Manager has addressed previously identified unresolved issues. A third monitoring piece is the DDDS Office of Quality Management (OQM) completes a comprehensive medical record and medication assistance observation in each of the Neighborhood Homes and Community Living Arrangements on an annual basis.

□ When oversight is not conducted by the Medicaid agency or the operating agency, the process to communicate information and findings from monitoring are regularly communicated to the Medicaid agency and the operating agency. The DDDS Office of Quality Management communicates with the State Medicaid office via reports and/or face to face meetings, on a quarterly basis, relative to the use of restrictives.

□ The DDDS State Nurse Consultant's monitoring role is designed to focus on all medication types and medication usage patterns ordered for each participant. The assigned nurse's methods for conducting monitoring in Neighborhood Homes and CLAs include the following activities: Review all medical issues related to the individual and complete a Monthly Medication and Health Audit.

The audit requires the nurse to check all participant's current Medication Administration Records (MARs) against Physician's Orders and against medication card labels to assure agreement. Count documentation on MARs to assure the correct number of pills or amounts of medication has been given. Check medications are adequately stocked, properly stored, and not expired. Compare count sheets and the amount of medication remaining against the amount noted on the count sheet. Assure Standing Medical Orders (SMOs) are updated annually by the physician.

Additionally, on an annual basis, the DDDS, OQM conducts a similar review of documentation of medications, review of medications present in the home, and direct observations of participants receiving assistance with their medication.

In Shared Living Homes, the provider completes a Foster/Respite Monthly Medication Record, which is forwarded to the participant's DDDS nurse consultant. This form lists all medications the participant is on, and whether the medication was held, or changed during the month reported on. For newly ordered medications, the nurse speaks with the provider about any side effects that need to be observed for and reported upon. The discussion includes the nurse making sure side effect information is received from the pharmacy.

The frequency of monitoring by the nurse in Neighborhood Homes and Community Living Arrangements occurs at least monthly with visits to each of these residential sites. Additionally, the OQM completes thorough and comprehensive medication reviews in each site on an annual basis as a part of the licensing / certification process.

In Shared Living homes, monitoring by the DDDS nurse includes assuring the receipt of the Foster / Respite Monthly Medication Record, at least monthly telephone contacts with the provider, and home visits at least annually to meet with the participant and the provider, or as indicated by participant health needs. The Nurse Consultant participates in the individual's ELP planning process, which includes discussion and documentation of the individual's medications, health status, and needs for support.

The state monitoring program gathers information concerning potentially harmful practices and employs information to improve quality by the following means: In Neighborhood Homes and CLAs, the nurse places a copy of the medication review in the "nursing medication review" section of the COR. The nurse notifies the site's program manager of any issues needing immediate attention. If there are no issues requiring immediate attention, the nurse leaves a note in the site's communication book that a medication review was completed and is reviewed by the program manager. Should the medication review identify any medication errors, a Medication Incident Report (General Event Report [GER] on the Therap Web Based Reporting

System- related to any event causing or could cause injury, which has serious impact on the individual or others) is filed. The annual review by the DDDS OQM serves as an indicator as to the effectiveness of the provider agency and nurse consultant's monitoring of the medications.

From these reports, incident specific corrections are required of provider agencies. From the GERS, the DDDS is able to create Data Analysis Reports for the review of medication error types and risks in the assistance with medication system, as well as identify corrective actions. The reports are generated for either a Provider or System Level of Inquiry.

In addition to the routine monitoring of potentially harmful practices, the DDDS Director or Medical Director assigns the DDDS Polypharmacy Committee the responsibility to complete a case study/review. This is especially helpful when a number of psychotropic medications are ordered for an individual. The committee provides an effort to reexamine the need for such a high number of medications.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

Not applicable. *(do not complete the remaining items)*

Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications. *(complete the remaining items)*

- ii. State Policy.** Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

DDDS Policy concerning administration of medications to individuals who are unable to self-administer and the responsibilities of providers for overseeing self-administration is entitled Assistance with Self-Administration of Medication, and is dated July 2008.

The purpose of the policy is to establish uniform standards for assistance of self-administration of medication by unlicensed health care professionals to protect the health and safety of individuals served. The policy states only staff who have successfully completed the Assistance with Self-Administration of Medication (AWSAM) training within the last 365 days, or health care professionals as permitted by DE Code may assist individuals served with his/her medication. The AWSAM policy applies to DDDS Community Services/Adult Special Populations Staff, Contractors and DDDS Supported Living Providers.

Policy Standards for AWSAM are as follows:

Unlicensed health care professionals successfully complete the Delaware Board of Nursing approved AWSAM course (including in class practicum and supervised medication passes) prior to assisting a person served with his/her medication.

Licensed health care professionals are required to complete the AWSAM training, yet, are not required to take annual re-certifications.

Unlicensed health care professionals must successfully complete annual (within 365 days) AWSAM training from an authorized instructor, before he/she assists a person with self-administration of medication.

Individuals approved to administer their own medication are require some degree of staff monitoring such as observation, assistance with medication recording or reviewing medication documentation. Such specific monitoring and safeguarding components for individuals who assist with his/her own medication are clearly documented in the ELP.

- All loose routine medication (i.e., not in blister pack) are counted and documented accordingly, on a daily basis. Loose PRN medication are documented on a count sheet each time the PRN medication is received.
- Medications/treatments may only be assisted with if in a properly labeled container, from the pharmacy, prescribing practitioner, or nurse.
- Orders indicate how often the person is to receive the medication.
- Orders are clearly written or clearly understood by the staff who receives the order.
- Additionally, the AWSAM Policy addresses in detail, PRN Orders, Standing Medical Orders, guidance for supporting participants with Health Care Provider Visits, detailed standards for clear Physician's Orders, proper Medication Storage, Accountability of Controlled Medications, details for Medication Administration Records, Agency Oversight, and Disposal of Medications.
- Assistance with Medication is the name of the authorized course provided by the DDDS Training and Professional Development (TAPD) Unit for all DDDS Community Services/Adult Special Populations Staff, Contractors and DDDS Supported Living Providers who have a role in assisting participants with their medical needs.

Enhanced program guidelines were implemented on June 1, 2008 for medication errors. The purpose of the enhanced curriculum is to create a more efficient system of oversight and administration of the Assist with Medication program and to clearly identify where responsibilities reside.

Following the successful completion of the classroom component of Assist with Medication training, trainees receive a voucher from DDDS. For successful completion, registrants must pass both a written test and a classroom practicum. The practicum requires the registrant to correctly demonstrate medication assistance techniques for Oral, Optic, Topical, Enema, and Ear. An inability to successfully complete the classroom component results in the trainee retaking the course. Trainees are allowed to retake a class 3 times in a single year.

Once the classroom component is successfully completed, trainees complete 10 successful medication passes in the field (only 1 observation permitted per 8-hour shift). A successful pass is defined as one in which all steps are completed correctly. All medication passes are completed under the supervision of an Authorized Supervisory Advisor.

An Authorized Supervisory Advisor is defined as:

- An EXPERIENCED staff person with 2 years or more of experience with assisting with medication, including no history of medication errors by the advisor within the 2 past years.
- A Supervisor with at least 6 months of experience with medication assistance.
- A Licensed Nurse with 3 months of experience.

The Authorized Supervisory Advisor use the DDDS Medication Pass Checklist to evaluate and provide feedback to the trainee and supervisor. The checklist is used to identify areas where the trainee requires additional instruction or practice.

Agencies ensure there is a system in place to monitor on-going performance and supervision of the field passes, along with the general program. The curriculum stresses the overall integrity of the agency program depends upon sound internal quality assurance practices. Following completion of the 10 successful medication passes, a final voucher is issued by the evaluating agency. The DDDS OQM Unit confirms both the Classroom/Practicum and the Supervised Advisor Vouchers are presented during routine annual audits. All vouchers must have accompanying documentation showing the successful Medication Pass logs.

Agencies assume responsibility for ensuring compliance and competency of the process. Agencies assume liability for the integrity of the agency medication program.

iii. **Medication Error Reporting.** *Select one of the following:*

Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).

Complete the following three items:

(a) Specify State agency (or agencies) to which errors are reported:

The types of medication errors providers must record and/or report to the Division of Developmental Disabilities Services include any deviation from a physician's plan of care, including Standing Medical Orders, that involve errors relative to assisting with the incorrect dose or at the incorrect time, assisting with the incorrect medication/treatment, assisting the incorrect individual with a medication/treatment, assisting with the medication/treatment via the incorrect correct route and assisting with the medication/treatment at the correct time (or not at all).

(b) Specify the types of medication errors that providers are required to *record*:

The types of medication errors providers record and/or report to the Division of Developmental Disabilities Services include any deviation from a physician's plan of care, including Standing Medical Orders, that involve errors relative to assisting with the incorrect dose or at the incorrect time, assisting with the incorrect medication/treatment, assisting the incorrect individual with a medication/treatment, assisting with the medication/treatment via the incorrect correct route and assisting with the medication/treatment at the correct time (or not at all).

(c) Specify the types of medication errors that providers must *report* to the State:

The types of medication errors providers record and/or report to the Division of Developmental Disabilities Services include any deviation from a physician's plan of care, including Standing Medical Orders, that involve errors relative to assisting with the incorrect dose or at the incorrect time, assisting with the incorrect medication/treatment, assisting the incorrect individual with a medication/treatment, assisting with the medication/treatment via the incorrect correct route and assisting with the medication/treatment at the correct time (or not at all).

Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.

Specify the types of medication errors that providers are required to record:

iv. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

DDDS is the state agency responsible for the on-going monitoring of waiver provider agencies' performance in administering participant medications. Monitoring occurs through routine review of medication error reports on the Therap system. Additionally, the DDDS Performance Analysis Committee (PAC) completes reports on the rates of medication errors by type, at a minimum of annually. Data is analyzed not only by error type, but also by provider agency. In this way, the DDDS can analyze systems wide challenges, as well as, pin point individual provider performance issues.

When oversight is not conducted by the Medicaid agency or the operating agency, the process to communicate information and findings to the Medicaid agency or the operating agency.

DDDS monitoring methods are designed to identify problems in provider performance and to support follow-up remediation actions and quality improvement activities. DDDS enhanced Assistance with Medication Curriculum and Policy described above is the best way to illustrate how the state actively seeks to review data and implement continuous quality improvement measures.

Data is acquired to identify trends and patterns and support improvement strategies primarily through the Therap GER system. Additional sources of data for drawing correlations are the OQM Neighborhood Home and Community Living Arrangements Certification Data and the Nurses' Monthly Health Audits. With the Therap GER system, a reviewer searches for Medication Errors as a whole, by type such as wrong dose, or by provider and type. The numbers of errors are looked at as a ratio of the number of reported errors compared to the number of participants on the waiver during a particular time period.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare

The State, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

G-a-1: The percentage of participants with substantiated incidents of Abuse/Neglect/Mistreatment by type. (The number of participants with substantiated incidents of Abuse/Neglect/Mistreatment by type/total number of waiver participants.)

Data Source (Select one):

Other

If 'Other' is selected, specify:

The DDDS PM46 Unit Data Base

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other	

	Specify: _____	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: _____	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: _____

Performance Measure:

G-a-2: The percentage of substantiated incidents of Abuse/Neglect/Mistreatment by type in which recommended follow-up was completed. (The number of substantiated incidents of Abuse/Neglect/Mistreatment by type in which recommended follow-up was completed/total number of substantiated incidents of Abuse/Neglect/Mistreatment by type.)

Data Source (Select one):

Other

If 'Other' is selected, specify:

The DDDS PM46 Unit Data Base

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = _____
<input type="checkbox"/> Other Specify: _____	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: _____

	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: Semi Annually

Performance Measure:

G-a-3: The percentage of participants reporting that they feel safe at home and at work. (The number of participants reporting that feel safe at home and at work/number of participants whose services and supports were reviewed)

Data Source (Select one):

Other

If 'Other' is selected, specify:

Individual Outcome and Satisfaction Assessment (IOSA)

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =

<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:

G-a-4: The percentage of participants receiving routine medical/mental health services, including screening, as indicated. (The number of participants receiving routine medical/mental health care services, including screenings, as indicated/the number of participants whose service and supports were reviewed by OQM)

Data Source (Select one):

Other

If 'Other' is selected, specify:

Office of Quality Management Individual Focused Certification Review Data Base

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review

<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

G-a-5: The percentage of day and residential providers by service type with adequate procedures and plans for emergencies, disasters, fire drills and evacuation needs. (The number of day and residential providers by type with adequate procedures and plans for emergencies, disasters, fire drills, and evacuation needs/total number of day and residential providers by service type.)

Data Source (Select one):

Other

If 'Other' is selected, specify:

The Office of Quality Management Certification Data Base

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	Continuously and Ongoing
	Other Specify:

Performance Measure:

G-a-6: The annual mortality rate for participants by age, gender, and cause of death:

natural or medicological compared to DDDS baseline established during 2001-2007.
 (Number of waiver participant's deaths by age, gender and cause of death: natural or medicological/DDDS established baseline rate.)

Data Source (Select one):

Other

If 'Other' is selected, specify:

Health Information Management and Mortality Data Spreadsheet

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach(check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other

	Specify:
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Performance Measure:

G-a-7: The percentage of reported incidents of emergency restrictive behavior intervention strategies implemented.(The number of reported emergency restrictive behavior intervention strategies implemented/total number of reported restrictive behavior intervention strategies implemented.)

Data Source (Select one):

Other

If 'Other' is selected, specify:

Therap Services Data Base

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually

	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

Individual problems are referred to the Regional Program Director as they are received or substantiated by staff. All reported incidents, deaths, or complaints are tracked and reported to the DDDS regional office immediately. A response to the report is included in the tracking system. More serious reports are investigated by staff from the Office of Quality Management and other Division of Developmental Disabilities Services staff, as applicable. Remediation is a coordinated effort by the DDDS Administration staff, Regional Office Staff, and other concerned parties that could include law enforcement. Less serious reports are resolved by the Regional office with the assistance of the case manager and other staff that could include Administration staff. The state routinely monitors and evaluates tracking systems to ensure all reported incidents/complaints are remediated.

All complaints are reviewed at the state level to ensure issues in the complaint have been addressed and the health and safety of the consumer is ensured.

Quarterly data for all incidents entered into the statewide tracking system are reviewed to identify outliers for follow up and response by the Regional Office and the Office of Quality Management.

Responses are monitored at the state level to ensure action is taken.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:



c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 2)

Under 1915(c) of the Social Security Act and 42 CFR 441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QMS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I), a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the QMS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to

undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QMS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

- i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The goal of the Division of Developmental Disabilities Services Quality Management System (QMS) for all waiver services is to ensure the program operates in accordance with approved program design, meets statutory and regulatory assurances and requirements, achieves desired outcomes for participants, and identifies improvement opportunities. DDDS is committed to a QM recognizing quality is no longer the purview of just one entity. Everyone has some role or responsibility regarding quality. Consequently, DDDS collects and analyzes trend data from a variety of sources relative to outcomes and indicators identified by individuals, families, providers, stakeholders and administrative authorities, with the objective of ongoing improvement in service delivery. The current QMS includes a number of processes to monitor the quality of residential and day waiver services.

The DDDS QMS is designed to:

- Involve individuals and their families/stakeholders
- Result in service improvement for individuals and providers of support
- Support choice and control by individuals and families
- Be dynamic and flexible
- Be based on the premise of collaboration
- Make information about quality of services/supports readily available and easy to understand
- Monitor assurances such as health and welfare, adequacy of plans of care, and provider qualifications

Major Roles and Responsibilities for DDDS Systemic Quality Improvement

The DDDS QM System emphasizes a number of internal and external groups/entities have a role in quality.

Following is a description of each group and their overall responsibilities.

The DDDS Performance Analysis Committee (PAC) is responsible for data compilation, analysis and developing reports on priority outcomes and performance measures. Roles and responsibilities of the PAC are as follows:

- Develop specifications for each performance measure, including identifying the frequency at which, data is aggregated and reported upon
- Ensure the ongoing data integrity and reliability
- Create reports of the data for various groups/entities responsible for reviewing the data and developing improvement strategies

- Reports are designed to provide meaningful data on both a Provider Level and a Systems Level for analysis. Generally such reports are developed on either a semi- or annual basis.
- Recommend creation or revision of information collection tools and data tracking instruments
- Revise the QM System and/or specific indicators based on identified needs within the system
- Track system improvement strategies of the various stakeholder groups to assist both in the production of a DDDS annual report and annual federal HCB Waiver 372 reports

Following are the various groups/entities that receive quality management reports and have overall responsibility for reviewing data and developing improvement strategies:

- Risk Management Committee An internal administrative committee appointed by the DDDS Director and charged with monitoring organizational risk through the review of key indicator data. They are additionally responsible for developing strategies that address risk management activities.
- Essential Lifestyle Planning (ELP) Oversight Committee A committee comprised of members both internal and external to DDDS and chaired by the Statewide ELP Coordinator. This committee is charged with the responsibility of reviewing and revising the DDDS ELP User's Manual and serves as the central repository of questions, recommendations, and improvement strategies relative to the ELP.
- Authorized Provider Committee This committee develops and maintains the Authorized Provider System (APS), to include authorizing new residential and day service providers by holding mandatory provider meetings and reviewing Authorized Provider applications; updating forms and the website for the Authorized Provider System; and making changes to the system as needed. The DDDS website includes a section under Authorized Providers, in which various provider level performance measure data analysis reports are posted.
- DDDS Quality Council A planned volunteer group of individuals, families and other stakeholders served by the Division who review quality management reports and make recommendations for system improvements. Membership is by appointment of the DDDS Director. This group is functional and reviews data on a minimum of a quarterly basis.
- Division of Medicaid and Medical Assistance (DMMA) The State Medicaid Agency with administrative authority over HCBS Waiver services in Delaware. The Division of Medicaid and Medical Assistance (DMMA) reviews quarterly performance reports provided by DDDS to fulfill their authority as the administering agency for waiver services.

Each group reviews applicable trends reports (identified by CMS waiver assurance) in order to recommend system wide improvement strategies as well as to identify and promote promising practices. Minutes from each of the review committees are maintained in order to identify recommendations or actions required. The minutes are shared with the Division Director/Designee who prioritizes the recommendations, authorizes the quality improvement strategies and assigns responsibilities for developing improvement strategies.

Generally, improvement strategies are developed collaboratively by the Division, participants/stakeholders, and representatives of Provider Agencies and then implemented through policy and/or process adjustments. DDDS continues to review the relevant data in order monitor the effectiveness of systems changes.

In addition to developing improvement strategies based on aggregate trend data, DDDS may also complete an in-depth analysis of a single or small number of very serious events affecting participant health and welfare. Called root cause analysis, it may result in development of statewide improvement strategies.

Statewide Across HCBS Waiver System

The Delaware Health and Social Services (DHSS), Division of Medicaid & Medical Assistance (DMMA) is the Medicaid agency with oversight responsibility for Medicaid and Waiver programs. DMMA developed and implemented its Quality Management Strategy (QMS) to promote an integrated, collaborative quality management approach among DMMA, managed care, waiver, and other medical assistance programs. Delaware's State-wide QMS mission is to:

- Assure Medicaid enrollees receive quality care and services identified in Waivers and Medicaid funded

programs by providing oversight for monitoring and tracking activities of quality plans, assurances and improvement activities;

Provide ongoing oversight responsibilities assuring Medicaid funded program quality plans meet CMS requirements of achieving ongoing compliance with the waiver assurances and other federal requirements.

DDDS as the Residential Waiver Program operator is integrated into the QMS as a participant in Medicaid's Quality Initiative Improvement (QII) Task Force. Using the HCBS quality framework as its foundation (e.g., design, discovery, remediation, and improvement), Delaware's QMS plan promotes compliance with CMS waiver assurances, and component elements. The QMS defines the roles and responsibilities of the DMMA Waiver Coordinator, and committees, task forces, and work groups ultimately responsible for the development, implementation, monitoring, and evaluation of the DDDS Residential program and its quality initiatives.

The Developmentally Disabled Waiver (control #0009) along with all other Delaware 1915c HCBS Waiver Programs has been integrated into the Delaware Medicaid QMS. The DMMA Waiver Coordinator is the person primarily responsible for the coordination and organization of all DMMA waiver oversight functions. The Waiver Coordinator:

- Is responsible for provider/operating agency monitoring and report tracking.
- Participates in and oversees the function of all DMMA Quality Improvement Committee (QIC) monitoring and reporting activities.
- Summarizes waiver monitoring/reporting results, and presents data based reports to the QIC, documenting such in QIC meeting minutes.
- Participates as a member of the DMMA QII Task Force and supports presentation of QIC reports to the QII.
- Serves as a liaison between the HCBS Waiver Operating Agencies and the DMMA task forces and work groups in order to promote the flow of information related to waiver operation and to coordinate the receipt of Operating Agency responses to DMMA inquiries.

The DMMA multi-disciplinary committees, task forces, and work groups responsible for the development, implementation, monitoring, and evaluation of the DDDS HCBS Waiver program and its quality initiatives are:

- The DMMA Quality Improvement Committee (QIC):
This internal committee provides DMMA with: Waiver oversight, priority setting, operating agency performance and report monitoring, review of discovery processes, development of remediation strategies- which may include the development of corrective action plans, and the identification of and implementation of quality improvement strategies. QIC reports to the QII Task Force through the Waiver Coordinator.
- The Quality Initiative Improvement (QII) Task Force:
This task force is responsible to: Develop and implement the DMMA QMS, integrate waiver quality strategies, oversee and provide technical support for operating agencies, provide a forum for best practice sharing among agencies, provide support/feedback to waiver programs, review findings from discovery processes, to provide feedback on quality measurement and improvement strategies to participating agencies/program staff, and to report to the Medicaid Managed Care Quality Assurance Leadership Team.
- The Medical Care Advisory Committee (MCAC):
The responsibilities of the MCAC include: a Review of QMS efforts, a Forum for input from key stakeholders in to quality efforts and key clinical management concerns, a Forum for input on State policy for health care delivery to Medicaid enrollees.
- The Medicaid Managed Care and Quality Assurance Leadership Team (MMCQALT):

The roles & responsibilities of the MMCQALT include:

Oversight of QMS,

Reporting to Medical Care Advisory Committee,
 Communication and support of Stakeholder Advisory groups,
 Oversight and direction to the Quality Improvement Initiative Task Force.

The Delaware QMS encompasses a continuous quality improvement (CQI) process and problem-solving approach that is applied to specific and measurable performance and operational activities.

The CQI process is used to:

- (1) Monitor quality of care, service indicator, and operational performance,
- (2) Identify opportunities for improvement that exist throughout the program,
- (3) Implement remediation strategies to improve outcomes and performance, and
- (4) Evaluate interventions to ensure remediation strategy was successful.

Once DDDS indicators and study topics are established, the DMMA QIC determines the design and methodology used to collect data that will objectively measure performance. Data analysis occurs to identify opportunities for improvement following the discovery stage. After employing the remediation strategy, re-evaluation occurs to assess the interventions. If demonstrable improvement from baseline to reassessment is not made, the cycle repeats. If significant improvement was achieved, the indicator/study topic retires, or is monitored less frequently. In addition to these activities, research, resolution, and remediation occur within the grievance/complaint processes that have been enhanced within DMMA to serve the DDDS Residential Waiver participants and providers.

ii. System Improvement Activities

Responsible Party <i>(check each that applies):</i>	Frequency of Monitoring and Analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Quality Improvement Committee	<input checked="" type="checkbox"/> Annually
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

b. System Design Changes

- i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

EVALUATION OF THE QUALITY MANAGEMENT SYSTEM:

The ability of the DDDS to collect, analyze and use information to provide internal and external stakeholders with accurate, timely and important information to improve the quality of services and supports is assessed on an ongoing basis through a formative evaluation.

The Performance Analysis Committee (PAC) has primary responsibility for determining if the various discovery processes and data sources accurately measure the outcomes and indicators. Problems with data collection activities are corrected as needed. As well, the PAC solicits ongoing feedback from the committees that review the various Data Analysis Reports.

Questions for committee members include the following:

- Was the information timely?
- Was the information helpful in identifying statewide trends?
- Were the reports easy to understand and follow?
- Are the outcomes and indicators meaningful or should they be changed?

In conjunction with the DDDS Office of Quality Management, Performance Analysis Committee, and entities noted in section a. i. above, proposed revisions to the DDDS Quality Management System are submitted to the Division's Executive Committee for review. Such revisions occur as the formal data analysis processes reveal further needs within the system. Review tools, Data Sources, Performance Measures, Sampling Strategies, and remediation activities are subject to review and modification if the desired outcomes as expressed by the HCBS Residential Waiver participants are not met.

Improvement strategies for trended data are developed by DDDS operational units such as Nursing, Behavioral, Residential Services, Fiscal, etc., with input received from various stakeholders and review/advisory committees.

The DDDS operational units are informed of the need to provide improvement strategies through the various applicable review committees' recommendations. The operational units are required to respond to the Division Director/Designee with their suggested improvement strategies. Once the improvement strategy is authorized, the plan is forwarded to the review committee for notification of actions to be implemented.

The Performance Analysis Committee is informed of the new strategy and adjusts the discovery process (as indicated) in order to accurately design and implement performance assessment. The PAC and Office of Quality Management (OQM) work together to develop monitoring tools, sampling strategies, and reporting requirements. Most discovery processes are in the domain of OQM activities. The OQM implements the revised discovery processes, measuring the effectiveness of the slated system improvement.

Results of OQM discovery processes are disseminated as follows:

- Reporting individual findings on an ongoing and continuous basis to applicable ID Teams, Provider Agencies, and DDDS Administrators, requiring specific individual plans of improvement as applicable.
- Saving individual discovery process data on the OQM data bases to create a sample.
- Providing Quarterly, Semi-annual or Annual Data Summaries to the PAC for analysis. (PAC in turn completes the data analysis and dissemination of System and/or Provider Level report process.)
- Reporting discovery data and remediation efforts on a quarterly basis to the Delaware Medicaid Agency (DMMA)

The OQM Director shall:

- Assure that all monitoring processes remain current and that data bases are being properly developed or repopulated for each reporting period.
- Assure that any concerns with the discovery process are effectively and efficiently resolved.
- Notify the Division Director of any newly identified trouble areas between formal report generating intervals.

In essence, the process is cyclical, whether evaluating an existing Performance Measure or one that is designed to specifically provide System Improvement. The cyclical process can be simplified to: Discovery/Assessment, Communication of Data in light of performance expectations, Plan Development/Modification, Communication of Plan, Plan Implementation, and repeat.

Finally, the entities responsible for monitoring and oversight are all defined in Appendix H, Section A., are: The Performance Analysis Committee, The Risk Management Committee, The Essential Lifestyle Planning (ELP) Oversight Committee, Authorized Provider Committee, the DDDS Quality Council, and the Medicaid and Medical Assistance Unit (DMMA). The DDDS Quality Management System identifies what Performance Measures each entity is responsible to review and the OQM and PAC provides the corresponding Data Analysis Reports as required.

- ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The Delaware, Division of Developmental Disabilities Services, Quality Improvement Strategy (QIS) is designed to monitor the effectiveness of the HCBS Residential Waiver in supporting people to achieve the outcomes they define for themselves in light of CMS assurances. Based upon the data collection system for the HCBS Residential Waiver, most data bases established to review a 100% sample on an annual basis. The data therefore, is broad based and inclusive of all demands placed on the waiver for individual outcome

support.

As the data receives analysis, the various committees assigned to review the data are given the authority to suggest revision to monitoring systems (as well as to make suggestions as to improving service delivery and increased levels of satisfaction). Some of the systems revisions are based upon newly developing "best practices" implemented in other states, or on a national level. The bottom line for all entities reviewing individual performance reports is to ask questions related to individual and systematic satisfaction with waived services. Are participants better off and more satisfied with their lives after having participated in the waiver? Or, are there portions of the waiver not effective in supporting individual satisfaction. It is these areas where satisfaction and personal outcome accomplishment is not effectively supported, will closely stimulate systemic revision to services and the monitoring/review be improved or developed.

Under the Direction of the DDDS Director, with the support of the Director's Executive Management Team, the Division's HCBS system as implemented in Delaware revises or amends in order to support increased satisfaction and personal outcome attainment for all participants. Not only does the DDDS system review assurances through established performance measures, DDDS remains open to identifying new measures more sensitive to participant needs or desires for supports and services. New initiatives by definition require changes in the way questions are asked and responses are provided. In other words, efforts to improve or increase satisfaction may require revised systems and processes. DDDS endeavors to make discovery, analysis, and systems implementation processes relevant.

The various performance review entities including the DDDS Director, the Director's Executive Team, identified review committees, and DMMA, share the responsibility for analyzing the effectiveness of the Quality Improvement System to support specified goals and outcomes. Such responsibility takes place formally with each committee's meeting to review performance related data on the aggregation frequency specified for each measure. During each entity review, discussion is to include questions as to validity or reliability of data, effectiveness of performance measures to assess the intent of the system, training needs of providers or discovery process reviewers, and plans to provide systems improvements. It is not enough to collect data and report. The DDDS QMS is designed to drive outcome based results, with accountability defined within the system.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

(a)The State of Delaware Auditor's office is the entity responsible for conducting periodic independent audits in accordance with the provisions of the Single Audit Act for state agencies within the state government of Delaware.

(b)The Delaware State Plan for Medical Assistance identifies the Delaware Department of Health and Social Services (DHSS) as the single state agency responsible for the administration of Delaware's Medicaid program. The Division of Medicaid and Medical Assistance (DMMA) has primary role and responsibility for Medicaid in Delaware.

(c)Delaware employs multiple levels of processes designed to ensure proper payment of claims both pre-and post-adjudication. DMMA contracts with Hewlett Packard (HP) to act as its fiscal agent for Medicaid claims payment functions using Delaware's Medicaid Management Information System (MMIS) certified by CMS as meeting the standards for automated systems of this type. All provider service claims are processed through Delaware's MMIS.

(d)Delaware requires each provider of HCBS Waiver services to have a Department of Health and Social Services contract. A requirement to this contract is an annual independent audit for each provider agency by a CPA firm. The results of this independent audit are submitted to the DDDS Office of Budget, Contracts, and Business Services within 30 days of conclusion of the independent audit. The independent audit is a required annual component of the contract.

In addition, per the MOU between DMMA and DDDS, the state conducts periodic reviews and audits of service

delivery providers, waiver limits, access to care, corrective action plans, and submits reports to DMMA on a quarterly basis.

(e) The DMMA Claims Processing Assessment System (CPAS) Coordinator in the Information Systems Unit of DMMA receives a monthly sample of claims generated from the MMIS for the purpose of quality control review. The monthly sample is reviewed to provide an overall assessment of the claims processing operation including: verification of claims payment accuracy, measurement of cost from errors, and establishment of a corrective action plan if needed. The CPAS Coordinator reviews claims against the participant eligibility data, provider eligibility data and rate structure. All claims for DD HCBS Waiver covered services claims are subject to being included in the CPAS monthly sample.

(f) The MMIS contains a Surveillance and Utilization Review (SUR) sub-system which organizes data and creates reports used by staff of the Surveillance and Utilization Review (SUR) Unit within DMMA. Reports are designed to detect patterns in paid provider claims which may indicate fraud and/or abuse. SUR team use these reports and other tools to identify specific providers on which to perform audits/investigations, referring providers as appropriate to the Medicaid Fraud Control Unit (MFCU) within the Delaware Attorney General's Office as required in the Delaware Administrative Code, Section 13940. DMMA works closely with its Attorney General's Office to prosecute instances of provider fraud. A Memorandum Of Understanding is in place between the Delaware DHSS and the Delaware Attorney General's Office which formalizes the responsibilities of each party regarding the investigation and prosecution of Medicaid fraud.

(g) The standard Medicaid Provider agreement requires all providers of services to maintain such records as are necessary to fully substantiate the nature and extent of services rendered to DMAP eligibles, including the Provider's schedule of fees charged to the general public to verify comparability of charges provided to non-DMAP individuals and to make all records available for the purpose of conducting audits to substantiate claims, costs" etc.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability

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

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

I-a-1: The percentage of claims billed in accordance with services specified in the Plan of Care and coinciding with the ICAP rate. (The number of claims billed in accordance with services specified in the Plan of Care and coinciding with the ICAP rate/number of claims billed.)

Data Source (Select one):

Other

If 'Other' is selected, specify:

OBCBS Data Sources- Tracking Data Base, Plan of Care(ELP), ICAP rates.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):

<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

I-a-2: The percentage of provider attendance reports for day and residential services that match what was claimed. (Number of provider attendance reports that match what was claimed/total number of provider attendance reports.)

Data Source (Select one):

Other

If 'Other' is selected, specify:

Attendance records and Medicaid billing reports

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:

I-3-a: The percentage of DDDS provider agencies with completed annual audited financial statements (Number of provider agencies with completed annual audited financial statements /total number of provider agencies.)

Data Source (Select one):

Other

If 'Other' is selected, specify:

Review of provider contract files for compliance

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other

	Specify:
--	----------

Performance Measure:

I-a-4: Percentage of waiver services which are prior-authorized. (Number of prior-authorized claims/total number of all claims)

Data Source (Select one):

Other

If 'Other' is selected, specify:

OBCBS Data Sources- Atlantes Reports, ICAP Rates, Claims Data(remittance reports.)

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach(check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually

	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

In addition to the manual claim verification described herein, the MMIS contains a Surveillance & Utilization Review (SUR) sub-system which organizes and scrutinizes claims data based on pre-set algorithms to create reports used by SUR unit staff. Reports are designed to detect patterns in paid provider claims which may indicate fraud and/or abuse.

The SUR team use these reports and other tools to identify specific providers to perform audits/investigations, referring providers as appropriate to the Medicaid Fraud Control Unit (MFCU) within the Delaware Attorney General's Office as required in the Delaware Administrative Code Section 13940. DMMA works closely with the Attorney General's Office to prosecute instances of provider fraud.

The MFCU itself may initiate investigations based on information received independent of DMMA (anonymous information, information from other law enforcement agencies, etc.) In these cases the MFCU works with the SUR staff to identify what error or fraud occurred.

In cases where it is decided funds have been incorrectly dispersed to providers (claim payments, DMMA will authorize its fiscal agent, HP, to perform an adjustment on those targeted claims in order to recoup any overpayments. This recoupment action is independent of any criminal prosecution or civil action the MFCU/Attorney General's Office may initiate.

When documentation is received it is reviewed by the SUR nurses or appropriate Medicaid Medical Consultant. The Medicaid Medical consultants (physicians, nurses, pharmacy, laboratory or optometrist) examine the documentation for accuracy of coding, quality of care and appropriateness of services billed. The determinations are returned to the auditor. The auditor reviews the determinations and recommendations of the medical consultant and compiles the final report.

The case dispositions include, but are not limited to:

1. No further action no evidence of fraud. For cases where there is no overpayment identified the case is closed and the provider is notified of the results by letter.
2. Problems identified requiring provider education no evidence of fraud. Refer for appropriate provider education and, if applicable, a request for reimbursement is sent to the provider by certified mail.
3. Overpayment identified no evidence of fraud - a request for reimbursement is sent to the provider by certified mail. When the majority of the services in question are not justifiable, the reviewer may recommend a full-scale audit on the provider. A full-scale audit is defined as an expanded scope review. This is generally performed in the field and includes a greater number of claims for review in the problematic area or in general areas.
4. Referral to MFCU - If any of the findings in the reviews meet the criteria established with the Delaware Medicaid Fraud Control Unit in the Department of Justice, the case will be referred to that Unit.

The request for reimbursement letter explains the findings of the review and gives the provider 30 days to dispute any findings of the review. If, after the 30 day limit the provider has not notified Medicaid they wish to dispute the findings or they have not reimbursed the overpayment, the recoupment account is established in order to recover the overpayment. The provider may request an administrative hearing per the DMMA general policy provider manual.

If warranted, follow up reviews are scheduled at 6 to 12 month time periods from results notification. Providers who are reluctant to comply with corrective action or where dollar amount identified as overpaid is in excess of \$500.00 may be candidates for follow-up reviews.

ii. **Remediation Data Aggregation**

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: DDDS staff	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

c. **Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

- a. **Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

The State of Delaware contracted with Mercer Government Human Services Consulting (Mercer) to develop a rate setting design for HCBS waiver services to be paid on a state-wide fee-for-service schedule that is linked to the needs of each person enrolled in the HCBS Waiver program. The process took three years to complete and included the State of Delaware, contracted provider agencies, advocates and other key stake holders. Mercer's methodology for the rate setting model has four key components: direct care salary expenses, employee related expenses, program indirect expenses and administrative expenses. Mercer conducted a compensation study to determine the appropriate wage of

salary expense for the direct care workers providing each type of service. Mercer also reviewed wage data provided by the Bureau of Labor Statistics.

In developing the other three rate components, Mercer first determined the allowable costs to be funded through each service and included only allowable indirect and administrative expenses.

Mercer used this information to develop rates that comply with the requirements of Section 1902(a)(30)(A) of the Social Security Act (... "payments are consistent with economy, efficiency, and quality of care and are sufficient to enlist enough providers") and the related federal regulations at 42 CFR 447.200-205.

The State of Delaware reviews the rate setting model every three years to ensure the adequate access to services and appropriate levels of reimbursement are maintained.

The component parts of the rates are cross walked or translated into a total number of support hours needed by each person as determined through the completion of the Inventory for Client and Agency Planning (ICAP) assessment tool. The ICAP assessments are performed face-to-face by an independent clinician for whom the state contracts (Arbitre Consulting, Inc.). The contractor submits the completed assessments via a HIPAA compliant means to the State. The ICAP assessment scores are used to generate a daily rate for the individual receiving services. For individuals receiving "prevocational - daily" or "day habilitation - daily" services, the daily rate is calculated through the use of a matrix which specifies the needed hours of service based on ICAP generated Broad Independence and General Maladaptive scores. These hours of services are converted to a daily rate by multiplying the needed hours of services by a rate per hour. The hourly rate is calculated using a set direct care wage and includes percentage add-ons for Employee Related Expenses (ERE), Program Indirect (PI) Expenses and Contract Administration. For individuals receiving "prevocational - hourly" or "day habilitation - hourly" services, the hourly rate, defined above, is paid for the actual hours of service received, billed in 15 minute increments.

Rates for day programs and prevocational services also have add-ons for Transportation and Facility costs. Rates are calculated by the DDDS Office of Budget, Contracts and Business Services. The rate setting system/methodology is outlined in the Mercer final report and the ICAP Rate Setting Matrix located on the State of Delaware website under Delaware Health and Social Services, Division of Developmental Disabilities Services, Individual Rate Setting.

Provider agencies and/or participants have the right to request a review of a rate if they do not feel the calculated rate is adequate. In a review, the agency/participant submits supporting documentation to the Director of Community Services who makes a recommendation for an exception to the Chief of Administration. The base unit rates, ERE and PI percentages, transportation and facility add-ons and matrix are published and are available for public comment and input. The ICAP rate process and establishment of rates are approved by the Delaware Division of Medicaid and Medical Assistance (DMMA) and the Rate Setting Committee.

Rates for "Supported Employment - Individual" have been calculated using actual cost data as reported by providers of Supported Employment Services. Total Medicaid allowable costs for each provider were tabulated and divided by total direct care staff (job coaches, employment specialists) hours worked. This provided a cost per hour for each provider based on direct care staff hours. The average cost per hour across all agencies was used to compute an hourly rate, which is expressed as a 15 minute billable unit by dividing the hourly rate by four.

Rates for Supported Employment - Small Group are based on the rate for Supported Employment - Individual, which is a one-to-one staff-to-consumer ratio. The payment rate for the addition of each consumer in the group shall be computed by dividing the payment rate for Supported Employment - Individual by the number of participants in the group (up to a maximum of 8) and applying a gross up factor to account for additional incremental costs related to the provision of group supported employment that would not have been captured in the base rate for Supported Employment - Individual. Supported Employment - Small Group will be paid in 15 minute billable units.

The rates for the services of the State of Delaware operated Day Programs are calculated based on the total actual annual costs, including personnel, benefits, supplies, and administration or overhead. The total actual costs are used to calculate a daily rate for this service. The Day Program rate is approved by Delaware's DMMA and Revenue Management Units. This area has been incorporated into an approved work plan and will be revised in accordance with the goals, objectives and timeframes identified in the work plan. The work plan includes the revision of the rate methodology for State Run Day Habilitation, Residential Habilitation, DDDS State Case Management, and Clinical/Behavioral consultative services. Transportation costs are now included in, and have been built into, the Residential Habilitation Services rate. See Work plan Section II.A.1-II.A.11 & III.A.1- III.A.7

Behavioral Consultation Services □ a single statewide rate will be developed for this service as follows. The midpoint of the salary range for the State of Delaware merit classification of Senior Behavior Analyst will be used as the basis of the computation of an hourly wage. A fringe benefit factor is added to the hourly wage based on the

Delaware State Employee fringe benefit package. A factor of 12% is added to the computed hourly wage that includes other employment costs to account for other direct non-salary costs such as training, supervision and travel. A separate factor of 12% is added on top of the computed hourly wage to account for administrative costs necessary to support the direct service. A 15 minute billable unit is computed by dividing the resulting hourly wage by four. The provision of behavioral consultation services and related documentation of the provision of service shall be billable in 15 minute increments. Units of time 1- 8 minutes shall not be billed. Units of time 8-15 minutes shall be billed as one 15 minute unit.

Nursing Consultation Services a single statewide rate will be developed for this service as follows. National average hourly wage data is obtained from the Bureau of Labor Statistics, Occupational Employment Statistics survey of the US DOL for the Registered Nurse job classification SOC code 29-1111 (Registered Nurse) in the industry code NAICS 623210 Residential MR Facilities. A fringe benefit factor is added to the hourly wage based on the Delaware State Employee fringe benefit package. A factor of 12% is added to the computed hourly wage that includes other employment costs to account for other direct non-salary costs such as training, supervision and travel. A separate factor of 12% is added on top of the computed hourly wage to account for administrative costs necessary to support the direct service. A 15 minute billable unit is computed by dividing the resulting hourly wage by four. The provision of nursing consultation services and related documentation of the provision of service shall be billable in 15 minute increments. Units of time 1- 8 minutes shall not be billed. Units of time 8-15 minutes shall be billed as one 15 minute unit.

- b. **Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

As with billings for all services provided under the Delaware Medical Assistance Program (DMAP), claims for HCBS waiver services are adjudicated by the State's Medicaid Fiscal Agent, HP, in the MMIS which it manages for DMMA. Providers submit electronic claims in the HIPAA standard 837 transactions (professional or institutional) first to a clearinghouse, Business Exchange Services (BES) which screens them against both HIPAA and Delaware proprietary minimum claim criteria. Claims are accepted, in which case they pass to the MMIS for adjudication if they meet the minimum criteria, or are rejected back to the provider along with the rejection reason. Providers can submit paper claims on the HCFA 1500 or the UB04 directly to HP. Paper claims are scanned into the MMIS. Providers can use any claims software resulting in a HIPAA standard clean claim. HIPAA compliant claims software is made available to DMAP providers free of charge via download from the DMAP website. Provider billing procedures are described in detail in a series of Provider Manuals on the DMAP website.

Provider claims are accepted 24/7 and are processed for payment once a week after the close of business each Friday. Funds for paid claims are available for payment the Monday following the Friday financial cycle. Providers may elect to receive payments via paper check or EFT.

This area has been incorporated into an approved work plan and will be revised in accordance with the goals, objectives and timeframes identified in the work plan. See Work plan Section II.A.1-II.A.11 & III.A.1- III.A.7

The billing for state-operated day habilitation, residential habilitation, residential transportation, case management services, and state clinical consultative services are entered as the State of Delaware/DDDS being the provider agency (where/when applicable). This area has been incorporated into an approved work plan and will be revised in accordance with the goals, objectives and timeframes identified in the work plan. See Work plan Section II.A.1-II.A.11 & III.A.1- III.A.7

The State of Delaware submits electronic claims in the HIPAA standard 837 transactions (professional) first to a clearinghouse, Business Exchange Services (BES) which screens them against both HIPAA and Delaware proprietary minimum claim criteria. Accepted claims are passed to the MMIS for adjudication if they meet the minimum criteria, or are rejected back to the State along with the rejection reason. The State of Delaware uses HIPAA compliant claims software that is made available to DMAP providers free of charge via download from the DMAP website.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

- c. **Certifying Public Expenditures** (*select one*):

No. State or local government agencies do not certify expenditures for waiver services.

Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.

Select at least one:

Certified Public Expenditures (CPE) of State Public Agencies.

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-a.)*

Certified Public Expenditures (CPE) of Local Government Agencies.

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

(a) Eligibility of Recipients - Applicants for Long Term Care Medicaid are screened against both financial and Level of Care (LOC) criteria before being enrolled in the HCBS Waiver. If they are enrolled in the waiver, they are assigned an eligibility category unique to the HCBS Waiver for developmental disabilities. This category is used by the MMIS during claims processing to determine which claims can be paid, consistent with waiver service limitations and requirements (i.e., prior authorization) programmed into the MMIS. The start and stop dates (if applicable) for the period of time the recipient is eligible for HCBS Waiver services is part of the eligibility record for each waiver recipient stored in the MMIS.

Provider Eligibility Only providers enrolled to provide services under the HCBS waiver for developmental disabilities are paid for waiver services for this program. For this purpose, unique waiver taxonomies are assigned to service providers for the DDS waived services. These taxonomies are associated with the provider in the MMIS at the time of enrollment. The MMIS is programmed to only accept claims for waiver services for HCBS waiver recipients from providers who are authorized to submit claims under one of the developmental disabilities waiver taxonomies.

The amount paid for each claim is based on the pre-authorization of the services each person is receiving as prescribed in their ELP (Plan of Care) entered into MMIS. If a pre-authorization is not in the MMIS, the claim will not pay. Claims for state-operated day programs, state case management, and state behavioral consultative services are based on a rate table which, for this HCBS waiver, is based on a combination of procedure code, taxonomy and, provider ID. All rates are provider and procedure code-specific. Automated pricing algorithms ensure the amount paid for a service meets state policy for that service (i.e. paying the lesser of the billed amount or the rate on file in the MMIS).

The payment for case management is a workplan item and the waiver will be modified to reflect the change to an administrative function. Transportation payment is a workplan item as well. Clinical Support payment issues will be addressed as a workplan action steps.

(b) The participants' Essential Lifestyle Plan lists and details the approved services prepared at the beginning of services and re-evaluated at a minimum annually or on an as needed basis (when applicable as situations change) thereafter. Once eligible for HCBS waiver services a contract is secured for the individual receiving services and their chosen provider(s). HCBS waiver services are pre-authorized by the state contract manager and entered into in the Atlantes Care Management System based on services selected by each participant during the ELP process. The MMIS checks each claim submitted by a provider against the eligibility record to insure the person receiving service was eligible for waiver services on the date of service and the service was authorized and did not exceed programmed service limitations as set by the pre-authorization.

Per the MOU between DMMA and DDDS, DDDS periodically reviews claims data against plans of care to monitor over and under utilization of services. DMMA is responsible for retrospective auditing of paid claims and utilization review of services provided through DDDS.

(c) Before a claim is processed there must be verification the service was provided. This verification varies according to the service; however the verification must be in writing and signed (either written or electronically) by the provider of service. The agencies providing residential, day, prevocational, and supported employment services are required to submit attendance/utilization reports to the DDDS monthly. These attendance reports are signed by a provider employee and verified by a provider supervisory employee as to verify that services were rendered.

Also, during the claims adjudication process, the MMIS is programmed to select a random sample of participants for whom claims were submitted (which will include DDDS Residential waiver participants) the system generates a letter on pre-printed state letterhead to be mailed to each of the selected participants. The letter provides the participant with dates, provider names and specific procedures which Medicaid has been asked to pay on behalf of that participant and asks the participant to indicate whether or not the services were provided and whether he/she was asked to make any payment for these services. It also provides a space for any comments the participant wishes to make. The participant is directed to mail the letter back. Returned letters warranting further investigation are referred to the Surveillance and Utilization Review (SUR) Unit (See Appendix I-1).

- e. **Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

- a. **Method of payments -- MMIS (select one):**

Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).

Payments for some, but not all, waiver services are made through an approved MMIS.

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for waiver services are not made through an approved MMIS.

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

- b. **Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.
- The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.
- The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

- Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

- c. **Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

No. The State does not make supplemental or enhanced payments for waiver services.

Yes. The State makes supplemental or enhanced payments for waiver services.

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the

non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

- d. Payments to State or Local Government Providers.** *Specify whether State or local government providers receive payment for the provision of waiver services.*

No. State or local government providers do not receive payment for waiver services. Do not complete Item I-3-e.

Yes. State or local government providers receive payment for waiver services. Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish: *Complete item I-3-e.*

The Division of Developmental Disabilities Services owns and operates four state-run day programs, two state-run neighborhood group homes, and three supported living sites. In addition, State of Delaware employees provide case management and Clinical/Behavioral consultative services. These services are addressed as a work plan action item to be addressed in the future.

This area has been incorporated into an approved work plan and will be revised in accordance with the goals, objectives and timeframes identified in the work plan.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

- e. Amount of Payment to State or Local Government Providers.**

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.

The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.

The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. **Provider Retention of Payments.** Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.

Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.



Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. **Additional Payment Arrangements**

i. **Voluntary Reassignment of Payments to a Governmental Agency.** *Select one:*

No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).

Specify the governmental agency (or agencies) to which reassignment may be made.

[Empty box for specifying governmental agency]



ii. **Organized Health Care Delivery System.** *Select one:*

No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.

Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

[Empty box for specifying details for OHCDS]



iii. **Contracts with MCOs, PIHPs or PAHPs.** *Select one:*

The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.

The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

- a. **State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one:*

- Appropriation of State Tax Revenues to the State Medicaid agency
- Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

a) The Delaware Division of Developmental Disabilities Services is appropriated the full portion of the budget for waiver costs.

b) The Delaware Division of Developmental Disabilities, Office of Budget, Contracts, and Business Services performs a reconciliation of the actual expenditures versus the budgeted amount and completes a transfer to the Medicaid agency in order to pay the matching funds per the annual budget epilogue signed into law on or before June 30th.

- Other State Level Source(s) of Funds.

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2- c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

- b. **Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One:*

Not Applicable. There are no local government level sources of funds utilized as the non-federal share.

Applicable

Check each that applies:

- Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

- Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2- c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

- c. Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one:*

None of the specified sources of funds contribute to the non-federal share of computable waiver costs

The following source(s) are used

Check each that applies:

- Health care-related taxes or fees**
- Provider-related donations**
- Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

- a. Services Furnished in Residential Settings.** *Select one:*

No services under this waiver are furnished in residential settings other than the private residence of the individual.

As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.

- b. **Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

The methodology the DDDS uses (based on the ICAP assessment) is only on service costs directly associated with the individual served. The DDDS does not use room and board costs to calculate rates.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.

Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

- a. **Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

No. The State does not impose a co-payment or similar charge upon participants for waiver services.

Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.

- i. **Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):

- Nominal deductible
- Coinsurance
- Co-Payment
- Other charge

Specify:

Appendix I: Financial Accountability**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)****a. Co-Payment Requirements.****ii. Participants Subject to Co-pay Charges for Waiver Services.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)****a. Co-Payment Requirements.****iii. Amount of Co-Pay Charges for Waiver Services.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)****a. Co-Payment Requirements.****iv. Cumulative Maximum Charges.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)****b. Other State Requirement for Cost Sharing.** Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one:*

No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.

Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration**J-1: Composite Overview and Demonstration of Cost-Neutrality Formula**

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

Level(s) of Care: ICF/MR

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	100815.00	6481.00	107296.00	371680.00	605.00	372285.00	264989.00
2	103055.93	6675.00	109730.93	408848.00	666.00	409514.00	299783.07
3	97762.67	6875.00	104637.67	449733.00	732.00	450465.00	345827.33
4	101333.96	7082.00	108415.96	494706.00	805.00	495511.00	387095.04
5	104301.59	7294.00	111595.59	544177.00	886.00	545063.00	433467.41

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

- a. **Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Number Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		ICF/MR
Year 1	940	940
Year 2	980	980
Year 3	1020	1020
Year 4	1060	1060
Year 5	1100	1100

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

- b. **Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The average length of stay on the DDDS Residential Waiver is derived from the 372 report. The average length of stay varies somewhat in accordance to how many individuals are added to the waiver in the first quarter, second quarter, third quarter, and fourth quarter of each year.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

- c. **Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

- i. **Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for

these estimates is as follows:

The estimated number of users, units/user, and the cost/unit are based on historical Medicaid expenditures from the annual 372 report. This data was then projected out over the five year estimate period based on the historical trends of this waiver.

- ii. **Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The Factor D data is based on the annual 372 report. Part D costs have been removed from this information. This data was then projected out over the five year estimate period based on the historical trends.

- iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Historical Medicaid expenditures for the DDDS Residential waiver participants from the internal MMIS system were analyzed along with data from the annual 372 report. This data was then projected out over the five year estimate period based on the historical trend of this waiver.

- iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Historical Medicaid expenditures for the DDDS Residential waiver participants from the internal MMIS system were analyzed along with data from the annual 372 report. This data was then projected out over the five year estimate period based on the historical trends of this waiver.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “*manage components*” to add these components.

Waiver Services	X
Case Management	
Day Habilitation	
Prevocational Services	
Residential Habilitation	
Supported Employment - Individual	
Supported Employment - Small Group	
Clinical Consultative Services: Behavioral Consultative Services/Nursing Consultative Services	
Transportation - Residential Services	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. **Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost

Case Management Total:						4275571.20
Case Management	Month	940	12.00	379.04	4275571.20	
Day Habilitation Total:						7092600.00
Day Habilitation - Daily	Day	240	250.00	118.21	7092600.00	
Day Habilitation - 15 minutes	Hour	0	0.00	0.01	0.00	
Prevocational Services Total:						9064800.00
Prevocational Services - Daily	Day	480	250.00	75.54	9064800.00	
Prevocational Services - 15 minutes	Hour	0	0.00	0.01	0.00	
Residential Habilitation Total:						66428209.50
Residential Services	Day	745	360.00	238.25	63898650.00	
Shared Living Arrangement	Day	195	365.00	35.54	2529559.50	
Supported Employment - Individual Total:						1693612.50
Supported Employment - Daily	Day	95	250.00	71.31	1693612.50	
Supported Employment - 15 minutes	Hour	0	0.00	0.01	0.00	
Supported Employment - Small Group Total:						0.00
Supported Employment - Small Group		0	0.00	0.01	0.00	
Clinical Consultative Services: Behavioral Consultative Services/Nursing Consultative Services Total:						4984608.00
Behavioral Consultative Services	Quarter Hour	0	0.00	0.01	0.00	
Nursing Consultative Services	Quarter Hour	0	0.00	0.01	0.00	
Clinical Consultative Services: Behavioral Consultative Services/Nursing Consultative Services	Month	685	12.00	606.40	4984608.00	
Transportation - Residential Services Total:						1226476.80
Transportation - Residential Services	Month	535	12.00	191.04	1226476.80	
GRAND TOTAL:						94765878.00
Total Estimated Unduplicated Participants:						940
Factor D (Divide total by number of participants):						100815.00
Average Length of Stay on the Waiver:						350

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to

automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						4546651.20
Case Management	Month	980	12.00	386.62	4546651.20	
Day Habilitation Total:						7536250.00
Day Habilitation - Daily	Day	250	250.00	120.58	7536250.00	
Day Habilitation - 15 minutes	Hour	0	0.00	0.01	0.00	
Prevocational Services Total:						9920187.50
Prevocational Services - Daily	Day	515	250.00	77.05	9920187.50	
Prevocational Services - 15 minutes	Hour	0	0.00	0.01	0.00	
Residential Habilitation Total:						70514986.25
Residential Services	Day	775	360.00	243.02	67802580.00	
Shared Living Arrangement	Day	205	365.00	36.25	2712406.25	
Supported Employment - Individual Total:						1818500.00
Supported Employment - Daily	Day	100	250.00	72.74	1818500.00	
Supported Employment - 15 minutes	Hour	0	0.00	0.01	0.00	
Supported Employment - Small Group Total:						0.00
Supported Employment - Small Group		0	0.00	0.01	0.00	
Clinical Consultative Services: Behavioral Consultative Services/Nursing Consultative Services Total:						5344099.20
Behavioral Consultative Services	Quarter Hour	0	0.00	0.01	0.00	
Nursing Consultative Services	Quarter Hour	0	0.00	0.01	0.00	
Clinical Consultative Services: Behavioral Consultative Services/Nursing Consultative Services	Month	720	12.00	618.53	5344099.20	
Transportation - Residential Services Total:						1314135.84
Transportation - Residential Services	Month	562	12.00	194.86	1314135.84	
GRAND TOTAL:						100994809.99
Total Estimated Unduplicated Participants:						980
Factor D (Divide total by number of participants):						103055.93
Average Length of Stay on the Waiver:						350

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						0.00
Case Management	Month	0	0.00	0.01	0.00	
Day Habilitation Total:						8804699.36
Day Habilitation - Daily	Day	260	250.00	121.78	7915700.00	
Day Habilitation - 15 minutes	Hour	38	816.00	28.67	888999.36	
Prevocational Services Total:						12768396.05
Prevocational Services - Daily	Day	535	250.00	77.82	10408425.00	
Prevocational Services - 15 minutes	Hour	101	815.00	28.67	2359971.05	
Residential Habilitation Total:						73255207.50
Residential Services	Day	795	360.00	245.45	70247790.00	
Shared Living Arrangement	Day	225	365.00	36.62	3007417.50	
Supported Employment - Individual Total:						2229136.05
Supported Employment - Daily	Day	0	0.00	0.01	0.00	
Supported Employment - 15 minutes	Hour	139	331.00	48.45	2229136.05	
Supported Employment - Small Group Total:						0.00
Supported Employment - Small Group		0	0.00	0.01	0.00	
Clinical Consultative Services: Behavioral Consultative Services/Nursing Consultative Services Total:						2660486.40
Behavioral Consultative Services	Quarter Hour	1020	96.00	13.94	1365004.80	
Nursing Consultative Services	Quarter Hour	1020	96.00	13.23	1295481.60	
Clinical Consultative Services: Behavioral Consultative Services/Nursing Consultative Services	Month	0	0.00	0.01	0.00	
Transportation - Residential Services Total:						0.00
Transportation - Residential Services	Month	0	0.00	0.01	0.00	
GRAND TOTAL:						99717925.36
Total Estimated Unduplicated Participants:						1020
Factor D (Divide total by number of participants):						97762.67
Average Length of Stay on the Waiver:						

350

Appendix J: Cost Neutrality Demonstration**J-2: Derivation of Estimates (8 of 9)****d. Estimate of Factor D.**

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						0.00
Case Management	Month	0	0.00	0.01	0.00	
Day Habilitation Total:						9763896.84
Day Habilitation - Daily	Day	279	250.00	124.22	8664345.00	
Day Habilitation - 15 minutes	Hour	47	816.00	28.67	1099551.84	
Prevocational Services Total:						14073646.25
Prevocational Services - Daily	Day	562	250.00	79.38	11152890.00	
Prevocational Services - 15 minutes	Hour	125	815.00	28.67	2920756.25	
Residential Habilitation Total:						77943100.50
Residential Services	Day	830	360.00	250.36	74807568.00	
Shared Living Arrangement	Day	230	365.00	37.35	3135532.50	
Supported Employment - Individual Total:						2813579.44
Supported Employment - Daily	Day	0	0.00	0.01	0.00	
Supported Employment - 15 minutes	Hour	172	331.00	49.42	2813579.44	
Supported Employment - Small Group Total:						0.00
Supported Employment - Small Group		0	0.00	0.01	0.00	
Clinical Consultative Services: Behavioral Consultative Services/Nursing Consultative Services Total:						2819769.60
Behavioral Consultative Services	Quarter Hour	1060	96.00	14.22	1447027.20	
Nursing Consultative Services	Quarter Hour	1060	96.00	13.49	1372742.40	
Clinical Consultative Services: Behavioral Consultative Services/Nursing Consultative Services	Month	0	0.00	0.01	0.00	

Transportation - Residential Services Total:						0.00
Transportation - Residential Services	Month	0	0.00	0.01	0.00	
GRANDTOTAL:						107413992.63
Total Estimated Unduplicated Participants:						1060
Factor D (Divide total by number of participants):						101333.96
Average Length of Stay on the Waiver:						350

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						0.00
Case Management	Month	0	0.00	0.01	0.00	
Day Habilitation Total:						10494483.44
Day Habilitation - Daily	Day	290	250.00	126.70	9185750.00	
Day Habilitation - 15 minutes	15 minutes	56	3264.00	7.16	1308733.44	
Prevocational Services Total:						15419498.40
Prevocational Services - Daily	Day	590	250.00	80.96	11941600.00	
Prevocational Services - 15 minutes	15 minutes	149	3260.00	7.16	3477898.40	
Residential Habilitation Total:						82397016.00
Residential Services	Day	860	360.00	255.36	79059456.00	
Shared Living Arrangement	Day	240	365.00	38.10	3337560.00	
Supported Employment - Individual Total:						1860360.00
Supported Employment - Daily	Day	0	0.00	0.01	0.00	
Supported Employment - 15 minutes	15 minutes	74	2000.00	12.57	1860360.00	
Supported Employment - Small Group Total:						1576140.00
Supported Employment - Small Group	15 minutes	109	3000.00	4.82	1576140.00	
Clinical Consultative Services: Behavioral Consultative Services/Nursing Consultative Services Total:						2984256.00

Behavioral Consultative Services	Quarter Hour	1100	96.00	14.50	1531200.00	
Nursing Consultative Services	Quarter Hour	1100	96.00	13.76	1453056.00	
Clinical Consultative Services: Behavioral Consultative Services/Nursing Consultative Services	Month	0	0.00	0.01	0.00	
Transportation - Residential Services Total:						0.00
Transportation - Residential Services	Month	0	0.00	0.01	0.00	
GRANDTOTAL:					114731753.84	
Total Estimated Unduplicated Participants:					1100	
Factor D (Divide total by number of participants):					104301.59	
Average Length of Stay on the Waiver:					350	