

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:**

DDDS Lifespan Waiver

C. **Waiver Number:** DE.0009

Original Base Waiver Number: DE.0009.

D. **Amendment Number:** DE.0009.R07.02

E. **Proposed Effective Date:** (mm/dd/yy)

07/01/17

Approved Effective Date: 02/14/18

Approved Effective Date of Waiver being Amended: 07/01/14

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

Proposed changes are of a technical nature to allow individuals enrolled in the DDDS Lifespan 1915(c) and the 1115 Waiver under the Diamond State Health Plan to receive their acute care benefits. Minor change to Performance Measure C-a-2 to reflect data reported (added the word "sites"). Corrected Performance Measure G-b-1 that was a duplication of Performance Measure G-a-2, PM now reflective of sub-assurance b (corrected PM was inadvertently omitted; DDDS feels this PM is vital to health and safety tracking and reporting).

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 checked="" type="checkbox"/> Waiver Application | Request I |

| | |
|--|---------------------|
| <input type="checkbox"/> Appendix A – Waiver Administration and Operation | |
| <input type="checkbox"/> Appendix B – Participant Access and Eligibility | |
| <input checked="" type="checkbox"/> Appendix C – Participant Services | Quality Improvement |
| <input type="checkbox"/> Appendix D – Participant Centered Service Planning and Delivery | |
| <input type="checkbox"/> Appendix E – Participant Direction of Services | |
| <input type="checkbox"/> Appendix F – Participant Rights | |
| <input checked="" type="checkbox"/> Appendix G – Participant Safeguards | Quality Improvement |
| <input type="checkbox"/> Appendix H | |
| <input type="checkbox"/> Appendix I – Financial Accountability | |
| <input type="checkbox"/> Appendix J – Cost-Neutrality Demonstration | |

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:

Proposed changes are of a technical nature to allow individuals enrolled in the DDDS Lifespan 1915(c) and the 1115 Waiver under the Diamond State Health Plan to receive their acute care benefits. Minor change to Performance Measure C-a-2 to reflect data reported (added the word “sites”). Corrected Performance Measure G-b-1 that was a duplication of Performance Measure G-a-2, PM now reflective of sub-assurance b (corrected PM was inadvertently omitted; DDDS feels this PM is vital to health and safety tracking and reporting).

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):
DDDS Lifespan 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

Waiver Number: DE.0009.R07.02

Draft ID: DE.008.07.08

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

Regular Waiver ▼

- E. **Proposed Effective Date of Waiver being Amended: 07/01/14**
Approved Effective Date of Waiver being Amended: 07/01/14

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 Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

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

Individuals enrolled in the DDDS Lifespan Waiver and living with their family can be concurrently enrolled in the 1115 Waiver under the Diamond State Health Plan to receive their acute care benefits.

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 Lifespan Waiver provides services and supports as an alternative to institutional placement for individuals with intellectual developmental disabilities (IDD) (including brain injury), autism spectrum disorder or Prader-Willi Syndrome.

The goal of these services is to support individuals to live healthy, independent and productive lives in the community. In addition, the amended waiver provides new flexible person-centered supports designed to assist the families to enable the waiver participant to remain in his/her family home for as long as possible. Services are intended to promote independence through strengthening the individual's capacity for self-care and self-sufficiency while respecting their needs and preferences. DDDS also offers the option for individuals to transition from ICF/IID institutions to the community using the waiver to provide residential and other supports.

The objectives of the DDDS Lifespan Waiver are to:

1. Promote independence for individuals enrolled in the waiver and promote the engagement of family and other natural supports whenever possible;
2. Offer an alternative to institutionalization through the provision of an array of services and supports that promote community integration and independence;
3. Protect the health and safety of the participants receiving services under the waiver.
4. Ensure the highest standards of quality and best practices, through a network of qualified providers.

The Department of Health and Social Services (DHSS) is the Single State Medicaid Agency per 42 CFR 431.10. The Division of Medicaid and Medical Assistance (DMMA) is designated as the Medical Assistance Unit per 42 CFR 431.11 DMMA designates the authority for operation of the waiver to DDDS through a Memorandum of Understanding (MOU) between DDDS and DMMA. DMMA maintains administrative and supervisory oversight of the DDDS Lifespan Waiver.

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*):

☒ **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*

☐ **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*
- 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. **Statewide**ness. Indicate whether the State requests a waiver of the statewide requirements in §1902(a)(1) of the Act (*select one*):
 - ☒ No
 - ☐ Yes

If yes, specify the waiver of statewide requirements that is requested (*check each that applies*):

- ☐ **Geographic Limitation.** A waiver of statewide requirements 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 statewide requirements 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-I 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 inpatients of a hospital, nursing facility or ICF/IID.
- 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 as 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: Between Aug - Dec 2013, the DDDS Director held 12 information gathering forums with family groups to gather information for the design of a "family support" HCBS waiver.

The General Assembly directed DDDS to propose a design for a waiver and then directed DDDS to develop a "family support" HCBS waiver application. As discussions progressed, it was decided that this goal could be achieved by amending the existing DDDS HCBS waiver rather than create a separate stand-alone waiver.

DDDS published a PDF of the complete waiver application, as well as a summary of the proposed changes, on its website for public review beginning 11/1/16. Public meetings were held on Nov 28, 29 and 30, 2016, in each of the 3 counties of Delaware at different times of day. A copy of the waiver application was also available in hard copy for public view in DDDS offices in each county of Delaware.

DMMA published notice regarding the renewal in the 11/1/16 Delaware Register of Regulations with a link to the website to view the complete application and instructions on how to submit comments. The comment period went from 11/1/16 – 12/19/16. The public hearing schedule allowed the required additional period of 15 days for the public to comment after the last public meeting.

DDDS sent email to its distribution lists for families, providers and other stakeholders on 9/23/16 and 11/18/16 announcing the public comment process for the Lifespan Waiver amendment.

Information about the Lifespan Amendment was also shared at the following public meetings:

- 4/17/16 and 10/26/16 Medical Care Advisory Committee (MCAC) quarterly meetings
- 9/21/16 DDDS Quarterly Provider Meeting
- 10/6/16 and 12/1/16 DDDS Day Service Provider meeting
- 11/15/16 DMMA's Bi-monthly joint MCO meeting
- 11/16/16 Governor's Council for Exceptional Citizens
- 11/17/16 Governor's Advisory Committee to DDDS, monthly meeting
- 11/18/16 Governor's Commission on Community Based Alternatives, quarterly meeting
- 11/21/16 State Council for Persons with Disabilities, monthly meeting

Tribal consultation was not required because there are no Federally-recognized Tribes located within the State of Delaware.

A number of changes were made to the amendment as a result of feedback received from the public during the comment period. A document summarizing the public comments and any changes made as a result of the comment is posted on the DDDS and DMMA websites along with the revised amendment that was submitted to CMS. Most of the public comment/questions requested clarification regarding elements of the waiver. Some of the specific comments recommending changes to the waiver were as follows:

\$2,700 limit for Respite/Personal Care – the public indicated that this amount was too low. DDDS explained this limit

was derived based on available state funding and that it is significantly more than DDDS is able to allow currently using only state funds.

Waiver financial limit 250% FBR- a commenter recommended raising the limit to 300% FBR. Response indicated that the state's financial constraints do not allow for an expansion at this time.

Process for applying the Needs based criteria for Residential Habilitation - DDDS responded that the needs based criteria will be applied by the case manager as part of the planning process and can be reassessed over time as the member's needs change.

Limits for new waiver services – DDDS indicated that the limits are necessary to enable the waiver expenditures to stay within available funding. Limits can be reevaluated over time.

Dental Services for waiver members - DDDS had requested funding in the FY16 budget to cover \$1,500/person/year but funding was not appropriated so this service was not added to the waiver.

WIOA - A commenter recommended adding a reference to WIOA. This change was made to the application.

Vehicle modifications – a commenter pointed out that the waiver language required the vehicle to be the primary means of transportation in order to qualify for funding. The commenter was concerned that this may restrict funding for individuals for whom the vehicle was one of several means of transportation. DDDS explained that the language was taken directly from CMS's Core Service definitions but did change the language to indicate that the vehicle must be "one of the primary modes of transportation".

Guardians prohibited as paid caregivers under the self-directed option – commenters indicated that this would limit options for caregivers, as many parents were encouraged by school officials and others to apply for guardianship of their adult children with IDD. DDDS does not want to unnecessarily limit caregivers, so the waiver was revised to allow guardians to be a self-directed caregiver and to indicate the circumstances and conditions under which this can be done.

Self-advocacy training – a commenter noted that this was listed under the covered activities for residential habilitation but not for the day & employment services or supported living. DDDS revised the application to add this activity to the other service definitions.

Obtaining 2 bids/estimates for purchase of equipment – a commenter expressed concern that there was no language allowing DDDS to waive the requirement to obtain 2 bids for the purchase of specified equipment in the event that a delay in receiving the equipment would jeopardize the health or safety of the participant. DDDS added language to the application that allows DDDS to waive the bid requirement under exigent circumstances.

- 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:

Williams

First Name:

Glyne

Title: Chief of Policy, Planning and Quality
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) 255-9628 **Ext:** ☐ TTY
Fax: (302) 255-4481
E-mail: glyne.williams@state.de.us

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

Last Name: Howe
First Name: Kathryn
Title: DDDS Director of Quality Improvement
Agency: Division of Developmental Disabilities Services
Address: 2540 Wrangle Hill Road, Suite 200
Address 2:
City: Bear
State: Delaware
Zip: 19701
Phone: (302) 836-2185 **Ext:** ☐ TTY
Fax: (302) 836-2642
E-mail: katie.howe@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:

Attachments

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- ☐ **Replacing an approved waiver with this waiver.**
- ☐ **Combining waivers.**
- ☐ **Splitting one waiver into two waivers.**
- ☐ **Eliminating a service.**
- ☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**
- ☐ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**
- ☐ **Reducing the unduplicated count of participants (Factor C).**
- ☐ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**
- ☐ **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**
- ☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

^
v

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

State of Delaware: Statewide Transition Plan for Compliance with Home and Community-Based Setting Rule; Updated March 30, 2016

The State assures that the settings transition plan included with this waiver amendment will be subject to any provisions or requirements included in the State's approved Statewide Transition Plan. The State will implement any required changes upon approval of the Statewide Transition Plan and will make conforming changes to its waiver when it submits the next amendment or renewal.

The following are the sections from the March 30, 2016 STP regarding the DDDS 1915(c) waiver.

FEBRUARY 2016 NOTE TO REVIEWER

On November 30, 2015, CMS submitted comments (via email) on the Delaware Statewide Transition Plan (the Plan). Delaware's Department of Health and Social Services (DHSS) is updating the Plan to respond to those comments and to reflect the current status of implementation activities as of February 2016. We direct you to the following sections of the Plan that contain updated information:

1. New sections "February 2016 Update to DDDS Waiver Assessment and Remediation Plan" for new information since publication of the Plan in September 2015;
2. Attachment 5 for CMS comments on the Plan and DHSS' responses;
3. Attachment 6 for updated state systemic assessments by provider setting type;
4. Attachment 7 for DDDS provider and member surveys; and
6. Attachment 9 for comments from March 2016 public comment period DDDS/DMMA responses.

We have also updated the Plan timelines on pages 20 and 47 to note, when appropriate, revised tasks, new tasks, new dates, and completion status. All new information is highlighted in bold text.

The Plan is an evolving process. In some instances our assessment activities and approaches have deviated from our original plan. In other instances we have added more detail regarding processes. We refer you to this new and updated information for the current status of our approaches, activities, and timeframes.

INTRODUCTION

In response to the Centers for Medicare & Medicaid Services (CMS) promulgating a rule which for the first time defines the standard of being "community-based," Delaware – and the individuals and families we serve – is committed to the goals of enhancing the quality of home- and community-based services (HCBS) and ensuring full access to the benefits of community living. The Department of Health and Social Services (DHSS) is driven by core values that enhance individuals' access to the least-restrictive environments, promotes individual choice, and engages families and significant others. DHSS has and will continue to engage stakeholders, and will continue to facilitate and promote a robust stakeholder process as the State conducts activities toward implementation of the Final Rule.

The intent of the rule, also referred to as the "Community Rule," is to ensure that people receiving federally funded HCBS have opportunities to access community services in the most-integrated settings possible. This includes opportunities to seek employment and work in competitive settings, engage in community life, control personal resources, and participate in the community to the same extent as people who do not receive HCBS. DHSS understands how important these services are to

Medicaid enrollees and will work collaboratively with individuals, their loved ones, and other stakeholders to ensure continuity of services, minimal disruption, and support during implementation.

The Final Rule required that states submit to CMS a Statewide Transition Plan on or before March 17, 2015: 1) demonstrating the process the State will undertake to assess the HCBS provided to participants and the settings in which these services are provided and 2) describing the assessment process and timeframes to ensure full compliance with federal requirements by March 17, 2019. Delaware's Division of Medicaid and Medical Assistance (DMMA), which is within DHSS, will submit the Plan addressing the above requirements for all programs offering in the State.

PURPOSE

The purpose of the Plan is to describe the process the State of Delaware will use to:

- Assess current State and provider policies, standards and practices against the Community Rule;
- Assess waiver services and settings against the Community Rule;
- Develop strategies to remediate situations that are determined not to be in compliance; and
- Demonstrate Delaware's full compliance with the Community Rule by March 17, 2019.

The specific elements addressed in the Plan include the following:

1. A description of the process to assess current policies, standards, practices, etc. against the Community Rule requirements for both the State and providers.
2. A description of the process that will be used to assess waiver services and settings against the Community Rule requirements, including timeframes for completion of various tasks.
3. A description of the process that was used to solicit public comment in the development of the draft Plan, including a 30 day comment period.
4. A summary of public comment received.
5. A description of how the public comment was used in the development of the Plan.
6. Time frames for producing a summary of how each setting meets or does not meet the federal Home and Community-Based (HCB) settings requirements.
7. Time frames for bringing State and provider policies, standards, practices, etc. into compliance.
8. Time frames for bringing all HCB settings into compliance.
9. A plan for ensuring the health and safety of participants who reside or are served in locations that need to meet corrective action requirements for the setting to come into compliance during the State's specified transition time.

The intent of the Plan is to: 1) ensure that participants receive Medicaid HCBS in settings that are integrated in and support full access to the greater community, 2) ensure the health and welfare of participants and 3) maintain the ability to receive federal funding for critical community based supports and services.

The Plan can be viewed online at: http://dhss.delaware.gov/dhss/dmma/hcbs_trans_plan.html.

OVERVIEW OF HCBS IN DELAWARE

Delaware provides multiple HCBS for Medicaid recipients through four federally approved programs: 1) Division of Developmental Disabilities Services (DDDS) 1915(c) waiver, 2) Diamond State Health Plan (DSHP), 3) Pathways to Employment (Pathways) program and 4) Promoting Optimal Mental Health for Individuals through Supports and Empowerment (PROMISE) program. PROMISE and Pathways are administered by DMMA's sister agencies within DHSS. PROMISE is administered by Delaware's Division of Substance Abuse and Mental Health (DSAMH) under Delaware's 1115 demonstration. Pathways is administered jointly by DDDS and the Division of Services for Aging and Adults with Physical Disabilities (DSAAPD) under concurrent 1915(b)(4) and 1915(i) authorities.

The DDDS waiver, operated by DDDS under a Memorandum of Agreement with DMMA provides HCBS as an alternative to institutional placement for individuals 12 and over with intellectual developmental disabilities (IDD), including brain injury, autism spectrum disorder and Prader Willi Syndrome. As of September 2014, 980 individuals are enrolled in the DDDS waiver.

The DSHP demonstration was initially approved in 1995, and implemented on January 1, 1996. The demonstration mandatorily enrolls Medicaid recipients into managed care organizations (MCOs). In addition to acute care services such as physician and nursing services, the demonstration also provides HCBS to eligible individuals (who would otherwise receive care in a nursing facility) through a mandated managed care delivery system called DSHP-Plus. As of December 2014, 176,454 individuals are enrolled in DSHP and 11,640 are enrolled in DSHP- Plus.

In December 2014, CMS approved two new programs that expanded the availability of HCBS options for Delaware Medicaid recipients. Pathways, effective January 1, 2015, is a program designed for persons age 14-25 with disabilities (intellectual disabilities, autism spectrum disorders, visual impairments or physical disabilities) who want to work. PROMISE, also effective January 1, 2015, is a program that provides enhanced behavioral health services and supports for persons 18 and over who have severe and persistent mental illness and/or a substance abuse disorder and who require HCBS to live and work in integrated settings. Since Pathways and PROMISE are new programs, prior to approval they had to meet all federal requirements, including requirements regarding the Community Rule. Therefore, Pathways and PROMISE are not

addressed in the Plan.

The following are the HCBS to be assessed under the Plan, organized by the HCBS program under which it is provided.
DDDS Waiver HCBS

The DDS waiver offers the following HCBS that will be addressed in the Plan (including excerpts of service definitions from the approved waiver):

Day Habilitation Services: Services that are regularly scheduled activities provided in a non-residential setting, separate from the participant's private residence or other residential living arrangement, such as assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills that enhance social development and develop skills in performing activities of daily living and community living, physical development, basic communication, self-care skills, domestic skills, community skills and community-inclusion activities. Activities and environments are designed to foster the acquisition of skills, building positive social behavior and interpersonal competence, greater independence and personal choice. Services are furnished consistent with the participant's person-centered plan and are integrated into the community as often as possible.

Day Habilitation Services focus on enabling the participant to attain or maintain his or her maximum potential and shall be coordinated with any needed therapies in the individual's person-centered services and supports plan, such as physical, occupational, or speech therapy.

Prevocational Services: Prevocational Services provide learning and work experiences, including volunteer work and/or internships, where the individual can develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated community settings. Services are expected to produce specific outcomes to be achieved, as determined by the individual and his/her services and supports planning team through an ongoing person-centered planning process evaluated annually. Prevocational Services may be furnished in fixed site locations or in community based settings.

Individuals receiving Prevocational Services must have employment-related goals in their person-centered services and supports plan; the general habilitation activities must be designed to support such employment goals. Competitive, integrated employment in the community 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 is considered to be the optimal outcome of Prevocational Services.

Residential Habilitation: Residential Habilitation 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. The scope of these services is based on the individual's need and can be around-the-clock or blocks of hours. Residential Habilitation Services may be provided in a neighborhood group home setting, a supervised or staffed apartment (community living arrangement), or a shared living arrangement (formerly titled adult foster care).

The following activities may be performed under all Residential Habilitation:

- Self-advocacy training that may include training to assist in expressing personal preferences, self-representation, and 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 Preparedness.
- Community access services inclusions 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.

Supported Employment – Individual: 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.

Supported Employment – Group: 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.

Supported Living: Supported living is support that is very individualized and is provided in a residence that is owned or leased by the waiver member. The amount and type of supports provided are dependent upon what the individual needs to live successfully in the community and must be described in their Plan of Care (ELP) but cannot exceed 40 hours per week for each member. Daily hours of support may vary based on the needs of the individual. Supported living encourages maximum physical integration into the community and is designed to assist the individual in reaching his or her life goals in a community setting.

The types of supports provided in these settings are tailored supports that provide assistance with acquisition, retention, or improvement in skills related to:

- Activities of daily living, such as personal grooming and cleanliness, domestic chores, or meal preparation, including planning, shopping, cooking, and storage activities;
- Social and adaptive skills necessary for participating in community life, such as building and maintaining interpersonal relationships, including a Circle of Support;
- Locating and scheduling appropriate medical services;
- Instrumental activities of daily living such as learning how to maintain a bank account, conducting banking transactions, managing personal finances in general;
- Learning how to use mass transportation;
- Learning how to select a housemate;
- How to acquire and care for a pet; and
- Learning how to shop.

The individual may want to learn a new skill or may have some proficiency in certain parts of a skill but want to learn how to complete the entire task independently. Supported living must be provided based on the individualized needs of each waiver member and at naturally occurring times for the activity, such as banking and those related to personal care. Supported living is provided on a one-on-one basis. If services are provided with two or more individuals present, the amount of time billed must be prorated based on the number of consumers receiving the service. Payments for Supported Living do not include room and board.

APPROACH TO DEVELOPING THE STATEWIDE TRANSITION PLAN

In 2014, DMMA initiated a process to re-procure MCOs for the DSHP program. The purpose of this re-procurement was to improve program oversight and administration as well as the quality of services offered to MCO members. This process began in 2013 with the drafting of a new MCO contract. In January 2014, DMMA published the request for proposal and new contracts were implemented January 1, 2015. DMMA conducted an extensive readiness review with the MCOs, which included both desk reviews of policies and procedures and onsite reviews with key MCO staff. Thus, 2014 was a resource-intensive period for DMMA and the MCOs as well as a period of significant transition. As a result, DMMA is at the early stages in its assessment activities related to the Plan.

DDDS has taken a lead role, with support by and coordination with DMMA, focusing on preliminary assessment of the DDDS waiver for compliance with the Community Rule. The results of this preliminary assessment are outlined below in the Plan.

It is important to note that the Plan identifies at a high level the activities and requirements that will be implemented for the DDDS waiver and the DSHP demonstration. For additional insight or intent regarding the Plan and the State's intent, we refer you to the responses to comments received on the Plan at the end of this document.

Moving forward, the specific approach and details surrounding each program will be further defined and will reflect the input and guidance of the particular program's stakeholders, and, as appropriate, will reflect the unique structure and organization of the program itself. As appropriate, the Plan will be revised and submitted to CMS if significant modifications are necessary. Revised versions of the Plan as well as any related materials that will be developed as part of the Plan's implementation will be published, providing additional opportunities for public feedback.

Delaware is committed to engaging with stakeholders and has sought public input from various stakeholders including participants, family members, associations, advocacy groups, and others throughout the process of the Plan development. During the implementation of the Plan, Delaware will continue to seek stakeholder input through a variety of opportunities and venues. Stakeholder input has strengthened the development of the Plan, and will be of critical importance during assessment and remediation.

Additional stakeholder feedback will come from the governing structure for the Plan. For the DDDS portion of the Plan, the Advisory Council to the Division of Developmental Disabilities Services (Advisory Council to DDDS) will serve as the steering committee for feedback in implementing the Plan. Various workgroups will be established by the Advisory Council to DDDS to implement specific tasks. It is our intent that the composition of the work groups will be representative of family members who represent the varying support needs of people within the DDDS service system and other key stakeholders. Similar to DDDS, DMMA will draw upon the experience and expertise of a stakeholder group, the Governor's Commission on Community Based Alternatives for Individuals with Disabilities (Governor's Commission on CBAID), as the key stakeholder advisory entity during the assessment processes for DSHP.

Although the description below regarding assessment and remediation activities is organized according to program area (DDDS waiver and DSHP demonstration), Delaware is committed to providing a comprehensive, coordinated approach to determining compliance with the Community Rule. This means that where appropriate, processes for the programs, activities and timeframes for the programs will be comparable.

Multiple agencies are involved in administering the State's Medicaid program. As such, a cross-agency team will monitor DMMA's assessment and remediation activities. The team will consist of representatives from DMMA, DDDS, DSAAPD, DSAMH and the Division of Long Term Care Residents Protection (DLTCRP). Other agencies will be included in the process as appropriate and as warranted by specific tasks. The team will meet at a minimum, monthly, but will meet more frequently if necessary depending on the task at hand. Regularly scheduled meetings will enable the team to touch base on key issues, to ensure that tasks remain on track and to develop and implement any necessary course modifications. Updates will be provided to key leadership, including the DHSS Secretary. DDDS will report to DMMA, on a regular frequency, regarding the status of implementing the DDDS waiver portion of the Plan.

Final responsibility for the development and submission of the Plan, including meeting the requirements for public notice, rests with DMMA. In the course of implementing the Plan, DMMA will be responsible for any negotiations with CMS regarding any possible changes to the Plan. DMMA will look to the cross-agency oversight body for guidance and direction in these processes.

STATEWIDE TRANSITION PLAN TIMELINE

Note to reviewer: Updates to the activity dates noted in the chart below can be found in the February 2016 updates to DSHP and DDDS assessment and remediation activities found later in the document.

The following is a high level timeline noting all phases of the Plan. Details regarding the activities in each phase and associated timeframes are described later in the Plan.

Activity Estimated Start Date Estimated End Date

Preparing and Submitting the Plan for CMS Approval

1st Stakeholder meeting for DDDS waiver transition plan. January 21, 2015 N/A

Incorporate stakeholder feedback into DDDS waiver transition plan. January 21, 2015 February 5, 2015

2nd Stakeholder meeting for DDDS waiver transition plan. January 28, 2015 N/A

Post the Plan for public comment. February 6, 2015 March 9, 2015

Publish the Plan in newspaper and on DMMA website. February 6, 2015 N/A

1st Public Hearing for the Plan (New Castle County). February 23, 2015 N/A

2nd Public Hearing for the Plan (Kent County). February 27, 2015 N/A

Review, incorporate and respond to public comments on the Plan. March 9, 2015 March 13, 2015

Modify the Plan and post on DMMA website (including summary of public comments and state response). On or before March 17, 2015 N/A

Submit the Plan to CMS for approval. On or before March 17, 2015 N/A

Implementing the Plan

Phase 1: Development of survey instruments and process to assess compliance with Community Rule. DDDS: February 2015 DDDS: July 2015

DSHP: April 2015 DSHP: July 2015

Phase 2: Implementation of survey instruments and processes developed in Phase 1 to assess compliance with Community Rule. DDDS: August 2015 DDDS: December 2015

DSHP: August 2015 DSHP: January 2016

Phase 3: Use assessment results and other data sources to create inventory of services and settings vis-à-vis compliance with Community Rule. DDDS: January 2016 DDDS: February 2016

DSHP: February 2016 DSHP: March 2016

Phase 4: Develop and approve remediation strategies to bring non-compliant services, settings, policies, etc. into compliance with Community Rule. DDDS: February 2016 DDDS: July 2016

DSHP: April 2016 DSHP: August 2016

Phase 5: Implement remediation strategies. DDDS: August 2016 DDDS: March 17, 2019

DSHP: September 2016 DSHP: March 17, 2019

Phase 6: Monitor ongoing compliance. DDDS: August 2016 DDDS: March 17, 2019

DSHP: September 2016 DSHP: March 17, 2019

REMEDIATION PLANS

This section of the Plan describes the assessment processes to determine compliance with the Community Rule and the remediation actions to address identified issues for the DDDS waiver and the DSHP demonstration. Activities for the DDDS waiver are presented first, followed by activities for the DSHP demonstration. The assessment and remediation activities are described in a sequential manner as “phases.”

This section also includes a matrix for each component of the Plan (DDDS waiver activities and DSHP demonstration activities) that organizes activities by the major categories of the Community Rule requirements.

DDDS Waiver Assessment and Remediation Plan

Phase 1: Development of survey instruments and processes to assess compliance with the Community Rule

Start Date: February 2015

End Date: July 2015

DDDS will work with the Advisory Council to DDDS and any work groups convened by the Advisory Council to DDDS to develop survey instruments and protocols to assess the extent to which the following either: comply with, are contradictory to or are silent on the requirements under the Community Rule:

- State laws, regulations, policies, etc. and provider policies; and
- HCBS and HCB settings.

The Advisory Council to DDDS will create one or more sub-work groups comprised of stakeholders (as enumerated in the matrix that follows) to develop the survey instruments. The CMS Exploratory questions for residential and non-residential settings will be incorporated into the survey instrument.

DDDS intends to create assessment instruments for provider policies regarding HCBS and HCB settings that will be completed by the providers as a self-assessment instrument. The self-assessment instruments must include a place for the provider to document how they meet the Community Rule requirement. For the provider policy assessment, this must take the form of citations and excerpts from written documents maintained by the provider. For the services and settings assessment, the provider must also provide documentation of compliance using such documentation as training curricula or staff performance plans in addition to other relevant documentation.

Delaware DDDS had hoped to be able to use data from the Delaware results of the National Core Indicators (NCI) survey as cross-validation of the provider self-assessment surveys, since the survey includes questions about employment, rights, service planning, community inclusion, choice, and health and safety. Unfortunately, we learned that we are not able to parse out the survey results into locations or types of settings. As a result of this and also because of feedback we received from the public hearings, DDDS will create a consumer survey instrument that will include the same types of questions as the DDDS Residential and Day Service surveys. The results from these surveys will be used to validate information received from the provider self-assessments in addition to the look-behind reviews.

Phase 2: Implementation of survey instruments and processes developed in Phase 1 to assess compliance with the Community Rule

Start Date: August 2015

End Date: December 2015

Assessment of State Laws, Regulations, Policies, etc.

The sub-work group of the Advisory Council to DDDS will work with staff of DDDS to administer the survey tool against State laws, regulations, policies, etc. to determine compliance with the Community Rule. A final report will be issued with the findings of the group. The report will indicate for each requirement under the Community Rule whether the State:

- Has sufficient written guidance and processes in place to ensure compliance.
- Has some written guidance and processes in place that must be augmented in order to ensure compliance.
- Has no written guidance or processes in place to ensure compliance.

Copies of the report will be provided to the cross-agency oversight body for review. In addition, copies of the report will be shared with stakeholder groups.

The review process will include the following State, Department and Division documents and related practices, at a minimum:

- Delaware Code
 - o Title 16, Chapter 11, Subchapter II. Rights of Patients
 - o Title 16, Chapter 55, Subchapter I. Declaration of General and Special Rights of Persons Diagnosed with Intellectual Disabilities and Other Specific Developmental Disabilities
 - o Title 25, Part III Landlord/Tenant Code
- Delaware Administrative Code
 - o Title 16, DHSS, Section 3000 DLTCRP, 3310 Neighborhood Homes for Persons with Developmental Disabilities (interpretive guidelines)
 - o Title 16, Section 3320 Intensive Behavioral Support and Educational Residence (IBSER)
- Department Policies
 - o PM 24 – Safeguarding client funds
 - o PM 25 Voter Registration – Federally Funded Programs
 - o PM 31 Site Selection for People with Disabilities
 - o PM 36 Standardized Requirements During the Development Phase of Community Based Residential Homes for the DHSS/Division
 - o PM 40 w/ Addendum A: Criminal Background Check
 - o PM 46 Policy Memorandum concerning Patient Abuse/Injury/Self Harm, etc.
 - o PM 62 Housing/Rent Calculations
- DMAP DDDS Provider Manual (on DMAP website)
- DDDS Waiver Provider Certification Application
- DDDS Waiver Service Provider Qualifications DDDS Waiver Application July 1, 2014 renewal approved by CMS
- DDDS Provider Contracts:
 - o Day and Residential Appendix A
 - o Residential Appendix A-1
 - o Shared living contract Appendix A and related documents
 - o Other contract documents
- DDDS standards
 - o DDDS Waiver Certification Standards Manual (on DDDS website)
- DDDS manuals
 - o A Guide to the Division of Developmental Disabilities Services In Delaware by the Arc of Delaware May 2010
 - o Case Manager Desk Manual
 - o ELP Manual and Forms (under revision)
 - o Nurse Consultant Manual
 - o Behavioral Consultant Manual (under revision)
- DDDS policies
 - o Community Services
 - o “Administrative” Policies (apply across all services)
- DDDS monitoring tools
 - o Case Manager monthly contact (in ECR)
 - o Office of Quality Improvement (OQI) Survey tool (used in the CSR and also in agency reviews)
- Staff performance plans

- o Senior Social Worker/Case Manager (DDDS Case Managers)
- o Social Worker/Case Manager Supervisor
- Provider lease agreements
- DDDS Provider Lease Approval form
- DDDS Curriculum for Direct Support Professional from the College of Direct Support

Additional relevant materials may be added to the review as they are identified.

Provider Self-Assessment of Provider Policies and Other Written Guidance

Waiver service providers will complete the self-assessment survey instrument developed in Phase I to assess their level of compliance with the Community Rule. In order to increase the provider response rate, a process will be created to follow-up with providers failing to meet requested response timeframes.

Based on the results of the survey, an authorized representative of each provider will attest in writing whether they believe that their organization's rules and policies are either fully compliant with the Community Rule or that remediation is necessary. Providers that indicate that remediation is necessary will be required to submit a Corrective Action Plan to the State within 30 days of submission of the provider self-assessment.

The sub-work group of the Advisory Council to DDDS will conduct "look-behind" reviews of a sample of the provider self-assessment survey results to validate the provider self-assessments.

DDDS and DMMA will develop an appeal process for providers to dispute the State's findings of non-compliance.

Provider Self-Assessment of Waiver Services and Settings

Waiver service providers will complete the self-assessment instrument developed in Phase I to assess their level of compliance with the Community Rule. Providers will need to complete a self-assessment for every site where the provider offers services. Similar to the provider self-assessment of policies and other written guidance process, DDDS will develop an acceptable response rate for the self-assessment instrument. In order to increase the provider response rate, a process will be created to follow-up with providers failing to meet requested response timeframes.

Based on the results of the survey, an authorized representative of each provider will attest in writing whether they believe that their organization settings are either fully compliant with the Community Rule or that remediation is necessary. Providers that indicate that remediation is necessary will be required to submit a Corrective Action Plan to the State within 30 days of submission of the provider-self assessment. The Corrective Action Plan must be approved by the State before it can be implemented.

Under the oversight of the Advisory Council to DDDS, the DDDS Office of Quality Improvement (OQI) will conduct "look-behind" reviews of a sample of the provider self-assessment survey results to validate the provider self-assessments. Look-behind reviews will include onsite visits. The Advisory Council to DDDS will assist in developing the methodology for the look-behind reviews, including sample composition and the process for onsite visits. The DDDS and DMMA will ensure that all review processes are conflict free and will develop dispute resolution processes for the findings.

Information obtained from the analysis of the consumer surveys will supplement data gathered from the provider self-assessments of the services and settings and the look-behind reviews.

Provider settings/services that will be reviewed for compliance as part of this process include:

- Neighborhood group homes;
- Community living arrangements (staffed apartments);
- Shared living arrangements;
- Day habilitation facilities and non-facility-based programs;
- Prevocational facilities and non-facility based programs; and
- Supported Employment providers.

Any assessment results that indicate approved deviations from the requirements under the Community Rule for specific waiver members must be supported by the individual needs of the waiver member as specified in the person-centered plan. Where deviation is recommended, the following standard must be met:

- Identification of a specific condition or individualized need that is directly proportionate to the deviation being recommended;
- Documentation of positive interventions and supports tried prior to the recommended deviation from the requirements, including less intrusive methods of meeting the need that were tried and did not work;
- Ongoing periodic review to measure the effectiveness of the deviation from standard practice;

- Establishment of a timeframe within which the deviation should be discontinued if it is no longer needed or effective;
- An assurance that the interventions and supports will cause no harm to the individual; and
- Informed consent of the individual or legal representative (see 42 CFR §441.301(c) (2) (xiii)(G)).

DMMA and DDDS will develop an appeal process for providers to dispute the State's findings of non-compliance.

Phase 3: Use assessment results and other data sources to finalize inventory of services and settings vis-à-vis compliance with the Community Rule

Start Date: January 2016

End Date: February 2016

DDDS will create an inventory of all waiver settings, both residential and non-residential, and each setting will be initially identified as either 1) not compliant, 2) presumed not to be compliant, 3) likely not to be compliant, or 4) fully compliant, the latter two of which will be based on the results of the provider self-assessments and the look-behind reviews conducted by the Advisory Council to DDDS sub-work group. The inventory will summarize how each setting meets or does not meet the federal HCBS requirements.

Settings PRESUMED NOT to be Compliant

DDDS will identify specific settings, both residential and non-residential, that are PRESUMED NOT to be HCBS compliant because they are on grounds of, or adjacent to, a public institution. , they are in a publicly or privately-owned facility providing inpatient treatment or they have the effect of isolating individuals from the broader community of individuals not receiving Medicaid HCBS. Stockley Center is the only public Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) in Delaware. This review will include residential and non-residential settings out of state for which waiver funds are currently being used. This review will be conducted by DDDS staff prior to the completion of the provider self-assessment by those agencies.

All Other Settings

DDDS staff will use the results of the following data sources to populate the inventory with the initial compliance status as outlined above:

- Provider self-assessments; and
- Look-behind reviews conducted by the Advisory Council to DDDS sub-work group.

An appeal process will be developed for providers to dispute the State's findings of non-compliance.

Phase 4: Develop remediation strategies to bring non-compliant services, settings policies, etc. into compliance with the Community Rule

Start Date: February 2016

End Date: July 2016

Based on the inventory of Delaware HCBS residential and non-residential settings, remediation will need to be developed for any services or settings that are determined to not meet the federal HCBS requirements. Providers for which remediation is necessary will be required to submit a Corrective Action Plan to the State within 30 days of submission of the provider self-assessment.

To the extent that remediation strategies have financial implications for the providers and for the State, budget strategies may need to be developed by the State.

Phase 5: Implement remediation strategies

Start Date: August 2016

End Date: March 17, 2019

Any Corrective Action Plans and other remediation strategies identified in Phase 4 must be fully implemented by March 17, 2019 so that the entire waiver service delivery system will be compliant with the Community Rule.

The State will ensure that throughout the remediation phase, measures will be put in place to continuously monitoring participant health and welfare and the quality of care. State staff and stakeholders will be engaged in this activity.

In the event that a provider is initially determined not to meet all appropriate HCBS requirements, participants will have the choice of continuing to receive services from the provider while the provider implements corrective action to bring the setting into compliance. Relocation processes will be tailored to each individual with full participation of the individual and his/her family/caregiver. DDDS will work with the individual and his/her family/caregiver and provider (existing and new), etc. to develop a smooth transition process that will ensure continuity of care and protect the health and welfare of the individual throughout the process. The individual's plan of care will be updated accordingly.

Phase 6: Monitor ongoing compliance

Start Date: August 2016

End Date: Ongoing

The DDDS Office of Quality Improvement will monitor progress on Corrective Action Plans and will also begin routine monitoring of compliance with the requirements of the Community Rule during the Transition period for providers for whom no Corrective Action Plan is in effect.

July 2015 Update to DDDS Waiver Assessment and Remediation Plan

State Self-Assessment Results

The results of the DDDS review of applicable state laws, regulations and policies are included as a new Attachment 3 to the Plan. The attachment is presented as a matrix that provides an overview of the extent to which current state laws, regulations and policies are compliant with the Community Rule final requirements, using the CMS exploratory questions as guidelines for the compliance review. Specifically, the matrix notes:

- The specific state document reviewed to determine compliance;
- Identified gaps, if any; and
- Recommended steps for remediation, including development of new policy.

Provider Surveys

DDDS has actively involved a diverse group of stakeholders in developing the provider surveys for DDDS waiver providers. The stakeholders include: self-advocates, families, parents, providers, attorneys specializing in disability law and the advocacy organizations such as the Advisory Council to DDDS. Stakeholders, along with DDDS staff, formed two workgroups to develop the provider surveys; one tasked with developing the residential services provider survey and the other responsible for developing the day services provider survey. Each workgroup was co-chaired by a self-advocate. The workgroups met nine times for three hours over the course of three months and drew upon CMS requirements and guidance, surveys from other state programs, and knowledge of the Delaware system of care to draft the final recommended surveys.

The workgroups were fully informed about their role in implementing the Plan. They were committed to the effort and appreciated being included in the process.

The provider surveys are currently under review by the Advisory Council to DDDS. In addition, DDDS is finalizing details of the provider survey pilot to test the validity of the provider survey tools. Upon completion of the provider pilot, DDDS will make any needed changes to the survey tools and process as a result of feedback gained from the pilot. DDDS is targeting August 2015 for implementation of the provider surveys. Once finalized, copies of the survey instruments will be made available to the public for general information.

Training

DDDS worked with Elsevier, the company that licenses the College of Direct Support training curriculum required by DDDS for all direct support staff that work with DDDS consumers, to determine whether the training modules required by DDDS are compliant with the Community Rule. The detailed findings of that review are included in the DDDS State-Self Assessment. All of the CDS modules required by DDDS were determined to be compliant with the Community Rule.

Other

DDDS has continued to engage stakeholders in meaningful discussions regarding implementation of the Plan, issues of concern and impact on service delivery. The following represents some of the stakeholder engagement activities that have occurred since March 2015:

- Presentation at meetings of stakeholder groups;
- Presentation at National Association of Councils on Developmental Disabilities 2015 Annual Conference; and
- Presentation to the DDDS Case Management Conference June 21, 2015.

February 2016 Update to DDDS Waiver Assessment and Remediation Plan

State Systemic Assessment

DDDS developed a matrix format using the requirements of the HCBS Final Rule as individual data elements in Phase 1. DDDS staff then systematically compared each existing state rule, regulation, policy, etc. in the list enumerated in the Plan to the list of requirements. For each requirement, the matrix included a space for DDDS to indicate: 1) the citation within each source document that was reviewed, 2) an indication of whether the source, supported the Rule, was silent on the Rule or incomplete, or contradictory to the Rule, and 3) a recommended corrective action strategy. A separate companion document

also included excerpts from the documents with the language that demonstrated compliance with the HCBS Final Rule.

The DDDS Director issued a final report of findings to the Advisory Council to DDDS at one of its regular monthly meetings. A revised version of the report will include an updated version of the matrix, included in Attachment 6, that more clearly indicates for each requirement under the HCBS Rule whether the State written laws and rules are:

- Compliant
- Not compliant and require either removal or revision to become compliant
- Silent

The report was also provided to the Delaware cross-agency oversight body for review. In addition, copies of the report were shared with stakeholder groups by publishing the report on the DMMA website with the other Plan materials.

DDDS is in the process of assigning responsibility internally for making changes as identified in the State Systemic Assessment or working with external entities to ensure that the changes are made.

Consumer Assessment of Settings and Services

Delaware DDS had hoped to be able to use data from the Delaware results of the NCI survey as cross-validation of the provider self-assessment surveys, but we learned that we are not able to parse out the survey results into locations or types of settings. As a result of this, and also because of feedback we received from the public hearings, DDDS convened a workgroup under the auspices of the Advisory Council to DDDS to develop a consumer survey instrument that includes the same types of questions as the DDDS Residential and Day Service surveys. The workgroup met on December 3, 2015 to work on the survey. The group decided to create two separate sets of questions, one for residential settings and one for day service settings.

The survey instruments were finalized on December 10, 2015. Because of the time lag involved in trying to use the NCI results and not being able to do so, the timeframe for developing and implementing the consumer survey fell outside of the planned timeframe for this phase of the process. We had also initially hoped to be able to use the results of the consumer survey to help target settings to be reviewed as part of the 20% sample for the look-behind reviews, but now this may not be possible because of the timing. To the extent they are available, the results from these surveys will be used to validate information received from the provider self-assessments in addition to the look-behind reviews.

Participant Survey

The participant survey was finalized in December 2015 and is currently being implemented. For waiver members with guardians, the survey will be mailed to the guardian to complete. Individuals who do not have a guardian will be assisted to complete the survey by either their DDDS case manager, the DDDS waiver manager, or a member of the staff of the DDDS Office of Quality Improvement. The results from these surveys will be used to validate information received from the provider self-assessments in addition to the look-behind reviews. The participant survey will be completed by March 31, 2016.

Assessment of Provider Settings and Policies

DDDS worked with the Advisory Council to DDDS to develop survey instruments and protocols to assess the extent to which providers either comply or do not comply with the requirements under the HCBS Rule.

Provider settings/services that are being reviewed for compliance as part of this process include:

- Neighborhood group homes
- Community living arrangements (staffed apartments)
- Shared living arrangements
- Day habilitation facilities and non-facility-based programs
- Prevocational facilities and non-facility based programs
- Supported employment providers
- Supported living providers
- Provider settings regulated by the IBSER regulations

Provider Self-Assessment of Settings and Policies

The Advisory Council to DDDS created two sub-work groups comprised of stakeholders (as enumerated in the matrix that follows), one for residential settings and one for day service settings, to develop the survey instruments to assess the compliance of each setting and service. The CMS exploratory questions for residential and non-residential settings were incorporated into the survey instruments.

Providers were informed that they must be prepared to provide documentation of how they meet the HCBS Rule requirement for any requirements they indicate they are meeting for each setting. They were informed that the following types of items

would constitute acceptable forms of documentation that they are complying with each requirement: citations or excerpts from written documents they maintain, training curricula, or staff performance plans.

All waiver service providers in Delaware have now completed the self-assessment survey instruments developed in Phase I for every site where the provider offers HCBS services in order to assess their level of compliance the HCBS Final Rule.

Provider Survey Methodology

The provider surveys for day and residential agency providers were launched September 4, 2015 and closed November 13, 2015. The surveys for Shared Living providers were launched November 11, 2015 and closed December 7, 2015. See Attachment 7 for a copy of the survey instruments for day and residential agency providers and shared living providers. Providers used the survey instrument to assess their level of compliance with the HCBS Final Rule as reflected in their practices and also in their policies and procedures.

Provider participation in the survey was mandatory. The following statement accompanied the provider survey: The survey must be completed no later than November 13, 2015. Failure to complete the survey for all relevant parts of your organization doing business with DDDS by that date may result in the termination of a provider's status as a DDDS Authorized Provider.

To assist providers in meeting the deadline, DDDS initiated the following actions:

- DDDS emailed a reminder to all qualified providers at the following increments: 10 days prior to the deadline, five days prior to the deadline, and two days prior to the deadline. The above mentioned statement regarding the consequences for failure to complete the survey was included in the reminder notices.
- Five days after the deadline, all providers who failed to complete the survey for all applicable settings were sent an email message giving them an additional 48 hours to complete the survey for all of their settings. The email notified providers that failure to comply would result in DDDS putting the provider on probation. Probation letters would include the timeframe within which the provider must submit their survey results. Failure to meet the timeframes as outlined in the probation letter would also result in DDDS pursuing progressive discipline, up to and including the discontinuation of the provider's contract and their status as a DDDS Authorized Provider.

Desk Review

Between November 2015 and January 2016, DDDS conducted desk reviews of the provider survey results. The desk reviews were conducted by the DDDS Office of Quality Improvement with augmentation by other DDDS staff, such as the Manager of the DDDS Day and Transition Unit, the DDDS Shared Living Coordinators, the DDDS Community Services Regional Program Directors, and DDDS case managers, and based on their subject matter expertise in specified areas. The purpose of the desk review was to ensure that all questions were answered and that narrative responses were provided where indicated. Another purpose of the desk review was for DDDS to use data it had acquired independently to validate provider responses to individual questions. The kinds of independent data used included the results of Quality Service Reviews conducted by the DDDS Office of Quality Improvement, past direct observations by DDDS staff, abuse/neglect/rights violation complaints, and case manager notes. Based on the independently available data, follow-up questions can be asked for particular settings. The independent data also helps to determine which settings to select for a look-behind review if the independent data conflicts with the provider responses to the self-assessment.

These other sources of information could contradict a provider's survey responses. For example, if a consumer living in a specified residence filed a rights complaint because they were not allowed to open their mail and the provider responds to the survey question that addresses that basic right by indicating that all residents have access to their mail, DDDS would follow up with that provider to request evidence of compliance. This setting may also be added to the sample of providers who will be subject to an onsite look-behind review, in addition to the 20% minimum sample that DDDS will review onsite.

DDDS will issue a Report of Findings to each provider based on the desk review of the provider's survey results. This Report will include a preliminary finding that the setting is either compliant or is non-compliant but could become compliant with modification or cannot become compliant. Providers that are determined to be non-compliant must submit either a CAP or must indicate that they cannot come into compliance in which case a plan to transition waiver members to a compliant provider will be developed.

The CAP must be submitted to the State within 60 days of receiving the Report of Findings. The State must approve the provider's proposed remediation strategies. While, in general, the State does not expect providers to take remedial action until the Plan is approved by the State, providers may choose to initiate remediation strategies prior to receiving approval of their CAP. If they do this, however, they run the risk that the proposed remediation strategy may not be accepted by the State. It is anticipated, however, that there may be settings and services where only "minor" remediation may be necessary.

As part of DDDS's review of provider self-assessments, it will look for areas of non compliance that appear to be common

across all providers, since this suggests that a more comprehensive remediation strategy may need to be pursued across all providers.

Onsite Look-Behind Reviews

In addition to the desk reviews, the DDDS Office of Quality Improvement will conduct “look-behind” reviews for a sample of the provider self-assessment survey results to validate the provider self-assessments. DDDS will conduct onsite look-behind reviews between January 31, 2016 and May 31, 2016. The look-behind reviews will either confirm or contradict the results of the desk review.

Look-behind reviews will include onsite visits to inspect the setting itself and to view written materials or other documentation that support the provider’s self-assessment of their status compliance with each requirement they are responsible for meeting under the Rule. DDDS will present a draft process outline to the Advisory Council to DDDS for conducting the look-behind reviews at its meeting in February. The outline will include how the settings will be selected for inclusion in the sample, who will conduct the onsite review, how will the results of the review be recorded, and how will the results be communicated to the provider.

Any assessment results that indicate approved deviations from the requirements under the HCBS Final Rule for specific waiver members must be supported by the individual needs of the waiver member and articulated in the person-centered plan. For the purpose of this review, a Behavior Support Plan developed per DDDS policy is considered to be part of the person-centered plan. Where deviation is recommended, the following standard must be met:

- Identification of a specific condition or individualized need that is directly proportionate to the deviation being recommended;
- Documentation of positive interventions and supports tried prior to the recommended deviation from the requirements, including less intrusive methods of meeting the need that were tried and did not work;
- Ongoing periodic review to measure the effectiveness of the deviation from standard practice;
- Establishment of a timeframe within which the deviation should be discontinued if it is no longer needed or effective;
- An assurance that the interventions and supports will cause no harm to the individual; and
- Informed consent of the individual or legal representative (see 42 CFR §441.301(c)(2)(xiii)(G)).

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Methodology for Selection of the 20% Minimum Sample

The recommendation to the Council will include the following elements regarding the selection of settings for the 20% minimum sample. At least one setting for each provider and service combination will be selected. The minimum 20% sampling criteria will be stratified by service. The selection of the settings to be reviewed for each provider will start with sites that are already scheduled to be reviewed during the period as part of the Quality Service Review survey (a random selection by waiver member) or the annual provider recertification reviews conducted by DDDS for settings that are licensed by the Division of Long Term Care Residents Protection. These are settings that would have otherwise been surveyed during this period anyway. This will enable DDDS to more efficiently use the time of its program review staff. DDDS will also use the results of Quality Service Reviews conducted by the DDDS Office of Quality Improvement, past direct observations by DDDS staff, abuse/neglect/rights violation complaints, and case manager notes to target additional settings for the look-behind review where independently obtained information conflicts with provider responses to one or more self-assessment questions. DDDS will also perform an onsite look-behind review for settings that indicate “substantial” non-compliance, as determined by DDDS, based on the results of the DDDS preliminary review of the provider self-assessment.

DDDS believes that the minimum sample size of 20%, plus any additional targeted settings as described above, will result in appropriate representation of the DDDS HCBS provider network.

To the extent that it is available within the timeframe within which the look-behind reviews will be conducted, information obtained from the analysis of the consumer surveys will also be used to target settings for the look-behind review. This is likely to result in sampling that will be greater than the 20% minimum sample size by service type.

In conducting the look-behind review, the DDDS reviewers will use the new survey tool that is being officially implemented for reviews that take place on or after July 1, 2016. That new review tool includes all of the requirements under the HCBS Rule. That means that within one year of July 1, all waiver sites, including those that were not selected for the look-behind review, will have had an onsite review against the HCBS requirements.

DDDS intends to assign the same member of the DDDS Office of Quality Improvement to conduct the look-behind reviews

for all sites operated by the same provider selected for review. Because providers would be expected to have common policies and procedures, this is likely to result in a streamlined review process across the settings with a consistent approach to the review.

The protocols for selecting the sample and for conducting the reviews were presented to the Advisory Council for DDDS at its February 2016 meeting.

Remediation

In addition to the Report of Findings that will be issued after the desk audits are completed, DDDS will issue a separate Report of Findings to each provider for which an onsite look-behind review was conducted. This Report will include a preliminary finding that the setting is either compliant, is non-compliant but could become compliant with modification or cannot become compliant. Providers with non-compliant settings must submit a CAP within 60 days of receiving the Report indicating that they are not compliant. The CAP must provide sufficient details regarding the following key elements:

- The specific non-compliant issue(s).
- Corrective actions to be taken to ameliorate the non-compliant issue.
- Dates by which the actions will be taken and the person responsible for each action.
- The strategy that will be employed to monitor progress toward coming into compliance.
- Strategy for continuous monitoring to ensure continued compliance.

DDDS must respond to or approve the CAP within 60 days of receiving it. In its letter of approval for each CAP, the State will indicate the frequency of reporting that must be done by the providers to the DDDS Office of Quality Improvement until the remediation is complete. It is anticipated that remediation for some non-compliant areas may take longer to address than others. DDDS will assign an OQI staff member to monitor the provider's implementation of the CAP. Quarterly onsite visits will be conducted by the OQI for any settings governed by a CAP to validate the progress described in the reports.

While, in general, the State does not expect providers to take remedial action until the Plan is approved by the State, providers may choose to initiate remediation strategies prior to receiving approval from the State of their CAP, but they run the risk that the proposed remediation strategy may not be accepted by the State. It is anticipated, however, that only "minor" remediation may be necessary for some settings.

To the extent that DDDS determines that systemic remediation across all providers is necessary and can be achieved through enhanced training of direct support professionals or others, statewide trainings will be coordinated or arranged by the DDDS Office of Professional Development. Additional trainings may need to be added to the DDDS required training curriculum for waiver providers by service type or type of direct support professional.

The State will ensure that throughout the remediation phase, measures will be put in place to continuously monitor participant health and welfare and the quality of care. State staff and stakeholders will be engaged in this activity. A single remediation strategy may be recommended to address multiple areas of non compliance if appropriate. The CAP must be approved by the State.

To the extent that remediation strategies have financial implications for the providers and for the State, budget strategies may need to be developed.

In the event that a provider is initially determined not to meet all appropriate HCBS requirements, participants will have the choice of continuing to receive services from the provider while the provider implements corrective action to bring the setting into compliance. Relocation processes will be tailored to each individual with full participation of the individual and his/her family/caregiver. DDDS will work with the individual and his/her family/caregiver, provider (existing and new), etc. to develop a smooth transition process that will ensure continuity of care and protect the health and welfare of the individual throughout the process. The individual's person-centered plan will be updated accordingly.

The timelines for completion of strategy will be specified in the CAP. CMS has required that states have remediation activities in place prior to the March 17, 2019 deadline to ensure that remediation activities are appropriate and successful. Therefore, all CAPs must be completed on or before July 31, 2018; this is a check point. DDDS believes this timeframe is sufficient to allow providers to address identified issues. As appropriate, DDDS will provide education and training on implementing remediation activities.

Providers will have an opportunity to appeal any findings, observations, or other areas of noncompliance with HCBS Final Rule. Provider requests must be submitted in writing on company letter head to the assigned DDDS Quality Improvement Facilitator within 15 days of receiving the Report of Findings and note the following:

- The specific level or area of non-compliance in question
- Rationale why the provider believes the finding is inaccurate

- Evidence to justify the appeal request

Within 10 days of receiving the appeal the assigned Quality Improvement Facilitator will communicate the recommended course of action to the provider. If unsatisfied with the assigned Quality Improvement Facilitator's decision, the provider may appeal the decision to the DDDS Informal Dispute Team, whose members include the Director of Quality Improvement, the DDDS Waiver Manager, and a Regional Director of Quality Improvement, by filing an appeal. This appeal must include all information originally filed in the request, along with a copy of the assigned DDDS Quality Improvement Facilitator's decision and a statement of issues, facts, documentation and authority identifying why the decision should be reversed.

The Informal Dispute Team will issue a recommendation within 60 days of receiving all required or requested information to the DDDS Division Director. The DDDS Division Director shall identify the specific issues, rule on each issue, state the facts supporting each ruling, and cite any pertinent statutory or regulatory authority.

If the Authorized Provider is unsatisfied with the decision, they may request an administrative hearing that shall be consistent with the Administrative Procedures Act, 29, Del.C.10101.

Homes on the Grounds of a Public Institution

Several years ago, before the HCBS Final Rule was promulgated, DDDS made a policy decision to get out of the business of providing direct residential services in competition with private providers. DDDS determined that its role should be as an oversight agency. Over the past several years, DDDS has reduced the census in state-operated homes and day habilitation settings by a combination of closing new referrals, natural attrition, and planned moves. Consumers have already been assisted by the DDDS case manager in selecting other providers/locations through a thoughtful, deliberate process. No one was rushed, and in all cases the needs and preferences of the waiver members and their families were solicited and honored. Many of the new residential sites they selected were closer to their guardians, families, and friends. The families were very pleased with these moves. DDDS described this process of natural attrition in Appendix D, sections 1 and 2 of its most recent waiver renewal that was effective July 1, 2014.

As of January 2015, two women remain in a waiver group home on the grounds of the Stockley Center, the State's only public ICF-IID facility. It is DDDS' intention to close this waiver residence. For this reason, the State does not intend to request heightened scrutiny. The women have intensive medical needs that require a specialized residence. A home is in the process of being built for these participants using the Universal design architecture (i.e. wider doorways, bigger bedrooms to accommodate medical equipment, etc.). The members have agreed to this setting. The new setting is under development on new property location that is compliant with HCB settings requirements (i.e. the property is not isolating in nature and allows for community integration). We are expecting a move-in date before the end of 2016. The new setting will be licensed by DLTCRP prior to being occupied and the provider chosen by the two waiver members will be surveyed prior to relocating the members to ensure compliance with all applicable HCB settings requirements.

Delaware Waiver Enrollees Residing in Other States

Several DDDS waiver members are supported in residences in other states that were determined to best meet their specialized needs. Because those residences are governed under the licensing body of the state in which they are located, if that state has made a determination regarding compliance with the HCBS Final Rule, DDDS will accept the decision of that state, under the assumption that that state's process will have to meet CMS scrutiny. DDDS has begun the process of communicating with those states for this purpose.

Beneficiary Relocation

For any beneficiaries who will require relocation, the State will ensure that the affected beneficiaries will have all the information and support they need to make informed choices about alternate settings. The State will also ensure that all the services and supports necessary will be in place at the time of relocation.

When transition to a new setting is required, DDDS will use the process described in Appendix D of its approved HCBS waiver application to assist waiver members in selecting waiver services and settings that will meet their needs. DDDS case managers will assist consumers in selecting other providers/locations through a thoughtful, deliberate process. Consideration will be given to elements of the home that may be important to the waiver member, such as proximity to guardians, families, friends, and community resources, availability of public transportation, and type of residence. Consideration will be given to support features that are necessary to ensure that the waiver member's needs will be met. As with any provider network, providers tend to develop specialty areas. Waiver members will be guided toward selecting providers who can best meet their needs, whatever they may be.

As noted in response to public comments in the September 17, 2015 update to the Plan, DHSS has no plans to remove any of the current services from the system. We are committed to supporting the needs and preferences of individuals within the requirements of the HCBS final regulations.

Ongoing Monitoring

Monitoring of compliance with the HCBS Final Rule will occur long before the March 17, 2019, federal implementation date. The DDDS Office of Quality Improvement will be tasked with monitoring progress on CAPs and will also begin routine monitoring of compliance with the requirements of the HCBS Final Rule, effective July 1, 2016, using the new survey tool it has created. DDDS anticipates developing several strategies to monitor DDDS waiver provider settings for compliance with the HCBS Final Rule.

One important strategy will be to incorporate some of the HCBS Final Rule requirements in current licensing processes. Neighborhood group homes for people with intellectual disabilities, intensive behavior support and educational residence, and rest care homes in which residential habilitation is provided are the only three waiver settings that are required to be licensed by the Division of Long Term Care Residents Protection (DLTCRP). DLTCRP performs annual inspections of all licensed sites and enforces environmental home standards. These standards largely involve attributes of the physical plan in which the service is delivered, as opposed to addressing the experience of the individuals who are receiving the services. In addition to licensure regulations, which only cover some of the waiver service categories, DDDS has been working on a revised set of standards for waiver providers that incorporate the requirements from the HCBS Final Rule and also incorporate measures for member satisfaction. The new standards will be implemented on July 1, 2018. The DDDS standards will be a companion to the DLTCRP licensure requirements that are codified in regulation. DDDS and DLTCRP are in the process of developing a memorandum of understanding (MOU) that will clearly define the roles of each Division in monitoring these two types of waiver residences.

The DDDS OQI is responsible for monitoring compliance with the DDDS standards via two structured processes: a Quality Service Review (QSR) which is performed for a sample of waiver members and an annual site visit for all waiver providers providing residential or day services.

QSRs are performed for all waiver settings. As part of the QSR, each year DDDS selects a random sample of waiver members at the 95% confidence interval for which the provider(s) will be reviewed against the DDDS standards. The review also assesses the compliance of the DDDS case managers against requirements, as described in the approved waiver. The review is a 360 degree approach that includes interviews of the member, family members, guardian (where applicable), and staff. The interviewer asks probing questions to measure consumer satisfaction and provider compliance and addresses all aspects of the member's life, including such elements as choice of service and setting, the person-centered plan, service delivery, and community integration. This process includes a review of the member's electronic case record and the provider's policies and procedures. As part of the QSR, OQI staff performs an onsite visit to assess compliance with DDDS standards.

Annual site visits are also conducted for all providers of day and residential services. For Shared Living providers, the annual site visit is conducted by a DDDS Shared Living Coordinator assigned to each home. These visits primarily review provider systemic records and do not usually include the review of individual member records. Because not all DDDS providers are required to be licensed, the DDDS standards for the non-licensed providers include requirements related to the safety and appropriateness of the setting similar to the standards that are assessed and monitored by the state licensing agency.

If any deficiencies against the standards are discovered by either the QSR or the annual site visit, the party in question will have 10 days to complete a CAP. These plans must include the responsible party (who will correct this), completion dates, and a plan to monitor the citation to prevent this in the future. OQI staff will verify that the CAP is being implemented within 90 days using onsite visits, record monitoring, etc. Providers that do not implement the CAP or where compliance does not improve can be put on a 90-day probation period and risk losing their status as an Authorized Provider.

In addition to the reviews performed by the DDDS Office of Quality Improvement, the DDDS case managers are also charged with performing monthly monitoring of the person-centered plan. Once each quarter, this monitoring must be conducted face to face with the waiver member. This presents another opportunity for the Division to monitor ongoing provider compliance with the requirements of the Rule.

Public Comments

Comments from DDDS Focus Group Meetings on the DDDS Waiver Portion of the Statewide Transition Plan
DDDS invited key stakeholders to provide input and comment on the DDDS activities outlined in the Plan at two focus group meetings held on January 21, 2015 and January 28, 2015. The meetings were held as part of the required process of public notice in order to allow Delaware to develop a comprehensive Plan. The organizations invited to participate in the meetings include:

- Developmental Disabilities (DD) Council.
- Delaware State Council for Persons with Disabilities (SCPD).
- State Ombudsman.

- Governor's Advisory Council for Exceptional Citizens (GACEC).
- Advisory Council to DDDS.
- Arc of DE.
- The Delaware Association of Rehabilitation Facilities (DELARF).
- People First (self-advocates).
- Disabilities Law Program.
- Delaware Family Voices.
- Waiver Providers.
- Families of individuals receiving DDDS waiver services & other DDDS services.

Those organizations and the public at large will also have the opportunity to provide comments in writing on the DDDS activities and the broader Plan as part of the public comment period.

The following input was received at the focus group meeting convened by DDDS on January 21, 2015.

Public Comments DDDS Response

A commenter indicated that DDDS should ensure that the Downs Syndrome Assn and Autism Speaks were included in the public input process. DDDS indicated that it would ensure that these organizations were included on the DDDS listserv that would be used to notify stakeholders when and where the draft Plan would be published for public comment.

A commenter recommended including families of individuals with an intellectual disability who were not enrolled in the DDDS waiver in the public comment process. Advisory Council to DDDS is made up of family members of both waiver and non-waiver participants, so they represent both groups. The Plan will be posted to the DMMA and DDDS websites and in the Delaware Register of Regulations. The public will be able to comment via multiple avenues.

A commenter recommended that the public comments received once the draft Plan is posted be summarized to avoid repetition but that the number of comments expressing the same notion be noted. This suggestion was passed on to DMMA since they will be receiving the written public feedback.

A commenter recommended that the public forums be transcribed as a record of the meeting. DDDS arranged for the recordings of the two focus group meetings to be transcribed.

A commenter recommended that the state use social media and other commonly used communication venues such as Facebook, Twitter, WDEL and the Delaware Register of Regulations to inform the public where the draft Plan can be found and how to comment. This recommendation was passed on to DMMA.

A commenter recommended that the Plan be translated into Spanish. This recommendation was passed on to DMMA.

Several commenters recommended the creation of a Steering Committee to assist with public input, review Plan work products and generally oversee the development and implementation of the assessment phase of the Plan. The chairperson of the Advisory Council to DDDS volunteered for the Advisory Council to DDDS to take on this role. This was unanimously supported by the stakeholders present. DDDS agreed that the Advisory Council to DDDS would be a logical group to function as a Steering Committee for the DDDS portion of the Plan.

Several providers recommended that the providers be allowed to perform a self-assessment of their policies and procedures and also their settings under the Rule. DDDS has incorporated this recommendation into its portion of the Plan.

A commenter suggested that the Advisory Council to DDDS create one or more sub-work groups to develop the provider self-assessment instruments and that the working group include representatives from provider agencies as well as families. DDDS has incorporated this recommendation into its portion of the Plan.

A commenter suggested that the sub-work group leverage survey instruments that may have already been developed by other states. DDDS has incorporated this recommendation into its portion of the Plan.

A commenter suggested that the provider self-assessment instrument for policies and procedures include a citation and excerpt from a publication that demonstrates compliance with each requirement. DDDS has incorporated this recommendation into its portion of the Plan.

A commenter suggested that a look-behind review be conducted by the state of a sample of providers who complete the self-assessment instruments for their policies and settings. DDDS has incorporated this recommendation into its portion of the

Plan.

A commenter suggested that the sample of settings to be reviewed as part of the look-behind process be a combination of targeted as well as random reviews. DDDS has indicated in the Plan that it will use a 20% sample.

A commenter suggested that Debbie Gottschalk from the Secretary's Office be asked to review Delaware's Landlord/Tenant Code vis-à-vis the Community Rule since she is a lawyer and has extensive experience in this area. DDDS has incorporated this recommendation into its portion of the Plan.

A commenter suggested including the Arc of Delaware's property management staff in a review of HUD home rules vis-à-vis the Community Rule. DDDS has incorporated this recommendation into its portion of the Plan.

Several commenters indicated that they believed that a likely outcome of the assessment of the settings might be that additional resources will be required in order to come into compliance with the Community Rule. DDDS has added an action item to its portion of the Plan indicating that resource needs, including a review of staffing ratios necessary to maximize opportunities for community inclusion, will be explored as part of the process of remediation for settings that do not comply with the Rule.

The following input was received at the focus group meeting convened by DDDS on January 28, 2015.

Public Comments DDDS Response

A commenter suggested that the list of state publications to be reviewed as part of the review of policies, procedures, etc. be qualified with a statement like "including but not limited to" in the event that there are other documents that need to be reviewed in addition to the list presented. DDDS has incorporated this recommendation into its portion of the Plan.

A commenter recommended that the Division create a "parking lot" for issues that might come up in the development and implementation of the Plan that are outside the scope of the Plan. DDDS agreed to do this.

A commenter recommended that the Division look for inconsistencies between responses to the NCI survey and the provider self-assessments of settings. DDDS is exploring whether we can get NCI data at the provider and setting level.

A provider recommended that providers should be represented on the sub-work group of the Advisory Council to DDDS that is going to develop the provider self-assessment instruments. The Plan does not specify the membership of the sub-work groups other than to say that they will be made up of "stakeholders", but DDDS did not have any objection to including a provider representative.

Several commenters recommended that DDDS give the providers a list of the policies and procedures that they would be required to submit to document compliance with the Rule. DDDS did not agree with that approach and indicated that neither it nor the sub-work group of the Advisory Council to DDDS would dictate to providers a set of policies and procedures that would be provided to demonstrate compliance with the Rule. It is incumbent upon each provider, as it completes the self-assessment instrument, to indicate what documentation enabled it to make a finding of compliance or non-compliance with each individual requirement under the Rule.

Comments on Statewide Transition Plan

The Plan was made available for review during three public comment periods – the first, from February 6, 2015 through March 9, 2015, the second, from July 27, 2015 through August 29, 2015, and the third, from February 1, 2016 to March 22, 2016. The purpose of the second public comment period was to receive feedback on updates to the Plan since the initial March 2015 publication. The purpose of the third public comment period was to receive feedback on updates to the Plan since the September 2015 publication.

During the first public comment period, comments were received from organizations and individual stakeholders including providers, parents, family members and friends of HCBS participants in Delaware. Nearly one hundred and thirty (130) comments were received from individuals. The following organizations submitted comments on the Plan:

- Disability Law Program at the Delaware Community Legal Aid Society, Inc. (DECLASI)
- Delaware Association of Rehabilitation Facilities (DelARF)
- Governor's Advisory Council for Exceptional Citizens (GACEC)
- Chimes Delaware
- State Council for Persons with Disabilities (SCPD)
- Delaware Developmental Disabilities Council
- National Association of Councils on Developmental Disabilities (NACDD)

- Easter Seals
- University of Delaware

In addition, DHSS would like to thank the Centers for Disabilities Studies at the University of Delaware and Autism Delaware for assisting the State in collecting public comment by organizing a public survey. Survey responses were received and are reflected in the summary below.

During the August, 2015 public comment period, DHSS again received comments from organizations and individuals. We received nineteen (19) individual comments. The following organizations submitted comments on the Plan:

- Delaware Association of Rehabilitation Facilities (DelARF)
- Chimes Delaware
- State Council for Persons with Disabilities (SCPD)
- Delaware Developmental Disabilities Council
- Families Speaking Up
- CERTS, Inc.
- Centers for Disabilities Studies

The charts in Attachments 1 and 2 provide a summary of the comments received and State responses, where applicable, to issues identified in both public comment periods. The charts also note the changes that were made to the Plan in response to feedback.

During the February, 2016 public comment period, DHSS again received comments from organizations and individuals. We received 34 individual comments. The following organizations submitted comments on the Plan:

- Chimes Delaware
- State Council for Persons with Disabilities (SCPD)
- Delaware Developmental Disabilities Council
- Families Speaking Up
- CERTS, Inc.
- Centers for Disabilities Studies
- Community Legal Aid Society, Inc. Disabilities Law Program
- Elwyn Delaware
- Kent-Sussex Industries (KSI)
- Easter Seals Delaware & Maryland's Eastern Shore
- Endless Possibilities in the Community (EPIC)
- Arc of Delaware
- Governor's Advisory Council for Exceptional Citizens (GACEC)
- National Health Law Program
- Autism Delaware

The chart in Attachment 9 provides a summary of the comments received and DHSS responses, where applicable, to issues identified in the February 2016 public comment period. The chart also notes the changes that were made to the Plan in response to feedback.

Delaware Statewide Transition Plan for Compliance with Home and Community-Based (HCB) Setting Rule: Amendment 1 after initial approval by CMS July 14, 2016

Site Specific Assessment Activities and Results

Introduction:

The Delaware Statewide Transition Plan for Compliance with Home and Community-Based Setting Rule (the Plan) was last updated and submitted to the Centers for Medicare & Medicaid (CMS) March 30, 2016. The Plan received initial CMS approval July 14, 2016. From this point forward, the Plan will be amended to provide updates and the current status of DHSS transition plan activities. This is the first amendment, which also addresses CMS comments received July 14, 2016.

Amendment 1 is a supplement to and builds on the Plan and demonstrates the evolution of DHSS activities to demonstrate compliance with all applicable federal requirements. The Plan is a living document that will continue to be updated as activities are completed and issues are identified.

Provider Self-Assessments, Participant Survey and Desk Review

As described in the Plan (pages 33-37), DDDS mandated the completion of comprehensive site-specific provider self-assessments of all HCB settings where participants receive HCBS under the DDDS HCBS waiver. The initial phase of this process consisted of the provider-self assessments and desk reviews conducted by DDDS staff of various documents providing a status report and onsite reviews. The provider self-assessment tool was mandatory for all providers of HCBS

under the DDDS waiver and all settings. In addition to addressing all federal HCB setting requirements, the provider self-assessment required providers to indicate if the setting was on or immediately adjacent to an institution. Additional details regarding the provider self-assessment can be found in the Plan (pages 33-35).

The following table shows the complete results of the site-specific provider self-assessment for all DDDS HCBS provider settings.

Setting Type Compliant Compliant w/
Modification Removed from Program Heightened
Scrutiny

Day Habilitation 6 28 1 0

Prevocational Service 5 3 0 0

Residential Habilitation* 0 429 1 0

Supported Employment 8 1 0 0

Total Settings (482) 19 461 2 0

*Neighborhood Group Home, Community Living Arrangement, Shared Living

A total of 136 providers (including two out of state entities) completed the assessment for 482 total settings, including 94 shared living settings. The first two provider self-assessments for Day Services and Residential agency providers were launched September 4, 2015 and closed November 13, 2015. This resulted in a total of 388 provider site self-assessments. The third provider self-assessment for Shared Living Providers was launched November 11, 2015 and closed December 7, 2015. This resulted in a total of 94 self-assessments. In total, DDDS received 482 unique submissions across all services and settings, yielding an overall provider self-assessment response rate of 100%.

DDDS also implemented a participant survey for each individual receiving HCBS. DDDS indicated in the February 2016 update to the Plan (page 32) that it was not able to use the NCI data, as initially planned, as an additional data input to validate the provider self-assessments because the NCI data could not be tied to specific providers or settings. As a result, DDDS decided to develop its own participant survey, but it was not able to be launched in time to use the survey results to help target the settings selected for the onsite look-behind reviews. Instead, the surveys were used as an additional source of information to validate the provider self-assessment and onsite reviews. This altered use of the participant survey was also described in the February 2016 update to the Plan (pages 32-33).

The participant survey was launched on February 20, 2016 and was distributed to DDDS case managers and participant guardians to help encourage participant engagement with the survey. A separate survey instrument was created for recipients of residential and day services, so some members received both surveys. To protect the confidentiality of participants, DDDS collects minimal identifying information in order to connect a member to a specific setting; participants are not publicly identified or shared with providers. DDDS conducted three regional trainings for case managers between February 2 and February 4, 2016 on how to assist the member to complete the survey, how to avoid influencing participant responses and submission procedures for completed surveys. Case managers and guardians have begun supporting participants in completing the survey on paper, and then mailing the survey to DDDS. Because the waiver members and their families had recently completed the NCI survey and to avoid “over surveying” the waiver population, DDDS decided that, for members who did not have a guardian, the survey would be completed during their next annual person-centered plan review date. This means that the surveys will not be conducted for all waiver members until February 2017.

To the extent that it was available during the time the desk audits and onsite reviews were being completed, the participant survey data was used as an additional input in the validation process. At the time of this amendment, DDDS has distributed 2,074 participant surveys and received 813 completed submissions, yielding a current response rate of 39% for the participant survey. DDDS is in the process of collecting at a minimum, at least one participant survey for each HCB setting and will keep the survey open until February 20, 2017. Assuming DDDS will receive a final participant response rate similar to DMMA (85%), DDDS hopes to receive, on average, three participant surveys for each setting.

DDDS conducted desk reviews of all provider settings, between November 2015 and January 2016, as an additional validation measure. The purpose of the desk review was threefold: to ensure that each survey question was answered, to ensure that additional comments were provided where required and to validate the responses, to the extent possible, with information DDDS already had on hand. DDDS used other available data sources such as: past provider evaluations, annual Quality Service Reviews (QSR), current/past incident reports and case manager notes to validate the results of all provider self-assessments. Following submission of the March 30, 2016 iteration of the Plan, CMS requested clarification on the difference between “setting presumed not to be compliant” and “settings likely to be compliant”. The language CMS questioned appeared in the original March 2015 Delaware submission of the Plan. In subsequent revisions, new “update” sections were added to the Plan to indicate both changes to the original submission and to update progress toward meeting plan milestones, but the original language was largely unchanged. In the interim, when the data became available from the provider self-assessments, it was organized into the categories enumerated on page 4 of the CMS June 2016 feedback to

Delaware, instead of the categories listed in the original submission of the Plan (page 16).

The desk review revealed that 19 settings were likely compliant with federal HCB settings requirements, while 461 provider settings were presumed to be non-compliant. Of the non-compliant settings in which residential habilitation is delivered, 293 of them, including Shared Living, only need a residency agreement in place to be in compliance. Two provider settings (including one-of-out state setting) were found to be institutional in nature, one because of its location on the grounds of a public institution and the other because of the aversive practices used by the provider that they were not willing to stop using. Both settings are in the process of being removed from the DDDS waiver program. DDDS expects to complete the beneficiary relocation process for the setting on the grounds of a public institution by March 30, 2017. DDDS is in the process of transitioning the other individuals out of setting.

As noted in the systemic assessment (Attachment 6 of the Plan), DDDS decided to create a work group that will design a model residency agreement template that can be used for each of the residential setting types under the approved waiver. New model agreements will be in place for all impacted HCB provider settings no later than December 2017.

Following completion of the desk reviews, DDDS issued a "Notice of Findings" to each provider setting noting any areas of non-compliance with federal HCB settings requirements. For any findings of non-compliance, provider settings were required to submit a CAP by no later than April 1, 2016. Provider settings were also given the opportunity to dispute any of the non-compliance findings and submit a request for reconsideration within 10 days from the date of the notice. No provider settings appealed the results of the desk review and all agencies submitted CAPs within the required timeframe.

Validation Activities: Onsite Review of Minimum 20% Sample of HCBS Provider Settings

The DDDS Office of Quality Improvement (OQI) was responsible for performing validation activities under the oversight of the DDDS Advisory Council which approved the methodology for selecting the sample and the procedures for conducting the reviews at its monthly meeting of February 18, 2016. As noted in the Plan (pages 36-37), DDDS selected a 20% sample of HCBS settings to receive an onsite review. By design, the 20% sample included at least one service and setting per provider agency. Shared Living settings were not included in the onsite all agencies that were noted for non-compliance due to the residency agreement. The pool for the 20% sample included all settings that were issued a CAP during the desk review process. Within the construct indicated above, specific setting locations were selected for review if they were already scheduled for a QSR during the onsite review period. Lastly, specific providers and settings were selected for the review if the provider self-assessment responses indicated non-compliance in three or more responses across the four domains of the survey or if the participant survey indicated differences from the provider responses in multiple areas. In total, 76 settings were selected for an onsite review, which represented all 40 in-state provider agencies. No out of state provider agencies were selected for the onsite review. As indicated in the Plan (pages 40), DDDS will accept the survey results for compliance with the HCBS final rule of the state in which these agencies are physically located.

The onsite review team used a standardized tool developed for the onsite reviews primarily based on the Council on Quality and Leadership (CQL) toolkit and customized for each type of waiver service. The tool included specific evaluation questions related to participant choice of a non-disability setting, setting location relevant to other institutional settings, findings from previous QSRs, the provider self-assessment, participant surveys, incident reports and interviews with staff/participants at the setting. The standardized tool included review areas that were exclusively focused on evaluating the isolation of individuals from the broader community. DDDS also required provider settings to submit policies, procedures and staff orientation materials in advance of the review and were included as part of the onsite review process.

DDDS completed the onsite reviews between February 2016 and May 2016. Provider agency staff that participated in the onsite review included executive directors, program coordinators, and house managers. DDDS also interviewed participants at the setting during the onsite review process when participants were available.

Onsite Review Findings and Remedial Actions

At the conclusion of the site-specific assessment process, DDDS was able to display the results for the provider settings in four categories:

- Category 1: Setting is compliant with federal HCB settings requirements.
- Category 2: Setting will be compliant with modifications.
- Category 3: Setting cannot meet federal HCB setting requirements and will be removed from the program.
- Category 4: Delaware will submit the setting for CMS heightened scrutiny review.

Based solely on the onsite review and not having a residency agreement in place, DDDS found that 56 provider settings selected for review were fully compliant with federal HCB settings requirements. Twenty provider settings were found to be compliant with modification and were required to submit a CAP. No provider settings surveyed as part of the onsite review will require removal from the program and/or the relocation of individuals (Category 3 – Delaware does not plan to submit any DDDS settings for heightened scrutiny review) (Category 4 – described below in Heightened Scrutiny).

The following table shows the complete results of the onsite review of a minimum 20% sample of DDDS HCBS provider settings.

Setting Type Compliant Compliant w/
Modification Removed from Program Heightened
Scrutiny

Day Habilitation 3 4 0 0

Prevocational Service 4 0 0 0

Residential Habilitation* 48 15 0 0

Supported Employment 1 1 0 0

Total Settings (76) 56 20 0 0

*Neighborhood Group Home, Community Living Arrangement, Shared Living

Following the completion of the onsite reviews, DDDS issued a “Notice of Findings” to each provider setting noting areas of non-compliance with federal HCB settings requirements. Provider settings were also given the opportunity to dispute any of the non-compliance findings and submit a request for reconsideration within 10 days from the date of the notice (see the Plan for details regarding the provider dispute resolution process page 39). No provider settings appealed the results of the onsite review.

Provider settings that were deemed “compliant” following the site-specific assessment process were notified by the DDDS of their compliance and required no remedial action. These provider settings will be subject to ongoing monitoring activities moving forward by DDDS, including annual QSRs.

Provider settings that were deemed “non-compliant with modification”, were issued a “Notice of Findings” and were required to submit a CAP describing in detail the remediation activities (for each non-compliant finding) that will be implemented to ensure compliance and the associated timeframe to complete the activities. Provider settings were required to submit their CAP to DDDS within 60 days of receipt of the notice for each non-compliant finding. CAPs for all settings were submitted within the required timeframe and will be closely monitored by DDDS. To sufficiently address the CAP, providers are required to submit evidence to DDDS for each non-compliant finding noted in the “Report of Findings”. The evidence required by the provider varies based on the type of non-compliant finding. For example, a provider noted for not having locks on bedroom doors are required to submit a work order and other evidence to demonstrate compliance. Providers noted for not offering participant choice pertaining to their daily schedule, are required to submit revised policies and procedures and describe steps the provider will take to enable participants more autonomy with their daily schedules. DDDS will validate all evidence submitted for each non-compliant finding through future QSR reviews and annual site evaluations and will provide technical assistance as appropriate. DDDS has also developed a quality manual that details standards by service type to assist providers with implementing the federal HCB setting requirements in their CAP. DDDS requires that all provider settings are in compliance with federal HCB settings requirements by March 17, 2019.

The following table shows the final results of the site-specific provider assessment for all DDDS HCBS provider settings, including changes to the ratings made as a result of the onsite review.

Setting Type Compliant Compliant w/
Modification Removed from Program Heightened
Scrutiny

Day Habilitation 5 29 1 0

Prevocational Service 6 2 0 0

Residential Habilitation* 0 429 1 0

Supported Employment 9 0 0 0

Total Settings 482 20 460 2 0

*Neighborhood Group Home, Community Living Arrangement, Shared Living

In summary, 461 settings were evaluated through the site-specific assessment process. Seventy-six settings were selected to have a look behind completed by the OQI. There are 460 provider settings, including Shared Living that reported “compliant with modification” with the most commonly required modification being a residency agreement. Following the desk review, one additional setting was found to be out of compliance. One setting that had originally been reported as non-compliant was changed to compliant due to provider misinterpretation of the survey questions. The remaining 74 sites remained the same. Two provider settings will be removed from the program. No provider setting will be subject to heightened scrutiny.

Key Themes

The site-specific assessments revealed three common themes of non-compliance across provider settings. The first theme noted for residential and shared living settings related to the lack of participant protections under the Delaware

landlord/tenant code, which have been addressed as part of the systemic assessment process detailed in Attachment 6 of the Plan. A second theme noted for residential and shared living settings, participants were not offered the opportunity to have a key or access device to the home or to appropriately lock bedroom doors. A third theme noted primarily for day programs, participants were unable to adequately choose their schedules to ensure choice of activities and integration with the community. In some cases, provider settings began to address non-compliant findings as a result of the desk review process prior to the onsite reviews and continue to address each finding through the CAP process. To remedy these issues, DDDS is in the process of issuing new service standards to help guide provider settings with compliance. DDDS has assigned OQI staff to support provider settings with developing continuous quality improvement plans in this area and to provide technical assistance as needed.

Beneficiary Relocation

The following is a description of the beneficiary relocation process that will be implemented for all Delaware HCBS programs (i.e., DSHP, DDDS HCBS Waiver, PROMISE and Pathways).

Case managers will work with affected members to ensure continuity of care and transition to a new provider and to find alternative providers, taking into consideration the member's preferences, interests and needs. Case managers will educate members about the relocation process, timeframes and the member's rights. Case managers will support the member in making an informed choice of providers from alternative providers that comply with the federal HCB settings requirements and will provide the necessary assistance to ensure this occurs.

MCOs or the operating agencies will send to the member and/or the member's caregiver or member's representative a formal notification letter no less than 30 calendar days prior to relocation that outlines the specific reason for the relocation and the relocation process and timeline. MCOs or operating agencies will also send the member's current provider a notification letter no less than 45 calendar days prior to relocation indicating the intent to relocate the member. The letter will direct the provider to participate with, as appropriate, DMMA, MCOs, operating agencies and other entities, in activities related to relocating the member.

Case managers will ensure that all services are in place in advance of the member's relocation and will monitor the transition to ensure successful placement and continuity of services. Case managers will conduct an onsite review of the member's new setting prior to the member's relocation and will touch base with members within the first 30 calendar days following transition, 90 calendar days after transition and ongoing as part of regularly scheduled visits to monitor the success of the transition.

Case managers will update the person-centered service plan as appropriate at all stages of the relocation process to note any identified issues and follow-up activities required with the member or the member's providers.

Ongoing Monitoring

Details of DDDS' ongoing monitoring approach can be found in the Plan (pages 41-42). DDDS' ongoing monitoring strategy will differ from the process described above for DSHP in so far as DDDS will have primary responsibility for monitoring functions, as opposed to the MCOs for DSHP. DDDS will update DMMA on the status of identified issues (at the provider setting level), remediation activities and timeframes during the standing HCBS oversight quarterly meeting. This will be a standing agenda item.

The following list describes the key elements of DDDS' ongoing monitoring approach:

- The DDDS Authorized Provider Committee will be responsible for ensuring that all new waiver providers demonstrate compliance with the HCBS final rule during the credentialing process prior to enrollment.
- Hewlett Packard Enterprise, the State's current provider enrollment contractor, will be responsible for requiring evidence that each waiver provided has been credentialed by DDDS, including compliance with HCB settings requirements, as part of the provider enrollment process.
- Ongoing review of provider compliance will occur during the annual provider review conducted by the DDDS OQI. This means that, while the onsite review only included a sample of the DDDS provider settings, by May 2017, all settings will have had an onsite review to assess compliance with the HCBS final rule at annual provider validation, and will also be the responsibility of the State's provider enrollment contractor.
- DDDS OQI will be responsible for monitoring compliance with the DDDS standards, which will include the HCBS requirements no later than July 2018, via two structured processes: a QSR which is performed for a sample of members and an annual site visit for all providers providing residential or day services.
- DDDS will ensure that provider issues are identified timely. DDDS will develop tools for case managers to assess provider compliance issues during touch point meetings.
- When issues are identified, DDDS will require provider CAPs that will be subject to DDDS approval. DDDS will ensure that identified issues are addressed timely through the CAP process.

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.

Delaware 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:

The Delaware Department of Health and Social Services (DHSS) is the state agency with overall responsibility 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 State Agency for the administration of Title XIX as per SSA 1905(a)(5).

Within DHSS, DMMA is designated as the "medical assistance unit" as specified in 42 CFR 431.11. DMMA is directly responsible for either the operation or oversight of all Medicaid funded programs. DDDS is responsible for the administration and operation of the DDDS Waiver.

A memorandum of understanding (MOU) between the two agencies enumerates the responsibilities of each party under the agreement and describes the methods used by DMMA to ensure that DDDS performs its assigned operational and administrative functions in accordance with waiver requirements.

DMMA conducts monitoring of the operation of the DDDS Lifespan Waiver on an ongoing basis. Monitoring includes, but is not limited to the review of DDDS provider audits/oversight reviews; quality assurance program data; policies and procedures; provider recruitment efforts; and maintenance of waiver enrollment against approved limits. DMMA meets with DDDS on at least a quarterly basis to review the operation of the waiver. Monitoring also occurs through three different processes:

- 1) Delaware Health and Social Services (DHSS) Quality Initiative Improvement (QII) Task Force;
- 2) DMMA Surveillance and Utilization Review (SUR) unit;
- 3) DMMA's Office of Medical Management and Delegated Services which has been designated to provide oversight for all HCBS waivers operated by other agencies within DHSS.

QII: DDDS has an internal quality assurance process, administered by the DDDS Office of Quality Improvement (OQI), which provides information on an ongoing basis to DMMA via the Department-wide QII Task Force. The DDDS OQI compiles and analyzes program performance data.

SUR: DMMA maintains and operates a CMS compliant MMIS. MMIS includes a SUR sub-system. On a quarterly basis, the SUR sub-system, produces reports that compare attributes for similar providers on such dimensions as service utilization, prior authorizations, diagnosis, etc. Providers who deviate from the norm are examined further by the SUR team of auditors. A case under review 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 sub-system 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's Office of Medical Management and Delegated Services are responsible for monitoring DDDS's operation of the DDDS Lifespan waiver. DDDS submits quarterly reports to DMMA documenting performance on waiver measures and where necessary, corrective action plans and reports on Medicaid Fair Hearings. DMMA and DDDS meet on a quarterly basis to review the operation of the DDDS waiver.

- 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.*

The following functions are performed by contracted entities:

Provider Relations Agent - DMMA 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 functions below:

- enrolling service providers, including executing the Medicaid provider agreement,
- conducting training for providers regarding claims processing
- processing claims,
- provider payment
- verifying provider licensure/certification on an annual basis

Fiscal Agent - DMMA contracts for claims processing and provider payment

Targeted Case Management - DDDS will contract with one or more vendors to provide targeted case management which will include specified quality oversight functions, as described in Appendix D. The state will competitively procure this service.

Agency With Choice - DDDS will contract with a vendor to manage the self-directed option for the new waiver services: Respite and Personal Care service using the Agency With Choice model.

- ☐ **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

contracted provider relations agent and fiscal agent vendors.

The Division of Developmental Disabilities Services is responsible for assessing the performance of the TCM vendor (s) and the Agency With Choice vendor.

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:
- For the Provider Relations and Fiscal Agent Contracts, DMMA convenes an MMIS Status Group composed of the Chief Administrators, fiscal staff, IT staff and other DMMA managers to review the performance of the contracted fiscal agent, including the provider relations function. This team meets once a month to assess performance measures under the fiscal agent contract and to discuss changes that need to be made to the MMIS or to the fiscal agent procedures. Performance measures include but are not limited to: timely enrollment of new providers, maintenance of provider enrollment criteria and timely response to provider inquiries. Operational policies and procedures are in place to ensure all provider activities are reviewed and approved by DMMA.

For the TCM contract(s), two staff from DDDS are assigned as the liaisons between the TCM vendor and DDDS. They will provide on-going monitoring of TCM vendor performance. Those individuals report to a DDDS Waiver Coordinator, which is a senior level position. The Waiver Coordinator is the contract manager for the TCM contract (s) and is responsible for assuring compliance with contract terms, including requirements for the TCM vendor such as timeliness of contacts, quality of work product, consumer/family complaints, etc. The contract specifies certain performance reporting that must be provided to DDDS on a monthly basis. The Waiver Coordinator receives those reports and can require corrective action when necessary.

For the Agency With Choice Broker, two staff from DDDS that are different from the staff positions referenced above, will monitor performance of the AWC broker contract. Those individuals also report to a DDDS Waiver Coordinator. The Waiver Coordinator is the contract manager for the AWC contract and is responsible for assuring compliance with contract terms, including all performance requirements for the AWC vendor such as timeliness of contacts, quality of work product, consumer/family complaints, etc. The contract specifies certain quarterly performance reporting that must be provided to DDDS. The Waiver Coordinator receives those reports and can require corrective action when necessary.

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 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 checked="" 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 the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. As necessary and applicable, performance measures should focus on:

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

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:

A-2: The percent of waiver enrollees that are within annual waiver limits. (Numerator: The total number of waiver enrollees. Denominator: The maximum number of waiver enrollees for the demonstration year per the approved application.)

Data Source (Select one):

Other

If 'Other' is selected, specify:

Annual enrollment limits from approved waiver application as compared to the # of unique Medicaid IDs queried from the Title XIX Ad Hoc Universe database with a DDDS waiver aid category.

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

Performance Measure:

A-4: Number and Percent of Fair Hearing Reports reviewed by the Medicaid agency
(Numerator: Number and Percent of Fair Hearing Reports reviewed by the Medicaid agency, Denominator: Number and Percent of 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 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 |
| | <input type="checkbox"/> Other Specify: <input type="text"/> |

A-5: Number and Percent of DMMA/DDDS's HCBS waiver quarterly monitoring meetings during which the waiver quality assurance and quality improvement activities are discussed. Numerator: Quarterly DMMA/DDDS meetings during which DDS waiver quality assurance and quality improvement activities are discussed; Denominator: Number of quarterly DMMA/DDDS meetings held.

Data Source (Select one):

Meeting minutes

If 'Other' is selected, specify:

| 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 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 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 type="checkbox"/> Annually |

| |
|--|
| <input type="checkbox"/> Continuously and Ongoing |
| <input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div> |

- 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.

DMMA instituted a quality improvement strategy that includes routine review of DDDS's administration of the DDDS HCBS waiver program each quarter, using the quarterly face to face meetings to identify program strengths and opportunities for improvement. Some of the DDDS processes reviewed by DMMA at the quarterly meetings include feedback from DDDS quarterly meetings that are open to all waiver providers and DDDS monthly meetings with Day Service and employment providers, DDDS complaint and incident logs and fair hearing reports. In addition, DDDS has renewed its participation in the National Core Indicators project as an additional source of data about the satisfaction of waiver participants. The NCI surveys started to be conducted in 2014. 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, Division of Medicare and Medicaid Assistance (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 may 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 waiver policy review: A review of waiver policies by DMMA prior to implementation ensures appropriate application of waiver principles that are consistent with the waiver application and other established Medicaid principles.

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.

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 DDDS 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: <div></div> | <input checked="" type="checkbox"/> Annually |
| | <input type="checkbox"/> Continuously and Ongoing |
| | <input type="checkbox"/> Other Specify: <div></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 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 one or more groups 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 or more waiver target groups, check each of the subgroups in the selected target group(s) 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 |
| <input type="checkbox"/> Aged or Disabled, or Both - General | | | | | |
| | <input type="checkbox"/> | Aged | <div></div> | <div></div> | <input type="checkbox"/> |
| | <input type="checkbox"/> | Disabled (Physical) | <div></div> | <div></div> | |
| | <input type="checkbox"/> | Disabled (Other) | <div></div> | <div></div> | |
| <input type="checkbox"/> Aged or Disabled, or Both - Specific Recognized Subgroups | | | | | |
| | <input type="checkbox"/> | Brain Injury | <div></div> | <div></div> | <input type="checkbox"/> |
| | <input type="checkbox"/> | HIV/AIDS | <div></div> | <div></div> | <input type="checkbox"/> |

| | | | | | |
|--|-------------------------------------|-------------------------------|----------------------|----------------------|-------------------------------------|
| | <input type="checkbox"/> | Medically Fragile | <input type="text"/> | <input type="text"/> | <input type="checkbox"/> |
| | <input type="checkbox"/> | Technology Dependent | <input type="text"/> | <input type="text"/> | <input type="checkbox"/> |
| <input checked="" type="checkbox"/> Intellectual Disability or Developmental Disability, or Both | | | | | |
| | <input checked="" type="checkbox"/> | Autism | 12 | <input type="text"/> | <input checked="" type="checkbox"/> |
| | <input type="checkbox"/> | Developmental Disability | <input type="text"/> | <input type="text"/> | <input type="checkbox"/> |
| | <input checked="" type="checkbox"/> | Intellectual Disability | 12 | <input type="text"/> | <input checked="" type="checkbox"/> |
| <input type="checkbox"/> Mental Illness | | | | | |
| | <input type="checkbox"/> | Mental Illness | <input type="text"/> | <input type="text"/> | |
| | <input type="checkbox"/> | Serious Emotional Disturbance | <input type="text"/> | <input type="text"/> | |

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

In order to be enrolled in the Lifespan waiver, individuals must have been determined to meet the following criteria:

1) Must be determined eligible for DDDS services per the criteria delineated in Title 16, Section 2100 of the Delaware Administrative Code. This eligibility criteria requires a diagnosis of an intellectual developmental disability (including brain injury), autism spectrum disorder or Prader Willi Syndrome assigned in the developmental period and also documented functional limitations.

2) Must meet established priority criteria for selection of entrance into the waiver or meet the criteria for one of the groups for which capacity has been reserved

3) Must meet level of care and financial eligibility for ICF/IID Services (as described in Appendix B-4)

- 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 | 1100 |
| Year 2 | 1150 |
| Year 3 | 1200 |
| Year 4 | 2372 |
| Year 5 | 2506 |

- 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).**

Purpose(s) the State reserves capacity for:

| Purposes |
|--|
| Aged out of Pathways to Employment 1915(i) |
| School graduates |
| Individuals returning to the community after a period of institutionalization |
| Individuals at risk of homelessness or in crisis and requiring out of home placement |

Appendix B: Participant Access and Eligibility

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

Purpose *(provide a title or short description to use for lookup)*:

Aged out of Pathways to Employment 1915(i)

Purpose *(describe)*:

DDDS will reserve capacity to add individuals with IDD who age out of the Pathways to Employment 1915(i) SPA at age 25.

Describe how the amount of reserved capacity was determined:

DDDS maintains statistics of individuals with IDD who are enrolled in the Pathways to Employment 1915(i) SPA that enables it to predict the number of individuals who will turn 25 during the demonstration year but who are expected to continue to need employment supports in order to maintain competitive employment in the community.

The capacity that the State reserves in each waiver year is specified in the following table:

| Waiver Year | Capacity Reserved |
|-------------|-------------------|
| Year 1 | 0 |
| Year 2 | 0 |
| Year 3 | 0 |
| Year 4 | 25 |
| Year 5 | 55 |

Appendix B: Participant Access and Eligibility

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

Purpose (provide a title or short description to use for lookup):

School graduates

Purpose (describe):

DDDS will reserve capacity to add individuals with IDD who have exited or are transitioning from K-12 schools who reside in a non-provider managed setting.

Describe how the amount of reserved capacity was determined:

Delaware DDDS has a close relationship with the Delaware Department of Education's (DOE) special education office. Each year, DDDS meets with representatives from DOE to identify the number of graduates who may qualify for DDDS services based on tracking data of students with IEPs.

The capacity that the State reserves in each waiver year is specified in the following table:

| Waiver Year | Capacity Reserved |
|-------------|-------------------|
| Year 1 | 0 |
| Year 2 | 0 |
| Year 3 | 0 |
| Year 4 | 1122 |
| Year 5 | 84 |

Appendix B: Participant Access and Eligibility

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

Purpose (provide a title or short description to use for lookup):

Individuals returning to the community after a period of institutionalization

Purpose (describe):

DDDS intends to reserve capacity for individuals who have been receiving services in an institution but who desire to return to the community.

Describe how the amount of reserved capacity was determined:

The number of reserved slots was based on historical data.

The capacity that the State reserves in each waiver year is specified in the following table:

| Waiver Year | Capacity Reserved |
|-------------|-------------------|
| Year 1 | 0 |
| Year 2 | 0 |
| Year 3 | 0 |
| Year 4 | 5 |
| Year 5 | 5 |

Appendix B: Participant Access and Eligibility

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

Purpose (provide a title or short description to use for lookup):

Individuals at risk of homelessness or in crisis and requiring out of home placement

Purpose (describe):

DDDS reserves capacity for individuals whose health and safety conditions pose a serious at risk immediate harm or death to the individual or others, who are the victims of abuse or neglect or who have experienced the loss of a caregiver or a change in the caregiver's status that prevents them from meeting the needs of the individual and that puts them at risk of homelessness. The need for residential services must be demonstrated, documented and prioritized using a standardized assessment tool administered by the state.

Describe how the amount of reserved capacity was determined:

The amount of reserved capacity was determined based on DDDS's experience using the standardized risk assessment tool for its comprehensive waiver for over the past 5 years.

The capacity that the State reserves in each waiver year is specified in the following table:

| Waiver Year | Capacity Reserved |
|-------------|-------------------|
| Year 1 | 0 |
| Year 2 | 0 |
| Year 3 | 0 |
| Year 4 | 60 |
| Year 5 | 60 |

Appendix B: Participant Access and Eligibility

B-3: NUMBER OF INDIVIDUALS SERVED (CONT.)

- 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 waiver:

The state will enroll individuals according to the groups for which we have reserved capacity. Individuals will be prioritized by level of risk as determined by DDDS using a standardized risk assessment tool.

If additional waiver capacity exists after all reserved capacity has been utilized for each category, entrance to the waiver will be managed using the risk categories as identified in the standardized risk assessment tool.

Many individuals who have already left school and are living in a non-provider managed residential setting are already receiving services from DDDS. Because this group is currently known to DDDS, they will be the initial priority enrollment group under this amendment.

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.

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 (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)
- ☐ Working individuals with disabilities who buy into Medicaid (TWWIIA 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:

Adults age 19 - 64 who are not pregnant and who are not otherwise mandatorily eligible with income at or below 133% FPL as authorized under section 1902(a)(10)(A)(I)(VIII) of the Act and codified at 42 CFR 435.119.

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:

- ☐ **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)**
- ☐ **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 7)**

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. 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:

Note: For the five-year period beginning January 1, 2014, the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

- ☒ **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 uses *spousal* post-eligibility rules under §1924 of the Act. Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time**

periods before January 1, 2014 or after December 31, 2018.

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018 (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 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

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:

- ☐ **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:*

For waiver enrollees that do not receive a residential habilitation service, the state will provide a maintenance needs allowance that is equal to the individual's total income as determined under the post eligibility process, which includes income that is placed in a Miller Trust. For those waiver participants that meet the criteria to receive residential habilitation services, the state will provide a maintenance needs allowance set at the Adult Foster Care Rate, which is the SSI standard plus the Optional State Supplement amount.

All earned income in the form of wages shall be allowed to be protected.

☐ **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:




Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

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 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

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:

- ☒ Other

Specify:

For waiver enrollees that do not receive a residential habilitation service, the state will provide a maintenance needs allowance that is equal to the individual's total income as determined under the post eligibility process, which includes income that is placed in a Miller Trust. For those waiver participants that meet the criteria to receive residential habilitation services, the state will provide a maintenance needs allowance set at the Adult Foster Care Rate, which is the SSI standard plus the Optional State Supplement amount.

All earned income in the form of wages shall be allowed to be protected.

- 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-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

- e. Regular Post-Eligibility Treatment of Income: §1634 State - 2014 through 2018.**

Answers provided in Appendix B-5-a indicate the selections in B-5-b also apply to B-5-e.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

- f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.**

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 (7 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

- g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.**

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. 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).

Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.

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:

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/IID Level of Care must meet the minimum criteria for a Qualified Intellectual Disability Professional as defined in 42 CFR 483.430.

- 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/IID:

In accordance with Delaware's eligibility regulation, an individual may be eligible if:

- He/she has a disability/disorder attributed to one or more of the following:
 - o Intellectual Developmental Disability, including brain injury; defined as a significant generalized limitation in intellectual functioning as evidenced by IQ scores approximately two standard deviations below the mean or
 - o Autism Spectrum Disorder or
 - o Prader-Willi Syndrome
- AND
- Significant limitations in adaptive behavior functioning, defined as performance that is at least two standard deviations below the mean of either:
 - o Score on a standardized measure of conceptual, social, or practical skills; or
 - o Overall score on a standardized measure of conceptual, social and practical skills;
- AND
- The disability originates before age 22

The individual must also be recommended for an ICF/ID level of care based on the Delaware "Assessment of Level of Care for ICF/IID and HCBS Waiver Services" standardized instrument completed by a Qualified Intellectual Disability Professional (QIDP) that includes the relevant medical and functional information necessary to evaluate an individual's need for an ICF/IID level of care. The QIDP assesses level of function in the following domains: ADLs, safety, household activities, community access, maintaining relationships, health maintenance, communication, psychological and services to prevent institutionalization. The QIDP also utilizes supporting documentation from past educational, psychological, medical, and social evaluations, which can assist in determining eligibility to ensure ICF level of care.

- 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 initial evaluation is conducted by a qualified professional as described in Appendix B.6.c. above using the criteria and instrument described in section d. above.

For evaluations and reevaluations, the case manager gathers information to complete the standardized assessment instrument to initially populate the Level of Care Assessment instrument or to document that the individual's level of care continues to meet the criteria. The case manager uses information from case notes, observations and reports from clinicians/doctors and hospitals to complete the assessment instrument. The case manager recommends whether or not the individual meets an ICF/IID based on the completed assessment. The recommendation made by the case manager is reviewed by qualified intellectual disabilities professional (QIDP). The Level of Care redetermination must be

approved by the QIDP in order for the individual to enroll in the Lifespan waiver. The Delaware Assessment of Level of Care for ICF/IID and HCBS waiver services instrument is used for both the initial evaluation and for reevaluations to document the Level of Care decision.

DDDS must make final approval of all recommendations indicating that the individual meets ICF/IID Level of Care.

- 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:

- 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*):

The case manager (which includes the Support Coordinator or Community Navigator) is responsible for ensuring that a Level of Care reevaluation is performed within twelve months of the previous determination. All Level of Care initial determination and re-evaluation forms are forwarded to the DDDS Health Information Management (HIM) unit for recording and tracking. HIM records the completion date of each initial LOC determination or re-determination in a central database. All LOC determinations will also be recorded in the electronic case record required by DDDS.

HIM uses this database to generate a list to the case manager (either a Support Coordinator or Community Navigator) alerting them to LOC re-determination dates that will be due within the upcoming 90 day period. HIM then tracks the receipt date of each LOC re-evaluation against the due date. Additional reminders are sent to the case manager at 60 and 30 days prior to the due date. This database also enables DDDS to track statistics on a monthly basis regarding the timeliness of LOC reevaluations. Scanned versions of the LOC reevaluations are stored in the electronic case record in addition to the original being retained by the DDDS Health Information Management unit.

- 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 original LOC determination is maintained at the Health Information Management unit (HIM) for as long as the person continues to receive services from DDDS. Redeterminations are maintained by HIM for a minimum of three years.

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

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

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 the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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 percent of participants enrolled during the period who had a level of care completed prior to the initiation of services. (Numerator: The number of participants enrolled during the period with a level of care completed prior to initiation of services. Denominator: Number of waiver participants enrolled during the period.)

Data Source (Select one):

Operating agency performance monitoring

If 'Other' is selected, specify:

The Division's Office of Health Information Management maintains the completed Level of Care assessments.

| 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: <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> | |

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

- 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 the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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.

- 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 the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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 percent of initial LOC determinations completed which utilized the instrument and process described in the approved waiver. Numerator: The number of initial LOC determinations completed which utilized the instrument and process described in the approved waiver. Denominator: The number of initial LOC determinations completed.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

| 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:

B.c.2: The percent of initial LOC determinations in which the criteria were applied correctly. Numerator: The number of initial LOC determinations in which the criteria were applied correctly. Denominator: The number of LOC determinations processed during the review period.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

| 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:

B.c.3 The % of LOC's where the applicant was determined not to meet LOC criteria in which the criteria was applied correctly. Numerator: The number of LOC determinations where the applicant was determined not to meet LOC criteria in which the criteria was applied correctly. Denominator: The total number of LOC determinations where the applicant was determined not to meet LOC criteria.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

| 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 | <input type="checkbox"/> Annually | <input type="checkbox"/> Stratified |

| | | |
|----------------------------------|---|---|
| Specify: <input type="text"/> | | 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"/> |

- 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.

In addition to the internal reviews of 100% of the Level of Care assessment forms, DMMA also reviews a sample of the forms in preparation for the quarterly meetings with DDDS at which any issues with the assessments can be discussed.

Data collected on all waiver performance measures is reported and reviewed via the DDDS Performance Analysis Committee (PAC). The Division has consolidated all performance data, including waiver assurances, into a formalized reporting tool called "DivStat" (named after the "CompStat", "CitiStat" and "StateStat" processes developed by NYPD, the City of Baltimore and the State of Maryland, respectively). This consolidated process began during 2013. In the future, the Division intends to make this data available to the public on its website.

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 DDDS Performance Analysis Committee (PAC) meets monthly to review DivStat data. At those meetings, measures that fall short of the standard are reviewed and corrective action is discussed. Quality Improvement Plans (QIP) are developed as necessary. Progress against QIPs is monitored at the monthly meetings. Performance data is routinely shared with parts of the organization that are responsible for the operational area captured by the measure (for instance, the case managers, fiscal staff, etc.) and assignments are made for implementing corrective actions necessary to improve performance. The PAC then tracks the performance data to see if the corrective action is having the desired effect, as indicated by improved data results.

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 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: <div style="border: 1px solid black; height: 20px; width: 100%;"></div> | <input checked="" type="checkbox"/> Annually |
| | <input checked="" 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 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).

After an individual has been assessed against the entry criteria for waiver enrollment and has been determined to meet the eligibility criteria for the waiver, a case manager informs the individual or his/her legal guardian of the choice between receiving institutional services or the list of HCB services available under the waiver in lieu of institutional services. The choice is documented on a standardized form called an "Agreement to Participate" which is signed by the participant or his or her legal representative. The HIM (Health Information Management) office maintains the original form and a copy is provided to the waiver member or their legal guardian. The signed form is maintained at HIM until the individual no longer receives any services from DDDS or dies.

After an initial interim plan of care has identified the services chosen by the waiver participant, a case manager assures that each enrolled member is offered choice among a set of qualified providers for each waiver service. The list of qualified providers for each service is maintained on the DDDS website. The case manager assists the participant in selecting one or more providers that can meet the individual's needs and any stated preferences they may have for a particular geographic location, etc. The participant's choice is documented in his or her written person centered service plan which replaces the initial interim plan of care.

- 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 standardized "Agreement to Participate" form is maintained at the Health Information Management unit (HIM) of DDDS for as long as the participant continues to receive services from DDDS or until the participant dies.

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):

DDDS ensures all DDDS applicants with limited proficiency in English have full access to DDDS services in his primary language, if needed. DDDS uses a vendor on the DHSS contract for the purchase of interpretative (oral and written) services. The vendor provides language services on a twenty-four hour, seven day a week basis for multiple 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.

In addition to the interpreter contracts maintained by DHSS for use by all DHSS divisions, the Division of Medicaid & Medical Assistance (DMMA) contracts for interpreter services for Spanish, Braille, and American Sign Language translation services for Medicaid enrollees as needed. DMMA also offers TTY service

DDDS also makes an effort to hire case managers who are bi-lingual and who sign ASL.

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 | |
|-------------------|-----------------------------------|--|
| Statutory Service | Day Habilitation | |
| Statutory Service | Personal Care | |
| Statutory Service | Prevocational Services | |
| Statutory Service | Residential Habilitation | |
| Statutory Service | Respite | |
| Statutory Service | Supported Employment - Individual | |
| | | |

| | |
|-----------------------------|--|
| Statutory Service | Supported Employment - Small Group |
| Extended State Plan Service | Assistive Technology for Individuals not otherwise covered by Medicaid |
| Other Service | Clinical Consultation: Behavioral |
| Other Service | Clinical Consultation: Nursing |
| Other Service | Community Transition |
| Other Service | Home or Vehible Accessibility Adaptations |
| Other Service | Specialized Medical Equipment and Supplies not otherwise covered by Medicaid |
| Other Service | Supported Living |

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):

HCBS Taxonomy:

Category 1:

Sub-Category 1:

04 Day Services 04020 day habilitation ▼

Category 2:

Sub-Category 2:

04 Day Services 04070 community integration ▼

Category 3:

Sub-Category 3:

▼

Category 4:

Sub-Category 4:

▼

Service Definition (Scope):

Day Habilitation service is the provision of regularly scheduled activities in a non-residential setting, separate from the participant's private residence or other residential living arrangement, such as assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills that enhance social development and develop skills in performing activities of daily living and community living, physical development, basic communication, self-care skills, domestic skills, community skills and community-inclusion activities. Activities and environments are designed to foster the acquisition of skills, building positive social behavior and interpersonal competence, greater independence and personal choice. Day Habilitation may include self-advocacy training to assist the participant in expressing personal preferences, self-representation, and individual rights and to make increasingly responsible choices. Services are furnished consistent with the participant's person-centered plan and are integrated into the community as often as possible. Meals are not provided as part of this service.

Day habilitation services focus on enabling the participant to attain or maintain his or her maximum potential and shall be coordinated with any needed therapies in the individual's person-centered services and supports plan, such as physical, occupational, or speech therapy.

Day Habilitation services are the provision of regularly scheduled activities that may be furnished at a fixed-site facility, in the general community, or any combination of service locations, provided that the activities take place in a non-residential setting that is separate from the participant's private residence or other residential living arrangement.

The provider must actively promote and be capable of providing opportunities for full access to participate in the greater community for those waiver participants that express a desire for such access and for whom it would not be contrary to their health and safety needs as articulated in their person centered plan. The provider must demonstrate that they support individuals to exercise their option to achieve their desired level of participation in the community. To the greatest extent possible, individuals should be exposed to a broad array of community experiences so that they can make informed choices about what they like and what they don't like.

Transportation to and from the program site is a component part of day habilitation and the cost of this transportation is included in the rate paid to providers of day habilitation services.

Day Habilitation - Community Participation

Community Participation services are the provision of scheduled activities outside of an individual's home that support acquisition, retention, or improvement in self-care, sensory-motor development, socialization, daily living skills, communication, community living, and social skills. Community Participation services include supervision, monitoring, training, education, demonstration, or support to assist with the acquisition and retention of skills and training and education in self-determination. Community Participation may include self-advocacy training to assist the participant in expressing personal preferences, self-representation, and individual rights and to make increasingly responsible choices. Each individual receiving Community Participation services works toward acquiring the skills to become an active member of the community. Services are furnished consistent with the participant's person-centered plan (PCP). Because Community Participation is very individualized and is heavily focused on community exploration, it can only be provided in staffing ratios of one staff to each participant or one staff to two participants.

Community Participation services focus on the continuation of the skills already learned in order to build natural supports in integrated settings. The individual is ready to interact and participate in community activities and needs the supports of staff to facilitate the relationship building between the individual and other non disabled participants within the community activities. Ideally, the paid staff will fade or decrease their support as the natural supports become sufficient to support the individual in the integrated settings and activities.

Community Participation may be furnished in the general community, or any combination of service locations, provided that the activities take place in a non-residential setting that is separate from the participant's private residence or other residential living arrangement. Individuals may gather at the beginning and end of the day at a "hub" before embarking on their activities of the day but may not spend any more than 1 hour in total at the hub per day. Other than the brief period at the beginning or end of the day, Community Participation cannot be delivered in a provider owned or managed setting.

The provider must actively promote and be capable of providing opportunities for full access to participate in the greater community for those waiver participants that express a desire for such access and for whom it would not be contrary to their health and safety needs as articulated in their person centered plan. The provider must demonstrate that they support individuals to exercise their option to achieve their desired level of participation in the community. To the greatest extent possible, individuals should be exposed to a broad array of community experiences so that they can make informed choices about what they like and what they don't like.

Transportation to and from the planned service location for each day, including a "hub", is a component part of Community Participation and the cost of this transportation is included in the rate paid to providers of community participation services.

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):

Other Standard (specify):

Must adhere to all standards, policies, and guidelines in the State of Delaware DDDS Day Habilitation Standards, 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.

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.

Must be credentialed by the Division of Developmental Disabilities as a qualified provider of Day Habilitation.

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.

All DDDS waiver providers must agree to accept the terms and conditions under the Medicaid provider contract as a condition of enrollment to provide services under the waiver.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Developmental Disabilities Services

Frequency of Verification:

The DDDS Office of Quality Improvement conducts provider compliance reviews on an annual basis 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:

Personal Care ▼

Alternate Service Title (if any):

Personal Care

HCBS Taxonomy:

Category 1:

Sub-Category 1:

08 Home-Based Services 08030 personal care ▼

Category 2:

Sub-Category 2:

08 Home-Based Services 08020 home health aide ▼

Category 3:

Sub-Category 3:

08 Home-Based Services 08010 home-based habilitation ▼

Category 4:

Sub-Category 4:

▼

Service Definition (Scope):

A range of assistance to enable waiver participants to accomplish tasks that they would normally do for themselves if they did not have a disability. This assistance may take the form of hands-on assistance (actually performing a task for the person) or cuing to prompt the participant to perform a task. Personal care services may be provided on an episodic or on a continuing basis. Health-related services that are provided may include skilled or nursing care and medication administration to the extent permitted by State law.

Personal care includes the provision of a range of services for participants who require assistance to meet their daily living needs, ensure adequate functioning in their home and permit safe access to the community. Personal care can be provided in the participant's residence (family home, own home or apartment), with or without family caregivers present, or in community settings and may not supplant other Waiver or state plan covered services (i.e., Day Habilitation, Prevocational Service, Supported Employment or Supported Living).

Personal care can include assistance, support and/or training in activities such as meal preparation; laundry;

routine household care and maintenance; activities of daily living such as bathing, eating, dressing, personal hygiene; shopping and money management; reminding/observing/monitoring of medications; supervision; socialization and relationship building; transportation; leisure choice and participation in regular community activities; attendance at medical appointments.

Personal care does not include the cost associated with room and board.

Personal care cannot be provided to individuals who are receiving residential habilitation in a provider-managed setting.

Personal Care includes a self-directed option that will be managed by a broker under the Agency With Choice model. The AWC broker will be funded as a Medicaid administrative activity.

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

The total expense for Personal Care and Respite services, combined, is limited to \$2,700 per waiver participant per waiver demonstration year. Personal care cannot be provided to waiver participants who receive residential habilitation in a provider-managed setting. If a waiver participant enrolled for less than an entire demonstration year, the annual limit will be prorated by the number of months remaining in the demonstration year.

The limit was established based on cost and utilization data DDDS has maintained for individuals receiving state funded family support services.

The limit will be periodically assessed and may be increased as budgetary resources allow.

Exceptions to the funding limit may be granted by DDDS authorized personnel with documented justification related to the health and safety needs of the participant.

To the extent that any listed services are covered under the state plan, the services under the waiver would be limited to additional services not otherwise covered under the state plan, but consistent with waiver objectives of avoiding institutionalization.

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 | Home Health Agency |
| Agency | Agency with Choice |
| Agency | Personal Attendant Services Agency (PASA) |

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Care

Provider Category:

Agency ▼

Provider Type:

Home Health Agency

Provider Qualifications

License (specify):

State Home Health Agency License from the Delaware Office of Health Facilities Licensing and Certification per Delaware Code Title 16, section 4406 Home Health Agencies (Licensure).

Certificate (specify):

Other Standard (specify):

Must be enrolled with Delaware Medicaid as a Home Health Agency under the State Plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

DMMA's contracted provider relations agency

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Personal Care

Provider Category:

Agency ▼

Provider Type:

Agency with Choice

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Must have a Medicaid administrative contract with the state to perform the function of an Agency with Choice Broker for individuals receiving respite or personal care. The broker will be responsible for ensuring that all self-directed caregivers meet applicable qualifications prior to the delivery of service. The broker must comply with all applicable state and federal requirements including the U.S. Fair Labor Standards Act.

Verification of Provider Qualifications

Entity Responsible for Verification:

Delaware 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: Personal Care

Provider Category:

Agency ▼

Provider Type:

Personal Attendant Services Agency (PASA)

Provider Qualifications

License (*specify*):

State Business license or 501(c)(3) status; and State Personal Attendant Services Agency License from the Delaware Office of Health Facilities Licensing and Certification per Delaware Code Title 16, section 4469

Certificate (*specify*):

Other Standard (*specify*):

Verification of Provider Qualifications

Entity Responsible for Verification:

DMMA's contracted provider relations agent

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:

Service:

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

Sub-Category 1:

| | |
|-----------------|------------------------------|
| 04 Day Services | 04010 prevocational services |
|-----------------|------------------------------|

Category 2:

Sub-Category 2:

| | |
|--|--|
| | |
|--|--|

Category 3:

Sub-Category 3:

| | |
|--|--|
| | |
|--|--|

Category 4:

Sub-Category 4:

| | |
|--|--|
| | |
|--|--|

Service Definition (*Scope*):

Per Delaware's Employment First Law, H.B. 319, signed into law in July 2012, and in accordance with other federal guidelines governing employment for persons with disabilities, agencies that provide services to persons with disabilities are required to consider competitive and integrated employment, including self-employment, as

the first option when serving people with disabilities who are of working age.

Prevocational Services provide learning and work experiences, including volunteer work and/or internships, where the individual can develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated community settings. Services are expected to produce specific outcomes to be achieved, as determined by the individual and his/her services and supports planning team through an ongoing person-centered planning process evaluated annually.

Initial referrals for prevocational services must also include a referral to the Division of Vocational Rehabilitation in order to determine eligibility for Vocational Rehabilitation services and to arrange for a formal community-based employment assessment. The results of the initial community-based employment assessment must support the outcome of integrated, competitive employment and include specific strategies to be achieved by participating in prevocational services that will ultimately enable the individual to obtain integrated, competitive employment.

In order to continue to be eligible for prevocational services, service recipients must, at minimum, be assessed annually for the continued need for Prevocational Services. Reviewing individual progress toward the previously identified specific strategies shall be included as part of the annual assessment. Individuals receiving prevocational services must have employment-related outcomes in their person-centered services and supports plan; the general habilitation strategies must be designed to support such employment outcomes. Individuals will be eligible for and can choose to participate in prevocational services while engaging in job development or job search activities in order to expand employability skills.

The optimal outcome for Prevocational Services is competitive, integrated employment in the community 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.

Prevocational services should enable each individual to attain the highest level of work in the most integrated setting and with the job matched to the individual's interests, strengths, priorities, abilities, and capabilities, while following applicable federal wage guidelines. Services are intended to develop and teach general skills; Examples include, but are not limited to: ability to communicate effectively with supervisors, co-workers and customers; generally accepted community workplace conduct and dress; ability to follow directions; ability to attend to tasks; workplace problem solving skills and strategies; general workplace safety and mobility training. Meals are not provided as part of this service.

The provider must actively promote and be capable of providing opportunities for full access to participate in the greater community for those waiver participants that express a desire for such access and for whom it would not be contrary to their health and safety needs as articulated in their person centered plan. The provider must demonstrate that they support individuals to exercise their option to achieve their desired level of participation in the community. To the greatest extent possible, individuals should be exposed to a broad array of community experiences so that they can make informed choices about what they like and what they don't like.

Transportation to and from the service location is a component part of prevocational services and the cost of this transportation is included in the rate paid to providers of prevocational services.

Documentation is maintained that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or IDEA (20 U.S.C. 1401 et seq.).

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):

If clients are paid a sub-minimum wage during the provision of pre-vocational service, a service provider site must be certified by the U.S. Department of Labor as a Work Activity Center as defined in Section 14(c) of the Fair Labor Standards Act.

Other Standard (specify):

Must be credentialled by the Division of Developmental Disabilities as a qualified provider of Prevocational Services.

Must adhere to all standards, policies, and guidelines in the State of Delaware Day Program Standards 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.

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.

All DDDS waiver providers must agree to accept the terms and conditions under the Medicaid provider contract as a condition of enrollment to provide services under the waiver.

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

Division of Developmental Disabilities Services

Frequency of Verification:

The DDDS Office of Quality Improvement conducts provider compliance reviews on an annual basis 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):

HCBS Taxonomy:

Category 1:

Sub-Category 1:

02 Round-the-Clock Services

02011 group living, residential habilitation

Category 2:

Sub-Category 2:

02 Round-the-Clock Services

02021 shared living, residential habilitation

Category 3:

Sub-Category 3:

16 Community Transition Services

16010 community transition services ▼

Category 4:

Sub-Category 4:

Service Definition (Scope):

Residential services may be available to individuals whose health and safety conditions pose a serious at risk immediate harm or death to the individual or others, who are the victims of abuse or neglect or who have experienced the loss of a caregiver or a change in the caregiver's status that prevents them from meeting the needs of the individual and that puts them at risk of homelessness. The need for residential services must be demonstrated, documented and prioritized using a standardized assessment tool administered by the state. Services must be provided in the most integrated setting to meet the individual's needs.

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 Person Centered Plan (PCP). The scope of these services are based on the individual's need and can be around-the-clock or blocks of hours.

Payments for residential habilitation are not made for room and board. Transportation is a component part of Residential Habilitation Services for Neighborhood Group Homes and Community Living Arrangements.

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. The methodology by which the costs of room and board are excluded from payments for Shared Living is described in Appendix I.

The following activities may be performed under all Residential Habilitation:

- Self-advocacy training that may include training to assist in expressing personal preferences, self-representation, and 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 from mental health counseling or 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 Preparedness
- 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.

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

Services provided under a shared living arrangement 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 DDS-certified 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 Division, although committed to one-person Shared Living homes, does allow for exceptions to the one-person rule. This exception automatically includes married couples who choose to live in a Shared Living arrangement. An individual (or their team on behalf of the individual) may request an exception to increase the maximum number up to 3. The exception request will be scrutinized to ensure it is consumer-driven and in the best interest of the individual already residing in the home. Exceptions to allow for up to 3 adult siblings who want to remain together or where 2 individuals are very close and want to live together are examples of exception requests that are very likely to be approved. 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.

The provider must actively promote and be capable of providing opportunities for full access to participate in the greater community for those waiver participants that express a desire for such access and for whom it would not be contrary to their health and safety needs as articulated in their person centered plan. The provider must demonstrate that they support individuals to exercise their option to achieve their desired level of participation in the community. To the greatest extent possible, individuals should be exposed to a broad array of community experiences so that they can make informed choices about what they like and what they don't like.

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

The need for residential services must be demonstrated in the individual's care plan and must describe the exploration of other services in more integrated settings and the determination that they would not meet the individual's needs. The amount, frequency and duration, and of these services are specified 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 |
|-------------------|---------------------------------|
| Agency | Residential Habilitation Agency |
| Individual | Shared Living Provider |

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*):

Neighborhood Group Homes physically located in Delaware must meet all Delaware Regulations for Neighborhood Homes for Persons with Developmental Disabilities in accordance with 16 Delaware Code, Chapter 11. Facilities operated in another state must be licensed or certified by the state agency(ies) designated to perform that function in each state.

Certificate (*specify*):
Other Standard (*specify*):

Must be credentialed by the Division of Developmental Disabilities as a qualified provider of Residential Habilitation.

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

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

All DDDS waiver providers must agree to accept the terms and conditions under the Medicaid provider contract as a condition of enrollment to provide services under the waiver.

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

For Neighborhood Group Homes, Delaware regulations for Neighborhood Homes for Persons with Developmental Disabilities specify that the Delaware Division of Long Term Care Residents Protection is the agency responsible for issuing licenses and certifying the compliance of facilities with minimum quality of care standards as specified in state laws and regulations.

For all other standards, the Delaware Division of Developmental Disabilities Services is the entity responsible for verification of standards.

Frequency of Verification:

The DDDS Office of Quality Improvement conducts provider compliance reviews on an annual basis or as needed based on service monitoring concerns.

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:

Shared Living Provider

Provider Qualifications**License (specify):**

For homes that host more than one waiver participant, the provider must be licensed under Delaware Administrative Code, Title 16, Section 3315, Rest (Family) Care Homes.

Certificate (specify):

Other Standard (specify):

Shared living providers must be credentialled by the Division of Developmental Disabilities as a qualified provider of Residential Habilitation, Shared Living.

DDDS Waiver providers must agree to accept the terms and conditions under the Medicaid provider contract as a condition of enrollment to provide services under the waiver.

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:

Statutory Service ▾

Service:

Respite ▾

Alternate Service Title (if any):

Respite

HCBS Taxonomy:**Category 1:****Sub-Category 1:**

| | |
|----------------------|--------------------------|
| 09 Caregiver Support | 09012 respite, in-home ▾ |
|----------------------|--------------------------|

Category 2:**Sub-Category 2:**

| | |
|------------------------|--------------------------|
| 08 Home-Based Services | 08020 home health aide ▾ |
|------------------------|--------------------------|

Category 3:**Sub-Category 3:**

| | |
|----------------------|------------------------------|
| 09 Caregiver Support | 09011 respite, out-of-home ▾ |
|----------------------|------------------------------|

Category 4:**Sub-Category 4:**

09 Caregiver Support

09011 respite, out-of-home

**Service Definition (Scope):**

Respite Services may be provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the participant. Federal financial participation is not to be charged for the cost of room and board except when provided as part of respite care furnished in a public ICF-IID facility.

Respite may be delivered in the participant's residence (family home, own home or apartment) or in community settings and may not supplant other Waiver or state plan covered services.

Facility-based respite includes services provided to participants unable to care for themselves and is furnished on a short-term basis because of the absence of relief of those persons who would normally support the participant.

Facility respite may be planned or may be used for individuals who are experiencing a short term crisis. Facility respite may be provided on the same day that an individual also receives a day service. However, payment will not be made for respite provided at the same time when other services that include care and supervision are provided.

Facility-based respite can be provided in the following settings: Medicaid-certified public ICF-IID, Licensed Neighborhood Group Home, DDS-credentialed Community Living Arrangement, shared living arrangement or other emergency temporary living arrangement that meets DDS standards.

Respite is not available to individuals receiving Residential Habilitation in a Neighborhood Group Home or Community Living Arrangement.

For respite that is provided in a licensed Group Home, Community Living Arrangement, or shared living arrangement, the state will ensure that the needs and best interest of the other residents in the home are taken into account and they agree to the proposed arrangement before authorizing the setting for the purpose of a respite service.

Respite includes a self-directed option that will be managed by a broker under the Agency With Choice model. The AWC broker will be funded as a Medicaid administrative activity. The AWC Broker will also process payments for participants who elect to receive respite at a respite camp.

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

The total payment for Respite and Personal Care services, combined, is limited to \$2,700 per waiver participant per waiver demonstration year. Respite cannot be provided to waiver participants who receive residential habilitation in a provider-managed setting. If a waiver participant enrolled for less than an entire demonstration year, the annual limit will be prorated by the number of months remaining in the demonstration year.

Respite and Personal Care provided in a public ICF-IID is limited to 15 days in a 365 day period.

The limit was established based on cost and utilization data DDS has maintained for individuals receiving state funded family support services.

The limit will be periodically assessed and may be increased as budgetary resources allow.

Exceptions to the funding limit may be granted by DDS authorized personnel with documented justification related to the health and safety needs of the participant.

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 | Agency with Choice |
| Agency | Shared Living Provider |
| Agency | Public ICF/IID |
| Agency | Personal Attendant Services Agency (PASA) |
| Agency | Home Health Agency |
| Agency | DDDS Residential Habilitation Agency |

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Respite****Provider Category:**

Agency ▼

Provider Type:

Agency with Choice

Provider Qualifications**License (specify):**

Certificate (specify):

Other Standard (specify):

Must have a Medicaid administrative contract with the state to perform the function of an Agency with Choice Broker for individuals receiving respite or personal care. The broker will be responsible for ensuring that all self-directed caregivers meet applicable qualifications prior to the delivery of service. The broker must comply with all applicable state and federal requirements including the U.S. Fair Labor Standards Act.

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

Delaware 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: Respite****Provider Category:**

Agency ▼

Provider Type:

Shared Living Provider

Provider Qualifications**License (specify):**

Certificate (*specify*):

Other Standard (*specify*):

Must be credentialled by DDDS as meeting the qualifications for Shared Living.

Verification of Provider Qualifications

Entity Responsible for Verification:

Delaware 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: Respite

Provider Category:

Agency

Provider Type:

Public ICF/IID

Provider Qualifications

License (*specify*):

Must be licensed by the Delaware Division of Long Term Care Residents Protection as a nursing facility.

Certificate (*specify*):

Must be certified by the Delaware Division of Long Term Care Residents Protection as meeting the federal qualifications of an Intermediate Care Facility for Individuals with Intellectual Disabilities.

Other Standard (*specify*):

Must be owned or operated by a government entity

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Long Term Care Residents Protection

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency

Provider Type:

Personal Attendant Services Agency (PASA)

Provider Qualifications

License (*specify*):

State Business License or 501(c)(3) status; and State Personal Attendant Services Agency License from the Delaware Office of Health Facilities Licensing and Certification per Delaware Code Title 16, section 4469.

Certificate (*specify*):

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

DMMA's contracted Provider Relations Agent

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency ▼

Provider Type:

Home Health Agency

Provider Qualifications

License (specify):

State Home Health Agency License from the Delaware Office of Health Facilities Licensing and Certification per Delaware Code Title 16, section 4406 Home Health Agencies (Licensure).

Certificate (specify):

Other Standard (specify):

Must be enrolled with Delaware Medicaid as a Home Health Agency under the State Plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

DMMA's contracted Provider Relations Agent

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency ▼

Provider Type:

DDDS Residential Habilitation Agency

Provider Qualifications

License (specify):

Neighborhood Group Homes physically located in Delaware must meet all Delaware Regulations for Neighborhood Homes for Persons with Developmental Disabilities in accordance with 16 Delaware Code, Chapter 11. Facilities operated in another state must be licensed or certified by the state agency designated to perform that function in each state.

Certificate (specify):

Other Standard (specify):

Must be credentialed by the Division of Developmental Disabilities as a qualified provider of Residential Habilitation

Must meet the DDDS standards for Residential Habilitation published on the DDDS website. This includes non-licensed agencies that provide Residential Habilitation in a Community Living Arrangement (i.e. staffed apartment).

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

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

HCBS Taxonomy:**Category 1:****Sub-Category 1:**

03 Supported Employment

03021 ongoing supported employment, individual

Category 2:**Sub-Category 2:**

Category 3:**Sub-Category 3:**

Category 4:**Sub-Category 4:**

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. Personal care services may be provided as a component under this service and included in the rate paid to providers, but personal care/assistance may not compromise the entirety of the service.

Transportation between the participant's place of residence and the employment site is a component part of individual supported employment services and the cost of this transportation is included in the rate paid to providers of individual supported employment but may not compromise the entirety of the service.

Documentation is maintained that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or IDEA (20 U.S.C. 1401 et seq.) Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following: incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment; or payments that are passed through to users of supported employment services.

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 | 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):*

Other Standard (specify):

Must be credentialed by the Delaware Division of Developmental Disabilities Services as a qualified provider of Supported Employment.

Must adhere to all standards, policies, and guidelines in the State of Delaware Day Program Standards 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.

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.

All DDDS waiver providers must agree to accept the terms and conditions under the Medicaid provider contract as a condition of enrollment to provide services under the waiver.

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

Division of Developmental Disabilities Services

Frequency of Verification:

The DDDS Office of Quality Improvement conducts provider compliance reviews on an annual basis 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:

Habilitation ▼

Alternate Service Title (if any):

Supported Employment - Small Group

HCBS Taxonomy:**Category 1:****Sub-Category 1:**

03 Supported Employment

03022 ongoing supported employment, group

Category 2:**Sub-Category 2:**

Category 3:**Sub-Category 3:**

Category 4:**Sub-Category 4:**

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. Individuals must be compensated at or above the minimum wage and the outcome of this service must be 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.

Transportation between the participant's place of residence and the employment site is a component part of individual supported employment services and the cost of this transportation is included in the rate paid to providers of individual supported employment but may not compromise the entirety of the service.

The provider must actively promote and be capable of providing opportunities for full access to participate in the greater community for those waiver participants that express a desire for such access and for whom it would not be contrary to their health and safety needs as articulated in their person centered plan. The provider must demonstrate that they support individuals to exercise their option to achieve their desired level of participation in the community. To the greatest extent possible, individuals should be exposed to a broad array of community experiences so that they can make informed choices about what they like and what they don't like.

Documentation is maintained that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or IDEA (20 U.S.C. 1401 et seq.) Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following: incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment; or payments that are passed through to users of supported employment services.

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 | Supported Employment |

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:

Supported Employment

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

Must be credentialed by the Division of Developmental Disabilities as a qualified provider of Supported Employment.

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.

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.

All DDDS waiver providers must agree to accept the terms and conditions under the Medicaid provider contract as a condition of enrollment to provide services under the waiver.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Developmental Disabilities Services

Frequency of Verification:

The DDDS Office of Quality Improvement conducts provider compliance reviews on an annual basis 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:

Extended State Plan Service ▼

Service Title:

Assistive Technology for Individuals not otherwise covered by Medicaid

HCBS Taxonomy:

Category 1:

Sub-Category 1:

| | |
|---|--------------------------------|
| 14 Equipment, Technology, and Modifications | 14031 equipment and technology |
|---|--------------------------------|

Category 2:

Sub-Category 2:

| | |
|---|--------------------------------|
| 14 Equipment, Technology, and Modifications | 14031 equipment and technology |
|---|--------------------------------|

Category 3:

Sub-Category 3:

| | |
|--|---|
| | ▼ |
|--|---|

Category 4:

Sub-Category 4:

| | |
|--|---|
| | ▼ |
|--|---|

Service Definition (Scope):

Assistive technology means an item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of participants. Assistive technology service means a service that directly assists a participant in the selection, acquisition, or use of an assistive technology device. Assistive technology includes--

- (A) the evaluation of the assistive technology needs of a participant, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the participant;
- (B) services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for participants;
- (C) services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;
- (D) coordination and use of necessary therapies, interventions, or services with assistive technology devices, such as therapies, interventions, or services associated with other services in the service plan;
- (E) training or technical assistance for the participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant; and
- (F) training or technical assistance for professionals or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of participants.

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

Assistive Technology not otherwise covered by Medicaid. EPSDT for individuals under age 21 and other State Plan services, such as the Home Health benefit must be accessed before this waiver benefit can be accessed. To the extent that any listed services are covered under the state plan, the services under the waiver would be limited to additional services not otherwise covered under the state plan, but consistent with waiver objectives of avoiding institutionalization.

Participants may only receive Assistive Technology if it has been determined to be medically necessary by a

competent health professional including, OT, PT, Speech Pathologist, audiologist, or certified AT specialist. Participants must explore off the shelf products before DDDS will approve the purchase of any specialized medical equipment. Participants are limited to the lowest cost option that will meet the person's needs, including refurbished equipment, but also take into account the timeliness of delivery to meet an immediate need and the availability of warranties.

Purchase of equipment is limited to \$500, including maintenance; with exceptions considered for cases of exceptional need. The limit for Assistive Technology was based on available state funds.

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 | Assistive Technology Professional Agency |
| Individual | Assistive Technology Professional |
| Agency | Assistive Technology Supplier |

Appendix C: Participant Services

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

Service Type: Extended State Plan Service

Service Name: Assistive Technology for Individuals not otherwise covered by Medicaid

Provider Category:

Agency ▼

Provider Type:

Assistive Technology Professional Agency

Provider Qualifications

License (*specify*):

Occupational Therapists, Physical Therapists or Speech Pathologists licensed by the Delaware Division of Professional Regulation under Title 24 of the Delaware Administrative Code, sections 2000, 2600 and 3700, respectively.

Certificate (*specify*):

Assistive Technology Professionals must be certified by ATP RESNA Rehabilitation Engineering and Assistive Technology Society of North America.

Other Standard (*specify*):

Verification of Provider Qualifications

Entity Responsible for Verification:

DMMA's contracted Provider Relations Agent

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Extended State Plan Service**Service Name: Assistive Technology for Individuals not otherwise covered by Medicaid**

Provider Category:

Individual ▾

Provider Type:

Assistive Technology Professional

Provider Qualifications**License (specify):**

Occupational Therapists, Physical Therapists or Speech Pathologists licensed by the Delaware Division of Professional Regulation under Title 24 of the Delaware Administrative Code, sections 2000, 2600 and 3700, respectively.

Certificate (specify):

Assistive Technology Professionals must be certified by ATP RESNA Rehabilitation Engineering and Assistive Technology Society of North America.

Other Standard (specify):**Verification of Provider Qualifications****Entity Responsible for Verification:**

DMMA's contracted Provider Relations Agent

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Extended State Plan Service**Service Name: Assistive Technology for Individuals not otherwise covered by Medicaid**

Provider Category:

Agency ▾

Provider Type:

Assistive Technology Supplier

Provider Qualifications**License (specify):**

State Business License

Certificate (specify):**Other Standard (specify):**

Durable Medical Equipment Suppliers must be enrolled with Medicaid as a state plan Durable Medical Equipment Provider.

Assistive Technology Suppliers

Entities qualified to supply AT equipment may include non-traditional off the shelf suppliers of equipment and technology as prescribed by a competent professional working within the scope of his or her practice.

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

DMMA's contracted Provider Relations Agent will perform verification for DME providers. DDDS will be responsible for verification for all other providers.

Frequency of Verification:

Annually for DME suppliers. For all other provider types, verification will be done prior to purchase of equipment.

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 Consultation: Behavioral

HCBS Taxonomy:

Category 1:

Sub-Category 1:

| | |
|--|------------------------|
| 10 Other Mental Health and Behavioral Services | 10040 behavior support |
|--|------------------------|

Category 2:

Sub-Category 2:

▼

Category 3:

Sub-Category 3:

▼

Category 4:

Sub-Category 4:

▼

Service Definition (Scope):

Behavioral Consultation:

Behavioral Consultation is provided under the Positive Behavior Support model. Behavioral Consultation results in individually designed behavior plans and strategies for 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 behavioral consultation is 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 Consultation service includes a functional behavioral assessment, development of a behavior support plan, and implementation of the behavioral support plan to enable individuals, families, and service providers to effectively support the waiver participants in their attainment of goals they have set. The Behavioral Consultation providers use an industry-standard functional behavioral assessment to determine the needs of each individual. The service includes periodic monitoring of the effectiveness of the behavioral support plan with requisite adjustments as indicated.

The Behavioral Consultation service may include the development of a Picture Exchange Communication System (PECS) for waiver participants who experience communication challenges.

The Behavior Consultation service may include preparation of a package of information about a waiver participants and presentation thereof to the Human Rights Committee (HRC) or PROBIS in cases where restrictive interventions are proposed.

Specifically, Behavioral Consultation includes:

- Completing an initial functional behavioral assessment to better understand the purpose, triggers, and what is causing the maladaptive behavior.
- Developing behavior support plans incorporating the principles of Positive Behavior Supports in order to reduce maladaptive or self-limiting behavior and increase appropriate positive behaviors. This may include the creation of a Picture Exchange Communication System (PECS).
- Providing consultation, training and direction to waiver participants' support team and other direct support professionals who work with the waiver participants who displays challenging, maladaptive or self-limiting behaviors. This may include
- Instructing support teams, direct support professionals and family members and others with whom the waiver participants routinely interacts on the principles of Positive Behavior Support and implementation of the behavior support plan. This may include training on a Picture Exchange Communication System (PECS) when applicable.
- Monitoring the outcome of the behavior support plan through data collection and observation associated with the implementation of the behavior support plan.
- Maintaining the waiver participants' record which may include the following: documentation of progress/treatment for people who have behavior support plans or mental health support plans on at least a monthly basis; the creation of a quarterly report that identifies target behaviors for which data will be collected for specific types of incidents and also delineates psychiatric appointments, medication training, staff training, mental health appointments, medical issues and at risk concerns that occurred during the quarter.

In cases where psychological or professional counselling or assessment services are indicated, upon request of the waiver participants, the BA will:

- Identify potential mental health practitioners
- Act as a liaison between the individual, his/her support team and the service provider to ensure that the mental health practitioner receives information necessary to appropriately treat the person

In cases where psychiatric services are needed, upon request of the waiver participants, the role of the BA is to:

- Identify potential mental health practitioners
- Act as a liaison between the individual, his/her support team and the service provider to ensure that the mental health practitioner receives information necessary to appropriately treat the person
- Instruct the team on how to carry out the prescribed treatment.
- Develops behavior support plans to ensure that the individual is supported in accordance with the principles of best practice.
- Monitors progress/treatment for people who have a behavior support plan
- Serves as a support team participants for people who have a behavior support plans
- Prepares necessary documentation for oversight committees such as PROBIS and HRC in accordance with DDDS policies

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

Behavioral Consultation under the Lifespan waiver is provided to individuals age 21 and over. For individuals under the age of 21, medically necessary Preventive Services, consistent with the service specifications and provider qualifications articulated in the State plan pursuant to the EPSDT benefit, must be exhausted prior to accessing the waiver benefit for Behavioral Consultation.

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 | Behavior Consultation |

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Clinical Consultation: Behavioral

Provider Category:

Agency ▼

Provider Type:

Behavior Consultation

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

Must be credentialed by the Delaware Division of Developmental Services as a qualified provider of Behavior Consultation.

Behavioral Consultants must have minimum education, training and/or experience demonstrating competence in each of the following areas:

- Possession of a Bachelor's degree or higher in Behavioral or Social Science or related field. Individuals who exceed the stated minimum qualifications may also provide Behavioral Consultation.
- Six months experience in developing functional assessment plans by assessing behavioral needs and determining behavioral objectives.
- Six months experience in evaluating and assessing client functioning using a variety of formal tests and survey tools.
- Six months experience in making recommendations as part of a client's service plan such as clinical treatment, counseling, or determining eligibility for health or human services/benefits.
- Six months experience in interpreting laws, rules, regulations, standards, policies, and procedures.

In addition to the requirements above, a Behavior Consultation providers must adhere to DDDS standards, policies and procedures applicable to Behavioral Services as described in the DDDS HCBS Waiver Services Behavioral Consultation Services Policy.

All DDDS waiver providers must agree to accept the terms and conditions under the Medicaid provider contract as a condition of enrollment to provide services under the waiver.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Developmental Disability 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:

Clinical Consultation: Nursing

HCBS Taxonomy:**Category 1:****Sub-Category 1:**

11 Other Health and Therapeutic Services

11010 health monitoring

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:****Service Definition (Scope):**

Nursing Consultation:

Nursing Consultation consists of the overall coordination and monitoring of the health care needs for waiver participants. These individuals live in community settings and have a prescribed medical treatment plan. This consultation assists caregivers in carrying out individual treatment/support plans and is necessary to improve the individual's independence and inclusion in their community. This service may be delivered in the individual's place of residence or in another community setting as described in the service plan.

Nursing Consultation consists of the following activities:

- Provides the clinical and technical guidance necessary to support the individual in managing his/her healthcare needs.
- Completes the Nursing Assessment, develops an integrated medical plan of care and monitors the effectiveness of the interventions on no less frequent than an annual basis.
- Completes the required DDDS medical alert forms such as the Fall Risk Assessment, Aspiration Assessment, and other assessments as appropriate on no less frequent than an annual basis.
- Completes on-site medication/record reviews for Neighborhood Homes and Community Living Arrangements (e.g. the monthly Health and Medication Review as outlined in all applicable DDDS policies and procedures.) Findings of all reviews shall be recorded in the electronic case record and any adverse findings must be reported as a critical incident for follow up and possible corrective action.
- Completes monthly contacts (by phone or in person) and at least an annual on-site visit for Shared Living Providers. During the on-site visit the nurse will verify that medication storage follows the DDDS guidelines.
- Completes Quarterly Nursing Reviews for individuals residing with Shared Living Providers.
- Monitors, reviews, and reconciles medication forms monthly and takes appropriate action as indicated for individuals residing with Shared Living Providers.
- In emergency situations, may perform a medical procedure within the registered nurse's scope of practice, experience and proficiency.
- Participates as an Interdisciplinary Team member.
- Attends the annual Person-Centered Plan (PCP) meetings and other meetings as appropriate.
- Provides ongoing health related training for waiver participants, direct support professionals and families.
- Maintains on-going accurate, timely, and relevant documentation of all health care issues. Updates all required documents as changes in health conditions warrant.
- Communicates to individuals/families/guardians/other service providers about health care issues.
- Attends medical appointments with the individual if indicated/warranted.

- Assists in obtaining resources and acts as an advocate and coordinator of health care services ensuring appropriate treatment, follow-up and resolution to healthcare issues occur.
- Assists waiver participants to transition from one residential living arrangement to another.
- Adheres to DDS healthcare protocols.
- Monitors medication administration activities performed by direct care staff or consumers and may provide consultation to a direct support professional regarding medication administration in specific situations where nursing expertise is required under the Nurse Practice Act.

Phone contacts to carry out any of the covered activities described above are considered a billable activity with proper documentation. Phone contacts lasting between one and 15 minutes can be billed as one unit of service.

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

EPSDT State Plan services must be accessed for individuals under the age of 21 before this waiver benefit can be accessed. To the extent that any listed services are covered under the state plan, the services under the waiver would be limited to additional services not otherwise covered under the state plan, but consistent with waiver objectives of avoiding institutionalization.

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 | Nurse Consultation |

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Clinical Consultation: Nursing

Provider Category:

Agency ▼

Provider Type:

Nurse Consultation

Provider Qualifications

License (*specify*):

Nurse Consultants must be a Registered Nurse (RN) licensed by the State of Delaware as prescribed in Delaware Code, Title 24, Chapter 19, Section 1910.

Certificate (*specify*):

Other Standard (*specify*):

Must be credentialled by the Delaware Division of Developmental Disabilities Services as a qualified provider of Nurse Consultation service.

Nurse Consultants must demonstrate the ability to work with individuals with Developmental and Intellectual Disabilities with a wide range in the intensity of support needs including cognitive impairments, autism, mobility, dual diagnosis (Developmental and Intellectual Disability & Mental Health support needs), or who have more significant health related challenges.

All DDDS waiver providers must agree to accept the terms and conditions under the Medicaid provider contract as a condition of enrollment to provide services under the waiver.

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:

Community Transition

HCBS Taxonomy:

Category 1:

Sub-Category 1:

16 Community Transition Services

16010 community transition services ▼

Category 2:

Sub-Category 2:

▼

Category 3:

Sub-Category 3:

▼

Category 4:

Sub-Category 4:

▼

Service Definition (Scope):

Community Transition Service

Payments may be made for Community Transition to facilitate transition from an institution to a community setting, consistent with SMDL 02-008, or to otherwise establish a community residence for a waiver participant who has been newly approved for residential habilitation or supported living and is moving from the family home. Community Transition will enable individuals whose means are limited to furnish and decorate his or her bedroom in a manner of his or her choosing consistent with the HCBS Rule and to foster independence. Community Transition includes the reasonable, documented cost of one-time expenses and services necessary to occupy a domicile in the community, including:

- Essential furnishings, including: Bed frame, mattress and box spring or futon, dresser, wardrobe, chair, trash can, lamps, desk, small table/nightstand, bookcase, linens and pillows, window covering, wall decorations, mirrors
- Bath mats & shower curtain, grab bars and other free-standing implements to increase stability in the bathroom
- Small appliances including blow dryer, vacuum cleaner, coffee maker, toaster
- Toiletries

- Kitchen items, including: hand towels, dishes, drinkware, flatware & utensils, knives, cookware, bowls and food storage
- Initial stocking of refrigerator and pantry
- Initial supply of cleaning supplies and laundry
- Initial supply of bathroom supplies
- Clothing
- Moving expenses
- Security deposits
- Set-up fees and deposits for utility access (telephone, electric, utility, cable)
- Pest eradication
- Cleaning service prior to occupancy
- Trial visits to waiver residential settings
- Lock and key

Community transition services shall not include monthly rental or mortgage expenses, food (other than initial purchases to stock a kitchen), regular utility charges, and/or household appliances or items that are intended for purely recreational purposes such as televisions or DVD players. Community transition expenses must included in the individual's person centered plan and must be approved by DDDS in advance. If an individual for whom waiver funds have been used for community transition expenses moves from one waiver-funded residential setting to another, they will be able to take any such furnishings with them to their new residence if they so choose.

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

Total Community Transition services are limited to \$4,000 per participant for 10 years. A unit of service is one transition.

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 | Residential Habilitation Agency |
| Agency | DDDS Approved Community Transition Provider |

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Community Transition

Provider Category:

Agency ▼

Provider Type:

Residential Habilitation Agency

Provider Qualifications

License (*specify*):

Neighborhood Group Homes physically located in Delaware must meet all Delaware Regulations for Neighborhood Homes for Persons with Developmental Disabilities in accordance with 16 Delaware Code, Chapter 11. Facilities operated in another state must be licensed or certified by the state agency(ies) designated to perform that function in each state.

Certificate (specify):

Other Standard (specify):

Must be credentialed by the Division of Developmental Disabilities as a qualified provider of Residential Habilitation.

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

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

All DDDS waiver providers must agree to accept the terms and conditions under the Medicaid provider contract as a condition of enrollment to provide services under the waiver.

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

For Neighborhood Group Homes, Delaware regulations for Neighborhood Homes for Persons with Developmental Disabilities specify that the Delaware Division of Long Term Care Residents Protection is the agency responsible for issuing licenses and certifying the compliance of facilities with minimum quality of care standards as specified in state laws and regulations.

For all other standards, the Delaware Division of Developmental Disabilities Services is the entity responsible for verification of standards.

Frequency of Verification:

The DDDS Office of Quality Improvement conducts provider compliance reviews on an annual basis or as needed based on service monitoring concerns.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Community Transition****Provider Category:**Agency **Provider Type:**

DDDS Approved Community Transition Provider

Provider Qualifications**License (specify):**

Certificate (specify):

Other Standard (specify):

Must be a DDDS-qualified provider of Community Transition Services

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

Division of Developmental Disabilities Services

Frequency of Verification:

Before services are initially rendered.

Appendix C: Participant Services

HCBS 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:

Home or Vehicle Accessibility Adaptations

HCBS Taxonomy:

Category 1:

Sub-Category 1:

14 Equipment, Technology, and Modifications

14020 home and/or vehicle accessibility adaptations

Category 2:

Sub-Category 2:

▼

Category 3:

Sub-Category 3:

▼

Category 4:

Sub-Category 4:

▼

Service Definition (Scope):

Home Modifications

Home modifications include those physical adaptations to the private residence of the participant or the participant's family, required by the participant's service plan, that are necessary to ensure the health, welfare and safety of the participant or that enable the participant to function with greater independence in the home. Such adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the participant. Modifications must comply with applicable building codes and must have building permits where required.

Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the participant. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair). Adaptations or alterations to an automobile or van that is the waiver participant's primary means of transportation in order to accommodate the special needs of the participant.

Vehicle adaptations are specified by the service plan as necessary to enable the participant to integrate more fully into the community and to ensure the health, welfare and safety of the participant. They include adaptations or alterations to an automobile or van that is one of the waiver participant's primary means of transportation in order to accommodate the special needs of the participant.

The following items are specifically excluded:

1. Adaptations or improvements to the vehicle that are of general utility, and are not of direct medical or remedial benefit to the individual;
2. Purchase or lease of a vehicle; and
3. Regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modifications.

Home and Vehicle Modifications may not be furnished to adapt living arrangements that are owned or leased by providers of waiver services.

Bids or estimates must be obtained from at least two vendors so that DDDS can select the most reasonable bid based on the work to be performed which may take into account such elements as the time necessary to perform the work. In the event that the time necessary to obtain two bids will result in a delay in receiving the service that could pose a health or safety risk to the participant, DDDS may waive this requirement. Providers must issue a warranty for their work for one year from the date of purchase.

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

Limited to \$6,000 per member every 5 years, inclusive of both services. The limit for home/vehicle modifications was based on experience from Delaware's Money Follows the Person program and is consistent with the limit for Delaware's LTSS home modification benefit limit under the 1115 waiver.

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 | Licensed contractor |
| Agency | Vendors |
| Agency | Licensed contractor |

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Home or Vehible Accessibility Adaptations

Provider Category:

Individual ▼

Provider Type:

Licensed contractor

Provider Qualifications

License (*specify*):

Delaware Business License

Certificate (*specify*):

Other Standard (*specify*):

Must be licensed as a contractor to do business within the State of Delaware and hold all applicable certifications and standards , if required by trade, and general liability insurance. Providers must warranty their work for one year from the date of purchase.

Verification of Provider Qualifications

Entity Responsible for Verification:

Delaware Division of Developmental Disabilities Services

Frequency of Verification:

Prior to authorization of service and payment

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Home or Vehible Accessibility Adaptations

Provider Category:

Agency ▼

Provider Type:

Vendors

Provider Qualifications

License (specify):

Delaware Business License

Certificate (specify):

Other Standard (specify):

Providers must be bonded and insured. Providers must warranty their work for one year from the date of purchase.

Verification of Provider Qualifications

Entity Responsible for Verification:

Delaware Division of Developmental Disabilities Services

Frequency of Verification:

Prior to authorization of service and payment

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Home or Vehible Accessibility Adaptations

Provider Category:

Agency ▼

Provider Type:

Licensed contractor

Provider Qualifications

License (specify):

Delaware Business License

Certificate (specify):

Other Standard (specify):

Must be licensed as a contractor to do business within the State of Delaware and hold all applicable certifications and standards, if required by trade, and general liability insurance. Providers must warranty their work for one year from the date of purchase.

Verification of Provider Qualifications

Entity Responsible for Verification:

Delaware Division of Developmental Disabilities Services.

Frequency of Verification:

Prior to authorization of service and payment

Appendix C: Participant Services

HCBS 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:

Specialized Medical Equipment and Supplies not otherwise covered by Medicaid

HCBS Taxonomy:

Category 1:

Sub-Category 1:

17 Other Services

17010 goods and services ▼

Category 2:

Sub-Category 2:

▼

Category 3:

Sub-Category 3:

▼

Category 4:

Sub-Category 4:

▼

Service Definition (Scope):

Specialized Medical Equipment and Services not otherwise covered by Medicaid

Specialized medical equipment and supplies include: (a) devices, controls, or appliances, specified in the person centered plan, that enable participants to increase their ability to perform activities of daily living; (b) devices, controls, or appliances that enable the participant to perceive, control, or communicate with the environment in which they live; (c) items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items; (d) such other durable and non-durable medical equipment not available under the State plan that is necessary to address participant functional limitations; and, (e) necessary medical supplies not available under the State plan. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the State plan and exclude those items that are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards of manufacture, design and installation.

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

Specialized Medical Equipment and Services not otherwise covered by Medicaid is only provided to individuals age 21 and over. All medically necessary Specialized Medical Equipment and Services for children under age 21 are covered in the State plan pursuant to the EPSDT benefit. To the extent that any listed services are covered under the state plan, the services under the waiver would be limited to additional services not otherwise covered under the state plan, but consistent with waiver objectives of avoiding institutionalization.

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 | Durable Medical Equipment Supplier |

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Specialized Medical Equipment and Supplies not otherwise covered by Medicaid****Provider Category:**

Agency ▼

Provider Type:

Durable Medical Equipment Supplier

Provider Qualifications**License (specify):**

State Business License

Certificate (specify):

Other Standard (specify):

Must be enrolled to provide Durable Medical Equipment under the State Plan.

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

DMMA's contracted Provider Relations Agent

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:

Supported Living

HCBS Taxonomy:**Category 1:****Sub-Category 1:**

08 Home-Based Services

08010 home-based habilitation ▼

Category 2:**Sub-Category 2:**

Category 3:**Sub-Category 3:**

Category 4:**Sub-Category 4:**

Service Definition (Scope):

Supported Living is support that is very individualized and is provided in a non-provider-managed residence that is owned or leased by the waiver participant. The amount and type of supports provided are dependent upon what the individual needs to live successfully in the community and must be described in their Person Centered Plan (PCP) but cannot exceed 40 hours per week for each participant. Daily hours of support may vary based on the needs of the individual. Supported living encourages maximum physical integration into the community and is designed to assist the individual in reaching his or her life goals in a community setting.

The types of supports provided in these settings are tailored supports that provide assistance with acquisition, retention, or improvement in skills related to:

- activities of daily living, such as personal grooming and cleanliness, domestic chores, or meal preparation , including planning, shopping, cooking, and storage activities;
- social and adaptive skills necessary for participating in community life, such as building and maintaining interpersonal relationships, including a Circle of Support;
- locating and scheduling appropriate medical services;
- instrumental activities of daily living such as learning how to maintain a bank account, conducting banking transactions, managing personal finances in general;
- learning how to use mass transportation;
- learning how to select a housemate;
- how to acquire and care for a pet
- learning how to shop.

The individual may want to learn a new skill or may have some proficiency in certain parts of a skill but want to learn how to complete the entire task independently. Supported Living includes self-advocacy training to assist the participant in expressing personal preferences, self-representation, and individual rights and to make increasingly responsible choices.

Supported living must be provided based on the individualized needs of each waiver participant and at naturally occurring times for the activity, such as banking and those related to personal care.

Supported living is provided on a one-on-one basis. If services are provided with two or more individuals present, the amount of time billed must be prorated based on the number of consumers receiving the service. Payments for Supported Living do not include room and board.

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

The maximum number of hours of support that can be provided to each individual is 40 hours per week. Exceptions may be granted by DDDS authorized personnel with documented justification related to the health and safety needs of the participant as documented in the person centered plan.

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 | Residential Habilitation Agency |

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Supported Living

Provider Category:

Agency ▼

Provider Type:

Residential Habilitation Agency

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

Supported living may be provided by an agency that has been credentialled by DDDS as a qualified provider of Residential Habilitation. Because this service is provided in a residence owned or leased by the waiver participant, licensing requirements that apply to Neighborhood Group Homes or Community Living Arrangements related to the residence do not apply.

All DDDS waiver providers must agree to accept the terms and conditions under the Medicaid provider contract as a condition of enrollment to provide services under the waiver.

Verification of Provider Qualifications

Entity Responsible for Verification:

Delaware Division of Developmental Disabilities Services

Frequency of Verification:

The DDDS Office of Quality Improvement conducts provider compliance reviews on an annual basis or as needed based on service monitoring concerns.

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:

Targeted Case Management (TCM) provided by one or more qualified providers. TCM will be provided to two distinct target groups: individuals living in the family home and individuals receiving residential habilitation under the DDDS Lifespan Waiver. For individuals living at home, TCM will be provided by one or more vendors who meet the provider qualifications specified in the SPA that will be selected via a competitive procurement process. For individuals living in a waiver residential setting, TCM will be provided by individuals employed by DDDS who meet the provider qualifications specified in the TCM SPA.

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):

All direct support professionals that have routine contact with waiver participants must have a criminal background check. This includes employees selected by a waiver participant to provide Respite or Personal Care service under the self-directed option.

The Background Check Center (BCC) was established via Delaware legislation in April 2012 and became a mandatory source of pre-employment screening in April 2013. The BCC is an electronic system which combines data streams from various sources for the purpose of determining an applicant's suitability for employment. The BCC provides background information from the following sources: Adult Abuse Registry, Sex Offender Registry, Child Protection Registry, Division of Professional Regulation Registry (as applicable), State and Federal Criminal Background Checks and Service Letters from prior employers. The Division of Long Term Care Residents Protection (DLTCRP) promulgated rules and regulations for the implementation of the legislation to require background checks for settings that they license. Those requirements are now codified in the DE Administrative Code, Title 16 §3105 and 3110.

HCBS waiver provider agencies that operate a home licensed by the DTCRP are required to utilize the BCC to determine if a person is suitable for employment, pursuant to the following laws:

- 11 Del.C. §1141- Criminal Background Check (State and Federal),
- 11 Del.C. §1142- Drug Screening
- 11 Del.C. §8563- Child Protection Screening
- 19 Del.C. §708- Service Letters from previous employers
- 11 Del.C. §8564- Adult Abuse Registry Check

The BCC is designed to notify employers of refreshed information regarding criminal convictions of their employees. This feature allows for HCBS providers to ensure on-going safeguards for the waiver participants whom they support.

HCBS waiver service providers who operate other waiver services are also obligated to ensure the safety of waiver participants by comprehensively screening applicants. Although the BCC process is not accessible to non-licensed providers, they nevertheless are required to incorporate minimal screening requirements into their internal provider policies. The provider policies must be made available to DDDS staff and waiver participants who are searching for service providers. The minimal required pre-screening requirements include State and Federal Criminal Background Checks, Adult Abuse Registry, Child Protection Registry, Delaware Sex Offender Registry and Drug Screening according to the DDDS Waiver Provider Standards. The processes by which a waiver provider can obtain the aforementioned screening is reviewed with new providers during their orientation to DDDS. The DDDS regularly addresses pre-screening requirements and related issues with providers during

the routine schedule provider meetings.

The DDDS Office of Quality Improvement completes Annual Certification reviews for all Waiver Service Providers. During each of these review, employee personnel files for are screened to assure that mandatory background investigations have been completed and that the results are on file with the specific provider agency.

- 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 Delaware Division of Long Term Care Residents Protection, as required by Delaware Code Title 11, §8564. A Child Protection Registry (CPR) is maintained by the Delaware 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 that 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 waiver standards for residential providers prohibit the employment of individuals with adverse findings in either the AAR or CPR check.

During the Provider Agency Certification Review Process, the Office of Quality Improvement (OQI) 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 OQI 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 OQI 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) ensure that every shared living provider

is screened against both the Adult Abuse Registry and Child Protection Registry, prior to their enrollment as a Medicaid waiver provider.

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 | |
|-------------------------|--|
| 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 four. However, in prior renewals, homes with more than four individuals were allowed per home. In order to minimize disruption to the lives of the affected individuals living in homes with more than four individuals, they will be allowed to continue to live under this arrangement as long as they choose to do so. The structures are single family dwellings located in residential neighborhoods throughout the state. No new settings with more than four residents will be authorized as of the renewal date.

Each resident must have their own bedroom unless they express a preference to share a room. The room must be designed and decorated to their preferences. The homes have a one full size bathroom for every four residents, complete kitchen and a dining area. Family and friends can privately meet with a resident or individual in a room designated for social gatherings. When necessary, homes must meet any accessibility requirements of the residents. The outside appearances 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 |
|---|--------------------------|
| Clinical Consultation: Nursing | <input type="checkbox"/> |
| Home or Vehicle Accessibility Adaptations | <input type="checkbox"/> |
| | |

| | |
|--|-------------------------------------|
| Day Habilitation | <input type="checkbox"/> |
| Respite | <input type="checkbox"/> |
| Supported Employment - Small Group | <input type="checkbox"/> |
| Specialized Medical Equipment and Supplies not otherwise covered by Medicaid | <input type="checkbox"/> |
| Assistive Technology for Individuals not otherwise covered by Medicaid | <input type="checkbox"/> |
| Supported Living | <input type="checkbox"/> |
| Prevocational Services | <input type="checkbox"/> |
| Supported Employment - Individual | <input type="checkbox"/> |
| Personal Care | <input type="checkbox"/> |
| Community Transition | <input type="checkbox"/> |
| Clinical Consultation: Behavioral | <input type="checkbox"/> |
| Residential Habilitation | <input checked="" type="checkbox"/> |

Facility Capacity Limit:

4

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:

^
v

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.*

☐ **Self-directed**

☐ **Agency-operated**

- 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.*

DDDS allows relatives to become qualified to provide Residential Habilitation under the Shared Living arrangement, Respite or Personal Care for waiver participants. Guardians of adult children may be paid to provide Respite and Personal Care under the self-directed option but only if approved by the Community Navigator. The participant's Community Navigator is instrumental in ensuring that services are appropriate for each participant.

The Community Navigator will administer a standardized risk assessment tool that includes screening questions to determine the appropriateness of the family member/legal guardian as the caregiver for an individual. The screening tool includes such questions as:

- Does having a family member/legal guardian as direct support staff expand the individual's support circle or risk diminishing it?
- Is this about the participant's wishes, desires, and needs or about supplementing a family member's income?
- Does this family member create a barrier to increased community integration or friendship development, etc.?

Based on the results of the assessment, the Community Navigator will make a recommendation to DDDS regarding whether the guardian should be allowed to be the self-directed caregiver. The state will make the final decision. If the Community Navigator believes that the guardian as caregiver will not be in the best interest of the participant, as a result of the screening process, the case must be reviewed by the DDDS Director of Community Services who will make a final determination.

When a guardian is paid as the caregiver under the self-directed option, in order to ensure the safety of waiver participants, DDDS instructs Community Navigators to locate a third party who can represent the waiver member and supervise the provider, including signing their time sheet, when the waiver participant is unable to do so. In these cases, the third party representative will be the joint employer with the AWC Broker. When a parent guardian who is the self-directed caregiver of an adult child is not the sole guardian, the other guardian may be designated as the representative. Relatives and guardians must meet any applicable provider standards for their provider type as specified in the Appendix C-1/C-3 in order to become a Shared Living provider or Community Living Support provider.

For relative or guardian caregivers, the team that develops the person centered plan will document how the person is qualified to meet the needs of the waiver participant and establish any additional training requirements that the caregiver must fulfill before being paid as a provider. A strong person-centered focus in the initial planning process is critical to ensuring that the care provided by relatives or guardians is in the best interest of the waiver participant. This process lays the ground work for assuring that the individual's opportunities for independence and exercising choice and control over his or her own life are preserved. It is the responsibility of the case manager to ensure that the voice of the waiver participant is heard and that the individual is supported to be a self-advocate in the planning process to ensure that the use of relatives or guardians is the preferred path. DDDS requires the Community Navigators to be trained in conflict resolution techniques in the event that a situation arises in the provision of care by a relative or guardian that must be resolved.

The AWC Broker will ensure that the relative/guardian caregiver meets the requirements before a paid service is rendered. Utilization will be monitored by the case manager against the person centered plan to ensure that services are provided for the benefit of and in the best interest of the individual.

- ☐ **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 the Delaware Medical Assistance Program (DMAP) web site. This website provides information about the DDDS Waiver program and completes 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). All DMMA enrollment conditions must be met by the prospective provider before the provider can become enrolled. Providers who contact the DMAP Provider Relations agent about enrollment who have not yet been determined to meet the qualifications to provide HCBS services by DDDS are directed back to DDDS to be assessed against the applicable provider standards, since qualification by DDDS is specified as an HCBS provider enrollment criteria. Qualified providers may enroll at any time. The successful completion of the required information shall result in a contract with DMMA.

Prospective service providers have unrestricted 24-hour access to the DDDS waiver provider qualification standards

and 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 Lifespan Waiver services. The DDDS Website (<http://www.dhss.delaware.gov/dhss/ddds/cps.html>) contains the instructions detailing the process.

Once a provider has successfully completed the enrollment process and has been enrolled with DMMA, they are added to a Directory of Enrolled Providers posted on the DDDS website. This list assists waiver participants in selecting a provider from a set of qualified providers.

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

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by 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 the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

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 percent of providers that meet applicable licensing, certification or other standards upon initial enrollment. Numerator: The percent of providers that meet applicable licensing, certification or other standards upon initial enrollment; Denominator: The number of waiver providers enrolled during the period.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Office of Quality Improvement 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="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 <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: <input type="text"/> |

Performance Measure:

C-a-2: The percent of provider sites determined to be in compliance with provider qualification standards per the approved waiver. Numerator: Number of providers determined to be in compliance with provider qualification standards per the approved waiver. Denominator: Number of providers reviewed against the provider qualification standards during the period.

Data Source (Select one):**Other**

If 'Other' is selected, specify:

The Office of Quality Improvement certification database

| | | |
|--|--|--|
| | | |
|--|--|--|

| 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"/> |

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

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

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.

- 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 the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

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 percent of provider direct support professionals in substantial compliance with DDDS training requirements. Numerator: Number of provider direct support professionals in substantial compliance with training requirements. Denominator: Number of DDDS waiver provider direct support professional staff.

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="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 checked="" type="checkbox"/> Other Specify: at least 25% of agency staff per site |
| <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"/> |

- 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 with which the various discovery processes are employed ranges 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). In addition to those monitoring processes, the case managers also conduct routine monthly reviews and quarterly visits to residential and day programs.

The scope of various reviews includes:

- People who receive services from DDDS,
- Settings where day or residential services are delivered
- Providers of HCB services and
- Service delivery system

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 provider's compliance with established regulatory and policy standards 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 Improvement (OQI) and Long Term Care staff in their annual certification and licensure surveys.

The DDDS Office of Quality Improvement (OQI) surveys waiver provider agencies against waiver standards.

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 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. Following the date by which corrections are to be made by the responsible parties, it is the DDDS's general practice to follow-up verifying that the corrections have been made and are acceptable. For those surveys done by the Office of Quality Improvement, verifications usually take the form of an additional look-behind review. With other disciplines, corrections may be verified at the time of the next routinely scheduled review, or through the submission of applicable documentation.

Should the necessary corrections not be performed or still leave room for improvement, further actions are generally 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 may be notified of the inadequacy of the response and the possibility of sanctions should improvements not be soon forthcoming. These sanctions may range from the provider being placed on contract probation, the granting of a Provisional License by the Division of Long Term Care Residents Protection, a freeze on the agency's ability to serve new participants, 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.

Finally, with ever increasing frequency, DDDS operational Units are attempting to track and document the results of their discovery processes in a variety of electronic databases. Designed within these databases are fields to track the verification of required improvements. This tracking may serve to provide a number of benefits. It may provide a prompt in the remediation process, offer a comparison of results longitudinally or among providers, or be 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 checked="" type="checkbox"/> Operating Agency | <input type="checkbox"/> Monthly |
| <input type="checkbox"/> Sub-State Entity | <input type="checkbox"/> Quarterly |
| | |

| | |
|--|--|
| <input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div> | <input checked="" type="checkbox"/> Annually |
| | <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 C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCBS Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

Delaware submitted its initial Statewide Transition Plan (STP) on March 17, 2015. The plan included HCBS services provided for the elderly and individuals with physical disabilities or HIV/AIDS under the 1115 waiver and also HCBS provided under the 1915(c) DDDS Waiver. To date, two revisions to the full STP have been provided to CMS: on September 17, 2015 and March 30, 2016. Additional changes were made to the Statewide Self-Assessment based on comments received from CMS to the March 30, 2016 submission. The state made the requested changes to the Statewide Self-Assessment submitted them to CMS on July 14, 2016. Delaware received initial approval of the STP from CMS on July 14, 2016. All of the versions of the STP that have been submitted to CMS have undergone an extensive public comment process prior to submission. All of the revisions to the STP are available on the DMMA website at the following address:

http://www.dhss.delaware.gov/dhss/dmma/hcbs_trans_plan.html

Another revision of the STP will be published for public comment in September 2016.

The STP and attachments are too voluminous to paste into the waiver amendment application, as they would more than double the size of the application.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Lifespan Plan (for individuals receiving residential habilitation) and Support Plan for Individuals and Families (for individuals living in the family home)

- 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:

DDDS will employ two different types of case management under this waiver: one for individuals living in a non-provider managed setting (Community Navigators) and one for individuals living in a provider-managed setting (Support Coordinators). This allows the state to employ different person centered planning processes designed to meet the needs of individuals as they change through their lifespan. The state has used the authority under 1915(g)(1) to create two TCM target groups to enable the state to preserve the longstanding effective provision of case management to individuals who live in a waiver funded setting by qualified state employees and to establish a different set of provider qualification criteria for individuals living at home. The qualifications for the individuals who will deliver case management for waiver participants under the TCM authority will be as follows:

For individuals who live in a provider-managed waiver setting, a Support Coordinator employed by the Delaware Division of Development Disabilities Services (DDDS) provides case management. In order to be qualified as a Support Coordinator, individuals must meet the minimum qualifications for the State of Delaware Merit System classification of "Senior Social Worker/Case Manager". These qualifications are also described in the Targeted Case Management SPA. Individuals who exceed the stated minimum qualifications may also provide case management. The Support Coordinator is responsible for creating, implementing and monitoring the Plan of Care (known as the Lifespan Plan). The minimum qualifications for a case manager are:

Possession of an Associate's 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 client's 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.

If a participant is dissatisfied with his/her case manager, he/she is supported to request a different case manager from among a pool of individuals who meet the specified criteria above.

Training in accordance with DDDS training policy.

The qualifications for the Community Navigators who will provide Targeted Case Management to individuals living in the family home, the qualifications are as follows:

Qualified providers are entities under contract with the State of Delaware with requisite expertise in supporting individuals with intellectual and developmental disabilities and their families.

Specifically, the providers will comply with Department standards, including regulations, contract requirements, policies, and procedures relating to provider qualifications. Individuals providing this service must:

1. Have an associate's degree or higher in behavioral, social sciences, or a related field OR experience in health or human services support, which includes interviewing individuals and assessing personal, health, employment, social, or financial needs in accordance with program requirements;

2. Have demonstrated experience and competency in supporting families;
3. Complete Department-required training, including training on the participant's service plan and the participant's unique and/or disability-specific needs, which may include but is not limited to: communication, mobility and behavioral support needs; and
4. Comport with other requirements as required by the Department.

These qualifications are also described in the Targeted Case Management SPA.

☐ **Social Worker**

Specify qualifications:

☐ **Other**

Specify the individuals and their qualifications:

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:*

DDDS, an agency of state government, employs the Support Coordinators who deliver case management for individuals living in a provider-managed waiver residential setting. DDDS also directly provides four services under the waiver: Residential Habilitation, Day Habilitation, Behavioral Consultation and Nurse Consultation. DDDS's provision of these services directly is a vestige of the days when the State of Delaware provided all of the direct services for participants with intellectual disabilities before the waiver existed. DDDS has been downsizing these programs through natural attrition, so as to avoid disruption to these waiver participants, as many of them have formed strong attachments to the state programs over time.

The DDDS provided settings have not been open for referral since 2014. They are also not included on the list of authorized providers on the DDDS website. There is sufficient choice and capacity within the set of non-state qualified providers in the waiver provider network, for all services except Behavioral Consultation in Sussex County.

Since the last renewal was approved, DDDS has successfully closed all of the waiver residences operated by DDDS, except one which is scheduled to close in May 2017, pending the opening of a new fully accessible waiver residence. DDDS case managers and program staff encourage waiver members to choose another provider besides DDDS at every opportunity.

In the meantime, while DDDS endeavors to close all state-operated services, it has adopted the following safeguards:

- Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;

- An opportunity for the participant to dispute the State's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;
- Direct oversight of the process or periodic evaluation by a State agency (in the waiver);
- Restricting the entity that develops the person-centered service plan from providing services without the direct approval of the State; and
- Requiring the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.

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.

The Division of Developmental Disabilities Services (DDDS) has established the Life Span Plan (LSP) as its person-centered planning tool for waiver participants living in provider-managed residential settings. For those waiver participants living in the family home DDDS has adopted a planning tool called the Support Plan for Individuals and Families (SPIF). Both of these planning tools/systems meet the CMS requirements for Person Centered Plans. For the purpose of this Appendix, these tools will hereafter be referred to as the "person-centered plan", "PCP" or simply, "the plan", unless more specificity is required.

To ensure that both planning systems are developed in the best interest of each participant, DDDS developed comprehensive policies and procedures to safeguard the integrity of both planning systems so that all CMS requirements are met.

According to DDDS policy, both the Life Span Plan and the Support Plan for Individuals and Families are person-centered plans, developed with the waiver participant, his/her family or guardian, other individuals providing support and other individuals the waiver participant has chosen to be part of the planning team. The plans will outline the individual's preferences, individual support needs, and lifestyle choices. Because the supports provided to waiver participants in a waiver residential setting tend to be more comprehensive, the Life Span Plan will be a more comprehensive planning tool. Both planning systems are supported by a case management function. For individuals living in a waiver residential setting, case management will be delivered by an individual called a "Support Coordinator" and for individuals living in their family home it will be delivered by an individual called a "Community Navigator". For the purpose of brevity, we will use the term "case manager" throughout the document unless more specificity is required.

Whenever a waiver participant has a legally appointed guardian or is a minor child, the guardian and parent, respectively, will be included in the planning process and in any other decision making process, along with the participant. For brevity, the waiver application may only refer to the participant in some instances, but those other individuals will be included as applicable.

- a) The templates for the DDDS PCPs can be accessed for view on the DDDS website at any time by anyone, regardless of whether they are enrolled in the Lifespan Waiver. The website contains an example of a completed Life Span Plan and Support Plan for Individuals and Families, a description of what the plans are, what each section of the PCP means, how it is developed, and how it is used by waiver participants.

The DDDS Office of Professional Development makes PCP training available to potential waiver applicants and their families/guardians or advocates on a regular basis. The training includes a description of the PCPs in a power point presentation. The presentation 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.

The "My Life My Plan" manual for Delaware is a resource with the most current DDDS-approved information relative to the development and implementation of the plans. All staff and providers comply with the guidelines set forth in this manual.

The case manager facilitates the development of the plan by managing the planning process and functions as an advocate for the waiver participant during the planning process.

One of the responsibilities of the case manager is to provide information to the participant in such a way as to maximize the participant's participation and involvement in the planning process plan.

The first step in the development of the PCP is for the case manager to explain the planning process to the waiver participant, spending time with the participant, reviewing the planning process and explaining the reasons for doing the plan with them. This discussion includes an explanation about the participant's right to choose providers from among a set of qualified service providers to provide services that are specified in the plan.

The case manager ensures that the participant is provided with the opportunity to receive comprehensive information about home and community based services available under the waiver and the participant has the right and opportunity to choose a service from among any qualified provider. The case manager explains that waiver participant also has the right to change providers at any time for any reason. The case manager is also responsible for ensuring that the participant is apprised of his or her individual rights.

DDDS uses the concept of a "robust" pre-planning process as a precursor to the Person Centered Planning (PCP) process in order to assure that the participant is at the center of his/her plan, directing, making decisions and choices with regard to services contained in his/her PCP, and is satisfied with the outcomes supported by the plan that is developed.

The pre-planning process begins at least two months before the initial or annual plan review meeting by engaging the participant in a conversation about his/her life, goals and aspirations and also includes any needed formal assessments. The conversation is an informal assessment process that takes a walk through time, discussing personal routines and preferences throughout the day, learning what makes a good day in the mind of the participant. The conversation continues along, leading to the discussion about short and long range "outcomes" the participant wants to achieve. For participants living in the family home, the shift from the Support Plan for Individuals and Families tool to the Life Span Plan tool builds on this concept that there is an expectation that this year's learning leads to new and richer future plans. The conversation also attempts to discern "Things that the participant Wants to Try or Things to Learn".

The participants outcomes may include, but are not limited to such items as: expanding the participant's circle of support, identifying where to live and with whom, what types of services and supports are needed in such living situations, career goals, what would the participant's ideal job be, where to work, important routines, important people, favorite things to do, interest in participating in clubs, civic organizations, religious/spiritual organizations and past accomplishments to celebrate and possibly build upon. These items can be delineated in the "MY Life My Plan Workbook" by the participant or their family, prior to the pre-planning discussion.

b) Standard I of the DDDS Person Centered Planning Policy delineates the participant's authority to determine who is included in the planning process. The waiver participant determines who they would like to invite to attend the planning meeting and when and where it is held, with the assistance of the case manager.

Following the introductory discussion(s), the case manager asks the participant who he or she wants to have involved in their plan development, whether the participant wishes to have the assistance of an advocate, how the participant wishes to be involved in the various conversations about the PCP development, and to identify any "off limits" topics that should not be discussed in the presence of specified others. A well-informed participant, supported by a knowledgeable case manager, will provide the basis for building a responsive support team. That team chosen by the participant will be dynamic with participants changing as outcomes are achieved or redesigned or new ones added.

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):

a. Who develops the plan who participates in the process, and the timing of the plan:

Using the results of the pre-planning activities, the case manager may complete an initial interim plan called “HCBS Initial Waiver Service Authorization” that addresses the essential waiver services that the individual must have in order to avoid institutionalization. Prior to development of this initial person-centered plan, the case manager meets with the participant to review the support needs of the individual and to discuss services and supports available to address them. The pre-planning will have gathered information about the participant’s preferences, likes, dislikes, level of independence, etc. The initial interim plan describes the circumstances that led the participant to seek waiver enrollment and the amount, duration and frequency of each service that is recommended for the participant until the full formal PCP can be developed. The initial interim plan may only be in place for 60 days. A formal person-centered plan that addresses the participant’s complete needs must be developed within 60 days of the date of the first receipt of a waiver service and must then be updated annually within 365 days of the date of the previous annual PCP conference. The case manager provides supports and information to the new waiver participant to enable them to direct and be actively engaged in the development of the initial interim plan.

DDDS will ensure, through the supportive case manager function, that the plan is developed and that the participant is supported to develop his or her plan, assisted by individuals of the participant’s choosing. The participant is always at the center of all planning activities and the timing and schedule regarding the development of the plan will fit around his/her needs. All planning activities are scheduled at times and locations convenient for the participant and their circle of support. Depending on the type of services included in the plan the frequency and intensity of the planning activities may vary. The following will highlight areas where those levels of service are addressed by the planning process.

Delaware recognizes that the needs of individuals with IDD change over time as they leave school seek employment and may need residential supports. Therefore, the planning process must also recognize these differences and acknowledge the important role that families play and how the waiver may assist the individual and their family in meeting life goals at all stages.

For waiver participants living in his/her family home, the planning process will focus on supporting the individual in the context of their family life. Regardless, of the setting in which the waiver participant lives, the case manager will assist the participant to form a support team and also to identify outcomes that he/she want to achieve.

The PCP will be developed by the waiver participant and his/her team in collaboration with the case manager. The case manager is responsible for supporting the participant to assure that they lead the plan development. The PCP is initially developed upon enrollment into the waiver and then it is updated annually thereafter. It is revised as needed during the year. Revisions are made as necessary throughout the year based on changes in the participant’s circumstances or support needs or circumstances of family participants who may be providing support to the individual.

Whenever a waiver participant has a legally appointed guardian or is a minor child, the guardian and parent, respectively, will be included in the planning process and in any other decision making process, along with the participant. For brevity, the waiver application may only refer to the participant in some instances, but those other individuals will be included as applicable.

b. Types of assessments conducted to support plan development to determine the participant’s needs, preferences & goals, & health care needs:

Delaware uses an internally-developed assessment tool called the Support Needs Assessment Profile (SNAP) and a proprietary assessment tool, the Inventory for Client and Agency Planning (ICAP) to support the development of the PCP. These tools are used determine the level of support for waiver participants. The ICAP incorporates a wide range of measures including a person’s demographic characteristics, adaptive and maladaptive behavior, diagnosis, health status, physical handicaps and more.

For individuals living in their family home, there are also a wide range of person-centered planning tools that will be available for the Community Navigator to use with the participant and their family to develop the PCP. Similar tools

are available for case managers to use as they support individuals in residential settings, calibrated to the needs of the individuals in the context in which they live. These tools can also inform the state's continuing effort to ensure that setting remains in compliance with the requirements under the HCBS settings rule. Tools that may be used include: Important To/Important For; Like and Admire; Good Day/Bad Day; One Page Profile; and the People Map. These tools will help the team that develops the plan to focus on strategies for success to encompass what the person does best and how best to use the person's strengths in the achievement of their desired outcomes.

As DDDS grows its culture of being a person-centered-thinking organization, it is placing greater emphasis on becoming more skilled in effectively using person centered planning tools. Those tools noted above are only some that are currently available. There are an increasing number of new methods and tools that can be incorporated into PCP best practices. Delaware is committed to increasing the capacity of each participant's support team for identifying the dreams, goals, and preferences of the waiver participant.

The plan will document the paid supports that will be provided through the waiver, the Medicaid State Plan or other resources, as well as unpaid supports, including the role the family plays in providing support to the participant, and other community supports that may be available. The PCP is a holistic plan that elicits information from the person and their family and is based on the strengths, abilities, and goals of the participant and documents the participant's (and their family's) vision of success for the future and the actions that will be taken to ensure success. The goal of the planning process is to look across the life span of the person and to engage in planning with them and their family to chart a course for success that focuses on independence, productivity, integration and inclusion in the community over their entire life.

c. How the participant is informed about what is available in the waiver:

The case manager will inform the waiver participant about waiver services and ensure that the person understands each of those services and how they can be used together to achieve their desired outcomes. This information will be shared with that person's team and be used to ensure that each outcome identified in the plan can be supported by the services available.

The participant and his/her team/family will be given service information in a format that best enables that individual to understand what the services are and how they can be used together to achieve his/her desired outcomes. The case manager will also explain to the participant's support team how they can support the outcome the person chooses.

Case manager supervisors will periodically review the work of the case managers to ensure that the case manager has properly informed waiver participants about available services and that that discussion is documented in the plan. This review may include interviews with waiver participants.

The planning process and the plan will both be documented in a single electronic case record system where it is fully accessible to the participant and his/her team. Anyone who supports the individual will be able to quickly see the outcomes, strategies to achieve them and identification of challenges and risks, as well as amount, duration and frequency for all waiver services included in the participant's PCP.

d. How the plan development process ensures that the service plan addresses participant goals, needs (health) and preferences.

An integral part of the planning process is to ascertain what the waiver participant sees as a successful future for themselves. The PCP will include a vision statement of what success looks like for the person to live a good and happy life.

DDDS provides information to the participant in a way that is easy to understand so the participant is able to make informed choices. DDDS assures during the assessment, plan development, and review/approval processes, the participant is assisted by individuals who know the participant well, have demonstrated care and concern for the participant and are trusted by the participant.

The plan will be developed using a person-centered planning process which will result in the establishment of a plan that includes the paid and unpaid supports the person will receive that will facilitate achievement of their goals. The plan is based on what is important TO the person as well as what is important FOR the person. The plan identifies outcomes the participant wants to achieve and the strategies that will be used to achieve them, including identifying the challenges and risks that may be encountered and methods to address them.

The plan development will consistently require the participant's involvement in every step of the process. The person centered planning tools paired with assessment information will inform the planning process. Active discussion with the person's team about both of those components will ensure that the outcomes identified by the participant are agreed to by everyone on the participant's support team and are responsive to the participant's goals and needs and preferences.

Delaware's unified electronic record system is designed to capture the person-centered plan. It documents the participant's selection of his/her team and the exploration of possible outcomes the person wants to achieve. It also records the discussion of what strategies will be implemented to achieve each outcome. It also documents the challenges and or risks that will need to be addressed in the Outcome and how they will be addressed.

The case manager plays a significant role in advocating for the participant throughout the planning process and, where necessary, ensuring that the PCP is truly person-centered and addresses the participant's hopes and dreams while providing appropriate supports, including medical supports if necessary, that will ensure the participant is living a as fulfilling a life as possible.

e. How waiver and other services are coordinated:

All participants of the support team have input into and review the PCP prior to implementation. During the meeting, the individual and the support team identify and assign responsibilities for implementing and monitoring the plan including other Medicaid services furnished through State Plan or other federal programs and coordination of any other natural supports. Each responsible participant is identified in writing in the PCP as well as the frequency of monitoring and the reporting/accountability requirements.

The Person Centered Plan (PCP) includes information identifying how services and supports will enhance the participant's life. This assessment data, including information about services the participant receives through other state and federal programs is coordinated by the case manager.

The case manager is responsible for ensuring that all services and supports are coordinated for the benefit of the waiver participant. This includes waiver services, State Plan services, as well as other paid and unpaid supports. The intensity of the coordination and monitoring of the achievement of plan outcomes will vary by person and the variety and intensity of services that will be provided. The PCP will contain sufficient guidance about what services and or supports will be required by the participant in order to achieve his/her desired outcomes. The plan will also outline timelines for achieving each outcome, including interim milestones as appropriate, strategies to achieve them and which team participant will be responsible for what. The case manager will track these activities and ensure that the established strategies are achieved.

The Plan is final when approved by the waiver participant or their guardian or any other legally appointed authority.

f. How waiver services are coordinated; how plan development provides for assignment of responsibilities to implement & monitor plan:

The case manager will ensure that a responsible person is identified for each support or service specified in the plan to help the participant to achieve his/her outcomes. Each participant of the support team that is responsible for one or more areas of the plan must sign the plan acknowledging that they understand and accept their assigned role. The case manager will ensure that the plan identifies the frequency for each activity or service. The plan will also include information on community resources accessed by the person and the personal networks (friends and families) supporting the person to meet their identified goals and needs. The case manager will be responsible for the overall monitoring of the plan.

g. How & when plan gets updated as the participant's needs change:

The PCP is revised as needed based on changes that impact the person's support needs due to any of the following: medical status, behavioral status or circumstances. For individuals living in his/her family home, an update to the plan may also be triggered by that a change in the circumstances, availability or physical ability of the primary support person in the family. The case manager will assemble the support team to review the plan as necessary. At a minimum the plan is revised and updated on an annual basis.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 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 into the person-centered plan through the development of each outcome.

As the individual and his/her team develop the plan, each outcome of that plan will contain the opportunity to evaluate the risk and or challenges associated with that outcome. If the risk assessment identifies a risk, it is the responsibility of the team to develop a risk mitigation strategy. The purpose of this element of the plan is to identify and address risk in order to prevent potential harm from occurring and to enhance the quality of life of the participant.

The assessment of potential risk and the development of risk mitigation strategies will involve the participant, 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 participant safe from serious harm and promote good health, independence and opportunity to live a satisfying life. Each participant's identified support needs vary depending upon his/her life experiences, abilities and environment. Each risk mitigation plan contains a description of how the qualified provider will create a system of providing emergency backup services and supports.

Areas where risk may need to be assessed and mitigation plans created could 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 (member signing his/her individual support plan, natural supports, lack of adequate supports, refusal of services, etc.)

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.

The DDDS system provides waiver participants with information they can use to make an informed choice among a set of qualified providers. In addition to personal contacts and discussions with the waiver participant regarding the selection of a provider from a set of qualified providers, DDDS maintains a list of qualified providers for each service by county on the DDDS website.

Whenever a waiver participant has a legally appointed guardian or is a minor child, the guardian and parent, respectively, will be included in the planning process and in any other decision making process, along with the participant. For brevity, the waiver application may only refer to the participant in some instances, but those other individuals will be included as applicable.

The case manager supports the waiver participant to choose from among a set of qualified providers. The case manager is responsible for assisting the participant to learn about waiver services and providers. This includes assisting the individual in setting up meetings with service providers in which they have expressed interest and attending those meetings with the waiver participant. The case manager is as active in the process as the individual wants them to be and can assist the participant in learning about the different providers so that the individual can make an informed choice.

The waiver participant, including his/her circle of support, may choose to access the current list of qualified service providers through the DDDS website. The website is maintained and the information is kept current. The website is organized by service and lists the providers that are qualified to provide that service and in which counties.

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 hard copy of the DDDS qualified provider list. As a part of the person centered 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.

DDDS provides the opportunity for waiver participants to interact with service providers and acquire information through semi-annual "Provider Fairs". The fairs are announced publicly and operate as "meet and greet" events. Waiver participants and their families may speak with service providers to get a feel for the services they provide and how they provide them. DDDS representatives are in attendance to assist families in obtaining more information on how to proceed with seeking services and 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. DDDS also provides opportunities for waiver participants to meet with each other in order to facilitate natural connections between participants and their families that result in information sharing.

DDDS has also developed a set of interview questions that waiver participants or families may want to ask a service provider in order to help determine if there is a good fit between the person and the provider. This questionnaire is provided to all waiver participants prior to the selection of any waiver services.

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). DMMA maintains responsibility for service plan approval. The person centered plan is maintained by DDDS in an electronic case record system. Prior to each quarterly meeting between DMMA and DDDS, DMMA provides DDDS with a list of clients for which the PCP will be reviewed and discussed at the meeting. DMMA selects two cases randomly from each region for a total of six Plans to be reviewed. DMMA may request, at any time, a hardcopy of the PCP for any DDDS waiver client. In addition, DMMA has access to the electronic case record software and may conduct spot checks of the PCP at any time.

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:

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. For those persons receiving residential services, the Support Coordinator is the primary person responsible for monitoring the implementation of the plan at a minimum of once a month. For persons living in the family home, the Community Navigator is responsible for monitoring the implementation of the plan at least monthly. The Community Navigator must have at least one face to face contact with the waiver participant each year. Monitoring will occur more frequently if a review of claims indicates that the waiver participant is not routinely receiving services in the amount, duration or frequency specified in the plan. Additional monitoring of all of the day services is conducted by the DDDS Day and Transition Unit. This is discussed below. Additional monitoring of self-directed Respite and Personal Care services by the Agency With Choice Broker is also described below. The Support Coordinators and Community Navigators will be hereafter referred to as "case managers" in this section.

Responsibilities of the case manager include ensuring that services are meeting the participant's needs and that they are provided in accordance with the PCP, including reviewing the amount, duration and frequency of services recommended in the plan. The case manager is responsible for continuing to ensure that the individual is able to exercise free choice of providers and that they understand this right. The case manager is responsible for ensuring that non-waiver health care services are identified and accessible, as needed. The case manager is responsible for ensuring that concerns which require action are identified and remedied promptly.

The Support Coordinator monitors the implementation of the participant's Life Span Plan on a monthly basis. At least once each calendar quarter, the Support Coordinator will conduct a face to face interview with the participant. The Support Coordinator must conduct at least two of the face to face interviews in the participant's home, during which the plan is reviewed with the participant, his/her or guardian, if applicable, and/or appropriate team participants to assess their satisfaction with the services provided and to review how the participant is progressing with the attainment of his/her stated priority outcomes.

During this monthly monitoring of individuals living in a waiver residential setting, the Support Coordinator will:

- Assess the extent to which the participant is receiving services according to his/her person-centered plan. This

includes monitoring that each provider has delivered services at the amount, frequency and duration specified in the PCP and that participants are accessing all supports and health-related services as indicated on the PCP.

- Evaluate whether the services furnished meet the participant's needs and help the participant become more independent.
- Assess the effectiveness of provider individual service plans and determine if changes are necessary.
- Review the participant's progress toward goals stated in the PCP.

During the face-to-face monitoring of the plan that occurs four times each year, the Support Coordinator will:

- Remind participants that they have free choice among 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 PCP meeting.
- Observe whether the participant appears healthy and is 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 participant's safety. For issues that are of concern, but where the participant is not at risk of imminent harm, 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 Support Coordinator may reconvene the participant's support team to address the issue.

The following reports assist the Support Coordinator in monitoring services:

- A monthly report completed by agency providers of residential habilitation that provides a status update on progress toward identified outcomes and any barriers the participant is experiencing in meeting those outcomes. The provider reports on what actions or steps they have taken to support the participant's attainment of identified outcomes.
- Quarterly audits completed by providers of Nurse or Behavioral Consultation, if applicable, that track and monitor behavioral interventions and physical health-status issues, as identified in the PCP.
- Quarterly Day Service/Vocational/Work reports completed by providers of day and employment services to report on the participant's progress in meeting identified outcomes and goals.
- Progress reports recorded for each individual service plan by each provider for each waiver service as identified and defined in the participant's PCP.
- Provider annual reports on progress toward achieving goals, as required for each individual.

The reports listed above are designed to assist the Support Coordinator in assessing the effectiveness of the services and supports the individual receives and to recommend changes when appropriate. Service providers use the electronic case record system to document contacts with participants, providers, family members and informal supports.

The Community Navigator reviews the implementation of the participant's Support Plan for Individuals and Families on a monthly basis and will provide additional support if the participant's plan requires changes.

When a participant wants to change a service provider, the case manager informs the current provider of the change and develops a transition plan to minimize disruption to the participant and to ensure continuity of care.

Office of Quality Improvement Monitoring:

The DDDS Office of Quality Improvement (OQI) completes a thorough review of the Life Span Plan for each participant receiving residential habilitation that is selected as part of the Annual Representative Sample. This review is completed as part of a comprehensive survey of participants' services and is included in the findings for the annual re-credentialing of service providers.

OQI utilizes a variety of review tools in order to assess compliance with applicable policies, procedures, standards and regulations. Deficiencies in service delivery result in the requirement for the responsible provider to implement a detailed Corrective Action Plan (CAP) to remediate the concern. OQI monitors the provider's progress with the implementation of the CAP. Data related to waiver performance measures is aggregated to assist the DDDS in identifying systems-level concerns that may require systemic modifications in order for the standard to be achieved.

DDDS Day & Transition Unit: The DDDS Day and Transition Unit monitors the utilization of day services for waiver participants based on specified triggers. They compare provider attendance records and claims data against service authorizations based on the PCP to look for: units higher or lower than what is expected, changes in Group Supported

Employment ratios, waiver participants whose authorized hours are exceptions to the ICAP. Providers who are determined to be at higher risk of claim errors based on prior reviews are reviewed more closely than other providers. When a review is triggered, the Unit looks at the PCP, progress/billable notes for each day service and incident reports to ensure that services are being delivered and billed in accordance with the PCP.

One of the duties of the Agency With Choice Broker is to monitor attendance records for employees of participants who have elected to self-direct to ensure that they are receiving services in accordance with the PCP. Concerns or discrepancies will be reported to the Community Navigator for follow up.

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:*

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

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

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 the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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 percent of participant Person Centered Plans that address the participant's support needs. Numerator: The number of participant PCPs that address the participant's support needs. Denominator: The number of participant Person Center Plans reviewed during the period.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

The Division of Developmental Disabilities Services Office of Quality

Improvement (OQI) 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: <div></div> | <input type="checkbox"/> Annually | <input type="checkbox"/> Stratified Describe Group: <div></div> |
| | <input checked="" type="checkbox"/> Continuously and Ongoing | <input type="checkbox"/> Other Specify: <div></div> |
| | <input type="checkbox"/> Other Specify: <div></div> | |

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

Performance Measure:

D-a-2:The percent of Person Centered Plans that identify participant preferences and how they will be met within the Plan. **Numerator:** The number of participant PCPs that identify participant preferences and how they will be met by the Plan. **Denominator:** The total number of participant Person Centered Plans reviewed during the period.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Office of Quality Improvement 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="text"/> | <input type="checkbox"/> Annually | <input type="checkbox"/> Stratified Describe Group: <input type="text"/> |
| | <input checked="" type="checkbox"/> Continuously and Ongoing | <input checked="" 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 checked="" type="checkbox"/> Annually |

| | |
|----------------------|---|
| <input type="text"/> | |
| | <input type="checkbox"/> Continuously and Ongoing |
| | <input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; margin-top: 5px;"></div> |

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

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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.

- 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 the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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 percent of participant Person Centered Plans that are reviewed with the member's team annually. Numerator: The number of participant PCPs that are reviewed with the team annually. Denominator: The number of participant PCPs reviewed during the period.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Division's Office of Quality Improvement'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="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:

D-c-2: The number and percent of person centered plans (PCP) that are revised when the needs of the participant have changed. Numerator: The number of PCPs that are revised when the needs of the participant have changed. Denominator: The total number of PCPs reviewed which require revision.

Data Source (Select one):
Record reviews, off-site

If 'Other' is selected, specify:

The Division's Office of Quality Improvement'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: <div><div></div><div></div></div> | <input type="checkbox"/> Annually | <input type="checkbox"/> Stratified Describe Group: <div><div></div><div></div></div> |
| | <input checked="" type="checkbox"/> Continuously and Ongoing | <input type="checkbox"/> Other Specify: <div><div></div><div></div></div> |
| | <input type="checkbox"/> Other Specify: <div><div></div><div></div></div> | |

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: <div><div></div><div></div></div> | <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 the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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: The number and percent of participant services delivered as specified in the person centered plan, including the type, scope, amount, duration and frequency.

Numerator: The total number of services delivered as specified in the PCP.

Denominator: The total number of PCPs reviewed for the period.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Office of Quality Improvement Individual Focused Certification Review-OQI

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: <div style="border: 1px solid black; height: 20px; width: 100%;"></div> | <input type="checkbox"/> Annually | <input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div> |
| | <input checked="" type="checkbox"/> Continuously and Ongoing | <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> | |
|--|---|--|

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

Performance Measure:

D-d-2: The percent of members receiving residential habilitation whose CM visit occurred each quarter as described in the approved waiver. Numerator: The number of members receiving res hab whose case manager (CM) met them to review the PCP once each quarter, two of which were in the member's home. **Denominator:** The number of waiver members reviewed during the period.

Data Source (Select one):**Record reviews, off-site**

If 'Other' is selected, specify:

Office of Quality Improvement Individual Focused Certification Review-OQI 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 | <input type="checkbox"/> Annually | <input type="checkbox"/> Stratified |

| | | |
|----------------------------------|---|---|
| Specify: <input type="text"/> | | 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 <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 type="text"/> | <input checked="" type="checkbox"/> Annually |
| | <input type="checkbox"/> Continuously and Ongoing |
| | <input type="checkbox"/> Other Specify: <input type="text"/> |

Performance Measure:

D-d-3 The number and percent of members for which progress toward goals included in the PCP is reviewed by the case manager as described on a frequency described in the PCP. **Numerator:** The number of members whose progress on PCP goals is reviewed by the CM on the specified frequency. **Denominator:** The total number of member PCPs reviewed during the period.

Data Source (Select one):**Record reviews, off-site**

If 'Other' is selected, specify:

Office of Quality Improvement Individual Focused Certification Review-OQI 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 | <input type="checkbox"/> Weekly | <input type="checkbox"/> 100% Review |

| | | |
|---|---|--|
| Agency | | |
| <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 % confidence interval |
| <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"/> |

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

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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-2: The number and percent of participants offered a choice of qualified providers. Numerator: The number of participants offered a choice of qualified providers. Denominator: The total number of participant records reviewed for the period.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

The Essential Lifestyle Plan documents that client choice was offered. The review is performed by the DDDS Office of Quality Improvement.

| 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% confidence interval |
| <input type="checkbox"/> Other Specify: <div></div> | <input type="checkbox"/> Annually | <input type="checkbox"/> Stratified Describe Group: <div></div> |
| | <input checked="" type="checkbox"/> Continuously and Ongoing | <input type="checkbox"/> Other Specify: <div></div> |
| | <input type="checkbox"/> Other Specify: <div></div> | |

Data Aggregation and Analysis:

| Responsible Party for data | Frequency of data aggregation and |
|----------------------------|-----------------------------------|
| | |

| aggregation and analysis (check each that applies): | 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: <div style="border: 1px solid black; height: 20px; width: 100%;"></div> | <input checked="" type="checkbox"/> Annually |
| | <input type="checkbox"/> Continuously and Ongoing |
| | <input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div> |

- 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 discovery portion of the Division's Quality Management System (QMS) relies on a robust performance monitoring system managed by the Office of Quality Improvement. This system is aligned with the CMS Quality Framework (Design, Discovery, Remediation, and Improvement).

For each step in the QMS, DDDS has identified: Assurances-Measures-Standards (Discovery), Reporting on the Individual Remediation (Remediation) and Quality Improvement Plans/Projects (Improvement).

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.

Certification reviews conducted by the Office of Quality Improvement are completed as followed:

Sample Selection: The Quality Service Review (QSR) attempts to gain input from individuals and to examine services in order to obtain a "snapshot" of the provider as a whole. The Lead OQI Facilitator (hereafter referred to as "OQI Facilitator") produces a list of the names of the individuals served by the provider. The Lead Quality Improvement Facilitator will also collect corrective action plans, training reports, and any other pertinent information. A random sample of no less than 15% of the provider's waiver caseload will be selected.

Notification and Scheduling: Written notice of the review dates is sent to the provider at least 60 calendar days in advance of the QSR. The Lead OQI Facilitator coordinates with the provider to schedule the review activities including: individual interviews, record reviews, general availability of staff for questions, observations of service, and physical site reviews.

Interview with the waiver participant: The OQI Facilitator conducts an interview with the participant, preferably in their home or other program. Providers will support participants to understand the purpose and intent of the interview. In some instances, an individual may need or want assistance to answer the questions. When assistance is needed or requested, the provider will make these arrangements in collaboration with the individual and/or guardian.

Record Review: The OQI Facilitator reviews provider policies and procedures, certifications (CARF, CQL, etc.), licensing documents, staff training files, and any other relevant information. The case manager files

(person centered plan, LOC completed, etc.) are also reviewed.

Exit Conference/ Feedback Discussion: The OQI Facilitators provide a written summary of the findings before the final Quality Certification Report is written. The OQI Facilitator will identify issues that need to be addressed within the Quality Improvement Plan.

Quality Certification Reporting: A Quality Certification Report is sent to the provider that contains an overview of the review process, agency strengths, recommendations, and areas for improvement and requirements for a Quality Improvement Plan.

DDDS Regional Offices also have a key role in ongoing monitoring in order to verify that 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: incident reports, case manager visits, OQI provider reviews etc. Each office has the ability to assemble a regional management team comprised of appropriate DDDS staffers and others as necessary in order to review unresolved and emerging serious individual concerns and provide technical assistance and/or resources to resolve the issue.

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.

Quality Certification Reporting: If a Quality Certification Report identifies areas for improvement and requirements for a Quality Improvement Plan, the provider must submit a Quality Improvement Plan to OQI that addresses each finding with specific objective(s), a timeline, and the contact information for the person(s) responsible for developing and implementing the plan. The QIP must be approved in writing by DDDS.

Once the improvement plan is developed by the provider, a designated manager within DDDS must approve the plan in writing within 15 days of receiving it. Elements for approving a Quality Improvement Plan can be found on the DDDS website at <http://dhss.delaware.gov/dhss/ddds/qa.html>

Following notification by the provider that the corrections were made, DDDS verifies that the corrections were made and that they are acceptable.

DDDS response to Continued Inadequate Performance: DDDS has a structured process for addressing continued inadequate performance by a provider. In addition to monitoring activities by OQI, any DDDS staff person may escalate concerns about provider performance through the organizational hierarchy in each DDDS Regional Office, ending with the DDDS Senior Leadership Team which represents all parts of DDDS. The Leadership team meets to review the data presented regarding the provider's inadequate performance and to make a recommendation to the DDDS Director regarding whether or not to put the provider on probation.

When a recommendation for probation is approved by the Director, the DDDS Director notifies the provider in writing including the areas where improvement is needed and the timelines for the completion of these activities within an initial six month probationary period. A meeting is also scheduled with the organization to go over the reason for probation.

OQI monitors the provider's compliance with the terms of the probation. At the end of the initial period of probation, the Director may extend it for another six months if the provider has not shown sufficient improvement in one or more areas requiring remediation.

OQI monitors the provider's compliance with the terms of the probation. At the end of the initial period of probation, the Director may extend it for another six months if the provider has not shown sufficient improvement in one or more areas requiring remediation.

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 type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div> | <input checked="" type="checkbox"/> Annually |
| | <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 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)

- a. Description of Participant Direction.** In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

(a) Individuals enrolled in the Lifespan waiver may choose to self-direct the waiver services known as Respite and Personal Care. Respite and Personal Care service is not available to participants who are receiving residential habilitation with an agency.

(b) As participants are initially enrolled and again at each annual plan review, the Community Navigator will offer participants who elect to receive the Respite and Personal Care services, the opportunity to self-direct the service as a joint employer with the AWC broker employer of record. Participants will be informed that they may self-direct Respite and Personal Care services. The election of Respite and Personal Care will be documented in the person centered plan and whether the participant has elected to self-direct. DDDS uses the Agency with Choice model to support participants who wish to self-direct. A participant may self-direct select supports and services and also receive traditional supports and services from a provider agency, as long as both services are included and described in the person-centered plan (PCP). Self-directed services include Respite and Personal Care.

(c) A participant may elect to self-direct Respite and Personal Care services, or may request more information about it during the initial and each subsequent planning meeting. New entrants to the waiver will thereby be offered the opportunity from the initial enrollment into the waiver. Community Navigators and DDDS Regional staff will be able to answer questions about the service option, and provide general written information. Community Navigators will also offer detailed information to waiver participants about self-direction opportunities at each individual's annual plan review.

Participants who choose to self-direct services will be assisted by an AWC broker under contract to the state. The AWC broker will be paid as an administrative cost.

The AWC broker will assist the participant to manage their self-directed services and other services included within specified service limit for Respite and Personal Care. Participants will be assisted to find, hire and manage qualified caregivers, establish work schedules, participate in the development of a back-up/emergency plan, establish the employee rate and track utilization against applicable limits. The AWC broker will also purchase service and remit payment for services by non-Medicaid enrolled entities, such as camps for respite. The AWC vendor will perform most of the administrative tasks normally performed by an employer including payroll withholding, ensuring that applicable payment rules are followed, conducting criminal background checks, etc.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one:*

- ☒ **Participant: Employer Authority.** As specified in *Appendix E-2, Item a*, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ☐ **Participant: Budget Authority.** As specified in *Appendix E-2, Item b*, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ☐ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in *Appendix E-2*. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies:*

- ☒ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- ☐ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- ☐ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy (*select one*):

- ☐ **Waiver is designed to support only individuals who want to direct their services.**
- ☐ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- ☒ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Individuals electing self-direction will use an Agency With Choice, co-employer model to direct their Respite and Personal Care service.

Individuals may continue to use self-direction as long as they meet the criteria in E-1-l.

Individuals who choose not to self-direct this service will be assisted to choose a qualified agency provider by their Community Navigator.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

A participant direction handbook was created as a means to inform the participant about the rights, responsibilities and the benefits and any risks associated with the participant directed option. This handbook is available on the DDS website and is included in the DDS-approved statewide Agency With Choice start up packet for participants who elect to self-direct. At the time of waiver enrollment, as the initial interim person centered plan is being developed, the Community Navigator is responsible for providing the handbook to the participant and discussing the pros and cons of self-direction as it relates to their particular circumstances and needs. The Community Navigator will ensure the participant understands the responsibilities associated both with this waiver and with participant-direction. The Community Navigators also provide participants with support and assistance in order to make the decision about whether to exercise participant direction authority and will refer participants to the Agency With Choice broker as necessary. This information will also be revisited with the participant by the Community Navigator at least annually when the PCP is reviewed and revised.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the State's policy concerning the direction of waiver services by a representative (*select one*):

- ☐ **The State does not provide for the direction of waiver services by a representative.**
- ☒ **The State provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

- ☒ **Waiver services may be directed by a legal representative of the participant.**
- ☒ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

DDDS will honor the decision making authority for parents of minor children, guardians and Powers of Attorney, for participants for whom they are in place.

Participants who do not have guardians have the right to have a designated surrogate to assist them with performing the role of the co-employer if they so choose. This includes using the option for Supported Decision Making recently enacted under Delaware law S.B. 230 and any other alternative decision making authorities recognized by the state.

The Agency With Choice broker is responsible to ensure that the guardians, Powers of Attorney or other selected surrogates understand and agree to assist the individual fulfill his/her responsibilities as the employer or managing employer. For surrogates (not including guardians or Powers of Attorney), this will include by ensuring that the surrogate reviews and completes the applicable DDDS Standard Agreement form.

If a surrogate is desired by the participant who does not have a guardian or Power of Attorney, the surrogate must:

- Effectuate the decision the participant would make for himself/herself;
- Accommodate the participant, to the extent necessary that they can participate as fully as possible in all decisions that affect them;
- Give due consideration to all information, including the recommendations of other interested and involved parties;
- Assure DDDS that he or she has no conflict of interest and will support the participant's best interests, and
- Embody the guiding principles of self-determination.

If a surrogate has not been designated by a court, the participant may designate a surrogate from the following list, as available and willing:

- A spouse (unless a formal legal action for divorce is pending);
- An adult child of the participant;
- A parent;
- An adult brother or sister;
- An adult grandchild;
- Any adult who has knowledge of the participant's preferences and values.

A surrogate may not receive payment for this function. In addition, a surrogate, other than guardians as described in C-2-e,may not receive payment for any waiver services the surrogate provides to the participant

for whom they are a surrogate.

The Agency With Choice (AWC) broker must recognize the participant's chosen surrogate as part of the participant's decision-making process, and provide the surrogate with all of the information, training, and support it would typically provide to a participant who is self-directing. The AWC broker must fully inform the surrogate of the rights and responsibilities of a surrogate. Once fully informed, the AWC broker must have the surrogate review and sign a DDDS Standard Agreement form, which must be given to the surrogate and maintained in the participant's file. The agreement lists the roles and responsibilities of the surrogate, states that the surrogate accepts the roles and responsibilities of this function, and states that the surrogate will abide by DDDS policies and procedures. Unless otherwise limited by the participant, the surrogate would assist in providing direction over the individual support plan for the Respite and Personal Care services that is being self-directed, selection of caregiver, approval of the worker's timesheets with assurance each timesheet is accurate and truthful and negotiation of payment rates for the caregiver. If the participant disagrees with a decision made by the surrogate who is not the parent of a minor child, guardian or Power of Attorney, the participant's decision prevails. The participant may revoke the designation at any time. The revocation should be in writing.

Monitoring of the person centered plan takes place with each participant at the minimum frequency specified in D-2-a. The plan review should identify any issues with the surrogate not acting in the best interest of the participant. The Community Navigator must address any issues noted.

The AWC broker is required to address and report any issues identified with the surrogate's performance including compliance to the DDDS policy on critical incident reporting, including suspected fraud or abuse.

The Community Navigator will assist the participant throughout this process.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

- g. Participant-Directed Services.** Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

| Waiver Service | Employer Authority | Budget Authority |
|----------------|-------------------------------------|--------------------------|
| Respite | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| Personal Care | <input checked="" type="checkbox"/> | <input type="checkbox"/> |

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

- h. Financial Management Services.** Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one:*

- ☒ **Yes. Financial Management Services are furnished through a third party entity.** (Complete item E-1-i).

Specify whether governmental and/or private entities furnish these services. *Check each that applies:*

☐ **Governmental entities**

☒ **Private entities**

- ☐ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.**
Do not complete Item E-1-i.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

- i. **Provision of Financial Management Services.** Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one:*

☐ FMS are covered as the waiver service specified in Appendix C-1/C-3

The waiver service entitled:

☒ FMS are provided as an administrative activity.

Provide the following information

- i. **Types of Entities:** Specify the types of entities that furnish FMS and the method of procuring these services:

A private entity that is selectively contracted by the state.

The Agency with Choice Broker was procured through a competitive RFP issued by the Delaware Division of Developmental Services. The vendor organization which was awarded the contract demonstrated clear superiority of experience and capabilities.

- ii. **Payment for FMS.** Specify how FMS entities are compensated for the administrative activities that they perform:

As an Agency With Choice broker, the agency will be compensated for the cost of recruitment, screening, establishing payment rates with participant input, processing timesheets, payroll and withholding, maintenance of employee records, issuing W-2s, processing payments for respite camps, submitting Medicaid claims on behalf the participant, assessing participant satisfaction and assisting the participant in performing supervisory functions, such as training and performance evaluation.

DDDS has developed a standard methodology for reimbursing AWC administrative activities. There is an initial one-time set-up payment for each new participant that elects to self-direct their Respite or Personal Care service and a separate standard on-going monthly payment. Payment to the vendor will be a fixed dollar amount for each participant who has elected to self-direct their Respite or Personal Care service. This monthly payment covers all on-going activities as specified in the vendor contract. The administrative payments to the AWC broker are entirely separate from the funds dedicated to the participant's allotment for services.

The AWC provider receives a monthly per participant administrative fee for the administrative service provided by the AWC as specified in the vendor contract. The monthly administrative fee is negotiated between DDDS and the AWC vendor and must be applied consistently across all participants who elect self-direction. The AWC broker must submit monthly invoices to the state. Administrative claims are submitted by the AWC broker to DDDS for approval and payments are made directly to the AWC broker from the Delaware Treasury via the Delaware State accounting system.

DDDS contracts with a single statewide AWC broker.

- iii. **Scope of FMS.** Specify the scope of the supports that FMS entities provide (*check each that applies*):

Supports furnished when the participant is the employer of direct support workers:

- ☒ Assist participant in verifying support worker citizenship status
- ☒ Collect and process timesheets of support workers
- ☒ Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance
- ☒ Other

Specify:

The individual and the AWC broker are co-employers, but the AWC broker is the employer of record.

In addition to the supports listed in section iii. above, the AWC broker will also perform the following activities on behalf of participants:

- arrange for or conduct background checks on prospective employees.
- assure prospective employees meet waiver requirements
- enroll self-directed employees that meet requirements and have valid licenses if applicable
- establish an hourly payment rate for each employee with participant input and within the State fee schedule
- respond to IRS inquiries regarding tax withholding
- ensure that all applicable FLSA rules for the payment of minimum wage and overtime are adhered to
- assist the participant in training techniques for their caregiver if necessary
- maintain a separate accounting for each participant and monitor participant utilization on a regular basis
- report account balances against the maximum allotment per participant to the appropriate AWC broker liaison in the DDDS Regional Office
- for participants that do not have a preferred employee in mind to provide Respite or Personal Care, the AWC vendor will make referrals and assist the individual in selecting an employee that will meet his or her needs.

Supports furnished when the participant exercises budget authority:

- ☐ **Maintain a separate account for each participant's participant-directed budget**
- ☐ **Track and report participant funds, disbursements and the balance of participant funds**
- ☐ **Process and pay invoices for goods and services approved in the service plan**
- ☐ **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- ☐ **Other services and supports**

Specify:

Additional functions/activities:

- ☒ **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- ☒ **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- ☒ **Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget**
- ☐ **Other**

Specify:

- iv. **Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

The Agency With Choice Broker contract was competitively procured using the approved State of Delaware and Department of Health and Social Services rules. An RFP that defined the contract requirements, standards, deliverables, reporting and performance metrics was issued. Those requirements were incorporated by reference into the contract that was signed with the selected vendor. The RFP requires that the AWC broker submit an independent financial audit to DDDS each year.

DDDS monitors and assesses the performance of the FMS in the following ways:

The participant (or the participant's surrogate) is the co-employer of workers who provide waiver services. A statewide AWC broker is, as the employer of record, an IRS-approved Fiscal/Employer Agent and functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law.

DDDS monitors the AWC vendor to ensure that the contract deliverables are met and participants are in receipt of AWC vendor services in accordance with their Individual Support Plan. Two individuals within DDDS are designated as Liaisons to the AWC vendor. They report to a Senior DDDS Manager who is the manager for the AWC vendor contract. The statewide AWC broker is monitored by DDDS at a frequency established by DDDS. DDDS monitors the AWC broker's performance of administrative activities, as well as adherence to contract conditions and waiver requirements. The Community Navigators are also responsible for reporting any issues regarding the statewide AWC broker to the DDDS AWC Liaisons or the contract manager as part of their job duties.

The DDDS AWC Liaisons review expenditures against waiver coverage and whether they are accurately and appropriately assigned and reported. The AWC broker is required to provide monthly reports and documentation to the DDDS AWC Liaisons that identifies the amounts paid to employees/caregivers on behalf of waiver participants. The AWC broker will maintain signed time sheets for all employees for each pay period which can be reviewed by the DDDS AWC Liaisons at any time. If errors are noted, the DDDS Liaisons will report them to the AWC vendor for correction by the following pay period. In addition to reviewing routine reports provided by the AWC vendor, the DDDS AWC Liaisons will also periodically conduct unannounced audits of AWC records at its office location.

DDDS AWC Liaisons identify inconsistencies between utilization, expenditures, dates of service, waiver enrollment date and claims and then follow up with AWC vendor to ensure that any errors are corrected. The DDDS AWC Liaison periodically monitor units paid and account balances to ensure there are sufficient funds in each account to cover services up to the approved limit. Systemic errors require a Plan of Correction from the AWC vendor which must be approved by the DDDS AWC contract manager and will be monitored by the DDDS AWC Liaisons.

DDDS monitors claims submitted by the AWC broker using established claims oversight methods. DDDS has safeguards to ensure the payments to the AWC broker for both administrative fees and Medicaid services are in accordance with all applicable regulations and requirements.

Periodically, the DDDS Liaisons will randomly select a number of provider files maintained by the AWC broker to verify such elements as provider screening and training, copy of IRS Forms W-4 and I-9, accuracy of wage payments and withholding, compliance with US DOL FLSA rules.

Quarterly, the DDDS AWC Liaisons will verify AWC vendor payment/filing of the State Income Tax, Unemployment Tax, Workers Compensation and IRS Forms 940 and 941 and Forms W-2/W-3.

At the end of the first year, DDDS will review all AWC broker systems and practices to confirm that standard operating procedures are in place to ensure compliance with contract requirements and Medicaid regulations. Annually, DDDS will also review required reporting on performance metrics such as timeliness of payroll and payment of other invoices by the AWC vendor, participant satisfaction, and timeliness of response to customer calls where a message is left after hours, complaints resolution, etc. as specified in the contract.

Community Navigators monitor participant service delivery at a frequency identified in Appendix D-2-a which includes the delivery of the administrative services provided by the AWC broker.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

- j. Information and Assistance in Support of Participant Direction.** In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested (*check each that applies*):

- ☒ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

The Community Navigators providing Targeted Case Management will have sufficient training and printed information to explain, in general, the self-directed option to families and participants. If the family is interested in this option, the Community Navigator connects the participant to the Agency with Choice provider.

- ☐ **Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (*check each that applies*):

| Participant-Directed Waiver Service | Information and Assistance Provided through this Waiver Service Coverage |
|--|--|
| Clinical Consultation: Nursing | <input type="checkbox"/> |
| Home or Vehicle Accessibility Adaptations | <input type="checkbox"/> |
| Day Habilitation | <input type="checkbox"/> |
| Respite | <input type="checkbox"/> |
| Supported Employment - Small Group | <input type="checkbox"/> |
| Specialized Medical Equipment and Supplies not otherwise covered by Medicaid | <input type="checkbox"/> |
| Assistive Technology for Individuals not otherwise covered by Medicaid | <input type="checkbox"/> |
| Supported Living | <input type="checkbox"/> |
| Prevocational Services | <input type="checkbox"/> |
| Supported Employment - Individual | <input type="checkbox"/> |
| Personal Care | <input type="checkbox"/> |
| Community Transition | <input type="checkbox"/> |
| Clinical Consultation: Behavioral | <input type="checkbox"/> |
| Residential Habilitation | <input type="checkbox"/> |

- ☒ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

a) In addition to the information provided to waiver participants and families by the Community Navigators

regarding the opportunity for self-direction, the Agency With Choice vendor will also be responsible for thoroughly explaining the self-direction roles and responsibilities so that participants can make an informed decision about whether this model will meet their needs.

b) The Agency with Choice Broker is a private entity that was procured through a competitive RFP issued by the Delaware Division of Developmental Services. The vendor organization which was awarded the contract demonstrated clear superiority of experience and capabilities.

DDDS has developed a standard methodology for reimbursing AWC administrative activities. There is an initial one-time set-up payment for each new participant that elects to self-direct their Respite or Personal Care service and a separate standard on-going monthly payment. Payment to the vendor will be a fixed dollar amount for each participant who has elected to self-direct their Respite or Personal Care service. This monthly payment covers all on-going activities as specified in the vendor contract. The administrative payments to the AWC broker are entirely separate from the funds dedicated to the participant's allotment for services.

The AWC provider receives a monthly per participant administrative fee for the administrative service provided by the AWC as specified in the vendor contract. The monthly administrative fee is negotiated between DDDS and the AWC vendor and must be applied consistently across all participants who elect self-direction. The AWC broker must submit monthly invoices to the state. Administrative claims are submitted by the AWC broker to DDDS for approval and payments are made directly to the AWC broker from the Delaware Treasury via the Delaware State accounting system.

DDDS contracts with a single statewide AWC broker.

c) Once a participant has elected to self-direct their Respite or Personal Care service, the AWC broker will perform the following functions:

- Ensure that they understand their role as distinct from the AWC role
- Assist the participant in selecting caregivers that meet his or her individual needs if the participant has not previously specified a caregiver
- If the agency chooses to, or if requested by the program participant, the AWC broker will conduct the interview, with the participant, and vet potential candidates who may be able to meet the participant's support needs under Respite or Personal Care service
- Ensure that employees meet basic minimum, non-participant-specific training requirements such as CPR or safe lifting techniques
- Assist the waiver participant in understanding and carrying out their role as the managing employer
- Assist the waiver participant in resolving conflicts with their employee
- Assist the waiver participant in creating a back-up plan in the event their regular caregiver is not available for one or more days
- terminate employees who fail to perform satisfactorily (this is different from the determination of a participant that an employee is not meeting their particular needs)
- notify the Community Navigator or one of the DDDS AWC Liaisons of any concerns

The AWC broker will also create and maintain a registry of prospective workers from which waiver participants may choose.

d) and e) DDDS will oversee the provision of this assistance through monitoring of the AWC vendor contract. DDDS monitors the AWC vendor to ensure that the contract deliverables are met and participants are in receipt of AWC vendor services in accordance with their Individual Support Plan. Two individuals within DDDS are designated as Liaisons to the AWC vendor. They report to a Senior DDDS Manager who is the manager for the AWC vendor contract. The statewide AWC broker is monitored by DDDS at a frequency established by DDDS. DDDS monitors the AWC broker's performance of administrative activities, as well as adherence to contract conditions and waiver requirements. The Community Navigators are also responsible for reporting any issues regarding the statewide AWC broker to the DDDS AWC Liaisons or the contract manager as part of their job duties.

The DDDS AWC Liaisons review expenditures against waiver coverage and whether they are accurately and appropriately assigned and reported. The AWC broker is required to provide monthly reports and documentation to the DDDS AWC Liaisons that identifies the amounts paid to employees/caregivers on behalf of waiver participants. The AWC broker will maintain signed time sheets for all employees for each pay period which can

be reviewed by the DDDS AWC Liaisons at any time. If errors are noted, the DDDS Liaisons will report them to the AWC vendor for correction by the following pay period. In addition to reviewing routine reports provided by the AWC vendor, the DDDS AWC Liaisons will also periodically conduct unannounced audits of AWC records at its office location.

DDDS AWC Liaisons identify inconsistencies between utilization, expenditures, dates of service, waiver enrollment date and claims and then follow up with AWC vendor to ensure that any errors are corrected. The DDDS AWC Liaison periodically monitor units paid and account balances to ensure there are sufficient funds in each account to cover services up to the approved limit. Systemic errors require a Plan of Correction from the AWC vendor which must be approved by the DDDS AWC contract manager and will be monitored by the DDDS AWC Liaisons.

DDDS monitors claims submitted by the AWC broker using established claims oversight methods. DDDS has safeguards to ensure the payments to the AWC broker for both administrative fees and Medicaid services are in accordance with all applicable regulations and requirements.

Periodically, the DDDS Liaisons will randomly select a number of provider files maintained by the AWC broker to verify such elements as provider screening and training, copy of IRS Forms W-4 and I-9, accuracy of wage payments and withholding, compliance with US DOL FLSA rules.

Quarterly, the DDDS AWC Liaisons will verify AWC vendor payment/filing of the State Income Tax, Unemployment Tax, Workers Compensation and IRS Forms 940 and 941 and Forms W-2/W-3.

At the end of the first year, DDDS will review all AWC broker systems and practices to confirm that standard operating procedures are in place to ensure compliance with contract requirements and Medicaid regulations. Annually, DDDS will also review required reporting on performance metrics such as timeliness of payroll and payment of other invoices by the AWC vendor, participant satisfaction, and timeliness of response to customer calls where a message is left after hours, complaints resolution, etc. as specified in the contract.

Community Navigators monitor participant service delivery at a frequency identified in Appendix D-2-a which includes the delivery of the administrative services provided by the AWC broker.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy (*select one*).

- ☒ **No. Arrangements have not been made for independent advocacy.**
- ☐ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

- l. Voluntary Termination of Participant Direction.** Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

Voluntary Termination of Participant Direction

An individual who elects to receive participant-directed Respite and Personal Care can elect to terminate participant direction at any time. The state ensures the continuity of services for and the health and welfare of the participant who elects to terminate participant directed Respite and Personal Care services.

Community Navigators shall facilitate a seamless transition to an alternative service delivery method so that there are no interruptions or gaps in services. Community Navigators shall ensure that employees remain in place until alternative providers are obtained and are scheduled to provide services. Community Navigators shall monitor the transition to ensure that the service is provided consistent with the person-centered plan and in keeping with the participant goals and objectives.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

- m. Involuntary Termination of Participant Direction.** Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Involuntary Termination of Participant Direction

Participants who opt to self-direct their Respite and Personal Care services receive a great deal of support to assist them in carrying out their responsibilities. This support leads to successful participant direction in most cases. However, there are a several circumstances under which the State would find it necessary to terminate participant direction. Specifically, the State involuntarily terminates the use of participant direction under the following circumstances:

- **Inability to self-direct.** If an individual consistently demonstrates a lack of ability to carry out the tasks needed to self-direct Respite and Personal Care services, including hiring, training, and supervising his or her respite provider or personal care attendant, and does not have a representative available and able to carry out these activities on his/her behalf, then the State would find it necessary to terminate the use of participant direction.
- **Fraudulent use of funds.** If there is substantial evidence that a participant has falsified documents related to participant directed services (for example authorizing payment when no services were rendered or otherwise knowingly submitting inaccurate timesheets), then the State would find it necessary to terminate the use of participant direction.
- **Health and welfare risk.** If the use of participant direction results in a health and welfare risk to the participant that cannot be rectified through intervention on the part of the AWC provider and/or the Community Navigator, then the State would find it necessary to terminate the use of participant direction.

In cases in which participant direction is discontinued, the Community Navigator makes arrangements immediately with the participant to select from a list of provider managed personal care entities (i.e., those home health agencies and personal assistance services agencies enrolled to provide the respite or personal care). Once the individual has selected a new Respite and Personal Care provider, the Community Navigator makes arrangements to have the agency-based service begin as soon as possible to minimize or eliminate any possible gap in service.

Community Navigators shall facilitate a seamless transition to alternative service delivery method so that there are no interruptions or gaps in services. Community Navigators shall ensure that employees remain in place until alternative providers are obtained and are scheduled to provide services. Community Navigators shall monitor the transition to ensure that the service is provided consistent with the person-centered plan and in keeping with the participant goals and objectives.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

- n. Goals for Participant Direction.** In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

| | Employer Authority Only | Budget Authority Only or Budget Authority in Combination with Employer Authority |
|-------------|-------------------------|--|
| Waiver Year | Number of Participants | Number of Participants |
| Year 1 | 0 | |
| Year 2 | 0 | |
| Year 3 | 0 | |
| Year 4 | 300 | |
| Year 5 | 310 | |

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

- a. **Participant - Employer Authority** Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:

- i. **Participant Employer Status.** Specify the participant's employer status under the waiver. *Select one or both:*

- ☒ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

The Agency With Choice broker will be the co-employer along with the participant.

- ☐ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

- ii. **Participant Decision Making Authority.** The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise:*

- ☒ **Recruit staff**
☒ **Refer staff to agency for hiring (co-employer)**
☒ **Select staff from worker registry**
☐ **Hire staff common law employer**
☐ **Verify staff qualifications**
☐ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

- ☒ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**
☒ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**

- ☐ Determine staff wages and benefits subject to State limits
- ☒ Schedule staff
- ☒ Orient and instruct staff in duties
- ☐ Supervise staff
- ☒ Evaluate staff performance
- ☒ Verify time worked by staff and approve time sheets
- ☐ Discharge staff (common law employer)
- ☒ Discharge staff from providing services (co-employer)
- ☒ Other

Specify:

The participant will provide information to the AWC broker as requested to facilitate common-law employer functions. The participant will also need to have a cooperative relationship with the AWC broker.

The participant will be supported to engage to the maximum extent possible in selecting an appropriate employee wage within an allowable and reasonable wage scale and to negotiate the wage with a potential employee.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

- b. Participant - Budget Authority** *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

- i. Participant Decision Making Authority.** When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more:*

- ☐ Reallocate funds among services included in the budget
- ☐ Determine the amount paid for services within the State's established limits
- ☐ Substitute service providers
- ☐ Schedule the provision of services
- ☐ Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3
- ☐ Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3
- ☐ Identify service providers and refer for provider enrollment
- ☐ Authorize payment for waiver goods and services
- ☐ Review and approve provider invoices for services rendered
- ☐ Other

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (5 of 6)**b. Participant - Budget Authority**

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

- ii. **Participant-Directed Budget** Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Appendix E: Participant Direction of Services**E-2: Opportunities for Participant-Direction (4 of 6)****b. Participant - Budget Authority**

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

- iii. **Informing Participant of Budget Amount.** Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Appendix E: Participant Direction of Services**E-2: Opportunities for Participant-Direction (5 of 6)****b. Participant - Budget Authority**

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

- iv. **Participant Exercise of Budget Flexibility.** *Select one:*

- ☐ **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ☐ **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services**E-2: Opportunities for Participant-Direction (6 of 6)****b. Participant - Budget Authority**

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

- v. **Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

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 Division of Developmental Disabilities Services (DDDS) mails written notifications to HCBS applicants and recipients at the time of an adverse eligibility decision, the lack of choice of service provider and/or if an HCB service is reduced, suspended or terminated for an individual. The notification is presented in understandable language, provides an explanation for the action, describes the applicant/recipient's right to Fair Hearing via the DHSS Division of Social Services under an MOU with the Medicaid Agency and explains the method by which a Fair Hearing can be requested. The Medicaid Fair Hearing is a State administrative hearing process and its regulations are published in the Delaware Administrative Code, Section 5000. Written notifications of adverse actions are required to include the following elements:

- The right to appeal the action through the Medicaid Fair Hearing process, through an internal DDDS appeal process (see F-2-b. below) or both;
- An explanation that the request for a Medicaid Fair Hearing must be in writing;
- An explanation that the applicant/recipient may be represented at a Fair Hearing by an attorney, friend or person of their choice;
- Contact information for the Community Legal Aid Society, Inc., including a toll free phone number and advise to the recipient that they offer free legal advice/representation;
- An explanation of the reason(s) for the DDDS action including the specific regulations that support said action

The written notice must be mailed at least within ten (10) days before the effective date of the action (this applies to HCBS waiver recipients; not applicants who are not currently receiving HCB services). Exceptions to the 10 day timely notice are delineated in Delaware Administrative Code, Title 16, §5302 and are consistent with 42 CFR 431.213.

Written notifications relative to adverse actions and the right to a Fair Hearing are maintained at the Office of Applicant Services (for applicants) or maintained in the individual's case record (for current HCBS recipients). The outcome of the Medicaid Fair Hearing is maintained by Medicaid Agency.

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.

The Division of Developmental Disabilities Services (DDDS) operates the DDDS HCBS Lifespan Waiver. In addition to the right to a Medicaid Fair Hearing through the DSS, an HCBS applicant or HCBS waiver service participant also has the right to an appeal any adverse action affecting Medicaid eligibility or benefits via an internal DDDS appeal process. The right to a DDDS appeal and a Medicaid Fair Hearing are simultaneously offered to an HCBS applicant or HCBS waiver service recipient when an adverse decision is made; including the denial of eligibility, the denial, reduction, suspension or termination of Medicaid HCBS services for an individual or the lack of choice of a service provider.

HCBS waiver applicants and participants are notified via written correspondence relative to all adverse actions, as delineated in the above paragraph. The notification of adverse action clearly states in understandable language that the applicant or HCBS waiver participant may appeal the adverse decision through the DDDS internal appeals process or through the Medicaid Fair Hearing process or both. An individual is not required to file a DDDS appeal request as a pre-requisite to accessing a Medicaid Fair Hearing process. The DDDS appeal is not a dispute resolution process that must be used in lieu of the Medicaid Fair Hearing, but it is offered as a less formal means of addressing grievances. The notification includes the reasons for the adverse action(s) including applicable citations and the information that was used to make the determination, effective date of action(s) and process by which a DDDS appeal may be requested. No action may be taken on a DDDS decision to deny, reduce, suspend or terminate HCBS waiver services, if an appeal request is received within the timely notice period (10 days before date of action). The notification also advises the reader of how, to whom and when a Medicaid Fair Hearing request with DSS can be made.

The DDDS appeal process is an internal agency operating mechanism and its regulations are published in the Delaware Administrative Code, Section 2101. The appeals committee membership includes a chairperson and representatives from the Stockley Center ICF-IID facility and all regions of the DDDS Community Services Unit.

Disputable items through the DDDS internal appeals process for waiver applicants or participants include:

- an adverse decision regarding a DDDS Level of Care determination or redetermination;
- the choice of service provider is not granted;
- an HCB waiver service is denied, reduced, suspended or terminated for an individual.

Procedural elements of the DDDS appeals process include the following elements:

- A timely notice (10 days before date of action) of intent to reduce, suspend or terminate waiver services must be mailed to the HCBS waiver recipient;
- Exceptions to the timely notice requirement are delineated in Delaware Administrative Code, Title 16, §5302 and are consistent with 42 CFR 431.213;
- DDDS appeals request must be received by the DDDS Appeals Committee chair within 30 calendar days of the decision;
- The appellant is contacted by the DDDS Appeals Committee chairperson within 5 working days of receipt of appeals request to schedule the appeal;
- Appeal meeting must be scheduled within 90 days of receiving the appeal request;
- HCBS waiver services must not be denied, reduced, suspended or terminated pending a decision of a DDDS appeal, Medicaid Fair Hearing or both, if a request for either is filed within ten (10) days of the proposed action implementation date. Exceptions to this rule are delineated in Delaware Administrative Code, Title 16, §5302;
- Appeal Committee members meet with the appellant, and his/her guests at the appeal meeting;
- Appeal committee chairperson offers the committee's recommendation to the Division Director within five (5) working days of the appeal.
- DDDS Division Director sends written notification of outcome to appellant within fifteen (15) working days of appeal. DDDS Division Director provides appellant with explanation of right to appeal decision to DSS via the Medicaid Fair Hearing process. Contact information is given by which a Medicaid Fair Hearing can be requested.
- DDDS Appeals Committee chairperson maintains all records associated with the appeal request. Data is tracked on an electronic database and reviewed by the DDDS Performance Analysis Committee.

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:

DDDS is responsible for the operation of the internal grievance/complaint system(s). In addition, DDDS requires each waiver provider to offer an internal dispute resolution process to waiver enrollees to provide an opportunity to address grievances at the lowest level possible. Waiver enrollees are not required to use either the provider grievance process of the DDDS internal dispute resolution process before exercising their right to a Medicaid Fair Hearing for any issue that is appealable through that process.

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 the DDDS grievance system:

The DDDS Director of Planning and Policy Development and Constituent Relations Liaison is the Rights Complaint Designee appointed by the Division Director. In accordance with the DDDS Rights Complaint policy, Individual Rights Complaint forms and instructions for the completion of such are prominently placed and accessible in all program and administrative offices and locations within DDDS-funded program areas. The DDDS Rights and Responsibilities Policy requires the Statement of Rights to be reviewed with the waiver participant and his/her guardian by the individual that leads the planning team during the annual meeting to discuss the person centered service plan. The Statement of Rights is broken into three sections: services and supports, privacy and choice. A waiver participant or any concerned person acting on behalf of the participant has the right to file a rights complaint with DDDS if they have reason to believe that a right is being violated or restricted without due process. Rights Complaints filed with the DDDS Rights Complaint Designee are investigated at a regional level. The completed investigations of a rights complaint are reviewed by the appropriate administrator and returned to the DDDS Client Rights Complaint Designee. For substantiated complaints, a Corrective Action Plan must be developed. The Plan must be reviewed and approved by the appropriate administrator before it is returned to the DDDS Client Rights Complaint Designee. The Director of Community Services contacts the complainant regarding the disposition of the complaint. The aforementioned process is completed within sixty (60) working days of the date the Rights Complaint Designee receives the rights complaint form. The outcome of the Rights Complaint is sent to the Human Rights Committee for review

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 types of incidents that HCBS providers are required to report to the Division. These incidents are known as reportable “PM46” incidents and “non –PM46” occurrences. PM46 refers to Department of Health and Social Services (DHSS) Policy Memorandum number forty-six that defines incidents that must be reported for services provided in all DHSS divisions. Because DDDS is a DHSS Division, any incident that meets the scope and definition of DHSS Policy Memorandum #46 must be reported and investigated using a standardized protocol. In addition, DHSS Divisions may define additional types of critical reportable incidents that fall outside of the scope of the DHSS PM46. DDDS has a policy that requires reporting for settings not covered under the PM46 scope and incidents that would not be required to be reported under PM46.

Reportable incidents under PM46 are defined as suspicion of any of the following occurrences:

1. Abuse shall mean:

- a. Physical abuse by unnecessarily inflicting pain or injury to a patient or resident. This includes but is not limited to, hitting, kicking, punching, slapping or pulling hair. When any act constituting physical abuse has been proven, the infliction of pain is assumed;
- b. Sexual abuse which includes, but is not limited to, any sexual contact, sexual penetration, or sexual intercourse by an employee or contractor, as defined in 11 DE Code, Ch. 5, §761, with an individual. It shall be no defense that the sexual contact, sexual penetration, or sexual intercourse was consensual;
- c. Sexual act (any) between staff and an individual and any non-consensual sexual act between individuals or between an individual and any other person such as a visitor;
- d. Emotional abuse which includes, but is not limited to, ridiculing, demeaning, humiliating, bullying or cursing at an individual, or threatening an individual with physical harm.

2. Financial Exploitation shall mean the illegal or improper use, control over, or withholding of the property, income, resources, or trust funds of the individual by any person or entity for any person’s or entity’s profit or advantage other than for the individual’s profit or advantage. “Financial exploitation” includes, but not limited to:

- a. The use of deception, intimidation, or undue influence by a person or entity in a position of trust and confidence with an individual to obtain or use the property, income, resources, or trust funds of an individual for the benefit of a person or entity other than the individual;
- b. The breach of a fiduciary duty, including but not limited to, the misuse of a power of attorney, trust, or a guardianship appointment that results in the unauthorized appropriation, sale or transfer of the property, income, resources or trust funds of the individual for the benefit of a person or entity other than the individual; and
- c. Obtaining or using an individual’s property, income, resources, or trust funds without lawful authority, by a person or entity who knows or clearly should know that the individual lacks the capacity to consent to the release or use of his or her property, income, resources, or trust funds.

3. Medication Diversion shall mean knowingly or intentionally interrupting, obstructing or altering the delivery or administration of a prescription drug to an individual receiving services, provided that such prescription was:

- a. Prescribed or ordered by a licensed health care practitioner for the individual receiving services and
- b. The interruption, obstruction or alteration occurred without the prescription or order of a licensed health care practitioner.

4. Mistreatment shall mean the inappropriate use of medications, isolation, or physical or chemical restraints on or of an individual receiving service.

5. Neglect shall mean:

- a. Lack of attention to the physical needs of an individual receiving service to include but not limited to toileting, bathing, nutrition and safety.
- b. Failure to report problems or changes in health problems or changes in health condition to an immediate supervisor or nurse;
- c. Failure to carry out a prescribed treatment plan or plan of care that resulted in a negative impact or potential

negative impact or the neglect resulted in a repeated trend

d. A knowing failure to provide adequate staffing which results in a medical emergency to any individual receiving services where there has been documented history of at least two (2) prior cited instances of such inadequate staffing within the past two (2) years in violation of minimum maintenance of staffing levels as required by statute or regulations promulgated by the Department, all so as to evidence a willful pattern of such neglect. (16 DE Code, §1161-1169).

6. Unanticipated Death shall include all deaths of individuals served that are of a suspicious and/or unusual nature. They shall also include those deaths whereby the Division of Forensic Science assumed jurisdiction.

7. Significant Injury shall include:

- a. Injury from an incident of unknown source in which the initial evaluation supports the conclusion that the injury is suspicious. Circumstances which may cause an injury to be suspicious are: the extent of the injury, the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma), the number of injuries observed at one particular point in time, or the incidence of injuries over time;
- b. Injury which results in transfer to an acute care facility for treatment or evaluation or which requires periodic neurological reassessment of the resident's clinical status by professional staff for up to twenty four (24) hours;
- c. Areas of contusions or bruises caused by staff to an individual served during ambulation, transport, transfer or bathing;
- d. Significant error or omission in medication/treatment, including drug diversion, which causes the resident discomfort, jeopardizes the individual's health and safety or requires periodic monitoring for up to forty eight (48) hours;
- e. A burn greater than first degree;
- f. Any serious unusual and/or life-threatening injury.

The process for reporting and following up on PM#46 incidents is as follows:

The person who has reasonable cause to believe that an individual has been abused, neglected, mistreated, financially exploited, had their medication diverted, received a significant injury or dies an unanticipated death shall immediately take actions to ensure the individual receives all necessary medical treatment and evaluation and then;

1. Take actions to protect all individuals from further physical or emotional harm and then;
2. Ensure that individuals reported to be victims of sexual assault are examined by SANE at the hospital and then (or concurrently if possible); contact the local law enforcement to report crimes against individuals and then;
3. Immediately call the DDDS Regional Investigative Coordinator and then;
4. Complete a written report within twenty four (24) hours and submit it to the DDDS Regional Investigative Coordinator and then if the incident happens in a Neighborhood Home;
5. Make a verbal report to the DLTCRP by telephoning the twenty four (24) hour toll free number at 1-877-453-0012.

The Office of Investigative Services shall notify the individual (reported victim) unless there is an identified guardian of person (or property if the allegation involves financial exploitation), health care surrogate pursuant to Title 16, §2507 or other legally authorized person of the guardian or primary contact person, or release of information has the potential to do harm or if the individual served (victim) expressly communicates that he/she does not want the non-guardian family contact person to be contacted about the allegation. Notifications shall occur with the following frequency:

- i. Initial notification on the day the reportable incident is reported to the OIS recipient of reportable incidents (verbal and written);
 - ii. Follow-up notifications if the investigation exceeds five(5) working days (for Long Term Care Facilities) or ten (10) calendar days (verbal or written);
 - iii. Notification at the conclusion of the investigation (verbal and written).
- Non PM46 occurrences per DDDS policy include:

- Any major medical episode (such as a trip to the Emergency Department but where abuse or neglect are not suspected)
- Any behavior which necessitates the use of a physical or restrictive procedure
- Choking incident requiring the use of the Heimlich Maneuver or other medical intervention

- Acts of aggression
- Elopement of Missing Individual
- Criminal arrest
- Possession of Illegal substances
- Possession of firearms, knives, or explosives
- Medication error
- Extensive damage to property due to an individual receiving services (valued at \$2,000)
- Attempted Suicide

These incidents must be reported via the electronic record within eight (8) hours of the incident. On a regular basis DDDS will review reported incidents, analyze data for trends, and recommend changes in policy, practice, or training that may reduce the risk of such events occurring in the future. State wide trends will be provided to Providers to enhance the awareness of activities and to formulate prevention strategies. DDDS also requires Providers to have policies and procedures that promote the utilization of their incident data to track trends and to determine if the recommendations made in the final written report were implemented and are effective.

- 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 waiver participants are advised of their right to be free of physical, verbal, sexual, psychological/emotional abuse and exploitation both during their initial person centered planning process and as part of their annual PCP review. A Statement of Rights was developed as a DDDS policy. The case manager explains these rights to waiver participants a minimum of once per year, at the time the person centered plan is reviewed. 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. These requirements are documented in the DDDS policy entitled Individuals Rights.

- 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 reporting of incidents is overseen at several levels. The most immediate review and monitoring occur at the level of the person centered planning team. Team members minimally include the Support Coordinators and staff from providers who have been chosen by the participant to deliver services. These are the same individuals who will also document incidents, develop plans of correction and monitor the effectiveness of such plans in achieving desired outcomes.

DDDS Office of Investigative Services maintains an electronic database that includes information about the type and frequency of investigated reportable incidents, the victim and location, the plan of correction/improvement and verification of such. The data shall be used to trend incidents, measure performance and provide input for strategic planning. This stand-alone data will be incorporated into the new unified electronic case record software and will no longer exist as a stand-alone database thereafter.

The DDDS Office of Quality Improvement reviews all reportable incident data for each provider on an annual basis as part of the review against the DDDS waiver provider standards.

For each reported incident, OQI Program Evaluators review the participant's electronic case record to determine if appropriate follow up actions were taken, if such actions were effective and if trends exist within or across providers. The outcome of the review of the incident management system by the Program Evaluators is incorporated into the annual report given to each provider.

The Office of Quality Improvement (OQI) reviews PM46 incident data for each participant included within the annual representative sample of Quality Service Reviews (QSR). The OQI Program Evaluators access the electronic case record for each participant identified within the sample and review any reportable incidents that are present for completion, follow up, and timeliness of interventions to improve safeguards, to identify trends that may impact additional participants, and to determine whether an allegation of abuse, neglect, mistreatment, or exploitation is present in the record that should have been forwarded for investigation per DHSS PM46 but was not. OQI generates a deficiency notice and a request for a detailed plan of improvement for any identified ongoing concern or unresolved issue.

Allegations of abuse, neglect, mistreatment, financial exploitation or significant injury must be reported in writing to the DDDS Office of Investigative Services. By policy, the Office of Investigative Services must also report some allegations to all or some of the following individuals/entities: the DHSS Secretary's Office, DDDS Director, Division of Long Term Care Residents Protection, Medicaid Fraud Control Unit of the Department of Justice, Division of Forensic Science, applicable DDDS Regional Program Director(s), the Executive Director of the provider and law enforcement. The investigation is forwarded to the Division of Long Term Care Residents Protection (DLTCRP) pursuant to DE Code, Title 16, §1132. The waiver participant, guardian of person (and property if the allegation involves financial exploitation) and primary family contact person are notified that an investigation has been initiated, except when the participant communicates he/she does not want such information released or the release of information has the potential to do harm.

DDDS is required to complete a comprehensive investigative report for each allegation and submit it to the appropriate party as identified in the DDDS abuse policy, within ten (10) days of the initial notification of an allegation of abuse, neglect, mistreatment, financial exploitation, unless there are extenuating circumstances requiring further investigation. DDDS must also notify DLTCRP for any residences that it licenses, pursuant to DE Code Title 16, §1134(9). Upon completion of the investigation, the Support Coordinator notifies the family member that the investigation is completed, actions have been taken to protect the waiver participant and whether a further level of review will be completed by the Division of Long Term Care Residents Protection, Medicaid Fraud Control Unit or the Delaware Attorney General.

Based on the type of substantiated allegation, some offenders will be reported to a central data base known as the Adult Abuse Registry (AAR) maintained by the Division of Long Term Care Residents Protection as required by DE Administrative Code Title 16 §3101. Names of offenders will remain in the AAR for a designated period of time. An appeal process is offered and the name of the substantiated offender remains on the AAR if the fair hearing officer determines that a preponderance of evidence supports the investigative determination. DE Administrative Code Title 16, §3101 requires that health care service providers, which include all waiver providers, check the names of applicants for employment against the AAR prior to making an offer of employment. Current employees must also be periodically checked against the AAR. DDDS contracts with HCBS waiver providers prohibit them from employing individuals whose names are on the AAR or for those individuals to provide direct support to HCBS waiver participants.

- 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.

The DDDS Performance Analysis Committee (PAC) reviews waiver performance measures to determine if risk reduction strategies are necessary to strengthen the DDDS systems or improve the quality of life for waiver members. The PAC 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 compliance with waiver assurances and other key data elements. The PAC subsequently generates reports that are shared within the division on a regularly scheduled frequency or as requested.

DDDS has created a reporting tool it calls "DivStat". This tool is reviewed by the PAC at its regularly scheduled meetings. The critical incident aggregate data is reported as part of the DivStat report and is reviewed by the PAC. The PAC evaluates the data, draws conclusions and looks for trends within or across providers.

Analysis of critical incident data and trends (as opposed to individual remediation that is shared with specific providers) are shared with waiver providers at the Quarterly Provider Meetings.

The DDDS Office of Quality Improvements participates on the DMMA Quality Improvement Initiative (QII) committee and communicates with the DMMA regarding waiver performance measures. In addition, DMMA and DDDS meet each quarter to review the waiver performance measures and to monitor the status of any active Plans of Improvement.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

- a. **Use of Restraints.** *(Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will*

display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)

☐ **The State does not permit or prohibits the use of restraints**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

☒ **The use of restraints 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.** 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). 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 Use of Restraints and Restrictive Procedures for Behavior Support, DDDS has adopted the philosophy and techniques of Positive Behavior Support. Positive supports are an essential foundational element in the design of services, programs and individual plans.

Under the DDDS Policy, several restrictive procedures are prohibited including:

1. The use of aversive interventions (as defined in the Policy)
2. Seclusion
3. Denial of nutritionally adequate diet (withholding meals)
4. Any behavioral treatment strategies that are not supported by empirical evidence.
5. Any restrictive interventions intended to control, manage, or change behaviors that are not part of an approved behavior support plan.
6. Mechanical restraints
7. Chemical Restraints
8. The use of bed rails for behavioral support
9. The use of enclosed cribs for behavioral support without a formal assessment and diagnosis by a medical professional operating within the scope of his/her practice of a corresponding mental health disorder

DDDS also prohibits the use of corporal punishment or threat of corporal punishment, psychological abuse or punishment, waiver participants disciplining other waiver participants or techniques or procedures used in the absence of other relative proactive supports.

All recommended planned restrictive interventions are required to be reviewed and approved by Peer Review of Behavior Intervention Strategies (PROBIS) and the Human Rights Committee (HRC).

A. A Behavior Health Support Plan that recommends the use of restrictive interventions must include:

1. The specific targeted behavior to be addressed and a description of the conditions for which the restrictive intervention is used.
2. The single behavioral outcome desired stated in observable or measurable terms.
3. A summary of the Functional Behavioral 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 interventions.
5. Methods and target dates for modifying or eliminating the target behavior.
6. Methods and target dates for a replacement behavior.
7. A description of the intervention to be used.
8. A risk/benefit analysis.
9. Medical clearance if appropriate
10. Informed Consent from the individual, Health Care Surrogate, and/ or Guardian.
11. The name of the person(s) responsible for monitoring and documenting the response to the planned

restrictive intervention.

12. A plan for reducing and/or eliminating the restriction or planned restraint written within the Behavioral Health Support Plan, and if appropriate a detailed explanation and justification for continuing the planned restraint or restrictive intervention.

Permitted Planned 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 DDDS-approved Mandt curriculum or other DDDS-approved crisis intervention training.

Permitted Use of Restraints for Emergency Crisis Intervention (as defined in DDDS Policy):

1. When an emergency crisis intervention is necessary, only restraints that are taught as part of a DDDS approved Crisis Intervention Curriculum are permitted to be used. Restraints must be terminated when the individual is no longer a risk to himself/herself or others;
 2. Immediately stop the implementation of an emergency crisis intervention if the individual exhibits signs of distress (i.e. respiratory distress, seizure activity, vomiting, bleeding, change of skin coloring, etc.)
 3. If the use of an Emergency Crisis Intervention planned or unplanned is used, an Emergency Medical/Behavioral Intervention Strategy (EMBIS) report must be completed by the staff involved with the intervention. A member of the DDDS Behavioral Unit must review the report for completeness and seek clarification of any issues noted. The support team must meet within 5 business days to discuss the individual's plan and circumstances surrounding the use of the intervention and develop or modify the behavior support plan. The EMBIS must be presented at PROBIS at the next scheduled meeting.
 4. The 911 emergency response systems shall only be used as a last resort or as intensity requires protecting the health and safety of the individual.
 5. Suicide threats shall be responded to as an emergency and 911 shall be contacted. If a written plan of intervention exists for the individual, staff shall follow it.
- ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints 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 providers' use of restraints. DDDS analyzes restraint data as described above.

Each provider has access to the electronic case record system (ECR). Every use of a restraint, whether it is planned or emergency, is reported in the ECR by the involved parties within 24 hours using the critical event reporting process for Emergency Medical/Behavioral Intervention Strategies (EMBIS). These reports describe the incident, the restrictive intervention that was used, a description of the events leading up to the restraint, the duration of the restraint and follow-up, as necessary to assure the health and safety of the individual.

The DDDS Regional Program Director (RPD) receives electronic notification of the use of a restraint and reviews the report. The Regional Program Director ensures the individual's health and safety. Information on the use of restrictive procedures for an individual is reviewed by the individual's support team at least bi-monthly or more frequently, as indicated, and the Behavioral Support Plan is modified as necessary.

Additionally, the Office of Quality Improvement conducts annual reviews which include consumer interviews where individuals are asked about their health and welfare. Prior to these interviews the Office of Quality Improvement reviews the electronic case record database for any incidences of the use of a restraint for that individual. DDDS meets with the Medicaid Agency quarterly to review waiver performance data that includes data on incidents and complaints.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

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 the Use of Restraints and Restrictive Procedures, positive supports are an essential foundational element in the design of services, programs and individual plans. The policy discourages the use of restrictive procedures.

DDDS has adopted definition for a restrictive procedure from the Disability Act of 2006. Restrictive Intervention is defined in the Disabilities Act as "any intervention that is used to restrict the rights or freedom of movement of a person with an intellectual disability including chemical restraint, mechanical restraint and seclusion".

DDDS has adopted definition for an aversive intervention from November 2014 Research Committee of the National Association of Directors of Developmental Disabilities Services (NASDDDS). Aversive interventions are defined as "interventions intended to inflict pain, discomfort and/or social humiliation or any intervention as perceived by the person to inflict pain, discomfort or social humiliation in order to reduce behavior. Examples of aversive interventions include, but are not limited to, electric skin shock, liquid spray to one's face and a strong, non-preferred taste applied to the mouth".

Before the use of planned restrictive interventions can be approved in a Behavior Support Plan, the use of alternative, less intrusive methods must be explored and determined to not meet the need.

All planned restrictive interventions are required to be reviewed by PROBIS and approved by the Human Rights Committee.

The use of restrictive and/or planned restraint interventions shall be an approved detailed planned procedure identified in the Behavior Health Support Plan that shall include:

1. The specific targeted behavior to be addressed and a description of the conditions for which the restrictive intervention is used.
2. The single behavioral outcome desired stated in observable or measurable terms.
3. A summary of the Functional Behavioral 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 interventions.
5. Methods and target dates for modifying or eliminating the target behavior.
6. Methods and target dates for a replacement behavior.
7. A description of the intervention to be used.
8. A risk/benefit analysis.
9. Medical clearance if appropriate
10. Informed Consent from the individual, Health Care Surrogate, and/ or Guardian.
11. The name of the person(s) responsible for monitoring and documenting the response to the planned restrictive intervention.
12. A plan for reducing and/or eliminating the restriction or planned restraint written within the Behavioral Health Support Plan, and if appropriate a detailed explanation and justification for continuing

the planned restraint or restrictive intervention.

Methods for Detecting Unauthorized use of Restrictive Interventions

Each provider has access to the electronic case record system. 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 Behavior Support Plan which will 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, provider support staff enters notes for each individual into the electronic case record system for each date of service. Case managers and DDDS clinical support staff review this information several times a week. The DDDS Regional Program Director receives electronic notification of the use of any restrictive interventions and reviews the report. Improper or unauthorized use of a restrictive intervention is considered abuse and is investigated through the critical event reporting processes.

Restrictive intervention information for each individual is reviewed by the participant's support team at least bi-monthly or more frequently, as indicated in the Behavior Support Plan. Restrictive intervention information is reviewed by the PROBIS committee.

The Office of Quality Improvement conducts Individual and Focused case reviews that include record reviews. For waiver participants for whom a restrictive intervention was applied, OQI conducts an interview with the participant to determine if the intervention was performed appropriately. Undocumented use of a restrictive procedure is reported to the Regional Program Director who is responsible for follow up to ensure the individual's health and safety and to 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 reportable critical incident process. The Office of Quality Improvement submits quarterly reports to the Delaware DMMA which includes data on incidents and complaints.

Education and Training Requirements for Personnel who Administer Restrictive Interventions:

The DDDS Training Policy specifies required trainings and timelines for completion for each type of practitioner that has direct contact with waiver participants. Provider compliance with training requirements for each staff participant is monitored by the both the DDDS Office of Professional Development, on a provider and statewide basis, and by the DDDS Office of Quality Improvement as a part of the Quality Service Review sampling process for an individual waiver participant selected in the sample.

These training requirements are considered minimal expectations to help support the individual and create a structure that prevents restrictive interventions. All providers must have procedures in place to address how people are supported in emergency situations where an individual's health and safety may be at risk.

Providers are required to train their direct support staff on the DDDS policy relevant to the use of restrictive interventions. All providers are required to participate in DDDS-approved crisis intervention training. Waiver providers must be certified for each specific restrictive intervention prior to its use with an individual.

DDDS-Approved Crisis Intervention System includes the following topics:

- 1) Environmental factors and triggers,
- 2) Positive behavioral support,
- 3) Person-centered alternatives to the use of restrictive interventions and 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, including permitted holds, and possible

negative psychological and physiological effects of 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 participants.

- 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:

DDDS is responsible for the oversight of the use of restrictive interventions and for ensuring that provider staff are trained in a DDDS-approved curriculum regarding crisis intervention. DDDS analyzes restrictive intervention data as described above.

Every use of a restrictive intervention is reported in the electronic case record by the involved parties employed by the provider within 24 hours using the proscribed reporting protocol. These reports provide information identified in the Behavior Support Plan which includes a description of the incident, a description of the events leading up to the restrictive intervention, the duration of the restrictive intervention and any required follow-up actions.

Additionally, provider support staff enters notes for each individual into the electronic case record system for each date of service. Case managers and DDDS clinical support staff review this information several times a week. The DDDS Regional Program Director receives electronic notification of the use of any restrictive interventions and reviews the report. Improper or unauthorized use of a restrictive intervention is considered abuse and is investigated through the critical event reporting processes.

Restrictive intervention information for each individual is reviewed by the member's support team at least bi-monthly or more frequently, as indicated in the Behavior Support Plan. Restrictive intervention information is reviewed by the PROBIS committee.

The Office of Quality Improvement conducts Individual and Focused case reviews that include record reviews. For waiver participants for whom a restrictive intervention was applied, OQU conducts an interview with the participant to determine if the intervention was performed appropriately. Undocumented use of a restrictive procedure is reported to the Regional Program Director who is responsible for follow up to ensure the individual's health and safety and to determine how to prevent further use of undocumented restrictive interventions.

The DDDS Office of Quality Improvement is also responsible for monitoring provider compliance with training requirements, including the requirement for training for provider staff in DDDS-approved crisis intervention techniques.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

- c. **Use of Seclusion.** *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

☒ **The State does not permit or prohibits the use of seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

The DDDS Policy on "Use of Restraints or Restrictive Interventions for Behavior Support" prohibits the use of seclusion for any reason. It is defined in the policy as one of the "prohibited practices".

The Quality Service Review (QSR) process conducted by the DDDS Office of Quality Improvement includes on-site inspection, record review, and individual survey, to ensure a standardized approach to measure compliance with DDDS quality standards. This includes monitoring the absence of prohibited restrictive interventions, including seclusion. Program evaluators from the Office of Quality Improvement (OQI) complete

the QSR to measure compliance with the DDDS provider standards which are consistent with the goals of the CMS HCBS Settings Rule, DDDS policies and procedures, and individual outcomes.

The case manager also asks the waiver participant if they have been isolated for any period as part of their face to face monitoring visits with the waiver participant. The case manager must use language that can be understood by the waiver participant.

Both the OQI Program Evaluators and the case managers will conduct an environmental scan of waiver settings to determine if there appear to be places where seclusion could be imposed.

- ☐ **The use of seclusion is permitted during the course of the delivery of waiver services.** Complete Items G-2-c-i and G-2-c-ii.

- i. **Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the State has established concerning the use of each type of 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).

- ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

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.

Residential Habilitation Agency Providers:

DDDS requires waiver residential habilitation agency providers to have a policy that provides for a medication management system that addresses the elements below for anyone for whom medications have been prescribed. The policy must include protocols to ensure that medication administration protocols for participants living in provider managed settings are followed in day programs, as applicable.

- An individual's ability to participate in the medication administration process
- Medication errors

Residential providers ensure that day program providers maintain a separate Medication Administration Record (MAR) for all medications administered. MARs are to be forwarded to the residential agency no later than the 5th day of the following month.

All waiver providers subject to Limited Lay Administration of Medication (LLAM) regulations are required to maintain a LLAM Monthly Medication Error Report, retained on site and readily available for inspection at all times. All waiver providers subject to LLAM must provide an annual LLAM report to DDDS for review. This annual reporting period is July 1st to June 30th, and must be received by the DDDS LLAM program coordinator no later than July 14th.

The residential provider agency is responsible for delivering medications to the day service site in a pharmacy container labeled by the pharmacy, prescribing practitioner, or RN and must ensure that the day service provider has the most current medication order on file.

The residential provider agency is responsible for notifying the day service provider of any medication changes.

- Staff certification in LLAM
- Timely submission of required reports to DDDS of information as required by the Delaware State Board of Nursing
- Effectiveness of corrective action plans

Shared Living Providers:

DDDS requires Shared Living Providers to coordinate with the DDDS Office of Resource Development and Management (ORDM) and the support team of the waiver participant to which they are providing services to:

- Maintain an annual Shared Living Medication Administration (SLAM) program certification issued by DDDS.
- Submit monthly medication reports to the Nurse Consultant, if the waiver participant has elected to receive that service or to a designated DDDS nurse if the participant has not elected to receive Nurse Consultation.
- Assess an individual's level of ability to participate in the medication process.
- Report any medication errors to the Physician, Nurse Consultant, designated DDDS nurse or Office of Investigative Services when warranted. This must occur within 24 business hours.

Health and Medication Management Monitoring:

The initial monitoring is completed in all residential habilitation agencies by agency staff that has been assigned this role by the provider. In sharing living settings, the Nurse Consultant or designated DDDS nurse and the shared living provider work in tandem to monitor participant medication regimens. Day services follow the same protocols as the residential providers in the management of medications for waiver participants in their settings. Additional monitoring of the day service provider administration of medication is conducted by the waiver residential provider agency, the Nurse Consultant or designated DDDS nurse, and the DDDS Office of Quality Improvement through its Quality Service Reviews.

Provider Agency Role: The scope of monitoring documentation by the residential waiver provider agency includes: daily medication administration record review and weekly review of the individual's health regimen (medications, orders, proper storage, appointments, etc.).

Nurse Consultant Role: For participants receiving Nurse Consultation, the Nurse Consultant reviews the provider monitoring tool and completes a medication and health audit at least monthly and communicates the findings to the provider for timely and appropriate follow up. The Nurse Consultant refers to the previous reviews to assure the designated staff has addressed any previously identified unresolved issues. Documentation in the electronic case record, including incident reports as needed, is completed on a frequency that is specified in the DDDS Community Occurrence Reporting Policy. This monitoring system is designed to detect opportunities to mitigate risk and improve processes through a system of accountability. The system evaluates all components of the health and medication management process. The Nurse Consultant also completes a Pre-Assessment to determine if the individual can be considered for self-administration of medication. Approval for the continuance of self-administration of medications is reviewed

by the team at the annual meeting or as indicated by errors, etc.

DDDS Office of Quality Improvement (OQI) Role: OQI, as part of their Quality Service Review (QSRs) requires residential habilitation agency provider staff to complete a comprehensive health and medication review for all waiver participants for whom medications have been prescribed. The agency must also observe its staff performing medication administration. Second-line monitoring is conducted on the use of behavior modifying medications as part of the monitoring of a Behavior Support Plan as described in Appendix G-2.

Per DDDS policy, a Behavior Support Plan must be developed for any individual for whom psychotropic medications are prescribed. The DDDS Peer Review of Behavioral Strategies Committee (PROBIS) must review, approve and monitor all Behavioral Support Plans that include the use of medication for the treatment of a mental illness or for the purpose of behavior control in the absence of a psychiatric diagnosis.

DDDS Policy indicates that Behavior Modifying medications be used if these steps are followed:

1. A Functional Behavioral Assessment is completed by a Behavior Analyst. If the Functional Behavioral Assessment recommends the use of a behavior modifying medication as in intervention, a referral will be made to a medical professional for further evaluation. All recommended behavior interventions must include Positive Supports.
2. If a behavior modifying medication is recommended, the prescriber shall provide a written order for the medication and note the indication for the medication use. Risks and benefits of the medication, including any side effects, will be documented as part of a risk benefit analysis. A designated support team participant shall obtain written or witnessed verbal Informed Consent for the use of the medication from the individual, Health Care Surrogate, or Guardian.
3. The medication shall be used in conjunction with the Behavior Support Plan.
4. The behavior modifying medication is only prescribed for a condition that is diagnosed according to the most current edition of the American Psychiatric Association's Diagnostic and Statistical Manual (DSM). Exceptions exist when a prescriber feels that there may be a beneficial treatment in which case it is monitored through the PROBIS committee for effectiveness.

Behavior Support Plans (BSP) that indicate the use of a psychotropic medication for the treatment of a mental illness must be reviewed by the support team prior to beginning the medication. Additionally, the BSP must be submitted to PROBIS within 90 days of beginning the medication and shall include the support team's recommendation for the frequency of future monitoring of the plan and who will monitor the continued use of the medication and its impact on the waiver participant.

A Program Manager that works for the waiver provider agency is also responsible for reviewing the participant's treatment plan for the behavior modifying medication on a monthly basis.

Monitoring includes recording the waiver participant's response to treatment in comparison to established treatment goals for which the medication was prescribed. The participant's support team is notified whenever the participant's response to treatment is not meeting established goals or if undesired side effects are identified. The support team, under the leadership a Behavior Consultant arranges for the participant to meet with the prescribing physician for further evaluation should the treatment not result in the desired outcome(s).

- 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 the policies and procedures regarding medication administration for waiver participants who receive a waiver-funded residential or day service. These are the only providers that are authorized to assist waiver participants with medication administration. Waiver participants who receive prescribed medications are encouraged to receive the Nurse Consultant waiver service as a health and safety measure. Participants who elect to receive this service are assisted by the case manager to select a provider from a set of qualified providers. For participants who choose not to receive

consultative nursing, a designated DDDS nurse monitors the management of their medications. The Nurse Consultant conducts a thorough monthly Health and medication monitoring review and issues a report of findings. The report of findings is stored in the participant's electronic case record to enable the designated staff to provide necessary follow up actions. The Nurse Consultant refers to the previous reviews to assure the designated staff has addressed previously identified unresolved issues. If the individual receiving medications has elected not to receive a Nurse Consultant service, a DDDS nurse will be assigned to do the monthly review only. A third monitoring piece is performed by the DDDS Office of Quality Improvement (OQI), as part of their annual sampling process for Neighborhood Homes and Community Living Arrangements. OQI completes a comprehensive medical record review and medication assistance observation as part of this process. This review includes all settings in which a waiver participant who is living in an agency provider managed setting receives a waiver service, including day programs. A DDDS nurse provides additional Health and Medication oversight which follows the OQI annual schedule for site reviews.

The Nurse Consultant's monitoring role is designed to focus on all medication types and medication usage patterns ordered for each participant. The Nurse Consultant's methods for conducting monitoring in Neighborhood Homes and CLAs include the review of all medical issues related to the individual and the completion of a Monthly Medication and Health Audit.

The audit requires the Nurse Consultant to check the waiver participant's current Medication Administration Records (MAR) against Physicians' Orders and against medication labels to assure agreement. An accountability of medication is completed. The Nurse Consultant also performs the following tasks:

- Ensures that medications are adequately stocked, properly stored, and not expired
- Compares count sheets and the amount of medication remaining against the amount noted on the count sheet
- Assures Standing Medical Orders (SMOs) are updated annually by the physician.

Additionally, on an annual basis, OQI 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. If the individual attends a day program, they also visit and review these items there.

In Shared Living homes, the provider completes a Monthly Medication Record, which is forwarded to the participant's Nurse Consultant. This form lists all medications the participant is taking and whether the medication was "held" or changed during the reporting month. For newly ordered medications, the nurse provides consultation to the provider about any potential side effects that need to be observed and reported if they occur. 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 OQI 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 nurse includes reviewing the Monthly Medication Record, monthly telephone or email contacts with the provider, and an annual home visit to meet with the participant and the provider and to verify that medications are stored as required by DDDS policy. Contacts or visits that are more frequent than the minimum requirements may be specified in the person centered plan based on the participant's health needs. The Nurse Consultant completes a quarterly health review in the electronic health record which is then forwarded to the Shared living provider to address any action steps. This review ensures all follow up physician orders are adhered to. The Nurse Consultant also participates in the individual's annual 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 completes the medication review in the electronic record and forwards the report to the designated provider staff via electronic mail. The designated provider staff corrects any errors or makes comments and returns the form to the nurse upon completion. The nurse notifies the designated provider staff of any issues needing immediate attention. Should the medication review identify any medication errors, a Medication Incident Report (General Event Report [GER] in the electronic case record system- related to any event causing or has the ability to potentially cause injury, which has serious impact on the individual or others) is filed by the provider and reported to the OIS. The annual review by the DDDS OQI serves as an indicator as to the effectiveness of the provider 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. Each provider agency is required to complete a monthly LLAM medication error report and maintain it on site. This report must also be forwarded to the DDDS on a monthly basis.

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).

Provider Administration of Medications:

The Limited Lay Administration of Medications (LLAM) curriculum provides agencies with a curriculum that is approved by the Delaware Board of Nursing for medication administration of unlicensed assistive personnel (UAP). The staff who has successfully completed the LLAM curriculum and/or annual recertification may administer medication. The LLAM curriculum applies to all residential agency waiver providers and includes any other day settings where waiver participants may spend their day. Shared living providers must complete and adhere to the DDDS's Sharing Living Medication Administration (SLMA).

LLAM Guidelines:

State LLAM regulations require that "Unlicensed Assistive Personnel" (UAP) must successfully complete all sections of the DDDS Limited Lay Administration of Medication (LLAM) Course.

Completion of the initial LLAM course required of all newly hired staff consists of:

Attend 2 (two) consecutive classroom days for 13 (thirteen) hours.

- Successful demonstration of skills
- Written exam with passing score of 85% or better
- Successful Demonstration of 10 (ten) Supervised Field Medication Passes
- Will be completed within 60 days of 1st day of class date

A "Letter of Completion" will be issued to each participant once the classroom portion of the course is completed, but is only valid after 10 (ten) medication passes have been successfully completed and signed by the provider supervisor/designee. The "Letter of Completion" and the corresponding completed "10 Supervised Field Medication Pass Observations" will be maintained in the employee file at the employing provider. Staff is not authorized to pass medications to DDDS individuals until these documents are signed and dated as indicated.

Failure to successfully complete all of the requirements of the program within the specified time frame of 60 days will require the participant UAP to re-take the two (2) day program before administering medications to individuals of DDDS.

If participant fails either the skill session(s) or exam, he/she may retake the session or exam one (1) time. If the participant fails a second time, he/she will be required to repeat the full two (2) day course after 6 months with recommendations from his/her supervisor that he/she is prepared to retake the course.

If a LLAM trained UAP commits two medication errors within a six (6) month time frame, he/she must repeat the entire LLAM training program including five (5) Supervised Field Medication Pass Observations before resuming LLAM duties.

Thereafter, the LLAM trained UAP must renew their training annually:

LLAM trained UAP's are required to maintain current CPR status.

The provider must monitor LLAM expiration dates for their staff. Any UAP whose LLAM training has expired will not be authorized to administer medications to DDDS individuals.

It is the provider's responsibility to monitor the number of medication errors and to take appropriate steps as outlined by this curriculum.

LLAM Instructor Qualifications

New Instructor Requirements:

- Active Delaware or compact state RN license in good standing.
- One year of clinical nursing experience, including experience in medication administration.
- At a minimum, observation of the presentation and successful completion of the core curriculum and any eligible program specific module to be taught.
- Presentation of at least one component of the core curriculum and any eligible program specific module to be taught with observation by a qualified instructor. Documentation of observation must be completed on the Limited Lay Administration of Medications (LLAM) Instructor Monitor Form and provided to the eligible program.

Once the above requirements have been completed, the nurse must submit the following documentation to the DDDS LLAM Program Coordinator:

- A copy of his/her RN license
- Resume'
- A copy of the class voucher to verify class attendance
- Limited Lay Administration of Medications Instructor Monitor Form
- Letter of Recommendation from his/her supervisor

- When the DDDS LLAM Program Coordinator determines all requirements have been met, a letter will be issued to the RN recognizing him/her as an approved instructor to teach Limited Lay Administration of Medication (LLAM) course that has been approved for the Division of Developmental Disabilities Services programs. The nurse must meet all requirements as outlined by the Board of Nursing to continue with his/her Instructor status.

Current Instructor Requirements:

- Qualified instructors must present a minimum of one core curricula and eligible program specific module per year. If an instructor fails to present in a single year, that instructor must again complete the core curriculum and any eligible program specific module before s/he will be deemed a qualified instructor.
- All instructors of courses related to "Assistance with Self-Administration of Medications" approved by the Board as of July 1, 2015 will qualify as LLAM instructors pursuant to regulation 5.3 without being required to satisfy regulations 5.3.1.3-5.3.1.4. Existing AWSAM instructors, grandfathered into the LLAM program need to present a minimum of one (1) course per year.

A list of all LLAM instructors will be maintained by the DDDS LLAM Program Coordinator and submitted annually to the Board of Nursing as part of the Limited Lay Administration of Medication (LLAM Annual

Report)

Field Medication Passes

The observed field medication passes are designed to give the UAP trainee the opportunity to practice the application of the information that they have learned in the classroom. The field pass is an exercise for the UAP trainee and serves as an opportunity for the authorized observer to share his/her knowledge and expertise with the trainee.

A medication pass is defined as administering or assisting with the administration of medication(s) during one (1) medication pass time regardless of how many individuals at this time were provided medication. A trainee can only receive credit for the completion of one medication pass at a time with no exceptions. Ten (10) supervised medication passes are required because the purpose of supervised passes is to help the trainee become familiar with the entire medication process from start to finish, with no errors.

The Provider is responsible for ensuring that there is a system in place to monitor the ongoing performance and supervision of the field medication passes occurring in all of its programs.

If the LLAM trained UAP trainee fails to correctly carry out any one (1) step of the medication pass, the medication pass is considered unsuccessful and must be repeated correctly at another time after reviewing the steps of the medication process.

In the event that a LLAM trained UAP transfers from one provider to another, five (5) medication passes are required to demonstrate competency. Staff is not authorized to pass medications to DDDS individuals until the five (5) medication passes are completed and documented on the Supervised Medication Pass Observation form. LLAM renewal will continue as required, on a yearly basis, from the date of the last renewal.

The authorized observer is:

- An employee with the division of Developmental Disabilities Services (DDDS) or a DDDS contractor with a minimum of two (2) years of experience. These individuals shall have no history of medication errors over the past one (1) year and shall be current in all criteria for LLAM trained UAP's from the Limited Lay Administration of Medication (LLAM) course; or
- A supervisor with DDDS or a DDDS contractor, at least at a Program Manager or Program Coordinator level with a minimum of six (6) months of experience. These individuals shall also be current in all criteria for LLAM trained UAP's from the Limited Lay Administration of Medication (LLAM) course; or
- The Observer currently holds a valid state of Delaware nursing license, has attended the two day Limited Lay Administration of Medication (LLAM) course through DDDS and has worked with the DDDS system for a minimum of three (3) months.

There is mutual responsibility between the authorized observer and the trainee. Extreme caution and care will be made to ensure the individual's safety during the process of medication administration. A medication error could be considered neglect, resulting in criminal investigation, charges, and or fines.

The LLAM trained UAP may:

Participate solely within the confines of the core curriculum and any applicable program eligible module

Administer medication without assessing the appropriateness or effectiveness of the prescribing practitioner's medication order.

Administer injectable emergency medications pursuant to the core curriculum.

The LLAM trained UAP may not:

Administer medications through a feeding tube, including nasogastric, gastrostomy, or jejunostomy tubes.

Be held responsible for assessing pharmacy accuracy either by identifying the appearance of the medication or assessing proper medication dosing for medications released by the pharmacy.

Documentation:

All providers will maintain the "Letter of completion" and 10 Supervised Field Medication Pass Observations in the employee file as evidence of compliance with the Delaware LLAM Program. Providers must 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 provider program and depends upon sound internal quality assurance practices. DDDS OQI confirms both the Classroom/Practicum and the Supervised Medication Field Passes are completed during routine annual audits.

Providers assume responsibility for ensuring compliance and competency of the process. Providers assume liability for the integrity of the provider 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:

It is the provider's responsibility to keep a monthly LLAM Medication error report. This report is retained on site and must be readily available for inspection at all times. A copy of the medication error report is sent to DDDS LLAM coordinator monthly. Per LLAM Providers are required to report medication errors to the Nurse Consultant (if applicable), the physician, and DDDS Office of Investigative Services (OIS). They are also required to make a report in the electronic case record system.

All providers and settings subject to the LLAM curriculum must provide an Annual Report to DDDS for review. This annual reporting period is July 1st to June 30th, and must be received by the DDDS LLAM program coordinator no later than July 14th. Please refer to attached "Limited Lay Administration of Medications (LLAM) Annual Report Form". The DDDS LLAM Coordinator provides this Annual Report to the Delaware Board of Nursing.

The DDDS Performance Analysis Committee (PAC) reviews reports on the rates of medication errors by type, at least annually. Data is analyzed not only by error type, but also by provider. In this way, the DDDS can analyze system-wide challenges, as well as pinpoint individual provider performance issues.

DDDS's monitoring methods are designed to identify problems in provider performance and to support follow-up remediation actions and quality improvement activities.

Data is acquired to identify trends and patterns and to support improvement strategies primarily through the electronic case record system. Additional sources of data for drawing correlations are the OQI Certification Database and the Nurse Consultant Monthly Health Audits.

(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).

The types of medication or treatment errors providers must record are:

- A. Medication is administered to the incorrect individual
- B. An individual receives the incorrect medication

- C. Medication is given via an incorrect route of administration
- D. Medication is administered at an incorrect time
- E. Medication is administered at an incorrect dose
- F. Medication is not administered at all (i.e., medication omission)
- G. Medication is administered without a prescription
- H. Medication is administered after the medication expiration date
- I. Medication is stored incorrectly (i.e., not stored according to label instructions)
- J. Medication documentation is transcribed incorrectly (e.g., failure to correctly document medication information in MAR)

It is the provider's responsibility to keep a monthly LLAM Medication error report. This report is retained on site and must be readily available for inspection at all times. A copy of the medication error report is sent to DDDS LLAM coordinator monthly. Per LLAM, providers are required to report medication errors to the Nurse Consultant (if applicable), the physician, and DDDS Office of Investigative Services (OIS). They are also required to make a report in the electronic case record system.

(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).

The types of medication or treatment errors providers must record are:

- A. Medication is administered to the incorrect individual
- B. An individual receives the incorrect medication
- C. Medication is given via an incorrect route of administration
- D. Medication is administered at an incorrect time
- E. Medication is administered at an incorrect dose
- F. Medication is not administered at all (i.e., medication omission)
- G. Medication is administered without a prescription
- H. Medication is administered after the medication expiration date
- I. Medication is stored incorrectly (i.e., not stored according to label instructions)
- J. Medication documentation is transcribed incorrectly (e.g., failure to correctly document medication information in MAR)

It is the provider's responsibility to keep a monthly LLAM Medication error report. This report is retained on site and must be readily available for inspection at all times. A copy of the medication error report is sent to DDDS LLAM coordinator monthly. Per LLAM, providers are required to report medication errors to the Nurse Consultant (if applicable), the physician, and DDDS Office of Investigative Services (OIS). They are also required to make a report in the electronic case record system.

All providers and settings subject to the LLAM curriculum must provide an Annual Report to DDDS for review. This annual reporting period is July 1st to June 30th, and must be received by the DDDS LLAM program coordinator no later than July 14th. Please refer to attached "Limited Lay Administration of Medications (LLAM) Annual Report Form". The DDDS LLAM Coordinator provides this Annual Report to the Delaware Board of Nursing.

The DDDS office of Quality Improvement will confirm that all required documentation as described in the above mentioned LLAM trained UAP criteria are present during audits, as evidence of the authorization to assist without direct supervision during the administration of medications.

A copy of the monthly error report is sent by provider to DDDS Office of Quality Improvement by the 5th of the month.

- ☐ **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 performance in medication management. Monitoring occurs through routine review of all medication error reports. Additionally, the DDDS Performance Analysis Committee (PAC) reviews reports on the rates of medication errors by type, at least annually. Data is analyzed not only by error type, but also by provider. In this way, the DDDS can analyze system-wide challenges, as well as pinpoint individual provider performance issues.

DDDS's monitoring methods are designed to identify problems in provider performance and to support follow-up remediation actions and quality improvement activities.

Data is acquired to identify trends and patterns and to support improvement strategies primarily through the electronic case record system. Additional sources of data for drawing correlations are the OQI Certification Database and the Nurse Consultant Monthly Health Audits.

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 demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. (For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")

i. Sub-Assurances:

- a. Sub-assurance:** *The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.* (Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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 number and percent of substantiated incidents of abuse, neglect, mistreatment, medication diversion or financial exploitation. Numerator: The number of substantiated incidents of abuse neglect, mistreatment, medication diversion or financial exploitation. Denominator: The total number of reported incidents.

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

The DDDS Office of Investigative Services 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: <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: <div style="border: 1px solid black; height: 20px; width: 100%;"></div> |
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Performance Measure:

G-a-2: The percent of participants receiving residential or day services that report that they feel safe in their waiver setting. Numerator: The number of participants receiving residential or day services that report they feel safe in their waiver setting. Denominator: The total number of participant files reviewed for the period.

Data Source (Select one):

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

If 'Other' is selected, specify:

| 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% Confidence interval |
| <input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div> | <input type="checkbox"/> Annually | <input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div> |
| | <input checked="" type="checkbox"/> Continuously and Ongoing | <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> | |

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-3: The percent of residential and day service providers with all-hazard emergency plans in place that met the standards of the DDDS policy. Numerator: The number of residential and day service providers that had all-hazard emergency plans in place that met the standards of the DDDS policy. Denominator: Total number of providers reviewed during the reporting period.

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="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: <div style="border: 1px solid black; height: 20px; width: 100%;"></div> | |
|--|---|--|

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

- b. *Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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-b-1: The percentage and numbers of substantiated cases of abuse, neglect, and exploitation where recommended actions to protect health and welfare were implemented. Numerator: The total number of substantiated cases of abuse, neglect, and exploitation where follow up was implemented. Denominator: The total number of substantiated cases of abuse, neglect, and exploitation.

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

The DDDS Investigative Services Unit Data Base

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

| | | |
|---|---|--|
| <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 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 <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 type="text"/> | <input checked="" type="checkbox"/> Annually |
| | <input type="checkbox"/> Continuously and Ongoing |
| | <input type="checkbox"/> Other Specify: <input type="text"/> |

Performance Measure:**G-b-2: The annual mortality rate for waiver participants by age, gender, and cause**

of death compared to DDDS baseline data established during 2001-2007.
 (Numerator: The number of waiver participants deaths by age, gender and cause
 of death: natural or medico logical. Denominator: DDDS established baseline
 mortality 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 checked="" type="checkbox"/> Annually |

| | |
|----------------------|--|
| <input type="text"/> | |
| | <input checked="" type="checkbox"/> Continuously and Ongoing |
| | <input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div> |

- c. **Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.**

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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-c-1: The percent of restraints or restrictive procedures applied that followed established DDS protocol. (Numerator: The number of restraints or restrictive procedures applied that followed DDS established protocol; Denominator: The total number of restraints or restrictive procedures applied during the reporting period.)

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Electronic case record data base; incident report

| 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 = <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div> |
| <input type="checkbox"/> Other Specify: | <input type="checkbox"/> Annually | <input type="checkbox"/> Stratified Describe Group: |

| | | |
|----------------------|---|---|
| <input type="text"/> | | <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"/> |

- d. **Sub-assurance:** *The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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-d-1: The percentage of waiver participants receiving demographically appropriate health care screenings. **Numerator:** The number of waiver participants who received demographically appropriate health care screenings. **Denominator:** The number of participants reviewed during the reporting period

who should have received health screens based on their demographics

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

The Office of Quality Improvement Individual Focused 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% confidence interval |
| <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: <div style="border: 1px solid black; height: 20px; width: 100%;"></div> |

- 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 DDDS 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 DDDS Office of Investigative Services, augmented by 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. 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 Improvement.

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 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: <div style="border: 1px solid black; height: 20px; width: 100%;"></div> | <input checked="" type="checkbox"/> Annually |
| | <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 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 QIS 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 OIS* 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 QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

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 Improvement Strategy (QIS) for all waiver services is to ensure that 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 QIS recognizing that quality is not under the purview of just one entity. Every part of DDDS 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 QIS includes a number of processes to monitor the quality of residential, day, and clinical consultative waiver services. The DDDS QIS is designed to:

- Monitor assurances contained in the approved waiver.
- Support collaboration with participants, their families, stakeholders, and other state agencies.
- Result in service improvement for individuals and providers of services
- Support choice and control by individuals and families
- Make information about quality of services readily available and understandable.

The DDDS Performance Analysis Committee (PAC) has the most significant role in the DDDS Quality Improvement System. The PAC includes representatives from the DDDS Office of Quality Improvement, Office of Investigative Services, DDDS Data Unit, DDDS Community Services and Administrator of the public ICF-IID operated by DDDS. Other parts of the organization are included as needed. This Committee is responsible for:

- Aggregation of discovery process data.
- Developing periodic reports on priority outcomes and performance measures for systems analysis and trending.
- Ensuring ongoing data integrity and reliability.
- Tracking system improvement strategies developed by various stakeholder groups.
- Trending discovery and remediation based data to ensure continuity of oversight by the DDDS.

In addition, other entities that also play a role in DDDS's Quality Improvement Strategy include:

- DDDS Authorized Provider Committee – This committee reviews applications from service providers who wish to become qualified to provide one or more waiver services against established qualification standards for each service. This committee then issues an approval or denial letter to the provider based on the circumstances. DDDS maintains the list of Authorized Waiver Providers on its website. This committee process supports the open and continuous enrollment of waiver service providers throughout the year. The committee also periodically reviews and may make changes to the forms and procedures used in the provider qualification process to assure ease of access for providers considering becoming a waiver provider.

- Division of Medicaid and Medical Assistance (DMMA) – DMMA is the State Medicaid Agency with administrative authority over HCBS Waiver services in Delaware. DMMA reviews performance reports issued by DDDS and provides feedback regarding both the measures, the performance data and any existing Quality Improvement Plans. At a minimum, DMMA and DDDS meet each quarter to go over the waiver performance data.
- 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 and quality improvement strategies. QIC reports to the QII Task Force through the Waiver Coordinator.
- The Quality Initiative Improvement (QII) Task Force is responsible to: 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.

These entities review data and reports in order to recommend system wide improvement strategies and to identify and promote promising practices. Minutes from each meeting are maintained in order to identify recommendations or follow up actions that are required and who is responsible for each action. The minutes are shared with the Division Director/Designee who reviews the quality improvement strategies and assigned responsibilities and prioritizes the recommendations when necessary.

The Division of Medicaid & Medical Assistance (DMMA) is the agency that has oversight responsibility for Medicaid including all HCBS 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 and;
- 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 is integrated into the DMMA 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 both individuals and committees, task forces, and work groups that are ultimately responsible for the development, implementation, monitoring, and evaluation of the DDDS 1915c HCBS waiver program and its quality initiatives.

The DMMA Chief of Policy, Planning and Quality is responsible for oversight of the DDDS 1915(c) waiver. The Chief and members of his staff:

- Participates in and oversees the function of all DMMA Quality Improvement Committee (QIC) monitoring and reporting activities.
- Summarizes waiver monitoring results, and presents data based reports to the QIC, documenting such in QIC meeting minutes.
- Serves as a liaison between the HCBS Waiver Operating Agencies, such as DDDS, 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.
- Participates as a member of the DMMA QII Task Force and supports presentation of QIC reports to the following 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:

Other entities with roles related to the DDDS Quality Improvement system include:

- 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. DDDS also

presents any amendments and renewals to MCAC for review as part of the public feedback process.

- 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, (4) evaluate interventions to ensure remediation strategy was successful, (5) provide stakeholders with meaningful information as to the operation of waiver services.

ii. System Improvement Activities

| Responsible Party <i>(check each that applies):</i> | Frequency of Monitoring 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 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

- 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.

DDDS collects, analyzes & uses data to provide internal and external stakeholders with accurate, timely and important information that can be used to evaluate & make recommendations for improvements to the quality of HCB services/supports.

The Performance Analysis Committee (PAC) has primary responsibility for determining if the various discovery processes and data sources accurately measure the outcomes and performance indicators. Problems with data collection activities are corrected as needed.

Areas for each measure reviewed by the PAC include:

- 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 Improvement, the Performance Analysis Committee, and entities noted in section a. i. above, may propose revisions for the DDDS Quality Management System to the Division's Leadership Team 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 DDDS HCBS waiver participants, are not met.

Sometimes improvement strategies for trended data result in changes to waiver service specifications, provider

qualification processes, case manager monitoring protocols or DDDS training policies. These changes are sometimes discussed at meetings of the Governor's Advisory Council to DDDS to solicit stakeholder input.

Recommendations for corrective action and system improvement are shared with the DDDS operational units that will need to develop and implement improvement strategies. The operational units are required to respond to the Division Director or designee with their suggested improvement strategies. Once the improvement strategy is finalized, it is implemented and the data monitoring is used to determine if the strategy achieved the desired result.

The Performance Analysis Committee monitors the impact of system changes using a reporting tool called "Divstat". The Office of Quality Improvement (OQI) is largely responsible for the discovery part of the process. A representative of OQI sits on the PAC work together to develop monitoring tools, sampling strategies, and reporting requirements. Most discovery processes are in the domain of OQI activities. The OQI implements the revised discovery processes, measuring the effectiveness of the slated system improvement.

Results of OQI discovery data are collected and disseminated as follows:

- Reporting individual findings on an ongoing and continuous basis to waiver participants and their circle of support, waiver providers, and DDDS Administrators, requiring specific individual plans of improvement as applicable.
- Saving individual discovery process data in an OQI data base 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)

As part of the DDDS continuous quality improvement process, the OQI Director:

- Assures that all monitoring processes remain current and that data bases are being properly developed or repopulated for each reporting period.
- Assures that any concerns with the discovery process are effectively and efficiently resolved.
- Notifies the Division Director of any newly identified trouble areas between formal report generating intervals.

The steps of this cyclical process for continuous quality improvement can be described as:

- Discovery/Assessment (based upon identified performance measures).
 - Communicate findings in light of performance expectations.
 - Formal review and analysis of findings.
 - Plan Development / Plan Modification based upon data analysis.
 - Documentation of and dissemination of Plan of Improvement to key stakeholders, including some form of training on or orientation to changes.
 - Implementation of the Plan.
 - Repeat processes focusing on performance-based data analysis.
- ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

DDDS collects, analyzes & uses data to provide internal and external stakeholders with accurate, timely and important information that can be used to evaluate & make recommendations for improvements to the quality of HCB services/supports. 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. The PAC also solicits ongoing feedback from DDDS organizational units and other external stakeholders.

The PAC looks at the following aspects of data reporting:

- 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 Division Director, the Office of Quality Improvement (OQI), and the PAC, proposed revisions to the DDDS Quality Management System may be submitted to the Division's Leadership Team for review. Such revisions would occur as the formal data analysis processes reveal unresolved needs within the system. Review tools, data sources, performance measures, sampling strategies, remediation activities and needed systems change are all subject to review and modification if they do not result in a structure that informs the Division about the health of the "system".

Recommendations for corrective action and system improvement are shared with the DDDS operational units that will need to develop and implement improvement strategies. The operational units are required to respond to the Division Director or designee with their suggested improvement strategies. Once the improvement strategy is finalized, it is implemented and the data monitoring is used to determine if the strategy achieved the desired result.

The Performance Analysis Committee monitors the impact of system changes using a reporting tool called "Divstat". The Office of Quality Improvement (OQI) is largely responsible for the discovery part of the process. A representative of OQI sits on the PAC work together to develop monitoring tools, sampling strategies, and reporting requirements. Most discovery processes are in the domain of OQI activities. The OQI implements the revised discovery processes, measuring the effectiveness of the slated system improvement.

Performance data produced by the PAC in the form of the "Divstat" reporting tool, is provided to the DDDS Director, the Director's Leadership Team and DMMA, which share the responsibility for analyzing the effectiveness of the Quality Improvement System to support specified goals and outcomes. Such responsibility is carried out in structured, routine meetings in which performance data is reviewed.

Each entity is empowered to raise issues such as the 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 and report data. The DDDS QMS is designed to drive outcome-based results, with clear accountability for who reports the data and who initiates system improvements.

The OQI and PAC shall work in tandem to adjust discovery processes (as indicated) in order to accurately design and implement performance assessment. The two QMS entities develop monitoring tools, sampling strategies, and reporting requirements with PAC functioning as the "brain" of the division and OQI as the "eyes and ears".

If done well, continuous quality improvement is a cyclical, iterative process.

The DDDS Quality Management System has been established to support the attainment of positive outcomes for waiver participants. System-wide performance data is aggregated and shared broadly, both within and external to DDDS. Performance data is provided to DMMA on a quarterly basis at the quarterly oversight meetings with DDDS. Performance data is also provided to CMS as part of the annual 372 report.

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).

DDDS requires each agency provider of HCBS Waiver services to submit an annual independent audit. DDDS also requires the Agency with Choice Vendor to submit an annual independent audit. The results of this independent audit must be submitted to the Division within 3 months of the end of the provider's fiscal year. This is tracked as a waiver

performance measure. Additionally, the State of Delaware Auditor's office is the entity responsible for conducting annual audits in accordance with the provisions of the Single Audit required under the OMB Uniform Guidance for state agencies within the state government of Delaware.

Per the MOU between DMMA and DDDS, DMMA is responsible for conducting utilization review of services provided under the waiver. DMMA and DDDS meet on a quarterly basis to review DDDS's performance under the waiver including all aspects of waiver administration.

All waiver claims are processed through Delaware's MMIS. Delaware employs multiple levels of processes designed to ensure proper payment of claims both pre-and post-adjudication. DMMA contracts with a fiscal agent to operate the MMIS. The current MMIS was certified by CMS as meeting the standards for automated claims processing systems per Part 11, Chapter 3 of the State Medicaid Manual.

DMMA uses a process for its post-payment review called Recipient Explanation of Medicaid Benefits (REOMB). Each month, a sample of 250 clients for whom a fee for service claim was adjudicated are selected randomly for the purpose of quality control review via the REOMB process. DXC selects all claims received for the individual within the target month. The SUR team and DMMA's Fiscal Agent (DXC) are responsible for the entire Recipient Explanation of Medicaid Benefits (REOMB) process.

All DDDS HCBS waiver members are subject to being included in the REOMB monthly sample. 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 REOMB Coordinator reviews claims against the participant eligibility data, provider enrollment and contract data and rate structure. As part of the validation process, the system generates a letter on state letterhead to be mailed to each of the selected Medicaid recipients. The letter provides the recipient with dates, provider name and specific procedures which Medicaid has paid on behalf of that recipient. The letter asks the recipient 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 recipient wishes to make. The recipient is directed to mail the letter back in a postage paid envelope. If the recipient does not respond to the letter, no additional follow up is conducted. If it is determined that an overpayment was made, a findings letter is mailed to the provider via certified mail. If no overpayment is received within fourteen days, arrangements are made with DMMA's fiscal agent to recoup funds from provider. This can include setting up an accounts receivable for the overpayment to be applied against future claims.

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. The reports use algorithms to detect patterns in paid provider claims which may indicate fraud and/or abuse. The SUR team uses these reports and other tools to identify specific providers on which to perform audits and 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.

The standard Medicaid Provider Contract for Services requires all providers of services to maintain or make available 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 to federal or state auditors for the purpose of conducting audits to substantiate claims, costs, etc.

Negative findings from post-payment validation activities are reported to the provider in writing by the entity that discovered the finding. For DMMA, this will be the REOMB Coordinator, the SUR unit or MFCU. For DDDS this will be the DDDS Office of Quality Improvement. The DDDS Offices of Community Services and Budget, Contracts and Business Services play a role in detecting inappropriate billing through their routine monitoring efforts. All findings are reported to OQI for follow up with the provider. Depending on the finding, a corrective action plan may be required. The provider will be notified in writing by OQI if a corrective action plan will be required. DDDS must approve the CAP before it can be implemented. While the correspondence will come from OQI, OQI may enlist the help of other parts of DDDS to monitor the implementation of the corrective action plan and report back to OQI so that can determine when the corrective action plan may be closed.

The case managers in the Community Services and administrative staff of the DDDS Day and Transition Unit, which is also part of Community Services, monitor provider case notes and the receipt of services against the person centered plan in the electronic case record on a monthly basis. Discrepancies are reported to the Office of Budgets, Contracts and Business Services (OBCBS) for initial investigation.

Staff from OBCBS work in tandem with staff from the DDDS Office of Quality Improvement, under the Office of Residents Protection, and Community Services to provide financial expertise when investigating deficiencies that involve provider or participant finances that are discovered through quality monitoring, abuse/neglect investigations, case manager monitoring or guardian or participant complaints. While Office of Resident Protection coordinates investigations and any provider probation process due to service deficiencies, ORP is able to call on the resources of OBCBS for assistance as needed.

If staff from OBCBS or Community Services identify or suspect a provider as submitting inappropriate claims, after three months without correction OQI may place the provider on probation which triggers enhanced monitoring of the provider in accord with the mandated Quality Improvement Plan to correct the problem.

Delaware believes this process is advantageous, as it connects both a programmatic and fiscal viewpoint to the provider oversight strategies.

A case of deficiency in implementation of proper and frequent financial oversight may result in OQI placing a provider on probation status for 3-6 months depending on the severity of the deficiency and the amount of time necessary for corrective action. OQI conducts monthly follow-up to verify implementation of approved corrective actions, with enhanced oversight of spending records, billing, or other specific monitoring as each case warrants. If improvement is not apparent after the first probation period, it can be extended another 3-6 months with ongoing increased monitoring and technical assistance. If the provider has not corrected the deficiency at the end of the second probation period, DDDS may end the business relationship with the agency.

Agency With Choice Broker:

Because the Agency With Choice vendor will be serving as the employer of record, it will submit and be paid for claims for self-directed services in the same manner as other fee for service Medicaid claims. The DDDS AWC liaisons will be responsible for monitoring claims paid to the AWC broker as the provider. The DDDS AWC liaisons will be responsible for ensuring that the AWC provider claims match what was paid to the employee. More detail regarding this process is provided in Appendix E, as required in that section.

In addition to monitoring claims submitted by the AWC broker, DDDS will also monitor performance against contractual requirements. Such requirements will include maintenance of documentation to comply with IRS and US DOL requirements such as: provider screening and training, copy of IRS Forms W-4 and I-9, accuracy of wage payments and withholding, payment of overtime and travel, as required.

Quarterly, the DDDS AWC Liaisons will verify AWC vendor payment/filing of the State Income Tax, Unemployment Tax, Workers Compensation and IRS Forms 940 and 941 and Forms W-2/W-3.

Annually, DDDS will also review the AWC broker's standard operating procedures and required reporting on performance metrics such as timeliness of payroll and payment of other invoices by the AWC vendor, participant satisfaction, and timeliness of response to customer calls where a message is left after hours, complaints resolution, etc. as specified in the contract. These processes are described in more detail in Appendix E.

Additional detail on financial integrity processes is provided in section I-2-d Billing Validation Process.

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 Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. (For waiver actions submitted before June 1, 2014, this assurance read "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. Sub-Assurances:

- a. Sub-assurance:** *The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.* (Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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 paid only for those services specified in the person centered plan. (Numerator: number of claims paid only for those services specified in the person centered plan; Denominator: number of paid claims for the period)

Data Source (Select one):

Other

If 'Other' is selected, specify:

DDDS Data Sources - Prior authorizations entered into the MMIS pursuant to the person centered plan; paid claim detail in the MMIS against the authorization.

| 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: <div style="border: 1px solid black; height: 20px; width: 100%;"></div> | <input checked="" type="checkbox"/> Annually | <input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div> |
| | <input type="checkbox"/> Continuously and Ongoing | <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> | |
|--|--|--|

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

Performance Measure:

I-a-2: The percentage of provider attendance reports reviewed for day and residential services that match what was claimed. (Numerator: Number of provider attendance reports reviewed for day and residential services that match what was claimed; Denominator: Number of provider attendance reports reviewed for the period)

Data Source (Select one):

Other

If 'Other' is selected, specify:

Attendance records submitted by the providers and claims, as processed in the MMIS

| 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 checked="" type="checkbox"/> Quarterly | <input type="checkbox"/> Representative Sample Confidence Interval = |

| | | |
|---|--|--|
| | | |
| <input type="checkbox"/> Other Specify: | <input type="checkbox"/> Annually | <input checked="" type="checkbox"/> Stratified Describe Group: by service by provider |
| | <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 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-a-3: The percentage of DDDS waiver provider agencies that submit completed annual audited financial statements. (Numerator: the number of DDDS waiver provider agencies that submit completed annual audited financial statements; Denominator: Number of DDDS waiver provider agencies.)

Data Source (Select one):**Financial audits**

If 'Other' is selected, specify:

| 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 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 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: <input type="text"/> |

Performance Measure:

I-a-4: Percentage of waiver claims which are prior-authorized.(Numerator: Number of paid claims that are prior authorized; Denominator: Number of paid

claims for the period.)

Data Source (Select one):

Other

If 'Other' is selected, specify:

Data Sources - MMIS data on paid DDDS waiver claims

| 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="text"/> |
| <input type="checkbox"/> Other Specify: <input type="text"/> | <input checked="" 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: <div style="border: 1px solid black; height: 20px; width: 100%;"></div> <div style="text-align: right;"> <div style="border-left: 1px solid black; border-right: 1px solid black; height: 10px; width: 10px; display: inline-block;"></div> <div style="border-left: 1px solid black; border-right: 1px solid black; height: 10px; width: 10px; display: inline-block;"></div> </div> |

- b. **Sub-assurance:** *The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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-5: The percent of rates for waiver services adhering to reimbursement methodology in the approved waiver. (Numerator: Number of rates for waiver services adhering to reimbursement methodology in the approved waiver; Denominator: Number of waiver rates.)

Data Source (Select one):

Other

If 'Other' is selected, specify:

The DMMA Reimbursement Unit reviews all waiver rates computed by DDDS to determine if they were computed pursuant to the approved methodology.

| 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 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 = <div style="border: 1px solid black; height: 20px; width: 100%;"></div> <div style="text-align: right;"> <div style="border-left: 1px solid black; border-right: 1px solid black; height: 10px; width: 10px; display: inline-block;"></div> <div style="border-left: 1px solid black; border-right: 1px solid black; height: 10px; width: 10px; display: inline-block;"></div> </div> |
| <input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div> <div style="text-align: right;"> <div style="border-left: 1px solid black; border-right: 1px solid black; height: 10px; width: 10px; display: inline-block;"></div> <div style="border-left: 1px solid black; border-right: 1px solid black; height: 10px; width: 10px; display: inline-block;"></div> </div> | <input type="checkbox"/> Annually | <input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div> <div style="text-align: right;"> <div style="border-left: 1px solid black; border-right: 1px solid black; height: 10px; width: 10px; display: inline-block;"></div> <div style="border-left: 1px solid black; border-right: 1px solid black; height: 10px; width: 10px; display: inline-block;"></div> </div> |
| | <input type="checkbox"/> Continuously and | <input type="checkbox"/> Other |

| | | |
|--|--|-------------------------|
| | Ongoing | Specify: <div></div> |
| | <input checked="" type="checkbox"/> Other Specify: Each time new rates are computed | |

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: <div></div> | <input type="checkbox"/> Annually |
| | <input type="checkbox"/> Continuously and Ongoing |
| | <input checked="" type="checkbox"/> Other Specify: Each time new rates are computed |

- 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 analyzes 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 uses 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). DMMA works closely with the Attorney General's Office to prosecute instances of provider fraud.

The MFCU itself may also 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 that funds have been paid to providers for services that determined to not comply with DMMA's published standards, DMMA will authorize its fiscal agent, to perform an adjustment on those

targeted claims in order to set up an accounts receivable against future claims to recoup any overpayments. If the accounts receivable does not result in a collection within a reasonable period of time, DMMA begins collection efforts to require the provider to send a check for the outstanding accounts receivable. 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 other DMMA subject matter experts. The subject matter experts (physicians, nurses, pharmacy, laboratory or optometrist, etc.) 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 these cases, there is no overpayment identified and the case is closed and the provider is notified of the results by letter.
2. Problems identified requiring provider education /no evidence of fraud. The provider is referred for appropriate training and, if applicable, a request for repayment 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 of 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.

The request for repayment 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 repaid the overpayment, the recoupment account is established in order to recover the overpayment. The provider may request an administrative hearing per the procedure described in the DMAP General Policy Manual on the DMAP website.

If warranted, follow up reviews are scheduled at 6 to 12 month time periods from results notification. Providers who do not comply with required corrective action or where the dollar amount identified as overpaid is in excess of \$500.00 may be candidates for follow-up reviews.

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.

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 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: <div style="border: 1px solid black; height: 20px; width: 100%;"></div> | <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.

| |
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| |
|--|

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).

DDDS is responsible for the development of statewide rates for waiver services through an MOU with DMMA, Delaware's Medicaid agency. DMMA is responsible for the final review & approval of all rates and for ensuring that rates are computed consistent with the approved methodology.

Rates for most Lifespan waiver services are based on a "market basket" methodology established in 2004. This includes residential habilitation, day habilitation, pre-vocational service, supported employment individual & group (added in October 2013), supported living, clinical consultation: behavioral & nurse (added to the methodology in 2012) and community participation, newly added under this amendment.

The last rebasing study for Direct Support Professional (DSP) rates was conducted in CY2013 at the direction of the Delaware General Assembly; results were published in January 2014. All DDDS HCBS providers completed a wage and cost survey in CY2013 and interviews were conducted with a representative cross section of 13 of the providers to validate the survey data, revisit assumptions and make sure nothing was missed in the survey.

The revisions to the composition of the market basket, the assumptions & the resulting rates were shared in draft with the provider agencies, advocates and other key stakeholders. Feedback was incorporated into the design and final rates. The Delaware provider association representing most of the DDDS waiver providers endorsed this approach. The report produced a set of recommended "Benchmark rates" for each service.

The methodology begins with the selection of a wage for each type of DSP. Wage data was obtained from the U.S. DOL BLS and job postings from national internet employment sites for job classifications with similar requirements & duties.

In addition to the wage, the market basket methodology adds the following components, as appropriate to each service:

- employment related expenses (%)
- program indirect expenses (%)
- administrative expenses (%)

Employment Related Expenses include benefits paid to or for workers above salary and wages. They include expenses such as health insurance, workers comp, unemployment compensation, state/federal payroll taxes, criminal

background checks and training.

Program Related Expenses support the delivery of the service but are either non-salary expenses or are a step removed from the direct delivery of the service. These include program management, rent, utilities, program supplies, technology expenses (phones, laptops, network, software licenses), vehicle costs for staff, quality assurance, staff recruitment costs, DSP staff time spent in allowable but not billable activities.

General and Administrative Expenses include functions that are necessary for the operation of the organization but cannot be directly related to a good or service produced by the organization. This includes: payroll and accounting, legal counsel, outside audit fees, general liability insurance, managerial salaries, corporate overhead, rent, utilities, office equipment and subscriptions.

These costs are either converted to percentages that are multiplied by the direct support hourly wage rate as a set of recursive percentages in order to develop an hourly provider DSP benchmark rate for each service or were added as individual cost factors, or a combination of both, depending on the service.

The formula to compute the hourly rate for each service using the rate components (expressed as a percentage) is as follows:

$$(\text{DSP wage} + (\text{DSP} * (1 + \text{ERE})) / (1 - \text{PI}) / (1 - \text{GA}))$$

Transportation to and from the service setting is a component part of the service for residential habilitation, day habilitation and prevocational service and is paid as an add-on to the direct support unit cost rate. Rates for residential services do not include any costs associated with room and board.

The estimated cost of implementing the Benchmark rates was \$37 million, of which the state share was \$18 million. As of the date when the 2014 benchmark rates were adopted. This is not likely to change in the near future.

The legislature determines the level of funding that may be available for services and rate increases each year. The legislature adopted the Benchmark rates from the 2014 study as the standard and all subsequent rate increases have been applied using the rebasing study within available funds. Some service rates are currently paid at a lower percentage of the benchmark than others. As funding for a rate increase has been made available, the goal is to use it to “level up” the rates to the same % of the benchmark over time. Over time, this approach would result in all services being at the same percent of the benchmark, but lack of available funding has limited Delaware’s ability to implement rate increases.

The DSP rates are periodically re-based using cost data from the most current period available. Each year, the Epilogue of the Budget Act enacted by the Delaware General Assembly indicates that DDDS “may rebase, once every one to three years” its Direct Support Professional rates. A date has not been set for the next rate rebase study. DDDS waiver rates are published on the DDDS website each year.

DDDS uses the Inventory for Client and Agency Planning (ICAP) assessment tool to determine the number of direct support hours needed for each waiver member for residential, day and employment services. The division also uses a separate structured assessment protocol, for waiver members that have behavioral or medical challenges that require additional support hours beyond what is indicated from the ICAP. For Nurse and Behavioral Consultation, DDDS uses custom-developed behavioral and nursing assessment instruments and protocols to determine the appropriate number of support hours based on the needs of each member.

While all rates are initially computed as hourly rate, they may be billed as 15 minute, hourly or per diem rates. Per diem rates are computed by multiplying the hourly rate for the service by the number of hours of support needed per day. 15 minute unit rates are computed by dividing the computed hourly rate by four.

The rate for the DDDS State-operated day habilitation program is computed on an annual basis using prior year actual annual costs, including personnel, benefits, program related expenses such as rent, utilities and supplies, and administration (using the indirect cost rate approved by the Division of Cost Allocation (DCA), U.S. DHHS). The total actual costs are divided by actual units of service to calculate a daily rate for this service.

Supported Employment - Small Group: DDDS must perform additional computations to the rate for this service to account for the number of waiver members in the group. Before the base rate is divided by the number of members in the group, a gross up factor is applied to the base rate for this service. This is to ensure that overhead costs are

properly captured, based on the assumption that simply dividing the base rate by 2 - 8 group members would not adequately capture an agency's incremental costs in delivering the service. The unit cost rate is then divided by the number of waiver members in the group from 2 – 8.

Community Participation service 1:2 staff ratio: Community Participation may be provided to no more than two individuals supported by a single staff person. The base hourly rate for this service is computed assuming a 1:1 staff to consumer ratio. Before the base rate is divided by 2, a gross up factor is applied to the base rate for the service. This is to ensure that overhead costs are properly captured, based on the assumption that simply dividing the base rate by the 2 individuals supported by a single DSP would not adequately capture an agency's incremental costs in delivering the service.

Community Transition: The approved provider of will submit an invoice with applicable receipts to DDDS for reimbursement. Invoices must be approved by DDDS before payment is made.

Specialized Medical Equipment, not otherwise covered under the State Plan, Assistive Technology equipment and Home or Vehicle Modifications: Bids or estimates of cost for a job, equipment, or supplies are obtained from at least two vendors the individual chooses or is assisted to choose. The lowest and best price will be authorized by DDDS if the price is reasonable based on the purchase experience of the DDDS or DMMA for similar jobs, equipment or supplies and up to the maximum allowed for the service, as described in Appendix C. Bids or estimates must be obtained from at least two vendors so that DDDS can select the most reasonable bid based on the work to be performed which may take into account such elements as the time necessary to perform the work. In the event that the time necessary to obtain two bids will result in a delay in receiving the service that could pose a health or safety risk to the participant, DDDS may waive this requirement but will use internet resources, within the time available, to identify a reasonable cost for the same or similar products and services.

Assistive Technology Assessment and Training: The fee development methodology and fee schedule rates were initially produced in 2014 as part of the Pathways to Employment SPA (see pg 29 Att 3.1.1 Pathways SPA). The rate is composed of provider cost modeling using information from independent data sources such as Delaware provider compensation studies, cost data, and fees from similar State Medicaid programs. The following list outlines the major allowable components to be used in fee development.

- Staffing Assumptions and Staff Wages
- Employee Related Expenses – Benefits, Employer Taxes (e.g., FICA, unemployment, and workers compensation)
- Staff Productivity Assumptions (e.g., time spent on billable activities)
- Program Related Expenses (e.g., management and supplies)
- Provider Overhead Expenses

They were developed as the total hourly provider costs, adjusted for productivity, and converted to the applicable unit of service.

Personal Care and Respite: For members who self-directed this service, payment rates will be established by AWC broker with input from the waiver member. The AWC provider will ensure that all rates and payments comply with the US DOL Fair Labor Standards Act. The AWC provider may reimburse for respite camps at the usual and customary fee for those entities. For members who choose to use a Home Health Agency (HHA) or Personal Attendant Services Agency (PASA), respite and personal care will be paid using the rates computed as follows. The rate for respite or personal care provided by a HHA will be set at the rate established under Attachment 4.19-B of the Delaware State Plan for Medical Assistance, page 6 for an HH Aide. This methodology and rate was approved by CMS effective 10/1/15. For respite or personal care provided by PASA, the rate will be 75% of the Medicaid rate for HHAs for an aide. This percentage was derived by comparing usual and customary hourly rates for aide services delivered through HHAs as opposed to PASA agencies and establishing the relationship between the rates. Payment for respite provided in a DDDS waiver residential facility will be made at the residential habilitation rate. Payment for respite in an ICF-IID will be made using the payment methodology described in Attachment 4.19-D of the State Plan.

Waiver rates are computed by DDDS and approved by DMMA. Approved rates are published on the DDDS website at the following link:

http://dhss.delaware.gov/dhss/ddds/waiver_rates.html

The public is invited to provide comment on rate determination methods during each renewal and amendment

process.

- 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:

Providers submit claims for DDDS HCBS waiver services to the MMIS which is operated by a fiscal agent under contract to DMMA. Claims are adjudicated in the MMIS and payment is made by the fiscal agent. All claims for waiver services are prior authorized by DDDS staff. Providers must bill against the approved authorization which indicates the maximum number of units for a specified period, the service which has been authorized and the unit rate. The provider can bill a lower number of units or a lower rate than what is authorized in order to reflect actual utilization, but they cannot bill more than what is authorized. An MMIS edit causes the claim to be paid at the lesser of the billed amount or the "rate on file", which is the rate on the Prior Authorization for most DDDS waiver claims.

Providers submit electronic claims for DDDS waiver services in the HIPAA-standard 837 professional claim transaction 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, but this capability is being phased out by DMMA as part of its "go green" initiative. Paper claims are scanned into the MMIS. Providers can use any claims software that results 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.

DDDS staff submit Medicaid claims for the state-operated services: day habilitation and clinical consultation: nursing and behavioral.

DDDS also submits claims on behalf of shared living providers who have voluntarily re-assigned their payment to a government agency per CMS Bulletin 94-4. These providers are individuals who meet the provider qualifications for shared living and who have waiver participants living in what is essentially a family home. As a group, these providers do not generally have the infrastructure necessary to submit and reconcile HIPAA compliant claims. This process is more fully described under Item I-3-g-i.

It is DDDS's intention to explore value-based purchasing models for waiver services to reinforce expectations with providers for the delivery of high quality waiver services.

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:

In addition to the financial integrity methods described in I-1, DDDS performs the following billing validation activities.

a) Recipient Eligibility for Waiver Services: Applicants who are enrolled in the DDDS waiver are assigned one of four categories of aid in DCIS (Delaware Client Information System), the eligibility/enrollment client database of Delaware DHSS. The aid categories then pass to the MMIS in a nightly automated data feed. The aid categories indicate whether the waiver participant is receiving SSI or is in the waiver Special Income Group. Edits have been established in the MMIS to require prior authorization for waiver claims based on their assignment to one of the four DDDS waiver aid categories. MMIS claim edits for participants enrolled with a waiver aid category require the dates of service for a waiver claim to be within the eligibility start and stop dates for the waiver aid category in order for the claim to process as paid as a waiver service. DMMA has also assigned specified procedure codes to be used for waiver services. These codes are set up so that they cannot be used for non-HCBS clients.

(b) Service is included in PCP: The waiver participant's PCP includes a list of the waiver services the client has chosen to receive. Among the DDDS program units that assist in the oversight of waiver services are the Office of Community Services which employs the case managers that oversee residential, day, employment and clinical services. The case manager and other designated employees communicate the amount, duration and frequency of each waiver service included in the PCP to the DDDS Office of Budget, Contracts and Business Services where a Prior Authorization is entered into the MMIS for each authorized waiver service. When a claim for a waiver service is submitted, the MMIS checks the claim against the Prior Authorization data in the MMIS. The PA number on the claim must match the PA number in the MMIS before the claim will be processed. Once a matching PA is found, the MMIS then performs additional edits to compare the Medicaid ID number, the provider NPI, the procedure code, the units of service and the rate billed against those elements recorded on the PA. As long as the unique client identifier, provider ID and procedure code match and the waiver eligibility, the dates of service and the rate are all within specified limits, the claim will process.

c) Services were provided: DDDS requires its providers to use an electronic case record system to document service provision. The agencies providing residential, day, prevocational, and supported employment services are also required to submit attendance/utilization reports to DDDS each month. These attendance reports are signed by an authoritative representative of the provider. Providers must also maintain case notes describing how the service they provided facilitates the ability of the client to meet their goals as described in the PCP. There must be one note per client per service per day at a minimum. DDDS has the ability to view the provider case notes in the electronic record and does so periodically to make sure that services identified as "provided" are also documented.

The DDDS Day and Transition Unit assists the case manager to monitor the utilization of day services for waiver participants based on specified triggers. They compare provider attendance records and claims data against service authorizations based on the PCP to look for: units higher or lower than what is expected, changes in Group Supported Employment ratios, waiver participants whose authorized hours are exceptions to the ICAP. Providers who are

determined to be at higher risk of claim errors based on prior reviews are reviewed more closely than other providers. When a review is triggered, the Unit looks at the PCP, progress/billable notes for each day service and incident reports to ensure that services are being delivered and billed in accordance with the PCP.

Because the Agency With Choice vendor will be serving as the employer of record, it will submit and be paid for claims for self-directed services in the same manner as other fee for service Medicaid claims. The DDDS AWC liaisons described in Appendix E will be responsible for monitoring claims paid to the AWC broker as the provider. The AWC liaisons will be responsible for ensuring that the AWC provider claims match what was paid to the employee. More detail regarding this process is provided in Appendix E, as required in that section.

In addition to the DDDS post payment claim validation activities, DMMA is also responsible for retrospective auditing of paid claims and utilization review of services provided. These processes are described in section I-1 of this Appendix.

If it is determined that an erroneous or fraudulent payment has been made, DMMA has the ability to recoup payments as follows. If valid claims are expected to be submitted by the provider for a future period, DMMA instructs its fiscal agent to set up an accounts receivable to recoup the full amount of the erroneous payment. The accounts receivable is satisfied when the full amount is reached. If no future claims are expected to be submitted or if the nature of the overpayment is related to substantiated fraud or criminal activity, the DMMA Program Integrity Unit may send a letter to the provider directing it to repay the amount with a check. If the provider does not provide the payment within the timeframe specified in the letter, DMMA refers the case to the Medicaid Fraud Control Unit of the Delaware Attorney General's Office. Legal action can be pursued in court if necessary.

- 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:

Payment for all waiver services, except for Residential Habilitation delivered by a Shared Living provider, are made through an approved MMIS.

As described in section g.i. of this Appendix, DDDS has a payment arrangement with its shared living providers that allows DDDS to pay them up front each month with 100% state funds via the State accounting system. The state allows providers of shared living service under the waiver to reassign their payment to the division if they so choose. Shared living providers are individuals who have agreed to share their home with a waiver participant to provide residential habilitation.

The providers submit an invoice for each month for the client(s) to which they provide shared living support. By reassigning their payment to a governmental agency, the provider does not have to obtain HIPAA compliant electronic claims software in order to be paid. The providers are paid at the Medicaid rate for the hours of support they provide up to a maximum of the support hours indicated by the participant's ICAP score. The DDDS fiscal section creates a prior authorization in the MMIS and then creates and submits a HIPAA-compliant claim to the MMIS based on the provider invoice. DDDS deposits the revenue to the state's General Fund, since it has already paid the provider up front. The result is that the net payment for the service is the state share plus federal share at the applicable FMAP. The state share for these claims is paid from the budget of the Division of

Medicaid and Medical Assistance.

The DDDS Shared Living Coordinators receive an invoice after the end of each month from each Shared Living provider that enumerates the dates of service during the month when residential habilitation was provided, consistent with the waiver standards. The invoice contains the documentation necessary to support a Medicaid claim as required under section 2500.2 of the State Medicaid Manual. The Shared Living Coordinators are in routine contact with the Shared Living Providers. The Coordinators check the invoice against the attendance, case notes in the electronic case record and the "Change of Status" record as in the DDDS Registry to look for gaps in service, such as hospitalizations, that were not reported by the Shared Living provider. Any discrepancies are investigated. By contract, the Shared Living providers are required to report all absences to DDDS. The Shared Living Coordinators enter the monthly data into a spreadsheet that is sent to the DDDS Office of Budget, Contracts and Business Services (OBCBS) along with a scanned PDF of the provider invoice. A Senior Accountant in OBCBS checks the invoice against the contracted rate for each participant receiving Shared Living (ICAP hours x standard hourly payment rate for Shared Living expressed as per diem). The Senior Accountant enters the participant utilization data into a separate Excel spreadsheet that is uploaded into MS Access where it is merged with data about the provider, such as the provider's SSN and bank account information. The monthly Access data file is uploaded to the state's accounting system from which the provider payments are generated. After the payment transactions have cleared the state accounting system, the Senior Accountant uses the provider invoice, which has already been verified against other data, to create a Medicaid claim to reimburse the state for the payment it made to the provider from the state accounting system. The Senior Accountant reconciles the remittance advices for the claims for each service month to the state accounts receivable and any discrepancies are followed up on and corrected.

Claims for Respite and Personal Care under the self-directed option will also be paid outside of the MMIS because the Agency With Choice vendor will be serving as the employer of record. After the AWC Broker has paid the self-directed caregiver as employee via its own accounting system, the AWC Broker will submit and be paid for Medicaid claims for self-directed services as a Medicaid provider in the same manner as other fee for service Medicaid claims. The broker will be responsible for performing all necessary tax withholding and will submit claims for the entire payment amount, inclusive of tax withholding, that it has. It will be paid outside of the MMIS. More detail regarding this process is provided in Appendix E.

The DDDS AWC liaisons are responsible for monitoring payments made by the AWC broker to its employees and also for monitoring Medicaid claims submitted to reimburse for outlays to the self-directed caregivers against utilization data and case notes in the electronic case record. The Community Navigators will, by monthly contact with the participant, monitor the provision of service against the person centered plan.

- ☐ **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:

The Division of Developmental Disabilities Services operates a state-run habilitation program, one neighborhood group home and provides Behavioral and Nurse Consultation Services, in addition to the network of non-government waiver providers. These are the last remaining state-operated services back from a time prior to the creation of the DDDS HCBS waiver when the state provided all of the services to support persons with intellectual disabilities. DDDS is phasing out these state-operated services through natural attrition.

Enrollment in all DDDS-operated services have been closed since July 1, 2014. Since that time, DDDS has been working to transition individuals from all state-operated services to other providers.

As of May 2017, the last 2 remaining residents in a state-operated neighborhood group (which is on the grounds of a public institution) will be transitioned to a new fully accessible home that will be managed by a private waiver provider that they chose.

DDDS has transitioned all but 75 individuals receiving Behavioral Consultation to private providers, 15 in the largest of the 3 counties and 50 in Sussex County, the southernmost county. The lack of qualified providers in Sussex County has stalled this transition. All but 27 individuals have been transitioned from the Nurse Consultation service. We expect all individuals to be transitioned to other providers by June 30, 2017.

Enrollment in DDDS state-operated Day Habilitation programs has been closed since 2011. Today there are only 90 people being served in state-operated day programs. The gradual reduction enables the state to achieve its desired outcome of ending state-operated day services with minimal negative impact on the participants.

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:

^
v

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.

The state allows providers of shared living service under the waiver to reassign their payment to the division if they so choose. Each shared living provider has a provider agreement with the Medicaid agency. By reassigning their payment to a governmental agency, the provider allows DDDS to pay them each month with 100% state funds via the State accounting system. This means that the provider does not have to obtain HIPAA compliant electronic claims software from DMMA's fiscal agent in order to be paid. Shared living providers are individuals who have agreed to share their home with a waiver participant to provide residential habilitation. The purpose of this arrangement is to process the payment for these providers sooner and with less administrative burden than if they submitted the claims to the MMIS themselves. The providers are paid at the Medicaid rate for the hours of support they provide up to a maximum of the support hours indicated by the participant's ICAP score. DDDS then submits the HIPAA compliant electronic claim to the MMIS on behalf of the provider and deposits the revenue to the state's General Fund. The result is that the net payment for the service is the state share plus federal share at the applicable FMAP. Because this service is the most "home-like" of the residential service options and typically results in the greatest community integration, DDDS feels that it is important to make this service the least burdensome as possible for the provider in order to encourage provider participation.

- 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:

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.**
- ☐ **This waiver is a part of a concurrent §1115/§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 §1115 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:

- ☐ **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 described in I-2-a. uses costs for direct support professionals and costs that are directly related to supporting those employees (such as supervision and staff training) to compute a payment rate. No costs related to the operation of the residential facilities are included in that process. DDDS determines the room and board costs for each facility which is paid either by the individual or the division with 100% state funds or a combination of both, if the individual's income is not sufficient to cover the room and board costs.

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-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: ICF/IID

| 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 | 94952.52 | 5045.00 | 99997.52 | 394063.00 | 7558.00 | 401621.00 | 301623.48 |
| 2 | 97647.00 | 5396.00 | 103043.00 | 421451.00 | 8229.00 | 429680.00 | 326637.00 |
| 3 | 98467.17 | 9019.00 | 107486.17 | 408352.00 | 6146.00 | 414498.00 | 307011.83 |
| 4 | 65471.20 | 9019.00 | 74490.20 | 424441.00 | 6146.00 | 430587.00 | 356096.80 |
| 5 | 66770.85 | 9019.00 | 75789.85 | 464084.00 | 6146.00 | 470230.00 | 394440.15 |

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 Unduplicated Number of Participants (from Item B-3-a) | Distribution of Unduplicated Participants by Level of Care (if applicable) |
|-------------|---|--|
| | | Level of Care: |
| | | ICF/IID |
| Year 1 | 1100 | 1100 |
| Year 2 | 1150 | 1150 |
| Year 3 | 1200 | 1200 |
| Year 4 | 2372 | 2372 |

| | | |
|--------|------|------|
| Year 5 | 2506 | 2506 |
|--------|------|------|

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 annual length of stay of participants receiving residential habilitation through the Lifespan Waiver is derived from actual data for days of enrollment for SFYs 10-15 based on historical paid claims data for waiver participants as reported on the annual CMS 372 report.

An alternate basis was used to determine the average length of stay data for the new population of graduates from K-12 school being added to the waiver because this is a new waiver population for which there is limited longitudinal data. The derivation of the ALOS is based on the monthly head count data for a five year period for individuals graduating from school and electing to receive DDDS non-waiver day programs. This data is maintained by the DDDS Day and Transition Unit. The Day and Transition Unit has observed seasonal patterns of enrollment as individuals graduate from school. This experience was applied to estimates for new cohorts of graduates each year. Based on this experience, we have observed that most graduates enroll in a day program the middle of August each year. To account for this, 46 days were subtracted from a 365 day year. A separate factor of 15 days was subtracted from the year to account for natural attrition due to individuals who die, move out of state or decide they no longer wish to receive a day service.

A weighted average length of stay was computed from the estimates of unique counts of participants and participant days per year across the two populations

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 for individuals receiving residential habilitation and for other waiver services they receive is based on historical Medicaid expenditures as reported on the annual 372 report.

For the new waiver participants to be enrolled in demonstration years 4 and 5 under this amendment, DDDS used internally maintained available utilization and payment data for SFY15 and 16. This group is comprised of individuals who are living in the family home that will be newly enrolled in demonstration years 4 and 5. Many of these individuals are known to and receiving non-waiver services from DDDS.

Current waiver Day services - Delaware used ad hoc queries against the MMIS database to derive the average units per person and the average cost per unit for day services for SFYs 15 and 15 (WYEs 1 and 2) for existing waiver members. FY15 data from the CMS 372 report for expenditures and participant counts by service category was also used. The data was arrayed by service. The data from WYEs 1 and 2 were compared to look for consistency.

Payment and utilization data from the non-waiver participants receiving day services were obtained and arrayed for SFY16. Delaware used client counts for the two populations (waiver and currently non-waiver) to compute a weighted average number of units per person and cost per unit across the two populations to be applied to WYEs 4 and 5. Delaware made assumptions about growth in the number of newly eligible waiver members for WYEs 4 and 5 based on past participant growth in the two populations (which is largely

constrained by the amount of newly appropriated funds for waiver members, and the number of individuals graduating from school for the non-waiver enrolled individuals). Estimated utilization of services across the day service array was assumed to be consistent with the distribution from the SFY16 data, the most current data set that was available at the time the estimates were computed.

Day Habilitation: Community Participation – DDDS conducted a state-funded pilot between September 2014 and Jan 2015 to explore the feasibility of this service. The estimates for both the number of individuals DDDS expects to request this service and the utilization per participant came from the pilot. The average cost per unit was computed using the DSP rate methodology for the other day services with wage and other rate components coming from the pilot.

Respite – estimates for respite were based on FY16 DDDS payment and utilization data maintained by DDDS in an excel spreadsheet to track expenditures by person by type of respite provider. Most of the expenditures are paid for self-directed caregivers and respite camps. Individuals also use Home Health Aides to a lesser extent. The cost per hour for the self-directed care was not recorded, so the Manager of the DDDS respite program provided estimates of the number of individuals for whom a specified hourly rate was believed to be paid based on the acuity of the individuals.

Personal Care – estimates were based on expenditures maintained by the DDDS Office of Budgets, Contracts and Business Services for payments made for personal care under a program DDDS calls “Individual and Family Assistance Payments” (IFAP). The data was recorded as a lump sum per family so the hourly rate of payment could not be computed. Assumptions had to be made regarding the hourly rates of payment and number of units (hours) based on information that was known about each family.

Home/vehicle modifications – estimates for the number of families who would seek this service were based on families for whom DDDS had paid for modifications in the past under the IFAP program. This data was not always recorded in a way that allowed an amount per family or per modification to be identified. Based on the amounts of past requests (some of which were not able to be funded), DDDS made the assumption that 70% of the requests would require the maximum funding of \$6,000 per person and that the other 30% would be for more minor modifications to the home that would be considerably less than the maximum.

Specialized medical equipment and supplies – estimates of numbers of individuals requesting this service is based on past requests received by DDDS (some of which were not able to be funded). Most of the requests received have been for specialized wheelchairs and other devices to assist with ambulation. Estimates for the average cost of pieces of equipment were obtained from the Harmon Healthcare website. Estimates for a customized wheelchair and ranged from \$2,000 to \$15,000.

Assistive Technology – Data from the 2010 US Census Report (Americans with Disabilities) published in 2012 was used to estimate the number of participants who are likely to need Assistive Technology. Cost data for assistive technology items was obtained from the American PrintHouse for the Blind website.

- 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:

In order to develop a revised projection of Factor D' values for amendment #1, the non-waiver cost per person from SFY11 – 16 was arrayed longitudinally. Data sources are as follows: for SFYs 11 and 12 queries run against the MMIS claims data. This data was used in lieu of the data for Factor D' that was reported on the 372 report prior to SFY13, as Delaware had accidentally been reporting the estimates from the approved application as if they were the Factor D' actuals. This has previously been shared with CMS. SFY13-15 data came from the 372 report. Data for FY16 came from a preliminary query of the actual data for the period (it is possible more claims may process with the 365 day timely filing window). The data for the period ranged from a low of \$3,922 to a high of \$8,756 per person and was highly variable with no clear trend. This made it difficult to use the data to project future cost per person.

We believe that the relatively small number of waiver members (less than 1,000 members for most years) is subject to variability due to the impact of outliers. A straight average for the period would indicate a cost of \$5,281, but we do not feel this would be representative of future costs. We have been enrolling more waiver members with complex medical needs who require Private Duty Nursing which is not covered under the waiver and must be accessed via the State Plan. We believe that the cost per person for SFY16 is the beginning of a trend that reflects the use of PDN, so we have used this value as the basis for estimating WYEs 3, 4 and 5.

Because there is not enough data to yet establish a true trend, we have assumed a modest growth in the cost per person of 3% for WYE 3 to allow for a ramp up and then have assumed no growth for WYEs 4-5.

The cost data above is only reflective of current waiver members. This amendment will essentially double the waiver enrollment for Delaware. We do not yet have a cost profile for the members to be added as a result of the amendment. Therefore, for new waiver participants living in their family home, DDDS assumes that their utilization of State Plan services will be the same as that of the current waiver participants.

The estimate for Factor D' does not include the cost of claims for prescription drugs for that can be covered by Part D. An edit exists in the MMIS that prevent Medicaid payment for Part D covered drugs for dual eligibles who are enrolled in Part D and for whom Medicaid is paying the Part D premium. The list of Part D covered drugs is updated by DMMA's fiscal agent any time CMS makes a change to the Part D formulary. The entire list is also reviewed annually by the fiscal agent, regardless of whether any changes are made to the Part D formulary during the year. Therefore, only costs for medically necessary, non-Part D covered drugs would be included in Factor D'.

- 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:

Delaware used data for Factor G, as reported on the CMS 372 report for SFYs 13-15, as well as preliminary cost per person data from a query of the MMIS for SFY16, as the basis the estimates for Factor G for WYEs 3-5. Both sets of cost data come from MMIS claims for residents in the state's public ICF/IID institution. An average percentage growth of 3.94% was observed over the 4 year period of the data set. This increase was applied to the SFY16 preliminary cost per person to revise the projections for WYEs 3-5.

- 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:

In order to develop a revised projection of Factor G' values for amendment #1, the non-waiver cost per person for institutionalized individuals from SFY11 – 16 was arrayed longitudinally. Data sources are as follows: for SFYs 11 and 12 queries run against the MMIS claims data. This data was used in lieu of the data for Factor G' that was reported on the 372 report prior to SFY13, as Delaware had accidentally been reporting the estimates from the approved application as if they were the Factor G' actuals. SFY13-15 data came from the 372 report. Data for FY16 came from a preliminary query of the actual data for the period (it is possible more claims may process with the 365 day timely filing window).

The actual Factor G' values have been relatively consistent over this 6 year period at around \$6,000 per person, with the exception of SFY15, which was \$11,050 per person.

The relatively small number of residents of the public ICF-IID (currently were 47 residents as of April 2017) make the Factor G' costs susceptible to variability due to the impact of outlier claims. Several extended hospitalizations occurred during SFY15 that accounted for the higher average cost that year. In SFY15 (WYE 1) hospital claims accounted for around 60% of the total Factor G' costs as compared to preliminary data for SFY16, where hospital costs accounted for only 40% of the non-ICF-IID costs. For this reason, the value for SFY15 was removed before an average cost per person was computed. Because the cost per person values used to compute the average did not show a clear trend of increased costs from year to year (some years the costs decreased), the computed average was used to project costs for WYEs 3-5 with no assumed growth in the cost per person for those future years.

The estimate for Factor G' does not include the cost of claims for prescription drugs for that can be covered by Part D. An edit exists in the MMIS that prevent Medicaid payment for Part D covered drugs for dual eligibles who are enrolled in Part D and for whom Medicaid is paying the Part D premium. The list of Part D covered drugs is updated by DMMA's fiscal agent any time CMS makes a change to the Part D formulary. The entire list is also reviewed annually by the fiscal agent, regardless of whether any changes are made to the Part D formulary during the year. Therefore, only costs for medically necessary, non-Part D covered drugs would be included in Factor G'.

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 |
|--|
| Day Habilitation |
| Personal Care |
| Prevocational Services |
| Residential Habilitation |
| Respite |
| Supported Employment - Individual |
| Supported Employment - Small Group |
| Assistive Technology for Individuals not otherwise covered by Medicaid |
| Clinical Consultation: Behavioral |
| Clinical Consultation: Nursing |
| Community Transition |
| Home or Vehicle Accessibility Adaptations |
| Specialized Medical Equipment and Supplies not otherwise covered by Medicaid |
| Supported Living |

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). 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. If applicable, check the capitation box next to that service. 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 | Capitation | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|--|--------------------------|------------|---------|---------------------|-----------------|----------------|-------------|
| Day Habilitation Total: | | | | | | | 10561651.60 |
| Day Habilitation - 15 minutes | <input type="checkbox"/> | 15 minutes | 30 | 3264.00 | 7.23 | 707961.60 | |
| Day Habilitation - per diem | <input type="checkbox"/> | Day | 350 | 220.00 | 127.97 | 9853690.00 | |
| Community Participation - 15 minutes | <input type="checkbox"/> | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| Personal Care Total: | | | | | | | 0.00 |
| Personal Care | <input type="checkbox"/> | hour | 0 | 0.00 | 0.01 | 0.00 | |
| Prevocational Services Total: | | | | | | | 7706340.00 |
| Prevocational Services - 15 minutes | <input type="checkbox"/> | 15 minutes | 30 | 1600.00 | 7.23 | 347040.00 | |
| Prevocational Services - per diem | <input type="checkbox"/> | Day | 400 | 225.00 | 81.77 | 7359300.00 | |
| Residential Habilitation Total: | | | | | | | 76424372.50 |

| | | | | | | | |
|--|--------------------------|----------------|-----|---------|--------|-------------|------------|
| Neighborhood Group Home/Comm Lvg Arrangement | <input type="checkbox"/> | Day | 825 | 350.00 | 257.91 | 74471512.50 | |
| Shared Living Arrangement | <input type="checkbox"/> | Day | 145 | 350.00 | 38.48 | 1952860.00 | |
| Respite Total: | | | | | | | 0.00 |
| Respite | <input type="checkbox"/> | hour | 0 | 0.00 | 0.01 | 0.00 | |
| Respite Camp | <input type="checkbox"/> | visit | 0 | 0.00 | 0.01 | 0.00 | |
| Respite ICF-IID | <input type="checkbox"/> | per diem | 0 | 0.00 | 0.01 | 0.00 | |
| Supported Employment - Individual Total: | | | | | | | 4000500.00 |
| Supported Employment - Individual -15 minutes | <input type="checkbox"/> | 15 minutes | 150 | 2100.00 | 12.70 | 4000500.00 | |
| Supported Employment - Small Group Total: | | | | | | | 1314900.00 |
| Supported Employment- Small Group - 15 minutes | <input type="checkbox"/> | 15 minutes | 90 | 3000.00 | 4.87 | 1314900.00 | |
| Assistive Technology for Individuals not otherwise covered by Medicaid Total: | | | | | | | 0.00 |
| AT Assessment /Training | <input type="checkbox"/> | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| AT equipment or repair | <input type="checkbox"/> | item | 0 | 0.00 | 0.01 | 0.00 | |
| Clinical Consultation: Behavioral Total: | | | | | | | 1547040.00 |
| Clinical Consultation: Behavioral | <input type="checkbox"/> | 15 minutes | 550 | 192.00 | 14.65 | 1547040.00 | |
| Clinical Consultation: Nursing Total: | | | | | | | 2135874.00 |
| Clinical Consultation: Nursing | <input type="checkbox"/> | 15 minutes | 985 | 156.00 | 13.90 | 2135874.00 | |
| Community Transition Total: | | | | | | | 0.00 |
| Community Transition | <input type="checkbox"/> | per transition | 0 | 0.00 | 0.01 | 0.00 | |
| Home or Vehible Accessibility Adaptations Total: | | | | | | | 0.00 |
| Home/ Vehicle Modifications | <input type="checkbox"/> | item | 0 | 0.00 | 0.01 | 0.00 | |
| Specialized Medical Equipment and Supplies not otherwise covered by Medicaid Total: | | | | | | | 0.00 |
| Specialized Medical Equipment and Supplies | <input type="checkbox"/> | item | 0 | 0.00 | 0.01 | 0.00 | |
| Supported Living Total: | | | | | | | 757099.20 |
| Supported Living | <input type="checkbox"/> | Hour | 30 | 1144.00 | 22.06 | 757099.20 | |

| | |
|---|-------------|
| GRAND TOTAL: | 10444777.30 |
| Total: Services included in capitation: | |
| Total: Services not included in capitation: | 10444777.30 |
| Total Estimated Unduplicated Participants: | 1100 |
| Factor D (Divide total by number of participants): | 94952.52 |
| Services included in capitation: | |
| Services not included in capitation: | 94952.52 |
| 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.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). 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. If applicable, check the capitation box next to that service. 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 | Capitation | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|--|--------------------------|------------|---------|---------------------|-----------------|----------------|-------------|
| Day Habilitation Total: | | | | | | | 11122042.00 |
| Day Habilitation - 15 minutes | <input type="checkbox"/> | 15 minutes | 40 | 3264.00 | 7.45 | 972672.00 | |
| Day Habilitation - per diem | <input type="checkbox"/> | Day | 350 | 220.00 | 131.81 | 10149370.00 | |
| Community Participation - 15 minutes | <input type="checkbox"/> | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| Personal Care Total: | | | | | | | 0.00 |
| Personal Care | <input type="checkbox"/> | hour | 0 | 0.00 | 0.01 | 0.00 | |
| Prevocational Services Total: | | | | | | | 8246095.00 |
| Prevocational Services - 15 minutes | <input type="checkbox"/> | 15 minutes | 40 | 1600.00 | 7.45 | 476800.00 | |
| Prevocational Services - per diem | <input type="checkbox"/> | Day | 410 | 225.00 | 84.22 | 7769295.00 | |
| Residential Habilitation Total: | | | | | | | 82111120.00 |
| Neighborhood Group Home/Comm Lvg Arrangement | <input type="checkbox"/> | Day | 860 | 350.00 | 265.65 | 79960650.00 | |
| Shared Living Arrangement | <input type="checkbox"/> | Day | 155 | 350.00 | 39.64 | 2150470.00 | |
| Respite Total: | | | | | | | 0.00 |
| Respite | <input type="checkbox"/> | hour | 0 | 0.00 | 0.01 | 0.00 | |
| Respite Camp | <input type="checkbox"/> | visit | 0 | 0.00 | 0.01 | 0.00 | |
| Respite ICF-IID | <input type="checkbox"/> | per diem | 0 | 0.00 | 0.01 | 0.00 | |

| | | | | | | | |
|--|--------------------------|----------------|-----|---------|-------|------------|--------------|
| Supported Employment - Individual Total: | | | | | | | 4394880.00 |
| Supported Employment - Individual - 15 minutes | <input type="checkbox"/> | 15 minutes | 160 | 2100.00 | 13.08 | 4394880.00 | |
| Supported Employment - Small Group Total: | | | | | | | 1503000.00 |
| Supported Employment- Small Group - 15 minutes | <input type="checkbox"/> | 15 minutes | 100 | 3000.00 | 5.01 | 1503000.00 | |
| Assistive Technology for Individuals not otherwise covered by Medicaid Total: | | | | | | | 0.00 |
| AT Assessment /Training | <input type="checkbox"/> | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| AT equipment or repair | <input type="checkbox"/> | item | 0 | 0.00 | 0.01 | 0.00 | |
| Clinical Consultation: Behavioral Total: | | | | | | | 1621401.60 |
| Clinical Consultation: Behavioral | <input type="checkbox"/> | 15 minutes | 560 | 192.00 | 15.08 | 1621401.60 | |
| Clinical Consultation: Nursing Total: | | | | | | | 2221198.20 |
| Clinical Consultation: Nursing | <input type="checkbox"/> | 15 minutes | 995 | 156.00 | 14.31 | 2221198.20 | |
| Community Transition Total: | | | | | | | 0.00 |
| Community Transition | <input type="checkbox"/> | per transition | 0 | 0.00 | 0.01 | 0.00 | |
| Home or Vehicle Accessibility Adaptations Total: | | | | | | | 0.00 |
| Home/ Vehicle Modifications | <input type="checkbox"/> | item | 0 | 0.00 | 0.01 | 0.00 | |
| Specialized Medical Equipment and Supplies not otherwise covered by Medicaid Total: | | | | | | | 0.00 |
| Specialized Medical Equipment and Supplies | <input type="checkbox"/> | item | 0 | 0.00 | 0.01 | 0.00 | |
| Supported Living Total: | | | | | | | 1074637.20 |
| Supported Living | <input type="checkbox"/> | hour | 35 | 1352.00 | 22.71 | 1074637.20 | |
| GRAND TOTAL: | | | | | | | 112294374.00 |
| Total: Services included in capitation: | | | | | | | |
| Total: Services not included in capitation: | | | | | | | 90176670.20 |
| Total Estimated Unduplicated Participants: | | | | | | | 1150 |
| Factor D (Divide total by number of participants): | | | | | | | 97647.00 |
| Services included in capitation: | | | | | | | |
| Services not included in capitation: | | | | | | | 78414.50 |
| 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.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). 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. If applicable, check the capitation box next to that service. 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 | Capitation | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|--|--------------------------|------------|---------|---------------------|-----------------|----------------|-------------|
| Day Habilitation Total: | | | | | | | 11477504.00 |
| Day Habilitation - 15 minutes | <input type="checkbox"/> | 15 minutes | 50 | 3264.00 | 7.52 | 1227264.00 | |
| Day Habilitation - per diem | <input type="checkbox"/> | Day | 350 | 220.00 | 133.12 | 10250240.00 | |
| Community Participation - 15 minutes | <input type="checkbox"/> | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| Personal Care Total: | | | | | | | 0.00 |
| Personal Care | <input type="checkbox"/> | hour | 0 | 0.00 | 0.01 | 0.00 | |
| Prevocational Services Total: | | | | | | | 8639770.00 |
| Prevocational Services - 15 minutes | <input type="checkbox"/> | 15 minutes | 50 | 1600.00 | 7.52 | 601600.00 | |
| Prevocational Services - per diem | <input type="checkbox"/> | Day | 420 | 225.00 | 85.06 | 8038170.00 | |
| Residential Habilitation Total: | | | | | | | 86359840.00 |
| Neighborhood Group Home/Comm Lvg Arrangement | <input type="checkbox"/> | Day | 895 | 350.00 | 268.31 | 84048107.50 | |
| Shared Living Arrangement | <input type="checkbox"/> | Day | 165 | 350.00 | 40.03 | 2311732.50 | |
| Respite Total: | | | | | | | 0.00 |
| Respite | <input type="checkbox"/> | hour | 0 | 0.00 | 0.01 | 0.00 | |
| Respite Camp | <input type="checkbox"/> | visit | 0 | 0.00 | 0.01 | 0.00 | |
| Respite ICF-IID | <input type="checkbox"/> | per diem | 0 | 0.00 | 0.01 | 0.00 | |
| Supported Employment - Individual Total: | | | | | | | 4715970.00 |
| Supported Employment - Individual - 15 minutes | <input type="checkbox"/> | 15 minutes | 170 | 2100.00 | 13.21 | 4715970.00 | |
| Supported Employment - Small Group Total: | | | | | | | 1669800.00 |
| Supported Employment- Small Group - 15 minutes | <input type="checkbox"/> | 15 minutes | 110 | 3000.00 | 5.06 | 1669800.00 | |
| Assistive Technology for Individuals not otherwise covered by Medicaid Total: | | | | | | | 0.00 |
| AT | | | | | | | |

| | | | | | | | |
|--|--------------------------|----------------|------|---------|-------|--------------|------------|
| Assessment / Training | <input type="checkbox"/> | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| AT equipment or repair | <input type="checkbox"/> | item | 0 | 0.00 | 0.01 | 0.00 | |
| Clinical Consultation: Behavioral Total: | | | | | | | 1667865.60 |
| Clinical Consultation: Behavioral | <input type="checkbox"/> | 15 minutes | 570 | 192.00 | 15.24 | 1667865.60 | |
| Clinical Consultation: Nursing Total: | | | | | | | 2267038.80 |
| Clinical Consultation: Nursing | <input type="checkbox"/> | 15 minutes | 1005 | 156.00 | 14.46 | 2267038.80 | |
| Community Transition Total: | | | | | | | 0.00 |
| Community Transition | <input type="checkbox"/> | per transition | 0 | 0.00 | 0.01 | 0.00 | |
| Home or Vehicle Accessibility Adaptations Total: | | | | | | | 0.00 |
| Home/ Vehicle Modifications | <input type="checkbox"/> | item | 0 | 0.00 | 0.01 | 0.00 | |
| Specialized Medical Equipment and Supplies not otherwise covered by Medicaid Total: | | | | | | | 0.00 |
| Specialized Medical Equipment and Supplies | <input type="checkbox"/> | item | 0 | 0.00 | 0.01 | 0.00 | |
| Supported Living Total: | | | | | | | 1362816.00 |
| Supported Living | <input type="checkbox"/> | Hour | 40 | 1456.00 | 23.40 | 1362816.00 | |
| GRAND TOTAL: | | | | | | 118160604.40 | |
| Total: Services included in capitation: | | | | | | | |
| Total: Services not included in capitation: | | | | | | 95171712.80 | |
| Total Estimated Unduplicated Participants: | | | | | | 1200 | |
| Factor D (Divide total by number of participants): | | | | | | 98467.17 | |
| Services included in capitation: | | | | | | | |
| Services not included in capitation: | | | | | | 79309.76 | |
| 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.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). 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. If applicable, check the capitation box next to that service. 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 | Capitation | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|--------------------------|------------|------|---------|---------------------|-----------------|----------------|------------|
|--------------------------|------------|------|---------|---------------------|-----------------|----------------|------------|

| | | | | | | | |
|--|--------------------------|------------|------|---------|---------|--------------|--------------|
| Day Habilitation Total: | | | | | | | 27476132.94 |
| Day Habilitation - 15 minutes | <input type="checkbox"/> | 15 minutes | 486 | 1098.00 | 8.11 | 4327723.08 | |
| Day Habilitation - per diem | <input type="checkbox"/> | Day | 1048 | 190.00 | 113.76 | 22651891.20 | |
| Community Participation - 15 minutes | <input type="checkbox"/> | 15 minutes | 51 | 1341.00 | 7.26 | 496518.66 | |
| Personal Care Total: | | | | | | | 460200.00 |
| Personal Care | <input type="checkbox"/> | hour | 60 | 767.00 | 10.00 | 460200.00 | |
| Prevocational Services Total: | | | | | | | 10204209.20 |
| Prevocational Services - 15 minutes | <input type="checkbox"/> | 15 minutes | 152 | 629.00 | 7.75 | 740962.00 | |
| Prevocational Services - per diem | <input type="checkbox"/> | Day | 610 | 187.00 | 82.96 | 9463247.20 | |
| Residential Habilitation Total: | | | | | | | 107263977.90 |
| Neighborhood Group Home/Comm Lvg Arrangement | <input type="checkbox"/> | Day | 1050 | 325.00 | 308.43 | 105251737.50 | |
| Shared Living Arrangement | <input type="checkbox"/> | Day | 145 | 318.00 | 43.64 | 2012240.40 | |
| Respite Total: | | | | | | | 2036859.84 |
| Respite | <input type="checkbox"/> | hour | 536 | 168.00 | 19.58 | 1763139.84 | |
| Respite Camp | <input type="checkbox"/> | visit | 153 | 1.00 | 1040.00 | 159120.00 | |
| Respite ICF-IID | <input type="checkbox"/> | per diem | 8 | 12.00 | 1193.75 | 114600.00 | |
| Supported Employment - Individual Total: | | | | | | | 3312312.50 |
| Supported Employment - Individual -15 minutes | <input type="checkbox"/> | 15 minutes | 469 | 565.00 | 12.50 | 3312312.50 | |
| Supported Employment - Small Group Total: | | | | | | | 1095517.02 |
| Supported Employment- Small Group - 15 minutes | <input type="checkbox"/> | 15 minutes | 178 | 1677.00 | 3.67 | 1095517.02 | |
| Assistive Technology for Individuals not otherwise covered by Medicaid Total: | | | | | | | 24618.00 |
| AT Assessment /Training | <input type="checkbox"/> | 15 minutes | 15 | 15.00 | 96.08 | 21618.00 | |
| AT equipment or repair | <input type="checkbox"/> | item | 15 | 1.00 | 200.00 | 3000.00 | |
| Clinical Consultation: Behavioral Total: | | | | | | | 944973.12 |
| Clinical Consultation: Behavioral | <input type="checkbox"/> | 15 minutes | 746 | 84.00 | 15.08 | 944973.12 | |
| Clinical Consultation: Nursing Total: | | | | | | | 1587637.26 |

| | | | | | | | |
|--|--------------------------|----------------|-----|--------|---------|------------|--------------|
| Clinical Consultation: Nursing | <input type="checkbox"/> | 15 minutes | 902 | 123.00 | 14.31 | 1587637.26 | |
| Community Transition Total: | | | | | | | 200000.00 |
| Community Transition | <input type="checkbox"/> | per transition | 50 | 1.00 | 4000.00 | 200000.00 | |
| Home or Vehicle Accessibility Adaptations Total: | | | | | | | 124488.00 |
| Home/ Vehicle Modifications | <input type="checkbox"/> | item | 26 | 1.00 | 4788.00 | 124488.00 | |
| Specialized Medical Equipment and Supplies not otherwise covered by Medicaid Total: | | | | | | | 68012.00 |
| Specialized Medical Equipment and Supplies | <input type="checkbox"/> | item | 28 | 1.00 | 2429.00 | 68012.00 | |
| Supported Living Total: | | | | | | | 498750.00 |
| Supported Living | <input type="checkbox"/> | Hour | 35 | 600.00 | 23.75 | 498750.00 | |
| GRAND TOTAL: | | | | | | | 155297687.78 |
| Total: Services included in capitation: | | | | | | | |
| Total: Services not included in capitation: | | | | | | | 117232612.74 |
| Total Estimated Unduplicated Participants: | | | | | | | 2372 |
| Factor D (Divide total by number of participants): | | | | | | | 65471.20 |
| Services included in capitation: | | | | | | | |
| Services not included in capitation: | | | | | | | 49423.53 |
| Average Length of Stay on the Waiver: | | | | | | | 329 |

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). 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. If applicable, check the capitation box next to that service. 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 | Capitation | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|--------------------------------------|--------------------------|------------|---------|---------------------|-----------------|----------------|-------------|
| Day Habilitation Total: | | | | | | | 30861377.64 |
| Day Habilitation - 15 minutes | <input type="checkbox"/> | 15 minutes | 529 | 1098.00 | 8.19 | 4757095.98 | |
| Day Habilitation - per diem | <input type="checkbox"/> | Day | 1173 | 190.00 | 114.90 | 25607763.00 | |
| Community Participation - 15 minutes | <input type="checkbox"/> | 15 minutes | 51 | 1341.00 | 7.26 | 496518.66 | |
| Personal Care Total: | | | | | | | 575250.00 |

| | | | | | | | |
|--|--------------------------|----------------|------|---------|---------|--------------|--------------|
| Personal Care | <input type="checkbox"/> | hour | 75 | 767.00 | 10.00 | 575250.00 | |
| Prevocational Services Total: | | | | | | | 11235178.79 |
| Prevocational Services - 15 minutes | <input type="checkbox"/> | 15 minutes | 166 | 629.00 | 7.81 | 815473.34 | |
| Prevocational Services - per diem | <input type="checkbox"/> | Day | 665 | 187.00 | 83.79 | 10419705.45 | |
| Residential Habilitation Total: | | | | | | | 113558722.90 |
| Neighborhood Group Home/Comm Lvg Arrangement | <input type="checkbox"/> | Day | 1100 | 325.00 | 311.51 | 111364825.00 | |
| Shared Living Arrangement | <input type="checkbox"/> | Day | 155 | 318.00 | 44.51 | 2193897.90 | |
| Respite Total: | | | | | | | 2356671.68 |
| Respite | <input type="checkbox"/> | hour | 592 | 181.00 | 18.94 | 2029458.88 | |
| Respite Camp | <input type="checkbox"/> | episode | 170 | 1.00 | 1040.00 | 176800.00 | |
| Respite ICF-IID | <input type="checkbox"/> | per diem | 10 | 12.00 | 1253.44 | 150412.80 | |
| Supported Employment - Individual Total: | | | | | | | 3689286.15 |
| Supported Employment - Individual -15 minutes | <input type="checkbox"/> | 15 minutes | 517 | 565.00 | 12.63 | 3689286.15 | |
| Supported Employment - Small Group Total: | | | | | | | 1213225.65 |
| Supported Employment- Small Group - 15 minutes | <input type="checkbox"/> | 15 minutes | 195 | 1677.00 | 3.71 | 1213225.65 | |
| Assistive Technology for Individuals not otherwise covered by Medicaid Total: | | | | | | | 42432.00 |
| AT Assessment /Training | <input type="checkbox"/> | 15 minutes | 20 | 20.00 | 96.08 | 38432.00 | |
| AT equipment or repair | <input type="checkbox"/> | item | 20 | 1.00 | 200.00 | 4000.00 | |
| Clinical Consultation: Behavioral Total: | | | | | | | 1006205.76 |
| Clinical Consultation: Behavioral | <input type="checkbox"/> | 15 minutes | 786 | 84.00 | 15.24 | 1006205.76 | |
| Clinical Consultation: Nursing Total: | | | | | | | 1829117.70 |
| Clinical Consultation: Nursing | <input type="checkbox"/> | 15 minutes | 937 | 135.00 | 14.46 | 1829117.70 | |
| Community Transition Total: | | | | | | | 200000.00 |
| Community Transition | <input type="checkbox"/> | per transition | 50 | 1.00 | 4000.00 | 200000.00 | |
| Home or Vehible Accessibility Adaptations Total: | | | | | | | 155488.00 |
| Home/ Vehicle | | | | | | | |

| | | | | | | | |
|--|--------------------------|---------|----|--------|---------|-----------------|------------------|
| Modifications | <input type="checkbox"/> | episode | 32 | 1.00 | 4859.00 | 155488.00 | |
| Specialized Medical Equipment and Supplies not otherwise covered by Medicaid Total: | | | | | | | 101010.00 |
| Specialized Medical Equipment and Supplies | <input type="checkbox"/> | item | 37 | 1.00 | 2730.00 | 101010.00 | |
| Supported Living Total: | | | | | | | 503790.00 |
| Supported Living | <input type="checkbox"/> | Hour | 35 | 600.00 | 23.99 | 503790.00 | |
| GRAND TOTAL: | | | | | | 167327756.27 | |
| Total: Services included in capitation: | | | | | | 124649696.07 | |
| Total: Services not included in capitation: | | | | | | 2506 | |
| Total Estimated Unduplicated Participants: | | | | | | 66770.85 | |
| Factor D (Divide total by number of participants): | | | | | | | |
| Services included in capitation: | | | | | | 49740.50 | |
| Services not included in capitation: | | | | | | | |
| Average Length of Stay on the Waiver: | | | | | | 328 | |