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 a Renewal to a §1915(c) Home and Community-Based Services Waiver

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:
This is a renewal of the DDDS Waiver that has been in continuous operation since 1987. The DDDS waiver is targeted to individuals with intellectual disabilities and autism spectrum disorder who can no longer live independently or with their family. The waiver includes an array of services and supports designed to enable the individual to live safely in the community and to respect and support their desire to work or engage in other productive activities.

The following changes are being made in this renewal application:

The term "Mental Retardation" has been changed to "Intellectual Developmental Disability" throughout the document.

Appendix A
* Performance measure A-3: Number and percent of performance reports reviewed by the Medicaid agency" was deleted. DDDS felt that this measure was redundant of PM A-5: Number and percent of DMMA/DDDS Quarterly Waiver Mandatory meetings during which the waiver quality assuance and quality improvement activities are discussed."
* Performance measure "A-1: Number and percent of waiver policies approved by the Medicaid agency prior to implementation"
was deleted.

Appendix B
* Minimum waiver eligibility age changed from four (4) years to twelve (12) years of age. There were only three clients under the age of 12 who have ever received a waiver service under any of the previous renewals. These clients were all eligible for SSI prior to their enrollment in the DDDS waiver.
* Qualifications for who may perform a Level of Care initial certification and recertification were changed from a physician and a psychologist, respectively, to a QIPD for both the initial and recertifications
• The minimum requirement for waiver services received per month was reduced from two (2) to one (1) because case management is no longer claimed as a waiver service
* Per the CMS Crosswalk of Current vs Revised Assurances, sub-assurance B-b-1, LOC annual reevaluations completed within 365 days of previous determination was deleted. DDDS will no longer report on this measure in the annual 372 report but will continue to track it

Appendix C
• Supported Living was added as a new waiver service under "Other".
* Clinical Consultation: Behavioral and Nursing was broken out into two different waiver services. In the previous version of the application, these two distinct services were combined into a single service category with different provider types

depending on whether they were behavioral or nursing in nature. We think separating them into two distinct services is less confusing. The service specifications and provider qualifications did not change, but were revised to make them more readable.
• Criteria for Shared Living was changed to allow relatives to be paid to provide this service as long as they are not the legal guardian for the consumer being served (C-1, C-2 e., C-3)
• The service definitions for Day Habilitation and Pre-Vocational service were revised to be more in line with the September 2011 revised CMS Core Service definitions. The new definitions were presented to the public via public forums that were held in the fall of 2012.
• Language was added in the provider qualifications to indicate that DDDS has adopted the College of Direct Support training curriculum and process as the vehicle by which waiver providers can comply with most Division training requirements as part of the provider qualification and recertification process
* PM C-c-2 was deleted. This measure had previously related to allowing providers to provide training through a different means than the DDDS-sponsored training. With the adoption of the College of Direct Support as the required training curriculum for waiver providers, this measure became obsolete.

Appendix D
* Language in this section was generally rewritten to make it more readable.
• PMs D-1-b and D-2-b were corrected from the current renewal application to indicate that DDDS is both the entity responsible for service plan development and monitoring of service plan implementation and is also a service provider.
* Per the CMS Crosswalk of Current vs Revised Assurances, PM D-b-1 was deleted related to monitoring whether service plan development is conducted in accordance with waiver policies and procedures
* Per the CMS Crosswalk of Current vs Revised Assurances, PM D-e-1 was deleted related to documenting the offer of choice between institutional and waiver services. This will continue to be tracked by not reported on the annual 372 report

Appendix F - this section was generally re-written to make it more readable

Appendix G
* This section was changed to reflect new procedures for the Assistance with Self-Administration of Medication curriculum to include online instruction through the College of Direct Support, with the approval of the Delaware Board of Nursing. This online training replaced day two of the two day training for all newly hired staff as well as annual recertification training for all staff. Participants must still successfully complete 10 supervised field medication pass observations. However, the definition of medication pass was changed to reflect assistance provided during one medication assistancetime without regard to the number of individuals.

Appendix I
* This section was generally rewritten to make it more readable.
• Language was added to describe how Shared Living providers reassign payment to a governmental entity (which is DDDS)
* I-3 a. was changed to indicate that not all providers are paid via the MMIS. Shared Living providers are paid via the State of Delaware accounting system "First State Financials".
• I-4 a. was corrected to indicate that the non-federal share is appropriated to the Single State Agency for the administration of Title XIX as per SSA 1905(a)(5).
* Per the CMS Crosswalk of Current vs Revised Assurances,a new performance measure was added regarding evidence that rates are consistent with the approved methodologies

References to "Therap" as the electronic case record system have been removed throughout the document. DDDS is in the process of reprocuring an electronic case record system and Therap may or may not be the successful bidder. References to the Office of Quality Management (OQM) were changed to the Office of Quality Improvement (OQI).

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

1. Request Information (1 of 3)

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

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

C. **Type of Request:renewal**

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

○ **3 years** ◉ **5 years**

Original Base Waiver Number: DE.0009
Draft ID: DE.08.07.00

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

Regular Waiver

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

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 in42 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:

H. Dual Eligiblity for Medicaid and Medicare.
Check if applicable:

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

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.
The Division of Developmental Disabilities Services (DDDS) Home and Community Based Services Waiver provides services and supports as an alternative to institutional placement for individuals with intellectual developmental disabilities (IDD) and autism spectrum disorder. The goal of these services is to support individuals to live healthy, independent and productive lives in the community. 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 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 members 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 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. Statewideness. Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

- ◉ **No**
- ○ **Yes**

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

☐ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State. *Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:*

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the

following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.
Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

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

A. Health & Welfare: The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-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 in-patients 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:
DDDS will publish the waiver application on its website with opportunity for the public to provide written feedback. In addition, hearings have been scheduled in each county of Delaware and the complete waiver application will be available for public view. A copy of the waiver application will also be available in DDDS offices in each county of Delaware. The DDDS website will direct the public to where they may view a hardcopy of the waiver application if they so choose. DDDS reports to an Advisory Council appointed by the Governor and also has routine communication with advocacy groups, such as the State Council for Persons with Disabilities, the Delaware Developmental Disabilities Council and the Governor's Council on Exceptional Citizens regarding the operation of the DDDS waiver and other programs and services operated by the Division. Additionally, DDDS will publish notice regarding the renewal in the Delaware Register of Regulations with a link to the website where the complete application may be found and will provide the public the opportunity to comment. The comment period is 30 days. Following this comment period, the State reviews, considers, and responds to all comments received.

DDDS meets monthly with an advisory council established by the Governor. The Governor's Advisory Council is briefed on the status of the waiver renewal at each meeting. The Medical Care Advisory Council (MCAC) was briefed on the major proposed changes to the DDDS waiver under the renewal at its quarterly meeting on September 11, 2013. The MCAC was also briefed on the waiver renewal again at its meeting in on February 19, 2014 (rescheduled from the original date of January 21 due to snow). The minutes from the February 19th meeting indicate that the Council endorsed the waiver renewal as presented by DDDS at the meeting.

J. **Notice to Tribal Governments**. The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. **Limited English Proficient Persons**. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

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

Last Name:	Chappell
First Name:	Daniel
Title:	Social Services Administrator
Agency:	Division of Medicaid and Medical Assistance
Address:	1901 N Dupont Hwy
Address 2:	

Lewis Bldg

City: New Castle

State: **Delaware**

Zip: 19720

Phone: (302) 255-9625 **Ext:** ☐ **TTY**

Fax: (302) 255-4425

E-mail: daniel.chappell@state.de.us

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

Last Name: Ashby

First Name: Edwarda (Eddi)

Title: HCBS Waiver Manager

Agency: Division of Developmental Disabilities Services

Address: 2540 Wrangle Hill Road, Suite 200

Address 2:

City: Bear

State: **Delaware**

Zip: 19701

Phone: (302) 836-2137 **Ext:** ☐ **TTY**

Fax: (302) 836-2647

E-mail: eddi.ashby@state.de.us

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.
Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

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: Williams

First Name: Glyne

Title: Chief of Medical Management and Delegated Services

Agency: Division of Medicaid and Medical Assistance, Delaware DHSS

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

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

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

   ◉ **The waiver is operated by the State Medicaid agency.**

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

○ **The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

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

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.
Division of Developmental Disabilities Services
(Complete item A-2-a).

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

Specify the division/unit name:

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

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

   a. **Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
   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 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 is responsible for monitoring DDDS's operation of the DDDS 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.:*
  Delaware contracts with a provider relations agent to perform specific administrative functions under the waiver, as indicated in Question # 7 of this section. Specific functions performed by this contractor include the functions below:

  Provider relations agent functions include:
  -enrolling service providers, including executing the Medicaid provider agreement,
  -conducting training regarding claims processing
  -processing claims,
  -provider payment
  -verifying provider licensure/certification on an annual basis

  The contracts with this vendor are signed by the DMMA Director.
- ( ) **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

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

   - (●) **Not applicable**
   - ( ) **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:
     - [ ] **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

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

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

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

Appendix A: Waiver Administration and Operation

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

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:
   DMMA 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 inquires. Operational policies and procedures are in place to ensure all provider activities are reviewed and approved by DMMA.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
   In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the

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

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. **Methods for Discovery: Administrative Authority**
The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.
   i. **Performance Measures**

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

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

Performance Measure:
A-2: Number and percent of unduplicated participants exceeding the maximum enrollment limits. (Number of persons enrolled per DDDS Quarterly Reports/maximum number of persons approved to be served)

Data Source (Select one):
Other
If 'Other' is selected, specify:
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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:

A-5: Number and percent of DMMA/DDDS's Quality Waiver Mandatory Meetings during which the Waiver quality assurance and quality improvement activities are discussed. (Numerator: QII meetings during which DDDS Waiver quality assurance and quality improvement activities are discussed Denominator: All QII meetings)

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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**

	☐ **Other** Specify:

Performance Measure:
A-4: Number and percent of Fair Hearing Reports reviewed by Medicaid agency. (Numerator: Fair Hearing Reports reviewed Denominator: all Fair Hearing reports)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Quarterly DDDS Performance Reports

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

	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
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 members. 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 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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
○ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☐	**Disabled (Physical)**			
	☐	**Disabled (Other)**			
○ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐

	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
◉ **Intellectual Disability or Developmental Disability, or Both**					
	☑	**Autism**	12		☑
	☐	**Developmental Disability**			☐
	☑	**Intellectual Disability**	12		☑
○ **Mental Illness**					
	☐	**Mental Illness**			
	☐	**Serious Emotional Disturbance**			

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

DDDS Waiver eligibility includes the following criteria:

1) Must be determined eligible for DDDS services per the criteria delineated in the Delaware Administrative Code which requires a diagnosis of an intellectual developmental disability, autism spectrum disorder or Prader Willi Syndrome with functional limitations

2) Must meet level of care and financial eligibility for ICF/IID Services;

3) Must be age 12 years or older;

4) Must be at risk of needing more intensive supports and needing either residential placement outside of the natural family home or supports in the natural home. Level of risk is identified by DDDS using a standardized risk assessment tool.

5) Individual is a current resident of ICF/IID or a nursing facility and has been determined to be eligible for DDDS services and is seeking home and community based services (criteria #4 above does not apply per Olmstead).

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	1000
Year 2	1050
Year 3	1100
Year 4	1150
Year 5	1200

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number

of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

- (●) **The State does not limit the number of participants that it serves at any point in time during a waiver year.**
- ( ) **The State limits the number of participants that it serves at any point in time during a waiver year.**

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

Table: B-3-b

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

Appendix B: Participant Access and Eligibility

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

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

- (●) **Not applicable. The state does not reserve capacity.**
- ( ) **The State reserves capacity for the following purpose(s).**

Appendix B: Participant Access and Eligibility

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

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

- (●) **The waiver is not subject to a phase-in or a phase-out schedule.**
- ( ) **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

- (●) **Waiver capacity is allocated/managed on a statewide basis.**
- ( ) **Waiver capacity is allocated to local/regional non-state entities.**

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

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

Once an individual has been determined to meet waiver eligibility criteria, enrollment into the waiver is determined according to the level of risk of each participant/potential member, with those having being at the highest level of risk being enrolled first.

Level of risk is identified by DDDS using a standardized risk assessment tool called "DDDS Crisis Indicators".

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**
- [x] **SSI recipients**
- [ ] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- [x] **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)**
- [x] **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:

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:

- [x] **A special income level equal to:**

Select one:

- ( ) **300% of the SSI Federal Benefit Rate (FBR)**
- (•) **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage: 250

- ( ) **A dollar amount which is lower than 300%.**

Specify dollar amount:

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

Select one:

- ( ) **100% of FPL**

○ **% of FPL, which is lower than 100%.**

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

◉ **Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-b (SSI State) and Item B-5-d)

○ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

○ **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

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

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

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

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

◉ **The following standard included under the State plan**

Select one:

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

(*select one*):

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

Specify the percentage: 250

- ○ **A dollar amount which is less than 300%.**

Specify dollar amount:

- ○ **A percentage of the Federal poverty level**

Specify percentage:

- ○ **Other standard included under the State Plan**

Specify:

- ○ **The following dollar amount**

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

- ○ **The following formula is used to determine the needs allowance:**

Specify:

- ○ **Other**

Specify:

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

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

Specify:

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

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

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

- ○ **The amount is determined using the following formula:**

Specify:

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

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

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

- ○ **The amount is determined using the following formula:**

Specify:

- ○ **Other**

Specify:

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

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

Select one:

- ○ **Not Applicable (see instructions)***Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- ◉ **The State does not establish reasonable limits.**
- ○ **The State establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

i. Allowance for the personal needs of the waiver participant

(*select one*):

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

  Specify percentage:

- ○ **The following dollar amount:**

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

- ○ **The following formula is used to determine the needs allowance:**

  Specify formula:

- ○ **Other**

  Specify:

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

Select one:

- (●) **Allowance is the same**
- ( ) **Allowance is different.**

Explanation of difference:

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

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

Select one:

- ( ) **Not Applicable (see instructions)***Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- (●) **The State does not establish reasonable limits.**
- ( ) **The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

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:

Has been recommended for an ICF/IID level of care based completion of the Delaware Assessment of Level of Care for ICF/IID and HCBS Waiver Services instrument by an individual with the qualifications specified in Appendix B.6.c.

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 reevaluations, the case manager completes the standardized assessment instrument 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

recommendation made by the case manager is reviewed by a qualified intellectual disabilities professional (QIDP) within DDDS. The Level of Care redetermination must be approved by the QIDP. The Delaware Assessment of Level of Care for ICF/IID and HCBS Waiver Services instrument is also completed for reevaluations to document the Level of Care decision.

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 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 Office of Budget, Contracts, and Business Services (OBCBS)for recording and tracking. OBCBS records the completion date of each initial LOC determination or re-determination in a central database.

OBCBS uses this database to generate a list to the case managers alerting them to LOC re-determination dates that will be due within the upcoming 90 day period. OBCBS 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. Copies of the LOC reevaluations are retained by the case manager and the DDDS Health Information Department. This new process which was instituted in 2012 has resulted in a timeliness rate of almost 100% each month since it was instituted.

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 determinations and redeterminations are maintained at the Health Information Management Department (HIM) of DDDS 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**
   i. **Sub-Assurances:**
      a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

Performance Measures

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

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

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

Data Source (Select one):
Operating agency performance monitoring
If 'Other' is selected, specify:
The Division's Office of Budget, Contracts & Business Services maintains a database of 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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

Performance Measures

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

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

c. ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

Performance Measures

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

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

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

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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:

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

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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**

☐ **Other**
Specify:

Performance Measure:
B.c.2 The percentage and numbers of initial LOC's determined in which the criteria were applied appropriately.

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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**

☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
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 these 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 near 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 throughout the year to review DivStat data. At those meetings, measures that fall short of the standard are reviewed and corrective action is discussed. 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 action. The PAC then tracks the performance data to see if the corrective action is having the desired effect, as indicate by improved data results.

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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

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

- (●) **No**
- ( ) **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

After an individual has been assessed at a risk level indicating the need for residential placement and has been determined to meet the eligibility criteria for the waiver, the individual or his or her legal guardian is informed of the choice between receiving waiver or institutional services and which services are available under the waiver. The choice is documented on the Agreement For Participation In Home And Community-Based Services form 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 DDDS assures each enrolled member is given freedom of choice among qualified providers of each service. The member's choice is documented in his or her written plan of care.

The individual or their guardian is informed of their choices by the case manager.

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

The Agreement For Participation In Home And Community-Based Services form is maintained at the Health Information Management Department (HIM) of DDDS for a period of not less than three years.

Appendix B: Participant Access and Eligibility

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

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):
The DDDS ensures all DDDS applicants with limited proficiency in English have full access to DDDS services in his primary language, if needed. DDDS 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	Prevocational Services		
Statutory Service	Residential Habilitation		
Statutory Service	Supported Employment - Individual		
Statutory Service	Supported Employment - Small Group		
Other Service	Clinical Consultation: Behavioral		
Other Service	Clinical Consultation: Nursing		
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):

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Day Habilitation services are 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. 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.

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.
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**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Day Habilitation

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Day Habilitation

Provider Category:
Agency
Provider Type:
Day Habilitation
Provider Qualifications
License *(specify):*

Certificate *(specify):*
Must be a Division of Developmental Disabilities Services Certified Provider.
Other Standard *(specify):*
Must adhere to all standards, policies, and guidelines in the State of Delaware 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.

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

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

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

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:

Prevocational Services

Alternate Service Title (if any):

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

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.

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.

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.

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**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Prevocational Services

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Prevocational Services

Provider Category:
Agency

Provider Type:
Prevocational Services

Provider Qualifications

License *(specify):*

Certificate *(specify):*
Must be a Division of Developmental Disabilities Services Certified Provider.

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 © of the Fair Labor Standards Act.

Other Standard *(specify):*
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.

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

Contractor shall conduct child abuse and adult abuse registry checks and obtain service letters in accordance with 19 Del. Code Section 708; and 11 Del. Code, Sections 8563 and 8564. Contractor

shall not employ individuals with adverse registry findings in the performance of contract.
The Contractor agrees that professional staff employed in the execution of this contract shall be state licensed, certified, or registered in their profession as required by state law. In the case of direct care personnel, certification shall be obtained through successful completion of a training program as required by the DDDS.

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):

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Residential services can include assistance with acquisition, retention, or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-institutional community-based setting. These services are individually planned and coordinated through the individual's (Essential Lifestyle Plan (ELP). 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 adult foster care 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, 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 inclusion 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 DDDS-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. 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.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The amount, frequency and duration, and of these services are determined by the individual's care plan. There are no specified limits.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Residential Habilitation Agency
Individual	Shared Living Arrangement 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 must meet all Delaware Regulations for Neighborhood Homes for Persons with Developmental Disabilities in accordance with 16 Delaware Code $1101.
Certificate *(specify):*
Must be a Division of Developmental Disabilities Certified Provider Agency
Other Standard *(specify):*
For Neighborhood Group Homes: Must meet the DDDS Standards for Neighborhood Group Homes as specified in the State of Delaware Residential 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 Arrangement Provider
Provider Qualifications
License *(specify):*

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

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

Supported Employment - Individual

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

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.

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 weq.) 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**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Supported Employment

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:
Supported Employment
Provider Qualifications
License *(specify):*

Certificate *(specify):*
Must be a Division of Developmental Disabilities Services Certified Provider.
Other Standard *(specify):*
Must adhere to all standards, policies, and guidelines in the State of Delaware Day Program 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.

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

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

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

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.

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

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

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

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 weq.) 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**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title

Agency	

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment - Small Group

Provider Category:
Agency
Provider Type:

Provider Qualifications
License *(specify):*

Certificate *(specify):*
Must be a Division of Developmental Disabilities Services Certified Provider.
Other Standard *(specify):*
Must adhere to all standards, policies, and guidelines in the State of Delaware Day Program Contract including:

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

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

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

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

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

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:

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

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 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 member in their attainment of goals they have set. The Behavioral Consultation providers use a standardized functional 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 shall include the development of behavioral strategies, as allowed within the scope of practice of the Behavior Consultant, and when clinically indicated and if desired by the waiver member and their family.

Specifically, Behavioral Consultation includes:

- Completing the Functional Assessment of Behavior, as needed, to better understand the purpose, triggers, and what is causing the maladaptive behavior.
- Providing consultation, training and direction to waiver member's support team and other direct support professionals who work with the waiver member who displays challenging, maladaptive or self-limiting behaviors.
- 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.
- Instructing support teams, direct support professionals and family members and others with whom the waiver member routinely interacts on the principles of Positive Behavior Support and implementation of the behavioral support plan.
- Monitoring the outcome of the behavioral support plan through data collection and observation associated with the implementation of the Behavior Support Plan.
- Maintaining the waiver member's 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 member, 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 member, 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 Mental Health Support plans to ensure that the individual is supported in accordance with the principles of best practice.
- Monitors progress/treatment for people who have Behavior Support Plans or mental health support Plans
- Serves as a Team member for people who have Behavior Support Plans or Mental Health Support Plans
- Prepares necessary documentation for oversight committees such as PROBIS and HRC in accordance with DDDS policies

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**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Clinical Consultation: Behavioral

Provider Category:
Agency
Provider Type:

Provider Qualifications
License *(specify):*

Certificate *(specify):*
Behavioral Consultants must have 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.
Other Standard *(specify):*
In addition to the requirements above, a Behavior Consultant must adhere to DDDS standards, policies and procedures applicable to Behavioral Services as described in the DDDS HCBS Waiver Services Behavioral Consultative 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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

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 home or in the community 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 Plan of Care and monitors the effectiveness of the interventions on no less frequent than an annual basis.
• Completes the DDDS Medical Alert forms, Fall Risk Assessment, Aspiration Assessment, and any 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 reported to DDDS and the appropriate agency staff for corrective action.
• Completes monthly contacts (phone/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 ELP meetings, Transfer Planning Conference meetings, and other meetings as appropriate.
• Provides ongoing health related training for individuals, staff, 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 members to transition from one residential living arrangement to another.
• Adheres to DDDS healthcare protocols.
• Monitors medication administration activities performed by direct care staff or consumers.

Shared Living Providers.
• Visits all assigned Shared Living Providers at least quarterly and more frequently as indicated.
• Monitors, reviews, and reconciles Shared Living Monthly Medication forms, and takes appropriate action as indicated.
• Adheres to DDDS, State and Federal policies and regulations.
• Ensures all new policies; procedures are read and signed within established time frame.
• Promotes functional independence of individuals during medication administration activities.
• Ensures documentation is accurate, timely, relevant and complete.

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

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **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	Nursing 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:
Nursing 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):*
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:
Supported Living

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ◉ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
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
- 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.
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.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Living

Provider Category:
Agency
Provider Type:

Provider Qualifications
License *(specify)*:

Certificate *(specify)*:
Supported living may be provided by an agency that has been determined by DDDS to meet the qualifications for residential habilitation.
Other Standard *(specify)*:
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:
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: Summary of Services Covered (2 of 2)

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

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.
  Check each that applies:
  - ☐ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
  - ☐ **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
  - ☐ **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
  - ☑ **As an administrative activity.** *Complete item C-1-c.*

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

The Division of Developmental Disabilities Services (DDDS) provides qualified case managers to individuals who are enrolled in the DDDS Waiver.

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

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

- ○ **No. Criminal history and/or background investigations are not required.**
- ◉ **Yes. Criminal history and/or background investigations are required.**

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

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, relative to individuals applying to work in a home that is licensed by the Division of Long Term Care Residents Protection (DLTCRP): 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 DLTCRP promulgated rules and regulations for the implementation of the legislation and such is memorialized in DE Administrative Code, Title 16 §3105 and 3110.
HCBS waiver service providers who 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 DelC. §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 service provides to ensure on-going safeguards for the waiver members whom they serve.
HCBS waiver service providers who operate a home not licensed by DLTCRP or otherwise provide services to a waiver member are also obligated to ensure the safety of waiver members by comprehensively screening applicants. Although the BCC process is not accessible to non-licensed providers, they never the less are required to incorporate minimal screening requirements into their internal provider policies. The provider

policies are available to DDDS staff and waiver members 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 Certification 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) ensures 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, up to five individuals were allowed per home. In order to minimize disruption to the lives of the affected individuals living in homes with five 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.

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
Supported Living	
Clinical Consultation: Nursing	
Supported Employment - Individual	

	☐
Prevocational Services	☐
Day Habilitation	☐
Clinical Consultation: Behavioral	☐
Supported Employment - Small Group	☐
Residential Habilitation	☑

Facility Capacity Limit:

4

Scope of Facility Sandards. 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	☑
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☑
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

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

Appendix C: Participant Services

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

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

- (●) **No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ( ) **Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

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

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

- ( ) **The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- (●) **The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

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

DDDS allows relatives to become certified to provide Shared Living service to waiver individuals. Relatives MAY NOT be paid as Shared Living providers if they are the legal guardian for the waiver member. The relative must meet all applicable provider standards in order to become a Shared Living provider.

- ( ) **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 certified as qualified to provide HCBS services by DDDS are directed back to DDDS to receive their certification, since DDDS certification 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 HCBS 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 members 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**
   i. **Sub-Assurances:**
      a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

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

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

Performance Measure:
C-a-2: Percent and numbers of continuing providers in compliance with DDDS Certification standards and state licensing regulation by type.

Data Source (Select one):
Other
If 'Other' is selected, specify:
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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
The Office of Quality Management Certification Data Base.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100%**

		Review
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
C-a-1: The percent and numbers of new providers obtaining initial certification/licensing status in order to begin serving members

Data Source (Select one):
Other
If 'Other' is selected, specify:
Office of Quality Improvement certification data base.

Responsible Party for	**Frequency of data**	**Sampling Approach**

data collection/generation *(check each that applies):*	**collection/generation** *(check each that applies):*	*(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

waiver requirements.

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

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

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

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

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

Performance Measure:
C-c-1: The percentage and numbers of provider staff in compliance with DDDS training requirements.

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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☑ **Other** Specify:

		at least 25% of agency staff per site
	☐ **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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The frequency 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,
Sites where they are provided day or residential services,
Providers of those services and
Service system itself

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

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

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

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

Monitoring the service provider' 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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**

	☐ **Continuously and Ongoing**
	☐ **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 Qualified Providers that are currently non-operational.

- ◉ **No**
- ○ **Yes**
  Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

- ◉ **Not applicable**- The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- ○ **Applicable** - The State imposes additional limits on the amount of waiver services.

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

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

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:
ELP-Essential Lifestyle Plan

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

☐ **Registered nurse, licensed to practice in the State**

☐ **Licensed practical or vocational nurse, acting within the scope of practice under State law**

☐ **Licensed physician (M.D. or D.O)**

☐ **Case Manager** (qualifications specified in Appendix C-1/C-3)

☑ **Case Manager** (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

The Delaware Division of Development Disabilities Services (DDDS) provides case management through the use of qualified individuals who must meet the minimum qualifications for the State of Delaware Merit System classification of "Senior Social Worker/Case Manager". Individuals who exceed the stated minimum qualifications may also provide case management. The case manager is responsible for creating, implementing and monitoring the Plan of Care (known as the Essential Lifestyle Plan (ELP)). 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 member is dissatisfied with his/her case manager, he/she is supported to request a different case manager from among a qualified pool.

☐ **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:*

In addition to being the employer for the case managers who develop the service plan, DDDS also directly provides three services under the waiver: Day Habilitation, Clinical Consultation (Nursing and Behavioral) and Residential Habilitation. 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 members with intellectual disabilities before the waiver existed. The Division has continued to provide these services to avoid disruption to these waiver members, as many of them have formed strong attachments to the state programs over time.

DDDS provided day and residential services are generally not open for admission. They are not included on the list of authorized providers on the DDDS website and members are discouraged from and not offered the option of choosing those programs. There is sufficient choice and capacity within the set of qualified providers in the waiver provider network, so that the state programs are not necessary.

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 Essential Lifestyle Plan (ELP) as its participant-centered planning process. DDDS developed comprehensive policies and procedures to safeguard the integrity of the ELP so the plan is developed in the best interest of each participant.

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

The case manager facilitates the development of the ELP and functions as an advocate for the waiver member during the planning process.

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

Following the introductory discussion(s), the case manager attempts to learn who the member wants to have involved in their ELP development, whether the member wishes to have the assistance of an advocate, how the member wishes to be involved in the various conversations about the ELP development, and to identify any "off limits" topics that should not be discussed in the presence of specified others.

The case manager ensures that the member is provided with the opportunity to receive comprehensive information about home and community based services available under the waiver and the member has the right and opportunity to choose a service from among any qualified provider. The waiver member also has the right to change providers at

any time for any reason. The case manager is also responsible for ensuring that the member is apprised of his or her individual rights.

According to the DDDS Essential Lifestyle Policy, Standard E., the provider, in cooperation with the waiver member and members of the support team (including the case manager), complete the appropriate risk assessment tools to appropriately plan for safeguards and protective oversight. The Individual Plans of Protective (IPOP) is described in detail in Appendix D, section d. Service Plan Development Process.

DDDS is actively working with the concept of a "robust pre-planning ELP process" in order to assure that the member is at the center of his/her ELP, directing, making decisions and choices with regard to services contained in his/her ELP, and is satisfied with the outcomes supported by the ELP.

The robust pre-planning process begins at least 2 months before the Annual Meeting by engaging the member in conversation about his/her life, goals and aspirations and also includes any needed formal assessments such as risk assessments and health 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 member. The conversation continues along, leading to the discussion about and identification of long range goals which the ELP language refers to as "Hopes and Dreams". The conversation also attempts to discern "Things that the member Wants to Try or Things to Learn".

The Hopes and Dreams or goals can include, but are not limited to: Where to live, with whom to live, what types of services and supports are needed in such living situations, career goals, what would the member'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, past accomplishments to celebrate and possibly build upon. These items can be delineated in the "ELP Workbook" by the member or their family, prior to the pre-planning discussion.

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):

Using the results of the pre-planning activities, the case manager completes an initial interim plan called "HCBS Initial Waiver Service Authorization". Prior to development of this initial plan, the case manager meets with the member to review the ELP Workbook and to discuss services and supports available and assists the member in identifying desired personal outcomes, services and supports for inclusion in the plan. The ELP Workbook includes information about the member's preferences, likes, dislikes, level of independence, etc. The initial interim plan describes the circumstances that led the member to seek waiver enrollment and the amount, duration and frequency of each service that is recommended for the member until the ELP can be developed. The initial interim plan may only be in place for 60 days. Supports and information are made available to the participant to direct and be actively engaged in the service plan development process.

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

The DDDS Essential Lifestyle Plan Profile template can be accessed on the DDDS website home page. The profile contains an example of a completed ELP, a description of what the ELP is, what each section of the ELP means, how it is developed, and how it is used by waiver participants.

One of the responsibilities of the case manager is to provide information to the member in such a way as to maximize

the member's participation and involvement in the planning process plan.

The DDDS Training and Professional Development (TAPD) Unit makes ELP training available to potential waiver applicants and their families/guardians or advocates on a regular basis. The training includes a description of the ELP 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 ELP User's Manual for Delaware is a resource with the most current DDDS approved information relative to the development and implementation of ELPs. All staff and providers comply with the guidelines set forth in this manual.

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

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

The case manager develops an initial interim Plan of Care that must address the member's need for essential Medicaid services prior to the first receipt of a waiver service. The Essential Lifestyle Plan must be developed within 60 days of the date of the first receipt of a waiver service and is then updated annually within 365 days of the date of the previous Annual ELP Conference. Plans are also updated whenever there is a change in the participant's needs for services and supports.

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

The case manager begins preparing for the ELP development with information the member has communicated important to him/her. That information includes the things that are important to the member such as their must-haves, their preferences, and significant events or accomplishments of the past year. The ELP Workbook can be used by the member to describe these items.

The ELP includes information identifying how services and supports will enhance the member's life. This information is obtained from a variety of assessment sources based on the needs of the individual and also includes a comprehensive health care assessment.

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's coordination efforts help to assist the participant with plan development and to ensure the ELP accurately reflects such services or programs.

The support team members who have been invited by the participant to attend the Annual ELP meeting are notified of the date, time and location for the meeting. Sensitive subjects that the member does not wish to discuss at the Annual ELP Meeting are discussed with appropriate team members and outlined in the final draft of the ELP.

All members of the support team have input into and review the Essential Lifestyle Plan 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 member is identified in writing in the ELP as well as the frequency of monitoring and the reporting/accountability requirements.

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

arrangements that are used for backup.

Individualized risk mitigation strategies are incorporated into the Essential Lifestyle Plan (ELP) through the development of Individual Plans of Protection (IPOP) and are developed in a manner sensitive to the individual's preferences. In addition, all qualified providers must have a system for providing emergency back-up services and supports approved by DDDS. The IPOP was developed to be a resource for individuals with developmental disabilities to use for planning purposes to ensure their health and safety, as well as encouraging individual choice and actions to minimize or prevent of serious types of incidents.

The elements of the IPOP include:

• Heightening safety planning awareness, to identify and address risk in order to prevent potential harm from occurring and to enhance the quality of life of the member;

• Directly involving the member, 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 member safe from serious harm and promote good health, independence and opportunity to live a satisfying life. Each member's identified support needs vary depending upon his/her life experiences, abilities and environment;

The areas incorporated into the IPOP include:

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

Data from the IPOPs are incorporated into the ELP.

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 members 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 member 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.

Waiver members are assigned to a case manager who is responsible for assisting them in the process of learning about waiver services and providers. This includes using the DDDS website to become more familiar with the network of qualified service providers, assisting the individual in setting up meetings with service providers in which they have expressed an interest, and attending those meetings with the waiver member. The case manager is as active in the

process as the individual wants them to be and can assist the member in learning about the different providers so that the individual can make an informed choice.

The service recipient, including his/her circle of support, may choose to access the current list of 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 county(ies).

If a service recipient and his/her circle of support cannot access the internet or are not proficient in the use of the internet, they can request a copy of the DDDS qualified provider list. As a part of the Essential Lifestyle planning process the individual and his/her family receives additional information from DDDS on how to proceed with seeking services and how to obtain more information from providers.

DDDS provides the opportunity for waiver members 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 members and their families may speak with service providers to get a feel for the services they provide & how the provide them. DDDS representatives are in attendance to assist families in obtaining more information on how to proceed with seeking services & how to obtain more information related to the providers. This venue provides an opportunity to meet a variety of providers and obtain useful information to guide them through the selection process. DDDS also provides opportunities for waiver members to meet with each other in order to facilitate natural connections between members and their families that result in information sharing.

DDDS has also developed a set of interview questions that waiver members or families may want to ask a service provider in order to help determine if that provider is right for the client. This questionnaire is provided to all waiver members 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 Plan of Care 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 Plan of Care 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 Plan of Care for any DDDS waiver client. In addition, DMMA has access to the electronic case record software and may conduct spot checks of the Plan of Care 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**
- [x] **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, which in Delaware is termed the Essential Lifestyle Plan (ELP). The case manager is the primary person responsible for monitoring the ELP at a minimum of once a month.

Responsibilities of the case manager include ensuring that: services meet the participant's needs, are provided in accordance with their ELP, including reviewing the amount, duration and frequency of services recommended in the ELP, the ELP identifies the individual's exercise of free choice of providers, non-waiver health care services are identified and accessible, and concerns which require action are identified and remedied promptly.

The case manager monitors the implementation of the participant's plan of care (the ELP) on a monthly basis. At least once each calendar quarter, the case manager will conduct a face to face interview with the participant. The case manager 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 members 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.

When a participant wants to change a service provider, the case manager assists with assuring the current provider is made aware of the change and a transition plan is developed.

During this monthly monitoring, the case manager will:

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

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

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

• Review the participant's progress toward goals stated in the ELP.

• Review the funds of the participant to ensure they maintain waiver eligibility.

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

• Remind participants that they have free choice 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 ELP 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 member's safety. In a less serious issue, the team will work with the participant, service providers and/or informal supports to address the issue. Depending on the severity and scope of the issue, the case manager may reconvene the planning team to address the issue.

Providers must complete the following reports to assist the case manager to monitor services:

• A monthly report is completed by the member's service providers. The service provider monthly report reviews identified outcomes and/or barriers on the ELP goals and expected outcomes and reports on the status of its implementation. The provider reports on what actions or steps they have taken to support the member's attainment of identified outcomes.

• When applicable, the case manager reviews the monthly nursing and/or behavioral audits completed under the Clinical Consultation service. These tools are used to track and monitor all behavioral interventions as identified on the ELP and physical health-status. The report provides findings that are communicated waiver service providers so any issues needing follow-up may be addressed.
•
When applicable, Quarterly Day Service/Vocational/Work reports are completed by providers of day and employment services to report on the member's progress in meeting identified outcomes and goals. The reports are entered into the electronic case record system or hard copies are forwarded to the provider Support Coordinator for inclusion in the member's record.

• In addition to the reports referenced above, progress reports are provided as identified and defined in the member's ELP.

• Service providers are required to create an annual report on progress toward achieving goals. This is used by the member and his/her selected support network for subsequent plan development/update activities.

The reports listed above are designed to assist the case manager 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.

Office of Quality Improvement Oversight:

The DDDS Office of Quality Improvement (OQI) completes a thorough review of the Plan of Care (ELP) for each member identified within the Annual Representative Sample. This review is completed as part of a comprehensive survey of members' services and is included in the findings for the Annual Certification of Service Providers.

The 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 Plans of Improvement to remediate the concern. The OQI follows up to monitor progress with the implementation of the improvement plan. Data related to applicable Performance Measures is then aggregated to assist the DDDS in identifying systems level concerns that may require systems level modification in order for the standard to be achieved

b. Monitoring Safeguards. *Select one:*

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

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

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

The case manager monitors the implementation of the ELP and monitors specific outcomes pertaining to

participant health and welfare. The case manager works for DDDS. DDDS is also a direct provider of the following waiver services: Day Habilitation, Residential Habilitation and Clinical Consultation: Behavioral and Nursing. 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 members with intellectual disabilities before the waiver existed. The Division has continued to provide these services to avoid disruption to these waiver members, as many of them have formed strong attachments to the state programs over time.

DDDS provided day and residential services are generally not open for admission. They are not included on the list of authorized providers on the DDDS website and members are discouraged from and not offered the option of choosing those programs. There is sufficient choice and capacity within the set of qualified providers in the waiver provider network, so that the state programs are not necessary.

The results of the case manager monitoring activities are documented within the electronic case record system. Families may escalate concerns to other entities, such as the DDDS Director of Planning and Policy Development or the DHSS Constituent Relations office.

Each quarter, each case manager supervisor picks a random case from one of the case managers under their supervision to perform a look-behind review on all expectations of the case manager as it relates to the development, implementation and monitoring of the Plan of Care. Feedback is given to the case manager with the findings of the review and corrective or remedial actions are taken as necessary, including recommending remedial training for the case manager.

In addition, system wide monitoring is conducted by the DDDS Office of Quality Improvement (OQI). The OQI reports to the DDDS Director. The OQI has full access to review all pertinent information related to the services each waiver member receives. This arrangement prevents a conflict of interest with regards to the identification of deficient practices.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

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

Performance Measures

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

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

Performance Measure:
D-a-1: The percentage and numbers of member's Plan of Care (Essential Lifestyle Plan) which address all of their assessed needs

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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:

D-a-2: The percentage and numbers of member's Plan of Care (Essential Lifestyle Plan) which address all of their identified personal goals, hopes and dreams

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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☑ **Other** Specify:
	☐ **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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**

☐ **Other**
Specify:

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

Performance Measures

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

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

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

Performance Measures

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

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

Performance Measure:
D-c-1: The percentage and numbers of members Plan of Care (Essential Lifestyle Plan) updated/revised on or before the annual review date.

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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence

		Interval = 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
D-c-2: The percentage and numbers of member's Plan of Care (Essential Lifestyle Plan) that were revised when there were changes in the members needs.

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):*
☐ **State Medicaid**	☐ **Weekly**	☐ **100% Review**

Agency		
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

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

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

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

Performance Measure:
D-d-3: The percentage and number of members for which progress toward meeting stated service goals is reviewed by each responsible service provider on a frequency identified in the member's Plan of Care (ELP).

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 *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**

☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
D-d-2: % of participants whose Case Manager met them to review the Plan of Care at least once each calendar qtr, 2 of which must be in the participant's home w/i the plan year. (# of participants whose Case Manager met them to review the POC at least once each calendar qtr (2 of which must be in the home within the plan year)/# of participants whose services and supports were reviewed by OQI.)

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 *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
D-d-1 The percent and number of members, whose chosen services are delivered according to the type, amount, duration and frequency specified in their Plan of Care (ELP)

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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and**	☐ **Other**

	Ongoing	Specify:
	☐ **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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

e. ***Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.***

Performance Measures

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

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

Performance Measure:
D-e-2: The percentage and number of members whose ELP documents that they have been provided choice among waiver services and providers

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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% confidence interval
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Delaware's Method for Addressing Individual Problems as Discovered:
The discovery portion of the Division's Quality Management System relies on a robust performance monitoring system managed by the Office of Quality Improvement.

In addition, there is oversight involvement by formal review committees within DDDS such as the ELP Oversight Committee, the Risk Management Committee and the Performance Analysis Committee.

For each step in the Quality Management System, DDDS has identified:
- Entities responsible for Discovery (measuring and monitoring)
- Frequency of monitoring
- Data Sources
- Party Responsible for Remediation
- Unit Responsible for Verifying Corrective Action

Many of the discovery and verification processes are used as data sources to measure the DDDS outcomes and indicators.

The remediation process leading to improvement in areas found below expectation varies with discipline involved in the initial discovery process.

After the initial survey or collection of information, the findings of the professionals involved in the discovery process are communicated with the providers or others who will be involved in sharing promising practices and taking corrective action when needed. Issues are initially discussed among involved parties so as to clearly communicate findings and desired outcomes, followed up by a written report noting those areas needing correction and a date by when such is to be completed.

The responsible party discusses the issue requiring remediation and develops a plan of improvement designed to provide satisfaction for the participant, or programmatic improvements for the areas impacted by the identified finding.

Once the improvement plan is developed by the provider, the applicable unit of DDDS is notified of the plan in writing.

Following notification that the corrections were made, it is the general practice of the DDDS to follow-up, verifying the corrections were made and are acceptable.

For those surveys done by the Office of Quality Improvement, verifications usually take the form of a documented look-behind review. The documentation includes a letter to the provider agency's director, with copies of the letter to the DDDS Director and applicable Regional DDDS personnel. With other disciplines, corrections may be verified at the time of the next normally scheduled review, through increased frequency of surveillance, or through the review of provider submitted applicable documentation.

Verifications in these other cases may be documented on the next scheduled discipline-specific monitoring report or immediately through the electronic case record system.

Regional Offices 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: PM-46/incident reports, case management visits, nursing 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.

DDDS response to Continued Inadequate Performance:

Should the necessary corrections not be performed or still leave room for improvement, further actions are taken. This begins with communication of the inadequacy of the response and guidance in making the proper corrections. Higher administrative authorities in the organization are notified of the inadequacy of the response and the possibility of sanctions should improvements not be soon forthcoming. These sanctions range from the provider being placed on contract probation, the granting of a Provisional License by LTCRP, a freeze on new individuals being placed with the agency, removal of people from the provider's care or, in extreme cases, contract termination.

• Generally, unless the infractions involve egregious health and safety, rights or criminal violations, much work and effort is made by Division staff to assist the provider to come up to the expected performance before the provider's qualifications would be revoked by the Division.

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

○ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

◉ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the

Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

- ○ **Yes. The State requests that this waiver be considered for Independence Plus designation.**
- ○ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The 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 HCBS 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 Division of Medicaid and Medical Assistance (DMMA) and explains the method by which a Fair Hearing can be requested. The DMMA 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 meet the following elements:
• Include the right to appeal the action through the DMMA Fair Hearing process, DDDS appeal process (see F.b. below) or both;
• Explain that the request for a DMMA fair hearing must be in writing;
• Explain that the applicant/recipient may be represented at a fair hearing by an attorney, friend or person of their choice;
• Include contact information for the Community Legal Aid Society, Inc. to include a toll free phone number and advise to the recipient of the notification that they offer free legal advice/representation;
• Explain the reason(s) for the DDDS action including the specific regulations that support said action and;
• 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 HCBS 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 DMMA fair hearing is maintained by the DMMA Office of Fair Hearings.

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 waiver. In addition to the right to a fair hearing through the DMMA, an HCBS applicant or HCBS waiver service recipient also has the right to an appeal any adverse action via the DDDS appeal process. The right to a DDDS appeal and a DMMA 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 reduction, suspension or termination of HCBS services for an individual or the lack of choice of a service provider.

HCBS waiver applicants and service recipients 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 service recipient may appeal the adverse decision through the DDDS appeals process or through the DMMA fair hearing process or both. An individual is not required to file a DDDS appeal request as a pre-requisite to accessing the DMMA fair hearing process. The DDDS appeal is not a dispute resolution process that must be used in lieu of the DMMA fair hearing. The notification includes the reasons for the adverse actions 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 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 Fair Hearing request with DMMA 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 and also included in the DDDS administrative policy entitled "Appeal Process". The appeals committee membership includes a chairperson and representatives from the Stockley Center ICF/IID facility and all regions of the DDDS Community Services Program.

Disputable items through the DDDS appeals committee include:
• an adverse decision regarding DDDS HCBS waiver eligibility;
• the choice of service provider is not granted;
• an HCBS waiver service is reduced, suspended or terminated for an individual.

Procedural operations 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 (or receipt of Office of Applicant Services file if the appeal is of the DDDS eligibility decision) to schedule appeal;
• Appeal meeting must be scheduled within 90 days of receiving the appeal request;
• HCBS waiver services must not be reduced, suspended or terminated pending a decision of a DDDS appeal, DMMA 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 DMMA. Contact information is given by which a DMMA 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 Risk Management 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 grievance/complaint system(s).

c. **Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Description of System:
The 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. Individual Rights are reviewed with the individual receiving services and his/her guardian or advocate on at least an annual basis, at the Essential Lifestyle Planning meeting. The list of individual rights are broken into three sections: services and supports, privacy and choice. An individual receiving services or any concerned person acting on behalf of an individual receiving services has the right to file a DDDS Rights Complaint if they have reason to believe that a right is being violated or restricted without due process. Rights Complaints are filed with the DDDS Rights Complaint Designee are investigated at a regional level. A corrective/improvement plan of action is developed, reviewed by the appropriate administrator and returned to the DDDS Client Rights Complaint Designee. The complainant is contacted after a final review and approval of the rights complaint outcome and plan of action by the Division Director. The aforementioned process is completed within sixty (60) working days of the date the Rights Complaint Designee receives the rights complaint form. The outcome is also sent to the Human Rights Committee for their review and input. This input is also shared with the Division Director and responded to accordingly.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. **Critical Event or Incident Reporting and Management Process.** Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program.*Select one:*

- ◉ **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ○ **No. This Appendix does not apply** *(do not complete Items b through e)*
  If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

b. **State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

DDDS has two (2) distinct mechanisms for reporting critical incidents. The first mechanism is to report incidents

which cause or could cause injury or which have serious impact on the consumer or others. General Event Reports (GER) are used to communicate and document these reportable incidents. DDDS requires providers to enter the following information into the electronic case record system to communicate an incident, the GER, plans of correction and the tracking of incidents. The following events are reportable incidents via the electronic case record system of incident reporting, per the DDDS General Event Report policy:

• - Events which violate or have the potential to violate an individual's human rights (ex: person is prevented from practicing their religion, person is expected to work without being paid);

• - Any explained or unexplained injury to an individual;

• - Accidents requiring non-routine first aid or outside medical attention;

• - An individual's unauthorized absence;

• - Events which involve or have the potential to involve the legal system/law enforcement;

• - Actions of an individual generally viewed as unacceptable social behavior in a community setting (i.e., public display of sexual activity, coerced or exploited sexual behavior, physical aggression, verbal abuse/aggression, self-injurious behavior, criminal activity, property destruction, suicide threat/attempt);

• - Events adversely impacting or have the potential to adversely impact the a person receiving services or affect the reputation/integrity of the Division's community based programs;

• - Significant destruction or loss of property;

• - Any behavior necessitating the use of a physical restrictive procedure (document on MBIS section of the General Event Report form, via Electronic record, in accordance with DDDS Behavior Support Policy);

• - Any situation which necessitates the use of a medical restraint (ex: papoose board used by dentist);

• - Any deviation from a physician's plan of treatment including medication errors;

• - Errors related to the documentation of a physician's treatment plan (ex: assisted with medications but failed to document such on the MAR);

• - Life-threatening or allergic reaction by an individual to medical treatment;

• - The death of an individual regardless of cause.

The person who witnessed or discovered the incident initiates the report immediately (as soon as the situation is stabilized and no later than the end of his/her shift). If the initiating person is a provider of Residential Habilitation (other than Shared Living), the incident report is channeled through his/her respective administrative review process.

The aforementioned incidents are required to be immediately reported via the electronic incident report form. This reporting requirement applies to all DDDS Community Services employees, waiver providers and Shared Living Providers. The reporting individual is required to be the person who witnessed or discovered the event. Policy statements, standards and procedures for the implementation of the incident reporting process is documented in the DDDS General Event Reporting policy.

The second mechanism for reporting critical incidents is in response to the Division of Developmental Disabilities Services (DDDS) administrative policy entitled "Abuse, Assault, Attempted Suicide, Neglect, Mistreatment, Financial Exploitation and Significant Injury (Response to)". This policy incorporates DDDS standards as well as the departmental incident reporting process known as "PM #46". Policy Memorandum 46 is a Department of Health and Social Services Policy Memorandum developed in response to Delaware law for the reporting and investigation of abuse allegations. Title 16, Section 1131-1134 of the Delaware Code addresses reporting and investigative requirements and is mirrored in the Delaware Department of Health and Social Services PM #46 and the DDDS Abuse, Neglect, Mistreatment, Financial Exploitation and Significant Injury Policy. Critical incidents requiring immediate reporting and investigating include the following:

1. Abuse:

a. Physical Abuse - the unnecessary infliction of pain or injury to an individual who receives services. This includes but is not limited to hitting, kicking, pinching, slapping, pulling hair, or any sexual molestation. When any act constituting physical abuse has been proven, the infliction of pain shall be assumed.
b. Sexual Abuse- includes but is not limited to any sexual contact, sexual penetration, or sexual intercourse, as those terms are defined in 11 Del. C. §761. It shall be no defense that the sexual contact, sexual penetration or sexual intercourse was consensual.
c. Emotional Abuse- includes but is not limited to ridiculing, demeaning, humiliating or cursing at an individual who receives services, or threatening to inflict physical harm.

2. Assault: includes sexual assault as defined in 11 Del. C. §611-§613

3. Attempted Suicide: action intended to end one's life

4. Neglect shall include the following:
a. Lack of attention to the physical needs of an individual receiving services including but not limited to toileting, bathing, meals and safety (to include supervision).
b. Failure to report health problems or changes in health problems or changes in health condition, of an individual receiving services, that may have the potential to cause adverse effects, to an immediate supervisor or medical professional.
c. Failure to carry out a prescribed treatment plan for an individual who receives services.
d. A knowing failure to provide adequate staffing which results in a medical emergency to an individual who receives services.

5. Mistreatment: the use of medications, isolation or physical or chemical restraints on or of an individual receiving services that are outside the parameters of the DDDS behavior support policy or approved by the DDDS.

6. Financial Exploitation: the illegal or improper use of an individual's resources or financial rights by another person, whether for profit or other advantage.

7. Significant Injury: an injury which is life threatening or causes severe disfigurement or significant impairment of bodily organ(s) or function(s) which cannot be justified on the basis of medical diagnosis or through internal investigation. Also included are any injuries requiring medical treatment (beyond first aid).

Immediate (as soon as the situation is stabilized) verbal reports are required to be made to the designated DDDS PM #46 Coordinator by DDDS staff, DDDS Shared Living Providers and contracted agency staff who have reason to suspect any of the aforementioned reportable incidents. All required reporters and all employees/contractors who are funded by the DDDS are required to fully cooperate with subsequent internal, civil and/or criminal investigations. Reports made after normal business hours are made to the DDDS staff on call.

Strategies For Preventing Abuse and Neglect: The individual's Individual Plan of Protection (IPOP) identifies risk factors that have the propensity to make a person a high risk for victimization. The IPOP identifies areas of vulnerability as well as corresponding supports designed to prevent the individual from becoming a victim of abuse/neglect. The risk factors and supports are identified by the individual and his/her support team and circle of family and friends. The risk factors are discussed and addressed at the individual's ELP and/or Transfer Planning Conference meeting. Some risk factors indicating a person's heightened vulnerability include but are not limited to the following:
• Misuse/inappropriate use of the telephone, internet or social media;
• Lack of understanding of safe sex practices and/or how to protect one's self from sexual exploitation;
• Minimal or non-existent support network (loner and easily exploited);
• History of victimization;
• Lack of awareness relative to how/where to report abuse, threats, fear for one's own safety.

Tracking of Reports
The DDDS reviews all incidents reported via the abuse/neglect protocol, coordinates all needed follow-up, files the reports, and aggregates and tracks the trends on a quarterly basis. Data analysis reports are sent to the Risk Management Committee on a quarterly basis. The Risk Management Committee reviews the results of trend analysis which may subsequently result in program changes, including the provision of provider training. The outcome of the Risk Management Committee review of abuse /neglect data is forwarded to the Division Director for further review. Incident report data (both GERs and abuse/neglect data) are linked to systemic performance improvement efforts as part of the waiver quality management plan.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or

families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

All waiver members are advised of their right to be free of physical, verbal, sexual, psychological/emotional abuse and exploitation. This education is provided by the case manager on a minimum of once per year, at the time of the Essential Planning (ELP) Conference. 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 Incident Management System of General Event Reports is overseen at several levels. The most immediate review and monitoring occurs at the team level. Team members minimally include the case manager and provider staff who are assigned to deliver services, document incidents, develop plans of correction or protection and monitor the effectiveness of such plans.
The DDDS Office of Quality Improvement reviews GER data on an annual basis, prior to conducting re-certifications of Neighborhood Group Homes and Community Living Arrangements. Program Evaluators review available data in the member's electronic case record to determine if appropriate actions were taken, if such actions were effective and if trends exist. The outcome of the review of the incident management system by the Program Evaluators is incorporated into the certification report.

The Office of Quality Improvement (OQI) reviews General Event Report (GER) data for each member included within the Annual Representative Sample of service reviews. The OQI Program Evaluators access the electronic case record for each member identified within the sample and review any GERs that are present for completion, follow up, and timeliness of interventions to improve safeguards, trends that may impact additional members, and to determine whether an allegation of Abuse, Neglect, Mistreatment, or Exploitation should have been forwarded for investigation. Any identified ongoing concern or unresolved issue would require the generation of a deficiency for the responsible provider. In turn, a detailed plan of improvement would be required.

Allegations of abuse, neglect, mistreatment, financial exploitation or significant injury reported to the DDDS PM #46 Coordinator/Designee are reported in writing to any combination of the following individuals/entities: the DHSS Secretary's Office, DDDS Director and Director's Designee, Division of Long Term Care Residents Protection, the Medicaid Fraud Control Unit of the Department of Justice, Medical Examiner's Office, applicable DDDS Regional Program Director(s)and the Provider Executive Director and investigator, as applicable. The DDDS PM #46 Coordinator/Designee ensures law enforcement authorities and/or health care providers are contacted, as necessary. The waiver member, 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 member communicates he/she does not want such information released or the release of information has the potential to do harm. The investigation is forwarded to the Division of Long Term Care Residents Protection (DLTCRP) pursuant to DE Code, Title 16, §1132.

The DDDS is required to complete a comprehensive investigative report, and submit it to the DLTCRP, pursuant to De Code Title 16, §1134(9) and/or the DDDS abuse policy, within ten (10) days of the initial allegation of abuse, neglect, mistreatment, financial exploitation or significant injury notification, unless it is determined there are extenuating circumstances requiring further investigation. Upon completion of the investigation, the case manager notifies the family member that the investigation is completed, actions have been taken to protect the individual receiving services and a further level of review may be completed by the Division of Long Term Care Residents Protection and possibly the Attorney General/Medicaid Fraud Control Unit.

Pursuant to DE Administrative Code Title 16 §3101 the Division of Long Term Care Residents Protection is authorized to maintain a central data base known as the Adult Abuse Registry (AAR). Names of offenders of substantiated investigations of abuse, neglect, mistreatment or financial exploitation are entered onto 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, to include waiver providers, verify if an applicant is entered on the AAR. Applicants and current employees are prohibited from working with HCBS waiver members, according to the contractual agreement with the DDDS.

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 Risk Management Committee reviews data presented by the DDDS Performance Analysis Committee to determine if risk reduction strategies are necessary to strengthen the DDDS systems or improve individuals' quality of life.

The Performance Analysis Committee is an administrative committee appointed by the Division Director and charged with the responsibility of collecting, reviewing and analyzing data that measures the Division's adherence to performance measures/indicators. The Performance Analysis Committee subsequently generates analytic reports to the various DDDS quality-related committees on a regularly scheduled frequency or as requested.

The Risk Management Committee issues reports of findings to the Division Director and requests for plans of corrections, as necessary, to the appropriate executive staff person.

Analysis of trends (as opposed to individual remediation that is shared with specific providers) is shared with all waiver providers on a routine basis.

The DDDS Office of Quality Improvements participates on the DMMA Quality Improvement Initiative (QII) committee and communicates with the DMMA regarding waiver performance measures.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 2)

a. Use of Restraints or Seclusion. *(Select one)*:

○ **The State does not permit or prohibits the use of restraints or seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints or seclusion and how this oversight is conducted and its frequency:

◉ **The use of restraints or seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints or Seclusion. Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints or seclusion). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

As outlined in the DDDS Policy on Behavior and/or Mental Health Support, positive supports are the essential foundation upon which all programs and individual plans are developed.

Prohibited procedures:

DDDS Policy on Behavior and/or Mental Health Support policy prohibits the use of mechanical restraints; corporal punishment or threat of corporal punishment; seclusion as defined as placing an individual in a locked room; chemical restraint; physical, verbal, sexual, or psychological abuse or punishment; denial of a nutritionally adequate diet (including the withholding of a meal); physical restraints which cause pressure or weight on the lungs, diaphragm or sternum causing chest compression; physical interventions which cause pain, hyper extend any part of the body beyond normal limits and any technique which puts or keeps a person off balance; individuals receiving services disciplining other individuals receiving services; techniques or procedures used for the convenience of staff, or as a substitute for a support program; intrusive techniques or procedures used in the absence of other relative proactive supports.

Permitted Personal Restraints:

Permitted planned personal restraints are limited to the one and two person side body hug and the one and two arm supporting technique as described in the Mandt Training protocol.

Use of Alternative methods before Instituting Restraints

If the member's Behavior and/or Mental Health Support Plan (BMHSP), developed by a qualified Behavior Consultant, includes an approved restraint, it must describe less intrusive techniques and resources used prior to the implementation of the restraint. Every attempt must be made to anticipate and de-escalate the behavior. It is only after these have been tried, and failed, the restraint may be implemented. An approved restraint may not be used as retribution, for the convenience of staff, as a substitute for program or in a way that interferes with the member's development.

Protocol for When Restraints can be employed

Restraints are always a last resort to protect a member's health and/or safety. The member is to be immediately released from the restraint per instructions in the BMHSP, is no longer a risk to themselves or others, or shows signs of distress.

For each restraint procedure developed by a qualified Behavior Consultant, the BMHSP must include the following:

1) Specific behavior to be addressed and a description of conditions for which the restraint procedure is used

2) Single behavioral outcome desired stated in observable or measurable terms,

3) Functional assessment to identify suspected antecedents and functions of the behavior,

4) Description of less intrusive techniques which must be used prior to the use of the restraint,

5) Methods and target dates for modifying or eliminating the behavior,

6) Methods and target dates for replacement behaviors,

7) Description of the procedure to be used,

8) Risk benefit analysis,

9) Medical clearance,

10) Consents from relevant parties, and

11) Name of the person responsible for monitoring and documenting progress with the plan.

Each BMHSP is reviewed by the Peer Review of Behavior Intervention Strategies committee (PROBIS) for completeness and compliance with best accepted practices consistent with DDDS policies and procedures.

The PROBIS committee is a DDDS committee appointed by the Division Director to review and approve BMHSPs. The BMHSP is reviewed by the Human Rights Committee to the protection of the rights of individuals served by DDDS. This committee is appointed by the Division Director and is made up of non-DDDS employees.

Methods for Detecting Unauthorized use of Restraints

Each provider has access to the electronic case record database. Every use of a restraint, whether it is planned or emergency, is electronically submitted by the involved parties within 24 hours using the General Event Reports (GER) and the Medical/Behavioral Intervention Strategies (MBIS) report.

These reports describe:

- The incident
- Description of the events leading up to the restraint
- Duration of the restraint, and
- Follow-up to assure the health and safety of the individual.

Additionally, provider residential support staff enters individual electronic Inter-Disciplinary Team notes (ID notes) in the electronic record database on a daily basis.

Case managers and clinical consultants review this information several times a week. The appropriate DDDS Regional Program Director receives electronic notification of the use of a restraint and reviews the report. The Regional Program Director ensures the member's health and welfare. Improper or unauthorized use of a restraint is considered abuse and investigated through the PM #46 procedures.

Aggregate individual restraint information is reviewed by the member's ID team at least bi-monthly or more frequently as indicated in the BMHSP. The Inter-Disciplinary Team (ID team) is comprised of the individual, parent/guardian, case manager, residential provider support staff as relevant, and clinical consultants as relevant. Additional members participate as appropriate or invited. It is charged with the development, oversight and modification of the Individual's Essential Lifestyle Plan and the Behavior and/or Mental Health Support Plan if needed.

Restraint information is reviewed monthly by the PROBIS committee. Restraint information is aggregated bi-annually by type, frequency, agency and geographic region by the Division's Performance Review Committee (PAC) and submitted to the DDDS Risk Management Committee for review and action.

The Office of Quality Improvement conducts Individual Focused Certification Reviews that include record reviews and consumer interviews. Where indicators are identified, individuals are asked about the use of restraints. Any undocumented use of a restraint is reported as a potential case of abuse and investigated through the PM#46 processes. The DDDS submits quarterly reports to the Delaware DMMA which includes the use of restraints.

Education and Training Requirements for Personnel who Administer Restraints

As articulated in the DDDS Training Policy, all state staff and waiver providers have required trainings and timelines which must be completed. Providers submit training compliance information through the electronic case record database. The Office of Quality Improvement monitors training compliance as a part of provider monitoring.

These training requirements are considered to be viewed as minimal expectations to help support the individual and create a structure that prevents restraint. All providers have procedures in place to address how people are supported in emergency situations where an individual’s health and welfare may be at risk.

All waiver providers are required to have specific trainings within established timelines prior to working alone with individuals. These training requirements include DDDS policies relevant to the use of restraints.

All waiver providers are required to participate in the Mandt System crisis intervention training or a DDDS approved equivalent. Contracted providers must be certified in a specific restraint prior to its use with an individual.

The Mandt System includes the following topics:

1) Environmental factors and triggers,

2) Positive behavioral support,

3) Person-centered alternatives to the use of restraint, training in body mechanics that illustrates how to avoid hyperextensions and other positions that may endanger individual safety,

4) Awareness of the impact of the individual’s health history on the application of a restraint,

5) Training in the use of approved restraints and possible negative psychological and physiological effects or restraints,

6) Monitoring of an individual's physical condition for signs of distress or trauma, and

7) Debriefing techniques with the supported individual as well as staff members.

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints or seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

DDDS is responsible for the oversight of the use of restraints. DDDS analyzes restraint data as described above under detecting unauthorized use of restraints.

Each provider has access to the electronic case record system. Every use of a restraint, whether it is planned or emergency, is electronically submitted by the involved parties within 24 hours using the General Event Reports (GER) and the Medical/Behavioral Intervention Strategies (MBIS) report. These reports describe the incident, a description of the events leading up to the restraint, the duration of the restraint, follow-up to assure the health and safety of the individual.

The DDDS Regional Program Director receives electronic notification of the use of a restraint and reviews the report. The Regional Program Director ensures the individual's health and welfare. Information on the use of restrictive procedures for an individual is reviewed by the individual's ID team at least bi-monthly or more frequently as indicated and Behavioral Support Plans are modified as necessary.

Additionally, the Office of Quality 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. The Office of Quality Improvement submits quarterly reports to the Delaware DMMA which includes data on incidents and complaints.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 2)

b. Use of Restrictive Interventions. *(Select one)*:

○ **The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

◉ **The use of restrictive interventions is permitted during the course of the delivery of waiver services**
Complete Items G-2-b-i and G-2-b-ii.

i. **Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

As articulated in the DDDS Policy on Behavior and/or Mental Health Support, positive supports are the essential foundation upon which all programs and individual plans are developed. Further, the policy discourages the use of restrictive procedures.

A restrictive procedure is defined as a practice which limits an individual's movement, ability to acquire positive reinforcement, results in the loss of valued objects or activities, or requires an individual to

engage in a behavior the individual would not engage in given freedom of choice.

The use of averse conditioning, defined as the contingent application of startling, painful or noxious stimuli is prohibited.

Use of Alternative methods before Instituting Restrictive Interventions

If the individual's Behavior and/or Mental Health Support Plan (BMHSP), developed by a qualified Behavior Specialist, include restrictive interventions, it must describe less intrusive techniques and resources which must be used prior to the implementation of the intervention. Every attempt is made to anticipate and de-escalate the behavior. It is only after these have been tried, and failed, the restrictive intervention are implemented.

A restrictive procedure may not be used as retribution, for the convenience of staff, as a substitute for the program or in a way that interferes with the individual's development.

Protocol for When Restrictive Interventions are Employed

For each restrictive intervention procedure developed by a qualified Behavior Specialist, the BMHSP includes the following:
1) the specific behavior to be addressed and a description of conditions for which the restrictive intervention is used

2) the single behavioral outcome desired stated in observable or measurable terms,

3) a functional assessment to identify suspected antecedents and functions of the behavior,

4) a description of less intrusive techniques used prior to the use of the restrictive intervention,

5) methods and target dates for modifying or eliminating the behavior,

6) methods and target dates for replacement behaviors,

7) a description of the intervention to be used,

8) a risk benefit analysis,

9) medical clearance if appropriate,

10) consents from relevant parties, and

11) the name of the person responsible for monitoring and documenting progress with the plan.

Each BMHSP are reviewed by the Peer Review of Behavior Intervention Strategies committee (PROBIS) for completeness and compliance with best accepted practices consistent with DDDS policies and procedures.

The PROBIS committee is a DDDS committee appointed by the Division Director to review and approve BMHSPs. The BMHSP also is reviewed by the Human Rights Committee (HRC) to ensure the protection of the rights of individuals served by DDDS. This committee is appointed by the Division Director and is made up of non-DDDS employees.

Methods for Detecting Unauthorized use of Restrictive Interventions

Each provider has access to the 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 BMHSP which may include a description of the incident, a description of the events leading up to the restrictive intervention, the duration of the restrictive intervention, follow-up to assure the health and safety of the individual.

Additionally, residential provider support staff enters individual electronic ID notes in the electronic case record system on a daily basis. Case managers and clinical support staff review this information several times a week. The DDDS Regional Program Director receives electronic notification of the use of a restrictive intervention and reviews the report. The Regional Program Director ensures the individual's health and welfare. Improper or unauthorized use of a restrictive intervention is considered abuse and investigated through the PM #46 processes.

Aggregate individual restrictive intervention information is reviewed by the member's ID team at least bi-monthly or more frequently as indicated in the BMHSP. Restrictive intervention information is reviewed by the PROBIS committee as identified by the DMHSP.

The Office of Quality Improvement conducts Individual/ Focused Certification Reviews that include record reviews and consumer interviews where indicators are identified concerning the use of restrictive interventions. Undocumented use of restrictive procedures is reported to the Regional Program Director for follow up to:

1) Ensure the individuals health and welfare, and

2) Determine how to prevent further use of undocumented restrictive interventions.

Any undocumented use of a restrictive procedure which constitutes suspected abuse or neglect is investigated through the PM #46 process. The Office of Quality 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.

As articulated in the DDDS Training Policy, all state staff and waiver provider staff have required trainings and timelines which must be completed. Providers submit training compliance as a part of provider monitoring.

These training requirements are considered to be viewed as minimal expectations to help support the individual and create a structure that prevents restrictive interventions. All providers have procedures in place to address how people are supported in emergency situations where an individual's health and welfare may be at risk.

All waiver providers have specific required trainings within established timelines which must be completed prior to working alone with individuals. These training requirements include DDDS policies relevant to the use of restrictive interventions. All contracted providers are required to participate in the Mandt System crisis intervention training or a DDDS approved equivalent. Waiver providers must be certified in a specific restrictive intervention prior to its use with an individual.

The Mandt System includes the following topics:

1) Environmental factors and triggers,

2) Positive behavioral support,

3) Person-centered alternatives to the use of restrictive intervention, training in body mechanics that illustrates how to avoid hyperextensions and other positions that may endanger individual safety,

4) Awareness of the impact of the individual's health history on the application of a restrictive intervention,

5) Training in the use of approved restrictive interventions and possible negative psychological and physiological effects or restrictive interventions,

6) Monitoring of an individual's physical condition for signs of distress or trauma, and

7) Debriefing techniques with the supported individual as well as staff members.

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

The DDDS is responsible for the oversight of the use of restrictive interventions. DDDS analyzes restrictive intervention data as described above under detecting unauthorized use of restrictive interventions

Each provider has access to the electronic case record system. Every use of a restrictive intervention is electronically submitted by the involved parties within 24 hours using the General Event Reports (GER) report. These reports provide information identified in the BMHSP which may include a description of the incident, a description of the events leading up to the restrictive intervention, the duration of the restrictive intervention, follow-up to assure the health and safety of the individual.

Additionally, residential waiver provider support staff enters individual electronic ID notes in the electronic case record system on a daily basis. Case managers and clinical support staff review this information several times a week. The DDDS Regional Program Director receives electronic notification of the use of a restrictive intervention and reviews the report. The Regional Program Director ensures the individual's health and welfare. Improper or unauthorized use of a restrictive intervention is considered abuse and investigated through the PM #46 processes.

Aggregate individual restrictive intervention information is reviewed by the member's ID team at least bi-monthly or more frequently as indicated in the BMHSP. Restrictive intervention information is also reviewed by the PROBIS committee as identified by the DMHSP.

The Office of Quality Improvement conducts annual record reviews and consumer interviews where individuals are asked about the use of restrictive interventions. Undocumented use of restrictive procedures is reported to the Regional Program Director for follow up to:

1) Ensure the individuals health and welfare, and

2) Determine how to prevent further use of undocumented restrictive interventions.

Any undocumented use of a restrictive procedure which constitutes suspected abuse or neglect is investigated through the PM #46 processes.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. **Applicability.** Select one:

- ○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. **Medication Management and Follow-Up**

i. **Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

Waiver providers have a system, as identified in their policy, whereby they minimally monitor regularly for medication errors, ensure staff that assist with medications have a current certification in Assistance with Self-Administration of Medication, respond to the Delaware State Board of Nursing with required information, provide their staff with necessary training and/or mentoring and apply corrective actions as required.

This responsibility is completed in all Neighborhood Homes and Community Living Arrangements (CLAs) by assigned provider personnel. Monitoring is conducted by the waiver provider." In Shared Living settings the DDDS Nurse and the waiver provider work in tandem to complete the monitoring processes.

• The scope of monitoring by the waiver provider is to review each participant's entire medication regimen,

assure adequate documentation, and to observe staff provide direct assistance for participants with taking their medications in accordance with the participant's ELP.

• The designated staff is expected to review all participant health related issues including medications during each day in which the designated staff is on duty in the site. The review is to entail a review of upcoming medical appointments for the participants, medication amounts present in the site, proper storage of the medications, and proper documentation of the medications which have been received by each participant. The role of the designated staff is to complete on at least a monthly basis, follow up to the issues tracked by the designated staff. This is to assure the designated staff is properly reviewing participants' medication. The designated staff assure proper incident reports are completed should a medication error be identified or investigation be required.

• This monitoring system is designed to detect potentially harmful practices by providing an accountability system. The system compares all components of a Physicians' Order for medication (i.e., correct medication, correct dose, correct recipient, correct route, correct time, etc.) to the documentation trail of what was received by the participant, and what the participant's ELP requires for supports.

• Second-line monitoring is conducted on the use of behavior modifying medications by the same processes as described in the paragraphs above as well as the additional processes described as follows:

The DDDS Peer Review of Behavioral Strategies Committee (PROBIS) reviews and approves multi-component Behavioral/Mental Health or Essential Lifestyle Plans. The committee is responsible for monitoring all plans that include the use of medication for the sole purpose of behavior control in the absence of a psychiatric diagnosis. PROBIS also completes an initial review of Mental Health Support Plans for the use of medication for the treatment of a mental illness.

DDDS Policy requires Behavior Support Plans and Mental Health Support Plans show an understanding of and address the individual's behavior / psychiatric symptoms in terms of:

a. the impact of environmental factors

b. the impact of social and interpersonal factors

c. the individual's coping skills

d. the impact of psychological/psychiatric factors

e. the individual's ability to understand and produce meaningful communication

f. any potential medical condition or physical disability

Mental Health Support Plans/Essential Lifestyle Plans outlining the use of psychotropic medication for the treatment of a mental illness is reviewed by the interdisciplinary team prior to or at the time of beginning the medication. Additionally, the plan is submitted to PROBIS within 90 days of beginning the medication and shall include the I. D. Team's recommendation relative to the future monitoring of the plan. This recommendation includes the proposed monitoring/review body (I. D. Team or PROBIS) and the suggested frequency of review.

PROBIS monitors and determines the frequency of monitoring of all Level II interventions and plans. Proposed changes are submitted to the PROBIS chair via e-mail/written notification prior to implementation if an intervention is added or deleted.

If PROBIS determines the interdisciplinary team is the monitor for the Mental Health Plan, the team assumes responsibility and no further committee reviews of the plan/program is necessary unless:

1. The diagnosis is changed to one not included in the major diagnostic class of the original diagnosis;

2. The class of medication prescribed is changed to another class;

3. The total daily dosage of the medication exceeds the recommended upper range listed in either the Physician's Desk Reference or the Nursing Drug Handbook.

The waiver provider's Program Manager reviews the participant's treatment plan involving behavior modifying medications on a monthly basis.

Monitoring includes notation of the participant's response to treatment in comparison to established treatment goals. The interdisciplinary team is notified whenever the participant's response to treatment is not meeting established goals or if undesired side effects are identified. The interdisciplinary team, then under the leadership of the Psychological Assistant or Behavior Analyst arranges for the participant to meet with the applicable physician for further evaluation should the treatment not provide desired outcomes.

ii. **Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

DDDS is the state agency responsible for the oversight of the policies and procedures regarding medication admnistation for waiver members. A qualified Nurse Consultant must conduct a thorough monthly medication monitoring function with a report generated as to the findings. A copy of findings is stored in each member'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. 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.

The Nurse Consultant's monitoring role is designed to focus on all medication types and medication usage patterns ordered for each participant. The assigned nurse's methods for conducting monitoring in Neighborhood Homes and CLAs include the 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 all participants current Medication Administration Records (MAR) against Physicians' Orders and against medication labels to assure agreement. An accountability of medication is completed. Check medications are adequately stocked, properly stored, and not expired. Compare count sheets and the amount of medication remaining against the amount noted on the count sheet. Assure Standing Medical Orders (SMOs) are updated annually by the physician.

Additionally, on an annual basis, the DDDS, 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.

In Shared Living homes, the provider completes a Foster/Respite Monthly Medication Record, which is forwarded to the participant's nurse consultant. This form lists all medications the participant is on, and whether the medication was "held," or changed during the month reported on. For newly ordered medications, the nurse speaks with the provider about any side effects that need to be observed for and reported upon. The discussion includes the nurse making sure side effect information is received from the pharmacy.

The frequency of monitoring by the nurse in Neighborhood Homes and Community Living Arrangements occurs at least monthly with visits to each of these residential sites. Additionally, the 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 assuring the receipt of the Foster / Respite Monthly Medication Record, at least monthly telephone contacts with the provider, and home visits at least annually to meet with the participant and the provider, or as indicated by participant health needs and to verify that medications are stored as required by DDDS policy. The Nurse Consultant participates in the individual's ELP planning process, which includes discussion and documentation of the individual's medications, health status, and needs for support.

The state monitoring program gathers information concerning potentially harmful practices and employs information to improve quality by the following means: In Neighborhood Homes and CLAs, the nurse places a copy of the medication review in the electronic record and forward the report to the designated agency staff via electronic mail. The designated agency staff corrects any errors or makes comments and returns the form to the nurse upon completion. The nurse notifies the designated agency staff of any issues needing immediate

attention. If there are no issues requiring immediate attention, the nurse leaves a note in the site's communication book that a medication review was completed and is reviewed by the program manager. Should the medication review identify any medication errors, a Medication Incident Report (General Event Report [GER] in the electronic case record system- related to any event causing or could cause injury, which has serious impact on the individual or others) is filed. The annual review by the DDDS OQI serves as an indicator as to the effectiveness of the provider agency and nurse consultant's monitoring of the medications.

From these reports, incident specific corrections are required of provider agencies. From the GERs, the DDDS is able to create Data Analysis Reports for the review of medication error types and risks in the assistance with medication system, as well as identify corrective actions. The reports are generated for either a provider or System Level of Inquiry.

The Division will review annual Delaware-specific data from the National Core Indicators Project on polypharmacy when it is available.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

- ○ **Not applicable.** *(do not complete the remaining items)*
- ◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

DDDS policy concerning assistance with self- administration of medications to individuals who are unable to self-administer and the responsibilities of providers for overseeing self-administration is entitled Assistance with Self-Administration of Medication, and is dated August 3, 2009.

The purpose of the policy is to establish uniform standards for assistance of self-administration of medication by unlicensed health care professionals to protect the health and safety of individuals served. The policy states only staff who have successfully completed the Assistance with Self-Administration of Medication (AWSAM) training and/or annual retraining, or health care professionals as permitted by DE Code may assist individuals served to self-administer his/her medication. The AWSAM policy applies to all waiver providers.

Policy Standards for AWSAM are as follows:

Unlicensed health care professionals successfully complete the Delaware Board of Nursing approved AWSAM course (including in class practicum and supervised medication passes) prior to assisting a person served with his/her medication.

•Licensed health care professionals are required to complete the initial AWSAM training, yet, are not required to take annual re-certifications.

•Unlicensed health care professionals must successfully complete annual AWSAM training from an authorized instructor, before he/she assists a person with self-administration of medication.

•Individuals approved to administer their own medication shall require some degree of staff monitoring such as observation, assistance with medication recording or reviewing medication documentation.

Such specific monitoring and safeguarding components for individuals who assist with his/her own medication

are clearly documented in the ELP.

•All loose routine medication (i.e., not in blister pack) are counted and documented accordingly, on a daily basis. Loose PRN medications are documented on a count sheet each time the PRN medication is received.

•Medications/treatments may only be assisted with if in a properly labeled container, from the pharmacy, prescribing practitioner, or nurse.

•Orders must indicate how often the person is to receive the medication.

•Orders must be clearly written or clearly understood by the staff who receives the order.

•Additionally, the AWSAM Policy addresses in detail, PRN Orders, Standing Medical Orders, guidance for supporting participants with Health Care Provider Visits, detailed standards for clear Physician's Orders, proper Medication Storage, Accountability of Controlled Medications, details for Medication Administration Records, Agency Oversight, and Disposal of Medications.

"•Assistance with Self Administration of Medication" is the authorized course provided by authorized training staff & the College of Direct Support (CDS) Medication Module for all waiver providers who have a role in assisting participants with their medical needs.
Enhanced program guidelines were implemented on June 1, 2008 for medication errors. The purpose of the enhanced curriculum is to create a more efficient system of oversight and administration of the Assist with Medication program and to clearly identify where responsibilities reside.

Assistance with Self Administration of Medication Guidelines

In order to assist a waiver member with their medication(s), staff must successfully complete all sections of the DDDS Assistance with Self Administration of Medications (AWSAM) Program. All newly hired staff must complete the two day class with the required supervised field medication pass observations. Thereafter, successful completion of the recertification class is required annually.

Handouts are distributed to all trainees no more than seven (7) days prior to his/her scheduled two day or recertification class. The handouts may not be present when completing the CDS AWSAM Module. The trainee must provide a picture identification to participate in any of the AWSAM classes.

Two Day Class with Supervised Field Medication Pass Observations

Day one will consist of classroom instruction with a registered nurse who has been approved by the Delaware Board of Nursing as an AWSAM instructor. An overview of medication safety, transcription of practitioners' orders, medical appointments, along with other pertinent information for the safe assistance with self-administration of medications will be included. The classroom instruction will include instruction of oral, optic (eye), topical, otic (ear), and rectal routes of administration along with a return demonstration by the participants. The participants must correctly complete the return demonstrations to successfully move on to day two.

Day One and Day Two must be completed on consecutive days.

Day Two is in a proctored setting and all lessons shall be completed during one session. No electronic devices are permitted in the area when completing these lessons. The proctor must be in a supervisory position within the agency.

Participants will complete the seven (7) medication lessons within the CDS. The DDDS AWSAM Program requires participants to complete a test following each lesson with a proficiency of 80% or better. If a participant fails any module, they may retake the lesson one (1) time.

Failure to successfully complete these requirements will result in the direct support professional(DSP) having to retake the two day course. If the DSP fails a second time, he/she will not be permitted to assist any individual with medications. The participant may retake the two day course after six (6) months with the recommendations from his/her supervisor.

Supervised Field Medication Pass Observations
DSPs must successfully complete 10 observed medication passes in the field after the successful completion of

Day One and Day Two.

The observed field medication passes are designed to give a DSP the opportunity to practice the application of the information that they have learned in the classroom. The field pass is an exercise for the DSP and it serves as an opportunity for the authorized observer to share his/her knowledge and expertise with the DSP. In order for this process to be effective, it requires feedback from the authorized observer and verbal cueing from the DSP. The DSP should state each step out loud as it is being performed. This will assist in committing the steps to memory and also in ensuring that all steps are followed according to procedures.

The authorized observer's signature on the medication pass checklist declares that the process occurred correctly. If it is determined that an error occurred during this process, the authorized observer will be held equally accountable as the DSP for the medication error. Therefore, it is imperative that all involved understand the seriousness of this process. In some instances, errors can be considered neglect and could result in a criminal investigation, charges and/or fines. Inadequate supervision during the assistance with medications can result in the loss of life. It is important that everyone participating in this process use caution and care.

A medication pass is defined as assistance that is provided during one medication assistance time. The number of individuals for whom assistance is provided or the number of sites in which assistance is provided is irrelevant. A DSP can only receive credit for the completion of one medication pass per medication assistance time. This observation will constitute a single medication pass. Successful completion of 10 supervised field medication passes is required. The purpose of supervised passes is to help the trainee become familiar with the entire medication program from start to finish.

Field Medication passes must be completed within 60 days of the course work (Days 1 and 2) or the trainee will have to repeat the basic AWSAM course.

Upon the successful completion of 10 supervised field medication passes the DSP will obtain an authorization (final voucher) from their Provider designee to assist with medications without direct supervision. The Provider is responsible for ensuring that there is a system in place to monitor the on-going performance and supervision of the field medication passes occurring in all of its programs.
The DDDS Office of Quality Improvement will confirm that all vouchers (classroom, College of Direct Support, and practicum) are present during audits, as evidence of the authorization to assist without direct supervision during the assistance with medications.

Authorized Observers:
In order to be authorized to observe during a field medication pass and sign the supporting documentation, one of the following provisions must be met.
I. The Observer is an employee of DDDS or a DDDS waiver provider with a minimum of 2 (two) years of experience. These individuals shall have no history of medication errors over the past 2 years and shall have a current voucher from the Assistance with Self Administration of Medication class; or
II. The Observer is a DDDS supervisor or a DDDS Provider, at least at a Program Manager or Program Coordinator level with a minimum of 6 (six) months of experience. These individuals shall also possess a current voucher in the Assistance with Self Administration of Medication Class; or
III. The Observer currently holds a valid state of Delaware Nursing license, has attended the two day Assistance with Self Administration of Medication class through DDDS, and has worked within the DDDS system for a minimum of 3 (three) months.

Recertification:
(This will be in a proctored setting and all lessons shall be completed during one setting. There will be no electronic devices permitted in the area when completing these modules. The proctor must be in a supervisory position within the Agency.)

Participants will complete the seven (7) medications lessons within the College of Direct Support. The DDDS AWSAM Program requires participants to complete a test following each lesson with a proficiency of 80% or better. If a participant fails any lesson, they can retake the lesson one (1) time.
If a participant fails a second time, they will then be required to attend the two day class (excluding the supervised medication passes). If the participant then fails the two day class, he/she will not be permitted to assist any individual with medications. The participant may retake the two day course after six (6) months with recommendations from his/her supervisor that he/she is prepared to retake the course.

Direct Support Professionals shall be scheduled to complete recertification every eleven (11) months. This will

allow time to retake any requirement(s) that the candidate did not successfully complete during the first attempt before his/her AWSAM authorization expires.

DOCUMENTATION:
All Agencies will maintain the voucher for the coursework, the practicum review sheet and the Agency authorization as evidence of compliance with the Delaware AWSAM Program.
Agencies ensure there is a system in place to monitor on-going performance and supervision of the field passes, along with the general program. The curriculum stresses the overall integrity of the agency program depends upon sound internal quality assurance practices. Following completion of the 10 successful medication passes, a final voucher is issued by the evaluating agency. The DDDS OQI Unit confirms both the Classroom/Practicum and the Supervised Advisor Vouchers are presented during routine annual audits. All vouchers must have accompanying documentation showing the successful Medication Pass logs.
Agencies assume responsibility for ensuring compliance and competency of the process. Agencies assume liability for the integrity of the agency medication program.

iii. Medication Error Reporting. *Select one of the following:*

◉ **Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**
Complete the following three items:

(a) Specify State agency (or agencies) to which errors are reported:

The types of medication errors providers must record and/or report to the Division of Developmental Disabilities Services include any deviation from a physician's plan of care, including Standing Medical Orders, that involve errors relative to assisting with the incorrect dose or at the incorrect time, assisting with the incorrect medication/treatment, assisting the incorrect individual with a medication/treatment, assisting with the medication/treatment via the incorrect correct route and assisting with the medication/treatment at the correct time (or not at all).

(b) Specify the types of medication errors that providers are required to *record:*

The types of medication errors providers record and/or report to the Division of Developmental Disabilities Services include any deviation from a physician’s plan of care, including Standing Medical Orders, that involve errors relative to assisting with the incorrect dose or at the incorrect time, assisting with the incorrect medication/treatment, assisting the incorrect individual with a medication/treatment, assisting with the medication/treatment via the incorrect correct route and assisting with the medication/treatment at the correct time (or not at all).

(c) Specify the types of medication errors that providers must *report* to the State:

The types of medication errors providers record and/or report to the Division of Developmental Disabilities Services include any deviation from a physician’s plan of care, including Standing Medical Orders, that involve errors relative to assisting with the incorrect dose or at the incorrect time, assisting with the incorrect medication/treatment, assisting the incorrect individual with a medication/treatment, assisting with the medication/treatment via the incorrect correct route and assisting with the medication/treatment at the correct time (or not at all).

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

DDDS is the state agency responsible for the on-going monitoring of waiver provider's performance in

Assisting with Self Administration of participants' medications. Monitoring occurs through routine review of medication error reports within the electronic case record system. Additionally, the DDDS Performance Analysis Committee (PAC) completes reports on the rates of medication errors by type, at least annually. Data is analyzed not only by error type, but also by provider agency. In this way, the DDDS can analyze system-wide challenges, as well as, pinpoint individual provider performance issues.

DDDS monitoring methods are designed to identify problems in provider performance and to support follow-up remediation actions and quality improvement activities. DDDS enhanced Assistance with Medication Curriculum and Policy described above is the best way to illustrate how the state actively seeks to review data and implement continuous quality improvement measures.

Data is acquired to identify trends and patterns and support improvement strategies primarily through the electronic case record system. Additional sources of data for drawing correlations are the OQI Neighborhood Home and Community Living Arrangements Certification Data and the Nurses Monthly Health Audits. With the electronic case record system, a reviewer searches for Medication Errors as a whole, by type such as wrong dose, or by provider and type. The numbers of errors are looked at as a ratio of the number of reported errors compared to the number of participants on the waiver during a particular time period.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. **Methods for Discovery: Health and Welfare**
The State, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.
   i. **Performance Measures**

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

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

Performance Measure:
G-a-3: The percentage of participants reporting that they feel safe at in their waiver service setting. (The number of participants reporting that feel safe in their waiver service setting/number of participants whose services and supports were reviewed)

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:
Individual Outcome & Satisfaction Assessment. DDDS recently began to implement the NCI survey process & will switch the data source for this measure to the NCI results as soon as they are available.

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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% Confidence interval
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
G-a-4: The number and percentage of waiver members receiving demographic appropriate health care screenings.(The number and percent of waiver members who received demographic appropriate health care screenings/the number of participants who should have received a screen based on their demographics)

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
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):*

☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95 % confidence interval
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
G-a-1: The percentage and numbers of members with substantiated incidents of Abuse/Neglect/Mistreatment/Exploitation/Unexplained Death by incident type.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:
The DDDS PM46 Unit Data Base

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

Performance Measure:
G-a-2: The percentage and numbers of substantiated cases of abuse, neglect and exploitation where recommended actions to protect health and welfare were

implemented.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:
The DDDS PM46 Unit Data Base

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

Performance Measure:
G-a-6: The annual mortality rate for waiver members by age, gender, and cause of death: natural or medicological compared to DDDS baseline established during 2001-2007. (Number of waiver member deaths by age, gender and cause of death: natural or medicological/DDDS established baseline rate.)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Health Information Management and Mortality Data Spreadsheet

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

	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
G-a-5: The percentage and numbers of day and residential providers by service type with adequate procedures and plans for emergencies, disasters, fire drills and evacuation needs.

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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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):*
☐ **State Medicaid Agency**	☐ **Weekly**

☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
G-a-7: The percentage and numbers of reported incidents of restrictive behavior intervention strategies (restraints or seclusion) implemented.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
Electronic case record 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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Individual problems are referred to the 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 Office of Quality Improvement and other Division of Developmental Disabilities Services staff, as applicable. Remediation is a coordinated effort by the DDDS Administration staff, Regional Office Staff, and other concerned parties that could include law enforcement. Less serious reports are resolved by the Regional office with the assistance of the case manager and other staff. 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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**

	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

- ◉ **No**
- ○ **Yes**
  Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QMS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the QMS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QMS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The goal of the Division of Developmental Disabilities Services' Quality 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 no longer the purview of just one entity. Everyone has some role or responsibility regarding quality. Consequently, DDDS collects and analyzes trend data from a variety of sources relative to outcomes and indicators identified by individuals, families, providers, stakeholders and administrative authorities, with the objective of ongoing improvement in service delivery. The current 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 Authorized Waiver.
• Support collaboration with participants, their families, stakeholders, and the state.
• 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.

Entities with Major Roles and Responsibilities for DDDS Quality Improvement System

The DDDS Performance Analysis Committee (PAC) 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.

The various DDDS committees responsible for reviewing data, trending, prioritizing findings, and developing quality improvement strategies are:
• Risk Management Committee – Monitors organizational risk through the review of key data, including specific HCBS Waiver Performance Measures. They also identify the need for the development of strategies that address risk identified through data analysis.
• Essential Lifestyle Planning (ELP) Steering Committee – A committee responsible for developing, reviewing, and revising the DDDS ELP protocols in order to assure a successful Plan of Care development process for participants.
• Authorized Provider Committee – This committee develops and maintains the list of Authorized Waiver Providers. This committee process supports the open and continuous enrollment of waiver service providers

throughout the year. The committee reviews all applications from providers who wish to become qualified to provide one or more waiver services against established qualification standards for each service. The committee also periodically reviews and may make changes to the enrollment process to assure ease of access and makes corresponding updates to the DDDS website as necessary to implement procedural changes, such as enrollment forms.
• Division of Medicaid and Medical Assistance (DMMA) – The State Medicaid Agency with administrative authority over HCBS Waiver services in Delaware. The Division of Medicaid and Medical Assistance (DMMA) reviews performance reports provided by DDDS under their authority as the administering agency for waiver services.

Each group reviews applicable reports in order to recommend system wide improvement strategies as well as to identify and promote promising practices. Minutes from each of the review committees are maintained in order to identify recommendations or actions required. The minutes are shared with the Division Director/Designee who prioritizes the recommendations, authorizes the quality improvement strategies and assigns responsibilities for developing improvement strategies.

The Division of Medicaid & Medical Assistance (DMMA) is the agency that has oversight responsibility for Medicaid including waiver programs. DMMA developed and implemented its Quality Management Strategy (QMS) to promote an integrated, collaborative quality management approach among DMMA, managed care, waiver, and other medical assistance programs. Delaware's State-wide QMS mission is to:
•Assure Medicaid enrollees receive quality care and services identified in waivers and Medicaid funded programs by providing oversight for monitoring and tracking activities of quality plans, assurances and improvement activities;
•Provide ongoing oversight responsibilities assuring Medicaid funded program quality plans meet CMS requirements of "achieving ongoing compliance with the waiver assurances" and other federal requirements.

DDDS 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 the DMMA Waiver Coordinator, 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 Waiver Coordinator is the person primarily responsible for the coordination and organization of DMMA waiver oversight functions. The Waiver Coordinator:
• 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:
• 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.

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.
• 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*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Quality Improvement Committee**	☑ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

The ability of the DDDS to collect, analyze and use information to provide internal and external stakeholders with accurate, timely and important information to improve the quality of services and supports is assessed on an ongoing basis through a formative evaluation.

The Performance Analysis Committee (PAC) has primary responsibility for determining if the various discovery processes and data sources accurately measure the outcomes and indicators. Problems with data collection activities are corrected as needed. As well, the PAC solicits ongoing feedback from the committees that review the various Data Analysis Reports.

Questions for committee members include the following:
• Was the information timely?
• Was the information helpful in identifying statewide trends?
• Were the reports easy to understand and follow?
• Are the outcomes and indicators meaningful or should they be changed?

In conjunction with the DDDS' Office of Quality Improvement, Performance Analysis Committee, and entities noted in section a. i. above, proposed revisions to the DDDS Quality Management System are submitted to the Division''s Executive Committee for review. Such revisions occur as the formal data analysis processes reveal further needs within the system. Review tools, data sources, performance measures, sampling strategies, and remediation activities are subject to review and modification if the desired outcomes as expressed by the DDDS HCBS waiver participants are not met.

Improvement strategies for trended data are developed for program areas such as Nursing and Behavioral Consultation, Residential Services, fiscal accountability, etc., with input received from various stakeholders and review/advisory committees.

The DDDS operational units are informed of the need to provide improvement strategies through the various

applicable review committees' recommendations. The operational units are required to respond to the Division Director/Designee with their suggested improvement strategies. Once the improvement strategy is authorized, the plan is forwarded to the review committee for notification of actions to be implemented.

The Performance Analysis Committee is informed of the new strategy and adjusts the discovery process (as indicated) in order to accurately design and implements performance assessment. The PAC and Office of Quality Improvement (OQI) 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 processes are disseminated as follows:
• Reporting individual findings on an ongoing and continuous basis to applicable ID Teams, waiver providers, and DDDS Administrators, requiring specific individual plans of improvement as applicable.
• Saving individual discovery process data on the OQI data bases to create a sample.
• Providing Quarterly, Semi-annual or Annual Data Summaries to the PAC for analysis. (PAC in turn completes the data analysis and dissemination of System and/or Provider Level report process.)
• Reporting discovery data and remediation efforts on a quarterly basis to the Delaware Medicaid Agency (DMMA)

The OQI Director shall:
• Assure that all monitoring processes remain current and that data bases are being properly developed or repopulated for each reporting period.
• Assure that any concerns with the discovery process are effectively and efficiently resolved.
• Notify the Division Director of any newly identified trouble areas between formal report generating intervals.

In essence, the process is cyclical, whether evaluating an existing Performance Measure or one that is designed to specifically provide System Improvement. The cyclical process can be simplified to: Discovery/Assessment, Communication of Data in light of performance expectations, Plan Development/Modification, Communication of Plan, Plan Implementation, and repeat.

Finally, the entities responsible for monitoring and oversight are all defined in Appendix H, Section A., are: The Performance Analysis Committee, The Risk Management Committee, The Essential Lifestyle Planning (ELP) Oversight Committee, Authorized Provider Committee, the DDDS Quality Council, and the Division of Medicaid and Medical Assistance (DMMA). The DDDS Quality Management System identifies what Performance Measures each entity is responsible to review and the OQI and PAC provides the corresponding Data Analysis Reports as required.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

EVALUATION OF THE QUALITY MANAGEMENT SYSTEM
The ability of the DDDS to collect, analyze and use information to provide internal and external stakeholders with accurate, timely and important information to improve the quality of services and supports is assessed on an ongoing basis through a formative evaluation. The Performance Analysis Committee (PAC) has primary responsibility for determining if the various discovery processes and data sources accurately measure the outcomes and indicators. Problems with data collection activities are corrected as needed. As well, the PAC solicits ongoing feedback from the committees that review the various Data Analysis Reports.

Questions for committee members include the following:
• Was the information timely?
• Was the information helpful in identifying statewide trends?
• Were the reports easy to understand and follow?
• Are the outcomes and indicators meaningful or should they be changed?

In conjunction with the DDDS 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 Executive Committee 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 would all be subject to review and modification should the desired outcomes as expressed by the DDDS HCBS waiver members not be met.

Improvement strategies for trended data are generally developed by DDDS operational units such as Nursing, Behavioral, Residential Services, Fiscal, etc., with input received from various stakeholders and

review/advisory committees. The DDDS operational units are informed of the need to provide improvement strategies through the various applicable review committees' recommendations.

The DDDS operational units are required to respond to the Division Director/Designee, OQI, and PAC with their suggested improvement strategies. Once the improvement strategy is authorized, the plan is forwarded to the applicable review committees for notification and review planned improvement strategies.

The various performance review entities including the DDDS Director, the Director's Executive Team, identified review committees, and DMMA, share the responsibility for analyzing the effectiveness of the Quality Improvement System to support specified goals and outcomes. Such responsibility takes place formally with each committee's meeting to review performance related data on the aggregation frequency specified for each measure.

The standing review committees and work groups responsible for ongoing performance monitoring, oversight and plan development (as applicable to the committee role) are all defined in Appendix H, Section A. In brief, those groups include: The Risk Management Committee, The Essential Lifestyle Planning (ELP) Oversight Committee, The Authorized Provider Committee, The DDDS Governor's Advisory Committee, and the Division of Medicaid and Medical Assistance (DMMA). The DDDS Performance Analysis Committee identifies under the direction of the Division Director what Performance Measures each entity is responsible for. The PAC then provides the corresponding Data Analysis Reports as required.

During each entity review, discussion is to include questions as to validity or reliability of data, effectiveness of performance measures to assess the intent of the system, training needs of providers or discovery process reviewers, and plans to provide systems improvements. It is not enough to collect data and report upon such. The DDDS QMS is designed to drive outcome based results, with accountability defined within the system.

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.

In essence, the DDDS QMS process is continuous and ongoing with formal review processes on a specified schedule - whether evaluating an existing Performance Measure, or providing discovery data on a newly identified subject area. The process can be simplified to flow 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.
• Plan Implementation.
• Repeat processes focusing on performance based data analysis.

The DDDS Quality Management System has been established to support positive outcomes attainment for program members. For each identified Performance Measure; Data Sources, Frequency of Data Collection, Sampling Strategies, and Frequency of Data Aggregation and Analysis, is defined. A sampling of system wide performance related data is provided to the DMMA on a quarterly basis, with fully aggregated data provided to DMMA annually. Specific Performance Measure aggregated data is also analyzed by assigned DDDS entities on frequencies identified with each measure. Upon the request of the Division Director or upon preliminary findings identification, additional performance reviews may be initiated. Each and every time that a formal review of performance based data is conducted, the DDDS Quality Improvement Strategies and Systems are objectively evaluated.

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 provider of HCBS Waiver services to submit an annual independent audit. The results of this independent audit are submitted to the Division within 30 days of conclusion of the independent audit. 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 OMB Circular A-133 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.

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.

The DMMA Claims Processing Assessment System (CPAS) Coordinator in the Information Systems Unit of DMMA receives a monthly sample of claims generated from the MMIS for the purpose of quality control review. The monthly sample is reviewed to provide an overall assessment of the claims processing operation including: verification of claims payment accuracy, measurement of cost from errors, and establishment of a corrective action plan if needed. The CPAS Coordinator reviews claims against the participant eligibility data, provider eligibility data and rate structure. All claims for DDDS HCBS Waiver services claims are subject to being included in the CPAS monthly sample.

The MMIS contains a Surveillance and Utilization Review (SUR) sub-system which organizes data and creates reports used by staff of the Surveillance and Utilization Review (SUR) Unit within DMMA. Reports are designed to detect patterns in paid provider claims which may indicate fraud and/or abuse. 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) 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.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. **Methods for Discovery: Financial Accountability**
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.
   i. **Performance Measures**

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

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

Performance Measure:
I-a-1: The percentage of claims paid only for those services specified in the Plan of Care. (The number of claims paid for services specified in the Plan of Care/number of claims paid.)

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDDS Data Sources- ELP (to define services authorized in the Plan of Care), MMIS to compare claims paid to claims authorized (authorization is specific to both service, maximum units and rate).

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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**

	☐ **Other** Specify:

Performance Measure:
I-a-4: Percentage of waiver services which are prior-authorized. (Number of paid prior authorized DDDS waiver claims/total number of all claims)

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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**

	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
I-a-3: The percentage of DDDS provider agencies with completed annual audited financial statements (Number of provider agencies with completed annual audited financial statements /total number of provider agencies.)

Data Source (Select one):
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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**

☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
I-a-2: The percentage of provider attendance reports for day and residential services that match what was claimed. (Number of provider attendance reports that match what was claimed/total number of provider attendance reports.)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Attendance records 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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation	**Frequency of data aggregation and**

and analysis *(check each that applies):*	**analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
I-a-5 Number and percent of rates for waiver services adhering to reimbursement methodology in the approved waiver (number of waiver rates that follow the approved methodology/number of waiver rates).

Data Source (Select one):
Other
If 'Other' is selected, specify:
The DMMA Reimbursment 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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **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*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. **Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Direct Support Professional Rates
DDDS uses a market basket methodology to establish a direct support professional rate for most of the services covered under the waiver that are provided by direct support professionals. This includes residential habilitation, day habilitation, pre-vocational service and supported living. The newly added service of Supported Living will be paid at the same rate for Residential Habilitation, as the provider qualifications are the same and the work performed by the direct support professionals is very similar. Supported Employment - Individual and Group are computed using a cost report methodology described below. This DSP rate methodology was initially established in 2004 to replace a process of negotiated rates. At that time the methodology was reviewed by provider agencies, advocates and other key stake holders. The methodology is comprised of four key components:

- direct support professional wage ($)
- employee related expenses (%)
- program indirect expenses (%)
- administrative expenses (%)

Wage data was obtained from authoritative sources such as the U.S. DOL Bureau of Labor Statistics for job classifications with similar requirements and duties as the different types of direct support professionals in order to derive an appropriate DSP hourly wage rate. In developing the other three rate components, the types of allowable costs to be included in the "market basket" were first defined and then cost data was collected from DDDS providers through cost reports and follow up interviews. These costs are converted to percentages that are multiplied by the direct support hourly wage rate in order to develop an hourly provider DSP rate for each service. A gross up factor is also applied to the ERE, PI and G & A components. The DSP rates are periodically re-based using cost data from the most current period available. In between re-basing cycles, the legislature may appropriate additional funds to allow an increase in the DSP rates as funds are available.

The hourly provider rates are designed to be applied to the number of daily direct support hours needed for each waiver member, as assessed by the Inventory for Client and Agency Planning (ICAP) assessment tool. Service utilization best practice standards and data from a sample of Delaware consumers were correlated with the Inventory for Client and Agency Planning (ICAP) individual assessment instrument. For clients that typically receive the exact same number of direct support hours per day, the hourly rate is multiplied by the DSP hours, as assessed per the ICAP, to create a per diem rate. For clients whose daily utilization may vary, the actual number of units must be billed by the provider at the established rate. For services that cannot be billed as a per diem, a 15-minute billable unit has been established. The rate for the 15 minute units is computed by dividing the hourly rates by four. Units of time between 1- 7 minutes shall not be billed. Units of time 8-15 minutes shall be billed as one 15 minute unit.

For individuals receiving day habilitation or pre-vocational service, the number of DSP hours authorized per day are determined through the use of a matrix which translates the Broad Independence and General Maladaptive scores from the ICAP assessment into the number of hour of DSP needed per day. For participants who elect to receive more than one day service in a single day, the provider(s) must bill using 15 minute units and may not bill a per diem rate. A different methodology, described below, is used for the state-operated Day Habilitation program.

For residential habilitation, transportation is applied as an add-on to the DSP per diem rate. Residential habilitation rates do not include any costs associated with room and board.

Day habilitation and prevocational service providers may receive an add-on payment to the direct support rate if they: 1) provide or pay for transportation to and from the program or 2) meet the requirements for the facility-based add on.

Rates for "Supported Employment - Individual" have been calculated using actual cost data as reported by providers of Supported Employment Services. Total Medicaid allowable costs for each provider were tabulated and divided by total direct care staff (job coaches, employment specialists) hours worked. This provided a cost per hour for each provider based on direct care staff hours. The average cost per hour across all agencies was used to compute an hourly rate, which is expressed as a 15 minute billable unit by dividing the hourly rate by four. Units of time 1- 8 minutes shall not be billed. Units of time 8-15 minutes shall be billed as one 15 minute unit.

Supported Employment - Small Group
The rate for Supported Employment - Small Group uses the rate for Supported Employment - Individual described above as the initial data input and performs additional computations to translate a rate that is computed based on a one-to-one staff-to-consumer ratio into a rate which takes into consideration the number of members in the group. The payment rate for the addition of each consumer in the group shall be computed by dividing the payment rate computed for Supported Employment – Small Group at a 1:1 ratio by the number of participants in the group (up to a maximum of 8) and applying a gross up factor to account for additional incremental costs related to the provision of group supported employment that would not have been captured in the base rate for Supported Employment - Individual. Supported Employment - Small Group will be paid in 15 minute billable units.

State-Operated Day Habilitation
The rate for Day Habilitation program operated by DDDS is calculated based on the total actual annual costs, including personnel, benefits, program related expenses like rent, utilities and supplies, and administration (using an indirect cost rate approved by the Division of Cost Allocation (DCA), U.S. DHHS). The total actual costs are divided by units of service to calculate a daily rate for this service.

Clinical Consultation: Nursing and Behavioral
A market basket methodology is also used to compute a unit cost rate for the Clinical Consultation services with the following differences:
- For the Behavioral Consultation Service - the midpoint of the salary range for the State of Delaware merit classification of Senior Behavior Analyst is used as the basis of the computation of an hourly clinician wage and the Employment Related Expenses is computed using the Delaware State Employee fringe benefit package.
- The authorized number of hours of Clinical Consultation is determined by a behavioral and/or nursing assessment performed for each waiver recipient by the state using a standardized instrument and not by the ICAP.

The State of Delaware periodically reviews the rate setting models to determine whether it still accurately reflects the items in the market basket and the costs of those items in relation to the direct support professional wage in the applicable service market and is sufficient to ensure adequate access to services for waiver members. Rates for DDDS waiver services may be increased from time to time as funds are appropriated by the Delaware General Assembly.

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/files/cps_rate_2013.pdf

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. Providers may elect to receive payments via paper check or EFT.

DDDS staff submit Medicaid claims for the state-operated services: day habilitation, residential 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 members 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.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one)*:

- (●) **No. State or local government agencies do not certify expenditures for waiver services.**
- ( ) **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

***Select at least one*:**

☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

(a) 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. In addition, DMMA has assigned a unique taxonomy for waiver providers to enable waiver claims

to be easily identified and included in production reports that report by Category of Service. Edits have been established in the MMIS to only pay claims with a DDDS waiver taxonomy for clients that also have been assigned one of the four DDDS waiver aid categories. The edits 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. If either the service start or stop dates are outside the waiver eligibility start and stop dates, the claim will deny.

(b)The waiver member's Essential Lifestyle Plan includes a list of the waiver services the client has chosen to receive. Among the DDDS program units that assist in the administration of waiver services are the Office of Community Services (oversees residential services, clinical consultation, and day and employment services) and the Office of Professional Services (oversees the shared living program). The case manager and other employees in these DDDS units communicate the amount, duration and frequency of each waiver service included in the ELP to the DDDS Office of Budget, Contracts and Business Services where a Prior Authorization is entered into the MMIS for each waiver service for each waiver member. 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 MID, 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.

DDDS periodically reviews claims data against plans of care to monitor under-utilization of services. DMMA is responsible for retrospective auditing of paid claims and utilization review of services provided through by the processes described in section I-1 of this Appendix.

c) 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 a provider employee and verified by a provider supervisory employee that services were rendered. Providers must also maintain case notes describing how they service facilitates the ability of the client to meet their goals as described in the ELP. 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.

As part of the CPAS review process, the MMIS is programmed to select a monthly random sample of participants for whom claims were submitted. Claims under the DDDS HCBS waiver may be included in the sample participants. 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. Returned letters warranting further investigation are referred to the Surveillance and Utilization Review (SUR) Unit (See Appendix I-1).

Provider is Qualified to Provide Waiver Service(s) - Only providers who have been determined qualified to provide services under the DDDS waiver can be paid for a waiver service. DMMA uses the aforementioned unique waiver taxonomy to control which providers can bill using a DDDS waiver taxonomy. DMMA links each qualified provider to the waiver taxonomy by use of a rate table. The rate table brings together provider NPIs or Atypical Provider Numbers (for qualified providers) and waiver procedure codes with the DDDS waiver taxonomy. If a claim was submitted by a provider that had not previously been entered into this table, it would deny indicating that the provider was not authorized to provide a waiver service. DMMA maintains the rate table in the MMIS with input from DDDS as new providers become qualified.

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:

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 member 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 member'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.

- [ ] **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.**
- [x] **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- [ ] **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

- [ ] **Providers are paid by a managed care entity or entities for services that are included in the State's contract**

with the entity.

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. **Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- (●) **No. The State does not make supplemental or enhanced payments for waiver services.**
- ( ) **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. **Payments to State or Local Government Providers.** *Specify whether State or local government providers receive payment for the provision of waiver services.*

- ( ) **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- (●) **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish: *Complete item I-3-e.*

The Division of Developmental Disabilities Services operates a state-run habilitation program, a small number of neighborhood group homes and apartments and provides Clinical Consultation services: Behavioral and Nursing, in addition to the non-government network of 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.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. **Amount of Payment to State or Local Government Providers.**

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

- ○ **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- ◉ **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- ○ **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- ◉ **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- ○ **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- ○ **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- ◉ **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

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 member 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 member'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.**

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-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

Level(s) of Care: ICF/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	104447.78	5045.00	109492.78	394063.00	7558.00	401621.00	292128.22
2	106947.00	5396.00	112343.00	421451.00	8229.00	429680.00	317337.00
3	107418.73	5770.00	113188.73	450741.00	8926.00	459667.00	346478.27
4	109081.61	6170.00	115251.61	482068.00	9681.00	491749.00	376497.39
5	110867.40	6599.00	117466.40	515572.00	10500.00	526072.00	408605.60

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Number Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		ICF/IID
Year 1	1000	1000
Year 2	1050	1050
Year 3	1100	1100
Year 4	1150	1150
Year 5	1200	1200

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 members on the DDDS Waiver is derived from actual historical paid claims data for waiver members.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. **Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

i. **Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

The estimated number of users, units/user, and the cost/unit are based on historical Medicaid expenditures as reported on the annual 372 report. This data was then projected over the five year renewal period based on the historical growth trends of this waiver.

ii. **Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The Factor D data is based on historical expenditures for State Plan services for waiver recipients as reported on the annual 372 report. This data was then projected over the five year renewal period based on the historical growth trends of this waiver.

iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Historical and current Medicaid expenditures from the MMIS for residents in the state's ICF/IID institution are used to create estimates for the cost of institutional services if the waiver did not exist. These institutional expenditures are reported annually on the 372 report. This data was then projected over the five year renewal period based on the historical growth trends of these expenditures.

iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Historical and current Medicaid expenditures for State Plan services from the MMIS for residents in the state's ICF/IID institution are used to create estimates for this cost. This data was then projected over the five year renewal period based on the historical growth trends of this waiver.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services
Day Habilitation
Prevocational Services
Residential Habilitation
Supported Employment - Individual
Supported Employment - Small Group
Clinical Consultation: Behavioral
Clinical Consultation: Nursing
Supported Living

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						**10561651.60**
Day Habilitation - 15 minutes	15 minutes	30	3264.00	7.23	**707961.60**	
Day Habilitation - per diem	Day	350	220.00	127.97	**9853690.00**	
Prevocational Services Total:						**7706340.00**
Prevocational Services - 15 minutes	15 minutes	30	1600.00	7.23	**347040.00**	
Prevocational Services - per diem	Day	400	225.00	81.77	**7359300.00**	
Residential Habilitation Total:						**76424372.50**
Neighborhood Group Home/Comm Lvg Arrangement	Day	825	350.00	257.91	**74471512.50**	
Shared Living Arrangement	Day	145	350.00	38.48	**1952860.00**	
Supported Employment - Individual Total:						**4000500.00**
Supported Employment - Individual -15 minutes	15 minutes	150	2100.00	12.70	**4000500.00**	
Supported Employment - Small Group Total:						**1314900.00**
Supported Employment- Small Group - 15 minutes	15 minutes	90	3000.00	4.87	**1314900.00**	
Clinical Consultation: Behavioral Total:						**1547040.00**

Clinical Consultation: Behavioral	15 minutes	550	192.00	14.65	**1547040.00**	
Clinical Consultation: Nursing Total:						**2135874.00**
Clinical Consultation: Nursing	15 minutes	985	156.00	13.90	**2135874.00**	
Supported Living Total:						**757099.20**
Supported Living	Hour	30	1144.00	22.06	**757099.20**	
GRAND TOTAL:						**104447777.30**
Total Estimated Unduplicated Participants:						**1000**
Factor D (Divide total by number of participants):						**104447.78**
Average Length of Stay on the Waiver:						350

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						**11122042.00**
Day Habilitation - 15 minutes	15 minutes	40	3264.00	7.45	**972672.00**	
Day Habilitation - per diem	Day	350	220.00	131.81	**10149370.00**	
Prevocational Services Total:						**8246095.00**
Prevocational Services - 15 minutes	15 minutes	40	1600.00	7.45	**476800.00**	
Prevocational Services - per diem	Day	410	225.00	84.22	**7769295.00**	
Residential Habilitation Total:						**82111120.00**
Neighborhood Group Home/Comm Lvg Arrangement	Day	860	350.00	265.65	**79960650.00**	
Shared Living Arrangement	Day	155	350.00	39.64	**2150470.00**	
Supported Employment - Individual Total:						**4394880.00**
Supported Employment - Individual -15 minutes	15 minutes	160	2100.00	13.08	**4394880.00**	
Supported Employment - Small Group Total:						**1503000.00**
Supported Employment- Small Group - 15 minutes	15 minutes	100	3000.00	5.01	**1503000.00**	
Clinical Consultation: Behavioral Total:						**1621401.60**
Clinical Consultation: Behavioral	15 minutes	560	192.00	15.08	**1621401.60**	

Clinical Consultation: Nursing Total:						**2221198.20**
Clinical Consultation: Nursing	15 minutes	995	156.00	14.31	**2221198.20**	
Supported Living Total:						**1074637.20**
Supported Living	Hour	35	1352.00	22.71	**1074637.20**	
GRAND TOTAL:						**112294374.00**
Total Estimated Unduplicated Participants:						**1050**
Factor D (Divide total by number of participants):						**106947.00**
Average Length of Stay on the Waiver:						350

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						**11477504.00**
Day Habilitation - 15 minutes	15 minutes	50	3264.00	7.52	**1227264.00**	
Day Habilitation - per diem	Day	350	220.00	133.12	**10250240.00**	
Prevocational Services Total:						**8639770.00**
Prevocational Services - 15 minutes	15 minutes	50	1600.00	7.52	**601600.00**	
Prevocational Services - per diem	Day	420	225.00	85.06	**8038170.00**	
Residential Habilitation Total:						**86359840.00**
Neighborhood Group Home/Comm Lvg Arrangement	Day	895	350.00	268.31	**84048107.50**	
Shared Living Arrangement	Day	165	350.00	40.03	**2311732.50**	
Supported Employment - Individual Total:						**4715970.00**
Supported Employment - Individual -15 minutes	15 minutes	170	2100.00	13.21	**4715970.00**	
Supported Employment - Small Group Total:						**1669800.00**
Supported Employment- Small Group - 15 minutes	15 minutes	110	3000.00	5.06	**1669800.00**	
Clinical Consultation: Behavioral Total:						**1667865.60**
Clinical Consultation: Behavioral	15 minutes	570	192.00	15.24	**1667865.60**	
Clinical Consultation: Nursing Total:						**2267038.80**

Clinical Consultation: Nursing	15 minutes	1005	156.00	14.46	**2267038.80**	
Supported Living Total:						**1362816.00**
Supported Living	Hour	40	1456.00	23.40	**1362816.00**	
			GRAND TOTAL:			**118160604.40**
			Total Estimated Unduplicated Participants:			**1100**
			Factor D (Divide total by number of participants):			**107418.73**
			Average Length of Stay on the Waiver:			350

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						**13253634.00**
Day Habilitation - 15 minutes	15 minutes	60	3264.00	7.60	**1488384.00**	
Day Habilitation - per diem	Day	350	250.00	134.46	**11765250.00**	
Prevocational Services Total:						**9042360.00**
Prevocational Services - 15 minutes	15 minutes	60	1600.00	7.60	**729600.00**	
Prevocational Services - per diem	Day	430	225.00	85.92	**8312760.00**	
Residential Habilitation Total:						**90209350.00**
Neighborhood Group Home/Comm Lvg Arrangement	Day	925	350.00	270.99	**87733012.50**	
Shared Living Arrangement	Day	175	350.00	40.43	**2476337.50**	
Supported Employment - Individual Total:						**5042520.00**
Supported Employment - Individual -15 minutes	15 minutes	180	2100.00	13.34	**5042520.00**	
Supported Employment - Small Group Total:						**1843200.00**
Supported Employment- Small Group - 15 minutes	15 minutes	120	3000.00	5.12	**1843200.00**	
Clinical Consultation: Behavioral Total:						**1832025.60**
Clinical Consultation: Behavioral	15 minutes	620	192.00	15.39	**1832025.60**	
Clinical Consultation: Nursing Total:						**2402868.00**
Clinical Consultation: Nursing	15 minutes	1055	156.00	14.60	**2402868.00**	

Supported Living Total:						**1817894.00**
Supported Living	Hour	50	1508.00	24.11	**1817894.00**	
				GRAND TOTAL:		**125443851.60**
				Total Estimated Unduplicated Participants:		**1150**
				Factor D (Divide total by number of participants):		**109081.61**
				Average Length of Stay on the Waiver:		350

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						**13770470.00**
Day Habilitation - 15 minutes	15 minutes	70	3264.00	7.75	**1770720.00**	
Day Habilitation - per diem	Day	350	250.00	137.14	**11999750.00**	
Prevocational Services Total:						**9543370.00**
Prevocational Services - 15 minutes	15 minutes	70	1600.00	7.75	**868000.00**	
Prevocational Services - per diem	Day	440	225.00	87.63	**8675370.00**	
Residential Habilitation Total:						**95544050.00**
Neighborhood Group Home/Comm Lvg Arrangement	Day	960	350.00	276.41	**92873760.00**	
Shared Living Arrangement	Day	185	350.00	41.24	**2670290.00**	
Supported Employment - Individual Total:						**5430390.00**
Supported Employment - Individual -15 minutes	15 minutes	190	2100.00	13.61	**5430390.00**	
Supported Employment - Small Group Total:						**2035800.00**
Supported Employment- Small Group - 15 minutes	15 minutes	130	3000.00	5.22	**2035800.00**	
Clinical Consultation: Behavioral Total:						**2019648.00**
Clinical Consultation: Behavioral	15 minutes	670	192.00	15.70	**2019648.00**	
Clinical Consultation: Nursing Total:						**2566738.20**
Clinical Consultation: Nursing	15 minutes	1105	156.00	14.89	**2566738.20**	
Supported Living Total:						**2130414.00**

Supported Living	Hour	55	1560.00	24.83	**2130414.00**	
			GRAND TOTAL:			**133040880.20**
			Total Estimated Unduplicated Participants:			**1200**
			Factor D (Divide total by number of participants):			**110867.40**
			Average Length of Stay on the Waiver:			350