PROMISE Reporting

Delaware is under an 1115 demonstration and is held to the home and community-based services (HCBS) assurances, as well as to the standard terms and conditions (STCs) of the 1115 demonstration approved on December 19, 2014 for the PROMISE amendment.[1] In addition to the HCBS assurances required by the Centers for Medicare and Medicaid Services (CMS), Delaware has the following reporting requirements:

- Thirty days from the approval date of the PROMISE amendment (December 19, 2014), the Division of Medicaid and Medical Assistance (DMMA) will submit to the Division of Substance Abuse and Mental Health (DSAMH) a description of how managed care organization (MCO) and PROMISE services will be coordinated (i.e., the Collaboration Agreement between DSAMH and the MCOs regarding MCO and PROMISE service coordination).
- As a distinct component of the 1115 demonstration waiver's quality management strategy (QMS), the State will comply with all aspects of HCBS assurances and standards for the PROMISE program, including oversight by the Medicaid agency. An amendment to the State's QMS to include PROMISE will be submitted within 90 days of demonstration waiver approval.
- Sixty days following the end of each quarter, DSAMH must report on the evaluation activities and interim findings, including lessons learned from the PROMISE program, and the effect of the PROMISE program on beneficiary health outcomes and quality of life (i.e., the status of the assurance monitoring).
- No later than April 1 after the close of each demonstration year, the State must submit an annual report including the effectiveness of the comprehensive quality strategy (which, for PROMISE, is included in the PROMISE HCBS Evidence Report to date). Note there are two additional financial reporting pieces due in the annual report as well, including expenditures and enrollment, which will be derived via Medicaid Management Information Systems (MMIS) reports programmed by HP.
- There is one additional "subassurance" that is no longer a 1915(c) waiver assurance but will be required of the PROMISE program through the STCs:
    - All PROMISE enrollees must be evaluated at least annually or as otherwise specified by the State.

[1] Under traditional HCBS programs in 1915(c) waivers, each state is required to submit an evidence report to the Centers for Medicare and Medicaid Services documenting performance on the HCBS assurances and performance measures. Formal submission of an evidence report is not a requirement of an 1115 demonstration authorizing HCBS services.

This report format is set up similar to a 1915(c) evidence report to facilitate the quarterly and annual reporting required by the demonstration STC, incorporating all HCBS assurances and the additional subassurance under the demonstration.

Delaware Division of Substance Abuse and Mental Health
PROMISE Program
Home and Community-Based Services Program
Evidence Report
January 1, 2015 to December 31, 2018

Introduction

PROMISE is required by the federal government to follow a continuous quality improvement process in its operations. The process involves continuous monitoring of the implementation of each waiver assurance and subassurance, methods for remediation or addressing identified individual problems and areas of noncompliance, and processes for a) aggregating collected information on discovery and remediation activities, and b) prioritizing and addressing needed systems changes on a regular basis.

This report template lists each required HCBS assurance, subassurance, and the relevant performance measures that are used to evaluate the assurances and/or subassurances. The numerators and denominators are defined and recorded for each performance measure, as well as each measure's compliance percentage.

In late 2013, some CMS HCBS assurances and subassurances changed, and reporting remediation efforts were modified. Remediation areas and efforts are noted, if applicable, in the evidence report, and an analysis of the results, plus any quality improvement recommendations, are listed. While remediation must occur for problem areas, reporting to CMS is now only required for substantiated instances of abuse, neglect, or exploitation. A new requirement is that quality improvement projects (QIPs) are required when any performance indicator falls below a threshold of 86%. A QIP must be implemented once the cause is found, unless the State provides justification accepted by CMS that a QIP is not necessary. QIPs will be noted in the quality improvement section of each performance measure. It is expected that any time a performance indicator falls below the threshold of 86%, a QIP will be initiated and noted in this report.

Assurance 1: Needs-Based Criteria

The State demonstrates that it implements the processes and instruments specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of need, consistent with the needs-based criteria in the demonstration. The processes and instruments described in the approved PROMISE 1115 amendment are applied appropriately and according to the approved description to determine if the needs-based criteria were met.

1. Subassurance: An evaluation for needs-based criteria is provided to all applicants for whom there is reasonable indication that services may be needed in the future.

2. Subassurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine initial participant level of need.

3. CMS 1115 requirement: All PROMISE enrollees must be evaluated at least annually or as otherwise specified by the State.

Assurance 2: Person-Centered Planning
The State demonstrates it has designed and implemented an effective system for reviewing the adequacy of recovery plans for waiver participants. Recovery plans address assessed needs of PROMISE participants, are updated annually, and document choice of services and providers.

1. Subassurance: Service plans address all members' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.

2. Subassurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.

3. Subassurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration, and frequency specified in the service plan.

4. Subassurance: Participants are afforded choice among waiver services and providers.

Assurance 3: Provider Qualifications
The State demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers. Providers meet required qualifications.

1. Subassurance: 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.

2. Subassurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

3. Subassurance: The State implements its policies and procedures for verifying that training is provided in accordance with State requirements and the approved waiver.

Assurance 4: Settings Meet the HCBS Setting Requirements

Assurance 5: State Medicaid Agency Oversight

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 agencies and contracted entities.

Assurance 6: Fiscal Accountability

The State Medicaid Agency (SMA) maintains financial accountability through payment of claims for services that are authorized and furnished to PROMISE participants by qualified providers.

1. Subassurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.

2. Subassurance: The State provides evidence that rates remain consistent with the approved rate methodology throughout the five-year waiver cycle.

Assurance 7: Health and Welfare

The State identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.

1. Subassurance: The State demonstrates on an ongoing basis that it identifies, addresses, and seeks to prevent instances of abuse, neglect, exploitation, and unexplained death.

2. Subassurance: The State demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.

3. Subassurance: The State policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.

4. Subassurance: The State establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.

HCBS Assurance Quality Improvement Process

DSAMH is responsible for reporting performance measures to the federal government for compliance with the PROMISE program.

The PROMISE program operates under the umbrella of the 1115 demonstration waiver, and both state plan and waiver services are delivered through a MCO and the DSAMH fee-for-service program. The PROMISE program has distinct requirements for quality management that are based on federal laws and regulations and are meant to ensure that the goals and intent of the waiver are met. During the initial waiver period, quality management programs and activities for each waiver will be developed and implemented separately. The quarterly quality assurance (QA) reports on performance measures will be implemented in compliance with HCBS guidance and regulations and 1115 STC waiver requirements. Quality management activities for HCBS during the initial waiver period will include oversight of the implementation of processes and procedures to address HCBS waiver assurances, care managers, oversight of plan implementation and service delivery, and record reviews to identify any issues related to meeting assurances. As the services and populations covered by PROMISE and the state plan are interrelated, and the infrastructure and processes for PROMISE oversight are put in place, the goal will be to better integrate quality management activities for all MCO Medicaid services and the PROMISE program and to begin to focus on quality improvement (QI). At the same time, it will be necessary to ensure that the specific quality management requirements of the demonstration continue to be met.

Performance measure (PM) reporting, related mainly to state plan health services through the MCO, will be implemented. The PROMISE amendment contains PMs specific to the HCBS services which will be implemented and reported to the State through the QA Committee. DSAMH staff will also ensure that reporting on grievances and appeals identifies those made specifically by or on behalf of PROMISE enrollees.

Quarterly quality management meetings with the quarterly QA Committee will occur after implementation of the PROMISE program. The meetings will focus a great deal on implementation of the overall concurrent waiver program and activities specific to PROMISE, including reporting requirements, refining of reports, and implementation of Inter-rater reliability record reviews. This setting provides an excellent backdrop for operationalizing the HCBS PMs and moving to the next level of trending, analyzing, and setting benchmarks for all services delivered in PROMISE.

The QA Committee will meet quarterly and work with the QA Unit, Fiscal Unit, and Provider Relations to conduct annual onsite reviews of PROMISE operations in conjunction with the

required PROMISE federal assurances. quarterly QA Committee activities will focus on quality improvement as well as implementation, with focus in both clinical and non-clinical areas.

The State will implement corrective action plans based on specific monitoring activities (such as the annual onsite review). Discovery activities that the SMA will conduct, in exercising its administrative authority over PROMISE, are described below. All of these activities, including analysis of performance measure reporting, findings from the quarterly QA Committee, analysis of grievances and appeals reports, record reviews by DSAMH, and review of provider network for adequacy and choice will be the basis for an ongoing corrective action/quality improvement plan. The corrective action/quality improvement plan will be a working document that will identify areas for improvement, progress, and target dates for completion. The areas for improvement will be prioritized and monitored on a day-to-day basis by the QA Committee. Progress, issues, and concerns will be presented to the quarterly QA Committee, which will serve as an advisory committee for the plan.

Through tracking and trending of performance reporting and findings from other oversight activities, the quarterly QA Committee expects to be able to identify any provider-specific and process-specific issues and implement corrective actions that will lead to overall quality improvement. As examples, with trending and tracking of complaints, a specific provider might be identified that needs additional training or even termination from the network; recurring and excessive delays in implementing service plans might result in changes in internal assessment/authorization processes; and inconsistencies identified in level of care determinations could result in additional training to ensure that staff have the same understanding of level of care criteria.

Progress on the corrective action/quality improvement plan will be presented quarterly to the quarterly QA Committee for comments and guidance. All HCBS waiver-related monitoring will be summarized and presented to CMS annually through the 372 report process and as requested.

The following pages contain each performance measure, as well as a brief explanation of calculation specifications, remediation data, analysis of results, and QI suggestions.

CONTENTS

ASSURANCE #1: Needs-Based Criteria ... 1

- Sub-Assurance: An evaluation for needs-based criteria is provided to all applicants for whom there is reasonable indication that services may be needed in the future. ... 1
  - Table A.1.a. Level of Need Requirements Description ... 1
  - Table A.1.b. Level of Need Requirements Results ... 1
  - Table A.1.c. Level of Need Requirements Remediation ... 2
  - Table A.1.d. Level of Need Requirements Analysis ... 2
  - Table A.1.e. Level of Need Requirements QI Recommendations/QIPs ... 2
- Sub-Assurance - The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine initial participant level of need. ... 2
  - Table A.2.a. Completed LON Determination Forms Description ... 2
  - Table A.2.b. Completed LON Determination Forms Results ... 3
  - Table A.2.c. Completed LON Determination Forms Remediation ... 3
  - Table A.2.d. Completed LON Determination Forms Analysis ... 3
  - Table A.2.e. Completed LON Determination Forms QI Recommendations/QIPs ... 3
  - Table A.3.a. Accurate Initial Determination Forms Description ... 3
  - Table A.3.b. Accurate Initial Determination Forms Results ... 4
  - Table A.3.c. Accurate Initial Determination Forms Remediation ... 4
  - Table A.3.d. Accurate Initial Determination Forms Analysis ... 4
  - Table A.3.e. Accurate Initial Determination Forms QI Recommendations/QIPs ... 4
- Sub-Assurance (CMS 1115) - All PROMISE enrollees must be evaluated at least annually or as otherwise specified by the State. ... 4
  - Table A.4.a. Beneficiaries Reevaluated Annually or as Needed Description ... 4
  - Table A.4.b. Beneficiaries Reevaluated Annually or as Needed Results ... 5
  - Table A.4.c. Beneficiaries Reevaluated Annually or as Needed Remediation ... 5
  - Table A.4.d. Beneficiaries Reevaluated Annually or as Needed Analysis ... 5

Table A.4.e. Beneficiaries Reevaluated Annually or as Needed QI Recommendations/QIPs 5

ASSURANCE #2: Person-Centered Planning 6

- Sub-Assurance - Service plans address all members' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means. 6
  - Table B.1.a. Service Plans Addressed Needs Description 6
  - Table B.1.b. Service Plans Addressed Needs Results 6
  - Table B.1.c. Service Plans Addressed Needs Remediation 7
  - Table B.1.d. Service Plans Addressed Needs Analysis 7
  - Table B.1.e. Service Plans Addressed Needs QI Recommendations/QIPs 7
- Sub-Assurance - Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs. 7
  - Table B.2.a. PROMISE Beneficiaries with Updated Recovery Plans Description 7
  - Table B.2.b. Beneficiaries with Updated Recovery Plans Results 8
  - Table B.2.c. Beneficiaries with Updated Recovery Plans Remediation 8
  - Table B.2.d. Beneficiaries with Updated Recovery Plans Analysis 8
  - Table B.2.e. Beneficiaries with Updated Recovery Plans QI Recommendations/QIPs 8
- Sub-Assurance - Services are delivered in accordance with the service plan, including the type, scope, amount, duration, and frequency specified in the service plan. 8
  - Table B.3.a. Beneficiaries with Services Delivered in Accordance with Service Plan PM Description 8
  - Table B.3.b. Beneficiaries with Services Delivered in Accordance with Service Plan Results 9
  - Table B.3.c. Beneficiaries with Services Delivered in Accordance with Service Plan Remediation 9
  - Table B.3.d. Beneficiaries with Services Delivered in Accordance with Service Plan Analysis 9
  - Table B.3.e. Beneficiaries with Services Delivered in Accordance with Service Plan QI Recommendations/QIPs 9

- Sub-Assurance - Participants are afforded choice between/among waiver services and providers. 10
    - Table B.4.a. Plans of Care Document Choice PM Description 10
    - Table B.4.b. Plans of Care Document Choice Results 10
    - Table B.4.c. Plans of Care Document Choice Remediation 10
    - Table B.4.d. Plans of Care Document Choice Analysis 10
    - Table B.4.e. Plans of Care Document Choice QI Recommendations/QIPs 11

ASSURANCE #3: Provider Qualifications 12

- 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. 12
- Sub-Assurance - The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. 13
    - Table C.1.a. Providers Meet Requirements Before Furnishing Services PM Description 13
    - Table C.1.b. Providers Meet Requirements Before Furnishing Services Results 13
    - Table C.1.c. Providers Meet Requirements Before Furnishing Services Remediation 13
    - Table C.1.d. Providers Meet Requirements Before Furnishing Services Analysis 13
    - Table C.1.e. Providers Meet Requirements Before Furnishing Services QI Recommendations/QIPs 14
    - Table C.2.a. Providers Meet Requirements While Furnishing Services PM Description 14
    - Table C.2.b. Providers Meet Requirements While Furnishing Services Results 14
    - Table C.2.c. Providers Meet Requirements While Furnishing Services Remediation 14
    - Table C.2.d. Providers Meet Requirements While Furnishing Services Analysis 14
    - Table C.2.e. Providers Meet Requirements While Furnishing Services QI Recommendations/QIPs 15
    - Table C.3.a. Providers with an Active PROMISE Agreement PM Description 15
    - Table C.3.b. Providers with an Active PROMISE Agreement Results 15

Table C.3.c. Providers with an Active PROMISE Agreement Remediation 15
Table C.3.d. Providers with an Active PROMISE Agreement Analysis 15
Table C.3.e. Providers with an Active PROMISE Agreement QI Recommendations/QIPs 16
Table C.4.a. Providers Serving PROMISE Beneficiaries PM Description 16
Table C.4.b. Providers Serving PROMISE Beneficiaries Results 16
Table C.4.c. Providers Serving PROMISE Beneficiaries Remediation 16
Table C.4.d. Providers with an Active PROMISE Agreement Analysis 16
Table C.4.e. Providers Serving PROMISE Beneficiaries QI Recommendations/QIPs 17

- Sub-Assurance: The State implements its policies and procedures for verifying that training is provided in accordance with State requirements 17

Table C.5.a. Providers Meeting Training Requirements PM Description 17
Table C.5.b. Providers Meeting Training Requirements Results 17
Table C.5.c. Providers Meeting Training Requirements Remediation 17
Table C.5.d. Providers Meeting Training Requirements Analysis 17
Table C.5.e. Providers Meeting Training Requirements QI Recommendations/QIPs 18

ASSURANCE #4: HCBS Settings 19
Table D.1.a. HCBS Settings Meeting Licensure Requirements PM Description 19
Table D.1.b. HCBS Settings Meeting Licensure Requirements Results 19
Table D.1.c. HCBS Settings Meeting Licensure Requirements Remediation 19
Table D.1.d. HCBS Settings Meeting Licensure Requirements Analysis 20
Table D.1.e. HCBS Settings Meeting Licensure Requirements QI Recommendations/QIPs 20

ASSURANCE #5: Operational Oversight 21
Table E.1.a. Performance Measure Reports Generated by DSAMH PM Description 21
Table E.1.b. Performance Measure Reports Generated by DSAMH Results 21

Table E.1.c. Performance Measure Reports Generated by DSAMH Remediation .. 22
Table E.1.d. Performance Measure Reports Generated by DSAMH Analysis......... 22
Table E.1.e. Performance Measure Reports Generated by DSAMH QI Recommendations/QIPs 22
Table E.2.a. STC Amendments, Renewals and Financial Reports Approved Prior to Implementation PM Description 22
Table E.2.b. STC Amendments, Renewals and Financial Reports Approved Prior to Implementation Results 23
Table E.2.c. STC Amendments, Renewals and Financial Reports Approved Prior to Implementation Remediation 23
Table E.2.d. STC Amendments, Renewals and Financial Reports Approved Prior to Implementation Analysis 23
Table E.2.e. STC Amendments, Renewals and Financial Reports Approved Prior to Implementation QI Recommendations/QIPs 23
Table E.3.a. STC Concepts and Policies Approved Prior to Development of an Implementation Plan PM Description 24
Table E.3.b. STC Concepts and Policies Approved Prior to Development of an Implementation Plan Results 24
Table E.3.c. STC Concepts and Policies Approved Prior to Development of an Implementation Plan Remediation 24
Table E.3.d. STC Concepts and Policies Approved Prior to Development of an Implementation Plan Analysis 24
Table E.3.e. STC Concepts and Policies Approved Prior to Development of an Implementation Plan QI Recommendations/QIPs 25

ASSURANCE #6: Fiscal Accountability........26

- Sub-Assurance - The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered. 26

Table F.1.a. Providers with Payment Recouped Without Documentation PM Description 26
Table F.1.b. Providers with Payment Recouped Without Documentation Results... 26

Table F.1.c. Providers with Payment Recouped Without Documentation Remediation 27

Table F.1.d. Providers with Payment Recouped Without Documentation Analysis.. 27

Table F.1.e. Providers with Payment Recouped Without Documentation QI Recommendations/QIPs 27

Table F.2.a. Claims Paid According to Recover Plan PM Description 27

Table F.2.b. Claims Paid According to Recover Plan Results 28

Table F.2.c. Claims Paid According to Recover Plan Remediation 28

Table F.2.d. Claims Paid According to Recover Plan Analysis 28

Table F.2.e. Claims Paid According to Recover Plan QI Recommendations/QIPs.. 28

- Sub-Assurance - The State provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle. 28

Table F.3.a. Rates Consistent Throughout the Waiver Cycle PM Description 28

Table F.3.b. Rates Consistent Throughout the Waiver Cycle Results 29

Table F.3.c. Rates Consistent Throughout the Waiver Cycle Remediation 29

Table F.3.d. Rates Consistent Throughout the Waiver Cycle Analysis 29

Table F.3.e. Rates Consistent Throughout the Waiver Cycle QI Recommendations/QIPs 29

ASSURANCE #7: Health and Welfare 30

- Sub-Assurance - The State demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death. 30

Table G.1.a. Reports Related to Abuse or Death with Investigation Initiated Timely PM Description 30

Table G.1.b. Reports Related to Abuse or Death with Investigation Initiated Timely Results 31

Table G.1.c. Reports Related to Abuse or Death with Investigation Initiated Timely Remediation 31

Table G.1.d. Reports Related to Abuse or Death with Investigation Initiated Timely Analysis 31

Table G.1.e. Reports Related to Abuse or Death with Investigation Initiated Timely QI Recommendations/QIPs 31
Table G.2.a. Beneficiaries who Received Information on Reporting Abuse PM Description 32
Table G.2.b. Beneficiaries who Received Information on Reporting Abuse Results 32
Table G.2.c. Beneficiaries who Received Information on Reporting Abuse Remediation 32
Table G.2.d. Beneficiaries who Received Information on Reporting Abuse Analysis32
Table G.2.e. Beneficiaries who Received Information on Reporting Abuse QI Recommendations/QIPs 32
Table G.3.a. Beneficiaries who Received Information on State Fair Hearings PM Description 33
Table G.3.b. Beneficiaries who Received Information on State Fair Hearings Results 33
Table G.3.c. Beneficiaries who Received Information on State Fair Hearings Remediation 33
Table G.3.d. Beneficiaries who Received Information on State Fair Hearings Analysis 33
Table G.3.e. Beneficiaries who Received Information on State Fair Hearings QI Recommendations/QIPs 33
Table G.4.a. Grievances Filed and Resolved Timely PM Description 34
Table G.4.b. Grievances Filed and Resolved Timely Results 34
Table G.4.c. Grievances Filed and Resolved Timely Remediation 34
Table G.4.d. Grievances Filed and Resolved Timely Analysis 34
Table G.4.e. Grievances Filed and Resolved Timely QI Recommendations/QIPs .. 34
Table G.5.a. Substantiated Allegations with Recommended Actions PM Description 35
Table G.5.b. Substantiated Allegations with Recommended Actions Results 35
Table G.5.c. Substantiated Allegations with Recommended Actions Remediation.. 35
Table G.5.d. Substantiated Allegations with Recommended Actions Analysis 35

Table G.5.e. Substantiated Allegations with Recommended Actions QI Recommendations/QIPs 36

- Sub-Assurance - The State demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible..... 36

Table G.6.a. Critical Incident Reports Reviewed Timely PM Description..... 36

Table G.6.b. Critical Incident Reports Reviewed Timely Results..... 36

Table G.6.c. Critical Incident Reports Reviewed Timely Remediation..... 37

Table G.6.d. Critical Incident Reports Reviewed Timely Analysis 37

Table G.6.e. Critical Incident Reports Reviewed Timely QI Recommendations/QIPs 37

- Sub-Assurance - The State policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed...... 37

Table G.7.a. Unauthorized Use of Restrictive Interventions PM Description 37

Table G.7.b. Unauthorized Use of Restrictive Interventions Results 38

Table G.7.c. Unauthorized Use of Restrictive Interventions Remediation 38

Table G.7.d. Unauthorized Use of Restrictive Interventions Analysis..... 38

Table G.7.e. Unauthorized Use of Restrictive Interventions QI Recommendations/QIPs..... 38

Table G.7.a. Beneficiaries Who Received Physical Exams PM Description..... 38

Table G.7.b. Beneficiaries Who Received Physical Exams Results..... 39

Table G.7.c. Beneficiaries Who Received Physical Exams Remediation 39

Table G.7.d. Beneficiaries Who Received Physical Exams Analysis..... 39

Table G.7.e. Beneficiaries Who Received Physical Exams QI Recommendations/QIPs..... 39

ASSURANCE #1: Needs-Based Criteria

The Eligibility and Enrollment Unit (EEU) gives the quarterly QA Committee reports on the screening of confirmed eligibility evaluations and the disenrollment request reasons. The QA Committee tracks and trends the rates over time and determines if there are ways to improve screening and eligibility evaluations, maintain provider continuity, and keep beneficiaries engaged in PROMISE. The team also reviews disenrollment requests to determine if there are quality of care concerns with particular providers or if there is an access to care issue that requires corrective action. All reports are shared with the QA Committee. The analysis is part of the state quality work plan and is reported to the QA Committee. The committee members discuss the findings to identify opportunities for improvement. If deficiencies are noted, the EEU and care managers must perform corrective action until compliance is met.

The State demonstrates that it implements the processes and instruments specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of need, consistent with the needs-based criteria in the demonstration. The processes and instruments described in the approved PROMISE 1115 amendment are applied appropriately and according to the approved description to determine if the needs-based criteria were met.

Subassurance: An evaluation for needs-based criteria is provided to all applicants for whom there is reasonable indication that services may be needed in the future.

Table A.1.a. Level of Need Requirements Description

Performance Measure	The Number and/or Percent of Beneficiaries That Were Determined to Meet Level of Need (LON) Requirements Prior to Receiving PROMISE Services
Numerator	The number of beneficiaries that were determined to meet LON requirements prior to receiving PROMISE services
Denominator	Total number of PROMISE beneficiaries
Data source	Record review, off site at the EEU
Sampling approach	100%

DATA:

Information obtained from January 1, 2015 through December 31, 2018 was collected through an annual record review of documentation off site at the EEU (including LON assessments) collected during reviews utilizing a survey tool. Data is specific to the PROMISE program.

Table A.1.b. LON Requirements Results

Numerator, Denominator, Percent	2015	2016	2017	2018
The number of beneficiaries determined to meet LON requirements prior to receiving PROMISE services				
Total number of PROMISE beneficiaries				
The percent of beneficiaries determined to meet LON requirements prior to receiving PROMISE services				

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Table A.1.c. LON Requirements Remediation

Year	Area Needing Remediation
2015	
2016	
2017	
2018	

Table A.1.d. LON Requirements Analysis

Year	Analysis of Results by Year
2015	
2016	
2017	
2018	

Table A.1.e. LON Requirements QI Recommendations/QIPs

Year	QI Recommendations/QIPs Initiated by Year
2015	
2016	
2017	
2018	

Subassurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine initial participant level of need.

Table A.2.a. Completed LON Determination Forms Description

Performance Measure	The Number and/or Percent of Beneficiaries' Initial LON Determination Forms/Instruments That Were Completed, as Required in the Approved 1115 Standard Terms and Conditions (STC)
Numerator	The number of beneficiaries' initial LON determination forms/instruments that were completed, as required in the approved 1115 STC
Denominator	Total number of PROMISE beneficiaries
Data source	Record review, off site at the EEU
Sampling approach	100%

DATA:

Information obtained from January 1, 2015 through December 31, 2018 was collected through an annual record review of documentation off site at the EEU (including LON assessments) collected during reviews utilizing a survey tool. Data is specific to the PROMISE program.

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Table A.2.b. Completed LON Determination Forms Results

Numerator, Denominator, Percent	2015	2016	2017	2018
The number of beneficiaries' initial LON determination forms/instruments that were completed, as required in the approved 1115 STC				
Total number of PROMISE beneficiaries				
The percent of beneficiaries' initial LON determination forms/instruments that were completed, as required in the approved 1115 STC				

Table A.2.c. Completed LON Determination Forms Remediation

Year	Area Needing Remediation
2015	
2016	
2017	
2018	

Table A.2.d. Completed LON Determination Forms Analysis

Year	Analysis of Results by Year
2015	
2016	
2017	
2018	

Table A.2.e. Completed LON Determination Forms QI Recommendations/QIPs

Year	QI Recommendations/QIPs Initiated by Year
2015	
2016	
2017	
2018	

Table A.3.a. Accurate Initial Determination Forms Description

Performance Measure	The Number and/or Percent of Beneficiaries' Initial Determinations Where LON Criteria Was Applied Correctly
Numerator	The total number of initial determinations where LON criteria was applied correctly
Denominator	Total number of initial determinations for the period
Data source	Record review, off site at EEU
Sampling approach	100%

DATA:

Information obtained from January 1, 2015 through December 31, 2018 was collected through a record review of documentation off site at the EEU (including LON assessments, initial determinations) collected during reviews utilizing a survey tool. Data is specific to the PROMISE program.

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Table A.3.b. Accurate Initial Determination Forms Results

Numerator, Denominator, Percent	2015	2016	2017	2018
The total number of initial determinations where level of need criteria was applied correctly				
Total number of initial determinations for the period				
The percent of initial determinations where level of need criteria was applied correctly				

Table A.3.c. Accurate Initial Determination Forms Remediation

Year	Area Needing Remediation
2015	
2016	
2017	
2018	

Table A.3.d. Accurate Initial Determination Forms Analysis

Year	Analysis of Results by Year
2015	
2016	
2017	
2018	

Table A.3.e. Accurate Initial Determination Forms QI Recommendations/QIPs

Year	QI Recommendations/QIPs Initiated by Year
2015	
2016	
2017	
2018	

Subassurance (CMS 1115): All PROMISE enrollees must be evaluated at least annually or as otherwise specified by the State.

Table A.4.a. Beneficiaries Reevaluated Annually or as Needed Description

Performance Measure	The Number and/or Percent of Beneficiaries Reevaluated at Least Annually or As Their Needs Change
Numerator	The number and/or percent of beneficiaries reevaluated at least annually or as their needs change
Denominator	Total number of PROMISE beneficiaries
Data source	Record review, offsite at the EEU
Sampling approach	100%

DATA:

Information obtained from January 1, 2015 through December 31, 2018 was collected through a record review of documentation offsite at the EEU (including Level of Need assessments, initial determinations) collected during reviews utilizing a survey tool. Data is specific to the PROMISE program.

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Table A.4.b. Beneficiaries Reevaluated Annually or as Needed Results

Numerator, Denominator, Percent	2015	2016	2017	2018
The number of beneficiaries reevaluated at least annually or as their needs change				
Total number of PROMISE beneficiaries				
The percent of beneficiaries reevaluated at least annually or as their needs change				

Table A.4.c. Beneficiaries Reevaluated Annually or as Needed Remediation

Year	Area Needing Remediation
2015	
2016	
2017	
2018	

Table A.4.d. Beneficiaries Reevaluated Annually or as Needed Analysis

Year	Analysis of Results by Year
2015	
2016	
2017	
2018	

Table A.4.e. Beneficiaries Reevaluated Annually or as Needed QI Recommendations/QIPs

Year	QI Recommendations/QIPs Initiated by Year
2015	
2016	
2017	
2018	

DRAFT

ASSURANCE #2: Person-Centered Planning

A person-centered focus is a fundamental component of the PROMISE program and required by CMS. Recovery planning should be developed in a person-centered manner with the active participation of the beneficiary, family, and providers and should be based on the beneficiary's condition, personal goals, and the standards of practice for the provision of the specific rehabilitative services. The information gathered by the EEU during the review of recovery plans is used as the evidence of CMS compliance related to the person-centered planning process.

The State demonstrates it has designed and implemented an effective system for reviewing the adequacy of recovery plans for waiver beneficiaries. Recovery plans address assessed needs of 1915(i) beneficiaries, are updated annually, and document choice of services and providers.

Subassurance: Service plans address all members' assessed needs (including health and safety risk factors) and personal goals either by the provision of waiver services or through other means.

Table B.1.a. Service Plans Addressed Needs Description

Performance Measure	Number and/or Percent of Beneficiaries With Service Plans That Address All Members' Assessed Needs (Including Health and Safety Risk Factors) and Personal Goals, Either by the Provision of Waiver Services or Through Other Means
Numerator	Number of beneficiaries with service plans that address all members' assessed needs (including health and safety risk factors) and personal goals either by the provision of waiver services or through other means
Denominator	Total number of PROMISE beneficiaries
Data source	Record review, off site in EEU
Sampling approach	100%

DATA:

Information obtained from January 1, 2015 through December 31, 2018 was collected through a record review of documentation offsite at the EEU (including service plans) collected during reviews utilizing the Comprehensive Survey Tool. Data is specific to the PROMISE program.

Table B.1.b. Service Plans Addressed Needs Results

Numerator, Denominator, Percent	2015	2016	2017	2018
Number of beneficiaries with service plans that address all members' assessed needs (including health and safety risk factors) and personal goals either by the provision of waiver services or through other means				
Total number of PROMISE beneficiaries				
The percent of beneficiaries with service plans that address all members' assessed needs (including health and safety risk factors) and personal goals either by the provision of waiver services or through other means				

DRAFT

Table B.1.c. Service Plans Addressed Needs Remediation

Year	Area Needing Remediation
2015	
2016	
2017	
2018	

Table B.1.d. Service Plans Addressed Needs Analysis

Year	Analysis of Results by Year
2015	
2016	
2017	
2018	

Table B.1.e. Service Plans Addressed Needs QI Recommendations/QIPs

Year	QI Recommendations/QIPs Initiated by Year
2015	
2016	
2017	
2018	

Subassurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.

Table B.2.a. PROMISE Beneficiaries with Updated Recovery Plans Description

Performance Measure	Number and/or Percent of PROMISE Beneficiaries With Current Recovery Plans Updated Less Than 12 Months Before QI Review
Numerator	The total number of PROMISE beneficiaries with current recovery plans updated less than 12 months before QI review
Denominator	Total number of PROMISE beneficiaries
Data source	Record review, off site in EEU
Sampling approach	100%

DATA:

Information obtained from January 1, 2015 through December 31, 2018 was collected through a record review of documentation off site at the EEU (including recovery plans), collected during reviews utilizing the Comprehensive Survey Tool. Data is specific to the PROMISE program.

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Table B.2.b. Beneficiaries with Updated Recovery Plans Results

Numerator, Denominator, Percent	2015	2016	2017	2018
The total number of PROMISE beneficiaries with current recovery plans updated less than 12 months before QI review				
Total number of PROMISE beneficiaries				
The percent of PROMISE beneficiaries with current recovery plans updated less than 12 months before QI review				

Table B.2.c. Beneficiaries With Updated Recovery Plans Remediation

Year	Area Needing Remediation
2015	
2016	
2017	
2018	

Table B.2.d. Beneficiaries With Updated Recovery Plans Analysis

Year	Analysis of Results by Year
2015	
2016	
2017	
2018	

Table B.2.e. Beneficiaries With Updated Recovery Plans QI Recommendations/QIPs

Year	QI Recommendations/QIPs Initiated by Year
2015	
2016	
2017	
2018	

Subassurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration, and frequency specified in the service plan.

Table B.3.a. Beneficiaries with Services Delivered in Accordance with Service Plan PM Description

Performance Measure	Number and/or Percent of Beneficiaries With Services Delivered in Accordance With the Recovery Plan, Including the Type, Scope, Amount, Duration, and Frequency Specified in the Recovery Plan and Doesn’t Exceed the Permissible Limits in the Program
Numerator	Number of beneficiaries with services delivered in accordance with the recovery plan, including the type, scope, amount, duration, and frequency specified in the recovery plan and doesn’t exceed the permissible limits in the program
Denominator	Total number of PROMISE beneficiaries
Data source	Care manager contacts, fiscal review, and quality assurance/performance indicator (QA/PI) annual onsites

DRAFT

Performance Measure	Number and/or Percent of Beneficiaries With Services Delivered in Accordance With the Recovery Plan, Including the Type, Scope, Amount, Duration, and Frequency Specified in the Recovery Plan and Doesn't Exceed the Permissible Limits in the Program
Sampling approach	100% for care manager contacts and fiscal review; 20% sample for QA/PI annual onsites

DATA:

Information obtained from January 1, 2015 through December 31, 2018 was collected through a review of documentation (including recovery plans, record reviews, and claims reviews utilizing the Comprehensive Survey Tool collected quarterly during care manager monitoring and fiscal reviews and annually through QA/PI onsite reviews. Data is specific to the PROMISE program.

Table B.3.b. Beneficiaries with Services Delivered in Accordance with Service Plan Results

Numerator, Denominator, Percent	2015	2016	2017	2018
Number of beneficiaries with services delivered in accordance with the recovery plan, including the type, scope, amount, duration, and frequency specified in the recovery plan and doesn't exceed the permissible limits in the program				
Total number of PROMISE beneficiaries				
The percent of beneficiaries with services delivered in accordance with the recovery plan, including the type, scope, amount, duration, and frequency specified in the recovery plan and doesn't exceed the permissible limits in the program				

Table B.3.c. Beneficiaries with Services Delivered in Accordance With Service Plan Remediation

Year	Area Needing Remediation
2015	
2016	
2017	
2018	

Table B.3.d. Beneficiaries with Services Delivered in Accordance With Service Plan Analysis

Year	Analysis of Results by Year
2015	
2016	
2017	
2018	

Table B.3.e. Beneficiaries with Services Delivered in Accordance With Service Plan QI Recommendations/QIPs

Year	QI Recommendations/QIPs Initiated by Year
2015	
2016	
2017	
2018	

DRAFT

Subassurance: Participants are afforded choice among waiver services and providers.

Table B.4.a. Plans of Care Document Choice PM Description

Performance Measure	Number and/or Percent of Beneficiaries With Plans of Care That Document Choice of Services, Providers, and Beneficiary Goals Consistent With Their Beneficiary Assessments
Numerator	Number of beneficiaries with plans of care that document choice of services, providers, and beneficiary goals consistent with their beneficiary assessments
Denominator	Total number of PROMISE beneficiaries
Data source	Record review, off site at EEU
Sampling approach	100%

DATA:

Information obtained from January 1, 2015 through December 31, 2018 was collected through a record review of documentation off site at the EEU (including plans of care), collected during reviews utilizing the Comprehensive Survey Tool. Data is specific to the PROMISE program.

Table B.4.b. Plans of Care Document Choice Results

Numerator, Denominator, Percent	2015	2016	2017	2018
Number of beneficiaries with plans of care that document choice of services, providers, and beneficiary goals consistent with their beneficiary assessments				
Total number of PROMISE beneficiaries				
Percent of beneficiaries with plans of care that document choice of services, providers, and beneficiary goals consistent with their beneficiary assessments				

Table B.4.c. Plans of Care Document Choice Remediation

Year	Area Needing Remediation
2015	
2016	
2017	
2018	

Table B.4.d. Plans of Care Document Choice Analysis

Year	Analysis of Results by Year
2015	
2016	
2017	
2018	

DRAFT

Table B.4.e. Plans of Care Document Choice QI Recommendations/QIPs

Year	QI Recommendations/QIPs Initiated by Year
2015	
2016	
2017	
2018	

DRAFT

ASSURANCE #3: Provider Qualifications

Federal regulations require that states maintain a network of qualified providers that initially and continually meet required standards for furnishing services under an HCBS authority, such as PROMISE, including licensure and certification standards. In Delaware, PROMISE service providers must submit evidence of the licensure or certification required for their provider type, as well as additional documentation supporting their qualifications to provide PROMISE services, both during the initial enrollment process and on a regular basis thereafter. A complete list of the PROMISE provider qualifications by service can be found in the PROMISE Manual, as well as the timeframes for re-verification of provider qualifications. These qualifications are important safeguards for beneficiaries enrolled in PROMISE to ensure that providers possess the requisite skills and competencies to meet the needs of the PROMISE population.

To receive federal Medicaid funds through the PROMISE program, Delaware must document that provider qualifications are verified and re-verified regularly through a series of assurances made to the federal government and monitored through PMs collected and reported to DMMA and the federal government. See the chart below for the performance measures regarding the verification of provider qualifications and training. Data for each performance measure will come from a review of 100% of provider files, and the expectation is that performance on each measure will be 100%. The PMs constitute the "Discovery Activity" for DSAMH to discover whether or not the division is complying with the federal assurance. Any problems uncovered must be addressed or "remediated" and those remediation activities must be documented and tracked to ensure that the problem is corrected. Under the PROMISE program, simply having a requirement for provider qualifications is not enough — DSAMH must assure CMS through documentation that the providers are qualified, and any problems with provider qualifications are addressed.

The Provider Relations Unit shall report quarterly the number and types of T-XIX practitioners (by service type, not facility or license type) relative to the number and types of Medicaid providers at the start date of the PROMISE program. The analysis includes the length of time that the Provider Relations Unit takes to credential providers, on average, and the number of providers denied credentials. The analysis is part of the state quality work plan and is reported to the state QA Committee. The committee members discuss the findings to identify opportunities for improvement. If deficiencies are noted, the Provider Relations Unit must perform corrective action until compliance is met.

The State demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers. Providers meet required qualifications. Subassurance: 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.

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Subassurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

Table C.1.a. Providers Meet Requirements Before Furnishing Services PM Description

Performance Measure	Number and/or Percent of PROMISE Providers Initially Meeting Licensure and Certification Requirements, as Well as Any Other PROMISE Training, General Provider Qualification, and/or Education Requirements Prior to Furnishing PROMISE Services
Numerator	Number of PROMISE providers initially meeting licensure and certification requirements, as well as any other PROMISE training, general provider qualification, and/or education requirements prior to furnishing PROMISE services
Denominator	Total number of PROMISE providers
Data source	Provider records within the Provider Relations and Fiscal Contracting Units
Sampling approach	100%

DATA:

Information obtained from January 1, 2015 through December 31, 2018 was collected through a review of documentation of provider files. Data is specific to the PROMISE program.

Table C.1.b. Providers Meet Requirements Before Furnishing Services Results

Numerator, Denominator, Percent	2015	2016	2017	2018
Number of PROMISE providers initially meeting licensure and certification requirements, as well as any other PROMISE training, general provider qualification, and/or education requirements prior to furnishing PROMISE services				
Total number of PROMISE providers				
Percent of PROMISE providers initially meeting licensure and certification requirements, as well as any other PROMISE training, general provider qualification, and/or education requirements prior to furnishing PROMISE services				

Table C.1.c. Providers Meet Requirements Before Furnishing Services Remediation

Year	Area Needing Remediation
2015	
2016	
2017	
2018	

Table C.1.d. Providers Meet Requirements Before Furnishing Services Analysis

Year	Analysis of Results by Year
2015	
2016	
2017	
2018	

DRAFT

Table C.1.e. Providers Meet Requirements Before Furnishing Services QI Recommendations/QIPs

Year	QI Recommendations/QIPs Initiated by Year
2015	
2016	
2017	
2018	

Table C.2.a. Providers Meet Requirements While Furnishing Services PM Description

Performance Measure	Number and/or Percent of PROMISE Providers Meeting Licensure and Certification Requirements While Furnishing Services
Numerator	Number of PROMISE providers meeting licensure and certification requirements while furnishing services
Denominator	Total number of PROMISE providers
Data source	Provider records within the Provider Relations and Fiscal Contracting Units
Sampling approach	100%

DATA:

Information obtained from January 1, 2015 through December 31, 2018 was collected through a review of documentation of provider files. Data is specific to the PROMISE program.

Table C.2.b. Providers Meet Requirements While Furnishing Services Results

Numerator, Denominator, Percent	2015	2016	2017	2018
Number of PROMISE providers meeting licensure and certification requirements while furnishing services				
Total number of PROMISE providers				
Percent of PROMISE providers meeting licensure and certification requirements while furnishing services				

Table C.2.c. Providers Meet Requirements While Furnishing Services Remediation

Year	Area Needing Remediation
2015	
2016	
2017	
2018	

Table C.2.d. Providers Meet Requirements While Furnishing Services Analysis

Year	Analysis of Results by Year
2015	
2016	
2017	
2018	

DRAFT

Table C.2.e. Providers Meet Requirements While Furnishing Services QI Recommendations/QIPs

Year	QI Recommendations/QIPs Initiated by Year
2015	
2016	
2017	
2018	

Table C.3.a. Providers With an Active PROMISE Agreement PM Description

Performance Measure	Number and/or Percent of PROMISE Providers With an Active PROMISE Agreement, as Well as a Medicaid Provider Agreement, With DSAMH/DMMA
Numerator	Number of PROMISE providers with an active PROMISE agreement, as well as a Medicaid provider agreement, with DSAMH/DMMA
Denominator	Total number of PROMISE providers
Data source	Provider records within the Provider Relations and Fiscal Contracting Units
Sampling approach	100%

DATA:

Information obtained from January 1, 2015 through December 31, 2018 was collected through a review of documentation (DSAMH/DMMA and PROMISE agreements) of provider files. Data is specific to the PROMISE program.

Table C.3.b. Providers With an Active PROMISE Agreement Results

Numerator, Denominator, Percent	2015	2016	2017	20218
Number of PROMISE providers with an active PROMISE agreement, as well as a Medicaid provider agreement, with DSAMH/DMMA				
Total number of PROMISE providers				
Percent of PROMISE providers with an active PROMISE agreement, as well as a Medicaid provider agreement, with DSAMH/DMMA				

Table C.3.c. Providers With an Active PROMISE Agreement Remediation

Year	Area Needing Remediation
2015	
2016	
2017	
2018	

Table C.3.d. Providers With an Active PROMISE Agreement Analysis

Year	Analysis of Results by Year
2015	
2016	
2017	
2018	

DRAFT

Table C.3.e. Providers With an Active PROMISE Agreement QI Recommendations/QIPs

Year	QI Recommendations/QIPs Initiated by Year
2015	
2016	
2017	
2018	

Table C.4.a. Providers Serving PROMISE Beneficiaries PM Description

Performance Measure	Number and/or Percent of Enrolled PROMISE Providers Serving PROMISE Beneficiaries (By Provider Type)
Numerator	Number of enrolled PROMISE providers serving PROMISE beneficiaries (by provider type)
Denominator	Total number of PROMISE providers
Data source	Provider records within the Provider Relations and Fiscal Contracting Units
Sampling approach	100%

DATA:

Information obtained from January 1, 2015 through December 31, 2018 was collected through a review of documentation of provider files. Data is specific to the PROMISE program.

Table C.4.b. Providers Serving PROMISE Beneficiaries Results

Numerator, Denominator, Percent	2015	2016	2017	2018
Number of enrolled PROMISE providers serving PROMISE beneficiaries (by provider type)				
Total number of PROMISE providers				
Percent of enrolled PROMISE providers serving PROMISE beneficiaries (by provider type)				

Table C.4.c. Providers Serving PROMISE Beneficiaries Remediation

Year	Area Needing Remediation
2015	
2016	
2017	
2018	

Table C.4.d. Providers with an Active PROMISE Agreement Analysis

Year	Analysis of Results by Year
2015	
2016	
2017	
2018	

DRAFT

Table C.4.e. Providers Serving PROMISE Beneficiaries QI Recommendations/QIPs

Year	QI Recommendations/QIPs Initiated by Year
2015	
2016	
2017	
2018	

Subassurance: The State implements its policies and procedures for verifying that training is provided in accordance with State requirements.

Table C.5.a. Providers Meeting Training Requirements PM Description

Performance Measure	Number and/or Percent PROMISE Providers Who Meet Training Requirements for Delivering PROMISE Services
Numerator	Number of PROMISE providers who meet training requirements for delivering PROMISE services
Denominator	Total number of PROMISE providers
Data source	Provider records within the Provider Relations and Fiscal Contracting Units
Sampling approach	100%

DATA:

Information obtained from January 1, 2015 through December 31, 2018 was collected through a review of documentation of provider files. Data is specific to the PROMISE program.

Table C.5.b. Providers Meeting Training Requirements Results

Numerator, Denominator, Percent	2015	2016	2017	2018
Number of PROMISE providers who meet training requirements for delivering PROMISE services				
Total number of PROMISE providers				
Percent of PROMISE providers who meet training requirements for delivering PROMISE services				

Table C.5.c. Providers Meeting Training Requirements Remediation

Year	Area Needing Remediation
2015	
2016	
2017	
2018	

Table C.5.d. Providers Meeting Training Requirements Analysis

Year	Analysis of Results by Year
2015	
2016	
2017	
2018	

DRAFT

Table C.5.e. Providers Meeting Training Requirements QI Recommendations/QIPs

Year	QI Recommendations/QIPs Initiated by Year
2015	
2016	
2017	
2018	

DRAFT

ASSURANCE #4: HCBS Settings

CMS requires that beneficiaries receiving HCBS services should live, work, and enjoy fully integrated lives in the community. Community-based residential settings (excluding assisted living) offer a cost-effective, community-based alternative to nursing facility care for persons with behavioral health needs. Characteristics of these settings include a) full access to the greater community; b) choice from among available service setting options that are appropriate for the individual; c) protection of the rights of privacy, dignity, respect, and freedom from coercion and restraint; d) optimization of autonomy and independence in making choices; and e) facilitation of choice regarding services and who provides them.

Care manager monitoring data will be aggregated and analyzed to ensure CMS requirements regarding HCBS settings are met.

Settings meet the home and community-based setting requirements.

Table D.1.a. HCBS Settings Meeting Licensure Requirements PM Description

Performance Measure	Number and/or Percent of HCBS Settings Meeting Appropriate Licensure or Certification Requirements
Numerator	The number of HCBS settings meeting appropriate licensure or certification requirements
Denominator	The total number of HCBS settings included in the PROMISE program
Data source	QA/PI sample of provider agency; care manager monitoring visits
Sampling approach	100% of QA/PI provider agency visits; 100% care manager monitoring visits

DATA:

Information obtained from January 1, 2015 through December 31, 2018 was collected through a review of documentation (provider credentialing information) by QA/PI and during care manager visits. Data is specific to the PROMISE program.

Table D.1.b. HCBS Settings Meeting Licensure Requirements Results

Numerator, Denominator, Percent	2015	2016	2017	2018
The number of HCBS settings meeting appropriate licensure or certification requirements				
The total number of HCBS settings included in the PROMISE program				
The percent of HCBS settings meeting appropriate licensure or certification requirements				

Table D.1.c. HCBS Settings Meeting Licensure Requirements Remediation

Year	Area Needing Remediation
2015	
2016	
2017	
2018	

DRAFT

Table D.1.d. HCBS Settings Meeting Licensure Requirements Analysis

Year	Analysis of Results by Year
2015	
2016	
2017	
2018	

Table D.1.e. HCBS Settings Meeting Licensure Requirements QI Recommendations/QIPs

Year	QI Recommendations/QIPs Initiated by Year
2015	
2016	
2017	
2018	

DRAFT

ASSURANCE #5: Operational Oversight

DMMA, which functions as the State Medicaid Agency*, must manage DSAMH and the PROMISE program by demonstrating it has designed and implemented an effective system for assuring the adequacy of program operations and oversight for waiver beneficiaries.

*As a technical matter, DSAMH is a division within the Single State Medicaid Agency, since in Delaware, the SMA is the Department of Health and Social Services, but the oversight of DMMA remains key.

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 agencies and contracted entities.

Table E.1.a. Performance Measure Reports Generated by DSAMH PM Description

Performance Measure	Number and/or Percent of Aggregated Performance Measure Reports Generated by the Operating Agency (DSAMH) and Reviewed by the SMA That Contain Discovery, Remediation, and System Improvement for Ongoing Compliance of the Assurances
Numerator	Number of aggregated performance measure reports generated by DSAMH and reviewed by DMMA that contain discovery, remediation, and system improvement for ongoing compliance of the assurances
Denominator	The total number of performance measure reports generated by DSAMH and reviewed by DMMA
Data source	Reports to DMMA on delegated administrative functions
Sampling approach	100%

DATA:

Information obtained from January 1, 2015 through December 31, 2018 was collected through a review of reports to DMMA on delegated administrative functions by DSAMH. Data is specific to the PROMISE program.

Table E.1.b. Performance Measure Reports Generated by DSAMH Results

Numerator, Denominator, Percent	2015	2016	2017	2018
Number of aggregated performance measure reports generated by DSAMH and reviewed by DMMA that contain discovery, remediation, and system improvement for ongoing compliance of the assurances				
The total number of performance measure reports generated by DSAMH and reviewed by DMMA				
Percent of aggregated performance measure reports generated by DSAMH and reviewed by DMMA that contain discovery, remediation, and system improvement for ongoing compliance of the assurances				

DRAFT

Table E.1.c. Performance Measure Reports Generated by DSAMH Remediation

Year	Area Needing Remediation
2015	
2016	
2017	
2018	

Table E.1.d. Performance Measure Reports Generated by DSAMH Analysis

Year	Analysis of Results by Year
2015	
2016	
2017	
2018	

Table E.1.e. Performance Measure Reports Generated by DSAMH QI Recommendations/QIPs

Year	QI Recommendations/QIPs Initiated by Year
2015	
2016	
2017	
2018	

Table E.2.a. STC Amendments, Renewals, and Financial Reports Approved Prior to Implementation PM Description

Performance Measure	Number and/or Percent of 1115 STC Amendments, Renewals, and Financial Reports Approved by DMMA Prior to Implementation by DSAMH
Numerator	Number of 1115 STC amendments, renewals, and financial reports approved by DMMA prior to implementation by DSAMH
Denominator	The total number of STC amendments, renewals, and financial reports produced by DMMA
Data source	Reports to DMMA on delegated administrative functions
Sampling approach	100%

DATA:

Information obtained from January 1, 2015 through December 31, 2018 was collected through a review of reports to DMMA on delegated administrative functions by DSAMH. Data is specific to the PROMISE program.

DRAFT

Table E.2.b. STC Amendments, Renewals, and Financial Reports Approved Prior to Implementation Results

Numerator, Denominator, Percent	2015	2016	2017	2018
Number of 1115 STC amendments, renewals, and financial reports approved by DMMA prior to implementation by DSAMH				
The total number of STC amendments, renewals, and financial reports produced by DMMA				
Percent of 1115 STC amendments, renewals, and financial reports approved by DMMA prior to implementation by DSAMH				

Table E.2.c. STC Amendments, Renewals, and Financial Reports Approved Prior to Implementation Remediation

Year	Area Needing Remediation
2015	
2016	
2017	
2018	

Table E.2.d. STC Amendments, Renewals, and Financial Reports Approved Prior to Implementation Analysis

Year	Analysis of Results by Year
2015	
2016	
2017	
2018	

Table E.2.e. STC Amendments, Renewals, and Financial Reports Approved Prior to Implementation QI Recommendations/QIPs

Year	QI Recommendations/QIPs Initiated by Year
2015	
2016	
2017	
2018	

DRAFT

Table E.3.a. STC Concepts and Policies Approved Prior to Development of an Implementation Plan PM Description

Performance Measure	Number and/or Percent of 1115 STC Concepts and Policies Requiring MMIS Programming Approved by DMMA Prior to the Development of a Formal Implementation Plan by DSAMH
Numerator	Number of 1115 STC concepts and policies requiring MMIS programming approved by DMMA prior to the development of a formal implementation plan by DSAMH
Denominator	The total number of STC concepts and policies requiring MMIS programming prior to the development of a formal implementation plan by DSAMH
Data source	Reports to DMMA on delegated administrative functions
Sampling approach	100%

DATA:

Information obtained from January 1, 2015 through December 31, 2018 was collected through a review of reports to DMMA on delegated administrative functions by DSAMH. Data is specific to the PROMISE program.

Table E.3.b. STC Concepts and Policies Approved Prior to Development of Implementation Plan Results

Numerator, Denominator, Percent	2015	2016	2017	2018
Number of 1115 STC concepts and policies requiring MMIS programming approved by DMMA prior to the development of a formal implementation plan by DSAMH				
The total number of STC concepts and policies requiring MMIS programming prior to the development of a formal implementation plan by DSAMH				
Percent of 1115 STC concepts and policies requiring MMIS programming approved by DMMA prior to the development of a formal implementation plan by DSAMH				

Table E.3.c. STC Concepts and Policies Approved Prior to Development of Implementation Plan Remediation

Year	Area Needing Remediation
2015	
2016	
2017	
2018	

Table E.3.d. STC Concepts and Policies Approved Prior to Development of Implementation Plan Analysis

Year	Analysis of Results by Year
2015	
2016	
2017	
2018	

DRAFT

Table E.3.e. STC Concepts and Policies Approved Prior to Development of Implementation Plan QI Recommendations/QIPs

Year	QI Recommendations/QIPs Initiated by Year
2015	
2016	
2017	
2018	

DRAFT

ASSURANCE #6: Fiscal Accountability

As part of the provider billing, the Fiscal Unit must ensure that processes are in place to prevent duplicate payment and that payment to providers is consistent with approved recovery plans, paid using rates consistent with the approved rate-setting methodology. Additional payments to providers outside of the Medicaid reimbursement may not subsidize Medicaid providers for Medicaid covered services to Medicaid beneficiaries.

Utilization review reports from providers are analyzed quarterly. Data on beneficiary utilization is reviewed annually. If the utilization review process identifies issues with program integrity, the Fiscal Unit shall follow up with providers, use corrective action plans when indicated, recoup overpayments, or report abusive or fraudulent claiming to the Medicaid Fraud Unit via the SMA.

The analysis is part of the state quality work plan and is reported to the state QA Committee. The committee members discuss the findings to identify opportunities for improvement. If deficiencies are noted, the contractor must perform corrective action until compliance is met.

The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to PROMISE participants by qualified providers.

Subassurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.

Table F.1.a. Providers With Payment Recouped Without Documentation PM Description

Performance Measure	Number and/or Percent of Providers That Have Payment Recouped for HCBS Services Without Supporting Documentation
Numerator	Number of providers that have had payment recouped for HCBS services without supporting documentation
Denominator	Number of providers who submitted claims
Data source	Routine claims verification audit
Sampling approach	Statistically valid sample with a 95% confidence level

DATA:

Information obtained from January 1, 2015 through December 31, 2018 was collected through a review of documentation of claims submitted and clinical record documentation to assure service was rendered, documented, and correctly coded, as well as an annual review of rate-setting methodology. Data is specific to the PROMISE program.

Table F.1.b. Providers With Payment Recouped Without Documentation Results

Numerator, Denominator, Percent	2015	2016	2017	2018
Number of providers that have had payment recouped for HCBS services without supporting documentation				
Number of providers who submitted claims				
Percent of providers that have had payment recouped for HCBS services without supporting documentation				

DRAFT

Table F.1.c. Providers With Payment Recouped Without Documentation Remediation

Year	Area Needing Remediation
2015	
2016	
2017	
2018	

Table F.1.d. Providers With Payment Recouped Without Documentation Analysis

Year	Analysis of Results by Year
2015	
2016	
2017	
2018	

Table F.1.e. Providers With Payment Recouped Without Documentation QI Recommendations/QIPs

Year	QI Recommendations/QIPs Initiated by Year
2015	
2016	
2017	
2018	

Table F.2.a. Claims Paid According to Recovery Plan PM Description

Performance Measure	Number and/or Percent of Claims Verified Through the DSAMH Compliance Audit to Have Been Paid in Accordance With the Participant's Individual Recovery Plan
Numerator	Number of sampled claims verified through the DSAMH compliance audit to have been paid in accordance with the participant's individual recovery plan
Denominator	Total number of sampled claims submitted
Data source	Routine claims verification audit
Sampling approach	Statistically valid sample with a 95% confidence level

DATA:

Information obtained from January 1, 2015 through December 31, 2018 was collected through a review of documentation of claims submitted and clinical record documentation to assure service was rendered, documented, and correctly coded, as well as an annual review of rate-setting methodology. Data is specific to the PROMISE program.

DRAFT

Table F.2.b. Claims Paid According to Recovery Plan Results

Numerator, Denominator, Percent	2015	2016	2017	2018
Number of sampled claims verified through the DSAMH compliance audit to have been paid in accordance with the participant's individual recovery plan				
Total number of sampled claims submitted				
Percent of sampled claims verified through the DSAMH compliance audit to have been paid in accordance with the participant's individual recovery plan				

Table F.2.c. Claims Paid According to Recovery Plan Remediation

Year	Area Needing Remediation
2015	
2016	
2017	
2018	

Table F.2.d. Claims Paid According to Recovery Plan Analysis

Year	Analysis of Results by Year
2015	
2016	
2017	
2018	

Table F.2.e. Claims Paid According to Recovery Plan QI Recommendations/QIPs

Year	QI Recommendations/QIPs Initiated by Year
2015	
2016	
2017	
2018	

Subassurance: The State provides evidence that rates remain consistent with the approved rate methodology throughout the five-year waiver cycle.

Table F.3.a. Rates Consistent Throughout the Waiver Cycle PM Description

Performance Measure	Number and/or Percentage of Rates That Remain Consistent With the Approved Rate Methodology Throughout the Waiver Cycle
Numerator	Number of rates that remain consistent with the approved rate methodology throughout the waiver cycle
Denominator	Total number of rates submitted
Data source	Annual review of rate-setting methodology
Sampling approach	100%

DRAFT

DATA:
Information obtained from January 1, 2015 through December 31, 2018 was collected through a review of documentation of rates, as well as an annual review of rate-setting methodology. Data is specific to the PROMISE program.

Table F.3.b. Rates Consistent Throughout the Waiver Cycle Results

Numerator, Denominator, Percent	2015	2016	2017	2018
Number of rates that remain consistent with the approved rate methodology throughout the waiver cycle				
Total number of rates submitted				
Percent of rates that remain consistent with the approved rate methodology throughout the waiver cycle				

Table F.3.c. Rates Consistent Throughout the Waiver Cycle Remediation

Year	Area Needing Remediation
2015	
2016	
2017	
2018	

Table F.3.d. Rates Consistent Throughout the Waiver Cycle Analysis

Year	Analysis of Results by Year
2015	
2016	
2017	
2018	

Table F.3.e. Rates Consistent Throughout the Waiver Cycle QI Recommendations/QIPs

Year	QI Recommendations/QIPs Initiated by Year
2015	
2016	
2017	
2018	

DRAFT

ASSURANCE #7: Health and Welfare

As part of the assurances made by Delaware to the federal government, the State is responsible for assuring the health and welfare of each beneficiary in the PROMISE program. The QA Unit is integrally involved in the tracking of health and welfare issues and addressing those issues through remediation efforts.

The Consumer Affairs Office, QA Unit, and EEU are required to track grievances and the appeals system. Grievance and appeal data are included in quarterly quality improvement reporting and are reviewed at least annually by the State QA Committee. Data are also included in quality improvement annual reports. Data are gathered and reported quarterly with quarterly review and annually, at a minimum.

This data is integrated into the PMs as part of the overall State performance improvement plan. The data is analyzed to identify trends, and general and critical incidents. The findings are reported to the State QA Committee. The committee members discuss the findings to identify opportunities for improvement. In addition, this information is used to assess the effectiveness of quality initiatives or projects. PMs are implemented when indicated by findings.

The MCO will provide encounter data to DMMA that includes primary care physical health service claims data for all PROMISE members, which can be aggregated by DSAMH.

All DSAMH Medicaid claims are paid fee-for-service, so DSAMH will have the data available to create reports needed.

The State identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.

Subassurance: The State demonstrates, on an ongoing basis, that it identifies, addresses, and seeks to prevent instances of abuse, neglect, exploitation, and unexplained death.

Table G.1.a. Reports Related to Abuse or Death With Investigation Initiated Timely PM Description

Performance Measure	Number and/or Percent of Reports Related to the Abuse, Neglect, or Exploitation of Beneficiaries and Unexplained Death Where an Investigation Was Initiated Within Established Timeframes
Numerator	Number of reports related to the abuse, neglect, or exploitation of beneficiaries, and unexplained death where an investigation was initiated within established timeframes
Denominator	Total number of reports related to the abuse, neglect, or exploitation of beneficiaries and unexplained death
Data source	QA reports related to abuse, neglect, exploitation, or unexplained deaths
Sampling approach	100%

DATA:

Information obtained from January 1, 2015 through December 31, 2018 was collected through performance monitoring by DSAMH of reports of abuse, neglect, exploitation, and unexplained deaths. Data is specific to the PROMISE program.

DRAFT

Table G.1.b. Reports Related to Abuse or Death With Investigation Initiated Timely Results

Numerator, Denominator, Percent	2015	2016	2017	2018
Number of reports related to the abuse, neglect, or exploitation of beneficiaries, and unexplained death where an investigation was initiated within established timeframes				
Number of reports related to the abuse, neglect, or exploitation of beneficiaries and unexplained death where an investigation was initiated within established timeframes				
Percent of reports related to the abuse, neglect, or exploitation of beneficiaries and unexplained death where an investigation was initiated within established timeframes				

Table G.1.c. Reports Related to Abuse or Death With Investigation Initiated Timely Remediation

Year	Area Needing Remediation
2015	
2016	
2017	
2018	

Table G.1.d. Reports Related to Abuse or Death With Investigation Initiated Timely Analysis

Year	Analysis of Results by Year
2015	
2016	
2017	
2018	

Table G.1.e. Reports Related to Abuse or Death With Investigation Initiated Timely QI Recommendations/QIPs

Year	QI Recommendations/QIPs Initiated by Year
2015	
2016	
2017	
2018	

DRAFT

Table G.2.a. Beneficiaries Who Received Information on Reporting Abuse PM Description

Performance Measure	Number and/or Percent of Beneficiaries Who Received Information on How to Report the Suspected Abuse, Neglect, or Exploitation of Adults
Numerator	Number of beneficiaries who report that they are informed about how to report abuse, neglect, and exploitation
Denominator	Total number of PROMISE beneficiaries
Data source	Care manager record review, on site at assessment centers
Sampling approach	100%

DATA:

Information obtained from January 1, 2015 through December 31, 2018 was collected through a combination of interviews, review of documentation (including interviews and review of records), and observation collected during reviews utilizing a survey tool. Data is specific to the PROMISE program.

Table G.2.b. Beneficiaries Who Received Information on Reporting Abuse Results

Numerator, Denominator, Percent	2015	2016	2017	2018
Number of beneficiaries who report that they are informed about how to report abuse, neglect, and exploitation				
Total number of PROMISE beneficiaries				
Percent of beneficiaries who report that they are informed about how to report abuse, neglect, and exploitation				

Table G.2.c. Beneficiaries Who Received Information on Reporting Abuse Remediation

Year	Area Needing Remediation
2015	
2016	
2017	
2018	

Table G.2.d. Beneficiaries Who Received Information on Reporting Abuse Analysis

Year	Analysis of Results by Year
2015	
2016	
2017	
2018	

Table G.2.e. Beneficiaries Who Received Information on Reporting Abuse QI Recommendations/QIPs

Year	QI Recommendations/QIPs Initiated by Year
2015	
2016	
2017	
2018	

DRAFT

Table G.3.a. Beneficiaries Who Received Information on State Fair Hearings PM Description

Performance Measure	Number and/or Percent of Beneficiaries Who Received Information Regarding Their Rights to a State Fair Hearing Via the Notice of Action
Numerator	Number of beneficiaries who received information regarding their rights to a state fair hearing via the Notice of Action
Denominator	Total number of PROMISE beneficiaries
Data source	EEU record review, on site at EEU
Sampling approach	100%

DATA:

Information obtained from January 1, 2015 through December 31, 2018 was collected through a combination of interview, review of documentation (including interviews and review of records), and observation collected during reviews utilizing a survey tool. Data is specific to the PROMISE program.

Table G.3.b. Beneficiaries Who Received Information on State Fair Hearings Results

Numerator, Denominator, Percent	2015	2016	2017	2018
Number of beneficiaries who received information regarding their rights to a state fair hearing via the Notice of Action				
Total number of PROMISE beneficiaries				
Percent of beneficiaries who received information regarding their rights to a state fair hearing via the Notice of Action				

Table G.3.c. Beneficiaries Who Received Information on State Fair Hearings Remediation

Year	Area Needing Remediation
2015	
2016	
2017	
2018	

Table G.3.d. Beneficiaries Who Received Information on State Fair Hearings Analysis

Year	Analysis of Results by Year
2015	
2016	
2017	
2018	

Table G.3.e. Beneficiaries Who Received Information on State Fair Hearings QI Recommendations/QIPs

Year	QI Recommendations/QIPs Initiated by Year
2015	
2016	
2017	
2018	

DRAFT

Table G.4.a. Grievances Filed and Resolved Timely PM Description

Performance Measure	Number and/or Percent of Grievances Filed by Beneficiaries That Were Resolved Within 14 Calendar Days According to Approved 1115 STC Guidelines
Numerator	Total number of grievances filed by beneficiaries that were resolved within 14 calendar days according to approved 1115 STC guidelines
Denominator	Total number of grievances that were filed
Data source	QA grievance log
Sampling approach	100%

DATA:

Information obtained from January 1, 2015 through December 31, 2018 was collected through review of the grievance log. Data is specific to the PROMISE program.

Table G.4.b. Grievances Filed and Resolved Timely Results

Numerator, Denominator, Percent	2015	2016	2017	2018
Number of grievances filed by beneficiaries that were resolved within 14 calendar days according to approved 1115 STC guidelines				
Total number of grievances filed by beneficiaries that were resolved within 14 calendar days according to approved 1115 STC guidelines				
Percent of grievances filed by beneficiaries that were resolved within 14 calendar days according to approved 1115 STC guidelines				

Table G.4.c. Grievances Filed and Resolved Timely Remediation

Year	Area Needing Remediation
2015	
2016	
2017	
2018	

Table G.4.d. Grievances Filed and Resolved Timely Analysis

Year	Analysis of Results by Year
2015	
2016	
2017	
2018	

Table G.4.e. Grievances Filed and Resolved Timely QI Recommendations/QIPs

Year	QI Recommendations/QIPs Initiated by Year
2015	
2016	
2017	
2018	

DRAFT

Table G.5.a. Substantiated Allegations With Recommended Actions PM Description

Performance Measure	Number and/or Percent of Allegations of Abuse, Neglect, or Exploitation Investigated That Were Later Substantiated, Where Recommended Actions to Protect Health and Welfare Were Implemented
Numerator	Number of allegations of abuse, neglect, or exploitation investigated that were later substantiated, where recommended actions to protect health and welfare were implemented
Denominator	Total number of substantiated allegations
Data source	QA database; reports related to abuse, neglect, or exploitation
Sampling approach	100%

DATA:

Information obtained from January 1, 2015 through December 31, 2018 was collected through performance monitoring by DSAMH of the QA database, as well as reports of abuse, neglect, or exploitation. Data is specific to the PROMISE program.

Table G.5.b. Substantiated Allegations With Recommended Actions Results

Numerator, Denominator, Percent	2015	2016	2017	2018
Number of allegations of abuse, neglect, or exploitation investigated that were later substantiated, where recommended actions to protect health and welfare were implemented				
Total number of substantiated allegations				
Percent of allegations of abuse, neglect, or exploitation investigated that were later substantiated, where recommended actions to protect health and welfare were implemented				

Table G.5.c. Substantiated Allegations With Recommended Actions Remediation

Year	Area Needing Remediation
2015	
2016	
2017	
2018	

Table G.5.d. Substantiated Allegations With Recommended Actions Analysis

Year	Analysis of Results by Year
2015	
2016	
2017	
2018	

DRAFT

Table G.5.e. Substantiated Allegations With Recommended Actions QI Recommendations/QIPs

Year	QI Recommendations/QIPs Initiated by Year
2015	
2016	
2017	
2018	

Subassurance: The State demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.

Table G.6.a. Critical Incident Reports Reviewed Timely PM Description

Performance Measure	Number and/or Percent of Beneficiaries' Critical Incidents That Were Reported, Initiated, Reviewed, and Completed Within Required Timeframes as Specified in the Approved 1115 STC
Numerator	Number of beneficiaries' critical incidents that were reported, initiated, reviewed, and completed within required timeframes as specified in the approved 1115 STC
Denominator	Total number of beneficiaries' critical incidents that were reported
Data source	QA reports related to critical incidents
Sampling approach	100%

DATA:

Information obtained from January 1, 2015 through December 31, 2018 was collected through performance monitoring by DSAMH of critical incident reports. Data is specific to the PROMISE program.

Table G.6.b. Critical Incident Reports Reviewed Timely Results

Numerator, Denominator, Percent	2015	2016	2017	2018
Number of beneficiaries' critical incidents that were reported, initiated, reviewed, and completed within required timeframes as specified in the approved 1115 STC				
Total number of beneficiaries' critical incidents that were reported				
Percent of beneficiaries' critical incidents that were reported, initiated, reviewed, and completed within required timeframes as specified in the approved 1115 STC				

DRAFT

Table G.6.c. Critical Incident Reports Reviewed Timely Remediation

Year	Area Needing Remediation
2015	
2016	
2017	
2018	

Table G.6.d. Critical Incident Reports Reviewed Timely Analysis

Year	Analysis of Results by Year
2015	
2016	
2017	
2018	

Table G.6.e. Critical Incident Reports Reviewed Timely QI Recommendations/QIPs

Year	QI Recommendations/QIPs Initiated by Year
2015	
2016	
2017	
2018	

Subassurance: The State policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.

Table G.7.a. Unauthorized Use of Restrictive Interventions PM Description

Performance Measure	Number and/or Percent of Unauthorized Uses of Restrictive Interventions That Were Appropriately Reported
Numerator	Total number of unauthorized uses of restrictive interventions that were appropriately reported
Denominator	Total number of reports of restrictive interventions
Data source	Reports related to restrictive interventions
Sampling approach	100%

DATA:

Information obtained from January 1, 2015 through December 31, 2018 was collected through performance monitoring by DSAMH of reports related to restrictive interventions. Data is specific to the PROMISE program.

DRAFT

Table G.7.b. Unauthorized Use of Restrictive Interventions Results

Numerator, Denominator, Percent	2015	2016	2017	2018
Number of unauthorized uses of restrictive interventions that were appropriately reported				
Total number of reports of restrictive interventions				
Percent of unauthorized uses of restrictive interventions that were appropriately reported				

Table G.7.c. Unauthorized Use of Restrictive Interventions Remediation

Year	Area Needing Remediation
2015	
2016	
2017	
2018	

Table G.7.d. Unauthorized Use of Restrictive Interventions Analysis

Year	Analysis of Results by Year
2015	
2016	
2017	
2018	

Table G.7.e. Unauthorized Use of Restrictive Interventions QI Recommendations/QIPs

Year	QI Recommendations/QIPs Initiated by Year
2015	
2016	
2017	
2018	

Subassurance: The State establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.

Table G.7.a. Beneficiaries Who Received Physical Exams PM Description

Performance Measure	Number and/or Percent of Waiver Beneficiaries Who Received Physical Exams Consistent With State PROMISE HCBS Policy
Numerator	Number of beneficiaries who received physical exams consistent with state PROMISE HCBS policy
Denominator	Total number of PROMISE beneficiaries
Data source	Claims data regarding primary care physical exams; care manager monitoring visit data
Sampling approach	100%

DATA:

DRAFT

Information obtained from January 1, 2015 through December 31, 2018 was collected through a review of documentation of claims submitted to assure service was rendered. Data is specific to the PROMISE program.

Table G.7.b. Beneficiaries Who Received Physical Exams Results

Numerator, Denominator, Percent	2015	2016	2017	2018
Number of beneficiaries who received physical exams consistent with state PROMISE HCBS policy				
Total number of PROMISE beneficiaries				
Percent of beneficiaries who received physical exams consistent with state PROMISE HCBS policy				

Table G.7.c. Beneficiaries Who Received Physical Exams Remediation

Year	Area Needing Remediation
2015	
2016	
2017	
2018	

Table G.7.d. Beneficiaries Who Received Physical Exams Analysis

Year	Analysis of Results by Year
2015	
2016	
2017	
2018	

Table G.7.e. Beneficiaries Who Received Physical Exams QI Recommendations/QIPs

Year	QI Recommendations/QIPs Initiated by Year
2015	
2016	
2017	
2018	

DRAFT