

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 waivers target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

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

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

1. Request Information

A. The State of Delaware requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

B. Program Title:

DDDS Lifespan Waiver

C. Waiver Number:DE.0009

Original Base Waiver Number: DE.0009.

D. Amendment Number:DE.0009.R08.06

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

10/01/22

Approved Effective Date: 10/01/22

Approved Effective Date of Waiver being Amended: 07/01/19

2. Purpose(s) of Amendment

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

Delaware proposes to amend the 1915(c)Lifespan waiver to add enhancements to current services in order to better meet the needs of individuals as well attract and retain support staff for those services. Enhancements to current services include, the addition of Registered Behavior Technicians (RBT) to Day Habilitation, Community Participation, Supported Employment, and Residential Habilitation services when the service recipient has an increased behavioral support need, the addition of American Sign Language (ASL) certified or fluent staff when the service recipient is Deaf and uses ASL to communicate, a tiered rate structure for Behavioral Consultation and Nurse Consultation services based upon the credentials and experience of the practitioner delivering those services, specifying that hearing aids are covered Assistive Technology devices, and the addition of Audiologist and hearing aid dispensers as provider types of that service. In addition, reimbursement for transportation for Day Habilitation and Pre-Vocational services will be billed separately as a component part of the service as a "round trip" on days when it is provided. Previously transportation was bundled into the reimbursement rate for those services. Delaware also seeks to add the provisions under the 21st Century Cares Act that allows HCBS providers to support service recipients during acute, in-patient hospital stays to the following services, Personal Care, Residential Habilitation, Medical Residential Habilitation, Nurse Consultation, and Behavioral Consultation. All of the enhancements to current waiver services are compliant with CMS HCBS Rule.

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently (*check each that applies*):

Component of the Approved Waiver	Subsection(s)
Waiver Application	2., 3., 6-I
Appendix A Waiver Administration and Operation	3., 5., 6., 7
Appendix B Participant Access and Eligibility	B-3
Appendix C Participant Services	C-1/C-3, C-c-1
Appendix D Participant Centered Service Planning and Delivery	D-1
Appendix E Participant Direction of Services	
Appendix F Participant Rights	
Appendix G Participant Safeguards	G-3
Appendix H	
Appendix I Financial Accountability	I-2-a
Appendix J Cost-Neutrality Demonstration	J-2-d

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

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

Specify:

Delaware Proposes the following changes:

Appendix B: Participant Access and Eligibility

•B-3: Number of Individuals Services

Remove Language for "Aged out of Pathways to Employment 1915(i)" and corresponding reserved capacity table. DDDS amended the Pathways to Employment State Plan Amendment (SPA) and removed the upper age limit effective 1/01/2022.

Appendix C: Service Specifications

•Revisions to Current Waiver Services:

Day Habilitation, Community Participation, and Pre-Vocational services had the following language added to the scopes of services to reflect that transportation will now be billed separately as a "round trip" component part of the service on days when it is provided; "Transportation to and from the service location may be billed separately as a component part of the service for days when it is provided."

In order to try to better meet the unique support needs of service recipients, DDDS added the following language to the scopes of Day Habilitation, Community Participation, Pre-Vocational, Supported Employment, Residential Habilitation, and Medical Residential Habilitation; "When it is clearly documented in the person centered plan that the service recipient is Deaf and uses American Sign Language (ASL) to communicate, DDDS may authorize a higher rate for the provider when the provider employs ASL certified or fluent staff to directly support the service recipient and their communication needs."

In order to try to better meet the unique support needs of service recipients, DDDS added the following language to the scopes of Day Habilitation, Community Participation, Pre-Vocational, Supported Employment, Residential Habilitation, and Medical Residential Habilitation; "When it is clearly documented in the person centered plan that the service recipient has an increased behavioral support need, DDDS may authorize a higher rate for the provider when the provider employs Registered Behavior Technicians (RBTs) to directly support the service recipient in order to meet their behavioral support needs. The provider must also employ a Board Certified Behavior Analyst (BCBA) to provide clinical supervision to the RBTs."

Through the Cares Act, states were given the ability to use HCBS dollars to allow HCBS providers to support the service recipient during acute, in-patient hospital stays to better meet their needs; beyond what is federally required of the hospital. In order to have this valuable support continue the following language was added to Personal Care, Residential Habilitation, Medical Residential Habilitation, Nurse Consultation, and Behavioral Consultation services; "In accordance with Section 601(d) of the Social Security Act, as added by Section 5001 of the Care Act, DDDS may authorize Personal Care services in an acute care hospital to meet the needs of the service recipient that are not met through the provision of hospital services and/or to ensure the smooth transitions between acute care settings and home and community based setting and to preserve the service recipient's functions. This service will not be authorized to substitute services that the hospital is obligated to provide under Federal or State law."

The combined annual budget for Respite and Personal Care services was increased from \$2700.00 to \$3500.00. DDDS corrected the provider type language for PASA providers to reflect Delaware Code 3345.

Behavioral Consultation was updated to reflect the tiered rate structure credentialing and experience requirements.

Nurse Consultation was updated to reflect the tiered rate structure credentialing and experience requirements.

Assistive Technology was updated to reflect the addition of hearing aids as covered devices or equipment. In addition, Audiologists and hearing aid dispensers were added as new provider types to this service.

Performance Measures C-a-2, C-a-3, C-b-1, and C-c-1 were clarified to better align with the way the date is captured, tracked, and reported.

Appendix D: Participant-Centered Planning and Service Delivery

•b. Service Plan Development Safeguards:

This section will be updated to reflect that "Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant. "DDDS has closed out the last

remaining State Operated Day programs during 2021.

Language has been added to reflect the use of the Charting the LifeCourse framework and tools as the foundation of the development of the person-centered plan and removed language about "My Life, My Plan."

D-1-d. During early 2019 through late 2019, the state tested the validity of the SNAP alongside the ICAP across approximately 250 service recipients. Because the assessments produced the same results, the state has decided to not implement the SNAP and removed language pertaining to SNAP from this section. No recipients will receive a loss or reduction of services by this change.

Appendix G: Participant Safeguards

Providers of Nurse Consultation services will be required to conduct more frequent face to face visits with services recipients residing in a Shared Living setting.

Appendix I: Financial Accountability

A rate methodology was added for the addition of ASL fluent staff to all Day Services including Supported Employment, Residential Habilitation and Medical Residential Habilitation.

A rate methodology was added for the addition of RBTs staff to all Day Services including Supported Employment and Residential Habilitation.

A rate methodology was added for the tiered rate structure for Nurse Consultation.

A rate methodology was added for the tiered rate structure for Behavioral Consultation.

Appendix J: Cost Neutrality

This section was updated for Waiver Year 4 and Waiver Year 5 including; revised counts of members, units, cost per unit and other factors necessary to demonstrate budget neutrality of waiver services versus institutional services.

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

1. Request Information (1 of 3)

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

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

DDDS Lifespan Waiver

C. Type of Request: amendment

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

3 years 5 years

Original Base Waiver Number: DE.0009

Waiver Number: DE.0009.R08.06

Draft ID: DE.008.08.03

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/19

Approved Effective Date of Waiver being Amended: 07/01/19

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so

that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: December 31, 2023). The time required to complete this information collection is estimated to average 160 hours per response for a new waiver application and 75 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. Request Information (2 of 3)

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

Hospital

Select applicable level of care

Hospital as defined in 42 CFR §440.10

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

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

Nursing Facility

Select applicable level of care

Nursing Facility as defined in 42 CFR ??440.40 and 42 CFR ??440.155

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

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

Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)

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

1. Request Information (3 of 3)

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

Select one:

Not applicable

Applicable

Check the applicable authority or authorities:

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

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

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

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

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

§1915(b)(2) (central broker)

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

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

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

Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

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

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

A program authorized under §1115 of the Act.

Specify the program:

Individuals enrolled in the DDDS Lifespan Waiver can be concurrently enrolled in the 1115 Waiver under the Diamond State Health Plan to receive their non-DDDS Lifespan Waiver acute care benefits.

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

The Division of Developmental Disabilities Services (DDDS) Home and Community Based Services Lifespan Waiver provides services and supports as an alternative to institutional placement for individuals with intellectual developmental disabilities (IDD) (including brain injury), autism spectrum disorder or Prader-Willi Syndrome.

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

The objectives of the DDDS Lifespan Waiver are to:

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

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

3. Components of the Waiver Request

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

- A. Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.
- B. Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- D. Participant-Centered Service Planning and Delivery.** Appendix D specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).
- E. Participant-Direction of Services.** When the state provides for participant direction of services, Appendix E specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

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

No. This waiver does not provide participant direction opportunities. Appendix E is not required.

- F. Participant Rights.** Appendix F specifies how the state informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.
- G. Participant Safeguards.** Appendix G describes the safeguards that the state has established to assure the health and welfare of waiver participants in specified areas.
- H. Quality Improvement Strategy.** Appendix H contains the Quality Improvement Strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the state makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the state's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The state requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in Appendix C that are not otherwise available under the approved Medicaid state plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in Appendix B.

B. Income and Resources for the Medically Needy. Indicate whether the state requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):

Not Applicable

No

Yes

C. Statewide. Indicate whether the state requests a waiver of the statewide requirements in §1902(a)(1) of the Act (*select one*):

No

Yes

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

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

Limited Implementation of Participant-Direction. A waiver of statewide 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 published a link to the PDF of the complete waiver application and a summary of the proposed changes on its website for public review beginning on May 1, 2022. Public meetings were held on May 16, 17, and 18, 2022, in each of the 3 counties of Delaware at different times of day. A copy of the waiver application was also available in hard copy for public view in DDDS offices in each county of Delaware.

In a further effort to ensure transparency with the public, DDDS published the changes to the waiver application in red font so that it was easier to review and provide feedback on.

DMMA published notice regarding the amendment in the May 1, 2022 Delaware Register of Regulations with a link to the website to view the complete application and instructions on how to submit comments. The comment period went from May 1, 2022-May 31, 2022. Public comments were accepted through U.S. mail, fax, and email. Delaware also allowed the required additional period of 15 days for the public to comment through June 15, 2022.

DDDS sent emails to its distribution lists for families, providers, and other stakeholders on April 21, 2022 announcing the public comment process and scheduled public hearing dates and times for the proposed Lifespan Waiver amendment.

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

- ~6/23/2021 Medical Care Advisory Council (MCAC), quarterly meeting
- ~3/17/2022 BA Best Practice, monthly meeting
- ~4/14/2022 DDDS All Provider, quarterly meeting
- ~4/19/2022 Nurse Best Practice, monthly meeting
- ~4/21/2022 DDDS Advisory Council, monthly meeting
- ~5/05/2022 DDDS Day Service Provider, monthly meeting
- ~5/05/2022 DDDS Residential Service Provider, monthly meeting
- ~5/11/2022 Delaware Developmental Disabilities Council, monthly meeting
- ~5/16/2022 State Council for Persons with Disabilities, monthly meeting
- ~5/17/2022 Governor's Advisory Council for Exception Citizens, monthly meeting

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

Only one change was made to the amendment as a result of feedback received from the public during the comment period. A document summarizing the public comments and any changes made as a result of the comment is posted on the DDDS and DMMA websites along with the revised amendment that was submitted to CMS. Most of the public comments/questions were to communicate support of the proposed changes and to thank DDDS for attempting to better meet the needs of service recipients.

The one change was based upon feedback received from the President of the Hearing Loss Association of Delaware, who first thanked DDDS for their consideration and support of hard of hearing service recipients by adding hearing aids as devices covered under Assistive Technology and then recommended adding hearing aid dispensers as authorized providers in addition to Audiologist (that DDDS had already included) as Audiologist may not always be affiliated with dispensers. DDDS included this additional provider type in this amendment to try to ensure a broader array of providers for this service and not inadvertently limit access to this service.

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:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Delaware**

Zip:

Phone: **Ext:** **TTY**

Fax:

E-mail:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Delaware**

Zip:

19901

Phone:

(302) 744-9600

Ext:

TTY

Fax:

(302) 744-9632

E-mail:

stacy.watkins@delaware.gov

8. Authorizing Signature

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

Signature:

Kimberly Xavier

State Medicaid Director or Designee

Submission Date:

Sep 12, 2022

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

Last Name:

Xavier

First Name:

Kimberly

Title:

Chief Social Service Administrator

Agency:

Division of Medicaid and Medical Assistance

Address:

1901 N. Dupont Highway

Address 2:

City:

New Castle

State:

Delaware

Zip:

19720

Phone:

(302) 255-9576 Ext: TTY

Fax: (302) 255-4425

E-mail: Attachments

Attachment #1: Transition Plan

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

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

Specify the transition plan for the waiver:

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

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

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

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

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

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

The state assures that this waiver amendment or renewal will be subject to any provisions or requirements included in the state's most recent and/or approved home and community-based settings Statewide Transition Plan. The state will implement any CMS required changes by the end of the transition period as outlined in the home and community-based settings Statewide Transition Plan.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Services (continued)

Medical Residential Habilitation-

Medical Residential Habilitation may include medication administration and performance of other non-complex health maintenance tasks, as permitted by State law. The Medical Residential Habilitation provider shall oversee the health care needs of the participant.

When it is clearly documented in the person centered plan that the service recipient uses sign language to communicate, DDDS may authorize a higher rate for Medical Residential Habilitation services when the provider employs ASL fluent or certified staff to directly support the service recipient and their communication needs.

DDDS will authorize the Nurse Consultation Service for all individuals for whom a physician has written an order for skilled nursing and who elect to receive this service via Medical Residential Habilitation. The Nurse Consultant will oversee the provision of Medical Residential Habilitation. A DDDS nurse will oversee the provision of Nurse Consultation. If an individual requires skilled nursing and chooses to receive it via Medical Residential Habilitation but does not want to receive Nurse Consultation, a DDDS nurse will oversee the provision of Medical Residential Habilitation.

The provider of Medical Residential Habilitation may not be the same provider as the provider of Nurse Consultation. DDDS may make an exception where the supply of those services within a geographic region of the state is not sufficient to enable different providers for those two waiver services. The DDDS Director of Community Services must approve any exceptions.

In accordance with Section 601(d) of the Social Security Act, as added by Section 5001 of the Cares Act, DDDS may authorize Medical Residential Habilitation services in an acute care hospital to meet the needs of the service recipient that are not met through the provision of hospital services and/or to ensure the smooth transitions between acute care settings and home and community based setting and to preserve the service recipient's functions. This service will not be authorized to substitute services that the hospital is obligated to provide under Federal or State law.

Appendix I-2 Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods (continued)

The rate for the service called "Medical Residential Habilitation" is computed in hourly units of service. DDDS computed the rate by defining a nursing wage for RN and LPN from BLS data and adding the same factors for Employee-Related Expenses (ERE), Program Indirect Expenses (PI), and General Administrative Expenses (GA) as for Residential Habilitation from the 2019 rate study.

The baseline Medical Residential Habilitation rate represents services provided by one RN to one individual. An adjusted reimbursement rate per individual is computed to allow Medical Residential Habilitation to be provided by a single RN for up to three (3) clients residing in a Neighborhood Group Home or Staffed Apartment or up to two (2) clients living with a Shared Living provider. Rates for nurse to client ratios greater than 1:1 are computed using the same methodology as individual PDN rates are computed under the State Plan as follows:

Two individuals: Rate for Each = 50% of 143% of baseline rate

Three individuals: Rate for Each = 33% of 214% of baseline rate

This is consistent with the methodology used by DMMA for fee for service rates for Private Duty Nursing.

Residential Habilitation: Shared Living-The rate for Residential Habilitation in a Shared Living setting is based off of the State's minimum wage and subject to available funds. DDDS pays an enhanced rate when the Shared Living provider is ASL fluent or certified and the member they support uses ASL to communicate.

Specialized Medical Equipment, not otherwise covered under the State Plan, Assistive Technology equipment and Home or Vehicle Modifications: Bids or estimates of cost for a job, equipment, or supplies are obtained from at least two vendors the individual chooses or is assisted to choose. The lowest and best price will be authorized by DDDS if the price is reasonable based on the purchase experience of the DDDS or DMMA for similar jobs, equipment or supplies and up to the maximum allowed for the service, as described in Appendix C. Bids or estimates must be obtained from at least two vendors so that DDDS can select the most reasonable bid based on the work to be performed which may take into account such elements as the time

necessary to perform the work. In the event that the time necessary to obtain two bids will result in a delay in receiving the service that could pose a health or safety risk to the participant, DDDS may waive this requirement but will use internet resources, within the time available, to identify a reasonable cost for the same or similar products and services.

Assistive Technology Assessment and Training: The fee development methodology and fee schedule rates were initially produced in 2014 as part of the Pathways to Employment SPA (see pg 29 Att 3.1.1 Pathways SPA). The rate is composed of provider cost modeling using information from independent data sources such as Delaware provider compensation studies, cost data, and fees from similar State Medicaid programs. The following list outlines the major allowable components to be used in fee development.

- Staffing Assumptions and Staff Wages
- Employee Related Expenses – Benefits, Employer Taxes (e.g., FICA, unemployment, and workers compensation)
- Staff Productivity Assumptions (e.g., time spent on billable activities)
- Program Related Expenses (e.g., management and supplies)
- Provider Overhead Expenses

They were developed as the total hourly provider costs, adjusted for productivity, and converted to the applicable unit of service.

Personal Care and Respite: For members who self-directed this service, payment rates will be established by AWC broker with input from the waiver member. The AWC provider will ensure that all rates and payments comply with the US DOL Fair Labor Standards Act. The AWC provider may reimburse for respite camps at the usual and customary fee for those entities. For members who choose to use a Home Health Agency (HHA) or Personal Attendant Services Agency (PASA), respite and personal care will be paid using the rates computed as follows. The rate for respite or personal care provided by a HHA will be set at the rate established under Attachment 4.19-B of the Delaware State Plan for Medical Assistance, page 6 for an HH Aide. This methodology and rate was approved by CMS effective 10/1/15. For respite or personal care provided by PASA, the rate will be 75% of the Medicaid rate for HHAs for an aide. This percentage was derived by comparing usual and customary hourly rates for aide services delivered through HHAs as opposed to PASA agencies and establishing the relationship between the rates. Payment for respite provided in a DDDS waiver residential facility will be made at the residential habilitation rate. Payment for respite provided in a shared living setting will be made at the residential habilitation rate for shared living providers. Payment for respite in an ICF-IID will be made using the payment methodology described in Attachment 4.19-D of the State Plan.

Community Participation service 1:2 staff ratio: The rate for Community Participation 1:1 is computed as part of the “market basket” methodology described above. Community Participation may be provided to no more than two individuals supported by a single staff person. Before the base rate is divided by 2 to compute the 1:2 ratio rate, a gross up factor is applied to the base rate for the service. This is to ensure that overhead costs are properly captured, based on the assumption that simply dividing the base rate by the 2 individuals supported by a single DSP would not adequately capture an agency's incremental costs in delivering the service.

Waiver rates are computed by DDDS and approved by DMMA. Approved rates are published on the DDDS website at the following link:

http://dhss.delaware.gov/dhss/ddds/waiver_rates.html

The public is invited to provide comment on rate determination methods during each renewal and amendment process

Appendix A: Waiver Administration and Operation

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

The waiver is operated by the state Medicaid agency.

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

The Medical Assistance Unit.

Specify the unit name:

(Do not complete item A-2)

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

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

Delaware Division of Developmental Disabilities Services

(Complete item A-2-a).

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

Specify the division/unit name:

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

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

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

The Delaware Department of Health and Social Services (DHSS) is the state agency with overall responsibility for Delaware's public health and social service programs. The DHSS houses both the Division of Medicaid and Medical Assistance (DMMA) and the Division of Developmental Disabilities Services (DDDS). The DHSS is the Single State Agency for the administration of Title XIX as per SSA 1905(a)(5).

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

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

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

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

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

SUR: DMMA maintains and operates a CMS compliant MMIS. MMIS includes a SUR sub-system. On a quarterly basis, the SUR sub-system, produces reports that compare attributes for similar providers on such dimensions as service utilization, prior authorizations, diagnosis, etc. Providers who deviate from the norm are examined further by the SUR team of auditors. A case under review may be resolved at the completion of the desk review and upon receipt of additional documentation from the provider. If it is determined a provider has been overpaid, a letter is sent by the SUR unit to the provider requesting the return of the overpayment.

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

DMMA's Office of Medical Management and Delegated Services are responsible for monitoring DDDS's operation of the DDDS Lifespan waiver. DDDS submits quarterly reports to DMMA documenting performance on waiver measures and where necessary, corrective action plans and reports on Medicaid Fair Hearings. DMMA and DDDS meet on a quarterly basis to review the operation of the DDDS waiver.

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

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

Appendix A: Waiver Administration and Operation

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

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

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

The following functions are performed by contracted entities:

Provider Relations Agent - DMMA contracts with a provider relations agent to perform specific administrative functions under the waiver, as indicated in Question # 7 of this section. Specific functions performed by this contractor include the functions below:

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

Fiscal Agent - DMMA contracts for claims processing and provider payment

Member Needs Assessment – DDDS contracts with a vendor to assess and recommend the number of direct support hours for members using a standardized assessment instrument as part of the person centered planning process and authorization of waiver services.

Waiver Rate Setting – DDDS periodically contracts with vendors to assist with waiver rate setting activities.

Incident Management System – DDDS contracts for an electronic incident management system to facilitate tracking of abuse and neglect allegations and to analyze program quality data.

Electronic Software System – DDDS contracts for an electronic case record system to facilitate case management including developing and monitoring the person centered plan and tracking provider engagement.

National Core Indicators Survey Administration – DDDS contracts with an external entity to administer the annual Core Indicators Survey to seek feedback on quality of life and quality of services from waiver members.

Direct Support Professional baseline Training – DDDS contracts with a vendor for web-based training for DSPs to ensure minimum levels of competency among waiver providers.

Targeted Case Management - DDDS contracts with one or more vendors to provide targeted case management which will include specified quality oversight functions, as described in Appendix D. The vendor also performs specified administrative case management activities as specified in the approved Cost Allocation Plan.

Agency With Choice - DDDS contracts with a vendor to manage the self-directed option for Respite and Personal Care service using the Agency With Choice model.

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

Appendix A: Waiver Administration and Operation

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

Not applicable

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

Check each that applies:

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

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

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

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

Appendix A: Waiver Administration and Operation

5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities. Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

The Division of Medicaid and Medical Assistance (DMMA) is responsible for assessing the performance of the contracted provider relations agent and fiscal agent vendors.

The Division of Developmental Disabilities Services is responsible for assessing the performance of all other vendors performing administrative activities necessary for the administration of the waiver.

Appendix A: Waiver Administration and Operation

6. Assessment Methods and Frequency. Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

For the Provider Relations and Fiscal Agent Contracts, the DMMA contract includes Service Level Agreements that specify performance metrics under the contract, such as timeliness standards for enrolling providers and for processing financial transactions. DMMA convenes a monthly meeting composed of the Chief Administrators, fiscal staff, IT staff, other DMMA managers and senior staff from the contracted entities to review the performance of the contracted fiscal agent and provider relations function. This team evaluates performance against the measures included in the vendor contracts and to discuss changes that need to be made to the MMIS or to the vendor 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.

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

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

All other DDDS contracts are monitored, managed, reviewed for performance, and renewed as necessary at a minimum of annually during the State Fiscal Year(SFY) by DDDS staff in the Community Services Unit (Member Needs Assessment, DSP Training), the Service Integrity and Enhancement Unit (Incident Management System, ECR, NCI Survey Administration) or the DDDS Office of Business Support Services (Waiver Rate Setting).

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		

Function	Medicaid Agency	Contracted Entity
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 States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

Performance Measure:

A-3: Number and Percent of DMMA/DDDS's HCBS waiver quarterly monitoring meetings during which the waiver quality assurance and quality improvement activities are discussed. Numerator: Quarterly DMMA/DDDS meetings during which DDDS waiver quality assurance and quality improvement activities are discussed; Denominator: Number of quarterly DMMA/DDDS meetings held.

Data Source (Select one):

Meeting minutes

If 'Other' is selected, specify:

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

<p>Sub-State Entity</p>	<p>Quarterly</p>	<p>Representative Sample Confidence Interval =</p> <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
<p>Other Specify:</p> <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<p>Annually</p>	<p>Stratified Describe Group:</p> <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	<p>Continuously and Ongoing</p>	<p>Other Specify:</p> <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	<p>Other Specify:</p> <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	

Data Aggregation and Analysis:

<p>Responsible Party for data aggregation and analysis (check each that applies):</p>	<p>Frequency of data aggregation and analysis(check each that applies):</p>
<p>State Medicaid Agency</p>	<p>Weekly</p>
<p>Operating Agency</p>	<p>Monthly</p>
<p>Sub-State Entity</p>	<p>Quarterly</p>
<p>Other Specify:</p> <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<p>Annually</p>
	<p>Continuously and Ongoing</p>
	<p>Other Specify:</p> <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

Performance Measure:

A-1: The percent of waiver enrollees that are within annual waiver limits. (Numerator: The total number of waiver enrollees. Denominator: The maximum number of waiver enrollees for the demonstration year per the approved application.)

Data Source (Select one):

Other

If 'Other' is selected, specify:

Annual enrollment limits from approved waiver application compared to the #of unique Medicaid IDs enrolled in the waiver for each demonstration year queried from the Title XIX AdHoc Universe database.

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly

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

Performance Measure:

A-2: Number and Percent of Medicaid Fair Hearing Decisions regarding waiver service or eligibility reviewed by the Medicaid agency (Numerator: Number of Medicaid Fair Hearing Decisions regarding waiver service or eligibility reviewed by the Medicaid agency, Denominator: Number of Fair Hearing Decisions regarding waiver service or eligibility.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Quarterly DDDS Performance Reports

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

	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
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 manages 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 or virtual 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 provider meetings, feedback from DDDS monthly meetings with Residential providers and Day/Employment providers, DDDS complaint and incident logs and Medicaid fair hearing decisions. In addition, DDDS uses data from the National Core Indicators project as an additional source of data about the satisfaction of waiver participants and to compare quality data from year to year and other states. After review of the reported information DMMA requests a corrective action plan when applicable. Any open corrective action plans are discussed no less frequently than at each quarterly DMMA/DDDS quality monitoring meeting to ensure that corrective actions are having the desired impact to drive system improvements.

b. Methods for Remediation/Fixing Individual Problems

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

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

The Division of Medicare and Medicaid Assistance (DMMA) has a Memorandum of Understanding with the Division of Developmental Disabilities Services (DDDS) delegating administrative duties with regards to the operation of the waiver. 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.

In addition, the DMMA will monitor DDDS's operation of the waiver to ensure compliance with all assurances and sub-assurances, through ongoing review of plans of care, utilization review/quality review processes provided by DDDS, and data obtained through the MMIS.

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

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

c. Timelines

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

No

Yes

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
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			

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
		Serious Emotional Disturbance			

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

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

- 1) Must be determined eligible for DDDS services per the criteria delineated in Title 16, Section 2100 of the Delaware Administrative Code. This eligibility criteria requires a diagnosis of an intellectual developmental disability (including brain injury), autism spectrum disorder or Prader Willi Syndrome assigned in the developmental period and also documented functional limitations.
- 2) Must meet established priority criteria for selection of entrance into the waiver or meet the criteria for one of the groups for which capacity has been reserved
- 3) Must meet level of care and financial eligibility for ICF/IID Services (as described in Appendix B-4)

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

Not applicable. There is no maximum age limit

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

A level higher than 100% of the institutional average.

Specify the percentage:

Other

Specify:

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

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

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

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

The following dollar amount:

Specify dollar amount:

The dollar amount (select one)

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

Specify the formula:

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

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

Specify percent:

Other:

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

can be assured within the cost limit:

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

The participant is referred to another waiver that can accommodate the individual's needs.

Additional services in excess of the individual cost limit may be authorized.

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

Other safeguard(s)

Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	2600
Year 2	2734
Year 3	2868
Year 4	3002
Year 5	3136

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	<input type="text"/>
Year 2	<input type="text"/>
Year 3	<input type="text"/>
Year 4	<input type="text"/>
Year 5	<input type="text"/>

Appendix B: Participant Access and Eligibility

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

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

Not applicable. The state does not reserve capacity.

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

Purpose(s) the state reserves capacity for:

Purposes
School graduates
Individuals at risk of homelessness or in crisis and requiring out of home placement
Individuals returning to the community after a period of institutionalization

Appendix B: Participant Access and Eligibility

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

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

School graduates

Purpose (*describe*):

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

Describe how the amount of reserved capacity was determined:

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

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

Waiver Year	Capacity Reserved
Year 1	605
Year 2	105
Year 3	107
Year 4	100
Year 5	84

Appendix B: Participant Access and Eligibility

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

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

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

Purpose (describe):

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

Describe how the amount of reserved capacity was determined:

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

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

Waiver Year	Capacity Reserved
Year 1	60
Year 2	60
Year 3	60
Year 4	60
Year 5	60

Appendix B: Participant Access and Eligibility

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

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

Individuals returning to the community after a period of institutionalization

Purpose (describe):

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

Describe how the amount of reserved capacity was determined:

The number of reserved slots was based on historical data.

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

Waiver Year	Capacity Reserved
Year 1	5
Year 2	5
Year 3	5
Year 4	5
Year 5	5

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:

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

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

The standardized risk assessment tool evaluates and applies a numerical value to the emotional health, cognitive functioning related to decision-making and judgment abilities, physical and behavioral health, environmental conditions, and economic condition of the household for both the individual as well as their primary caregiver(s). Those with the highest needs and/or highest deficits in each sub-category are given the highest numerical value that is compiled into a cumulative scoring to determine the appropriate risk category. There are three identified categories; Emergency, High Risk, and Intermediate Risk. Those that are in the Emergency category are individuals and/or their primary caregiver(s) that are at risk for abuse, neglect, or homelessness with the two subsequent categories being less critical but still indicative of the need for services.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

- a. **1. State Classification.** The state is a (*select one*):

§1634 State

SSI Criteria State

209(b) State

- 2. Miller Trust State.**

Indicate whether the state is a Miller Trust State (*select one*):

No

Yes

- b. **Medicaid Eligibility Groups Served in the Waiver.** Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the state plan. The state applies all applicable federal financial participation limits under the plan. *Check all that apply:*

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

Low income families with children as provided in §1931 of the Act

SSI recipients

Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121

Optional state supplement recipients

Optional categorically needy aged and/or disabled individuals who have income at:

Select one:

100% of the Federal poverty level (FPL)

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

Specify percentage:

Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)

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

Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)

Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)

Medically needy in 209(b) States (42 CFR §435.330)

Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)

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

Specify:

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

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

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

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

Select one and complete Appendix B-5.

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

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

Check each that applies:

A special income level equal to:

Select one:

300% of the SSI Federal Benefit Rate (FBR)

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

Specify percentage:

A dollar amount which is lower than 300%.

Specify dollar amount:

Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)

Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)

Medically needy without spend down in 209(b) States (42 CFR §435.330)

Aged and disabled individuals who have income at:

Select one:

100% of FPL

% of FPL, which is lower than 100%.

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

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

Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses spousal post-eligibility rules under §1924 of the Act.

Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (select one).

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

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

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

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

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

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

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

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

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

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

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

The state uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who

is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

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

The following standard included under the state plan

Select one:

SSI standard

Optional state supplement standard

Medically needy income standard

The special income level for institutionalized persons

(select one):

300% of the SSI Federal Benefit Rate (FBR)

A percentage of the FBR, which is less than 300%

Specify the percentage:

A dollar amount which is less than 300%.

Specify dollar amount:

A percentage of the Federal poverty level

Specify percentage:

Other standard included under the state Plan

Specify:

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

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

The following dollar amount

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

The following formula is used to determine the needs allowance:

Specify:

Other

Specify:

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

Not Applicable

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

Specify:

Specify the amount of the allowance (select one):

SSI standard

Optional state supplement standard

Medically needy income standard

The following dollar amount:

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

The amount is determined using the following formula:

Specify:

iii. Allowance for the family (select one):

Not Applicable (see instructions)

AFDC need standard

Medically needy income standard

The following dollar amount:

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

The amount is determined using the following formula:

Specify:

Other

Specify:

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

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

Select one:

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

The state does not establish reasonable limits.

The state establishes the following reasonable limits

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

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

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

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

i. Allowance for the personal needs of the waiver participant

(select one):

SSI standard

Optional state supplement standard

Medically needy income standard

The special income level for institutionalized persons

A percentage of the Federal poverty level

Specify percentage:

The following dollar amount:

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

The following formula is used to determine the needs allowance:

Specify formula:

Other

Specify:

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

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

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

Select one:

Allowance is the same

Allowance is different.

Explanation of difference:

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

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

Select one:

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

The state does not establish reasonable limits.

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

ii. Frequency of services. The state requires (select one):

The provision of waiver services at least monthly

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

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

The DDDS requires all waiver services to be delivered at least monthly to waiver members unless it is respite services. Waiver participants living in their family home whose waiver qualifying service is respite will receive this service on a frequency as specified in the person-centered plan. Respite Services for those living in the family home may be the only waiver service that is needed, considering all available paid and unpaid supports, to keep the participant from requiring institutional placement and should occur as needed to provide the caregiver(s) with a break in order to allow the participant to continue to remain living in the family home. All waiver members receive routine monthly monitoring under a Targeted Case Management State Plan authority under 1915(g).

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 a government agency under contract with the Medicaid agency.

Specify the entity:

Other

Specify:

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

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

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

Level of Care Criteria ICF/IID:

In accordance with Delaware’s eligibility criteria, an individual may be eligible if:

-He/she has a disability/disorder attributed to one or more of the following:

- Intellectual Developmental Disability, including brain injury; defined as a significant generalized limitation in intellectual functioning as evidenced by IQ scores approximately two standard deviations below the mean, or
- Autism Spectrum Disorder, or
- Prader-Willi Syndrome

AND

-Significant limitations in adaptive behavior functioning, defined as performance that is at least two standard deviations below the mean of either:

- Score on a standardized measure of conceptual, social, or practical skills; or
- Overall score on a standardized measure of conceptual, social and practical skills;

AND

-The disability originates before age 22

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

e. Level of Care Instrument(s). Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care (*select one*):

The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.

A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.

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

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

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

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

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

- g. Reevaluation Schedule.** Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule (*select one*):

Every three months

Every six months

Every twelve months

Other schedule

Specify the other schedule:

- h. Qualifications of Individuals Who Perform Reevaluations.** Specify the qualifications of individuals who perform reevaluations (*select one*):

The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.

The qualifications are different.

Specify the qualifications:

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

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

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

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

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

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:

B-a-1: The percent of participants enrolled during the period who had a level of care completed prior to the initiation of services. (Numerator: The number of participants enrolled during the period with a level of care completed prior to initiation of services. Denominator: Number of waiver participants enrolled during the period.)

Data Source (Select one):

Operating agency performance monitoring

If 'Other' is selected, specify:

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

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative

		Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

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

Performance Measures

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

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

Performance Measure:

B.c.1: The percent of initial LOC determinations completed which utilized the instrument and process described in the approved waiver. Numerator: The number of initial LOC determinations completed which utilized the instrument and process described in the approved waiver. Denominator: The number of initial LOC determinations completed.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

Performance Measure:

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

which the criteria was applied correctly. Denominator: The total number of LOC determinations where the applicant was determined not to meet LOC criteria.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly

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

Performance Measure:

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

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

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

	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
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 all waiver performance measures is reported and reviewed via the DDDS Quality Assurance Committee (QAC). The Division has consolidated all performance data, including waiver assurances, into a formalized reporting tool called "DivStat" (named after the "CompStat", "CitiStat" and "StateStat" processes developed by NYPD, the City of Baltimore and the State of Maryland, respectively). This consolidated process began during 2013. In the future, the Division intends to make this data available to the public on its website.

b. Methods for Remediation/Fixing Individual Problems

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

ii. Remediation Data Aggregation

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

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

c. Timelines

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

No

Yes

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	Day Habilitation		
Statutory Service	Personal Care		
Statutory Service	Prevocational Services		
Statutory Service	Residential Habilitation		
Statutory Service	Respite		
Statutory Service	Supported Employment - Individual		
Statutory Service	Supported Employment - Small Group		
Extended State Plan Service	Assistive Technology not otherwise covered by Medicaid		
Other Service	Behavioral Consultation		
Other Service	Community Transition		
Other Service	Home or Vehicle Accessibility Adaptations		
Other Service	Nurse Consultation		
Other Service	Specialized Medical Equipment and Supplies not otherwise covered by Medicaid		
Other Service	Supported Living		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Day Habilitation

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

04 Day Services

Sub-Category 1:

04020 day habilitation

Category 2:

04 Day Services

Sub-Category 2:

04070 community integration

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

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

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

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

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

Individuals may gather at the beginning and end of the day at a "hub" before embarking on their activities of the day but may not spend any more than 1 hour in total at the hub during the scheduled program delivery day. Other than the brief period at the beginning or end of the day, Day Habilitation non-facility based services cannot be delivered in a provider owned or managed setting.

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

When it is clearly documented in the person centered plan that the service recipient uses sign language to communicate, DDDS may authorize a higher rate for Day Habilitation services when the provider employs ASL fluent or certified staff to directly support the service recipient and their communication needs.

When it is clearly documented in the person centered plan that the service recipient has an increased behavioral support needs, DDDS may authorize a higher rate for Day Habilitation services when the provider employs Registered Behavior Technicians (RBTs) to directly support the service recipient in order to meet their behavioral support needs. The provider must also employ a Board Certified Behavior Analyst (BCBA) to oversee the RBTs.

Transportation to and from the service location may be billed separately as a component part of the service for days when it is provided.

Community Participation-

Community Participation services are the provision of scheduled activities outside of an individual's home that support acquisition, retention, or improvement in self-care, sensory-motor development, socialization, daily living skills, communication, community living, and social skills. Community Participation services include supervision, monitoring, training, education, demonstration, or support to assist with the acquisition and retention of skills and training and education in self-determination. Community Participation may include self-advocacy training to assist the participant in expressing personal preferences, self-representation, and individual rights and to make increasingly responsible choices. Each individual receiving Community Participation services works toward acquiring the skills to become an active member of the community. Services are furnished consistent with the participant's person-

centered plan (PCP). Because Community Participation is very individualized and is heavily focused on community exploration, it can only be provided in staffing ratios of one staff to each participant or one staff to two participants.

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

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

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

When it is clearly documented in the person centered plan that the service recipient uses sign language to communicate, DDDS may authorize a higher rate for Community Participation services when the provider employs ASL fluent or certified staff to directly support the service recipient and their communication needs.

When it is clearly documented in the person centered plan that the service recipient has an increased behavioral support need, DDDS may authorize a higher rate for Community Participation services when the provider employs Registered Behavior Technicians (RBTs) to directly support the service recipient in order to meet their behavioral support needs. The provider must also employ a Board Certified Behavior Analyst (BCBA) to oversee the RBTs.

Transportation to and from the service location including a "hub" may be billed separately as a component part of the service for days when it is provided.

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Day Habilitation
Agency	Community Participation

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*):

Delaware Business License

Certificate (*specify*):

Staff that are providing direct support to Deaf service recipients must be American Sign Language (ASL) certified or demonstrate ASL fluency in order for the state to provide a higher reimbursement to the provider.

Staff that are providing direct support to service recipients with an increased behavioral support need must hold a valid Registered Behavioral Technician (RBT) certification and be overseen by a Board Certified Behavior Analyst (BCBA) in order for the state to provide a higher reimbursement to the provider.

Other Standard (*specify*):

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

Must meet the DDDS Standards for Day Habilitation as specified in the DDDS Provider Standards for Home and Community Based Services.

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.

In accordance with 19 Del. Code Section 708; and 11 Del. Code, Sections 8563 and 8564, the Contractor shall utilize the Background Check Center to conduct background checks which include:

- adult abuse registry
- child protection registry
- sex offender registry
- Office of Inspected General
- Division of Professional Regulation Registry
- State and Federal Background Check

In addition, the Contractor shall obtain service letters. Contractor shall not employ individuals with adverse registry findings in the performance of contract.

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

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

The DDDS Authorized Provider Committee

Frequency of Verification:

The DDDS Office of Service Integrity and Enhancement 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: Day Habilitation

Provider Category:

Agency

Provider Type:

Community Participation

Provider Qualifications

License (*specify*):

Delaware Business License

Certificate (*specify*):

Staff that are providing direct support to Deaf service recipients must be American Sign Language (ASL) certified or demonstrate ASL fluency in order for the state to provide a higher reimbursement to the provider.

Staff that are providing direct support to service recipients with an increased behavioral support need must hold a valid Registered Behavioral Technician (RBT) certification and be overseen by a Board Certified Behavior Analyst (BCBA) in order for the state to provide a higher reimbursement to the provider.

Other Standard (*specify*):

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

Must meet the DDDS Standards for Day Habilitation as specified in the DDDS Provider Standards for Home and Community Based Services.

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.

In accordance with 19 Del. Code Section 708; and 11 Del. Code, Sections 8563 and 8564, the Contractor shall utilize the Background Check Center to conduct background checks which include:

- adult abuse registry
- child protection registry
- sex offender registry
- Office of Inspected General
- Division of Professional Regulation Registry
- State and Federal Background Check

In addition, the Contractor shall obtain service letters. Contractor shall not employ individuals with adverse registry findings in the performance of contract.

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

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

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

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

The DDDS Authorized Provider Committee

Frequency of Verification:

The DDDS Office of Service Integrity and Enhancement conducts provider compliance reviews on an annual basis or as needed based on service monitoring concerns.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Personal Care

Alternate Service Title (if any):

Personal Care

HCBS Taxonomy:

Category 1:

08 Home-Based Services

Sub-Category 1:

08030 personal care

Category 2:

08 Home-Based Services

Sub-Category 2:

08020 home health aide

Category 3:

08 Home-Based Services

Sub-Category 3:

08010 home-based habilitation

Service Definition (Scope):

Category 4:

Sub-Category 4:

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

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

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

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

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

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

In accordance with Section 601(d) of the Social Security Act, as added by Section 5001 of the Cares Act, DDDS may authorize Personal Care services in an acute care hospital to meet the needs of the service recipient that are not met through the provision of hospital services and/or to ensure the smooth transitions between acute care settings and home and community based setting and to preserve the service recipient's functions. This service will not be authorized to substitute services that the hospital is obligated to provide under Federal or State law.

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

The total expense for Personal Care and Respite services, combined, is limited to \$3,500 per waiver participant per waiver demonstration year. Personal care cannot be provided to waiver participants who receive residential habilitation in a provider-managed setting. If a waiver participant enrolled for less than an entire demonstration year, the annual limit will be prorated by the number of months remaining in the demonstration year.

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

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

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

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

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agency
Agency	Personal Attendant Services Agency (PASA)
Agency	Agency with Choice

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Personal Care

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License (specify):

State Home Health Agency License from the Delaware Office of Health Care Quality per Delaware Administrative Code Title 16, sections 4410 Skilled Home Health Agencies (Licensure) or 4406 Home Health Agencies –Aide Only (Licensure).

Certificate (specify):

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

The DDDS Authorized Provider Committee

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Personal Care

Provider Category:

Agency

Provider Type:

Personal Attendant Services Agency (PASA)

Provider Qualifications

License *(specify):*

State Business license or 501 (c)(3) status; and Licensure from the Delaware Office Health Care Quality per Delaware Administrative Code Title 16, section 3345 Personal Assistance Services Agencies Certificate.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

The DDDS Authorized Provider Committee

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Personal Care

Provider Category:

Agency

Provider Type:

Agency with Choice

Provider Qualifications

License *(specify):*

Delaware Business License

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Delaware Division of Developmental Disabilities Services

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: 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):

HCBS Taxonomy:

Category 1:

04 Day Services

Sub-Category 1:

04010 prevocational services

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

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

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

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

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

The optimal outcome for Prevocational Services is competitive, integrated employment in the community for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

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

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

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

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

When it is clearly documented in the person centered plan that the service recipient uses sign language to

communicate, DDDS may authorize a higher rate for Pre-Vocational services when the provider employs ASL fluent or certified staff to directly support the service recipient and their communication needs.

When it is clearly documented in the person centered plan that the service recipient has an increased behavioral support need, DDDS may authorize a higher rate for Pre-Vocational services when the provider employs Registered Behavior Technicians (RBTs) to directly support the service recipient in order to meet their behavioral support needs. The provider must also employ a Board Certified Behavior Analyst (BCBA) to oversee the RBTs.

Transportation to and from the service location may be billed as a component part of the service for days when it is provided.

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

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

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Prevocational Services

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Prevocational Services

Provider Category:

Agency

Provider Type:

Prevocational Services

Provider Qualifications

License (*specify*):

Delaware Business License

Certificate (*specify*):

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

Staff that are providing direct support to Deaf service recipients must be American Sign Language (ASL) certified or demonstrate ASL fluency in order for the state to provide a higher reimbursement to the provider.

Staff that are providing direct support to service recipients with an increased behavioral support need must hold a valid Registered Behavioral Technician (RBT) certification and be overseen by a Board Certified Behavior Analyst (BCBA) in order for the state to provide a higher reimbursement to the provider.

Other Standard (*specify*):

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

Must meet the DDDS Standards for Prevocational Services as specified in the DDDS Provider Standards for Home and Community Based Services.

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.

In accordance with 19 Del. Code Section 708; and 11 Del. Code, Sections 8563 and 8564, the Contractor shall utilize the Background Check Center to conduct background checks which include:

- adult abuse registry
- child protection registry
- sex offender registry
- Office of Inspected General
- Division of Professional Regulation Registry
- State and Federal Background Check

In addition, the Contractor shall obtain service letters. 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 Service Integrity and Enhancement conducts provider compliance reviews on an annual basis or as needed based on service monitoring concerns.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Residential Habilitation

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

02 Round-the-Clock Services

Sub-Category 1:

02011 group living, residential habilitation

Category 2:

02 Round-the-Clock Services

Sub-Category 2:

02021 shared living, residential habilitation

Category 3:

16 Community Transition Services

Sub-Category 3:

16010 community transition services

Service Definition (Scope):

Category 4:

02 Round-the-Clock Services

Sub-Category 4:

02013 group living, other

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

Residential Habilitation can include assistance with acquisition, retention, or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making & household chores, eating & 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 member's person centered plan. The amount, duration, frequency, and scope of these services are based on the member's need.

Payments for residential habilitation are not made for room and board. Transportation is a component part of Residential Habilitation 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, up-keep and improvement. The methodology by which the costs of room and board are excluded from payments for Shared Living is described in Appendix I.

The following activities may be performed under Residential Habilitation:

- Self-advocacy training that may include training to assist in expressing personal preferences, self-representation, and individual rights and to make increasingly responsible choices.
- Independent living training which may include personal care, household services, child & 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, personal finances, planning and decision making.
- Implementation and follow-up from mental health counseling or behavioral or other therapeutic interventions by residential staff, under the direction of a professional, that are aimed at increasing the overall effective functioning of an individual.
- Emergency Preparedness
- Community access services that explore available community resources, natural supports available to the member, and develop methods to access additional services/supports/activities desired by the member.

Supervision which may include a provider safeguarding an individual with developmental disabilities or utilizing technology for the same purpose.

Residential Habilitation may be provided in a neighborhood group home setting, a supervised or staffed apartment (aka community living arrangement), or a shared living arrangement.

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. DDDS prefers one-person Shared Living homes but allows for exceptions to the one-person rule for married couples or the preference of the individual, including siblings or friends who desire to live in the same home. Exceptions may be granted for the maximum number of 3. Separate payment is not made for homemaker or chore services furnished to a participant receiving shared living arrangement services, since these services are integral to and inherent in the provision of shared living arrangement services.

The Residential Habilitation provider must actively promote and be capable of providing opportunities for full

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

When it is clearly documented in the person-centered plan that the service recipient uses sign language to communicate, DDDS may authorize a higher rate for Residential Habilitation services provided by either an agency or a Shared Living Provider where the person supporting the member is ASL fluent or certified.

When it is clearly documented in the person centered plan that the service recipient has an increased behavioral support need, DDDS may authorize a higher rate for Residential Habilitation services when the provider employs Registered Behavior Technicians (RBTs) to directly support the service recipient in order to meet their behavioral support needs. The provider must also employ a Board Certified Behavior Analyst (BCBA) to oversee the RBTs.

Residential Habilitation services may be delivered out-of-state (i.e. out of network) because services within the State are unavailable or insufficient to meet the person's needs. In making this determination, careful consideration must be given to the reason for providing the services, as well as alternatives which may contribute more to an individual's ability to receive quality supports in a community based setting. When this occurs, the provider must either agree to meet all of the provider requirements under the DDDS waiver or DDDS may accept the provider qualification standards of the other state or DDDS may enter into an interstate agreement with the other state that will specify the role of each state in ensuring that waiver services are delivered in accordance with specified standards. DDDS remains responsible for the assurance of the health and welfare of the beneficiary even where on-site monitoring may be performed by the home state under the interstate agreement.

In these cases the provider of out-of-State services must be chosen just as freely as the provider of in-State services. The provider must have a provider agreement with the Medicaid agency and Medicaid payment must be made directly to the provider.

DDDS may authorize a retainer payment to a Shared Living provider for periods when the waiver member is hospitalized or is temporarily absent from the home for reasons other than hospitalization. For hospitalizations DDDS may authorize up to 7 days within each 30 day period. The 30-day count begins with the first day of hospitalization or the first day of a new hospitalization following a previous 30-day period and return back to the shared living residence. An individual may be absent from the shared living provider's home for reasons other than hospitalization for a period of 18 days per year without interruption of reimbursement as long as the reasons for such absences are documented in the individual's person-centered plan.

In accordance with Section 601(d) of the Social Security Act as added by Section 5001 of the Cares Act, DDDS may authorize Residential Habilitation services in an acute care hospital to meet the needs of the service recipient that are not met through the provision of hospital services and/or to ensure the smooth transitions between acute care settings and home and community based setting and to preserve the service recipient's functions. This service will not be authorized to substitute services that the hospital is obligated to provide under Federal or State law.

Medical Residential Habilitation-

Medical Residential Habilitation shall mean a type of residential service selected by the waiver member, that includes the provision of direct skilled nursing services and habilitative services and supports that enable a participant to acquire, retain, or improve skills necessary to reside in a community-based setting. In addition, Medical Residential Habilitation supports each resident's independence and full integration into the community, ensures each resident's choice and rights, and comports fully with standards applicable to HCBS settings delivered under Section 1915(c) of the Social Security Act, including those requirements applicable to provider-owned or controlled homes, except as supported by the individual's specific assessed need and set forth in the person-centered plan.

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

Medical Residential Habilitation must be medically necessary and provided in accordance with a physician's order and the person-centered plan. The participant who receives Medical Residential Habilitation, must have a medical diagnosis and treatment needs that would justify the provision of direct skilled nursing services that must be

provided directly by a registered nurse (RN) or a licensed practical nurse (LPN) operating within his/her scope of practice under state law. Nursing services must be needed on a daily basis and at a level which cannot, for practical purposes, be provided through pre-scheduled skilled nursing visits during the course of a day and which cannot be more cost-effectively provided through a combination of waiver services and other nursing services available under the state plan. There must be an order by a physician, physician assistant, or nurse practitioner for one or more specifically identified skilled nursing services, excluding nursing assessment or oversight, which must be provided directly by a registered nurse or licensed practical nurse under the supervision of a registered nurse, operating within his/her scope of practice under state law.

The Medical Residential Habilitation provider may elect to have the nurse also be responsible for the provision of non-skilled services including eating, toileting, grooming, and other activities of daily living, needed by the individual during the period that Medical Residential Habilitation services are authorized and provided, unless such assistance cannot be safely provided by the Nurse while also attending to the individual’s skilled nursing needs. However, the need for Medical Residential Habilitation shall depend only on the skilled nursing needs of the participant. Medical Residential Habilitation shall be provided in an appropriately licensed or DDDS-certified residential setting, including a neighborhood group home, a supervised or staffed apartment (community living arrangement), or a shared living arrangement.

The Medical Residential Habilitation provider shall be responsible for providing the level of services and supports specified in the person centered plan, including skilled nursing services, up to 24 hours per day 7 days a week when the participant is not attending work or other day services, based on the individualized needs of each participant; however, a nurse is not required to be present in the home during those time periods when skilled nursing services are not medically necessary. One nurse may provide services to more than one person supported in the home during the same time period if it is medically appropriate to do so.
(see Main - "Additional Needed Information (Optional) text box for the continuation of service specifications for Medical Residential Habilitation.

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

The need for residential services must be demonstrated in the individual's care plan and must describe the exploration of other services in more integrated settings and the determination that they would not meet the individual's needs. The amount, frequency, and duration, and scope of these services are specified by the individual's care plan. The services under the waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with the waiver objectives of avoiding institutionalization.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Shared Living Provider
Agency	Residential Habilitation Agency

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Residential Habilitation

Provider Category:

Individual

Provider Type:

Shared Living Provider

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

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

In order to provide Medical Residential Habilitation, the Shared Living Provider must also be a registered nurse (RN) or advance practice registered nurse (APRN) who has a professional license from the State of Delaware to provide nursing services as prescribed in Delaware Code, Title 24, Chapter 19, Section 1910.

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

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

Must meet the DDDS Standards for Shared Living as specified in the DDDS Provider Standards for Home and Community Based Services.

Medical Residential Habilitation Nurses 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 and Mental Health support needs), or who have more significant health related challenges by meeting specified DDDS training requirements.

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 Service Integrity and Enhancement 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:

Agency

Provider Type:

Residential Habilitation Agency

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

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

<p>Medical Residential Habilitation Nurses must be a registered nurse (RN), licensed practical nurse (LPN) or advance practice registered nurse (APRN) who has a professional license from the State of Delaware to provide nursing services as prescribed in Delaware Code, Title 24, Chapter 19, Sections 1910 and 1914.</p>
--

Certificate (*specify*):

<p>Staff that are providing direct support to Deaf service recipients must be American Sign Language (ASL) certified or demonstrate ASL fluency in order for the state to provide a higher reimbursement to the provider.</p>

<p>Staff that are providing direct support to service recipients with an increased behavioral support need must hold a valid Registered Behavioral Technician (RBT) certification and be overseen by a Board Certified Behavior Analyst (BCBA) in order for the state to provide a higher reimbursement to the provider.</p>
--

Other Standard (*specify*):

<p>Must be credentialed by the Division of Developmental Disabilities as a qualified provider of Residential Habilitation.</p>
--

<p>For Neighborhood Group Homes: Must meet the DDDS Standards for Neighborhood Group Homes as specified in the DDDS Provider Standards for Home and Community Based Services.</p>

<p>For Staffed Apartments: Must meet the DDDS Standards for Community Living Arrangements as specified in the DDDS Provider Standards for Home and Community Based Services.</p>
--

<p>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.</p>
--

<p>Out of state providers must submit evidence of satisfactory licensure or certification by the state agency designated to perform that function.</p>
--

<p>Medical Residential Habilitation Nurses 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 and Mental Health support needs), or who have more significant health related challenges by meeting specified DDDS training requirements.</p>
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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 Health Care Quality 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 Service Integrity and Enhancement 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:

Respite

Alternate Service Title (if any):

Respite

HCBS Taxonomy:

Category 1:

09 Caregiver Support

Sub-Category 1:

09012 respite, in-home

Category 2:

08 Home-Based Services

Sub-Category 2:

08020 home health aide

Category 3:

09 Caregiver Support

Sub-Category 3:

09011 respite, out-of-home

Service Definition (Scope):

Category 4:

09 Caregiver Support

Sub-Category 4:

09011 respite, out-of-home

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

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

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

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

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

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

For respite that is provided in a licensed Group Home, Community Living Arrangement, or shared living arrangement, the state will ensure that the needs and best interest of the other residents in the home are taken into account and they agree to the proposed arrangement before authorizing the setting for the purpose of a respite service. Prior-approval is required by the Director of Community Services or Designee for an individual living in the family home to access respite services in a Group Home or Community Living Arrangement.

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

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

The total payment for Respite and Personal Care services, combined, is limited to \$3,500 per waiver participant per waiver demonstration year. Respite cannot be provided to waiver participants who receive residential habilitation in a provider-managed setting. If a waiver participant enrolled for less than an entire demonstration year, the annual limit will be prorated by the number of months remaining in the demonstration year.

Respite and Personal Care provided in a public ICF-IID is limited to 15 days per state fiscal year.

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

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

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

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency

Provider Type:

Agency with Choice

Provider Qualifications

License (specify):

Delaware Business License

Certificate (specify):

Other Standard (specify):

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Delaware Developmental Disabilities Services

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency

Provider Type:

Public ICF/IID

Provider Qualifications

License (specify):

Must be licensed by the Delaware Division of Health Care Quality as a nursing facility.

Certificate (specify):

Must be certified by the Delaware Division of Health Care Quality as meeting the federal qualifications of an Intermediate Care Facility for Individuals with Intellectual Disabilities.

Other Standard (specify):

Must be owned or operated by a government entity

Verification of Provider Qualifications

Entity Responsible for Verification:

The DDDS Authorized Provider Committee

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency

Provider Type:

Personal Attendant Services Agency (PASA)

Provider Qualifications

License (specify):

State Personal Attendant Services Agency License from the Delaware Office of Health Care Quality per Delaware Administrative Code Title 16, section 3345 Personal Assistance Services Agencies

Certificate (specify):

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

The DDDS Authorized Provider Committee

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency

Provider Type:

Shared Living Provider

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Must meet the DDDS Standards for Shared Living as specified in the DDDS Provider Standards for Home and Community Based Services.

Verification of Provider Qualifications

Entity Responsible for Verification:

Delaware Division of Developmental Disabilities Services

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License (*specify*):

State Personal Attendant Services Agency License from the Delaware Office of Health Care Quality per Delaware Administrative Code Title 16, section 4410 Skilled Home Health Agencies (Licensed) or 4406 Home Health Agencies-Aide Only (Licensure).

Certificate (*specify*):

Other Standard (*specify*):

Verification of Provider Qualifications

Entity Responsible for Verification:

The DDDS Authorized Provider Committee

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency

Provider Type:

DDDS Residential Habilitation Agency

Provider Qualifications

License (*specify*):

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

Certificate (*specify*):

Other Standard (*specify*):

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

Must meet the DDDS Standards for Community Living Arrangements or Neighborhood Group Homes as specified in the DDDS Provider Standards for Home and Community Based Services.

Out of state providers must submit evidence of satisfactory licensure or certification by the state agency designated to perform that function.

Verification of Provider Qualifications

Entity Responsible for Verification:

Delaware Division of Developmental Disabilities Services

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

Supported Employment - Individual

HCBS Taxonomy:

Category 1:

03 Supported Employment

Sub-Category 1:

03021 ongoing supported employment, individual

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

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

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

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

When it is clearly documented in the person centered plan that the service recipient uses sign language to communicate, DDDS may authorize a higher rate for Supported Employment services when the provider employs ASL fluent or certified staff to directly support the service recipient and their communication needs.

When it is clearly documented in the person centered plan that the service recipient has an increased behavioral support need, DDDS may authorize a higher rate for Supported Employment services when the provider employs Registered Behavior Technicians (RBTs) to directly support the service recipient in order to meet their behavioral support needs. The provider must also employ a Board Certified Behavior Analyst (BCBA) to oversee the RBTs.

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

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*):

Delaware Business License

Certificate (*specify*):

Staff that are providing direct support to Deaf service recipients must be American Sign Language (ASL) certified or demonstrate ASL fluency in order for the state to provide a higher reimbursement to the provider.

Staff that are providing direct support to service recipients with an increased behavioral support need must hold a valid Registered Behavioral Technician (RBT) certification and be overseen by a Board Certified Behavior Analyst (BCBA) in order for the state to provide a higher reimbursement to the provider.

Other Standard (*specify*):

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

Must meet the DDDS Standards for Supported Employment as specified in the DDDS Provider Standards for Home and Community Based Services.

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.

In accordance with 19 Del. Code Section 708; and 11 Del. Code, Sections 8563 and 8564, the Contractor shall utilize the Background Check Center to conduct background checks which include:

- adult abuse registry
- child protection registry
- sex offender registry
- Office of Inspected General
- Division of Professional Regulation Registry
- State and Federal Background Check

In addition, the Contractor shall 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:

Office of Service Integrity and Enhancement conducts provider compliance reviews on an annual basis or as needed based on service monitoring concerns.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Habilitation

Alternate Service Title (if any):

Supported Employment - Small Group

HCBS Taxonomy:

Category 1:

03 Supported Employment

Sub-Category 1:

03022 ongoing supported employment, group

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

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

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

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

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

When it is clearly documented in the person centered plan that the service recipient uses sign language to communicate, DDDS may authorize a higher rate for Group Supported Employment services when the provider employs ASL fluent or certified staff to directly support the service recipient and their communication needs.

When it is clearly documented in the person centered plan that the service recipient has an increased behavioral support need, DDDS may authorize a higher rate for Group Supported Employment services when the provider employs Registered Behavior Technicians (RBTs) to directly support the service recipient in order to meet their behavioral support needs. The provider must also employ a Board Certified Behavior Analyst (BCBA) to oversee the RBTs.

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

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

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Supported Employment

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Supported Employment - Small Group

Provider Category:

Agency

Provider Type:

Supported Employment

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Staff that are providing direct support to Deaf service recipients must be American Sign Language (ASL) certified or demonstrate ASL fluency in order for the state to provide a higher reimbursement to the provider.

Staff that are providing direct support to service recipients with an increased behavioral support need must hold a valid Registered Behavioral Technician (RBT) certification and be overseen by a Board Certified Behavior Analyst (BCBA) in order for the state to provide a higher reimbursement to the provider.

Other Standard (*specify*):

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

Must meet the DDDS Standards for Supported Employment as specified in the DDDS Provider Standards for Home and Community Based Services.

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.

In accordance with 19 Del. Code Section 708; and 11 Del. Code, Sections 8563 and 8564, the Contractor shall utilize the Background Check Center to conduct background checks which include:

- adult abuse registry
- child protection registry
- sex offender registry
- Office of Inspected General
- Division of Professional Regulation Registry
- State and Federal Background Check

In addition the Contractor shall 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 Service Integrity and Enhancement conducts provider compliance reviews on an annual basis or as needed based on service monitoring concerns.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Assistive Technology not otherwise covered by Medicaid

HCBS Taxonomy:

Category 1:

14 Equipment, Technology, and Modifications

Sub-Category 1:

14031 equipment and technology

Category 2:

14 Equipment, Technology, and Modifications

Sub-Category 2:

14031 equipment and technology

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

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

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

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

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

Participants may only receive Assistive Technology if it has been determined to be medically necessary by a competent health professional including, OT, PT, Speech Pathologist, audiologist, or certified AT specialist. Participants must explore off the shelf products before DDDS will approve the purchase of any specialized assistive technology equipment. Participants are limited to the lowest cost option that will meet the person's needs, including refurbished equipment, but also take into account the timeliness of delivery to meet an immediate need and the availability of warranties.

Purchase of equipment is limited to \$500, including maintenance every 3 years; with exceptions considered for cases of exceptional need both for cost and frequency. The limit for Assistive Technology was based on available state funds.

Service Delivery Method (check each that applies):

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Assistive Technology Professional Agency
Agency	Assistive Technology Supplier
Individual	Assistive Technology Professional

Appendix C: Participant Services

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

Service Type: Extended State Plan Service

Service Name: Assistive Technology not otherwise covered by Medicaid

Provider Category:

Agency

Provider Type:

Assistive Technology Professional Agency

Provider Qualifications

License (specify):

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

Certificate (specify):

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

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

The DDDS Authorized Provider Committee

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Extended State Plan Service

Service Name: Assistive Technology not otherwise covered by Medicaid

Provider Category:

Agency

Provider Type:

Assistive Technology Supplier

Provider Qualifications

License (specify):

Delaware Business License
 Delaware Hearing Aid Dispenser license

Certificate (specify):

Other Standard (specify):

Durable Medical Equipment Suppliers must be enrolled with Medicaid as a state plan Durable Medical Equipment Provider.
 Assistive Technology Suppliers
 Entities qualified to supply AT equipment may include non-traditional off the shelf suppliers of equipment and technology as prescribed by a competent professional working within the scope of his or her practice.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Extended State Plan Service

Service Name: Assistive Technology not otherwise covered by Medicaid

Provider Category:

Individual

Provider Type:

Assistive Technology Professional

Provider Qualifications

License (*specify*):

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

Certificate (*specify*):

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

Other Standard (*specify*):

Verification of Provider Qualifications

Entity Responsible for Verification:

The DDDS Authorized Provider Committee

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:

Behavioral Consultation

HCBS Taxonomy:

Category 1:

10 Other Mental Health and Behavioral Services

Sub-Category 1:

10040 behavior support

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (*Scope*):

Category 4:

Sub-Category 4:

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. This service may be delivered in the individual's place of residence or in another community setting as described in the person centered plan.

The Behavioral Consultation service includes a functional behavioral assessment, development of a behavior support plan, and implementation of the behavioral support plan to enable individuals, families, and service providers to effectively support the waiver participants in their attainment of goals they have set. The Behavioral Consultation providers use an industry-standard functional behavioral assessment to determine the needs of each individual. The service includes periodic monitoring of the effectiveness of the behavioral support plan with requisite adjustments as indicated.

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

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

Specifically, Behavioral Consultation includes:

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

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

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

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

- Identify potential mental health practitioners
- Act as a liaison between the individual, his/her support team and the service provider to ensure that the mental health practitioner receives information necessary to appropriately treat the person
- Instruct the team on how to carry out the prescribed treatment.
- Develops behavior support plans to ensure that the individual is supported in accordance with the principles of

best practice.

- Monitors progress/treatment for people who have a behavior support plan
- Serves as a support team participants for people who have a behavior support plans
- Prepares necessary documentation for oversight committees such as PROBIS and HRC in accordance with DDDS policies
- Attend mental health appointments when specified in the Behavior Support Plan

In accordance with Section 601(d) of the Social Security Act, as added by Section 5001 of the Cares Act, DDDS may authorize Behavioral Consultation services in an acute care hospital to meet the needs of the service recipient that are not met through the provision of hospital services and/or to ensure the smooth transitions between acute care settings and home and community based setting and to preserve the service recipient’s functions. This service will not be authorized to substitute services that the hospital is obligated to provide under Federal or State law.

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

The services under the waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with the waiver objectives of avoiding institutionalization.

Service Delivery Method (check each that applies):

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Behavior Consultation

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Consultation

Provider Category:

Agency

Provider Type:

Behavior Consultation

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

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

Must meet the DDDS Standards for Behavioral Consultation as specified in the DDDS Provider Standards for Home and Community Based Services.

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

Practitioner credentials-

Tier One: Bachelor’s degree in behavioral or social science or related field, or

Tier Two: Master’s degree in behavioral or social science or related field, or Board Certified Assistant Behavior Analyst (BCaBA), or Master of Social Work (MSW), or Licensed Clinical Social Worker (LCSW), or

Tier Three: Doctorate degree in behavioral or social science or related field, or Board Certified Behavior Analyst (BCBA), or Board Certified Behavior Analyst-Doctoral (BCBA-D), or Doctorate in Social Work (DSW), or Doctorate in Psychology (Psych D)

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

In accordance with 19 Del. Code Section 708; and 11 Del. Code, Sections 8563 and 8564, the Contractor shall utilize the Background Check Center to conduct background checks which include:

- adult abuse registry
- child protection registry
- sex offender registry
- Office of Inspected General
- Division of Professional Regulation Registry
- State and Federal Background Check

In addition, the Contractor shall obtain service letters. Contractor shall not employ individuals with adverse registry findings in the performance of contract.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Developmental Disabilities Services

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Community Transition

HCBS Taxonomy:

Category 1:

16 Community Transition Services

Sub-Category 1:

16010 community transition services

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Community Transition Service

Payments may be made for Community Transition to facilitate transition from an institution to a community setting, consistent with SMDL 02-008, for individuals who transition from provider-operated settings to their own private residence in the community. Community Transition will enable individuals whose means are limited to furnish and decorate his or her bedroom in a manner of his or her choosing consistent with the HCBS Settings Rule and to foster independence. Community Transition includes the reasonable, documented cost of one-time expenses and services necessary to occupy a domicile in the community, including:

- Essential furnishings, including: Bed frame, mattress and box spring or futon, dresser, wardrobe, chair, trash can, lamps, desk, small table/nightstand, bookcase, linens and pillows, window covering, wall decorations, mirrors
- Bath mats & shower curtain, grab bars and other free-standing implements to increase stability in the bathroom
- Small appliances including blow dryer, vacuum cleaner, coffee maker, toaster
- Toiletries
- Kitchen items, including: hand towels, dishes, drinkware, flatware & utensils, knives, cookware, bowls and food storage
- Initial supply of cleaning supplies and laundry
- Initial supply of bathroom supplies
- Clothing
- Moving expenses
- Security deposits
- Set-up fees and deposits for utility access (telephone, electric, utility, cable)
- Pest eradication
- Cleaning service prior to occupancy
- Lock and key

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

Community Transition Services are furnished only to the extent that they are reasonable and necessary as determining through the service plan development process, clearly identified in the service plan and the person is unable to meet such expense or when the services cannot be obtained from other sources.

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

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

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Residential Habilitation Agency
Agency	DDDS Approved Community Transition Provider

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Community Transition

Provider Category:

Agency

Provider Type:

Residential Habilitation Agency

Provider Qualifications

License (*specify*):

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

Certificate (*specify*):

Other Standard (*specify*):

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

For Neighborhood Group Homes: Must meet the DDDS Standards for Neighborhood Group Homes as specified in the DDDS Provider Standards for Home and Community Based Services.

For Staffed Apartments: Must meet the DDDS Standards for Community Living Arrangements as specified in the DDDS Provider Standards for Home and Community Based Services.

Out of state providers must submit evidence of satisfactory licensure or certification by the state agency designated to perform that function.

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 Health Care Quality 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 Service Integrity and Enhancement conducts provider compliance reviews on an annual basis or as needed based on service monitoring concerns.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Community Transition

Provider Category:

Agency

Provider Type:

DDDS Approved Community Transition Provider

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

Must be a DDDS-qualified provider of Community Transition Services

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Developmental Disabilities Services

Frequency of Verification:

Before services are initially rendered.

Appendix C: Participant Services

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:

Home or Vehicle Accessibility Adaptations

HCBS Taxonomy:

Category 1:

14 Equipment, Technology, and Modifications

Sub-Category 1:

14020 home and/or vehicle accessibility adaptations

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Home Modifications

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

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

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

The following items are specifically excluded:

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

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

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

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

Limited to \$6,000.00 per member every 5 years, inclusive of both services. The limit for home/vehicle modifications was based on experience from Delaware’s Money Follows the Person program and is consistent with the limit for Delaware’s LTSS home modification benefit limit under the 1115 waiver. Exceptions may be granted by the Director of Community Services or designee with documented justification related to the health, welfare, and safety of the participant as outlined in the person-centered plan

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed contractor
Agency	Vendors-Vehicle Modifications
Individual	Licensed contractor

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Home or Vehicle Accessibility Adaptations

Provider Category:

Agency

Provider Type:

Licensed contractor

Provider Qualifications

License (*specify*):

Delaware Business License

Certificate (*specify*):

Other Standard (*specify*):

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Delaware Division of Developmental Disabilities Services.

Frequency of Verification:

Prior to authorization of service and payment

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Home or Vehicle Accessibility Adaptations

Provider Category:

Agency

Provider Type:

Vendors-Vehicle Modifications

Provider Qualifications

License (specify):

Delaware Business License

Certificate (specify):

Other Standard (specify):

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Delaware Division of Developmental Disabilities Services

Frequency of Verification:

Prior to authorization of service and payment

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Home or Vehicle Accessibility Adaptations

Provider Category:

Individual

Provider Type:

Licensed contractor

Provider Qualifications

License (specify):

Delaware Business License

Certificate (*specify*):

Other Standard (*specify*):

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Delaware Division of Developmental Disabilities Services

Frequency of Verification:

Prior to authorization of service and payment

Appendix C: Participant Services

C-1/C-3: 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:

Nurse Consultation

HCBS Taxonomy:

Category 1:

11 Other Health and Therapeutic Services

Sub-Category 1:

11010 health monitoring

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Comment):

Nurse Consultation:

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

Nurse 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 comprehensive Nursing Assessment and all component parts, and monitors the effectiveness of health interventions, updating the assessment as needed, but no less frequently than annually during robust pre-planning for the person-centered plan. Component parts of the Nursing Assessment includes:
 - Diagnoses and conditions, allergies, medications, labs/radiology, utilization of medical services, vital signs, height/weight, nutrition, oral/dental, systems summary, behavior symptoms and management, infection control, communication/vision/hearing, activities of daily living, and health practices
 - Fall Risk Assessment
 - Aspiration Assessment
 - Medical Alert Form
 - Significant Medical Conditions
 - any other specific health protocols necessary to support the service recipient's health
- Completes on-site medication/record reviews for Neighborhood Homes and Community Living Arrangements (e.g. the monthly Health and Medication Review as outlined in all applicable DDDS policies and procedures.) Findings of all reviews shall be recorded in the electronic case record and any adverse findings must be reported as a critical incident for follow up and possible corrective action.
- Completes monthly contacts (by phone or in person) and at least 2 home visits annually for those service recipients that are level 1-2 on the Assessment of Need for services and a minimum of quarterly home visits for those service recipients that are level 3 and above that reside in a Shared Living home. During the on-site visit the nurse will verify that medication storage follows the DDDS guidelines.
- Completes Quarterly Nursing Reviews for individuals residing with Shared Living Providers.
- Monitors, reviews, and reconciles medication forms monthly and takes appropriate action as indicated for individuals residing with Shared Living Providers.
- In emergency situations, may perform a medical procedure within the registered nurse's scope of practice, experience and proficiency.
- Participates as an Interdisciplinary Team member.
- Attends the annual Person-Centered Plan (PCP) meetings and other meetings as appropriate.
- Provides ongoing health related training for waiver participants, direct support professionals and families.
- Maintains on-going accurate, timely, and relevant documentation of all health care issues. Updates all required documents as changes in health conditions warrant.
- Communicates to individuals/families/guardians/other service providers about health care issues.
- Attends medical appointments with the individual if indicated/warranted.
- Assists in obtaining resources and acts as an advocate and coordinator of health care services ensuring appropriate

treatment, follow-up and resolution to healthcare issues occur.

- Assists waiver participants to transition from one residential living arrangement to another.
- Adheres to DDDS healthcare protocols.
- Monitors medication administration activities performed by direct care staff or consumers and may provide consultation to a direct support professional regarding medication administration in specific situations where nursing expertise is required under the Nurse Practice Act.

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

In accordance with Section 601(d) of the Social Security Act, as added by Section 5001 of the Cares Act, DDDS may authorize Nurse Consultation services in an acute care hospital to meet the needs of the service recipient that are not met through the provision of hospital services and/or to ensure the smooth transitions between acute care settings and home and community based setting and to preserve the service recipient’s functions. This service will not be authorized to substitute services that the hospital is obligated to provide under Federal or State law.

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

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

Service Delivery Method (check each that applies):

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Nurse Consultation

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Nurse Consultation

Provider Category:

Agency

Provider Type:

Nurse Consultation

Provider Qualifications

License (specify):

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

Certificate (specify):

Other Standard (specify):

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

Nurse Consultation practitioners must have minimum education, training and/or experience demonstrating competence as follows.

•Practitioner credentials:

Tier One: Licensed Registered Nurse, or

Tier Two: Licensed Registered Nurse with two or more years Intellectual/Developmental Disability (IDD) experience, or

Tier Three: Licensed Registered Nurse with two or more years Intellectual/Developmental Disability (IDD) experience and national certification with specialty in intellectual/Developmental Disability (IDD).

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:

Specialized Medical Equipment and Supplies not otherwise covered by Medicaid

HCBS Taxonomy:

Category 1:

17 Other Services

Sub-Category 1:

17010 goods and services

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Specialized Medical Equipment and Services not otherwise covered by Medicaid

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

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

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

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Durable Medical Equipment Supplier

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Equipment and Supplies not otherwise covered by Medicaid

Provider Category:

Agency

Provider Type:

Durable Medical Equipment Supplier

Provider Qualifications**License (specify):**

Delaware Business License

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

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

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

Delaware Division of Developmental Disabilities Services

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Supported Living

HCBS Taxonomy:**Category 1:**

08 Home-Based Services

Sub-Category 1:

08010 home-based habilitation

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

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

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

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

- activities of daily living, such as personal grooming and cleanliness, domestic chores, or meal preparation , including planning, shopping, cooking, and storage activities;
- social and adaptive skills necessary for participating in community life, such as building and maintaining interpersonal relationships, including a Circle of Support that includes natural supports;
- 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
- facilitating connections to community-based activities

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

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

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

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

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

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Residential Habilitation Agency
Agency	DDDS Approved Supported Living Provider

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Supported Living

Provider Category:

Agency

Provider Type:

Residential Habilitation Agency

Provider Qualifications

License (specify):

Delaware Business License

Certificate (specify):

Other Standard (specify):

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

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

Must adhere to all standards, policies, and guidelines in the State of Delaware Supported Living Standards including:

Must meet the DDDS Standards for Supported Living as specified in the DDDS Provider Standards for Home and Community Based Services.

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

In accordance with 19 Del. Code Section 708; and 11 Del. Code, Sections 8563 and 8564, the Contractor shall utilize the Background Check Center to conduct background checks which include:

- adult abuse registry
- child protection registry
- sex offender registry
- Office of Inspected General
- Division of Professional Regulation Registry
- State and Federal Background Check

In addition, the Contractor shall obtain service letters. 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:

Delaware Division of Developmental Disabilities Services

Frequency of Verification:

The DDDS Office of Service Integrity and Enhancement conducts provider compliance reviews on an annual basis or as needed based on service monitoring concerns.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Supported Living

Provider Category:

Agency

Provider Type:

DDDS Approved Supported Living Provider

Provider Qualifications

License *(specify):*

Delaware Business License

Certificate *(specify):*

Other Standard *(specify):*

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

Must adhere to all standards, policies, and guidelines in the State of Delaware Supported Living Standards including:

Must meet the DDDS Standards for Supported Living as specified in the DDDS Provider Standards for Home and Community Based Services.

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

In accordance with 19 Del. Code Section 708; and 11 Del. Code, Sections 8563 and 8564, the Contractor shall utilize the Background Check Center to conduct background checks which include:

- adult abuse registry
- child protection registry
- sex offender registry
- Office of Inspected General
- Division of Professional Regulation Registry
- State and Federal Background Check

In addition, the Contractor shall obtain service letters. 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:

Delaware Division of Developmental Disabilities Services

Frequency of Verification:

Office of Service Integrity and Enhancement 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.*

As a primary care case management system service under a concurrent managed care authority. *Complete item C-1-c.*

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

Targeted Case Management (TCM) provided by one or more qualified providers. TCM will be provided to two distinct target groups: individuals living in the family home and individuals receiving residential habilitation under the DDDS Lifespan Waiver. TCM providers must meet the qualification standards as specified in the approved TCM SPAs. This includes providers that have been selected via a competitive procurement process and also qualified individuals employed by the state.

Appendix C: Participant Services

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

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

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

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

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

All direct support professionals that have routine contact with waiver participants must have a criminal background check.

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

All individuals who work for HCBS waiver service provider agencies and have direct client contact are required to utilize the BCC to determine if a person is suitable for employment, pursuant to the following laws:

11 Del.C. §1141- Criminal Background Check (State and Federal),

11 Del.C. §1142- Drug Screening

11 Del.C. §8563- Child Protection Screening

19 Del.C. §708- Service Letters from previous employers

11 Del.C. §8564- Adult Abuse Registry Check

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

Employees selected by a waiver participant to provide Respite or Personal Care service under the self-directed option must also have background check completed in a system approved by DDDS.

The DDDS Office of Service Integrity and Enhancement completes Annual Certification reviews for all Waiver Service Providers. During each of these reviews, employee personnel files 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 Residential, Day, Employment, Supported Living, and Behavioral Consultation that may have the opportunity to have personal contact with persons receiving services.

Although Delaware Code Title 11, §8564, Delaware Code, Title 11, §8563 only requires this for certain services, DDDS requires this for all service providers within the DDDS Provider Standards for Home and Community Based Services.

The requirement for AAR checks also applies to temporary employment agencies and contractors that place employees or otherwise provide services to individuals in DDDS residential homes and day services as indicated in the DDDS Provider Standards for Home and Community Based Services.

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 Provider Standards for Home and Community Based Services prohibit the employment of individuals with adverse findings in either the AAR or CPR check.

The DDDS Provider Standards for Home and Community Based Services prohibit the employment of individuals with adverse findings in either the AAR or CPR check.

During the Provider Agency Certification Review Process, the provider agency completes a staff qualifications and training review checklist. On the checklist, the contracted provider indicates the dates of 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 worker. The requirement for check is once per worker.

DDDS SIE verifies the information by reviewing the data against a report provided by the Delaware Division of Health Care Quality, and an on-site employee records review.

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

Additionally, Delaware's Division of Health Care Quality reviews all Criminal Background and Abuse Registry documentation in Neighborhood Group homes during annual licensing inspections. The DDDS Office of Community Services 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)

Note: Required information from this page (Appendix C-2-c) is contained in response to C-5.

Appendix C: Participant Services

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

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

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

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

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

Self-directed

Agency-operated

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

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

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

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

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

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

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

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

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

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

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

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

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

Other policy.

Specify:

--

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

The Delaware Medicaid (DMMA) provider relations agent provides prospective DDDS Waiver providers access to the Delaware Medical Assistance Program (DMAP) web site. This website provides information about the DDDS Waiver program and completes enrollment instructions. In addition to the DMAP web site, the provider relations agent has a toll-free phone line available for general information (800-999-3371). All DMMA enrollment conditions must be met by the prospective provider before the provider can become enrolled. Providers who contact the DMAP Provider Relations agent about enrollment who have not yet been determined to meet the qualifications to provide HCBS services by DDDS are directed back to DDDS to be assessed against the applicable provider standards, since qualification by DDDS is specified as an HCBS provider enrollment criteria. Qualified providers may enroll at any time. The successful completion of the required information shall result in a contract with DMMA.

Prospective service providers have unrestricted 24-hour access to the DDDS waiver provider qualification standards and provider enrollment forms. These may be completed by prospective service providers who believe that they meet the qualifications to provide one or more of the DDDS Lifespan Waiver services. The DDDS Website (<http://www.dhss.delaware.gov/dhss/ddds/cps.html>) contains the instructions detailing the process.

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

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:

C-a-2: The percent of Quality Improvement Plans (QIPs) for licensed providers determined to be in compliance with DDDS Provider Standards for Home and Community Based Services. Numerator: Number of QIPs determined to be in

compliance DDDS Provider Standards for Home and Community Based Services.
Denominator: Total number of QIPs for licensed providers reviewed during the period.

Data Source (Select one):

Other

If 'Other' is selected, specify:

The Office of Service Integrity and Enhancement certification database

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly

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

Performance Measure:

C-a-1: % of providers required to be licensed/certified that meet required licensing, certification & other standards upon initial enrollment. Numerator: # of providers required to be licensed/certified that meet required licensing, certification & other standards upon initial enrollment; Denominator: # of providers required to be licensed or certified enrolled during the period.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Office of Service Integrity and Enhancement certification data base

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

Specify: <input type="text"/>		Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

Performance Measure:

C-a-3: The percentage of residential and day services provider sites with site-level, all-hazard emergency plans in place that meet the DDDS standards. Numerator: The number of residential and day services provider sites with site-level, all-hazard emergency plans in place that meet the DDDS standards. Denominator: The total number of provider sites reviewed during the reporting period.

Data Source (Select one):

Other

If 'Other' is selected, specify:

The Office of Service Integrity and Enhancement Quality Service Review

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other	Annually

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
Specify: <input type="text"/>	
	Continuously and Ongoing
	Other Specify: <input type="text"/>

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

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

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

Performance Measure:

C-b-1: The % of QIPs for non-licensed providers determined to be in compliance with DDDS Provider Standards for HCBS. Numerator: # of QIPs for non-licensed/certified providers determined to be in compliance with DDDS Provider Standards for HCBS. Denominator: Total # of QIPs for non-licensed/certified providers reviewed during the period.

Data Source (Select one):

Other

If 'Other' is selected, specify:

DDDS Office of Service Integrity and Enhancement data base

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

		Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

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

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

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

Performance Measure:

C-c-1: The percent of provider direct support staff in compliance with DDDS training requirements. Numerator: Number of DSPs/DSP Managers whose training was completed as required for the reporting period. Denominator: Total number of DSPs/DSP Managers who were assigned training for the reporting period.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Office of Training data base

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

	Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input style="width: 100%; height: 20px;" type="text"/>

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

The frequency with which the various discovery processes are employed ranges from an as-needed basis (e.g., incident investigations, placement tracking or mortality reviews) to an annual basis (e.g., certification or verification of licensure of the service provider). In addition to those monitoring processes, the case managers also conduct routine monthly reviews and quarterly visits to residential and day programs.

The scope of various reviews includes:

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

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

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

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

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

Monitoring the service provider's compliance with established regulatory and policy standards is an ongoing function of DDDS staff, including case managers, in their monthly routine or quarterly site visits, as well as the principal duty of the Office of Service Integrity and Enhancement (SIE) and Health Care Quality staff in their annual certification and licensure surveys.

The DDDS Office of Service Integrity and Enhancement (SIE) surveys waiver provider agencies against DDDS Provider Standards for Home and Community Based Services.

b. Methods for Remediation/Fixing Individual Problems

- i.** Describe the States 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 Service Integrity and Enhancement, 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 Health Care Quality, 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.

DDDS continues to evolve it’s organizational culture towards a more collaborative approach of offering technical assistance to providers for compliance and quality improvement. DDDS Office of Service Integrity and Enhancement now engages directly with providers regarding quality improvement needs and efforts; provides consultation, offers suggestions for improvement, and makes recommendations in order to assist with root cause analysis and remediation.

ii. Remediation Data Aggregation

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

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>

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.

The total expense for Personal Care and Respite services, combined, is limited to \$3500 per waiver participant per waiver demonstration year. Personal Care and Respite services cannot be provided to waiver participants who receive residential habilitation in a provider-managed setting with the exception of Respite services for Shared Living providers. If a waiver participant is enrolled for less than an entire demonstration year, the annual limit will be prorated by the number of months remaining in the demonstration year.

The limit was established based on cost and utilization data DDDS has maintained for individuals receiving state funded family support services. The limit will be periodically assessed and may be increased as budgetary resources allow.

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

The case managers will notify the service recipient and their family/legal guardians of the current approved budget amount when the need for Respite or Personal Care services is initially identified and again when completing or updating the person-centered plan and authorization for the service(s). The case manager will assist the service recipient with referral to the AWC broker if they choose to self-direct their service(s) and the AWC broker will again review the approved budget amount with the service recipient and their family.

Prospective Individual Budget Amount. There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.

Furnish the information specified above.

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

Furnish the information specified above.

Other Type of Limit. The state employs another type of limit.

Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

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

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

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

The Delaware Statewide Transition Plan for Compliance with Home and Community-Based Setting Rule (the STP) was last updated and submitted to the Centers for Medicare & Medicaid (CMS) March 30, 2016. The STP received initial CMS approval July 14, 2016. A copy of the STP can be viewed at the following address:

http://dhss.delaware.gov/dhss/dmma/hcbs_trans_plan.html. Please refer to the Plan for details regarding background, covered home and community-based services (HCBS), and provider settings assessed by the Department of Health and Social Services (DHSS).

Delaware received final approval of the STP October 13, 2017.

From this point forward, the STP will be amended to provide updates and the current status of Delaware transition plan activities.

DDDS has incorporated all of the standards from the HCBS Settings Rule into both its provider standards and its case management practices. The Service Integrity and Enhancement Unit monitors compliance with the standards as part of its quarterly Quality Service Reviews and its annual provider certification reviews.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

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

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

Registered nurse, licensed to practice in the state

Licensed practical or vocational nurse, acting within the scope of practice under state law

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

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

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

Specify qualifications:

DDDS delivers case management under a Targeted Case Management State Plan authority under 1915(g)(1). DDDS employs two types of case management entities to deliver TCM to waiver members: Community Navigators primarily support individuals who live in the family home and Support Coordinators support individuals living in a provider-managed setting. DDDS has specified different person-centered planning processes designed to meet the needs of individuals as they change through their lifespan. Both processes comply with the requirements for person centered planning under the HCBS Settings Rule. TCM may be delivered by either qualified state employees as specified below or by a contracted entity for which the case managers must meet the qualification criteria specified below.

A Support Coordinator employed by the Delaware Division of Development Disabilities Services (DDDS) must meet the minimum qualifications for the State of Delaware Merit System classification of "Senior Social Worker/Case Manager". These qualifications are also described in the Targeted Case Management SPA. Individuals who exceed the stated minimum qualifications may also provide case management. The minimum qualifications for a case manager are:

Possession of an Associate's Degree or higher Behavioral or Social Science or related field OR

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

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

Training in accordance with DDDS training policy.

The qualifications for the Community Navigators who are employed by a contracted entity to provide Targeted Case Management are as follows:

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

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

1. Have an associate's degree or higher in behavioral, social sciences, or a related field OR experience in health or human services support, which includes interviewing individuals and assessing personal, health, employment, social, or financial needs in accordance with program requirements;
2. Have demonstrated experience and competency in supporting families;
3. Complete Department-required training, including training on the participant's service plan and the participant's unique and/or disability-specific needs, which may include but is not limited to: communication, mobility and behavioral support needs; and
4. Comport with other requirements as required by the Department.

These qualifications are also described in the Targeted Case Management SPAs approved by CMS.

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:*

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 use of the Charting the LifeCourse framework and tools as the foundation of its person-centered planning tool for waiver participants. These planning tools/system meets the CMS requirements for Person Centered Plans. For the purpose of this Appendix, these tools will hereafter be referred to as the "person-centered plan", "PCP" or simply, "the plan", unless more specificity is required.

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

According to DDDS policy, person-centered plans, developed with the waiver participant, his/her family or guardian, other individuals providing support and other individuals the waiver participant has chosen to be part of the planning team. The plans will outline the individual's preferences, individual support needs, and lifestyle choices.

The planning system is supported by a case management function. For individuals living in a waiver residential setting, case management will be delivered by an individual called a "Support Coordinator" and for individuals living in their family home it will be delivered by an individual called a "Community Navigator". For the purpose of brevity, we will use the term "case manager" throughout the document unless more specificity is required.

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

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

The DDDS Office of Professional Development makes PCP training available to potential waiver applicants and their families/guardians or advocates on a regular basis. The training includes a description of the PCPs in a power point presentation. The presentation illustrates each step in the plan development process, and the facilitator takes the time to answer questions as they come up during the training session.

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

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

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

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

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

The pre-planning process begins at least 90 days before the initial or annual plan review meeting by engaging the participant in a conversation about his/her life, goals and aspirations and also includes any needed formal assessments. The conversation is an informal assessment process that takes a walk through time, discussing personal routines and

preferences throughout the day, learning what makes a good day in the mind of the participant. The conversation continues along, leading to the discussion about short and long range “outcomes” the participant wants to achieve through the use of the Life Trajectory tool.

The participants outcomes may include, but are not limited to such items as: expanding the participant’s circle of support, identifying where to live and with whom, what types of services and supports are needed in such living situations, career goals, what would the participant’s ideal job be, where to work, important routines, important people, favorite things to do, interest in participating in clubs, civic organizations, religious/spiritual organizations and past accomplishments to celebrate and possibly build upon. The Integrated Supports STAR can also help to identify additional supports, both paid and unpaid, that may be available to assist with goal attainment

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

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

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

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

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

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

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

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

Delaware uses a proprietary assessment tool, the Inventory for Client and Agency Planning (ICAP) to support the development of the PCP. DDDS uses this tool to help determine the level of support for waiver participants. The ICAP incorporates a wide range of measures including a person’s demographic characteristics, adaptive and maladaptive behavior, diagnosis, health status, physical handicaps and more.

There are a wide range of person-centered planning tools that will be available for the Community Navigator and Support Coordinator to use with the participant and their support circle to develop the PCP. These tools can also inform the state’s continuing efforts to ensure that settings remain in compliance with the requirements under the HCBS settings rule. Tools that may be used include: Personal Focus Worksheet to gather Important To/For, Charting the LifeCourse Trajectory-Your Good life, STAR for strategizing and developing natural supports. These tools will help the team that develops the plan to focus on strategies for success to encompass what they want for their own life and how to best use the person’s strengths and assets to accomplish their desired outcomes

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

DDDS became a member of the Supporting Families Community of Practice (CoP) in 2016. DDDS has held two state-wide annual "kick-off" events with support from the national CoP team since that time in order to engage individuals, their families, case managers, and providers to become more familiar with this new person centered planning philosophy. DDDS now uses tools from the LifeCourse toolkit to assist and encourage individuals and their families to develop their plans in accordance with their vision for their "good life". DDDS continues to use its annual National CoP TA hours to engage provider agencies, service recipients, families, and other external stakeholders to continue to grow the Delaware CoP.

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

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

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

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

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

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

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

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

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

The plan will be developed using a person-centered planning process which will result in the establishment of a plan that

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

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

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

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

e. How waiver and other services are coordinated:

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

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

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

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

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

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

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

The PCP is revised as needed based on changes that impact the person's support needs due to any of the following: medical status, behavioral status or circumstances. For individuals living in his/her family home, an update to the plan

may also be triggered by that a change in the circumstances, availability or physical ability of the primary support person in the family. The case manager will assemble the support team to review the plan as necessary. At a minimum the plan is revised and updated on an annual basis.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

The assessment of potential risk and the development of risk mitigation strategies will involve the participant, his/her family/legal guardian, and other individuals who know him/her best to describe support services, strategies or interventions necessary in each risk area to keep the participant safe from serious harm and promote good health, independence and opportunity to live a satisfying life. Each participant's identified support needs vary depending upon his/her life experiences, abilities and environment. Each risk mitigation plan contains a description of how the qualified provider will create a system of providing emergency backup services and supports.

Areas where risk may need to be assessed and mitigation plans created could include:

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

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

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

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

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

DDDS provides the opportunity for waiver participants to interact with service providers and acquire information through semi-annual "Provider Fairs". The fairs are announced publicly and operate as "meet and greet" events. Waiver participants and their families may speak with service providers to get a feel for the services they provide and how they provide them. DDDS representatives are in attendance to assist families in obtaining more information on how to proceed with seeking services and how to obtain more information related to the providers. This venue provides an opportunity to meet a variety of providers and obtain useful information to guide them through the selection process. DDDS also provides opportunities for waiver participants to meet with each other in order to facilitate natural connections between participants and their families that result in information sharing.

DDDS has also developed a set of interview questions that waiver participants or families may want to ask a service provider in order to help determine if there is a good fit between the person and the provider. This questionnaire is provided to all waiver participants prior to the selection of any waiver services.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

The service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i). DMMA maintains responsibility for service plan approval. The person centered plan is maintained by DDDS in an electronic case record system. Prior to each quarterly meeting between DMMA and DDDS, DMMA provides DDDS with a list of clients for which the PCP will be reviewed and discussed at the meeting. DMMA selects two cases randomly from each region for a total of six Plans to be reviewed. DMMA may request, at any time, a hardcopy of the PCP for any DDDS waiver client. In addition, DMMA has access to the electronic case record software and may conduct spot checks of the PCP at any time.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Every three months or more frequently when necessary

Every six months or more frequently when necessary

Every twelve months or more frequently when necessary

Other schedule

Specify the other schedule:

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

Medicaid agency

Operating agency

Case manager

Other

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

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

The Division of Developmental Disabilities Services (DDDS) provides for ongoing monitoring of the implementation of each waiver participant's service plan. For those persons receiving residential services, the Support Coordinator is the primary person responsible for monitoring the implementation of the plan at a minimum of once a month. For persons living in the family home, the Community Navigator is responsible for monitoring the implementation of the plan at least monthly. The Community Navigator must have at least one face to face contact with the waiver participant each year. Monitoring will occur more frequently if a review of claims indicates that the waiver participant is not routinely receiving services in the amount, duration or frequency specified in the plan. Additional monitoring of all of the day services is conducted by the DDDS Day and Transition Unit. This is discussed below. Additional monitoring of self-directed Respite and Personal Care services by the Agency With Choice Broker is also described below. The Support Coordinators and Community Navigators will be hereafter referred to as "case managers" in this section.

Responsibilities of the case manager include ensuring that services are meeting the participant's needs and that they are provided in accordance with the PCP, including reviewing the amount, duration and frequency of services recommended in the plan. The case manager is responsible for continuing to ensure that the individual is able to exercise free choice of providers and that they understand this right. The case manager is responsible for ensuring that non-waiver health care services are identified and accessible, as needed. The case manager is responsible for ensuring that concerns which require action are identified and remedied promptly.

The Support Coordinator monitors the implementation of the participant's person centered plan on a monthly basis. At least once each calendar quarter, the Support Coordinator will conduct a face to face interview with the participant. The Support Coordinator must conduct at least two of the face to face interviews in the participant's home, during which the plan is reviewed with the participant, his/her or guardian, if applicable, and/or appropriate team participants to assess their satisfaction with the services provided and to review how the participant is progressing with the attainment of his/her stated priority outcomes.

During this monthly monitoring of individuals living in a waiver residential setting, the Support Coordinator will:

- Assess the extent to which the participant is receiving services according to his/her person-centered plan. This includes monitoring that each provider has delivered services at the amount, frequency and duration specified in the PCP and that participants are accessing all supports and health-related services as indicated on the PCP.
- Evaluate whether the services furnished meet the participant's needs and help the participant become more independent.
- Assess the effectiveness of provider individual service plans and determine if changes are necessary.
- Review the participant's progress toward goals stated in the PCP.

During the face-to-face monitoring of the plan that occurs four times each year, the Support Coordinator will:

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

If, at any point, there is belief that a participant's health and welfare is in jeopardy, actions must be taken immediately to assure the participant's safety. For issues that are of concern, but where the participant is not at risk of imminent harm, the team will work with the participant, service providers and/or informal supports to address the issue. Depending on the severity and scope of the issue, the Support Coordinator may reconvene the participant's support team to address the issue.

The following reports assist the Support Coordinator in monitoring services:

- A quarterly report completed by agency providers of residential habilitation that provides a status update on progress toward identified outcomes and any barriers the participant is experiencing in meeting those outcomes. The provider reports on what actions or steps they have taken to support the participant's attainment of identified outcomes.
- Quarterly audits completed by providers of Nurse or Behavioral Consultation, if applicable, that track and monitor behavioral interventions and physical health-status issues, as identified in the PCP.
- Quarterly Day Service/Vocational/Work reports completed by providers of day and employment services to report on

the participant's progress in meeting identified outcomes and goals.

- Progress reports recorded for each individual service plan by each provider for each waiver service as identified and defined in the participant's PCP.
- Provider annual reports on progress toward achieving goals, as required for each individual.

The reports listed above are designed to assist the Support Coordinator in assessing the effectiveness of the services and supports the individual receives and to recommend changes when appropriate. Service providers use the electronic case record system to document contacts with participants, providers, family members and informal supports.

The Community Navigator reviews the implementation of the participant's person centered plan on a monthly basis and will provide additional support if the participant's plan requires changes.

When a participant wants to change a service provider, the case manager informs the current provider of the change and develops a transition plan to minimize disruption to the participant and to ensure continuity of care.

When DDDS cannot safely support a waiver member in an in-state provider-managed residential setting and must seek a residential setting in another state, their on-going care is monitored against the person centered plan by the assigned DDDS Support Coordinator and the DDDS Service Integrity and Enhancement unit.

Support Coordinators conduct a face to face quarterly meeting with the out of state waiver member. Currently, this is possible because the state has a very small number of members being served in an out of state setting and the out of state settings are within driving distance. If the state accesses an out of state setting that is not within easy travel distance, a quarterly face to face meeting will still be conducted; however, the meeting may be conducted using video technology such as Skype. Out of state providers are required to provide quarterly progress reports to the DDDS Support Coordinators just like the in-state providers. DDDS Support Coordinators review the quarterly progress reports to assess progress and ensure that services are being delivered as described in the person-centered plan. If DDDS is the representative payee for the individual, the Support Coordinator will review the client trust account balance for each out of state service recipient in the same manner as they do for in-state service recipients.

Office of Service Integrity and Enhancement Monitoring:

The DDDS Office of Service Integrity and Enhancement (SIE) completes a thorough review of the PCP for each participant receiving residential habilitation and/or day habilitation that is selected as the focus person. This review is completed as part of a comprehensive survey of participants' services and is included in the findings for the annual re-credentialing of service providers.

SIE 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 online Quality Improvement Plan (QIP) to remediate the concern. SIE monitors the provider's progress with the implementation of the CAP. Data related to waiver performance measures is aggregated to assist the DDDS in identifying systems-level concerns that may require systemic modifications in order for the standard to be achieved.

When DDDS cannot safely support a waiver member in an in-state provider-managed residential setting and must seek a residential setting in another state, their on-going care is monitored against the person centered plan by the assigned DDDS Support Coordinator and the DDDS Service Integrity and Enhancement unit.

DDDS has different options for conducting quality oversight and monitoring of incident reporting depending on the individual circumstances of each case. If the provider agrees to meet all of the DDDS Lifespan waiver provider requirements, DDDS will employ its regular process for provider monitoring and oversight using the Quality Service Review process described in Appendix G of the waiver application. DDDS also has the option to develop an interstate agreement with the host state, which outlines a shared responsibility for monitoring and oversight of the waiver member. The interstate agreement specifies the role of each state in ensuring health and safety. Delaware may also enter into an interstate agreement with another state in which Delaware agrees to accept the host state provider standards for monitoring and oversight of services and the host state carries out the monitoring and sends reports to DDDS.

DDDS Day & Transition Unit: The DDDS Day and Transition Unit monitors the utilization of day services for waiver participants based on specified triggers. They compare provider attendance records and claims data against service

authorizations based on the PCP to look for: units higher or lower than what is expected, changes in Group Supported Employment ratios, waiver participants whose authorized hours are exceptions to the ICAP. Providers who are determined to be at higher risk of claim errors based on prior reviews are reviewed more closely than other providers. When a review is triggered, the Unit looks at the PCP, progress/billable notes for each day service and incident reports to ensure that services are being delivered and billed in accordance with the PCP.

One of the duties of the Agency With Choice Broker is to monitor attendance records for employees of participants who have elected to self-direct to ensure that they are receiving services in accordance with the PCP. Concerns or discrepancies will be reported to the Community Navigator for follow up.

b. Monitoring Safeguards. *Select one:*

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

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

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

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

In order to ensure the person centered plan monitoring conducted by those furnishing direct services is in the best interest of the waiver participant, DDDS utilizes a variety of service review processes and sources. The case manager is responsible for monitoring the implementation of services as specified in the person centered plan and reporting on the status of services and supports the participant has identified. This includes both waived and non-waived services.

The case manager reviews and monitors the implementation of services at least monthly. The case manager reports findings from review activities to the agency for implementation of improvement plans or actions to resolve the participant's concerns.

The case manager role reflects a position of advocacy for the participant to receive satisfaction with his/her desired and identified outcomes. As there are situations in which the case manager may perform supports or services for the participant, such as to serve as the selected plan facilitator, DDDS oversight of services includes additional monitoring safeguards.

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

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

SIE has full access to review all pertinent information related to the participant in order to review and assess all services and supports provided to the waiver participant. SIE is able to verify service delivery through direct observation, interview, and thorough record reviews to ensure the person centered plan is implemented as specified.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

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

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:

D-a-1: The percent of participant Person Centered Plans that address the participant's support needs. Numerator: The number of participant PCPs that address the participant's support needs. Denominator: The number of participant Person Center Plans reviewed during the period.

Data Source (Select one):

Other

If 'Other' is selected, specify:

The PCP-DDDS Electronic Case Record System (ECRS).

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px; text-align: center;">95%</div>
Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>

	Continuously and Ongoing	Other Specify: <input style="width: 100px; height: 20px;" type="text"/>
	Other Specify: <input style="width: 100px; height: 20px;" type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input style="width: 100%; height: 20px;" type="text"/>

Performance Measure:

D-a-2:The percent of Person Centered Plans that identify participant preferences and how they will be met within the Plan. **Numerator:** The number of participant PCPs that identify participant preferences and how they will be met is outlined by the Plan. **Denominator:** The total number of participant Person Centered Plans reviewed during the period.

Data Source (Select one):

Other

If 'Other' is selected, specify:

The PCP-DDDS Electronic Case Record System (ECRS)

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="text"/>	
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

D-a-3: The percent of individuals that have individual-level emergency plans that are updated at least annually. Numerator: The number of individuals that have individual-level emergency plans that are updated at least annually. Denominator: The total number of individuals at sites reviewed for the reporting period.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Office of Service Integrity and Enhancement-Quality Service Review results

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 = <input type="text" value="95%"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify:

		<input type="text"/>
	<p>Other Specify:</p> <input type="text"/>	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:

D-b-1 The percent of person centered plans (PCP) that were are monitored in

accordance with established policies and procedures. **Numerator:** The number of PCPs that were monitored in accordance with established policies and procedures. **Denominator:** The total number of PCPs reviewed for the reporting period.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Office of Service Integrity and Enhancement-Quality Service Reviews

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 = <input type="text" value="95%"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

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

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

Performance Measures

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

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

Performance Measure:

D-c-2: The percent of person centered plans (PCP) that are revised when the needs of the participant have changed. Numerator: The number of PCPs that are revised when the needs of the participant have changed. Denominator: The total number of PCPs reviewed which require revision.

Data Source (Select one):

Other

If 'Other' is selected, specify:

The PCP-DDDS Electronic Case Record System (ECRS)

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review

Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text" value="95%"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	<input type="text"/>

Performance Measure:

D-c-1:The percent of participant Person Centered Plans that are reviewed with the member's team annually. **Numerator:** The number of participant PCPs that are reviewed with the team annually. **Denominator:** The number of participant PCPs reviewed during the period.

Data Source (Select one):

Other

If 'Other' is selected, specify:

The PCP-DDDS Electronic Case Record System (ECRS)

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

	<input style="width: 80%; height: 20px;" type="text"/>	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input style="width: 100%; height: 20px;" type="text"/>

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

Performance Measures

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

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

Performance Measure:

D-d-1: The percent of person centered plans in which services are delivered in accordance with the specified type, scope, amount, frequency, and duration.

Numerator: The total number of person centered plans in which services delivered in accordance with the specified type, scope, amount, frequency, and duration.

Denominator: The total number of PCPs reviewed for the period.

Data Source (Select one):

Other

If 'Other' is selected, specify:

The PCP-DDDS Electronic Case Record System (ECRS)

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other	Annually

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
Specify: <input type="text"/>	
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

D-d-2: The percent of members receiving residential habilitation whose CM visit occurred each quarter as described in the approved waiver. Numerator: The number of members receiving res hab whose case manager (CM) met them to review the PCP once each quarter, two of which were in the member's home. Denominator: The number of waiver members reviewed during the period.

Data Source (Select one):

Other

If 'Other' is selected, specify:

The DDDS Electronic Care Record System (ECRS)

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

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

Data Aggregation and Analysis:

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

Performance Measure:

D-d-3 The percent of members for which progress toward goals included in the PCP is reviewed by the case manager as described on a frequency described in the PCP. **Numerator:** The number of members whose progress on PCP goals is reviewed by the CM on the specified frequency. **Denominator:** The total number of member PCPs reviewed during the period.

Data Source (Select one):

Other

If 'Other' is selected, specify:

The PCP- DDS Electronic Case Record System (ECSR)

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
<input type="text"/>	
	Continuously and Ongoing
	Other Specify: <input type="text"/>

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

Performance Measures

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

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

Performance Measure:

D-e-2: The percent of participants offered a choice of qualified providers. Numerator:
The number of participants offered a choice of qualified providers. Denominator:
The total number of participant records reviewed for the period.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

The PCP-DDDS Electronic Case Record (ECRS)

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
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: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

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

The discovery portion of the Division's Quality Management System (QMS) relies on a robust performance monitoring system managed by the Office of Service Integrity and Enhancement. This system is aligned with the CMS Quality Framework (Design, Discovery, Remediation, and Improvement).

For each step in the QMS, DDDS has identified: Assurances-Measures-Standards (Discovery), Reporting on the Individual Remediation (Remediation) and Quality Improvement Plans/Projects (Improvement).

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

Service Integrity and Enhancement has implemented an online provider record that allows for real time data and finding to be shared between the Division and the provider. This also allows for a better tracking process to measure provider's compliance with the Provider Standards for Home and Community Based Services.

Service Integrity and Enhancement (SIE) will conduct both annual and bi annual reviews of residential sites. A site may qualify for a bi annual review if it meets the following criteria: Score over a 90% on the initial compliance score and have no complaints about deteriorating standards of care within a 365 day period. Regardless of the qualification of a bi annual review, SIE maintains that during a provider review a minimum number of sites are still reviewed. This number was adopted from the focus person selection of Appendix J Intermediate Care Facilities for Individuals with Intellectual Disabilities and can also be found in the Service Integrity State Operations Manual table 102.

SIE annually certifies all authorized providers that provide: Residential Services, Day Habilitation, Employment Services, Nursing Consultation and Behavioral Consultation.

Notification and scheduling: Written notice of the review is sent to the provider within 60 business days of the review. This notification includes a checklist that requires the provider to submit its waived roster to the Lead Program Evaluator. A report is run to determine the sites compliance score and licenses expiration date. Site selection will be evaluated based on the above criteria. Program Evaluators are assigned accordingly. For Day Habilitation and Prevocational sites, a team of two Program Evaluators are assigned.

Offsite Review (Task 1R): The Lead Program Evaluator will distribute the selected waiver participant list and house selection list among the other Program Evaluators. The Lead Program Evaluator will review Provider wide standards such as Provider Organization policies, procedures, staff trainings and qualifications. Program Evaluators review incident reports and previous Quality Service Reviews for their assigned site(s).

Record Review (Task 2R): The objectives of the record review are to verify that the provider is supporting the individual as identified in the Person-centered plan (PCP); review if revisions were made to help support the outcomes; and verify that needed health and safety supports are in place.

Information Gathering on site (Task 3R): Information gathering on site consists of observations and focus person(s) review. During general observations the Program Evaluator uses protocols identified in the Service Integrity State Operations Manual (adopted from CMS State Operations Manual) to observe physical features in the home that affect residents or potential resident's quality of life, health and safety. The objectives of the resident review are to determine how the resident outcomes and resident's quality of life are related to the provision of care by the provider staff; if supports provided by the provider has assisted residents to reach or maintain their highest well-being; and if the residents are assisted to have the best quality of life.

Interview with the waiver participant: The SIE Program Evaluator conducts an interview with the participant, preferably in their home or other program. Providers will support participants to understand the purpose and intent of the interview. In some instances, an individual may need or want assistance to answer the questions. When assistance is needed or requested, the provider will make these arrangements in collaboration with the individual and/or guardian.

Debriefing: During the conclusion of the site visit, the Program Evaluator may discuss the findings of the review. The purpose of the debriefing is to informally communicate preliminary findings and to provide an opportunity for the exchange of information. The debriefing is conducted as a courtesy to the provider.

Findings report/Quality Improvement Plan: The Program Evaluator will enter all findings into Quality Improvement Plan template within the electronic data. The provider will develop a Quality Improvement Plan on the template within the electronic system.

DDDS Regional Offices also have a key role in ongoing monitoring in order to verify that issues on an individual and provider level are resolved. Regional Directors have access to reports tracking issues and follow-up, along with monthly summary reports from various discovery processes including: incident reports, case manager visits, SIE provider reviews etc. Each office has the ability to assemble a regional management team comprised of appropriate DDDS staffers and others as necessary in order to review unresolved and emerging serious individual concerns and provide technical assistance and/or resources to resolve the issue.

b. Methods for Remediation/Fixing Individual Problems

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

Quality Improvement Plan: If findings are identified for areas for improvement, the provider must submit a Quality Improvement Plan to SIE that addresses each finding with specific objective(s), a timeline, and the contact information for the person(s) responsible for developing and implementing the plan. The QIP must be approved in writing by DDDS.

Once the improvement plan is developed by the provider, a Program Evaluator must approve the plan in writing within 15 days of receiving it. Elements for approving a Quality Improvement Plan can be found on the DDDS website at

<http://dhss.delaware.gov/dhss/ddds/qa.html>

Following notification by the provider that the corrections were made, DDDS verifies that the corrections were made and that they are acceptable.

DDDS response to continued inadequate performance: DDDS has a structured process for addressing continued inadequate performance by a provider. In addition to monitoring activities by SIE, any DDDS staff person may escalate concerns about provider performance through the organizational hierarchy in each DDDS Regional Office, ending with the DDDS Senior Leadership Team which represents all parts of DDDS. The Leadership team meets to review the data presented regarding the provider's inadequate performance and to make a recommendation to the DDDS Director regarding whether or not to put the provider on probation.

When a recommendation for probation is approved by the Director, the DDDS Director notifies the provider in writing including the areas where improvement is needed and the timelines for the completion of these activities within an initial six month probationary period. A meeting is also scheduled with the organization to go over the reason for probation.

SIE monitors the provider's compliance with the terms of the probation. At the end of the initial period of probation, the Director may extend it for another six months if the provider has not shown sufficient improvement in one or more areas requiring remediation.

SIE monitors the provider's compliance with the terms of the probation. At the end of the initial period of probation, the Director may extend it for another six months if the provider has not shown sufficient improvement in one or more areas requiring remediation.

ii. Remediation Data Aggregation

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input data-bbox="319 548 794 631" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input data-bbox="865 862 1337 945" type="text"/>

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

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

(a) Individuals enrolled in the Lifespan waiver may choose to self-direct the waiver services known as Respite and Personal Care. Respite and Personal Care service is not available to participants who are receiving residential habilitation with an agency.

(b) As participants are initially enrolled and again at each annual plan review, the Community Navigator will offer participants who elect to receive the Respite and Personal Care services, the opportunity to self-direct the service as a joint employer with the AWC broker employer of record. Participants will be informed that they may self-direct Respite and Personal Care services. The election of Respite and Personal Care will be documented in the person centered plan and whether the participant has elected to self-direct. DDDS uses the Agency with Choice model to support participants who wish to self-direct. A participant may self-direct select supports and services and also receive traditional supports and services from a provider agency, as long as both services are included and described in the person-centered plan (PCP). Self-directed services include Respite and Personal Care.

(c) A participant may elect to self-direct Respite and Personal Care services, or may request more information about it during the initial and each subsequent planning meeting. New entrants to the waiver will thereby be offered the opportunity from the initial enrollment into the waiver. Community Navigators and DDDS Regional staff will be able to answer questions about the service option, and provide general written information. Community Navigators will also offer detailed information to waiver participants about self-direction opportunities at each individual's annual plan review.

Participants who choose to self-direct services will be assisted by an AWC broker under contract to the state. The AWC broker will be paid as an administrative cost.

The AWC broker will assist the participant to manage their self-directed services and other services included within specified service limit for Respite and Personal Care. Participants will be assisted to find, hire and manage qualified caregivers, establish work schedules, participate in the development of a back-up/emergency plan, establish the employee rate and track utilization against applicable limits. The AWC broker will also purchase service and remit payment for services by non-Medicaid enrolled entities, such as camps for respite. The AWC vendor will perform most of the administrative tasks normally performed by an employer including payroll withholding, ensuring that applicable payment rules are followed, conducting criminal background checks, etc.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver.
Select one:

Participant: Employer Authority. As specified in *Appendix E-2, Item a*, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.

Participant: Budget Authority. As specified in *Appendix E-2, Item b*, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.

Both Authorities. The waiver provides for both participant direction opportunities as specified in *Appendix E-2*. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies:*

Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.

Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.

The participant direction opportunities are available to persons in the following other living arrangements

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy (*select one*):

Waiver is designed to support only individuals who want to direct their services.

The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.

The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.

Specify the criteria

Individuals electing self-direction will use an Agency With Choice, co-employer model to direct their Respite and Personal Care service.

Individuals may continue to use self-direction as long as they meet the criteria in E-1-l.

Individuals who choose not to self-direct this service will be assisted to choose a qualified agency provider by their Community Navigator.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

A participant direction handbook was created as a means to inform the participant about the rights, responsibilities and the benefits and any risks associated with the participant directed option. This handbook is available on the DDDS website and is included in the DDDS-approved statewide Agency With Choice start up packet for participants who elect to self-direct. At the time of waiver enrollment, as the initial interim person centered plan is being developed, the Community Navigator is responsible for providing the handbook to the participant and discussing the pros and cons of self-direction as it relates to their particular circumstances and needs. The Community Navigator will ensure the participant understands the responsibilities associated both with this waiver and with participant-direction. The Community Navigators also provide participants with support and assistance in order to make the decision about whether to exercise participant direction authority and will refer participants to the Agency With Choice broker as necessary. This information will also be revisited with the participant by the Community Navigator at least annually when the PCP is reviewed and revised.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the state's policy concerning the direction of waiver services by a representative (*select one*):

The state does not provide for the direction of waiver services by a representative.

The state provides for the direction of waiver services by representatives.

Specify the representatives who may direct waiver services: (*check each that applies*):

Waiver services may be directed by a legal representative of the participant.

Waiver services may be directed by a non-legal representative freely chosen by an adult participant.

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

DDDS will honor the decision making authority for parents of minor children, guardians and Powers of Attorney, for participants for whom they are in place.

Participants who do not have guardians have the right to have a designated surrogate to assist them with performing the role of the co-employer if they so choose. This includes using the option for Supported Decision Making recently enacted under Delaware law S.B. 230 and any other alternative decision making authorities recognized by the state.

The Agency With Choice broker is responsible to ensure that the guardians, Powers of Attorney or other selected surrogates understand and agree to assist the individual fulfill his/her responsibilities as the employer or managing employer. For surrogates (not including guardians or Powers of Attorney), this will include by ensuring that the surrogate reviews and completes the applicable DDDS Standard Agreement form.

If a surrogate is desired by the participant who does not have a guardian or Power of Attorney, the surrogate must:

- Effectuate the decision the participant would make for himself/herself;
- Accommodate the participant, to the extent necessary that they can participate as fully as possible in all decisions that affect them;
- Give due consideration to all information, including the recommendations of other interested and involved parties;
- Assure DDDS that he or she has no conflict of interest and will support the participant's best interests, and
- Embody the guiding principles of self-determination.

If a surrogate has not been designated by a court, the participant may designate a surrogate from the following list, as available and willing:

- A spouse (unless a formal legal action for divorce is pending);
- An adult child of the participant;
- A parent;
- An adult brother or sister;
- An adult grandchild;
- Any adult who has knowledge of the participant's preferences and values.

A surrogate may not receive payment for this function. In addition, a surrogate, other than guardians as described in C-2-e, may not receive payment for any waiver services the surrogate provides to the participant for whom they are a surrogate.

The Agency With Choice (AWC) broker must recognize the participant's chosen surrogate as part of the participant's decision-making process, and provide the surrogate with all of the information, training, and support it would typically provide to a participant who is self-directing. The AWC broker must fully inform the surrogate of the rights and responsibilities of a surrogate. Once fully informed, the AWC broker must have the surrogate review and sign a DDDS Standard Agreement form, which must be given to the surrogate and maintained in the participant's file. The agreement lists the roles and responsibilities of the surrogate, states that the surrogate accepts the roles and responsibilities of this function, and states that the surrogate will abide by DDDS policies and procedures. Unless otherwise limited by the participant, the surrogate would assist in providing direction over the individual support plan for the Respite and Personal Care services that is being self-directed, selection of caregiver, approval of the worker's timesheets with assurance each timesheet is

accurate and truthful and negotiation of payment rates for the caregiver. If the participant disagrees with a decision made by the surrogate who is not the parent of a minor child, guardian or Power of Attorney, the participant's decision prevails. The participant may revoke the designation at any time. The revocation should be in writing.

Monitoring of the person centered plan takes place with each participant at the minimum frequency specified in D-2-a. The plan review should identify any issues with the surrogate not acting in the best interest of the participant. The Community Navigator must address any issues noted.

The AWC broker is required to address and report any issues identified with the surrogate's performance including compliance to the DDDS policy on critical incident reporting, including suspected fraud or abuse.

The Community Navigator will assist the participant throughout this process.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Personal Care		
Respite		

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one:*

Yes. Financial Management Services are furnished through a third party entity. (Complete item E-1-i).

Specify whether governmental and/or private entities furnish these services. *Check each that applies:*

Governmental entities

Private entities

No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. Do not complete Item E-1-i.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one:*

FMS are covered as the waiver service specified in Appendix C-1/C-3

The waiver service entitled:

FMS are provided as an administrative activity.

Provide the following information

- i. Types of Entities:** Specify the types of entities that furnish FMS and the method of procuring these services:

A private entity that is selectively contracted by the state.

The Agency with Choice Broker was procured through a competitive RFP issued by the Delaware Division of Developmental Services. The vendor organization which was awarded the contract demonstrated clear superiority of experience and capabilities.

- ii. Payment for FMS.** Specify how FMS entities are compensated for the administrative activities that they perform:

As an Agency With Choice broker, the agency will be compensated for the cost of recruitment, screening, establishing payment rates with participant input, processing timesheets, payroll and withholding, maintenance of employee records, issuing W-2s, processing payments for respite camps, submitting Medicaid claims on behalf the participant, assessing participant satisfaction and assisting the participant in performing supervisory functions, such as training and performance evaluation.

DDDS has developed a standard methodology for reimbursing AWC administrative activities. There is an initial one-time set-up payment for each new participant that elects to self-direct their Respite or Personal Care service, an on-going annual payment per service recipient for continued participant training, staff screening and training, annual budgeting, etc, and a separate standard on-going monthly payment. Payment to the vendor will be a fixed dollar amount for each participant who has elected to self-direct their Respite or Personal Care service. The administrative payments to the AWC broker are entirely separate from the funds dedicated to the participant's allotment for services.

The AWC provider receives a monthly per participant administrative fee for the administrative service provided by the AWC as specified in the vendor contract. The monthly administrative fee is negotiated between DDDS and the AWC vendor and must be applied consistently across all participants who elect self-direction. The AWC broker must submit monthly invoices to the state. Administrative claims are submitted by the AWC broker to DDDS for approval and payments are made directly to the AWC broker from the Delaware Treasury via the Delaware State accounting system.

DDDS contracts with a single statewide AWC broker.

- iii. Scope of FMS.** Specify the scope of the supports that FMS entities provide (*check each that applies*):

Supports furnished when the participant is the employer of direct support workers:

Assist participant in verifying support worker citizenship status

Collect and process timesheets of support workers

Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance

Other

Specify:

The individual and the AWC broker are co-employers, but the AWC broker is the employer of record.

In addition to the supports listed in section iii. above, the AWC broker will also perform the following activities on behalf of participants:

- arrange for or conduct background checks on prospective employees.
- assure prospective employees meet waiver requirements
- enroll self-directed employees that meet requirements and have valid licenses if applicable
- establish an hourly payment rate for each employee with participant input and within the State fee schedule
- respond to IRS inquiries regarding tax withholding
- ensure that all applicable FLSA rules for the payment of minimum wage and overtime are adhered to
- assist the participant in training techniques for their caregiver if necessary
- maintain a separate accounting for each participant and monitor participant utilization on a regular basis
- report account balances against the maximum allotment per participant to the appropriate AWC broker liaison in the DDDS Regional Office
- for participants that do not have a preferred employee in mind to provide Respite or Personal Care, the AWC vendor will make referrals and assist the individual in selecting an employee that will meet his or her needs.

Supports furnished when the participant exercises budget authority:

- Maintain a separate account for each participant's participant-directed budget**
- Track and report participant funds, disbursements and the balance of participant funds**
- Process and pay invoices for goods and services approved in the service plan**
- Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- Other services and supports**

Specify:

Additional functions/activities:

- Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget**
- Other**

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

The Agency With Choice Broker contract was competitively procured using the approved State of Delaware and Department of Health and Social Services rules. An RFP that defined the contract requirements, standards, deliverables, reporting and performance metrics was issued. Those requirements were incorporated by reference into the contract that was signed with the selected vendor. The RFP requires that the AWC broker submit an independent financial audit to DDDS each year.

DDDS monitors and assesses the performance of the FMS in the following ways:

The participant (or the participant's surrogate) is the co-employer of workers who provide waiver services. A statewide AWC broker is, as the employer of record, an IRS-approved Fiscal/Employer Agent and functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law.

DDDS monitors the AWC vendor to ensure that the contract deliverables are met and participants are in receipt of AWC vendor services in accordance with their Individual Support Plan. Two individuals within DDDS are designated as Liaisons to the AWC vendor. They report to a Senior DDDS Manager who is the manager for the AWC vendor contract. The statewide AWC broker is monitored by DDDS at a frequency established by DDDS. DDDS monitors the AWC broker's performance of administrative activities, as well as adherence to contract conditions and waiver requirements. The Community Navigators are also responsible for reporting any issues regarding the statewide AWC broker to the DDDS AWC Liaisons or the contract manager as part of their job duties.

The DDDS AWC Liaisons review expenditures against waiver coverage and whether they are accurately and appropriately assigned and reported. The AWC broker is required to provide monthly reports and documentation to the DDDS AWC Liaisons that identifies the amounts paid to employees/caregivers on behalf of waiver participants. The AWC broker will maintain signed time sheets for all employees for each pay period which can be reviewed by the DDDS AWC Liaisons at any time. If errors are noted, the DDDS Liaisons will report them to the AWC vendor for correction by the following pay period. In addition to reviewing routine reports provided by the AWC vendor, the DDDS AWC Liaisons will also periodically conduct unannounced audits of AWC records at its office location.

DDDS AWC Liaisons identify inconsistencies between utilization, expenditures, dates of service, waiver enrollment date and claims and then follow up with AWC vendor to ensure that any errors are corrected. The DDDS AWC Liaison periodically monitor units paid and account balances to ensure there are sufficient funds in each account to cover services up to the approved limit. Systemic errors require a Plan of Correction from the AWC vendor which must be approved by the DDDS AWC contract manager and will be monitored by the DDDS AWC Liaisons.

DDDS monitors claims submitted by the AWC broker using established claims oversight methods. DDDS has safeguards to ensure the payments to the AWC broker for both administrative fees and Medicaid services are in accordance with all applicable regulations and requirements.

Periodically, the DDDS Liaisons will randomly select a number of provider files maintained by the AWC broker to verify such elements as provider screening and training, copy of IRS Forms W-4 and I-9, accuracy of wage payments and withholding, compliance with US DOL FLSA rules.

Quarterly, the DDDS AWC Liaisons will verify AWC vendor payment/filing of the State Income Tax, Unemployment Tax, Workers Compensation and IRS Forms 940 and 941 and Forms W-2/W-3.

At the end of the first year, DDDS will review all AWC broker systems and practices to confirm that standard operating procedures are in place to ensure compliance with contract requirements and Medicaid regulations. Annually, DDDS will also review required reporting on performance metrics such as timeliness of payroll and payment of other invoices by the AWC vendor, participant satisfaction, and timeliness of response to customer calls where a message is left after hours, complaints resolution, etc. as specified in the contract.

Community Navigators monitor participant service delivery at a frequency identified in Appendix D-2-a which includes the delivery of the administrative services provided by the AWC broker.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested (*check each that applies*):

Case Management Activity. Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

The Community Navigators providing Targeted Case Management will have sufficient training and printed information to explain, in general, the self-directed option to families and participants. If the family is interested in this option, the Community Navigator connects the participant to the Agency with Choice provider.

Waiver Service Coverage.

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (*check each that applies*):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Home or Vehicle Accessibility Adaptations	
Assistive Technology not otherwise covered by Medicaid	
Personal Care	
Respite	
Day Habilitation	
Supported Employment - Individual	
Prevocational Services	
Supported Employment - Small Group	
Community Transition	
Supported Living	
Behavioral Consultation	
Residential Habilitation	
Nurse Consultation	
Specialized Medical Equipment and Supplies not otherwise covered by Medicaid	

Administrative Activity. Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the

methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

a) In addition to the information provided to waiver participants and families by the Community Navigators regarding the opportunity for self-direction, the Agency With Choice vendor will also be responsible for thoroughly explaining the self-direction roles and responsibilities so that participants can make an informed decision about whether this model will meet their needs.

b) The Agency with Choice Broker is a private entity that was procured through a competitive RFP issued by the Delaware Division of Developmental Services. The vendor organization which was awarded the contract demonstrated clear superiority of experience and capabilities.

DDDS has developed a standard methodology for reimbursing AWC administrative activities. There is an initial one-time set-up payment for each new participant that elects to self-direct their Respite or Personal Care service, an on-going annual payment per service recipient for continued participant training, staff screening and training, annual budgeting, etc, and a separate standard on-going monthly payment. Payment to the vendor will be a fixed dollar amount for each participant who has elected to self-direct their Respite or Personal Care service. The administrative payments to the AWC broker are entirely separate from the funds dedicated to the participant's allotment for services.

The AWC provider receives a monthly per participant administrative fee for the administrative service provided by the AWC as specified in the vendor contract. The monthly administrative fee is negotiated between DDDS and the AWC vendor and must be applied consistently across all participants who elect self-direction. The AWC broker must submit monthly invoices to the state. Administrative claims are submitted by the AWC broker to DDDS for approval and payments are made directly to the AWC broker from the Delaware Treasury via the Delaware State accounting system.

DDDS contracts with a single statewide AWC broker.

c) Once a participant has elected to self-direct their Respite or Personal Care service, the AWC broker will perform the following functions:

- Ensure that they understand their role as distinct from the AWC role
- Assist the participant in selecting caregivers that meet his or her individual needs if the participant has not previously specified a caregiver
- If the agency chooses to, or if requested by the program participant, the AWC broker will conduct the interview, with the participant, and vet potential candidates who may be able to meet the participant's support needs under Respite or Personal Care service
- Ensure that employees meet basic minimum, non-participant-specific training requirements such as CPR or safe lifting techniques
- Assist the waiver participant in understanding and carrying out their role as the managing employer
- Assist the waiver participant in resolving conflicts with their employee
- Assist the waiver participant in creating a back-up plan in the event their regular caregiver is not available for one or more days
- terminate employees who fail to perform satisfactorily (this is different from the determination of a participant that an employee is not meeting their particular needs)
- notify the Community Navigator or one of the DDDS AWC Liaisons of any concerns

The AWC broker will also create and maintain a registry of prospective workers from which waiver participants may choose.

d) and e) DDDS will oversee the provision of this assistance through monitoring of the AWC vendor contract. DDDS monitors the AWC vendor to ensure that the contract deliverables are met and participants are in receipt of AWC vendor services in accordance with their Individual Support Plan. Two individuals within DDDS are designated as Liaisons to the AWC vendor. They report to a Senior DDDS Manager who is the manager for the AWC vendor contract. The statewide AWC broker is monitored by DDDS at a frequency established by DDDS. DDDS monitors the AWC broker's performance of administrative activities, as well as adherence to contract conditions and waiver requirements. The Community Navigators are also responsible for reporting any issues regarding the statewide AWC broker to the DDDS AWC Liaisons or the contract manager as part of their job duties.

The DDDS AWC Liaisons review expenditures against waiver coverage and whether they are accurately and appropriately assigned and reported. The AWC broker is required to provide monthly reports and documentation to the DDDS AWC Liaisons that identifies the amounts paid to employees/caregivers on behalf of waiver participants. The AWC broker will maintain signed time sheets for all employees for each pay period which can be reviewed by the DDDS AWC Liaisons at any time. If errors are noted, the DDDS Liaisons will report them to the AWC vendor for correction by the following pay period. In addition to reviewing routine reports provided by the AWC vendor, the DDDS AWC Liaisons will also periodically conduct unannounced audits of AWC records at its office location.

DDDS AWC Liaisons identify inconsistencies between utilization, expenditures, dates of service, waiver enrollment date and claims and then follow up with AWC vendor to ensure that any errors are corrected. The DDDS AWC Liaison periodically monitor units paid and account balances to ensure there are sufficient funds in each account to cover services up to the approved limit. Systemic errors require a Plan of Correction from the AWC vendor which must be approved by the DDDS AWC contract manager and will be monitored by the DDDS AWC Liaisons.

DDDS monitors claims submitted by the AWC broker using established claims oversight methods. DDDS has safeguards to ensure the payments to the AWC broker for both administrative fees and Medicaid services are in accordance with all applicable regulations and requirements.

Periodically, the DDDS Liaisons will randomly select a number of provider files maintained by the AWC broker to verify such elements as provider screening and training, copy of IRS Forms W-4 and I-9, accuracy of wage payments and withholding, compliance with US DOL FLSA rules.

Quarterly, the DDDS AWC Liaisons will verify AWC vendor payment/filing of the State Income Tax, Unemployment Tax, Workers Compensation and IRS Forms 940 and 941 and Forms W-2/W-3.

At the end of the first year, DDDS will review all AWC broker systems and practices to confirm that standard operating procedures are in place to ensure compliance with contract requirements and Medicaid regulations. Annually, DDDS will also review required reporting on performance metrics such as timeliness of payroll and payment of other invoices by the AWC vendor, participant satisfaction, and timeliness of response to customer calls where a message is left after hours, complaints resolution, etc. as specified in the contract.

Community Navigators monitor participant service delivery at a frequency identified in Appendix D-2-a which includes the delivery of the administrative services provided by the AWC broker.

Appendix E: Participant Direction of Services

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k. Independent Advocacy (*select one*).

No. Arrangements have not been made for independent advocacy.

Yes. Independent advocacy is available to participants who direct their services.

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

I. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

Voluntary Termination of Participant Direction

An individual who elects to receive participant-directed Respite and Personal Care can elect to terminate participant direction at any time. The state ensures the continuity of services for and the health and welfare of the participant who elects to terminate participant directed Respite and Personal Care services.

Community Navigators shall facilitate a seamless transition to an alternative service delivery method so that there are no interruptions or gaps in services. Community Navigators shall ensure that employees remain in place until alternative providers are obtained and are scheduled to provide services. Community Navigators shall monitor the transition to ensure that the service is provided consistent with the person-centered plan and in keeping with the participant goals and objectives.

Appendix E: Participant Direction of Services**E-1: Overview (12 of 13)**

- m. Involuntary Termination of Participant Direction.** Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Involuntary Termination of Participant Direction

Participants who opt to self-direct their Respite and Personal Care services receive a great deal of support to assist them in carrying out their responsibilities. This support leads to successful participant direction in most cases. However, there are a several circumstances under which the State would find it necessary to terminate participant direction. Specifically, the State involuntarily terminates the use of participant direction under the following circumstances:

- **Inability to self-direct.** If an individual consistently demonstrates a lack of ability to carry out the tasks needed to self-direct Respite and Personal Care services, including hiring, training, and supervising his or her respite provider or personal care attendant, and does not have a representative available and able to carry out these activities on his/her behalf, then the State would find it necessary to terminate the use of participant direction.
- **Fraudulent use of funds.** If there is substantial evidence that a participant has falsified documents related to participant directed services (for example authorizing payment when no services were rendered or otherwise knowingly submitting inaccurate timesheets), then the State would find it necessary to terminate the use of participant direction.
- **Health and welfare risk.** If the use of participant direction results in a health and welfare risk to the participant that cannot be rectified through intervention on the part of the AWC provider and/or the Community Navigator, then the State would find it necessary to terminate the use of participant direction.

In cases in which participant direction is discontinued, the Community Navigator makes arrangements immediately with the participant to select from a list of provider managed personal care entities (i.e., those home health agencies and personal assistance services agencies enrolled to provide the respite or personal care). Once the individual has selected a new Respite and Personal Care provider, the Community Navigator makes arrangements to have the agency-based service begin as soon as possible to minimize or eliminate any possible gap in service.

Community Navigators shall facilitate a seamless transition to alternative service delivery method so that there are no interruptions or gaps in services. Community Navigators shall ensure that employees remain in place until alternative providers are obtained and are scheduled to provide services. Community Navigators shall monitor the transition to ensure that the service is provided consistent with the person-centered plan and in keeping with the participant goals and objectives.

Appendix E: Participant Direction of Services**E-1: Overview (13 of 13)**

- n. Goals for Participant Direction.** In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 1	320	
Year 2	350	
Year 3	360	
Year 4	375	
Year 5	390	

Appendix E: Participant Direction of Services

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

a. Participant - Employer Authority Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both:*

Participant/Co-Employer. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

The Agency With Choice broker will be the co-employer along with the participant.

Participant/Common Law Employer. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise:*

Recruit staff

Refer staff to agency for hiring (co-employer)

Select staff from worker registry

Hire staff common law employer

Verify staff qualifications

Obtain criminal history and/or background investigation of staff

Specify how the costs of such investigations are compensated:

Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

The method to conduct background checks for participant directed services is the same as Appendix C-2-a.

Determine staff duties consistent with the service specifications in Appendix C-1/C-3.

Determine staff wages and benefits subject to state limits

Schedule staff

Orient and instruct staff in duties

Supervise staff

Evaluate staff performance

Verify time worked by staff and approve time sheets

Discharge staff (common law employer)

Discharge staff from providing services (co-employer)

Other

Specify:

The participant will provide information to the AWC broker as requested to facilitate common-law employer functions. The participant will also need to have a cooperative relationship with the AWC broker.

The participant will be supported to engage to the maximum extent possible in selecting an appropriate employee wage within an allowable and reasonable wage scale and to negotiate the wage with a potential employee.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more:*

Reallocate funds among services included in the budget

Determine the amount paid for services within the state's established limits

Substitute service providers

Schedule the provision of services

Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3

Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3

Identify service providers and refer for provider enrollment

Authorize payment for waiver goods and services

Review and approve provider invoices for services rendered

Other

Specify:

--

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

- ii. Participant-Directed Budget** Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

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Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

- iii. Informing Participant of Budget Amount.** Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

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Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

- iv. Participant Exercise of Budget Flexibility.** *Select one:*

Modifications to the participant directed budget must be preceded by a change in the service plan.

The participant has the authority to modify the services included in the participant directed budget without prior approval.

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

- v. Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

DMMA mails written notifications to HCBS applicants and recipients at the time of an adverse waiver eligibility decision. The Division of Developmental Disabilities Services (DDDS) mails written notifications to HCBS waiver recipients at the time of an adverse decision regarding the lack of choice of service provider and/or if an HCB service is reduced, suspended or terminated for an individual. DDDS also mails written notification to any waiver participant that moves to another state or does not receive any waiver qualifying service of the intent to dis-enroll them from the waiver due to no longer meeting the eligibility criteria. The notification is presented in understandable language, provides an explanation for the action, describes the applicant/recipient's right to Fair Hearing via the DHSS Division of Social Services under an MOU with the Medicaid Agency and explains the method by which a Fair Hearing can be requested. The Medicaid Fair Hearing is a State administrative hearing process and its regulations are published in the Delaware Administrative Code, Section 5000. Written notifications of adverse actions are required to include the following elements:

- The right to appeal the action through the Medicaid Fair Hearing process, through an internal DDDS appeal process (see F-2-b. below) or both;
- An explanation that the request for a Medicaid Fair Hearing must be in writing;
- An explanation that the applicant/recipient may be represented at a Fair Hearing by an attorney, friend or person of their choice;
- Contact information for the Community Legal Aid Society, Inc., including a toll free phone number and advise to the recipient that they offer free legal advice/representation;
- An explanation of the reason(s) for the DDDS action including the specific regulations that support said action

The written notice must be mailed at least within ten (10) days before the effective date of the action (this applies to HCBS waiver recipients; not applicants who are not currently receiving HCB services). Exceptions to the 10 day timely notice are delineated in Delaware Administrative Code, Title 16, §5302 and are consistent with 42 CFR 431.213.

Written notifications relative to adverse actions and the right to a Fair Hearing are maintained at the Office of Applicant Services (for applicants) or maintained in the individual's case record (for current HCBS recipients). The outcome of the Medicaid Fair Hearing is maintained by Medicaid Agency.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

No. This Appendix does not apply

Yes. The state operates an additional dispute resolution process

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The Division of Developmental Disabilities Services (DDDS) operates the DDDS HCBS Lifespan Waiver. In addition to the right to a Medicaid Fair Hearing through the DSS, DDDS also offers an HCBS applicant or HCBS waiver participant an internal DDDS appeal process to appeal any adverse action affecting Medicaid eligibility or benefits. DDDS informs members simultaneously of their right to a DDDS internal appeal and a Medicaid Fair Hearing when an adverse decision is made; including the denial of eligibility, the denial, reduction, suspension or termination of Medicaid HCBS services for an individual or the lack of choice of a service provider.

HCBS waiver applicants and participants are notified via written correspondence relative to all adverse actions, as delineated in the above paragraph. The notification of adverse action clearly states in understandable language that the applicant or HCBS waiver participant may appeal the adverse decision through the DDDS internal appeals process or through the Medicaid Fair Hearing process or both. An individual is not required to file a DDDS appeal request as a prerequisite to accessing a Medicaid Fair Hearing process. The DDDS appeal is not a dispute resolution process that must be used in lieu of the Medicaid Fair Hearing, but it is offered as a less formal means of addressing grievances. The notification includes the reasons for the adverse action(s) including applicable citations and the information that was used to make the determination, effective date of action(s) and process by which a DDDS appeal may be requested. No action may be taken on a DDDS decision to deny, reduce, suspend or terminate HCBS waiver services, if an appeal request is received within the timely notice period (10 days before date of action). The notification also advises the reader of how, to whom and when a Medicaid Fair Hearing request with DSS can be made.

The DDDS appeal process is an internal agency operating mechanism and its regulations are published in the Delaware Administrative Code, Section 2101. The appeals committee membership includes a chairperson and representatives from the Stockley Center ICF-IID facility and all regions of the DDDS Community Services Unit.

Disputable items through the DDDS internal appeals process for waiver applicants or participants include:

- an adverse decision regarding a DDDS Level of Care determination or redetermination;
- the choice of service provider is not granted;
- an HCB waiver service is denied, reduced, suspended or terminated for an individual.

Procedural elements of the DDDS appeals process include the following elements:

- A timely notice (10 days before date of action) of intent to reduce, suspend or terminate waiver services must be mailed to the HCBS waiver recipient;
- Exceptions to the timely notice requirement are delineated in Delaware Administrative Code, Title 16, §5302 and are consistent with 42 CFR 431.213;
- DDDS appeals request must be received by the DDDS Appeals Committee chair within 30 calendar days of the decision;
- The appellant is contacted by the DDDS Appeals Committee chairperson within 5 working days of receipt of appeals request to schedule the appeal;
- Appeal meeting must be scheduled within 90 days of receiving the appeal request;
- HCBS waiver services must not be denied, reduced, suspended or terminated pending a decision of a DDDS appeal, Medicaid Fair Hearing or both, if a request for either is filed within ten (10) days of the proposed action implementation date. Exceptions to this rule are delineated in Delaware Administrative Code, Title 16, §5302;
- Appeal Committee members meet with the appellant, and his/her guests at the appeal meeting;
- Appeal committee chairperson offers the committee's recommendation to the Division Director within five (5) working days of the appeal.
- DDDS Division Director sends written notification of outcome to appellant within fifteen (15) working days of appeal. DDDS Division Director provides appellant with explanation of right to appeal decision to DSS via the Medicaid Fair Hearing process. Contact information is given by which a Medicaid Fair Hearing can be requested.
- DDDS Appeals Committee chairperson maintains all records associated with the appeal request. Data is tracked on an electronic database and reviewed by the DDDS Performance Analysis Committee.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

No. This Appendix does not apply

Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver

- b. Operational Responsibility.** Specify the state agency that is responsible for the operation of the grievance/complaint system:

DDDS is responsible for the operation of the internal grievance/complaint system(s). In addition, DDDS requires each waiver provider to offer an internal dispute resolution process to waiver enrollees to provide an opportunity to address grievances at the lowest level possible. Waiver enrollees are not required to use either the provider grievance process of the DDDS internal dispute resolution process before exercising their right to a Medicaid Fair Hearing for any issue that is appealable through that process.

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

Description of the DDDS grievance system:

The DDDS Director appoints an individual to hear internal grievances. In accordance with the DDDS Rights Complaint policy, Individual Rights Complaint forms and instructions for the completion of such are prominently placed and accessible in all program and administrative offices and locations within DDDS-funded program areas. The DDDS Rights and Responsibilities Policy requires the Statement of Rights to be reviewed with the waiver participant and his/her guardian by the individual that leads the planning team during the annual meeting to discuss the person centered service plan. The Statement of Rights is broken into three sections: services and supports, privacy and choice. A waiver participant or any concerned person acting on behalf of the participant has the right to file a rights complaint with DDDS if they have reason to believe that a right is being violated or restricted without due process. Rights Complaints filed with the DDDS Rights Complaint Designee are investigated at a regional level. The completed investigations of a rights complaint are reviewed by the appropriate administrator and returned to the DDDS Client Rights Complaint Designee. For substantiated complaints, a Corrective Action Plan must be developed. The Plan must be reviewed and approved by the appropriate administrator before it is returned to the DDDS Client Rights Complaint Designee. The Director of Community Services contacts the complainant regarding the disposition of the complaint. The aforementioned process is completed within sixty (60) working days of the date the Rights Complaint Designee receives the rights complaint form. The outcome of the Rights Complaint is sent to the Human Rights Committee for review

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

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

Yes. The state operates a Critical Event or Incident Reporting and Management Process (*complete Items b through e*)

No. This Appendix does not apply (*do not complete Items b through e*)

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

- b. State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an

appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

DDDS has two (2) distinct types of incidents that HCBS providers are required to report to the Division. These incidents are known as reportable "PM46" incidents and "non-PM46" occurrences. PM46 refers to Department of Health and Social Services (DHSS) Policy Memorandum number forty-six that defines incidents that must be reported for services provided in all DHSS divisions. Because DDDS is a DHSS Division, any incident that meets the scope and definition of DHSS Policy Memorandum #46 must be reported and investigated using a standardized protocol. In addition, DHSS Divisions may define additional types of critical reportable incidents that fall outside of the scope of the DHSS PM46. DDDS has a policy that requires reporting for settings not covered under the PM46 scope and incidents that would not be required to be reported under PM46.

Reportable incidents under PM46 are defined as suspicion of any of the following occurrences:

(1) "Abuse" means the infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish and includes all of the following:

a. Physical abuse. — "Physical abuse" means the unnecessary infliction of pain or injury to a patient or resident. "Physical abuse" includes hitting, kicking, punching, slapping, or pulling hair. If any act constituting physical abuse has been proven, the infliction of pain is presumed.

b. Sexual abuse. — "Sexual abuse" includes any sexual contact, sexual penetration, or sexual intercourse, as those terms are defined in § 761 of Title 11, with a patient or resident by an employee or volunteer working at a facility. It is not a defense that the sexual contact, sexual penetration, or sexual intercourse was consensual.

c. Emotional abuse. — "Emotional abuse" means the use of oral, written, or gestured language that includes disparaging and derogatory terms to patients, residents, their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. "Emotional abuse" includes the violation of resident rights and privacy through the posting of inappropriate materials on social media. "Emotional abuse" includes all of the following: ridiculing, demeaning, humiliating, or cursing at a patient or resident; punishment or deprivation; or threatening a patient or resident with physical harm.

d.1. Medication diversion. — "Medication diversion" means the knowing or intentional interruption, obstruction, or alteration of the delivery, or administration of a prescription drug to a patient or resident, if both of the following apply:

A. The prescription drug was prescribed or ordered by a licensed independent practitioner for the patient or resident.

B. The interruption, obstruction, or alteration occurred without the prescription or order of a licensed independent practitioner.

d.2. "Medication diversion" does not mean conduct performed by any of the following:

A. A licensed independent practitioner or licensed health-care professional who acted in good faith within the scope of the individual's practice or employment.

B. An individual acting in good faith while rendering emergency care at the scene of an emergency or accident

(2) "Financial exploitation" means the illegal or improper use of a patient's or resident's resources or financial rights by another person, whether for profit or other advantage.

(3) "Mistreatment" means the inappropriate use of medications, isolation, or physical or chemical restraints on or of a patient or resident.

(4) "Neglect" means the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Neglect includes all of the following:

a) Lack of attention to physical needs of the patient or resident including toileting, bathing, meals, and safety.

b) Failure to report patient or resident health problems or changes in health problems or changes in health condition to an immediate supervisor or nurse.

c) Failure to carry out a prescribed treatment plan for a patient or resident.

d) A knowing failure to provide adequate staffing which results in a medical emergency to any patient or resident where

there has been a documented history of at least 2 prior cited instances of such inadequate staffing within the past 2 years in violation of minimum maintenance of staffing levels as required by statute or regulations promulgated by the Department, all so as to evidence a willful pattern of such neglect.

The process for reporting and following up on PM#46 incidents is as follows:

The person who has reasonable cause to believe that an individual has been abused, neglected, mistreated, financially exploited, had their medication diverted, received a significant injury or dies an unanticipated death shall immediately take actions to ensure the individual receives all necessary medical treatment and evaluation and then;

1. Take actions to protect all individuals from further physical or emotional harm and then;
2. Ensure that individuals reported to be victims of sexual assault are examined by SANE at the hospital and then (or concurrently if possible); contact the local law enforcement to report crimes against individuals and then;
3. Immediately call the DDDS Regional Investigative Coordinator and then;
4. Complete a written report within twenty four (24) hours and submit it to the DDDS Regional Investigative Coordinator and then if the incident happens in a Neighborhood Home;
5. Make a verbal report to the DLTCRP by telephoning the twenty four (24) hour toll free number at 1-877-453-0012.

The DDDS Office of Incident Resolution(OIR) shall notify the individual (reported victim) unless there is an identified guardian of person (or property if the allegation involves financial exploitation), health care surrogate pursuant to Title 16, §2507 or other legally authorized person of the guardian or primary contact person, or release of information has the potential to do harm or if the individual served (victim) expressly communicates that he/she does not want the non-guardian family contact person to be contacted about the allegation. Notifications shall occur with the following frequency:

- i. Initial notification on the day the reportable incident is reported to the OIR recipient of reportable incidents (verbal and written);
- ii. Follow-up notifications if the investigation exceeds five(5) working days (for Long Term Care Facilities) or ten (10) calendar days (verbal or written);
- iii. Notification at the conclusion of the investigation (verbal and written).

Non PM46 occurrences per DDDS policy include:

- Any major medical episode (such as a trip to the Emergency Department but where abuse or neglect are not suspected)
- Any behavior which necessitates the use of a physical or restrictive procedure
- Choking incident requiring the use of the Heimlich Maneuver or other medical intervention
- Acts of aggression
- Elopement of Missing Individual
- Criminal arrest
- Possession of Illegal substances
- Possession of firearms, knives, or explosives
- Medication error
- Extensive damage to property due to an individual receiving services (valued at \$2,000)
- Attempted Suicide

These incidents must be reported via the electronic record. On a regular basis DDDS will review reported incidents, analyze data for trends, and recommend changes in policy, practice, or training that may reduce the risk of such events occurring in the future. State wide trends will be provided to Providers to enhance the awareness of activities and to formulate prevention strategies. DDDS also requires Providers to have policies and procedures that promote the utilization of their incident data to track trends and to determine if the recommendations made in the final written report were implemented and are effective.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including

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

All waiver participants are advised of their right to be free of physical, verbal, sexual, psychological/emotional abuse and exploitation both during their initial person centered planning process and as part of their annual PCP review. A Statement of Rights was developed as a DDDS policy. The case manager explains these rights to waiver participants a minimum of once per year, at the time the person centered plan is reviewed. The case manager is responsible for the development of ongoing teaching and support strategies designed to assist participants to understand and exercise his/her rights. These requirements are documented in the DDDS policy entitled Individuals Rights.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

The reporting of incidents is overseen at several levels. The most immediate review and monitoring occur at the level of the person centered planning team. Team members minimally include the Support Coordinators and staff from providers who have been chosen by the participant to deliver services. These are the same individuals who will also document incidents, develop plans of correction and monitor the effectiveness of such plans in achieving desired outcomes.

DDDS Office of Incident Resolution maintains an electronic database that includes information about the type and frequency of investigated reportable incidents, the victim and location, the plan of correction/improvement and verification of such. The data shall be used to trend incidents, measure performance and provide input for strategic planning. This stand-alone data will be incorporated into the new unified electronic case record software and will no longer exist as a stand-alone database thereafter.

The DDDS Office of Service Integrity and Enhancement reviews all reportable incident data for each provider on an annual basis as part of the review against the DDDS waiver provider standards.

For each reported incident, SIE Program Evaluators review the participant's electronic case record to determine if appropriate follow up actions were taken, if such actions were effective and if trends exist within or across providers. The outcome of the review of the incident management system by the Program Evaluators is incorporated into the annual report given to each provider.

The Office of Service Integrity and Enhancement reviews PM46 incident data for each participant included within the annual representative sample of Quality Service Reviews (QSR). The SIE Program Evaluators access the electronic case record for each participant identified within the sample and review any reportable incidents that are present for completion, follow up, and timeliness of interventions to improve safeguards, to identify trends that may impact additional participants, and to determine whether an allegation of abuse, neglect, mistreatment, or exploitation is present in the record that should have been forwarded for investigation per DHSS PM46 but was not. SIE generates a deficiency notice and a request for a detailed plan of improvement for any identified ongoing concern or unresolved issue.

Allegations of abuse, neglect, mistreatment, financial exploitation or significant injury must be reported in writing to the DDDS Office of Incident Resolution. By policy, the Office of Incident Resolution must also report some allegations to all or some of the following individuals/entities: the DHSS Secretary's Office, DDDS Director, Health Care Quality (HCQ), Medicaid Fraud Control Unit of the Department of Justice, Division of Forensic Science, applicable DDDS Regional Program Director(s), the Executive Director of the provider and law enforcement. The investigation is forwarded to the Health Care Quality pursuant to DE Code, Title 16, §1132. The waiver participant, guardian of person (and property if the allegation involves financial exploitation) and primary family contact person are notified that an investigation has been initiated, except when the participant communicates he/she does not want such information released or the release of information has the potential to do harm.

DDDS is required to complete a comprehensive investigative report for each allegation and submit it to the appropriate party as identified in the DDDS abuse policy, within ten (10) days of the initial notification of an allegation of abuse, neglect, mistreatment, financial exploitation, unless there are extenuating circumstances requiring further investigation. DDDS must also notify DLTCRP for any residences that it licenses, pursuant to DE Code Title 16, §1134(9). Upon completion of the investigation, the Support Coordinator notifies the family member that the investigation is completed, actions have been taken to protect the waiver participant and whether a further level of review will be completed by the Division of Health Care Quality, Medicaid Fraud Control Unit or the Delaware Attorney General.

Based on the type of substantiated allegation, some offenders will be reported to a central data base known as the Adult Abuse Registry (AAR) maintained by the Division of Long Term Care Residents Protection as required by DE Administrative Code Title 16 §3101. Names of offenders will remain in the AAR for a designated period of time. An appeal process is offered and the name of the substantiated offender remains on the AAR if the fair hearing officer determines that a preponderance of evidence supports the investigative determination. DE Administrative Code Title 16, §3101 requires that health care service providers, which include all waiver providers, check the names of applicants for employment against the AAR prior to making an offer of employment. Current employees must also be periodically checked against the AAR. DDDS contracts with HCBS waiver providers prohibit them from employing individuals whose names are on the AAR or for those individuals to provide direct support to HCBS waiver participants.

- e. Responsibility for Oversight of Critical Incidents and Events.** Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is

conducted, and how frequently.

The DDDS Quality Assurance Committee (QAC) reviews waiver performance measures to determine if risk reduction strategies are necessary to strengthen the DDDS systems or improve the quality of life for waiver members. The QAC is an administrative committee appointed by the Division Director and charged with the responsibility of collecting, reviewing and analyzing data that measures the Division's compliance with waiver assurances and other key data elements. The QAC subsequently generates reports that are shared within the division on a regularly scheduled frequency or as requested.

DDDS has created a reporting tool it calls "DivStat". This tool is reviewed by the QAC at its regularly scheduled meetings. The critical incident aggregate data is reported as part of the DivStat report and is reviewed by the QAC. The QAC evaluates the data, draws conclusions and looks for trends within or across providers.

Analysis of critical incident data and trends (as opposed to individual remediation that is shared with specific providers) are shared with waiver providers at the Quarterly Provider Meetings.

The DDDS Office of Service Integrity and Enhancement participates on the DMMA Quality Improvement Initiative (QII) committee and communicates with the DMMA regarding waiver performance measures. In addition, DMMA and DDDS meet each quarter to review the waiver performance measures and to monitor the status of any active Plans of Improvement.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

- a. Use of Restraints.** *(Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

The state does not permit or prohibits the use of restraints

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

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

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

As outlined in the DDDS Policy on Use of Restraints and Restrictive Procedures for Behavior Support, DDDS has adopted the philosophy and techniques of Positive Behavior Support. Positive supports are an essential foundational element in the design of services, programs and individual plans.

Under the DDDS Policy, several restrictive procedures are prohibited including:

1. The use of aversive interventions (as defined in the Policy)
2. Seclusion
3. Denial of nutritionally adequate diet (withholding meals)
4. Any behavioral treatment strategies that are not supported by empirical evidence.
5. Any restrictive interventions intended to control, manage, or change behaviors that are not part of an approved behavior support plan.
6. Mechanical restraints
7. Chemical Restraints
8. The use of bed rails for behavioral support
9. The use of enclosed cribs for behavioral support without a formal assessment and diagnosis by a medical professional operating within the scope of his/her practice of a corresponding mental health disorder

DDDS also prohibits the use of corporal punishment or threat of corporal punishment, psychological abuse or punishment, waiver participants disciplining other waiver participants or techniques or procedures used in the absence of other relative proactive supports.

All recommended planned restrictive interventions must be described in a Behavior Support Plan and are required to be reviewed and approved by Peer Review of Behavior Intervention Strategies (PROBIS) and the Human Rights Committee (HRC).

A. A Behavior Support Plan that recommends the use of restrictive interventions must include:

1. The specific targeted behavior to be addressed and a description of the conditions for which the restrictive intervention is used.
2. The single behavioral outcome desired stated in observable or measurable terms.
3. A summary of the Functional Behavioral Assessment to identify suspected antecedents and functions of the behavior.
4. A description of less intrusive techniques used prior to the use of the restrictive interventions.
5. Methods and target dates for modifying or eliminating the target behavior.
6. Methods and target dates for a replacement behavior.
7. A description of the intervention to be used.
8. A risk/benefit analysis.
9. Medical clearance if appropriate
10. Informed Consent from the individual, Health Care Surrogate, and/ or Guardian.
11. The name of the person(s) responsible for monitoring and documenting the response to the planned restrictive intervention.
12. A plan for reducing and/or eliminating the restriction or planned restraint written within the Behavioral Support Plan, and if appropriate a detailed explanation and justification for continuing the planned restraint or restrictive intervention.

Permitted Planned Personal Restraints:

Permitted planned personal restraints are limited to the one and two-person side body hug and the one and two-arm supporting technique, as described in the DDDS-approved Mandt curriculum or other DDDS-approved crisis intervention training.

Permitted Use of Restraints for Emergency Crisis Intervention (as defined in DDDS Policy):

1. When an emergency crisis intervention is necessary, only restraints that are taught as part of a DDDS approved Crisis Intervention Curriculum are permitted to be used. Restraints must be terminated when the individual is no longer a risk to himself/herself or others;

2. Immediately stop the implementation of an emergency crisis intervention if the individual exhibits signs of distress (i.e. respiratory distress, seizure activity, vomiting, bleeding, change of skin coloring, etc.)
3. If the use of an Emergency Crisis Intervention planned or unplanned is used, an Emergency Medical/Behavioral Intervention Strategy (EMBIS) report must be completed by the staff involved with the intervention. A member of the DDDS Behavioral Unit must review the report for completeness and seek clarification of any issues noted. The support team must meet within 5 business days to discuss the individual's plan and circumstances surrounding the use of the intervention and develop or modify the behavior support plan. The EMBIS must be presented at PROBIS at the next scheduled meeting.
4. The 911 emergency response systems shall only be used as a last resort or as intensity requires protecting the health and safety of the individual.
5. Suicide threats shall be responded to as an emergency and 911 shall be contacted. If a written plan of intervention exists for the individual, staff shall follow it.

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

DDDS is responsible for the oversight of the providers' use of restraints. DDDS analyzes restraint data as described above.

Each provider has access to the electronic case record system (ECR). Every use of a restraint, whether it is planned or emergency, is reported in the ECR by the involved parties within 24 hours using the critical event reporting process for Emergency Medical/Behavioral Intervention Strategies (EMBIS). These reports describe the incident, the restrictive intervention that was used, a description of the events leading up to the restraint, the duration of the restraint and follow-up, as necessary to assure the health and safety of the individual.

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

Additionally, the Office of Service Integrity and Enhancement conducts annual reviews which include consumer interviews where individuals are asked about their health and welfare. Prior to these interviews the Office of Service Integrity and Enhancement reviews the electronic case record database for any incidences of the use of a restraint for that individual. DDDS meets with the Medicaid Agency quarterly to review waiver performance data that includes data on incidents and complaints.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

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

The state does not permit or prohibits the use of restrictive interventions

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

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

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

As articulated in the DDDS Policy on the Use of Restraints and Restrictive Procedures, positive supports are an essential foundational element in the design of services, programs and individual plans. The policy discourages the use of restrictive procedures.

DDDS has adopted definition for a restrictive procedure from the Disability Act of 2006. Restrictive Intervention is defined in the Disabilities Act as "any intervention that is used to restrict the rights or freedom of movement of a person with an intellectual disability including chemical restraint, mechanical restraint and seclusion".

DDDS has adopted definition for an aversive intervention from November 2014 Research Committee of the National Association of Directors of Developmental Disabilities Services (NASDDDS). Aversive interventions are defined as "interventions intended to inflict pain, discomfort and/or social humiliation or any intervention as perceived by the person to inflict pain, discomfort or social humiliation in order to reduce behavior. Examples of aversive interventions include, but are not limited to, electric skin shock, liquid spray to one's face and a strong, non-preferred taste applied to the mouth".

Before the use of planned restrictive interventions can be approved in a Behavior Support Plan, the use of alternative, less intrusive methods must be explored and determined to not meet the need.

All planned restrictive interventions are required to be reviewed by PROBIS and approved by the Human Rights Committee.

The use of restrictive and/or planned restraint interventions shall be an approved detailed planned procedure identified in the Behavior Health Support Plan that shall include:

1. The specific targeted behavior to be addressed and a description of the conditions for which the restrictive intervention is used.
2. The single behavioral outcome desired stated in observable or measurable terms.
3. A summary of the Functional Behavioral Assessment to identify suspected antecedents and functions of the behavior.
4. A description of less intrusive techniques used prior to the use of the restrictive interventions.
5. Methods and target dates for modifying or eliminating the target behavior.
6. Methods and target dates for a replacement behavior.
7. A description of the intervention to be used.
8. A risk/benefit analysis.
9. Medical clearance if appropriate
10. Informed Consent from the individual, Health Care Surrogate, and/ or Guardian.
11. The name of the person(s) responsible for monitoring and documenting the response to the planned restrictive intervention.
12. A plan for reducing and/or eliminating the restriction or planned restraint written within the Behavioral Health Support Plan, and if appropriate a detailed explanation and justification for continuing the planned restraint or restrictive intervention.

Methods for Detecting Unauthorized use of Restrictive Interventions

Each provider has access to the electronic case record system. Every use of a restrictive intervention is electronically submitted by the involved parties within 24 hours using the General Event Report (GER) report.

These reports provide information identified in the Behavior Support Plan which will include a description of the incident, a description of the events leading up to the restrictive intervention, the duration of the restrictive intervention, follow-up to assure the health and safety of the individual.

Additionally, provider support staff enters notes for each individual into the electronic case record system for each date of service. Case managers and DDDS clinical support staff review this information several times a week. The DDDS Regional Program Director receives electronic notification of the use of any restrictive interventions and reviews the report. Improper or unauthorized use of a restrictive intervention is considered

abuse and is investigated through the critical event reporting processes.

Restrictive intervention information for each individual is reviewed by the participant's support team at least bi-monthly or more frequently, as indicated in the Behavior Support Plan. Restrictive intervention information is reviewed by the PROBIS committee.

The Office of Service Integrity and Enhancement conducts Individual and Focused case reviews that include record reviews. For waiver participants for whom a restrictive intervention was applied, SIE conducts an interview with the participant to determine if the intervention was performed appropriately. Undocumented use of a restrictive procedure is reported to the Regional Program Director who is responsible for follow up to ensure the individual's health and safety and to determine how to prevent further use of undocumented restrictive interventions.

Any undocumented use of a restrictive procedure which constitutes suspected abuse or neglect is investigated through the reportable critical incident process. The Office of Service Integrity and Enhancement submits quarterly reports to the Delaware DMMA which includes data on incidents and complaints.

Education and Training Requirements for Personnel who Administer Restrictive Interventions:

The DDDS Training Policy specifies required trainings and timelines for completion for each type of practitioner that has direct contact with waiver participants. Provider compliance with training requirements for each staff participant is monitored by the both the DDDS Office of Professional Development, on a provider and statewide basis, and by the DDDS Office of Service Integrity and Enhancement as a part of the Quality Service Review sampling process for a site selected during the review.

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

Providers are required to train their direct support staff on the DDDS policy relevant to the use of restrictive interventions. All providers are required to participate in DDDS-approved crisis intervention training. Waiver providers must be certified for each specific restrictive intervention prior to its use with an individual.

DDDS-Approved Crisis Intervention System includes the following topics:

- 1) Environmental factors and triggers,
- 2) Positive behavioral support,
- 3) Person-centered alternatives to the use of restrictive interventions and training in body mechanics that illustrates how to avoid hyperextensions and other positions that may endanger individual safety,
- 4) Awareness of the impact of the individual's health history on the application of a restrictive intervention,
- 5) Training in the use of approved restrictive interventions, including permitted holds, and possible negative psychological and physiological effects of restrictive interventions,
- 6) Monitoring of an individual's physical condition for signs of distress or trauma, and
- 7) Debriefing techniques with the supported individual as well as staff participants.

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

DDDS is responsible for the oversight of the use of restrictive interventions and for ensuring that provider staff are trained in a DDDS-approved curriculum regarding crisis intervention. DDDS analyzes restrictive intervention data as described above.

Every use of a restrictive intervention is reported in the electronic case record by the involved parties employed by the provider within 24 hours using the proscribed reporting protocol. These reports provide information identified in the Behavior Support Plan which includes a description of the incident, a description of the events leading up to the restrictive intervention, the duration of the restrictive intervention and any required follow-up actions.

Additionally, provider support staff enters notes for each individual into the electronic case record system for each date of service. Case managers and DDDS clinical support staff review this information several times a week. The DDDS Regional Program Director receives electronic notification of the use of any restrictive interventions and reviews the report. Improper or unauthorized use of a restrictive intervention is considered abuse and is investigated through the critical event reporting processes.

Restrictive intervention information for each individual is reviewed by the member's support team at least bi-monthly or more frequently, as indicated in the Behavior Support Plan. Restrictive intervention information is reviewed by the PROBIS committee.

The Office of Service Integrity and Enhancement conducts Individual and Focused case reviews that include record reviews. For waiver participants for whom a restrictive intervention was applied, SIE conducts an interview with the participant to determine if the intervention was performed appropriately. Undocumented use of a restrictive procedure is reported to the Regional Program Director who is responsible for follow up to ensure the individual's health and safety and to determine how to prevent further use of undocumented restrictive interventions.

The DDDS Office of Service Integrity and Enhancement and the DDDS Training Unit are responsible for monitoring provider compliance with training requirements, including the requirement for training for provider staff in DDDS-approved crisis intervention techniques.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

The state does not permit or prohibits the use of seclusion

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

The DDDS Policy on "Use of Restraints or Restrictive Interventions for Behavior Support" prohibits the use of seclusion for any reason. It is defined in the policy as one of the "prohibited practices".

The Quality Service Review (QSR) process conducted by the DDDS Office of Service Integrity and Enhancement includes on-site inspection, record review, and individual survey, to ensure a standardized approach to measure compliance with DDDS quality standards. This includes monitoring the absence of prohibited restrictive interventions, including seclusion. Program Evaluators from the Office of Service Integrity and Enhancement (SIE) complete the QSR to measure compliance with the DDDS Provider Standards for Home and Community Based Services, which are consistent with the goals of the CMS HCBS Settings Rule, DDDS policies and procedures, and individual outcomes.

The case manager also asks the waiver participant if they have been isolated for any period as part of their face to face monitoring visits with the waiver participant. The case manager must use language that can be understood by the waiver participant.

Both the SIE Program Evaluators and the case managers will conduct an environmental scan of waiver settings to determine if there appear to be places where seclusion could be imposed.

The use of seclusion is permitted during the course of the delivery of waiver services. Complete Items G-2-c-i and G-2-c-ii.

- i. Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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

Appendix G: Participant Safeguards

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

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

- a. Applicability.** Select one:

No. This Appendix is not applicable (do not complete the remaining items)

Yes. This Appendix applies (complete the remaining items)

- b. Medication Management and Follow-Up**

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

Residential Habilitation Agency Providers:

DDDS requires waiver residential habilitation agency providers to have a policy that provides for a medication management system that addresses the elements below for anyone for whom medications have been prescribed. The policy must include protocols to ensure that medication administration protocols for participants living in provider managed settings are followed in day programs, as applicable.

- An individual's ability to participate in the medication administration process
- Medication errors

Residential providers ensure that day program providers maintain a separate Medication Administration Record (MAR) for all medications administered. MARs are to be forwarded to the residential agency no later than the 5th day of the following month.

All waiver providers subject to Limited Lay Administration of Medication (LLAM) regulations are required to maintain a LLAM Monthly Medication Error Report, retained on site and readily available for inspection at all times. All waiver providers subject to LLAM must provide an annual LLAM report to DDDS for review. This annual reporting period is July 1st to June 30th, and must be received by the DDDS LLAM program coordinator no later than July 14th.

The residential provider agency is responsible for delivering medications to the day service site in a pharmacy container labeled by the pharmacy, prescribing practitioner, or RN and must ensure that the day service provider has the most current medication order on file.

The residential provider agency is responsible for notifying the day service provider of any medication changes.

- Staff certification in LLAM
- Timely submission of required reports to DDDS of information as required by the Delaware State Board of Nursing
- Effectiveness of corrective action plans

Shared Living Providers:

DDDS requires Shared Living Providers to coordinate with the DDDS Office of Community Services and the support team of the waiver participant to which they are providing services to:

- Maintain an annual Shared Living Medication Administration (SLAM) program certification issued by DDDS.
- Submit monthly medication reports to the Nurse Consultant, if the waiver participant has elected to receive that service or to a designated DDDS nurse if the participant has not elected to receive Nurse Consultation.
- Assess an individual's level of ability to participate in the medication process.
- Report any medication errors to the Physician, Nurse Consultant, and Office of Incident Resolution when warranted. This must occur within 24 business hours.

Health and Medication Management Monitoring:

The initial monitoring is completed in all residential habilitation agencies by agency staff that has been assigned this role by the provider. In Shared Living settings, the Nurse Consultant or designated DDDS nurse monitors participant medication regimens. Day services follows the same protocols as the residential providers in the management of medications for waiver participants in their settings. Additional monitoring of the day service provider administration of medication is conducted by the Nurse Consultant and the DDDS Office of Service Integrity and Enhancement through its Quality Service Reviews.

Provider Agency Role: The scope of monitoring documentation by the residential waiver provider agency includes: daily medication administration record review and weekly review of the individual's health regimen (medications, orders, proper storage, appointments, etc.). The residential provider agency must ensure that proper monitoring and oversight is in place to ensure that medications are being administered as ordered.

Nurse Consultant Role: For participants that are authorized to receive Nurse Consultation, the Nurse Consultant reviews and monitors the provider's records and completes a medication and health audit at least monthly and communicates the findings to the provider for timely and appropriate follow up. The Nurse Consultant refers to the previous reviews to assure the designated staff has addressed any previously identified unresolved issues. Documentation in the electronic case record, including incident reports as needed, is completed on a frequency that is specified in the DDDS Community Occurrence Reporting Policy. This monitoring system is designed to detect opportunities to mitigate risk and improve processes through a system of accountability. The system evaluates all components of the health and medication management process. The Nurse Consultant also completes a Pre-Assessment to determine if the individual can be considered for self-administration of medication. Approval for the continuance of self-administration of medications is reviewed by the team at the annual meeting or as indicated by errors, etc. If the waiver participant does not receive Nurse Consultation, DDDS Office of Service and Enhancement provides the above outlined review and monitoring through the Quality Service Review (QSR) process.

DDDS Office of Service Integrity and Enhancement (SIE) Role: SIE, as part of their Quality Service Review (QSRs) requires residential habilitation agency provider staff to complete a comprehensive health and medication review for all waiver participants for whom medications have been prescribed. The agency must also observe its staff performing medication administration. Second-line monitoring is conducted on the use of behavior modifying medications as part of the monitoring of a Behavior Support Plan as described in Appendix G-2.

A Behavior Support Plan must be developed for any individual as specified per DDDS policy. The DDDS Peer Review of Behavioral Strategies Committee (PROBIS) must review, approve and monitor all Behavioral Support Plans that include the use of medication for the treatment of a mental illness or for the purpose of behavior control in the absence of a psychiatric diagnosis.

DDDS Policy indicates that Behavior Modifying medications be used if these steps are followed:

1. A Functional Behavioral Assessment is completed by a Behavior Analyst. If the Functional Behavioral Assessment recommends the use of a behavior modifying medication as in intervention, a referral will be made to a medical professional for further evaluation. All recommended behavior interventions must include Positive Supports.
2. If a behavior modifying medication is recommended, the prescriber shall provide a written order for the medication and note the indication for the medication use. Risks and benefits of the medication, including any side effects, will be documented as part of a risk benefit analysis.
3. The medication shall be used in conjunction with the Behavior Support Plan.
4. The behavior modifying medication is only prescribed for a condition that is diagnosed according to the most current edition of the American Psychiatric Association's Diagnostic and Statistical Manual (DSM). Exceptions exist when a prescriber feels that there may be a beneficial treatment in which case it is monitored through the PROBIS committee for effectiveness.

Behavior Support Plans (BSP) that indicate the use of a psychotropic medication for the treatment of a mental illness must be reviewed by the support team prior to beginning the medication. Additionally, the BSP must be submitted to PROBIS within 90 days of beginning the medication and shall include the support team's recommendation for the frequency of future monitoring of the plan and who will monitor the continued use of the medication and its impact on the waiver participant.

A Program Manager that works for the waiver provider agency is also responsible for reviewing the participant's treatment plan for the behavior modifying medication on a monthly basis.

Monitoring includes recording the waiver participant's response to treatment in comparison to established treatment goals for which the medication was prescribed. The participant's support team is notified whenever the participant's response to treatment is not meeting established goals or if undesired side effects are identified. The support team, under the leadership a Behavior Consultant arranges for the participant to meet with the prescribing physician for further evaluation should the treatment not result in the desired outcome(s).

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

DDDS is the state agency responsible for the oversight of the policies and procedures regarding medication administration for waiver participants who receive a waiver-funded residential or day service. Participants who are authorized to receive Nurse Consultation service are assisted by the case manager to select a provider from a set of qualified providers. The Nurse Consultant conducts a thorough monthly Health and medication monitoring review and issues a report of findings. The report of findings is stored in the participant's electronic case record to enable the designated staff to provide necessary follow up actions. The Nurse Consultant refers to the previous reviews to assure the designated staff has addressed previously identified unresolved issues. If the individual does not receive Nurse Consultation services and does not self-administer their prescribed medications, a DDDS nurse will be assigned to provide oversight and monitoring to the residential provider that would be responsible for assisting the individual with medication administration. A third monitoring piece is performed by the DDDS Office of Service Integrity and Enhancement (SIE), as part of their annual sampling process for Neighborhood Homes and Community Living Arrangements. SIE completes a comprehensive medical record review and medication assistance observation as part of this process. This review includes all settings in which a waiver participant who is living in an agency provider managed setting receives a waiver service, including day programs. A DDDS nurse provides additional Health and Medication oversight which follows the SIE annual schedule for site reviews.

The Nurse Consultant's monitoring role is designed to focus on all medication types and medication usage patterns ordered for each participant. The Nurse Consultant's methods for conducting monitoring in Neighborhood Homes and CLAs include the review of all medical issues related to the individual and the completion of a Monthly Medication and Health Audit.

The audit requires the Nurse Consultant to check the waiver participant's current Medication Administration Records (MAR) against Physicians' Orders and against medication labels to assure agreement. An accountability of medication is completed. The Nurse Consultant also performs the following tasks:

- Ensures that medications are adequately stocked, properly stored, and not expired
- Compares count sheets and the amount of medication remaining against the amount noted on the count sheet
- Assures Standing Medical Orders (SMOs) are updated annually by the physician.

Additionally, on an annual basis, SIE conducts a similar review of documentation of medications, review of medications present in the home, and direct observations of participants receiving assistance with their medication. If the individual attends a day program, they also visit and review these items there.

In Shared Living homes for individuals that are authorized to receive Nurse Consultation, the provider completes a Monthly Medication Record, which is forwarded to the participant's Nurse Consultant. If the individual does not receive Nurse Consultation services and does not self-administer their prescribed medications, the Monthly Medication Record will be forwarded to the assigned DDDS nurse for review. This form lists all medications the participant is taking and whether the medication was "held" or changed during the reporting month. For newly ordered medications, the nurse provides consultation to the provider about any potential side effects that need to be observed and reported if they occur. The discussion includes the nurse making sure side effect information is received from the pharmacy. The frequency of monitoring by the nurse in Neighborhood Homes and Community Living Arrangements occurs at least monthly with visits to each of these residential sites. Additionally, SIE completes a comprehensive medication review at each site identified in the Quality Service Review process.

In Shared Living Homes, monitoring by the nurse includes reviewing the Monthly Medication Record, monthly telephone or email contacts with the provider, and at least 2 home visits annually for those service recipients that are level 1-2 and a minimum of quarterly home visits for those service recipients that are level 3 and higher to meet with the participant and the provider and verify that medications are stored as required by DDDS policy. The Nurse Consultant completes a quarterly health review in the electronic health record which is then forwarded to the Shared living provider to address any action steps. This review ensures all follow up physician orders are adhered to. The Nurse Consultant also participates in the individual's annual planning process, which includes discussion and documentation of the individual's medications, health status, and needs for support.

The state monitoring program gathers information concerning potentially harmful practices and employs information to improve quality by the following means: In Neighborhood Homes and CLAs, the nurse completes the medication review in the electronic record and forwards the report to the designated provider staff via electronic mail. The designated provider staff corrects any errors or makes comments and returns the form to the

nurse upon completion. The nurse notifies the designated provider staff of any issues needing immediate attention. Should the medication review identify any medication errors, a Medication Incident Report (General Event Report [GER] in the electronic case record system- related to any event causing or has the ability to potentially cause injury, which has serious impact on the individual or others) is filed by the provider and reported to the OIR. The annual provider review by the DDDS SIE serves as an indicator as to the effectiveness of the provider and nurse consultant's monitoring of the medications.

From these reports, incident specific corrections are required of provider agencies. From the GERs, the DDDS is able to create Data Analysis Reports for the review of medication error types and risks in the assistance with medication system, as well as identify corrective actions. The reports are generated for either a provider or System Level of Inquiry. Each provider agency is required to complete a monthly LLAM medication error report and maintain it on site. This report must also be forwarded to the DDDS on a monthly basis.

Appendix G: Participant Safeguards

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

c. Medication Administration by Waiver Providers

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

Not applicable. *(do not complete the remaining items)*

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

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

Provider Administration of Medications:

The Limited Lay Administration of Medications (LLAM) curriculum provides agencies with a curriculum that is approved by the Delaware Board of Nursing for medication administration of unlicensed assistive personnel (UAP). The staff who has successfully completed the LLAM curriculum and/or annual recertification may administer medication. The LLAM curriculum applies to all residential agency waiver providers and includes any other day settings where waiver participants may spend their day. Shared living providers must complete and adhere to the DDDS's Sharing Living Medication Administration (SLMA).

LLAM Guidelines:

State LLAM regulations require that "Unlicensed Assistive Personnel" (UAP) must successfully complete all sections of the DDDS Limited Lay Administration of Medication (LLAM) Course.

Completion of the initial LLAM course required of all newly hired staff consists of:

Attend 2 (two) consecutive classroom days for 13 (thirteen) hours.

- Successful demonstration of skills
- Written exam with passing score of 85% or better
- Successful Demonstration of 10 (ten) Supervised Field Medication Passes
- Will be completed within 60 days of 1st day of class date

A "Letter of Completion" will be issued to each participant once the classroom portion of the course is completed, but is only valid after 10 (ten) medication passes have been successfully completed and signed by the provider supervisor/designee. The "Letter of Completion" and the corresponding completed "10 Supervised Field Medication Pass Observations" will be maintained in the employee file at the employing provider. Staff is not authorized to pass medications to DDDS individuals until these documents are signed and dated as indicated.

Failure to successfully complete all of the requirements of the program within the specified time frame of 60 days will require the participant UAP to re-take the two (2) day program before administering medications to individuals of DDDS.

If participant fails either the skill session(s) or exam, he/she may retake the session or exam one (1) time. If the participant fails a second time, he/she will be required to repeat the full two (2) day course after 6 months with recommendations from his/her supervisor that he/she is prepared to retake the course.

If a LLAM trained UAP commits two medication errors within a six (6) month time frame, he/she must repeat the entire LLAM training program including five (5) Supervised Field Medication Pass Observations before resuming LLAM duties.

Thereafter, the LLAM trained UAP must renew their training annually:

LLAM trained UAP's are required to maintain current CPR status.

The provider must monitor LLAM expiration dates for their staff. Any UAP whose LLAM training has expired will not be authorized to administer medications to DDDS individuals.

It is the provider's responsibility to monitor the number of medication errors and to take appropriate steps as outlined by this curriculum.

LLAM Instructor Qualifications

New Instructor Requirements:

- Active Delaware or compact state RN license in good standing.

- One year of clinical nursing experience, including experience in medication administration.
- At a minimum, observation of the presentation and successful completion of the core curriculum and any eligible program specific module to be taught.
- Presentation of at least one component of the core curriculum and any eligible program specific module to be taught with observation by a qualified instructor. Documentation of observation must be completed on the Limited Lay Administration of Medications (LLAM) Instructor Monitor Form and provided to the eligible program.

Once the above requirements have been completed, the nurse must submit the following documentation to the DDDS LLAM Program Coordinator:

- A copy of his/her RN license
- Resume
- A copy of the class voucher to verify class attendance
- Limited Lay Administration of Medications Instructor Monitor Form
- Letter of Recommendation from his/her supervisor

When the DDDS LLAM Program Coordinator determines all requirements have been met, a letter will be issued to the RN recognizing him/her as an approved instructor to teach Limited Lay Administration of Medication (LLAM) course that has been approved for the Division of Developmental Disabilities Services programs. The nurse must meet all requirements as outlined by the Board of Nursing to continue with his/her Instructor status.

Current Instructor Requirements:

- Qualified instructors must present a minimum of one core curricula and eligible program specific module per year. If an instructor fails to present in a single year, that instructor must again complete the core curriculum and any eligible program specific module before s/he will be deemed a qualified instructor.
- All instructors of courses related to "Assistance with Self-Administration of Medications" approved by the Board as of July 1, 2015 will qualify as LLAM instructors pursuant to regulation 5.3 without being required to satisfy regulations 5.3.1.3-5.3.1.4. Existing AWSAM instructors, grandfathered into the LLAM program need to present a minimum of one (1) course per year.

A list of all LLAM instructors will be maintained by the DDDS LLAM Program Coordinator and submitted annually to the Board of Nursing as part of the Limited Lay Administration of Medication (LLAM Annual Report)

Field Medication Passes

The observed field medication passes are designed to give the UAP trainee the opportunity to practice the application of the information that they have learned in the classroom. The field pass is an exercise for the UAP trainee and serves as an opportunity for the authorized observer to share his/her knowledge and expertise with the trainee.

A medication pass is defined as administering or assisting with the administration of medication(s) during one (1) medication pass time regardless of how many individuals at this time were provided medication. A trainee can only receive credit for the completion of one medication pass at a time with no exceptions. Ten (10) supervised medication passes are required because the purpose of supervised passes is to help the trainee become familiar with the entire medication process from start to finish, with no errors.

The Provider is responsible for ensuring that there is a system in place to monitor the ongoing performance and supervision of the field medication passes occurring in all of its programs.

If the LLAM trained UAP trainee fails to correctly carry out any one (1) step of the medication pass, the medication pass is considered unsuccessful and must be repeated correctly at another time after reviewing the steps of the medication process.

In the event that a LLAM trained UAP transfers from one provider to another, five (5) medication passes are required to demonstrate competency. Staff is not authorized to pass medications to DDDS individuals until the five (5) medication passes are completed and documented on the Supervised Medication Pass Observation form. LLAM renewal will continue as required, on a yearly basis, from the date of the last renewal.

The authorized observer is:

- An employee with the division of Developmental Disabilities Services (DDDS) or a DDDS contractor with a minimum of two (2) years of experience. These individuals shall have no history of medication errors over the past one (1) year and shall be current in all criteria for LLAM trained UAP's from the Limited Lay Administration of Medication (LLAM) course; or
- A supervisor with DDDS or a DDDS contractor, at least at a Program Manager or Program Coordinator level with a minimum of six (6) months of experience. These individuals shall also be current in all criteria for LLAM trained UAP's from the Limited Lay Administration of Medication (LLAM) course; or
- The Observer currently holds a valid state of Delaware nursing license, has attended the two day Limited Lay Administration of Medication (LLAM) course through DDDS and has worked with the DDDS system for a minimum of three (3) months.

There is mutual responsibility between the authorized observer and the trainee. Extreme caution and care will be made to ensure the individual's safety during the process of medication administration. A medication error could be considered neglect, resulting in criminal investigation, charges, and or fines.

The LLAM trained UAP may:

Participate solely within the confines of the core curriculum and any applicable program eligible module

Administer medication without assessing the appropriateness or effectiveness of the prescribing practitioner's medication order.

Administer injectable emergency medications pursuant to the core curriculum.

The LLAM trained UAP may not:

Administer medications through a feeding tube, including nasogastric, gastrostomy, or jejunostomy tubes.

Be held responsible for assessing pharmacy accuracy either by identifying the appearance of the medication or assessing proper medication dosing for medications released by the pharmacy.

Documentation:

All providers will maintain the "Letter of completion" and 10 Supervised Field Medication Pass Observations in the employee file as evidence of compliance with the Delaware LLAM Program. Providers must ensure there is a system in place to monitor on-going performance and supervision of the field passes, along with the general program. The curriculum stresses the overall integrity of the provider program and depends upon sound internal quality assurance practices. DDDS OQI confirms both the Classroom/Practicum and the Supervised Medication Field Passes are completed during routine annual audits.

Providers assume responsibility for ensuring compliance and competency of the process. Providers assume liability for the integrity of the provider medication program.

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

Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).

Complete the following three items:

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

It is the provider's responsibility to keep a monthly LLAM Medication error report. This report is retained on site and must be readily available for inspection at all times. A copy of the medication error report is sent to DDDS LLAM coordinator monthly. Per LLAM Providers are required to report med errors to the Nurse Consultant (if applicable), the physician, and DDDS Office of Incident Resolution(OIR). They are also required to make a report in the electronic case record system.

All providers and settings subject to the LLAM curriculum must provide an Annual Report to DDDS for review. This annual reporting period is July 1st to June 30th, and must be received by the DDDS LLAM program coordinator no later than July 14th. Please refer to attached "Limited Lay Administration of Medications (LLAM) Annual Report Form". The DDDS LLAM Coordinator provides this Annual Report to the Delaware Board of Nursing.

The DDDS Quality Assurance Committee (QAC) reviews reports on the rates of medication errors by type, at least annually. Data is analyzed not only by error type, but also by provider. In this way, the DDDS can analyze system-wide challenges, as well as pinpoint individual provider performance issues.

DDDS's monitoring methods are designed to identify problems in provider performance and to support follow-up remediation actions and quality improvement activities.

Data is acquired to identify trends and patterns and to support improvement strategies primarily through the electronic case record system. Additional sources of data for drawing correlations are the SIE Incident Management Database and the Nurse Consultant Monthly Health Audits.

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

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

The types of medication or treatment errors providers must record are:

- A. Medication is administered to the incorrect individual
- B. An individual receives the incorrect medication
- C. Medication is given via an incorrect route of administration
- D. Medication is administered at an incorrect time
- E. Medication is administered at an incorrect dose
- F. Medication is not administered at all (i.e., medication omission)
- G. Medication is administered without a prescription
- H. Medication is administered after the medication expiration date
- I. Medication is stored incorrectly (i.e., not stored according to label instructions)
- J. Medication documentation is transcribed incorrectly (e.g., failure to correctly document medication information in MAR)

It is the provider's responsibility to keep a monthly LLAM Medication error report. This report is retained on site and must be readily available for inspection at all times. A copy of the medication error report is sent to DDDS LLAM coordinator monthly. Per LLAM, providers are required to report med errors to the Nurse Consultant (if applicable), the physician, and DDDS Office of Incident Resolution (OIR). They are also required to make a report in the electronic case record system.

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

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

The types of medication or treatment errors providers must record are:

- A. Medication is administered to the incorrect individual
- B. An individual receives the incorrect medication
- C. Medication is given via an incorrect route of administration
- D. Medication is administered at an incorrect time
- E. Medication is administered at an incorrect dose
- F. Medication is not administered at all (i.e., medication omission)
- G. Medication is administered without a prescription
- H. Medication is administered after the medication expiration date
- I. Medication is stored incorrectly (i.e., not stored according to label instructions)
- J. Medication documentation is transcribed incorrectly (e.g., failure to correctly document medication information in MAR)

It is the provider's responsibility to keep a monthly LLAM Medication error report. This report is retained on site and must be readily available for inspection at all times. A copy of the medication error report is sent to DDDS LLAM coordinator monthly. Per LLAM, providers are required to report med errors to the Nurse Consultant (if applicable), the physician, and DDDS Office of Incident Resolution (OIR). They are also required to make a report in the electronic case record system.

All providers and settings subject to the LLAM curriculum must provide an Annual Report to DDDS for review. This annual reporting period is July 1st to June 30th, and must be received by the DDDS LLAM program coordinator no later than July 14th. Please refer to attached "Limited Lay Administration of Medications (LLAM) Annual Report Form". The DDDS LLAM Coordinator provides this Annual Report to the Delaware Board of Nursing.

The DDDS office of Service Integrity and Enhancement will confirm that all required documentation as described in the above mentioned LLAM trained UAP criteria are present during audits, as evidence of the authorization to assist without direct supervision during the administration of medications.

A copy of the monthly error report is sent by provider to DDDS Office of Incident Resolution and DDDS Training Unit by the 5th of the month.

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

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

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

DDDS' is the state agency responsible for the on-going monitoring of waiver provider performance in medication management. Monitoring occurs through routine review of all medication error reports. Additionally, the DDDS Quality Assurance Committee (QAC) reviews reports on the rates of medication errors by type, at least annually. Data is analyzed not only by error type, but also by provider. In this way, the DDDS can analyze system-wide challenges, as well as pinpoint individual provider performance issues.

DDDS's monitoring methods are designed to identify problems in provider performance and to support follow-up remediation actions and quality improvement activities.

Data is acquired to identify trends and patterns and to support improvement strategies primarily through the electronic case record system. Additional sources of data for drawing correlations are the SIE Incident Management Database and the Nurse Consultant Monthly Health Audits.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. (For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")

i. Sub-Assurances:

- a. *Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death. (Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:

G-a-1: The percent of critical incidents that are investigated within the required time per DDDS policy. Numerator: The number of critical incidents that are investigated within the required time frame. Denominator: The total number of critical incidents reported to or identified by DDDS during the reporting period.

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

The DDDS Office of Incident Resolution Data Base

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	Other Specify: <input type="text"/>

Performance Measure:

G-a-2: The percent of substantiated critical incidents for which DDDS had approved the quality improvement plan(s) Numerator: The number of substantiated critical incidents for which DDDS has approved the quality improvement plan(s).

Denominator: Total number of substantiated critical incidents for which a quality improvement plan was required.

Data Source (Select one):

On-site observations, interviews, monitoring

If 'Other' is selected, specify:

The DDDS Office of Incident Resolution Data Base

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

	Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input style="width: 100%; height: 20px;" type="text"/>

Performance Measure:

G-a-3 The % of providers with substantiated incidents with a quality improvement plan (QIP) receiving technical assistance to reduce recurrence of incidents.

Numerator: The number of Providers w/ substantiated incidents requiring QIPs receiving technical assistance. Denominator: The number of Providers w/ substantiated incidents requiring QIPs.

Data Source (Select one):

Other

If 'Other' is selected, specify:

The DDDS Office of Incident Resolution Data Base

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	<input style="width: 100%; height: 20px;" type="text"/>

b. Sub-assurance: *The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.*

Performance Measures

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

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

Performance Measure:

G-b-1: The % of substantiated critical incidents of abuse, neglect,etc where recommended actions to protect health and welfare were implemented. Numerator: The total # of substantiated critical incidents of abuse, neglect, exploitation,& unexplained deaths where follow up was implemented. Denominator: The total # of substantiated cases of abuse, neglect, exploitation,& unexplained deaths.

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

The DDDS Investigative Services Unit Data Base

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input style="width: 100%; height: 20px;" type="text"/>
Other	Annually	Stratified

Specify: <input type="text"/>		Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

c. Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.

Performance Measures

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

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

Performance Measure:

G-c-1: The percent of restraints or restrictive procedures applied that followed established DDDS protocol. (Numerator: The number of restraints or restrictive procedures applied that followed DDDS established protocol; Denominator: The total number of restraints or restrictive procedures applied during the reporting period.)

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Electronic case record data base; incident report

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input data-bbox="1078 1227 1264 1308" type="text"/>
Other Specify: <input data-bbox="408 1451 647 1532" type="text"/>	Annually	Stratified Describe Group: <input data-bbox="1078 1451 1264 1532" type="text"/>
	Continuously and Ongoing	Other Specify: <input data-bbox="1078 1675 1264 1756" type="text"/>
	Other Specify: <input data-bbox="718 1899 954 1980" type="text"/>	

Data Aggregation and Analysis:

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

- d. *Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.*

Performance Measures

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

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

Performance Measure:

G-d-1: The percent of completed demographically appropriate health screenings for individuals living in a provider managed setting per DDDS protocols. Numerator: The number of completed demographically appropriate health care screenings. Denominator: The total number of demographically appropriate health care screenings that should have been completed.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

The Office of Service Integrity and Enhancement Individual Focused Review

Responsible Party for data collection/generation	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
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<i>(check each that applies):</i>		
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: fit-content;">95% confidence interval</div>
Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>
	Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>	Annually

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	Continuously and Ongoing
	Other Specify: <input type="text"/>

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States 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. Critical incident reports are investigated by staff from the DDDS Office of Incident Resolution, augmented by other Division of Developmental Disabilities Services staff, as applicable. Remediation is a coordinated effort by the DDDS Administration staff, Regional Office Staff, and other concerned parties that could include law enforcement. Less serious reports are resolved by the Regional office with the assistance of the case manager and other staff as appropriate. 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 Service Integrity and Enhancement.

Responses are monitored at the state level to ensure appropriate action is taken.

ii. Remediation Data Aggregation

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

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

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
<input type="checkbox"/>	
	Continuously and Ongoing
	Other Specify: <input type="checkbox"/>

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 3)

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

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

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

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

Quality Improvement Strategy: Minimum Components

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

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

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and

- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

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

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

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

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

The goal of the Division of Developmental Disabilities Services' Quality Improvement Strategy (QIS) for all waiver services is to ensure that the program operates in accordance with approved program design, meets statutory and regulatory assurances and requirements, achieves desired outcomes for participants, and identifies improvement opportunities. DDDS is committed to a QIS recognizing that quality is not under the purview of just one entity. Every part of DDDS has some role or responsibility regarding quality. Consequently, DDDS collects and analyzes trend data from a variety of sources relative to outcomes and indicators identified by individuals, families, providers, stakeholders and administrative authorities, with the objective of ongoing improvement in service delivery. The current QIS includes a number of processes to monitor the quality of residential, day, and clinical consultative waiver services. The DDDS QIS is designed to:

- Monitor assurances contained in the approved waiver.
- Support collaboration with participants, their families, stakeholders, and other state agencies.
- Result in service improvement for individuals and providers of services
- Support choice and control by individuals and families
- Make information about quality of services readily available and understandable.

The DDDS Quality Assurance (QA) Committee has the most significant role in the DDDS Quality Improvement System. The QA Committee includes representatives from the DDDS Office of Service Integrity and Enhancement, DDDS Community Services, and DDDS Office of Business Support Services. Other parts of the organization are included as needed. This Committee is responsible for:

- Incident Resolution
- Performance Measures
- Technical Assistance
- Aggregation of discovery process data.
- Developing periodic reports on priority outcomes and performance measures for systems analysis and trending.
- Ensuring ongoing data integrity and reliability.
- Tracking system improvement strategies developed by various stakeholder groups.
- Trending discovery and remediation based data to ensure continuity of oversight by the DDDS.

In addition, other entities that also play a role in DDDS's Quality Improvement Strategy include:

- DDDS Authorized Provider Committee – This committee reviews applications from service providers who wish to become qualified to provide one or more waiver services against established qualification standards for each service. This committee then issues an approval or denial letter to the provider based on the circumstances. DDDS maintains the list of Authorized Waiver Providers on its website and within an electronic database. This committee process supports the open and continuous enrollment of waiver service providers throughout the year. The committee also periodically reviews and may make changes to the forms and procedures used in the provider qualification process to assure ease of access for providers considering becoming a waiver provider.
- Division of Medicaid and Medical Assistance (DMMA) – DMMA is the State Medicaid Agency with administrative authority over HCBS Waiver services in Delaware. DMMA reviews performance reports issued by DDDS and provides feedback regarding both the measures, the performance data and any existing Quality Improvement Plans. At a minimum, DMMA and DDDS meet each quarter to go over the waiver performance data.
- The DMMA Quality Improvement Committee (QIC): This internal committee provides DMMA with: waiver oversight, priority setting, operating agency performance and report monitoring, review of discovery processes, development of remediation and quality improvement strategies. QIC reports to the QII Task Force through the Waiver Coordinator.
- The Quality Initiative Improvement (QII) Task Force is responsible to: integrate waiver quality strategies, oversee and provide technical support for operating agencies, provide a forum for best practice sharing among agencies, provide support/feedback to waiver programs, review findings from discovery processes, to provide feedback on quality measurement and improvement strategies to participating agencies/program staff, and to report to the Medicaid Managed Care Quality Assurance Leadership Team.

These entities review data and reports in order to recommend system wide improvement strategies and to identify

and promote promising practices. Minutes from each meeting are maintained in order to identify recommendations or follow up actions that are required and who is responsible for each action. The minutes are shared with the Division Director/Designee who reviews the quality improvement strategies and assigned responsibilities and prioritizes the recommendations when necessary.

The Division of Medicaid & Medical Assistance (DMMA) is the agency that has oversight responsibility for Medicaid including all HCBS programs. DMMA developed and implemented its Quality Management Strategy (QMS) to promote an integrated, collaborative quality management approach among DMMA, managed care, waiver, and other medical assistance programs. Delaware's State-wide QMS mission is to:

- Assure Medicaid enrollees receive quality care and services identified in waivers and Medicaid funded programs by providing oversight for monitoring and tracking activities of quality plans, assurances and improvement activities and;
- Provide ongoing oversight responsibilities assuring Medicaid funded program quality plans meet CMS requirements of "achieving ongoing compliance with the waiver assurances" and other federal requirements.

DDDS is integrated into the DMMA QMS as a participant in Medicaid's Quality Initiative Improvement (QII) Task Force. Using the HCBS quality framework as its foundation (e.g., design, discovery, remediation, and improvement), Delaware's QMS plan promotes compliance with CMS waiver assurances, and component elements. The QMS defines the roles and responsibilities of both individuals and committees, task forces, and work groups that are ultimately responsible for the development, implementation, monitoring, and evaluation of the DDDS 1915c HCBS waiver program and its quality initiatives.

The DMMA Chief of Policy, Planning and Quality is responsible for oversight of the DDDS 1915(c) waiver. The Chief and members of his staff:

- Participates in and oversees the function of all DMMA Quality Improvement Committee (QIC) monitoring and reporting activities.
- Summarizes waiver monitoring results, and presents data based reports to the QIC, documenting such in QIC meeting minutes.
- Serves as a liaison between the HCBS Waiver Operating Agencies, such as DDDS, and the DMMA task forces and work groups in order to promote the flow of information related to waiver operation and to coordinate the receipt of Operating Agency responses to DMMA inquiries.
- Participates as a member of the DMMA QII Task Force and supports presentation of QIC reports to the following DMMA multi-disciplinary committees, task forces, and work groups responsible for the development, implementation, monitoring, and evaluation of the DDDS HCBS waiver program and its quality initiatives:

Other entities with roles related to the DDDS Quality Improvement system include:

- The Medical Care Advisory Committee (MCAC): The responsibilities of the MCAC include: a Review of QMS efforts, a Forum for input from key stakeholders in to quality efforts and key clinical management concerns, a forum for input on State policy for health care delivery to Medicaid enrollees. DDDS also presents any amendments and renewals to MCAC for review as part of the public feedback process.
- The Medicaid Managed Care and Quality Assurance Leadership Team (MMCQALT): The roles & responsibilities of the MMCQALT include: oversight of QMS, reporting to Medical Care Advisory Committee, communication and support of stakeholder advisory groups, oversight and direction to the Quality Improvement Initiative Task Force.

The Delaware QMS encompasses a continuous quality improvement (CQI) process and problem-solving approach that is applied to specific and measurable performance and operational activities. The CQI process is used to: (1) monitor quality of care, service indicator, and operational performance, (2) identify opportunities for improvement that exist throughout the program, (3) implement remediation strategies to improve outcomes and performance, (4) evaluate interventions to ensure remediation strategy was successful, (5) provide stakeholders with meaningful information as to the operation of waiver services.

ii. System Improvement Activities

Responsible Party <i>(check each that applies):</i>	Frequency of Monitoring and Analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Quality Improvement Committee	Annually
Other Specify: <div data-bbox="320 616 868 689" style="border: 1px solid black; height: 33px; width: 100%;"></div>	Other Specify: <div data-bbox="938 616 1485 689" style="border: 1px solid black; height: 33px; width: 100%;"></div>

b. System Design Changes

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

DDDS collects, analyzes & uses data to provide internal and external stakeholders with accurate, timely and important information that can be used to evaluate & make recommendations for improvements to the quality of HCB services/supports.

The Quality Assurance Committee (QAC) has primary responsibility for determining if the various discovery processes and data sources accurately measure the outcomes and performance indicators. Problems with data collection activities are corrected as needed.

Areas for each measure reviewed by the QAC include:

- Was the information timely?
- Was the information helpful in identifying statewide trends?
- Were the reports easy to understand and follow?
- Are the outcomes and indicators meaningful or should they be changed?

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

Sometimes improvement strategies for trended data result in changes to waiver service specifications, provider qualification processes, case manager monitoring protocols or DDDS training policies. These changes are sometimes discussed at meetings of the Governor's Advisory Council to DDDS to solicit stakeholder input.

Recommendations for corrective action and system improvement are shared with the DDDS operational units that will need to develop and implement improvement strategies. The operational units are required to respond to the Division Director or designee with their suggested improvement strategies. Once the improvement strategy is finalized, it is implemented and the data monitoring is used to determine if the strategy achieved the desired result.

The Quality Assurance Committee monitors the impact of system changes using a reporting tool called "Divstat". The Office of Service Integrity and Enhancement (SIE) is largely responsible for the discovery part of the process. A representative of SIE and Community Services sits on the QA Committee work together to develop monitoring tools, sampling strategies, and reporting requirements. Most discovery processes are in the domain of SIE activities. The SIE implements the revised discovery processes, measuring the effectiveness of the slated system improvement.

Results of SIE discovery data are collected and disseminated as follows:

- Reporting individual findings on an ongoing and continuous basis to waiver participants and their circle of support, waiver providers, and DDDS Administrators, requiring specific individual plans of improvement as applicable.
- Saving individual discovery process data in an electronic data base to create a sample.
- Providing quarterly, semi-annual or annual data summaries to the QAC for analysis. (QAC in turn completes the data analysis and dissemination of system and/or provider level report process.)
- Reporting discovery data and remediation efforts on a quarterly basis to the Delaware Medicaid Agency (DMMA)

As part of the DDDS continuous quality improvement process, the Director of Service Integrity and Enhancement:

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

The steps of this cyclical process for continuous quality improvement can be described as:

- Discovery/Assessment (based upon identified performance measures).
- Communicate findings in light of performance expectations.
- Formal review and analysis of findings.
- Plan Development / Plan Modification based upon data analysis.
- Documentation of and dissemination of Plan of Improvement to key stakeholders, including some form of training on or orientation to changes.
- Implementation of the Plan.
- Repeat processes focusing on performance-based data analysis.

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

DDDS collects, analyzes & uses data to provide internal and external stakeholders with accurate, timely and important information that can be used to evaluate & make recommendations for improvements to the quality of HCB services/supports. The Quality Assurance Committee (QAC) has primary responsibility for determining if the various discovery processes and data sources accurately measure the outcomes and indicators. Problems with data collection activities are corrected as needed. The QAC also solicits ongoing feedback from DDDS organizational units and other external stakeholders.

The QAC looks at the following aspects of data reporting:

- Was the information timely?
- Was the information helpful in identifying statewide trends?
- Were the reports easy to understand and follow?
- Are the outcomes and indicators meaningful or should they be changed?

In conjunction with the DDDS Division Director, the Office of Service Integrity and Enhancement (SIE), and the QAC, proposed revisions to the DDDS Quality Management System may be submitted to the Division's Leadership Team for review. Such revisions would occur as the formal data analysis processes reveal unresolved needs within the system. Review tools, data sources, performance measures, sampling strategies, remediation activities and needed systems change are all subject to review and modification if they do not result in a structure that informs the Division about the health of the "system".

Recommendations for corrective action and system improvement are shared with the DDDS operational units that will need to develop and implement improvement strategies. The operational units are required to respond to the Division Director or designee with their suggested improvement strategies. Once the improvement strategy is finalized, it is implemented and the data monitoring is used to determine if the strategy achieved the desired result.

The Quality Assurance Committee monitors the impact of system changes using a reporting tool called "Divstat". The Office of Service Integrity and Enhancement (SIE) and Community Services are largely responsible for the discovery part of the process. Representatives from SIE and Community Services sits on the QAC and work together to develop monitoring tools, sampling strategies, and reporting requirements. Most discovery processes are in the domain of SIE activities. The SIE implements the revised discovery processes, measuring the effectiveness of the slated system improvement.

Performance data produced by the QAC in the form of the "Divstat" reporting tool, is provided to the DDDS Director, the Director's Leadership Team and DMMA, which share the responsibility for analyzing the effectiveness of the Quality Improvement System to support specified goals and outcomes. Such responsibility is carried out in structured, routine meetings in which performance data is reviewed.

Each entity is empowered to raise issues such as the validity or reliability of data, effectiveness of performance measures to assess the intent of the system, training needs of providers or discovery process reviewers, and plans to provide systems improvements. It is not enough to collect and report data. The DDDS QMS is designed to drive outcome-based results, with clear accountability for who reports the data and who initiates system improvements.

The SIE and QAC shall work in tandem to adjust discovery processes (as indicated) in order to accurately design and implement performance assessment. The two QMS entities develop monitoring tools, sampling strategies, and reporting requirements with Quality Assurance Committee functioning as the "brain" of the division and Service Integrity and Enhancement as the "eyes and ears".

If done well, continuous quality improvement is a cyclical, iterative process.

The DDDS Quality Management System has been established to support the attainment of positive outcomes for waiver participants. System-wide performance data is aggregated and shared broadly, both within and external to DDDS. Performance data is provided to DMMA on a quarterly basis at the quarterly oversight meetings with DDDS. Performance data is also provided to CMS as part of the annual 372 report.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months (*Select one*):

No

Yes (*Complete item H.2b*)

b. Specify the type of survey tool the state uses:

HCBS CAHPS Survey :

NCI Survey :

NCI AD Survey :

Other (*Please provide a description of the survey tool used*):

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

DDDS requires each agency provider of HCBS Waiver services to submit an annual independent audit. DDDS also requires the Agency with Choice Vendor to submit an annual independent audit. The results of this independent audit must be submitted to the Division within 3 months of the end of the provider's fiscal year. This is tracked as a waiver performance measure. Additionally, the State of Delaware Auditor's office is the entity responsible for conducting annual audits in accordance with the provisions of the Single Audit required under the OMB Uniform Guidance for state agencies within the state government of Delaware.

Per the MOU between DMMA and DDDS, DMMA is responsible for conducting utilization review of services provided under the waiver. DMMA and DDDS meet on a quarterly basis to review DDDS's performance under the waiver including all aspects of waiver administration.

All waiver claims are processed through Delaware's MMIS. Delaware employs multiple levels of processes designed to ensure proper payment of claims both pre-and post-adjudication. DMMA contracts with a fiscal agent to operate the MMIS. The current MMIS was certified by CMS as meeting the standards for automated claims processing systems per Part 11, Chapter 3 of the State Medicaid Manual.

DMMA uses a process for its post-payment review called Recipient Explanation of Medicaid Benefits (REOMB). Each month, a sample of 250 clients for whom a fee for service claim was adjudicated are selected randomly for the purpose of quality control review via the REOMB process. The goal of the random sampling process includes making sure to avoid participants being duplicated in future months. Per a spreadsheet, the SUR Team Auditors track all REOMB letters received. Participants previously sampled in a prior monthly sample can be identified, and notification can be provided to the fiscal agent that this has occurred. DXC selects all claims received for the individual within the target month. The sample size was determined by the Division's actuary and is statistically representative. The 250 REOMBs are sent out monthly to be reviewed and returned to DMMA in self-address envelopes. From May 2018 through April 2019, 714 REOMBs have been returned from the clients and reviewed. On average, there are ~10 REOMBs per month returned to DMMA as undeliverable. The SUR team and DMMA's Fiscal Agent (DXC) are responsible for the entire Recipient Explanation of Medicaid Benefits (REOMB) process.

All DDDS HCBS waiver members are subject to being included in the REOMB monthly sample. The monthly sample is reviewed to provide an overall assessment of the claims processing operation including: verification of claims payment accuracy, measurement of cost from errors, and establishment of a corrective action plan, if needed. The REOMB Coordinator reviews claims against the participant eligibility data, provider enrollment and contract data and rate structure. As part of the validation process, the system generates a letter on state letterhead to be mailed to each of the selected Medicaid recipients. The letter provides the recipient with dates, provider name and specific procedures which Medicaid has paid on behalf of that recipient. The letter asks the recipient to indicate whether or not the services were provided and whether he/she was asked to make any payment for these services. It also provides a space for any comments the recipient wishes to make. The recipient is directed to mail the letter back in a postage paid envelope. If the recipient does not respond to the letter, no additional follow up is conducted. If it is determined that an overpayment was made, a findings letter is mailed to the provider via certified mail. If no overpayment is received within fourteen days, arrangements are made with DMMA's fiscal agent to recoup funds from provider. This can include setting up an accounts receivable for the overpayment to be applied against future claims.

The MMIS contains a Surveillance and Utilization Review (SUR) sub-system which organizes data and creates reports used by staff of the Surveillance and Utilization Review (SUR) Unit within DMMA. The reports use algorithms to detect patterns in paid provider claims which may indicate fraud and/or abuse. The SUR team uses these reports and other tools to identify specific providers on which to perform audits and investigations, referring providers as appropriate to the Medicaid Fraud Control Unit (MFCU) within the Delaware Attorney General's Office as required in the Delaware Administrative Code, Section 13940. DMMA works closely with its Attorney General's Office to prosecute instances of provider fraud. A Memorandum of Understanding is in place between the Delaware DHSS and the Delaware Attorney General's Office which formalizes the responsibilities of each party regarding the investigation and prosecution of Medicaid fraud.

The standard Medicaid Provider Contract for Services requires all providers of services to maintain or make available such records as are necessary to fully substantiate the nature and extent of services rendered to DMAP eligibles, including the provider's schedule of fees charged to the general public to verify comparability of charges provided to non-DMAP individuals and to make all records available to federal or state auditors for the purpose of conducting audits to substantiate claims, costs, etc.

Negative findings from post-payment validation activities are reported to the provider in writing by the entity that discovered the finding. For DMMA, this will be the REOMB Coordinator, the SUR unit or MFCU. For DDDS this will be the DDDS Office of Service Integrity and Enhancement. The DDDS Offices of Business Support Services (OBSS) play a role in detecting inappropriate billing through their routine monitoring efforts. All findings are reported to SIE for follow up

with the provider. Depending on the finding, a corrective action plan or other follow up activities may be required. The provider will be notified in writing by SIE if a corrective action plan will be required. DDDS must approve the CAP before it can be implemented. While the correspondence will come from SIE, SIE may enlist the help of other parts of DDDS to monitor the implementation of the corrective action plan and report back to SIE so that can determine when the corrective action plan may be closed.

The case managers and administrative staff of the DDDS Day and Transition Unit, both in the Community Services section of DDDS, monitor provider case notes and the receipt of services against the person centered plan in the electronic case record on a monthly basis. Discrepancies are reported to the Office of Business Support Services (OBSS) for initial investigation.

Staff from OBSS work in tandem with staff from the DDDS Office of Service Integrity and Enhancement, and DDDS Community Services to provide financial expertise when investigating deficiencies that involve provider or participant finances that are discovered through quality monitoring, abuse/neglect investigations, case manager monitoring or guardian or participant complaints. While the Office of Service Integrity and Enhancement coordinates investigations and any provider probation process due to service deficiencies, SIE is able to call on the resources of OBSS for assistance as needed.

If staff from OBSS or Community Services identify or suspect a provider as submitting inappropriate claims, after three months without correction, SIE may place the provider on probation which triggers enhanced monitoring of the provider in accord with the mandated Quality Improvement Plan to correct the problem.

Delaware believes this process is advantageous, as it connects both a programmatic and fiscal viewpoint to the provider oversight strategies.

A case of deficiency in implementation of proper and frequent financial oversight may result in SIE placing a provider on probation status for 3-6 months depending on the severity of the deficiency and the amount of time necessary for corrective action. SIE conducts monthly follow-up to verify implementation of approved corrective actions, with enhanced oversight of spending records, billing, or other specific monitoring as each case warrants. If improvement is not apparent after the first probation period, it can be extended another 3-6 months with ongoing increased monitoring and technical assistance. If the provider has not corrected the deficiency at the end of the second probation period, DDDS may end the business relationship with the agency.

Agency With Choice Broker:

Because the Agency With Choice vendor will be serving as the employer of record, it will submit and be paid for claims for self-directed services in the same manner as other fee for service Medicaid claims. The DDDS AWC liaisons will be responsible for monitoring claims paid to the AWC broker as the provider. The DDDS AWC liaisons will be responsible for ensuring that the AWC provider claims match what was paid to the employee. More detail regarding this process is provided in Appendix E, as required in that section.

In addition to monitoring claims submitted by the AWC broker, DDDS will also monitor performance against contractual requirements. Such requirements will include maintenance of documentation to comply with IRS and US DOL requirements such as: provider screening and training, copy of IRS Forms W-4 and I-9, accuracy of wage payments and withholding, payment of overtime and travel, as required.

Quarterly, the DDDS AWC Liaisons will verify AWC vendor payment/filing of the State Income Tax, Unemployment Tax, Workers Compensation and IRS Forms 940 and 941 and Forms W-2/W-3.

Annually, DDDS will also review the AWC broker's standard operating procedures and required reporting on performance metrics such as timeliness of payroll and payment of other invoices by the AWC vendor, participant satisfaction, and timeliness of response to customer calls where a message is left after hours, complaints resolution, etc. as specified in the contract. These processes are described in more detail in Appendix E.

Additional detail on financial integrity processes is provided in section I-2-d Billing Validation Process.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial

accountability of the waiver program. (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")

i. Sub-Assurances:

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

(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

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

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

Performance Measure:

I-a-2: The percent of provider utilization records that match what was claimed.

Numerator: Number of provider utilization records reported for day and residential services that match what was claimed; Denominator: Number of provider utilization records reported for the period.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Utilization 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 = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/> by service by provider

	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px auto;"></div>
	Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px auto;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<i>State Medicaid Agency</i>	<i>Weekly</i>
<i>Operating Agency</i>	<i>Monthly</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>
Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px auto;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px auto;"></div>

Performance Measure:

I-a-3: The percent of enrolled DDDS waiver provider agencies that submit completed annual audited financial statements. Numerator: the number of enrolled DDDS waiver provider agencies that submit completed annual audited financial statements; Denominator: Number of enrolled DDDS waiver provider agencies

Data Source (Select one):

Financial audits

If 'Other' is selected, specify:

Financial audits received by OBSS

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):

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	Specify: <input type="text"/>

Performance Measure:

I-a-4: Percent of waiver claims which are prior-authorized. (Numerator: Number of paid claims that are prior authorized; Denominator: Number of paid claims for the period.)

Data Source (Select one):

Other

If 'Other' is selected, specify:

Data Sources - MMIS data on paid DDS 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):
<i>State Medicaid Agency</i>	<i>Weekly</i>	<i>100% Review</i>
<i>Operating Agency</i>	<i>Monthly</i>	<i>Less than 100% Review</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>	<i>Representative Sample</i> <i>Confidence Interval =</i> <input type="text"/>
<i>Other</i> <i>Specify:</i> <input type="text"/>	<i>Annually</i>	<i>Stratified</i> <i>Describe Group:</i> <input type="text"/>
	<i>Continuously and Ongoing</i>	<i>Other</i> <i>Specify:</i> <input type="text"/>
	<i>Other</i> <i>Specify:</i> <input type="text"/>	

Data Aggregation and Analysis:

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

Performance Measure:

I-a-1: The percent of claims paid only for those services specified in the person centered plan. (Numerator: number of claims paid only for those services specified in the person centered plan; Denominator: number of paid claims for the period)

Data Source (Select one):

Other

If 'Other' is selected, specify:

DDDS Data Sources - Prior authorizations entered into the MMIS pursuant to the person centered plan; paid claim detail in the MMIS against the PCP.

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

<i>Specify:</i> <input type="text"/>		<i>Describe Group:</i> <input type="text"/>
	<i>Continuously and Ongoing</i>	<i>Other Specify:</i> <input type="text"/>
	<i>Other Specify:</i> <input type="text"/>	

Data Aggregation and Analysis:

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

Performance Measure:

I-a-5: The percent of rates for waiver services adhering to reimbursement methodology in the approved waiver. (Numerator: Number of rates for waiver services adhering to reimbursement methodology in the approved waiver; Denominator: Number of waiver rates.)

Data Source (Select one):

Other

If 'Other' is selected, specify:

The DMMA Reimbursement Unit reviews all waiver rates computed by DDDS to

determine if they were computed pursuant to the approved methodology.

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/>	
	Continuously and Ongoing
	Other Specify: <input type="checkbox"/>

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

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

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

Performance Measure:

I-b-1: Percent of waiver claims paid using rates that follow the rate methodology in the approved waiver application. Numerator = percentage of claims paid using rates that follow the rate methodology in the approved waiver application. Denominator = all waiver claims paid.

Data Source (Select one):

Other

If 'Other' is selected, specify:

MMIS data on paid DDS 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 =

		95% confidence level 5% confidence interval
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States 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

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

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).

DDDS is responsible for the development of statewide rates for waiver services through an MOU with DMMA. DMMA is responsible for the final review & approval of all rates and for ensuring that rates are computed consistent with the approved methodology.

Rates for most Lifespan waiver services are based on a “market basket” methodology initially established in 2004. The market basket methodology, also commonly referred to as the “brick” methodology, replaced a process of negotiated rates that DDDS used prior to 2004. DDDS rebased the benchmark rates in January 2014 and then again in January 2019 as directed by the Delaware legislature. DDDS completed the DSP rate rebase and published the results in January 2019. The 2019 rate study included the following services: residential habilitation, facility-based and non-facility based day habilitation, community participation, facility-based and non-facility based pre-vocational services, supported employment individual & group and supported living. DDDS also used the market basket methodology to compute an hourly rate for the service of Medical Residential Habilitation.

A market basket is a set of goods and services that together indicate the cost of a product or a service. The Consumer Price Index is an example of a market basket. A market basket is often described as a fixed-weight index because it centers on how much more or less it would cost, at a later time, to purchase the same mix of goods or services that was purchased in a base period.

As with the 2014 rebase, in the 2019 rebase, DDDS reviewed and made revisions to the composition of the market basket and to the assumptions for all of the rate components based on observed and anticipated changes in service delivery. In the 2019 study, DDDS re-evaluated and refreshed the DSP wages and the other components of the “market basket” used to create the DSP rates to address changes in operating costs, additional types of expenses, and the relationship between costs to the wage. The 2019 rate study reflects changes in service delivery in response to the CMS HCBS Settings Rule published in January 2014.

DDDS shared the 2019 rate study and benchmark rates with the provider agencies, advocates and other key stakeholders while in draft. DDDS incorporated their feedback into the final rates and was documented in the rate study. DDDS worked closely with the Delaware provider association representing most of the DDDS waiver providers on the study.

The Direct Support Professional (DSP) rates are made up of four components:

- DSP Wage*
- employment related expenses*
- program indirect expenses*
- administrative expenses*

DSP Wage Rate: The methodology requires the selection of a wage proxy for each type of Direct Support Professional (DSP). DDDS obtained wage data from the U.S. DOL Bureau of Labor Statistics and job postings from national internet employment sites for job classifications with similar requirements & duties. DDDS identified the need for three distinct categories of Direct Support Professionals with three different wage rates. The three categories and wages are: DSP Residential Habilitation and Facility-Based Day Services \$14.11/hr, DSP Non-Facility Based Day Services \$15.06/hr and Supported Employment, Community Participation and Supported Living \$18.84. DDDS adopted this different approach to acknowledge the different qualifications required for DSPs who provide support in integrated community settings versus facility-based settings. The DSPs who perform their work in the broader community are required to perform their duties without the close support of a supervisor. Since these staff must be able to act in a more independent manner, the staff must have different competencies. Thus, the qualifications for this type of staff are more rigorous.

The “market basket” or brick approach adds the following components on top of the wage and are expressed as percentages. These components can vary between types of service:

- employment related expenses (%)*
- program indirect expenses (%)*
- administrative expenses (%)*

Employment Related Expenses: include benefits paid to or for workers above salary and wages. They include expenses such as health insurance, workers comp, unemployment compensation, state/federal payroll taxes, criminal background checks and training.

Program Related Expenses: support the delivery of the service but are either non-salary expenses or are a step removed from the direct delivery of the service. These include program management, program rent, utilities, program supplies, technology expenses (phones, laptops, network, software licenses), vehicle costs for staff, quality assurance, staff recruitment costs & DSP staff time spent in allowable but not billable activities.

General and Administrative Expenses include functions that are necessary for the operation of the organization but cannot be directly related to a good or service produced by the organization. This includes: payroll and accounting, legal counsel, outside audit fees, general liability insurance, managerial salaries, corporate overhead, rent, utilities, office equipment and subscriptions.

Whereas the 2014 study used a survey tool provided by the consultant to collect and analyze provider financial data, the 2019 study used the provider General Ledgers from the providers as the source of provider cost data for the non-wage components of the market basket: Employment Related Expenses (ERE), Program Indirect Expenses (PI), and General and Administrative Expenses (G&A). The Provider General Ledgers and chart of accounts were used to code expenses as ERE, PI or G&A or unallowable (such as room and board expenses for residential settings). The analysis of expense data did not reflect any significant difference in provider cost profiles for ERE or G&A expenses, thus, the percentages assigned for ERE and G&A do not differ among service type. However, the expense data did demonstrate a need to assign a different percentage for PI costs; therefore, each service has a distinct PI percentage included in the calculation of the rate.

The costs for ERE, PI and G&A are converted to percentages that are multiplied by the direct support hourly wage rate as a set of recursive percentages in order to develop an hourly provider DSP benchmark rate for each service.

The formula to compute the hourly rate for each service using the rate components (expressed as a percentage) is as follows:

$$(DSP \text{ wage} + (DSP * (1 + ERE)) / (1 - PI) / (1 - GA))$$

Impact of State Funding on Provider Rates: The legislature determines the level of funding that is available for services and rate increases each year based on the approved Benchmark rates as the standard. The goal is to use available funding to “level up” the rates to the same % of the benchmark and to reach the benchmark over time. As of July 1, 2022, all rates included in the 2019 DSP rebasing study were at a minimum of 85.2% of the benchmark. The legislature has not yet voted on the Operating Budget bill for SFY2023 so the percent of the benchmark rates from the 2019 rebasing study for this state fiscal year is not yet known.

The DSP rates are periodically re-based using cost data from the most current period available. The Epilogue of the Budget Act enacted by the Delaware General Assembly indicates that DDDS “may rebase, once every one to three years” its Direct Support Professional rates. DDDS publishes waiver rates on the DDDS website for each year.

The rate for Day Habilitation, Community Participation, Pre-Vocational, Supported Employment, and agency Residential Habilitation services when the DSP is certified or fluent in American Sign Language (ASL) is computed in hourly units of service. DDDS computed the rate by using the previously defined three categories of DSPs blended with BLS data for translators/interpreters and adding the same factors for Employee- Related Expenses (ERE), Program Indirect Expenses (PI), and General Administrative Expenses (GA) as established in the 2019 rate study.

The rate for Day Habilitation, Community Participation, Pre-Vocational, Supported Employment, and Residential Habilitation services when the DSP is a Registered Behavior Technician (RBT) is computed in hourly units of service. DDDS computed the rate by using the previously defined three categories of DSPs blended with BLS data for Substance Abuse, Behavioral Disorder, and Mental Health Counselors and adding the same factors for Employee- Related Expenses (ERE), Program Indirect Expenses (PI), and General Administrative Expenses (GA) as established in the 2019 rate study.

In 2020, DDDS commissioned a rate study for the Nurse and Behavioral Consultation services. To ensure a robust provider network that can meet the needs of a changing client base, DDDS has developed a tiered rate structure that pays a higher rate for more highly experienced/ credentialled staff. DDDS used U.S. DOL BLS wage data for Nurse and Behavior Specialist job classifications to compute the base rate and two additional rate tiers for each service, using successively higher BLS wage percentiles for each classification to represent the higher credentials and levels of

experience. All other components of the market basket for these rates (i.e. employee rated, program related, and general and administration) were updated based on the most current data available.

Transportation to and from the service setting is a component part of the service for residential habilitation and is paid as an add-on to the direct support unit cost rate. Rates for residential services do not include any costs associated with room and board. For Day Habilitation, Community Participation, and Pre-Vocational services, transportation to and/or from the service location may be billed separately as a component part of the service for days when it is provided.

Determining the number of hours of direct support: DDDS uses a standardized assessment tool to determine the number of direct support hours needed for each waiver member for residential, day, employment and nurse and behavioral consultation services as part of the person centered planning process.

While all rates are initially computed as hourly rate, they may be billed as 15 minute unit, hourly or per diem rates as specified in Appendix J. Per diem rates are computed by multiplying the hourly rate for the service by the number of hours of support needed per day. 15 minute unit rates are computed by dividing the computed hourly rate by four.

When it is necessary to provide Residential Habilitation services out-of-state (i.e. out of network), the payment shall be the lesser of: the State Medicaid rate for the provider/service in that state, the provider's usual and customary rate or a negotiated rate that is lower than the Medicaid or usual and customary rate.

Supported Employment - Small Group: The hourly rate for Group Supported Employment is computed as part of the "market basket" methodology described above. DDDS must perform additional computations to the rate for this service to account for the number of waiver members in the group. The unit cost rate is then divided by the number of waiver members in the group from 2 – 8.

Community Transition: Goods and services will be reimbursed at cost. The provider of will submit an invoice with applicable receipts to DDDS for reimbursement. Invoices must be approved by DDDS before payment is made.

(see Main - "Additional Needed Information (Optional) text box for the continuation of the Rate Determination Methods.

- 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. 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.

In the case of the self-directed services, the self-directed caregiver who delivers respite or personal care to the waiver member is paid by the Agency with Choice Broker using a payroll system that computes and pays the appropriate amount of federal and state payroll taxes (FICA, Medicare, workers comp, etc.). The Agency With Choice Broker then submits claims to the MMIS to get reimbursed for the payment it has made to the self-directed caregiver, inclusive of wages and applicable payroll taxes.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

- c. Certifying Public Expenditures** (select one):

No. state or local government agencies do not certify expenditures for waiver services.

Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.

Select at least one:

Certified Public Expenditures (CPE) of State Public Agencies.

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-a.)

Certified Public Expenditures (CPE) of Local Government Agencies.

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

In addition to the financial integrity methods described in I-1, DDDS performs the following billing validation activities.

a) Recipient Eligibility for Waiver Services: Applicants who are enrolled in the DDDS waiver can be identified by coding entered into the Assist Worker Web, the eligibility/enrollment client database of Delaware DHSS. This coding then passes to the MMIS in a nightly automated data feed. The coding indicates whether the waiver participant is receiving SSI or is in the waiver Special Income Group under 42 CFR 435.217. Edits have been established in the MMIS to require prior authorization for waiver claims based on the client's eligibility coding. MMIS claim edits for participants enrolled in the waiver require the dates of service for a waiver claim to be within the eligibility start and stop dates for waiver enrollment. DMMA and DDDS have worked together assigned specified coding for waiver services. These codes are set up so that they cannot be used for non-HCBS clients.

b) Service is included in PCP: The waiver participant's PCP includes a list of the waiver services the client has chosen to receive and has been authorized as part of the planning process. Among the DDDS program units that assist in the oversight of waiver services are the Office of Community Services which employs the case managers that oversee the delivery of waiver services. The case manager and other designated employees communicate the amount, duration and frequency of each waiver service authorized in the PCP to the DDDS Office of Business Support Services where a Prior Authorization is entered into the MMIS for each authorized waiver service. When a claim for a waiver service is submitted, the MMIS checks the claim against the Prior Authorization in the MMIS. The PA number on the claim must match the PA number in the MMIS before the claim will be adjudicated using pre-established claims processing rules and edits and audits. Once a matching PA is found, the MMIS then performs additional edits to compare data on the claim with data on the Prior Authorization. As long as the units and unit cost billed are equal to or less than the amount authorized, the claim will process.

c) Services were provided: DDDS requires its providers to use an electronic case record system to document service provision. The agencies providing residential, day, prevocational, and supported employment services are also required to submit attendance/utilization reports to DDDS each month. These attendance reports are signed by an authoritative representative of the provider. Provider staff must also create and maintain case notes describing how the service they provided facilitates the ability of the client to meet their goals as described in the PCP. There must be one note per client per service per day at a minimum. DDDS has the ability to view the provider case notes in the electronic record and does so periodically to make sure that services identified as "provided" are also documented. This data is reviewed as part of the Quality Service Review process conducted by the DDDS Service Integrity and Enhancement Unit.

The DDDS Day and Transition Unit assists the case manager to monitor the utilization of day services for waiver participants based on specified triggers. They compare provider attendance records and claims data against service authorizations based on the PCP to look for: units higher or lower than what is expected, changes in Group Supported Employment ratios, waiver participants whose authorized hours are exceptions to the ICAP. Providers who are determined to be at higher risk of claim errors based on prior reviews are reviewed more closely than other providers. When a review is triggered, the Unit looks at the PCP, progress/billable notes for each day service and incident reports to ensure that services are being delivered and billed in accordance with the PCP.

Because the Agency With Choice vendor serves as the employer of record, it submits and is paid for claims for self-directed services in the same manner as other fee for service Medicaid claims. The DDDS AWC liaisons described in Appendix E are responsible for monitoring claims paid to the AWC broker as the provider. The AWC liaisons are responsible for ensuring that the AWC provider claims match what was paid to the employee. More detail regarding this process is provided in Appendix E, as required in that section.

In addition to the DDDS post payment claim validation activities, the DMMA SUR unit also conducts retrospective audits of paid claims. DDDS waiver claims are also subject to review as part of the PERM audit process. These processes are described in section I-1 of this Appendix.

When a provider bills the Medicaid program for claim that is determined to be inappropriate, the DMMA Program Integrity Unit will be involved. At the time it is determined the billing is inappropriate the State will set up an Accounts Receivable (AR). When the provider submits additional claims, the "paid amount" is deducted from the AR until the overpayment for the inappropriate billing is satisfied. The recoupment will be split between the State Share and FFP based on the attributes of the client's basis of eligibility the service which determine the federal share. These FFP rules are programmed into the state's MMIS. Payment for that provider will be automatically reported on the State's Budget Reports, net of any recouped overpayment, which in turn will be reported on the CMS-64. The state also has the option of demanding a check from the provider if no future claims are expected to which to apply the AR.

- 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:

Direct payments to self-directed caregivers who provide Respite and Personal Care under the self-directed option are paid outside of the MMIS because the Agency With Choice vendor serves as the employer of record, as a joint employer with the waiver member. After the AWC Broker has paid the self-directed caregiver as employee via its own payroll system, the AWC Broker submits claims to the MMIS and is paid for Medicaid claims for self-directed services as a Medicaid provider in the same manner as other fee for service Lifespan waiver claims. The broker will be responsible for performing all necessary tax withholding and will submit claims for the entire amount it has paid to the self-directed caregiver, inclusive of tax withholding. More detail regarding this process is provided in Appendix E.

Payments for waiver services are not made through an approved MMIS.

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

- b. Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):

The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.

The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.

The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

The Agency with Choice Broker functions in a limited fiscal agent role because it issues payments to self-directed caregivers (as described in Appendix E) that are outside of the MMIS and then submits claims under its own provider number to be reimbursed for the initial outlay to the self-directed caregiver.

All other waiver services are paid directly to the provider of the waiver services.

DDDS monitors the AWC vendor to ensure that the contract deliverables are met and participants are in receipt of AWC vendor services in accordance with their Individual Support Plan. Two individuals within DDDS are designated as Liaisons to the AWC vendor. They report to a Senior DDDS Manager who is the manager for the AWC vendor contract. The statewide AWC broker is monitored by DDDS at a frequency established by DDDS. DDDS monitors the AWC broker's performance of administrative activities, as well as adherence to contract conditions and waiver requirements. The Community Navigators are also responsible for reporting any issues regarding the statewide AWC broker to the DDDS AWC Liaisons or the contract manager as part of their job duties.

The DDDS AWC Liaisons review expenditures against waiver coverage and whether they are accurately and appropriately assigned and reported. The AWC broker is required to provide monthly reports and documentation to the DDDS AWC Liaisons that identifies the amounts paid to employees/caregivers on behalf of waiver participants. The AWC broker will maintain signed time sheets for all employees for each pay period which can be reviewed by the DDDS AWC Liaisons at any time. If errors are noted, the DDDS Liaisons will report them to the AWC vendor for correction by the following pay period. In addition to reviewing routine reports provided by the AWC vendor, the DDDS AWC Liaisons will also periodically conduct unannounced audits of AWC records at its office location.

DDDS AWC Liaisons identify inconsistencies between utilization, expenditures, dates of service, waiver enrollment date and claims and then follow up with AWC vendor to ensure that any errors are corrected. The DDDS AWC Liaison periodically monitor units paid and account balances to ensure there are sufficient funds in each account to cover services up to the approved limit. Systemic errors require a Plan of Correction from the AWC vendor which must be approved by the DDDS AWC contract manager and will be monitored by the DDDS AWC Liaisons.

DDDS monitors claims submitted by the AWC broker using established claims oversight methods. DDDS has safeguards to ensure the payments to the AWC broker for both administrative fees and Medicaid services are in accordance with all applicable regulations and requirements.

Periodically, the DDDS Liaisons will randomly select a number of provider files maintained by the AWC broker to verify such elements as provider screening and training, copy of IRS Forms W-4 and I-9, accuracy of wage payments and withholding, compliance with US DOL FLSA rules.

Quarterly, the DDDS AWC Liaisons will verify AWC vendor payment/filing of the State Income Tax, Unemployment Tax, Workers Compensation and IRS Forms 940 and 941 and Forms W-2/W-3.

At the end of the first year, DDDS will review all AWC broker systems and practices to confirm that standard operating procedures are in place to ensure compliance with contract requirements and Medicaid regulations. Annually, DDDS will also review required reporting on performance metrics such as timeliness of payroll and payment of other invoices by the AWC vendor, participant satisfaction, and timeliness of response to customer calls where a message is left after hours, complaints resolution, etc. as specified in the contract.

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.

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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.

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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:

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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:

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

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.

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.

The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.

The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.

This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.

If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.

In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver 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.

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 in the delivery of a direct waiver service (such as supervision and staff training) to compute a payment rate. No costs related to the operation of the residential facilities themselves are included as a data input in that process. Room and board costs for each residential setting are paid by the individual. For individuals whose income is not sufficient to cover the room and board costs, DDDS may subsidize the cost using 100% state funds. These costs are never claimed to Medicaid for anyone living in an HCBS setting.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. Select one:

No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.

Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

No. *The state does not impose a co-payment or similar charge upon participants for waiver services.*

Yes. *The state imposes a co-payment or similar charge upon participants for one or more waiver services.*

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):

Nominal deductible

Coinsurance

Co-Payment

Other charge

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:

No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.

Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	71030.35	11547.00	82577.35	533651.00	6103.00	539754.00	457176.65
2	72123.42	12349.00	84472.42	570739.00	6619.00	577358.00	492885.58
3	72668.16	13206.00	85874.16	610406.00	7179.00	617585.00	531710.84
4	88120.45	10338.60	98459.05	407448.00	6500.00	413948.00	315488.95
5	90256.86	11200.00	101456.86	410000.00	6800.00	416800.00	315343.14

Appendix J: Cost Neutrality Demonstration

a. **Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		ICF/IID	
Year 1	2600		2600
Year 2	2734		2734
Year 3	2868		2868
Year 4	3002		3002
Year 5	3136		3136

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. **Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The average annual length of stay of participants receiving residential habilitation through the Lifespan Waiver is derived from actual data for days of enrollment for SFY 16-17 based on historical paid claims data for waiver participants as reported on the annual CMS 372 report.

An alternate basis was used to determine the average length of stay data for the new population of graduates from K-12 school being added to the waiver because this is a new waiver population for which there is limited longitudinal data. The derivation of the ALOS is based on the monthly head count data for a five year period for individuals graduating from school and electing to receive DDDS non-waiver day programs. This data is maintained by the DDDS Day and Transition Unit. The Day and Transition Unit has observed seasonal patterns of enrollment as individuals graduate from school. This experience was applied to estimates for new cohorts of graduates each year. Based on this experience, we have observed that most graduates enroll in a day program the middle of August each year. To account for this, 46 days were subtracted from a 365 day year. A separate factor of 15 days was subtracted from the year to account for natural attrition due to individuals who die, move out of state or decide they no longer wish to receive a day service.

A weighted average length of stay was computed from the estimates of unique counts of participants and participant days per year across the two populations.

Delaware experienced delays in making programming modifications to the MMIS necessary to implement the waiver amendment that was approved by CMS effective 7/1/17. These changes were necessary to enable:

- the new population of individuals living in the family home to enroll
- providers of the newly added services to enroll
- claims for the newly added waiver services to be adjudicated

Therefore, there is no actual claims data for these new waiver services and newly enrolled members to use to reproject cost and utilization data beyond what was projected for the Lifespan amendment that became effective 7/1/17.

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 and methodology for these estimates is as follows:

Update to Factor D for WYs 4&5: DDDS tried to understand the impact of the Public Health Emergency (PHE) on the estimates for WYs 4 &5. During the PHE, some waiver members decided to “retire” from receiving day and employment services, some members decided to return to day services but at a reduced frequency, and provider staff capacity declined as Direct Support Professionals chose other forms of employment that required less face-to-face contact. When those programs that had closed reopened, some were only able to re-open at reduced capacity due to reduced staffing levels. The changing landscape created significant variation in the number of users and cost per user in the actual data from what DDDS had initially projected which DDDS anticipates will continue to impact estimates for WYs 4&5. As the original estimates for WYs 4&5 were developed in SFY2019 when the Renewal application was submitted, DDDS now has access to actual data from additional periods to add to its estimating capability. To that end, DDDS used actual data from Delaware’s CMS 372 reports from State Fiscal Years 2018-2020 and data queried from the MMIS for SFY2021 to reevaluate the estimates for WYs 4&5. Armed with all available data and after conversations with its provider network, DDDS updated the estimated number of users, units/user, and the cost/unit for each service which resulted in a change to Factor D for those years.

The estimated number of users, units/user, and the cost/unit for individuals receiving residential habilitation and for other waiver services they receive is based on historical Medicaid expenditures as reported on the annual 372 report as well as available funds allocated from the state legislature annually.

For the new waiver participants that became eligible to enrolled in WYEs 4 and 5 of renewal 07, DDDS used internally maintained available utilization and payment data for SFY17 and 18 (WYEs 3 & 4 of Renewal 07). This group is comprised of individuals who are living in the family home that should have been newly enrolled in WYEs 4 and 5 of renewal 07. Many of these individuals are known to and receiving non-waiver services from DDDS.

However, implementation of the waiver amendment that was approved effective 7/1/17 was delayed because of difficulties making changes to the MMIS necessary to enroll people and providers and to process the new claims.

Current waiver Day services - Delaware used ad hoc queries against the MMIS database to derive the average units per person and the average cost per unit for day services for SFYs 17 (WYEs 3 and 4 of Renewal 07) for existing waiver members. FY16 and 17 data from the CMS 372 report for expenditures and participant counts by service category was also used. The data was arrayed by service. The data from WYEs 3 and 4 of Renewal 07 were compared to look for consistency.

Payment and utilization data from the non-waiver participants receiving day services were obtained and arrayed for SFY17. Delaware used client counts for the two populations (waiver and currently non-waiver) to compute a weighted average number of units per person and cost per unit across the two populations to be applied to WYEs 4 and 5 in Renewal 07. Delaware made assumptions about growth in the number of newly eligible waiver members for WYEs 4 and 5 in Renewal 07 based on past participant growth in the two populations (which is largely constrained by the amount of newly appropriated funds for waiver members, and the number of individuals graduating from school for the non-waiver enrolled individuals). Estimated utilization of services across the day service array was assumed to be consistent with the distribution from the SFY16 and 17 data, the most current data set that was available at the time the estimates were computed.

Day Habilitation non-facility and Prevocational non-facility-DDDS estimated the number of users for these services based upon the communication from new school graduates indicating their desire to receive services in the community during the person-centered planning process.

Day Habilitation: Community Participation – DDDS conducted a state-funded pilot between September 2014 and Jan 2015 to explore the feasibility of this service. The estimates for both the number of individuals DDDS expects to request this service and the utilization per participant came from the pilot. The average cost per unit was computed using the DSP rate methodology for the other day services with wage and other rate components coming from the pilot.

Respite – estimates for respite were based on FY17 DDDS payment and utilization data maintained by DDDS in an excel spreadsheet to track expenditures by person by type of respite provider. Most of the expenditures are paid for self-directed caregivers and respite camps. Individuals also use Home Health Aides to a lesser extent.

The cost per hour for the self-directed care is based off of a standardized rate derived from available state funds with an increase to the standard rate based on the acuity of the individuals.

Personal Care – estimates were based on expenditures maintained by the DDDS Office of Budgets, Contracts and Business Services for payments made for personal care under a program DDDS calls “Individual and Family Assistance Payments” (IFAP). The data was recorded as a lump sum per family so the hourly rate of payment could not be computed. Assumptions had to be made regarding the hourly rates of payment and number of units (hours) based on information that was known about each family.

Home/vehicle modifications – estimates for the number of families who would seek this service were based on families for whom DDDS had paid for modifications in the past under the IFAP program. This data was not always recorded in a way that allowed an amount per family or per modification to be identified. Based on the amounts of past requests (some of which were not able to be funded), DDDS made the assumption that 70% of the requests would require the maximum funding of \$6,000 per person and that the other 30% would be for more minor modifications to the home that would be considerably less than the maximum.

Specialized medical equipment and supplies – estimates of numbers of individuals requesting this service is based on past requests received by DDDS (some of which were not able to be funded). Most of the requests received have been for specialized wheelchairs and other devices to assist with ambulation. Estimates for the average cost of pieces of equipment were obtained from the Harmon Healthcare website. Estimates for a customized wheelchair ranged from \$2,000 to \$15,000.

Assistive Technology – Data from the 2010 US Census Report (Americans with Disabilities) published in 2012 was used to estimate the number of participants who are likely to need Assistive Technology. Cost data for assistive technology items was obtained from the American PrintHouse for the Blind website.

Medical Residential Habilitation-The estimated numbers of individuals requesting this service was based on the current number of waiver members receiving Private Duty Nursing (PDN) under State Plan as well as the estimated number of individuals living in a skilled nursing facility, that with the addition of this service, can reside in community based setting and have their skilled nursing needs met. The addition of this service will increase the average cost per person for waiver paid claims.

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:*

Update to Factor D' for WYs 4&5: During the PHE, access to non-waiver health care was limited for a variety of reasons. This impacted utilization and cost of those services and is likely to have a continuing impact through the Renewal 008 period. Nevertheless, DDDS reviewed the available actual MMIS claims data for non-waiver services from SFY2018 – 2021 and used it to adjust its projections for D' prime for WYs 4&5.

In order to develop a revised projection of Factor D' values for the renewal, the non-waiver cost per person from SFY11 – 17 was arrayed longitudinally. Data sources are as follows: for SFYs 11 and 12 queries run against the MMIS claims data. This data was used in lieu of the data for Factor D' that was reported on the 372 report prior to SFY13, as Delaware had accidentally been reporting the estimates from the approved application as if they were the Factor D' actuals. This has previously been shared with CMS. SFY13-17 data came from the 372 report. Data for FY18 came from a query of the actual data for the period (it is possible more claims may process with the 365 day timely filing window). The data for the period ranged from a low of \$3,922 to a high of \$8,756 per person and was highly variable with no clear trend. This made it difficult to use the data to project future cost per person however, DDDS applied a growth factor of 1.0694% each year to estimate the future amounts for Factor D'.

The cost data above is only reflective of current waiver members. For the reasons described above related to the delay in making the necessary changes to the MMIS for the Lifespan Amendment (Renewal 07, Amendment #1), we do not have claims data from WYEs 4 & 5 of Renewal 07 to use to project future numbers of members or their utilization of each new service. In the absence of this data, DDDS assumes that the projected utilization of new members for existing services will be the same as that of the current waiver participants. The estimates related to utilization and members using the new waiver services added in amendment #1 to Renewal 07 have not been revised due to lack of better data.

The State's estimates for Factor D' are lower than Factor G' for each waiver year because the individuals residing at Stockley Center, the public ICF-IID used in the cost neutrality calculations, typically have a much higher medical acuity than individuals served under the HCBS waiver.

The estimate for Factor D' does not include the cost of claims for prescription drugs for that can be covered by Part D. An edit exists in the MMIS that prevent Medicaid payment for Part D covered drugs for dual eligibles who are enrolled in Part D and for whom Medicaid is paying the Part D premium. The list of Part D covered drugs is updated by DMMA's fiscal agent any time CMS makes a change to the Part D formulary. The entire list is also reviewed annually by the fiscal agent, regardless of whether any changes are made to the Part D formulary during the year. Therefore, only costs for medically necessary, non-Part D covered drugs would be included in Factor D'.

- iii. Factor G Derivation.** *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Update to Factor G for WYs 4&5: For WYs 4&5, DDDS reviewed its original estimates for Factor G for WYs 4&5 and compared them to actual data from CMS 372 reports for SFYs 2018-2020 plus data queried from the MMIS for SFY2021 to reevaluate the estimates for WYs 4&5 and adjust as necessary, where supported by the new data. DDDS determined that the actual data warranted adjustments in the estimates for WYs 4&5.

Delaware used data for Factor G, as reported on the CMS 372 report for SFYs 13-17, as well as preliminary cost per person data from a query of the MMIS for SFY18, as the basis the estimates for Factor G for WYEs 3-5. Both sets of cost data come from MMIS claims for residents in the state's public ICF/IID institution. An average percentage growth of 1.0695% was observed over the 4 year period of the data set. This increase was applied to the SFY18 preliminary cost per person to revise the projections for the renewal.

- 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:*

Update to Factor G' for WYs 4&5: For WYs 4&5, DDDS reviewed its original estimates for Factor G' for WYs 4&5 and compared them to actual data from CMS 372 reports for SFYs 2018-2020 plus data queried from the MMIS for SFY2021 to reevaluate the estimates for WYs 4&5 and adjust as necessary, where supported by the new data. During the PHE, access to non-waiver health care was limited for a variety of reasons. This impacted utilization and cost of those services. Many health facilities still have significant delays in arranging appointments for non-emergency care. While the unprecedented nature of this period affected the payments for healthcare services which is reflected in the data, DDDS believes that there are likely to be residual effects that may impact Factor G' costs in WYs 4&5 and has adjusted these estimates downward accordingly.

In order to develop a revised projection of Factor G' values for amendment #1, the non-waiver cost per person for institutionalized individuals from SFY11 – 18 was arrayed longitudinally. Data sources are as follows: for SFYs 11 and 12 queries run against the MMIS claims data. This data was used in lieu of the data for Factor G' that was reported on the 372 report prior to SFY13, as Delaware had accidentally been reporting the estimates from the approved application as if they were the Factor G' actuals. SFY13-17 data came from the 372 report. Data for FY18 came from a preliminary query of the actual data for the period (it is possible more claims may process with the 365 day timely filing window). DDDS applied a growth factor of 1.0846% each year to estimate the future amounts for Factor G'.

The actual Factor G' values have been relatively consistent over this 6 year period at around \$6,000 per person, with the exception of SFY15, which was \$11,050 per person. This year was not used in the computation of the trend because it was seen as an outlier.

The relatively small number of residents of the public ICF-IID (currently were 47 residents as of April 2017) make the Factor G' costs susceptible to variability due to the impact of outlier claims. Several extended hospitalizations occurred during SFY15 that accounted for the higher average cost that year. In SFY15 hospital claims accounted for around 60% of the total Factor G' costs as compared to preliminary data for SFY18, where hospital costs accounted for only 40% of the non-ICF-IID costs. For this reason, the value for SFY15 was removed before an average cost per person was computed. Because the cost per person values used to compute the average did not show a clear trend of increased costs from year to year (some years the costs decreased), the computed average was used to project costs for the renewal.

The estimate for Factor G' does not include the cost of claims for prescription drugs for that can be covered by Part D. An edit exists in the MMIS that prevent Medicaid payment for Part D covered drugs for dual eligibles who are enrolled in Part D and for whom Medicaid is paying the Part D premium. The list of Part D covered drugs is updated by DMMA's fiscal agent any time CMS makes a change to the Part D formulary. The entire list is also reviewed annually by the fiscal agent, regardless of whether any changes are made to the Part D formulary during the year. Therefore, only costs for medically necessary, non-Part D covered drugs would be included in Factor G'.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “manage components” to add these components.

Waiver Services	
Day Habilitation	
Personal Care	
Prevocational Services	
Residential Habilitation	
Respite	
Supported Employment - Individual	
Supported Employment - Small Group	
Assistive Technology not otherwise covered by Medicaid	

<i>Waiver Services</i>	
<i>Behavioral Consultation</i>	
<i>Community Transition</i>	
<i>Home or Vehicle Accessibility Adaptations</i>	
<i>Nurse Consultation</i>	
<i>Specialized Medical Equipment and Supplies not otherwise covered by Medicaid</i>	
<i>Supported Living</i>	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. **Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937).** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:							26185406.80
Community Participation - 15 minutes	<input type="checkbox"/>	15 minutes	51	1250.00	8.08	515100.00	
Day Habilitation non facility-15 minutes	<input type="checkbox"/>	15 minutes	70	1250.00	7.98	698250.00	
Day Habilitation facility-15 minutes	<input type="checkbox"/>	15 minutes	40	1250.00	7.88	394000.00	
Day Habilitation facility-per diem	<input type="checkbox"/>	Day	1189	220.00	93.96	24578056.80	
Day Habilitation Transportation	<input type="checkbox"/>	per trip	0	0.00	0.01	0.00	
Personal Care Total:							450000.00
Personal Care	<input type="checkbox"/>	hour	60	750.00	10.00	450000.00	
Prevocational Services Total:							12510376.80
Prevocational Service-facility per diem	<input type="checkbox"/>	Day	665	220.00	77.80	11382140.00	
GRAND TOTAL:							184678910.36
Total: Services included in capitation:							
Total: Services not included in capitation:							184678910.36
Total Estimated Unduplicated Participants:							2600
Factor D (Divide total by number of participants):							71030.35
Services included in capitation:							
Services not included in capitation:							71030.35
Average Length of Stay on the Waiver:							350

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Prevocational Services-non facility 15 minutes		15 minutes	20	1250.00	7.98	199500.00	
Prevocational Service-facility 15 minutes		15 minutes	166	710.00	7.88	928736.80	
Prevocational Service Transportation		per trip	0	0.00	0.01	0.00	
Residential Habilitation Total:							131610780.00
Shared Living Arrangement		Day	155	350.00	39.20	2126600.00	
Neighborhood Group Home/Comm Lvg Arrangement		Day	1160	350.00	308.68	125324080.00	
Medical Residential Habilitation		Hour	20	3500.00	59.43	4160100.00	
Respite Total:							2491827.76
Respite Camp		visit	170	1.00	1250.00	212500.00	
Respite ICF-IID		per diem	14	12.00	1324.07	222443.76	
Respite		hour	600	181.00	18.94	2056884.00	
Supported Employment - Individual Total:							5113905.50
Supported Employment - Individual -15 minutes		15 minutes	517	730.00	13.55	5113905.50	
Supported Employment - Small Group Total:							1587210.30
Supported Employment-Small Group - 15 minutes		15 minutes	195	1758.00	4.63	1587210.30	
Assistive Technology not otherwise covered by Medicaid Total:							43432.00
AT Assessment /Training		15 minutes	20	20.00	96.08	38432.00	
GRAND TOTAL:							184678910.36
<i>Total: Services included in capitation:</i>							
<i>Total: Services not included in capitation:</i>							184678910.36
<i>Total Estimated Unduplicated Participants:</i>							2600
<i>Factor D (Divide total by number of participants):</i>							71030.35
<i>Services included in capitation:</i>							
<i>Services not included in capitation:</i>							71030.35
<i>Average Length of Stay on the Waiver:</i>							350

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
AT equipment or repair		item	20	1.00	250.00	5000.00	
Behavioral Consultation Total:							1163008.00
Behavioral Consultation		15 minutes	826	100.00	14.08	1163008.00	
Community Transition Total:							160000.00
Community Transition		per transition	40	1.00	4000.00	160000.00	
Home or Vehicle Accessibility Adaptations Total:							160000.00
Home/ Vehicle Modifications		per transition	40	1.00	4000.00	160000.00	
Nurse Consultation Total:							1753099.20
Clinical Consultation: Nursing		15 minutes	972	135.00	13.36	1753099.20	
Specialized Medical Equipment and Supplies not otherwise covered by Medicaid Total:							54600.00
Specialized Medical Equipment and Supplies		item	20	1.00	2730.00	54600.00	
Supported Living Total:							1395264.00
Supported Living		Hour	52	1040.00	25.80	1395264.00	
GRAND TOTAL:							184678910.36
<i>Total: Services included in capitation:</i>							
<i>Total: Services not included in capitation:</i>							184678910.36
<i>Total Estimated Unduplicated Participants:</i>							2600
<i>Factor D (Divide total by number of participants):</i>							71030.35
<i>Services included in capitation:</i>							
<i>Services not included in capitation:</i>							71030.35
<i>Average Length of Stay on the Waiver:</i>							350

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:							28467540.20
Community Participation - 15 minutes		15 minutes	71	1250.00	8.08	717100.00	
Day Habilitation non facility-15 minutes		15 minutes	85	1250.00	7.98	847875.00	
Day Habilitation facility-15 minutes		15 minutes	32	1250.00	7.88	315200.00	
Day Habilitation facility-per diem		Day	1219	220.00	99.14	26587365.20	
Day Habilitation Transportation		per trip	0	0.00	0.01	0.00	
Personal Care Total:							562500.00
Personal Care		hour	75	750.00	10.00	562500.00	
Prevocational Services Total:							13144480.00
Prevocational Service-facility per diem		Day	650	220.00	82.98	11866140.00	
Prevocational Services-non facility 15 minutes		15 minutes	30	1250.00	7.98	299250.00	
Prevocational Service-facility 15 minutes		15 minutes	175	710.00	7.88	979090.00	
Prevocational Service Transportation		per trip	0	0.00	0.01	0.00	
Residential Habilitation Total:							139894300.00
Shared Living Arrangement		Day	165	350.00	39.20	2263800.00	
Neighborhood Group Home/Comm Lvg Arrangement		Day	1220	350.00	308.68	131806360.00	
Medical Residential Habilitation		Hour	28	3500.00	59.43	5824140.00	
Respite Total:							2688234.76
GRAND TOTAL:							197185440.20
Total: Services included in capitation:							197185440.20
Total: Services not included in capitation:							2734
Total Estimated Unduplicated Participants:							72123.42
Factor D (Divide total by number of participants):							72123.42
Services included in capitation:							72123.42
Services not included in capitation:							350
Average Length of Stay on the Waiver:							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Camp		visit	190	1.00	1250.00	237500.00	
Respite ICF-IID		per diem	14	12.00	1324.07	222443.76	
Respite		hour	650	181.00	18.94	2228291.00	
Supported Employment - Individual Total:							5707124.50
Supported Employment - Individual -15 minutes		15 minutes	547	770.00	13.55	5707124.50	
Supported Employment - Small Group Total:							1750001.10
Supported Employment - Small Group - 15 minutes		15 minutes	215	1758.00	4.63	1750001.10	
Assistive Technology not otherwise covered by Medicaid Total:							55540.00
AT Assessment /Training		15 minutes	25	20.00	96.08	48040.00	
AT equipment or repair		item	25	1.00	300.00	7500.00	
Behavioral Consultation Total:							1405578.24
Behavioral Consultation		15 minutes	846	118.00	14.08	1405578.24	
Community Transition Total:							160000.00
Community Transition		per transition	40	1.00	4000.00	160000.00	
Home or Vehicle Accessibility Adaptations Total:							183670.20
Home/ Vehicle Modifications		item	36	1.00	5101.95	183670.20	
Nurse Consultation Total:							1608811.20
Clinical Consultation: Nursing		15 minutes	892	135.00	13.36	1608811.20	
GRAND TOTAL:							197185440.20
Total: Services included in capitation:							
Total: Services not included in capitation:							197185440.20
Total Estimated Unduplicated Participants:							2734
Factor D (Divide total by number of participants):							72123.42
Services included in capitation:							
Services not included in capitation:							72123.42
Average Length of Stay on the Waiver:							350

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Specialized Medical Equipment and Supplies not otherwise covered by Medicaid Total:							81900.00
Specialized Medical Equipment and Supplies	<input type="checkbox"/>	item	30	1.00	2730.00	81900.00	
Supported Living Total:							1475760.00
Supported Living	<input type="checkbox"/>	hour	55	1040.00	25.80	1475760.00	
GRAND TOTAL:							197185440.20
<i>Total: Services included in capitation:</i>							
<i>Total: Services not included in capitation:</i>							197185440.20
<i>Total Estimated Unduplicated Participants:</i>							2734
<i>Factor D (Divide total by number of participants):</i>							72123.42
<i>Services included in capitation:</i>							
<i>Services not included in capitation:</i>							72123.42
<i>Average Length of Stay on the Waiver:</i>							350

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:							30818049.60
Community Participation - 15 minutes	<input type="checkbox"/>	15 minutes	91	1250.00	8.08	919100.00	
Day Habilitation non facility-15 minutes	<input type="checkbox"/>	15 minutes	100	1250.00	7.98	997500.00	
Day Habilitation facility-15 minutes	<input type="checkbox"/>	15 minutes	24	1250.00	7.88	236400.00	
GRAND TOTAL:							208412289.62
<i>Total: Services included in capitation:</i>							
<i>Total: Services not included in capitation:</i>							208412289.62
<i>Total Estimated Unduplicated Participants:</i>							2868
<i>Factor D (Divide total by number of participants):</i>							72668.16
<i>Services included in capitation:</i>							
<i>Services not included in capitation:</i>							72668.16
<i>Average Length of Stay on the Waiver:</i>							350

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation facility-per diem		Day	1249	220.00	104.32	28665049.60	
Day Habilitation Transportation		per trip	0	0.00	0.01	0.00	
Personal Care Total:							675000.00
Personal Care		hour	90	750.00	10.00	675000.00	
Prevocational Services Total:							13744395.20
Prevocational Service-facility per diem		Day	635	220.00	88.16	12315952.00	
Prevocational Services-non facility 15 minutes		15 minutes	40	1250.00	7.98	399000.00	
Prevocational Service-facility 15 minutes		15 minutes	184	710.00	7.88	1029443.20	
Prevocational Service Transportation		per trip	0	0.00	0.01	0.00	
Residential Habilitation Total:							148177820.00
Shared Living Arrangement		Day	175	350.00	39.20	2401000.00	
Neighborhood Group Home/Comm Lvg Arrangement		Day	1280	350.00	308.68	138288640.00	
Medical Residential Habilitation		Hour	36	3500.00	59.43	7488180.00	
Respite Total:							2916419.44
Respite Camp		visit	210	1.00	1250.00	262500.00	
Respite ICF-IID		per diem	16	12.00	1324.07	254221.44	
Respite		hour	700	181.00	18.94	2399698.00	
Supported Employment - Individual Total:							6332863.50
Supported Employment - Individual -15		15 minutes	577	810.00	13.55	6332863.50	
GRAND TOTAL:							208412289.62
Total: Services included in capitation:							
Total: Services not included in capitation:							208412289.62
Total Estimated Unduplicated Participants:							2868
Factor D (Divide total by number of participants):							72668.16
Services included in capitation:							
Services not included in capitation:							72668.16
Average Length of Stay on the Waiver:							350

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
minutes							
Supported Employment - Small Group Total:							1831396.50
Supported Employment - Small Group - 15 minutes		15 minutes	225	1758.00	4.63	1831396.50	
Assistive Technology not otherwise covered by Medicaid Total:							66648.00
AT Assessment /Training		15 minutes	30	20.00	96.08	57648.00	
AT equipment or repair		item	30	1.00	300.00	9000.00	
Behavioral Consultation Total:							1658286.08
Behavioral Consultation		15 minutes	866	136.00	14.08	1658286.08	
Community Transition Total:							160000.00
Community Transition		per transition	40	1.00	4000.00	160000.00	
Home or Vehicle Accessibility Adaptations Total:							224996.10
Home/ Vehicle Modifications		item	42	1.00	5357.05	224996.10	
Nurse Consultation Total:							1482559.20
Clinical Consultation: Nursing		15 minutes	822	135.00	13.36	1482559.20	
Specialized Medical Equipment and Supplies not otherwise covered by Medicaid Total:							109200.00
Specialized Medical Equipment and Supplies		item	40	1.00	2730.00	109200.00	
Supported Living Total:							214656.00
Supported						214656.00	
GRAND TOTAL:							208412289.62
Total: Services included in capitation:							208412289.62
Total: Services not included in capitation:							2868
Total Estimated Unduplicated Participants:							72668.16
Factor D (Divide total by number of participants):							72668.16
Services included in capitation:							72668.16
Services not included in capitation:							
Average Length of Stay on the Waiver:							350

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Living		Hour	8	1040.00	25.80		
GRAND TOTAL:							208412289.62
Total: Services included in capitation:							
Total: Services not included in capitation:							208412289.62
Total Estimated Unduplicated Participants:							2868
Factor D (Divide total by number of participants):							72668.16
Services included in capitation:							
Services not included in capitation:							72668.16
Average Length of Stay on the Waiver:							350

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:							20543760.80
Community Participation - 15 minutes		15 minutes	77	1000.00	9.66	743820.00	
Day Habilitation non facility-15 minutes		15 minutes	139	1000.00	9.71	1349690.00	
Day Habilitation facility-15 minutes		15 minutes	46	1000.00	8.76	402960.00	
Day Habilitation facility-per diem		Day	562	220.00	122.61	15159500.40	
Day Habilitation Transportation		Round Trip	824	220.00	15.93	2887790.40	
Personal Care Total:							2014875.00
Personal Care		hour	150	750.00	17.91	2014875.00	
Prevocational Services Total:							8427752.80
GRAND TOTAL:							264537579.44
Total: Services included in capitation:							
Total: Services not included in capitation:							264537579.44
Total Estimated Unduplicated Participants:							3002
Factor D (Divide total by number of participants):							88120.45
Services included in capitation:							
Services not included in capitation:							88120.45
Average Length of Stay on the Waiver:							350

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Prevocational Service-facility per diem		Day	231	220.00	105.09	5340673.80	
Prevocational Services-non facility 15 minutes		15 minutes	62	1000.00	9.71	602020.00	
Prevocational Service-facility 15 minutes		15 minutes	58	710.00	8.76	360736.80	
Prevocational Service Transportation		Round Trip	351	220.00	27.51	2124322.20	
Residential Habilitation Total:							216906095.00
Shared Living Arrangement		Day	115	350.00	112.88	4543420.00	
Neighborhood Group Home/Comm Lvg Arrangement		Day	1100	350.00	548.89	211322650.00	
Medical Residential Habilitation		Hour	5	3500.00	59.43	1040025.00	
Respite Total:							978547.80
Respite Camp		visit	200	1.00	2000.00	400000.00	
Respite ICF-IID		per diem	4	10.00	1324.07	52962.80	
Respite		hour	150	185.00	18.94	525585.00	
Supported Employment - Individual Total:							4887925.00
Supported Employment - Individual -15 minutes		15 minutes	350	850.00	16.43	4887925.00	
Supported Employment - Small Group Total:							1316390.40
Supported Employment - Small Group - 15 minutes		15 minutes	130	1758.00	5.76	1316390.40	
Assistive Technology not otherwise covered by Medicaid Total:							12108.00
GRAND TOTAL:							264537579.44
<i>Total: Services included in capitation:</i>							
<i>Total: Services not included in capitation:</i>							264537579.44
<i>Total Estimated Unduplicated Participants:</i>							3002
<i>Factor D (Divide total by number of participants):</i>							88120.45
<i>Services included in capitation:</i>							
<i>Services not included in capitation:</i>							88120.45
<i>Average Length of Stay on the Waiver:</i>							350

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
AT Assessment /Training		15 minutes	5	20.00	96.08	9608.00	
AT equipment or repair		item	5	1.00	500.00	2500.00	
Behavioral Consultation Total:							2975843.64
Behavioral Consultation		15 minutes	886	154.00	21.81	2975843.64	
Community Transition Total:							20000.00
Community Transition		per transition	5	1.00	4000.00	20000.00	
Home or Vehicle Accessibility Adaptations Total:							120000.00
Home/ Vehicle Modifications		item	20	1.00	6000.00	120000.00	
Nurse Consultation Total:							3202659.00
Clinical Consultation: Nursing		15 minutes	1140	135.00	20.81	3202659.00	
Specialized Medical Equipment and Supplies not otherwise covered by Medicaid Total:							13650.00
Specialized Medical Equipment and Supplies		item	5	1.00	2730.00	13650.00	
Supported Living Total:							3117972.00
Supported Living		Hour	55	1040.00	54.51	3117972.00	
GRAND TOTAL:							264537579.44
Total: Services included in capitation:							
Total: Services not included in capitation:							264537579.44
Total Estimated Unduplicated Participants:							3002
Factor D (Divide total by number of participants):							88120.45
Services included in capitation:							
Services not included in capitation:							88120.45
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.

ii. **Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields.

All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:							21890235.20
Community Participation - 15 minutes		15 minutes	116	1000.00	9.66	1120560.00	
Day Habilitation non facility-15 minutes		15 minutes	154	1000.00	9.71	1495340.00	
Day Habilitation facility-15 minutes		15 minutes	58	1000.00	8.76	508080.00	
Day Habilitation facility-per diem		Day	578	220.00	122.61	15591087.60	
Day Habilitation Transportation		Round Trip	906	220.00	15.93	3175167.60	
Personal Care Total:							2350687.50
Personal Care		hour	175	750.00	17.91	2350687.50	
Prevocational Services Total:							8524126.60
Prevocational Service-facility per diem		Day	231	220.00	105.09	5340673.80	
Prevocational Services-non facility 15 minutes		15 minutes	65	1000.00	9.71	631150.00	
Prevocational Service-facility 15 minutes		15 minutes	62	710.00	8.76	385615.20	
Prevocational Service Transportation		Round Trip	358	220.00	27.51	2166687.60	
Residential Habilitation Total:							232136012.50
Shared Living Arrangement		Day	120	350.00	112.88	4740960.00	
Neighborhood Group Home/Comm Lvg Arrangement		Day	1175	350.00	548.89	225731012.50	
Medical						1664040.00	
GRAND TOTAL:							283045500.92
<i>Total: Services included in capitation:</i>							
<i>Total: Services not included in capitation:</i>							283045500.92
<i>Total Estimated Unduplicated Participants:</i>							3136
<i>Factor D (Divide total by number of participants):</i>							90256.86
<i>Services included in capitation:</i>							
<i>Services not included in capitation:</i>							90256.86
<i>Average Length of Stay on the Waiver:</i>							350

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Residential Habilitation		Hour	8	3500.00	59.43		
Respite Total:							1226983.50
Respite Camp		visit	230	1.00	2000.00	460000.00	
Respite ICF-IID		per diem	5	10.00	1324.07	66203.50	
Respite		hour	200	185.00	18.94	700780.00	
Supported Employment - Individual Total:							5556626.00
Supported Employment - Individual -15 minutes		15 minutes	380	890.00	16.43	5556626.00	
Supported Employment - Small Group Total:							1417651.20
Supported Employment- Small Group - 15 minutes		15 minutes	140	1758.00	5.76	1417651.20	
Assistive Technology not otherwise covered by Medicaid Total:							12108.00
AT Assessment /Training		15 minutes	5	20.00	96.08	9608.00	
AT equipment or repair		item	5	1.00	500.00	2500.00	
Behavioral Consultation Total:							3398695.92
Behavioral Consultation		15 minutes	906	172.00	21.81	3398695.92	
Community Transition Total:							20000.00
Community Transition		per transition	5	1.00	4000.00	20000.00	
Home or Vehicle Accessibility Adaptations Total:							150000.00
Home/ Vehicle Modifications		item	25	1.00	6000.00	150000.00	
Nurse Consultation Total:							3230752.50
GRAND TOTAL:							283045500.92
Total: Services included in capitation:							
Total: Services not included in capitation:							283045500.92
Total Estimated Unduplicated Participants:							3136
Factor D (Divide total by number of participants):							90256.86
Services included in capitation:							
Services not included in capitation:							90256.86
Average Length of Stay on the Waiver:							350

Waiver Service/ Component	Capi- tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Clinical Consultation: Nursing		15 minutes	1150	135.00	20.81	3230752.50	
Specialized Medical Equipment and Supplies not otherwise covered by Medicaid Total:							13650.00
Specialized Medical Equipment and Supplies		item	5	1.00	2730.00	13650.00	
Supported Living Total:							3117972.00
Supported Living		Hour	55	1040.00	54.51	3117972.00	
GRAND TOTAL:							283045500.92
<i>Total: Services included in capitation:</i>							
<i>Total: Services not included in capitation:</i>							283045500.92
Total Estimated Unduplicated Participants:							3136
Factor D (Divide total by number of participants):							90256.86
<i>Services included in capitation:</i>							
<i>Services not included in capitation:</i>							90256.86
Average Length of Stay on the Waiver:							350