source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
C-a-1: The percent of providers that meet applicable licensing, certification or other standards upon initial enrollment. Numerator: The percent of providers that meet applicable licensing, certification or other standards upon initial enrollment; Denominator: The number of waiver providers enrolled during the period.

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

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

Data Aggregation and Analysis:

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

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
The Office of Quality Improvement certification database

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

Data Aggregation and Analysis:

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

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

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

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

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

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

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

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

Performance Measure:
C-c-1: The percent of provider direct support professionals in substantial compliance with DDDS training requirements. Numerator: Number of provider direct support professionals in substantial compliance with training requirements. Denominator: Number of DDDS waiver provider direct support professional staff.

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

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

		at least 25% of agency staff per site
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

The frequency with which the various discovery processes are employed ranges from an as-needed basis (e.g., incident investigations, placement tracking or mortality reviews) to an annual basis (e.g., certification or licensure of the service provider). In addition to those monitoring processes, the case managers also conduct routine monthly reviews and quarterly visits to residential and day programs.

The scope of various reviews includes:

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

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

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

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

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

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
After the initial survey or collection of information, the findings of the professionals involved in the discovery process are communicated with the providers or others who will be involved in sharing promising practices and taking corrective action when needed. Issues are initially discussed among involved parties so as to clearly communicate findings and desired outcomes, followed up by a written report noting those areas needing correction and a date by when such is to be completed. Following the date by which corrections are to be made by the responsible parties, it is the DDDS's general practice to follow-up verifying that the corrections have been made and are acceptable. For those surveys done by the Office of Quality Improvement, verifications usually take the form of an additional look-behind review. With other disciplines, corrections may be verified at the time of the next routinely scheduled review, or through the submission of applicable documentation.

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

Finally, with ever increasing frequency, DDDS operational Units are attempting to track and document the results of their discovery processes in a variety of electronic databases. Designed within these databases are fields to track the verification of required improvements. This tracking may serve to provide a number of benefits. It may provide a prompt in the remediation process, offer a comparison of results longitudinally or among providers, or be used by the Division in a variety of systems-improvement efforts.

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

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

c. Timelines

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

◉ **No**
○ **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

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

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

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

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

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

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

Appendix 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.

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

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:
Lifespan Plan (for individuals receiving residential habilitation) and Support Plan for Individuals and Families (for individualis 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**
- [x] **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)
- [x] **Case Manager** (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

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

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

Possession of an Associate's Degree or higher Behavioral or Social Science or related field OR

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

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

Training in accordance with DDDS training policy.

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

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

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

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

2. Have demonstrated experience and competency in supporting families;

3. Complete Department-required training, including training on the participant's service plan and the participant's unique and/or disability-specific needs, which may include but is not limited to: communication, mobility and behavioral support needs; and

4. Comport with other requirements as required by the Department.

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

☐ **Social Worker**

Specify qualifications:

☐ **Other**

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

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

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

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

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

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

In the meantime, while DDDS endeavors to close all state-operated services, it has adopted the following safeguards:
• Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;
• An opportunity for the participant to dispute the State's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;
• Direct oversight of the process or periodic evaluation by a State agency (in the waiver);
• Restricting the entity that develops the person-centered service plan from providing services without the direct approval of the State; and
• Requiring the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

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

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

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

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

The DDDS Office of Professional Development makes PCP training available to potential waiver applicants and their families/guardians or advocates on a regular basis. The training includes a description of the PCPs in a power point presentation. The presentation illustrates each step in the plan development process, and the facilitator takes the time to answer questions as they come up during the training session.

The "My Life My Plan" manual for Delaware is a resource with the most current DDDS-approved information relative to the development and implementation of the plans. All staff and providers comply with the guidelines set forth in this manual.
The case manager facilitates the development of the plan by managing the planning process and functions as an advocate for the waiver participant during the planning process.

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

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

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

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

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

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

Using the results of the pre-planning activities, the case manager may complete an initial interim plan called "HCBS Initial Waiver Service Authorization" that addresses the essential waiver services that the individual must have in order to avoid institutionalization. Prior to development of this initial person-centered plan, the case manager meets with the participant to review the support needs of the individual and to discuss services and supports available to address them. The pre-planning will have gathered

information about the participant's preferences, likes, dislikes, level of independence, etc. The initial interim plan describes the circumstances that led the participant to seek waiver enrollment and the amount, duration and frequency of each service that is recommended for the participant until the full formal PCP can be developed. The initial interim plan may only be in place for 60 days. A formal person-centered plan that addresses the participant's complete needs must be developed within 60 days of the date of the first receipt of a waiver service and must then be updated annually within 365 days of the date of the previous annual PCP conference. The case manager provides supports and information to the new waiver participant to enable them to direct and be actively engaged in the development of the initial interim plan.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DDDS provides the opportunity for waiver participants to interact with service providers and acquire information through semi-annual "Provider Fairs". The fairs are announced publicly and operate as "meet and greet" events. Waiver participants and their families may speak with service providers to get a feel for the services they provide and how they provide them. DDDS representatives are in attendance to assist families in obtaining more information on how to proceed with seeking services and how to obtain more information related to the providers. This venue provides an opportunity to meet a variety of providers and obtain useful information to guide them through the selection process. DDDS also provides opportunities for waiver participants to meet with each other in order to facilitate natural connections between participants and their families that result in information sharing.

DDDS has also developed a set of interview questions that waiver participants or families may want to ask a service provider in order to help determine if there is a good fit between the person and the provider. This questionnaire is provided to all waiver participants prior to the selection of any waiver services.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

The service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i). DMMA maintains responsibility for service plan approval. The person centered plan is maintained by DDDS in an electronic case record system. Prior to each quarterly meeting between DMMA and DDDS, DMMA provides DDDS with a list of clients for which the PCP will be reviewed and discussed at the meeting. DMMA selects two cases randomly from each region for a total of six Plans to be reviewed. DMMA may request, at any time, a hardcopy of the PCP for any DDDS waiver client. In addition, DMMA has access to the electronic case record software and may conduct spot checks of the PCP at any time.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

○ **Every three months or more frequently when necessary**

○ **Every six months or more frequently when necessary**

◉ **Every twelve months or more frequently when necessary**

○ **Other schedule**

Specify the other schedule:

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

- [ ] **Medicaid agency**
- [x] **Operating agency**
- [ ] **Case manager**
- [ ] **Other**

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

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

The Division of Developmental Disabilities Services (DDDS) provides for ongoing monitoring of the implementation of each waiver participant's service plan. For those persons receiving residential services, the Support Coordinator is the primary person responsible for monitoring the implementation of the plan at a minimum of once a month. For persons living in the family home, the Community Navigator is responsible for monitoring the implementation of the plan at least monthly. The Community Navigator must have at least one face to face contact with the waiver participant each year. Monitoring will occur more frequently if a review of claims indicates that the waiver participant is not routinely receiving services in the amount, duration or frequency specified in the plan. Additional monitoring of all of the day services is conducted by the DDDS Day and Transition Unit. This is discussed below. Additional monitoring of self-directed Respite and Personal Care services by the Agency With Choice Broker is also described below. The Support Coordinators and Community Navigators will be hereafter referred to as "case managers" in this section.

Responsibilities of the case manager include ensuring that services are meeting the participant's needs and that they are provided in accordance with the PCP, including reviewing the amount, duration and frequency of services recommended in the plan. The case manager is responsible for continuing to ensure that the individual is able to exercise free choice of providers and that they understand this right. The case manager is responsible for ensuring that non-waiver health care services are identified and accessible, as needed. The case manager is responsible for ensuring that concerns which require action are identified and remedied promptly.

The Support Coordinator monitors the implementation of the participant's Life Span Plan on a monthly basis. At least once each calendar quarter, the Support Coordinator will conduct a face to face interview with the participant. The Support Coordinator must conduct at least two of the face to face interviews in the participant's home, during which the plan is reviewed with the participant, his/her or guardian, if applicable, and/or appropriate team participants to assess their satisfaction with the services provided and to review how the participant is progressing with the attainment of his/her stated priority outcomes.

During this monthly monitoring of individuals living in a waiver residential setting, the Support Coordinator will:

• Assess the extent to which the participant is receiving services according to his/her person-centered plan. This includes monitoring that each provider has delivered services at the amount, frequency and duration specified in the PCP and that participants are accessing all supports and health-related services as indicated on the PCP.
• Evaluate whether the services furnished meet the participant's needs and help the participant become more independent.
• Assess the effectiveness of provider individual service plans and determine if changes are necessary.
• Review the participant's progress toward goals stated in the PCP.

During the face-to-face monitoring of the plan that occurs four times each year, the Support Coordinator will:
• Remind participants that they have free choice among qualified providers.

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

If, at any point, there is belief that a participant's health and welfare is in jeopardy, actions must be taken immediately to assure the participant's safety. For issues that are of concern, but where the participant is not at risk of imminent harm, the team will work with the participant, service providers and/or informal supports to address the issue. Depending on the severity and scope of the issue, the Support Coordinator may reconvene the participant's support team to address the issue.

The following reports assist the Support Coordinator in monitoring services:

• A monthly report completed by agency providers of residential habilitation that provides a status update on progress toward identified outcomes and any barriers the participant is experiencing in meeting those outcomes. The provider reports on what actions or steps they have taken to support the participant's attainment of identified outcomes.
• Quarterly audits completed by providers of Nurse or Behavioral Consultation, if applicable, that track and monitor behavioral interventions and physical health-status issues, as identified in the PCP.
• Quarterly Day Service/Vocational/Work reports completed by providers of day and employment services to report on the participant's progress in meeting identified outcomes and goals.
• Progress reports recorded for each individual service plan by each provider for each waiver service as identified and defined in the participant's PCP.
• Provider annual reports on progress toward achieving goals, as required for each individual.

The reports listed above are designed to assist the Support Coordinator in assessing the effectiveness of the services and supports the individual receives and to recommend changes when appropriate. Service providers use the electronic case record system to document contacts with participants, providers, family members and informal supports.

The Community Navigator reviews the implementation of the participant's Support Plan for Individuals and Families on a monthly basis and will provide additional support if the participant's plan requires changes.

When a participant wants to change a service provider, the case manager informs the current provider of the change and develops a transition plan to minimize disruption to the participant and to ensure continuity of care.

Office of Quality Improvement Monitoring:

The DDDS Office of Quality Improvement (OQI) completes a thorough review of the Life Span Plan for each participant receiving residential habilitation that is selected as part of the Annual Representative Sample. This review is completed as part of a comprehensive survey of participants' services and is included in the findings for the annual re-credentialing of service providers. OQI utilizes a variety of review tools in order to assess compliance with applicable policies, procedures, standards and regulations. Deficiencies in service delivery result in the requirement for the responsible provider to implement a detailed Corrective Action Plan (CAP) to remediate the concern. OQI monitors the provider's progress with the implementation of the CAP. Data related to waiver performance measures is aggregated to assist the DDDS in identifying systems-level concerns that may require systemic modifications in order for the standard to be achieved.

DDDS Day & Transition Unit: The DDDS Day and Transition Unit monitors the utilization of day services for waiver participants based on specified triggers. They compare provider attendance records and claims data against service authorizations based on the PCP to look for: units higher or lower than what is expected, changes in Group Supported Employment ratios, waiver participants whose authorized hours are exceptions to the ICAP. Providers who are determined to be at higher risk of claim errors based on prior reviews are reviewed more closely than other providers. When a review is triggered, the Unit looks at the PCP, progress/billable notes for each day service and incident reports to ensure that services are being delivered and billed in accordance with the PCP.

One of the duties of the Agency With Choice Broker is to monitor attendance records for employees of participants who have elected to self-direct to ensure that they are receiving services in accordance with the PCP. Concerns or discrepancies will be reported to the Community Navigator for follow up.

b. Monitoring Safeguards. *Select one:*

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

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

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. **Sub-Assurances:**

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

Performance Measures

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

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

Performance Measure:
D-a-1:The percent of participant Person Centered Plans that address the participant's support needs. Numerator:The number of participant PCPs that address the participant's support needs. Denominator: The number of participant Person Center Plans reviewed during the period.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
The Division of Developmental Disabilities Services Office of Quality Improvement (OQI) Individual Focused Certification Review.

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

	☐ Other Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
D-a-2:The percent of Person Centered Plans that identify participant preferences and how they will be met within the Plan. Numerator: The number of participant PCPs that identify participant preferences and how they will be met by the Plan. Denominator: The total number of participant Person Centered Plans reviewed during the period.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
Office of Quality Improvement Individual Focused Certification Review.

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

	Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

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

Performance Measures

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

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

Performance Measure:
D-c-1:The percent of participant Person Centered Plans that are reviewed with the member's team annually. Numerator: The number of participant PCPs that are reviewed with the team annually. Denominator: The number of participant PCPs reviewed during the period.

Data Source (Select one):
Record reviews, off-site

If 'Other' is selected, specify:
Division's Office of Quality Improvement's Individual Focused Certification Review Data Base.

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

Data Aggregation and Analysis:

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

Performance Measure:
D-c-2: The number and percent of person centered plans (PCP) that are revised when the needs of the participant have changed. Numerator: The number of PCPs that are revised when the needs of the participant have changed. Denominator: The total number of PCPs reviewed which require revision.

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

The Division's Office of Quality Improvement's Individual Focused Certification Review Data Base.

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
D-d-1: The number and percent of participant services delivered as specified in the person centered plan, including the type, scope, amount, duration and frequency. Numerator: The total number of services delivered as specified in the PCP. Denominator: The total number of PCPs reviewed for the period.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
Office of Quality Improvement Individual Focused Certification Review-OQI Certification Data Base

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

Data Aggregation and Analysis:

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

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

Performance Measure:
D-d-2: The percent of members receiving residential habilitation whose CM visit occurred each quarter as described in the approved waiver. Numerator: The number of members receiving res hab whose case manager (CM) met them to review the PCP once each quarter, two of which were in the member's home. Denominator: The number of waiver members reviewed during the period.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
Office of Quality Improvement Individual Focused Certification Review-OQI Certification Data Base.

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
D-d-3 The number and percent of members for which progress toward goals included in the PCP is reviewed by the case manager as described on a frequency described in the PCP. Numerator: The number of members whose progress on PCP goals is reviewed by the CM on the specified frequency. Denominator: The total number of member PCPs reviewed during the period.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
Office of Quality Improvement Individual Focused Certification Review-OQI Certification Data Base

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

Data Aggregation and Analysis:

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

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

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

Performance Measures

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

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

Performance Measure:
D-e-2: The number and percent of participants offered a choice of qualified providers. Numerator: The number of participants offered a choice of qualified providers. Denominator: The total number of participant records reviewed for the period.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
The Essential Lifestyle Plan documents that client choice was offered. The review is performed by the DDDS Office of Quality Improvement.

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

	☐ Other Specify:	

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The discovery portion of the Division's Quality Management System (QMS) relies on a robust performance monitoring system managed by the Office of Quality Improvement. This system is aligned with the CMS Quality Framework (Design, Discovery, Remediation, and Improvement).

For each step in the QMS, DDDS has identified: Assurances-Measures-Standards (Discovery), Reporting on the Individual Remediation (Remediation) and Quality Improvement Plans/Projects (Improvement).

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

Sample Selection: The Quality Service Review (QSR) attempts to gain input from individuals and to examine services in order to obtain a "snapshot" of the provider as a whole. The Lead OQI Facilitator (hereafter referred to as "OQI Facilitator") produces a list of the names of the individuals served by the provider. The Lead Quality Improvement Facilitator will also collect corrective action plans, training reports, and any other pertinent information. A random sample of no less than 15% of the provider's waiver caseload will be selected.

Notification and Scheduling: Written notice of the review dates is sent to the provider at least 60 calendar days in advance of the QSR. The Lead OQI Facilitator coordinates with the provider to schedule the review activities including: individual interviews, record reviews, general availability of staff for questions, observations of service, and physical site reviews.

Interview with the waiver participant: The OQI Facilitator conducts an interview with the participant, preferably in their home or other program. Providers will support participants to understand the purpose and intent of the interview. In some instances, an individual may need or want assistance to answer the questions. When assistance is needed or requested, the provider will make these arrangements in collaboration with the individual and/or guardian.

Record Review: The OQI Facilitator reviews provider policies and procedures, certifications (CARF, CQL, etc.), licensing documents, staff training files, and any other relevant information. The case manager files (person centered plan, LOC

completed, etc.) are also reviewed.

Exit Conference/ Feedback Discussion: The OQI Facilitators provide a written summary of the findings before the final Quality Certification Report is written. The OQI Facilitator will identify issues that need to be addressed within the Quality Improvement Plan.

Quality Certification Reporting: A Quality Certification Report is sent to the provider that contains an overview of the review process, agency strengths, recommendations, and areas for improvement and requirements for a Quality Improvement Plan.

DDDS Regional Offices also have a key role in ongoing monitoring in order to verify that issues on an individual and provider level are resolved. Regional Directors have access to reports tracking issues and follow-up, along with monthly summary reports from various discovery processes including: incident reports, case manager visits, OQI provider reviews etc. Each office has the ability to assemble a regional management team comprised of appropriate DDDS staffers and others as necessary in order to review unresolved and emerging serious individual concerns and provide technical assistance and/or resources to resolve the issue.

b. Methods for Remediation/Fixing Individual Problems

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

Quality Certification Reporting: If a Quality Certification Report identifies areas for improvement and requirements for a Quality Improvement Plan, the provider must submit a Quality Improvement Plan to OQI that addresses each finding with specific objective(s), a timeline, and the contact information for the person(s) responsible for developing and implementing the plan. The QIP must be approved in writing by DDDS.

Once the improvement plan is developed by the provider, a designated manager within DDDS must approve the plan in writing within 15 days of receiving it. Elements for approving a Quality Improvement Plan can be found on the DDDS website at http://dhss.delaware.gov/dhss/ddds/qa.html

Following notification by the provider that the corrections were made, DDDS verifies that the corrections were made and that they are acceptable.

DDDS response to Continued Inadequate Performance: DDDS has a structured process for addressing continued inadequate performance by a provider. In addition to monitoring activities by OQI, any DDDS staff person may escalate concerns about provider performance through the organizational hierarchy in each DDDS Regional Office, ending with the DDDS Senior Leadership Team which represents all parts of DDDS. The Leadership team meets to review the data presented regarding the provider's inadequate performance and to make a recommendation to the DDDS Director regarding whether or not to put the provider on probation.

When a recommendation for probation is approved by the Director, the DDDS Director notifies the provider in writing including the areas where improvement is needed and the timelines for the completion of these activities within an initial six month probationary period. A meeting is also scheduled with the organization to go over the reason for probation.

OQI monitors the provider's compliance with the terms of the probation. At the end of the initial period of probation, the Director may extend it for another six months if the provider has not shown sufficient improvement in one or more areas requiring remediation.

OQI monitors the provider's compliance with the terms of the probation. At the end of the initial period of probation, the Director may extend it for another six months if the provider has not shown sufficient improvement in one or more areas requiring remediation.

ii. Remediation Data Aggregation

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

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

Responsible Party *(check each that applies)*:	**Frequency of data aggregation and analysis** *(check each that applies)*:
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

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

Appendix E: Participant Direction of Services

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

◉ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
○ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

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

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

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

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

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
Respite	☑	☐
Personal Care	☑	☐

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**

☑ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

○ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

◉ **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

A private entity that is selectively contracted by the state.

The Agency with Choice Broker was procured through a competitive RFP issued by the Delaware Division of Developmental Services. The vendor organization which was awarded the contract demonstrated clear superiority of experience and capabilities.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

As an Agency With Choice broker, the agency will be compensated for the cost of recruitment, screening, establishing payment rates with participant input, processing timesheets, payroll and withholding, maintenance of employee records, issuing W-2s, processing payments for respite camps, submitting Medicaid claims on behalf the participant, assessing participant satisfaction and assisting the participant in performing supervisory functions, such as training and performance evaluation.

DDDS has developed a standard methodology for reimbursing AWC administrative activities. There is an initial one-time set-up payment for each new participant that elects to self-direct their Respite or Personal Care service and a separate standard on-going monthly payment. Payment to the vendor will be a fixed dollar amount for each participant who has elected to self-direct their Respite or Personal Care service. This monthly payment covers all on-going activities as specified in the vendor contract. The administrative payments to the AWC broker are entirely separate from the funds dedicated to the participant's allotment for services.

The AWC provider receives a monthly per participant administrative fee for the administrative service provided by the AWC as specified in the vendor contract. The monthly administrative fee is negotiated between DDDS and the AWC vendor and must be applied consistently across all participants who elect self-direction. The AWC broker must submit monthly invoices to the state. Administrative claims are submitted by the AWC broker to DDDS for approval and payments are made directly to the AWC broker from the Delaware Treasury via the Delaware State accounting system.

DDDS contracts with a single statewide AWC broker.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

- [x] **Assist participant in verifying support worker citizenship status**
- [x] **Collect and process timesheets of support workers**
- [x] **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- [x] **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:

- [x] **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- [x] **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- [x] **Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other**

Specify:

iv. **Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

The Agency With Choice Broker contract was competitively procured using the approved State of Delaware and Department of Health and Social Services rules. An RFP that defined the contract requirements, standards, deliverables, reporting and performance metrics was issued. Those requirements were incorporated by reference into the contract that was signed with the selected vendor. The RFP requires that the AWC broker submit an independent financial audit to DDDS each year.

DDDS monitors and assesses the performance of the FMS in the following ways:

The participant (or the participant's surrogate) is the co-employer of workers who provide waiver services. A statewide AWC broker is, as the employer of record, an IRS-approved Fiscal/Employer Agent and functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law.

DDDS monitors the AWC vendor to ensure that the contract deliverables are met and participants are in receipt of AWC vendor services in accordance with their Individual Support Plan. Two individuals within DDDS are designated as Liaisons to the AWC vendor. They report to a Senior DDDS Manager who is the manager for the AWC vendor contract. The statewide AWC broker is monitored by DDDS at a frequency established by DDDS. DDDS monitors the AWC broker's performance of administrative activities, as well as adherence to contract conditions and waiver requirements. The Community Navigators are also responsible for reporting any issues regarding the statewide AWC broker to the DDDS AWC Liaisons or the contract manager as part of their job duties.

The DDDS AWC Liaisons review expenditures against waiver coverage and whether they are accurately and appropriately assigned and reported. The AWC broker is required to provide monthly reports and documentation to the DDDS AWC Liaisons that identifies the amounts paid to employees/caregivers on behalf of waiver participants. The AWC broker will maintain signed time sheets for all employees for each pay period which can be reviewed by the DDDS AWC Liaisons at any time. If errors are noted, the DDDS Liaisons will report them to the AWC vendor for correction by the following pay period. In addition to reviewing routine reports provided by the AWC vendor, the DDDS AWC Liaisons will also periodically conduct unannounced audits of AWC records at its office location.

DDDS AWC Liaisons identify inconsistencies between utilization, expenditures, dates of service, waiver enrollment date and claims and then follow up with AWC vendor to ensure that any errors are corrected. The DDDS AWC Liaison periodically monitor units paid and account balances to ensure there are sufficient funds in each account to cover services up to the approved limit. Systemic errors require a Plan of Correction from the AWC vendor which must be approved by the DDDS AWC contract manager and will be monitored by the DDDS AWC Liaisons.

DDDS monitors claims submitted by the AWC broker using established claims oversight methods. DDDS has safeguards to ensure the payments to the AWC broker for both administrative fees and Medicaid services are in accordance with all applicable regulations and requirements.

Periodically, the DDDS Liaisons will randomly select a number of provider files maintained by the AWC broker to verify such elements as provider screening and training, copy of IRS Forms W-4 and I-9, accuracy of wage payments and withholding, compliance with US DOL FLSA rules.

Quarterly, the DDDS AWC Liaisons will verify AWC vendor payment/filing of the State Income Tax, Unemployment Tax, Workers Compensation and IRS Forms 940 and 941 and Forms W-2/W-3.

At the end of the first year, DDDS will review all AWC broker systems and practices to confirm that standard operating procedures are in place to ensure compliance with contract requirements and Medicaid regulations. Annually, DDDS will also review required reporting on performance metrics such as timeliness of payroll and payment of other invoices by the AWC vendor, participant satisfaction, and timeliness of response to customer calls where a message is left after hours, complaints resolution, etc. as specified in the contract.

Community Navigators monitor participant service delivery at a frequency identified in Appendix D-2-a which includes the delivery of the administrative services provided by the AWC broker.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☑ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

The Community Navigators providing Targeted Case Management will have sufficient training and printed information to explain, in general, the self-directed option to families and participants. If the family is interested in this option, the Community Navigator connects the participant to the Agency with Choice provider.

☐ **Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Clinical Consultation: Nursing	☐
Home or Vehible Accessibility Adaptations	☐
Day Habilitation	☐
Respite	☐
Supported Employment - Small Group	☐
Specialized Medical Equipment and Supplies not otherwise covered by Medicaid	☐
Assistive Technology for Individuals not otherwise covered by Medicaid	☐
Supported Living	☐
Prevocational Services	☐
Supported Employment - Individual	☐
Personal Care	☐
Community Transition	☐
Clinical Consultation: Behavioral	☐
Residential Habilitation	☐

☑ **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 need their needs.

b) The Agency with Choice Broker is a private entity that was procured through a competitive RFP issued by the Delaware Division of Developmental Services. The vendor organization which was awarded the contract demonstrated clear superiority of experience and capabilities.

DDDS has developed a standard methodology for reimbursing AWC administrative activities. There is an initial one-time set-up payment for each new participant that elects to self-direct their Respite or Personal Care service and a separate standard on-going monthly payment. Payment to the vendor will be a fixed dollar amount for each participant who has elected to self-direct their Respite or Personal Care service. This monthly payment covers all on-going activities as specified in the vendor contract. The administrative payments to the AWC broker are entirely separate from the funds dedicated to the participant's allotment for services.

The AWC provider receives a monthly per participant administrative fee for the administrative service provided by the AWC as specified in the vendor contract. The monthly administrative fee is negotiated between DDDS and the AWC vendor and must be applied consistently across all participants who elect self-direction. The AWC broker must submit monthly invoices to the state. Administrative claims are submitted by the AWC broker to DDDS for approval and payments are made directly to the AWC broker from the Delaware Treasury via the Delaware State accounting system.

DDDS contracts with a single statewide AWC broker.

c) Once a participant has elected to self-direct their Respite or Personal Care service, the AWC broker will perform the following

functions:

- Ensure that they understand their role as distinct from the AWC role
- Assist the participant in selecting caregivers that meet his or her individual needs if the participant has not previously specified a caregiver
- If the agency chooses to, or if requested by the program participant, the AWC broker will conduct the interview, with the participant, and vet potential candidates who may be able to meet the participant's support needs under Respite or Personal Care service
- Ensure that employees meet basic minimum, non-participant-specific training requirements such as CPR or safe lifting techniques
- Assist the waiver participant in understanding and carrying out their role as the managing employer
- Assist the waiver participant in resolving conflicts with their employee
- Assist the waiver participant in creating a back-up plan in the event their regular caregiver is not available for one or more days
- terminate employees who fail to perform satisfactorily (this is different from the determination of a participant that an employee is not meeting their particular needs)
- notify the Community Navigator or one of the DDDS AWC Liaisons of any concerns

The AWC broker will also create and maintain a registry of prospective workers from which waiver participants may choose.

d) and e) DDDS will oversee the provision of this assistance through monitoring of the AWC vendor contract. DDDS monitors the AWC vendor to ensure that the contract deliverables are met and participants are in receipt of AWC vendor services in accordance with their Individual Support Plan. Two individuals within DDDS are designated as Liaisons to the AWC vendor. They report to a Senior DDDS Manager who is the manager for the AWC vendor contract. The statewide AWC broker is monitored by DDDS at a frequency established by DDDS. DDDS monitors the AWC broker's performance of administrative activities, as well as adherence to contract conditions and waiver requirements. The Community Navigators are also responsible for reporting any issues regarding the statewide AWC broker to the DDDS AWC Liaisons or the contract manager as part of their job duties.

The DDDS AWC Liaisons review expenditures against waiver coverage and whether they are accurately and appropriately assigned and reported. The AWC broker is required to provide monthly reports and documentation to the DDDS AWC Liaisons that identifies the amounts paid to employees/caregivers on behalf of waiver participants. The AWC broker will maintain signed time sheets for all employees for each pay period which can be reviewed by the DDDS AWC Liaisons at any time. If errors are noted, the DDDS Liaisons will report them to the AWC vendor for correction by the following pay period. In addition to reviewing routine reports provided by the AWC vendor, the DDDS AWC Liaisons will also periodically conduct unannounced audits of AWC records at its office location.

DDDS AWC Liaisons identify inconsistencies between utilization, expenditures, dates of service, waiver enrollment date and claims and then follow up with AWC vendor to ensure that any errors are corrected. The DDDS AWC Liaison periodically monitor units paid and account balances to ensure there are sufficient funds in each account to cover services up to the approved limit. Systemic errors require a Plan of Correction from the AWC vendor which must be approved by the DDDS AWC contract manager and will be monitored by the DDDS AWC Liaisons.

DDDS monitors claims submitted by the AWC broker using established claims oversight methods. DDDS has safeguards to ensure the payments to the AWC broker for both administrative fees and Medicaid services are in accordance with all applicable regulations and requirements.

Periodically, the DDDS Liaisons will randomly select a number of provider files maintained by the AWC broker to verify such elements as provider screening and training, copy of IRS Forms W-4 and I-9, accuracy of wage payments and withholding, compliance with US DOL FLSA rules.

Quarterly, the DDDS AWC Liaisons will verify AWC vendor payment/filing of the State Income Tax, Unemployment Tax, Workers Compensation and IRS Forms 940 and 941 and Forms W-2/W-3.

At the end of the first year, DDDS will review all AWC broker systems and practices to confirm that standard operating procedures are in place to ensure compliance with contract requirements and Medicaid regulations. Annually, DDDS will also review required reporting on performance metrics such as timeliness of payroll and payment of other invoices by the AWC vendor, participant satisfaction, and timeliness of response to customer calls where a message is left after hours, complaints resolution, etc. as specified in the contract.

Community Navigators monitor participant service delivery at a frequency identified in Appendix D-2-a which includes the delivery of the administrative services provided by the AWC broker.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

◉ **No. Arrangements have not been made for independent advocacy.**
○ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

Voluntary Termination of Participant Direction
An individual who elects to receive participant-directed Respite and Personal Care can elect to terminate participant direction at any time. The state ensures the continuity of services for and the health and welfare of the participant who elects to terminate participant directed Respite and Personal Care services.

Community Navigators shall facilitate a seamless transition to an alternative service delivery method so that there are no interruptions or gaps in services. Community Navigators shall ensure that employees remain in place until alternative providers are obtained and are scheduled to provide services. Community Navigators shall monitor the transition to ensure that the service is provided consistent with the person-centered plan and in keeping with the participant goals and objectives.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Involuntary Termination of Participant Direction
Participants who opt to self-direct their Respite and Personal Care services receive a great deal of support to assist them in carrying out their responsibilities. This support leads to successful participant direction in most cases. However, there are a several circumstances under which the State would find it necessary to terminate participant direction. Specifically, the State involuntarily terminates the use of participant direction under the following circumstances:

• Inability to self-direct. If an individual consistently demonstrates a lack of ability to carry out the tasks needed to self-direct Respite and Personal Care services, including hiring, training, and supervising his or her respite provider or personal care attendant, and does not have a representative available and able to carry out these activities on his/her behalf, then the State would find it necessary to terminate the use of participant direction.
• Fraudulent use of funds. If there is substantial evidence that a participant has falsified documents related to participant directed services (for example authorizing payment when no services were rendered or otherwise knowingly submitting inaccurate timesheets), then the State would find it necessary to terminate the use of participant direction.
• Health and welfare risk. If the use of participant direction results in a health and welfare risk to the participant that cannot be rectified through intervention on the part of the AWC provider and/or the Community Navigator, then the State would find it necessary to terminate the use of participant direction.

In cases in which participant direction is discontinued, the Community Navigator makes arrangements immediately with the participant to select from a list of provider managed personal care entities (i.e., those home health agencies and personal assistance services agencies enrolled to provide the respite or personal care). Once the individual has selected a new Respite and Personal Care provider, the Community Navigator makes arrangements to have the agency-based service begin as soon as possible to minimize or eliminate any possible gap in service.

Community Navigators shall facilitate a seamless transition to alternative service delivery method so that there are no interruptions or

gaps in services. Community Navigators shall ensure that employees remain in place until alternative providers are obtained and are scheduled to provide services. Community Navigators shall monitor the transition to ensure that the service is provided consistent with the person-centered plan and in keeping with the participant goals and objectives.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 1	0	
Year 2	0	
Year 3	0	
Year 4	300	
Year 5	310	

Appendix E: Participant Direction of Services

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

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☑ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

The Agency With Choice broker will be the co-employer along with the participant.

☐ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☑ **Recruit staff**
☑ **Refer staff to agency for hiring (co-employer)**
☑ **Select staff from worker registry**
☐ **Hire staff common law employer**
☐ **Verify staff qualifications**
☐ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

☑ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

- [x] **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
- [ ] **Determine staff wages and benefits subject to State limits**
- [x] **Schedule staff**
- [x] **Orient and instruct staff in duties**
- [ ] **Supervise staff**
- [x] **Evaluate staff performance**
- [x] **Verify time worked by staff and approve time sheets**
- [ ] **Discharge staff (common law employer)**
- [x] **Discharge staff from providing services (co-employer)**
- [x] **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.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

iii. Informing Participant of Budget Amount. Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

iv. Participant Exercise of Budget Flexibility. *Select one*:

- ○ **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ○ **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

The Division of Developmental Disabilities Services (DDDS) mails written notifications to HCBS applicants and recipients at the time of an adverse eligibility decision, the lack of choice of service provider and/or if an HCB service is reduced, suspended or terminated for an individual. The notification is presented in understandable language, provides an explanation for the action, describes the applicant/recipient's right to Fair Hearing via the DHSS Division of Social Services under an MOU with the Medicaid Agency and explains the method by which a Fair Hearing can be requested. The Medicaid Fair Hearing is a State administrative hearing process and its regulations are published in the Delaware Administrative Code, Section 5000. Written notifications of adverse actions are required to include the following elements:

- The right to appeal the action through the Medicaid Fair Hearing process, through an internal DDDS appeal process (see F-2-b. below) or both;
- An explanation that the request for a Medicaid Fair Hearing must be in writing;
- An explanation that the applicant/recipient may be represented at a Fair Hearing by an attorney, friend or person of their choice;
- Contact information for the Community Legal Aid Society, Inc., including a toll free phone number and advise to the recipient that they offer free legal advice/representation;
- An explanation of the reason(s) for the DDDS action including the specific regulations that support said action

The written notice must be mailed at least within ten (10) days before the effective date of the action (this applies to HCBS waiver recipients; not applicants who are not currently receiving HCB services). Exceptions to the 10 day timely notice are delineated in Delaware Administrative Code, Title 16, §5302 and are consistent with 42 CFR 431.213.

Written notifications relative to adverse actions and the right to a Fair Hearing are maintained at the Office of Applicant Services (for applicants) or maintained in the individual's case record (for current HCBS recipients). The outcome of the Medicaid Fair Hearing is maintained by Medicaid Agency.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

○ **No. This Appendix does not apply**

◉ **Yes. The State operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The Division of Developmental Disabilities Services (DDDS) operates the DDDS HCBS Lifespan Waiver. In addition to the right to a Medicaid Fair Hearing through the DSS, an HCBS applicant or HCBS waiver service participant also has the right to an appeal any adverse action affecting Medicaid eligibility or benefits via an internal DDDS appeal process. The right to a DDDS appeal and a Medicaid Fair Hearing are simultaneously offered to an HCBS applicant or HCBS waiver service recipient when an adverse decision is made; including the denial of eligibility, the denial, reduction, suspension or termination of Medicaid HCBS services for an individual or the lack of choice of a service provider.

HCBS waiver applicants and participants are notified via written correspondence relative to all adverse actions, as delineated in the above paragraph. The notification of adverse action clearly states in understandable language that the applicant or HCBS waiver participant may appeal the adverse decision through the DDDS internal appeals process or through the Medicaid Fair Hearing process or both. An individual is not required to file a DDDS appeal request as a pre-requisite to accessing a Medicaid Fair Hearing process. The DDDS appeal is not a dispute resolution process that must be used in lieu of the Medicaid Fair Hearing, but it is offered as a less formal means of addressing grievances. The notification includes the reasons for the adverse action(s) including applicable citations and the information that was used to make the determination, effective date of action(s) and process by which a DDDS appeal may be requested. No action may be taken on a DDDS decision to deny, reduce, suspend or terminate HCBS waiver services, if an appeal request is received within the timely notice period (10 days before date of action). The notification also advises the reader of how, to whom and when a Medicaid Fair Hearing request with DSS can be made.

The DDDS appeal process is an internal agency operating mechanism and its regulations are published in the Delaware Administrative Code, Section 2101. The appeals committee membership includes a chairperson and representatives from the Stockley Center ICF-IID facility and all regions of the DDDS Community Services Unit.

Disputable items through the DDDS internal appeals process for waiver applicants or participants include:
- an adverse decision regarding a DDDS Level of Care determination or redetermination;
- the choice of service provider is not granted;
- an HCB waiver service is denied, reduced, suspended or terminated for an individual.

Procedural elements of the DDDS appeals process include the following elements:
- A timely notice (10 days before date of action) of intent to reduce, suspend or terminate waiver services must be mailed to the HCBS waiver recipient;
- Exceptions to the timely notice requirement are delineated in Delaware Administrative Code, Title 16, §5302 and are consistent with 42 CFR 431.213;
- DDDS appeals request must be received by the DDDS Appeals Committee chair within 30 calendar days of the decision;
- The appellant is contacted by the DDDS Appeals Committee chairperson within 5 working days of receipt of appeals request to schedule the appeal;
- Appeal meeting must be scheduled within 90 days of receiving the appeal request;
- HCBS waiver services must not be denied, reduced, suspended or terminated pending a decision of a DDDS appeal, Medicaid Fair Hearing or both, if a request for either is filed within ten (10) days of the proposed action implementation date. Exceptions to this rule are delineated in Delaware Administrative Code, Title 16, §5302;
- Appeal Committee members meet with the appellant, and his/her guests at the appeal meeting;
- Appeal committee chairperson offers the committee's recommendation to the Division Director within five (5) working days of the appeal.
- DDDS Division Director sends written notification of outcome to appellant within fifteen (15) working days of appeal. DDDS Division Director provides appellant with explanation of right to appeal decision to DSS via the Medicaid Fair Hearing process. Contact information is given by which a Medicaid Fair Hearing can be requested.
- DDDS Appeals Committee chairperson maintains all records associated with the appeal request. Data is tracked on an electronic database and reviewed by the DDDS Performance Analysis Committee.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

○ **No. This Appendix does not apply**

◉ **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:

DDDS is responsible for the operation of the internal grievance/complaint system(s). In addition, DDDS requires each waiver provider to offer an internal dispute resolution process to waiver enrollees to provide an opportunity to address grievances at the lowest level possible. Waiver enrollees are not required to use either the provider grievance process of the DDDS internal dispute resolution process before exercising their right to a Medicaid Fair Hearing for any issue that is appealable through that process.

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

Description of the DDDS grievance system:

The DDDS Director of Planning and Policy Development and Constituent Relations Liaison is the Rights Complaint Designee appointed by the Division Director. In accordance with the DDDS Rights Complaint policy, Individual Rights Complaint forms and instructions for the completion of such are prominently placed and accessible in all program and administrative offices and locations within DDDS-funded program areas. The DDDS Rights and Responsibilities Policy requires the Statement of Rights to be reviewed with the waiver participant and his/her guardian by the individual that leads the planning team during the annual meeting to discuss the person centered service plan. The Statement of Rights is broken into three sections: services and supports, privacy and choice. A waiver participant or any concerned person acting on behalf of the participant has the right to file a rights complaint with DDDS if they have reason to believe that a right is being violated or restricted without due process. Rights Complaints filed with the DDDS Rights Complaint Designee are investigated at a regional level. The completed investigations of a rights complaint are reviewed by

the appropriate administrator and returned to the DDDS Client Rights Complaint Designee. For substantiated complaints, a Corrective Action Plan must be developed. The Plan must be reviewed and approved by the appropriate administrator before it is returned to the DDDS Client Rights Complaint Designee. The Director of Community Services contacts the complainant regarding the disposition of the complaint. The aforementioned process is completed within sixty (60) working days of the date the Rights Complaint Designee receives the rights complaint form. The outcome of the Rights Complaint is sent to the Human Rights Committee for review

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

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

(●) **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*

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

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

DDDS has two (2) distinct types of incidents that HCBS providers are required to report to the Division. These incidents are known as reportable "PM46" incidents and "non –PM46" occurrences. PM46 refers to Department of Health and Social Services (DHSS) Policy Memorandum number forty-six that defines incidents that must be reported for services provided in all DHSS divisions. Because DDDS is a DHSS Division, any incident that meets the scope and definition of DHSS Policy Memorandum #46 must be reported and investigated using a standardized protocol. In addition, DHSS Divisions may define additional types of critical reportable incidents that fall outside of the scope of the DHSS PM46. DDDS has a policy that requires reporting for settings not covered under the PM46 scope and incidents that would not be required to be reported under PM46.

Reportable incidents under PM46 are defined as suspicion of any of the following occurrences:

1. Abuse shall mean:
a. Physical abuse by unnecessarily inflicting pain or injury to a patient or resident. This includes but is not limited to, hitting, kicking, punching, slapping or pulling hair. When any act constituting physical abuse has been proven, the infliction of pain is assumed;
b. Sexual abuse which includes, but is not limited to, any sexual contact, sexual penetration, or sexual intercourse by an employee or contractor, as defined in 11 DE Code, Ch. 5, §761, with an individual. It shall be no defense that the sexual contact, sexual penetration, or sexual intercourse was consensual;
c. Sexual act (any) between staff and an individual and any non-consensual sexual act between individuals or between an individual and any other person such as a visitor;
d. Emotional abuse which includes, but is not limited to, ridiculing, demeaning, humiliating, bullying or cursing at an individual, or threatening an individual with physical harm.

2. Financial Exploitation shall mean the illegal or improper use, control over, or withholding of the property, income, resources, or trust funds of the individual by any person or entity for any person's or entity's profit or advantage other than for the individual's profit or advantage. "Financial exploitation" includes, but not limited to:
a. The use of deception, intimidation, or undue influence by a person or entity in a position of trust and confidence with an individual to obtain or use the property, income, resources, or trust funds of an individual for the benefit of a person or entity other than the individual;
b. The breach of a fiduciary duty, including but not limited to, the misuse of a power of attorney , trust, or a guardianship appointment that results in the unauthorized appropriation, sale or transfer of the property, income, resources or trust funds of the individual for the benefit of a person or entity other than the individual; and
c. Obtaining or using an individual's property, income, resources, or trust funds without lawful authority, by a person or entity who knows or clearly should know that the individual lacks the capacity to consent to the release or use of his or her property, income, resources, or trust funds.

3. Medication Diversion shall mean knowingly or intentionally interrupting, obstructing or altering the delivery or administration of a prescription drug to an individual receiving services, provided that such prescription was:

a. Prescribed or ordered by a licensed health care practitioner for the individual receiving services and
b. The interruption, obstruction or alteration occurred without the prescription or order of a licensed health care practitioner.

4. Mistreatment shall mean the inappropriate use of medications, isolation, or physical or chemical restraints on or of an individual receiving service.

5. Neglect shall mean:
a. Lack of attention to the physical needs of an individual receiving service to include but not limited to toileting, bathing, nutrition and safety.
b. Failure to report problems or changes in health problems or changes in health condition to an immediate supervisor or nurse;
c. Failure to carry out a prescribed treatment plan or plan of care that resulted in a negative impact or potential negative impact or the neglect resulted in a repeated trend
d. A knowing failure to provide adequate staffing which results in a medical emergency to any individual receiving services where there has been documented history of at least two (2) prior cited instances of such inadequate staffing within the past two (2) years in violation of minimum maintenance of staffing levels as required by statute or regulations promulgated by the Department, all so as to evidence a willful pattern of such neglect. (16 DE Code, §1161-1169).

6. Unanticipated Death shall include all deaths of individuals served that are of a suspicious and/or unusual nature. They shall also include those deaths whereby the Division of Forensic Science assumed jurisdiction.

7. Significant Injury shall include:
a. Injury from an incident of unknown source in which the initial evaluation supports the conclusion that the injury is suspicious. Circumstances which may cause an injury to be suspicious are: the extent of the injury, the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma), the number of injuries observed at one particular point in time, or the incidence of injuries over time;
b. Injury which results in transfer to an acute care facility for treatment or evaluation or which requires periodic neurological reassessment of the resident's clinical status by professional staff for up to twenty four (24) hours;
c. Areas of contusions or bruises caused by staff to an individual served during ambulation, transport, transfer or bathing;
d. Significant error or omission in medication/treatment, including drug diversion, which causes the resident discomfort, jeopardizes the individual's health and safety or requires periodic monitoring for up to forty eight (48) hours;
e. A burn greater than first degree;
f. Any serious unusual and/or life-threatening injury.

The process for reporting and following up on PM#46 incidents is as follows:

The person who has reasonable cause to believe that an individual has been abused, neglected, mistreated, financially exploited, had their medication diverted, received a significant injury or dies an unanticipated death shall immediately take actions to ensure the individual receives all necessary medical treatment and evaluation and then;

1. Take actions to protect all individuals from further physical or emotional harm and then;
2. Ensure that individuals reported to be victims of sexual assault are examined by SANE at the hospital and then (or concurrently if possible); contact the local law enforcement to report crimes against individuals and then;
3. Immediately call the DDDS Regional Investigative Coordinator and then;
4. Complete a written report within twenty four (24) hours and submit it to the DDDS Regional Investigative Coordinator and then if the incident happens in a Neighborhood Home;
5. Make a verbal report to the DLTCRP by telephoning the twenty four (24) hour toll free number at 1-877-453-0012.

The Office of Investigative Services shall notify the individual (reported victim) unless there is an identified guardian of person (or property if the allegation involves financial exploitation), health care surrogate pursuant to Title 16, §2507 or other legally authorized person of the guardian or primary contact person, or release of information has the potential to do harm or if the individual served (victim) expressly communicates that he/she does not want the non-guardian family contact person to be contacted about the allegation. Notifications shall occur with the following frequency:

i. Initial notification on the day the reportable incident is reported to the OIS recipient of reportable incidents (verbal and written);

ii. Follow-up notifications if the investigation exceeds five(5) working days (for Long Term Care Facilities) or ten (10) calendar days (verbal or written);

iii. Notification at the conclusion of the investigation (verbal and written).
Non PM46 occurrences per DDDS policy include:

• Any major medical episode (such as a trio to the Emergency Department but where abuse or neglect are not suspected)
• Any behavior which necessitates the use of a physical or restrictive procedure

- Choking incident requiring the use of the Heimlich Maneuver or other medical intervention
- Acts of aggression
- Elopement of Missing Individual
- Criminal arrest
- Possession of Illegal substances
- Possession of firearms, knives, or explosives
- Medication error
- Extensive damage to property due to an individual receiving services (valued at $2,000)
- Attempted Suicide

These incidents must be reported via the electronic record within eight (8) hours of the incident. On a regular basis DDDS will review reported incidents, analyze data for trends, and recommend changes in policy, practice, or training that may reduce the risk of such events occurring in the future. State wide trends will be provided to Providers to enhance the awareness of activities and to formulate prevention strategies. DDDS also requires Providers to have policies and procedures that promote the utilization of their incident data to track trends and to determine if the recommendations made in the final written report were implemented and are effective.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

All waiver participants are advised of their right to be free of physical, verbal, sexual, psychological/emotional abuse and exploitation both during their initial person centered planning process and as part of their annual PCP review. A Statement of Rights was developed as a DDDS policy. The case manager explains these rights to waiver participants a minimum of once per year, at the time the person centered plan is reviewed. The case manager is responsible for the development of ongoing teaching and support strategies designed to assist participants to understand and exercise his/her rights. These requirements are documented in the DDDS policy entitled Individuals Rights.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

The reporting of incidents is overseen at several levels. The most immediate review and monitoring occur at the level of the person centered planning team. Team members minimally include the Support Coordinators and staff from providers who have been chosen by the participant to deliver services. These are the same individuals who will also document incidents, develop plans of correction and monitor the effectiveness of such plans in achieving desired outcomes.

DDDS Office of Investigative Services maintains an electronic database that includes information about the type and frequency of investigated reportable incidents, the victim and location, the plan of correction/improvement and verification of such. The data shall be used to trend incidents, measure performance and provide input for strategic planning. This stand-alone data will be incorporated into the new unified electronic case record software and will no longer exist as a stand-alone database thereafter.

The DDDS Office of Quality Improvement reviews all reportable incident data for each provider on an annual basis as part of the review against the DDDS waiver provider standards.

For each reported incident, OQI Program Evaluators review the participant's electronic case record to determine if appropriate follow up actions were taken, if such actions were effective and if trends exist within or across providers. The outcome of the review of the incident management system by the Program Evaluators is incorporated into the annual report given to each provider.

The Office of Quality Improvement (OQI) reviews PM46 incident data for each participant included within the annual representative sample of Quality Service Reviews (QSR). The OQI Program Evaluators access the electronic case record for each participant identified within the sample and review any reportable incidents that are present for completion, follow up, and timeliness of interventions to improve safeguards, to identify trends that may impact additional participants, and to determine whether an allegation of abuse, neglect, mistreatment, or exploitation is present in the record that should have been forwarded for investigation per DHSS PM46 but was not. OQI generates a deficiency notice and a request for a detailed plan of improvement for any identified ongoing concern or unresolved issue.

Allegations of abuse, neglect, mistreatment, financial exploitation or significant injury must be reported in writing to the DDDS Office of Investigative Services. By policy, the Office of Investigative Services must also report some allegations to all or some of the following individuals/entities: the DHSS Secretary's Office, DDDS Director, Division of Long Term Care Residents Protection, Medicaid Fraud Control Unit of the Department of Justice, Division of Forensic Science, applicable DDDS Regional Program Director(s), the Executive Director of the provider and law enforcement. The investigation is forwarded to the Division of Long Term Care Residents Protection (DLTCRP) pursuant to DE Code, Title 16, §1132. The waiver participant, guardian of person (and

property if the allegation involves financial exploitation) and primary family contact person are notified that an investigation has been initiated, except when the participant communicates he/she does not want such information released or the release of information has the potential to do harm.

DDDS is required to complete a comprehensive investigative report for each allegation and submit it to the appropriate party as identified in the DDDS abuse policy, within ten (10) days of the initial notification of an allegation of abuse, neglect, mistreatment, financial exploitation, unless there are extenuating circumstances requiring further investigation. DDDS must also notify DLTCRP for any residences that it licenses, pursuant to DE Code Title 16, §1134(9). Upon completion of the investigation, the Support Coordinator notifies the family member that the investigation is completed, actions have been taken to protect the waiver participant and whether a further level of review will be completed by the Division of Long Term Care Residents Protection, Medicaid Fraud Control Unit or the Delaware Attorney General.

Based on the type of substantiated allegation, some offenders will be reported to a central data base known as the Adult Abuse Registry (AAR) maintained by the Division of Long Term Care Residents Protection as required by DE Administrative Code Title 16 §3101. Names of offenders will remain in the AAR for a designated period of time. An appeal process is offered and the name of the substantiated offender remains on the AAR if the fair hearing officer determines that a preponderance of evidence supports the investigative determination. DE Administrative Code Title 16, §3101 requires that health care service providers, which include all waiver providers, check the names of applicants for employment against the AAR prior to making an offer of employment. Current employees must also be periodically checked against the AAR. DDDS contracts with HCBS waiver providers prohibit them from employing individuals whose names are on the AAR or for those individuals to provide direct support to HCBS waiver participants.

e. **Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The DDDS Performance Analysis Committee (PAC) reviews waiver performance measures to determine if risk reduction strategies are necessary to strengthen the DDDS systems or improve the quality of life for waiver members. The PAC is an administrative committee appointed by the Division Director and charged with the responsibility of collecting, reviewing and analyzing data that measures the Division's compliance with waiver assurances and other key data elements. The PAC subsequently generates reports that are shared within the division on a regularly scheduled frequency or as requested.
DDDS has created a reporting tool it calls "DivStat". This tool is reviewed by the PAC at its regularly scheduled meetings. The critical incident aggregate data is reported as part of the DivStat report and is reviewed by the PAC. The PAC evaluates the data, draws conclusions and looks for trends within or across providers.

Analysis of critical incident data and trends (as opposed to individual remediation that is shared with specific providers) are shared with waiver providers at the Quarterly Provider Meetings.

The DDDS Office of Quality Improvements participates on the DMMA Quality Improvement Initiative (QII) committee and communicates with the DMMA regarding waiver performance measures. In addition, DMMA and DDDS meet each quarter to review the waiver performance measures and to monitor the status of any active Plans of Improvement.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. **Use of Restraints.** *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

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

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

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

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

As outlined in the DDDS Policy on Use of Restraints and Restrictive Procedures for Behavior Support, DDDS has adopted the philosophy and techniques of Positive Behavior Support. Positive supports are an essential foundational element in the design of services, programs and individual plans.

Under the DDDS Policy, several restrictive procedures are prohibited including:

1. The use of aversive interventions (as defined in the Policy)
2. Seclusion
3. Denial of nutritionally adequate diet (withholding meals)
4. Any behavioral treatment strategies that are not supported by empirical evidence.
5. Any restrictive interventions intended to control, manage, or change behaviors that are not part of an approved behavior support plan.
6. Mechanical restraints
7. Chemical Restraints
8. The use of bed rails for behavioral support
9. The use of enclosed cribs for behavioral support without a formal assessment and diagnosis by a medical professional operating within the scope of his/her practice of a corresponding mental health disorder

DDDS also prohibits the use of corporal punishment or threat of corporal punishment, psychological abuse or punishment, waiver participants disciplining other waiver participants or techniques or procedures used in the absence of other relative proactive supports.

All recommended planned restrictive interventions are required to be reviewed and approved by Peer Review of Behavior Intervention Strategies (PROBIS) and the Human Rights Committee (HRC).

A. A Behavior Health Support Plan that recommends the use of restrictive interventions must include:

1. The specific targeted behavior to be addressed and a description of the conditions for which the restrictive intervention is used.
2. The single behavioral outcome desired stated in observable or measurable terms.
3. A summary of the Functional Behavioral Assessment to identify suspected antecedents and functions of the behavior.
4. A description of less intrusive techniques used prior to the use of the restrictive interventions.
5. Methods and target dates for modifying or eliminating the target behavior.
6. Methods and target dates for a replacement behavior.
7. A description of the intervention to be used.
8. A risk/benefit analysis.
9. Medical clearance if appropriate
10. Informed Consent from the individual, Health Care Surrogate, and/ or Guardian.
11. The name of the person(s) responsible for monitoring and documenting the response to the planned restrictive intervention.
12. A plan for reducing and/or eliminating the restriction or planned restraint written within the Behavioral Health Support Plan, and if appropriate a detailed explanation and justification for continuing the planned restraint or restrictive intervention.

Permitted Planned Personal Restraints:

Permitted planned personal restraints are limited to the one and two-person side body hug and the one and two-arm supporting technique, as described in the DDDS-approved Mandt curriculum or other DDDS-approved crisis intervention training.

Permitted Use of Restraints for Emergency Crisis Intervention (as defined in DDDS Policy):

1. When an emergency crisis intervention is necessary, only restraints that are taught as part of a DDDS approved Crisis Intervention Curriculum are permitted to be used. Restraints must be terminated when the individual is no longer a risk to himself/herself or others;
2. Immediately stop the implementation of an emergency crisis intervention if the individual exhibits signs of distress (i.e. respiratory distress, seizure activity, vomiting, bleeding, change of skin coloring, etc.)
3. If the use of an Emergency Crisis Intervention planned or unplanned is used, an Emergency Medical/Behavioral Intervention Strategy (EMBIS) report must be completed by the staff involved with the intervention. A member of the DDDS Behavioral Unit must review the report for completeness and seek clarification of any issues noted. The support team must meet within 5 business days to discuss the individual's plan and circumstances surrounding the use of the intervention and develop or modify the behavior support plan. The EMBIS must be presented at PROBIS at the next scheduled meeting.

4. The 911 emergency response systems shall only be used as a last resort or as intensity requires protecting the health and safety of the individual.
5. Suicide threats shall be responded to as an emergency and 911 shall be contacted. If a written plan of intervention exists for the individual, staff shall follow it.

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

DDDS is responsible for the oversight of the providers' use of restraints. DDDS analyzes restraint data as described above.

Each provider has access to the electronic case record system (ECR). Every use of a restraint, whether it is planned or emergency, is reported in the ECR by the involved parties within 24 hours using the critical event reporting process for Emergency Medical/Behavioral Intervention Strategies (EMBIS). These reports describe the incident, the restrictive intervention that was used, a description of the events leading up to the restraint, the duration of the restraint and follow-up, as necessary to assure the health and safety of the individual.

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

Additionally, the Office of Quality Improvement conducts annual reviews which include consumer interviews where individuals are asked about their health and welfare. Prior to these interviews the Office of Quality Improvement reviews the electronic case record database for any incidences of the use of a restraint for that individual. DDDS meets with the Medicaid Agency quarterly to review waiver performance data that includes data on incidents and complaints.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

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

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

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

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

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

As articulated in the DDDS Policy on the Use of Restraints and Restrictive Procedures, positive supports are an essential foundational element in the design of services, programs and individual plans. The policy discourages the use of restrictive procedures.

DDDS has adopted definition for a restrictive procedure from the Disability Act of 2006. Restrictive Intervention is defined in the Disabilities Act as "any intervention that is used to restrict the rights or freedom of movement of a person with an intellectual disability including chemical restraint, mechanical restraint and seclusion".

DDDS has adopted definition for an aversive intervention from November 2014 Research Committee of the National Association of Directors of Developmental Disabilities Services (NASDDDS). Aversive interventions are defined as "interventions intended to inflict pain, discomfort and/or social humiliation or any intervention as perceived by the person to inflict pain, discomfort or social humiliation in order to reduce behavior. Examples of aversive interventions include, but are not limited to, electric skin shock, liquid spray to one's face and a strong, non-preferred taste applied to the mouth".

Before the use of planned restrictive interventions can be approved in a Behavior Support Plan, the use of alternative, less intrusive methods must be explored and determined to not meet the need.

All planned restrictive interventions are required to be reviewed by PROBIS and approved by the Human Rights Committee.

The use of restrictive and/or planned restraint interventions shall be an approved detailed planned procedure identified in the Behavior Health Support Plan that shall include:

1. The specific targeted behavior to be addressed and a description of the conditions for which the restrictive intervention is used.
2. The single behavioral outcome desired stated in observable or measurable terms.
3. A summary of the Functional Behavioral Assessment to identify suspected antecedents and functions of the behavior.
4. A description of less intrusive techniques used prior to the use of the restrictive interventions.
5. Methods and target dates for modifying or eliminating the target behavior.
6. Methods and target dates for a replacement behavior.
7. A description of the intervention to be used.
8. A risk/benefit analysis.
9. Medical clearance if appropriate
10. Informed Consent from the individual, Health Care Surrogate, and/ or Guardian.
11. The name of the person(s) responsible for monitoring and documenting the response to the planned restrictive intervention.
12. A plan for reducing and/or eliminating the restriction or planned restraint written within the Behavioral Health Support Plan, and if appropriate a detailed explanation and justification for continuing the planned restraint or restrictive intervention.

Methods for Detecting Unauthorized use of Restrictive Interventions

Each provider has access to the electronic case record system. Every use of a restrictive intervention is electronically submitted by the involved parties within 24 hours using the General Event Report (GER) report.

These reports provide information identified in the Behavior Support Plan which will include a description of the incident, a description of the events leading up to the restrictive intervention, the duration of the restrictive intervention, follow-up to assure the health and safety of the individual.

Additionally, provider support staff enters notes for each individual into the electronic case record system for each date of service. Case managers and DDDS clinical support staff review this information several times a week. The DDDS Regional Program Director receives electronic notification of the use of any restrictive interventions and reviews the report. Improper or unauthorized use of a restrictive intervention is considered abuse and is investigated through the critical event reporting processes.

Restrictive intervention information for each individual is reviewed by the participant's support team at least bi-monthly or more frequently, as indicated in the Behavior Support Plan. Restrictive intervention information is reviewed by the PROBIS committee.

The Office of Quality Improvement conducts Individual and Focused case reviews that include record reviews. For waiver participants for whom a restrictive intervention was applied, OQI conducts an interview with the participant to determine if the intervention was performed appropriately. Undocumented use of a restrictive procedure is reported to the Regional Program Director who is responsible for follow up to ensure the individual's health and safety and to determine how to prevent further use of undocumented restrictive interventions.

Any undocumented use of a restrictive procedure which constitutes suspected abuse or neglect is investigated through the reportable critical incident process. The Office of Quality Improvement submits quarterly reports to the Delaware DMMA which includes data on incidents and complaints.

Education and Training Requirements for Personnel who Administer Restrictive Interventions:

The DDDS Training Policy specifies required trainings and timelines for completion for each type of practitioner that has direct contact with waiver participants. Provider compliance with training requirements for each staff participant is monitored by the both the DDDS Office of Professional Development, on a provider and statewide basis, and by the DDDS Office of Quality Improvement as a part of the Quality Service Review sampling process for an individual waiver participant selected in the sample.

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

Providers are required to train their direct support staff on the DDDS policy relevant to the use of restrictive interventions. All providers are required to participate in DDDS-approved crisis intervention training. Waiver providers must be certified for each specific restrictive intervention prior to its use with an individual.

DDDS-Approved Crisis Intervention System includes the following topics:

1) Environmental factors and triggers,
2) Positive behavioral support,
3) Person-centered alternatives to the use of restrictive interventions and training in body mechanics that illustrates how to avoid hyperextensions and other positions that may endanger individual safety,
4) Awareness of the impact of the individual's health history on the application of a restrictive intervention,
5) Training in the use of approved restrictive interventions, including permitted holds, and possible negative psychological and physiological effects of restrictive interventions,
6) Monitoring of an individual's physical condition for signs of distress or trauma, and
7) Debriefing techniques with the supported individual as well as staff participants.

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

DDDS is responsible for the oversight of the use of restrictive interventions and for ensuring that provider staff are trained in a DDDS-approved curriculum regarding crisis intervention. DDDS analyzes restrictive intervention data as described above.

Every use of a restrictive intervention is reported in the electronic case record by the involved parties employed by the provider within 24 hours using the proscribed reporting protocol. These reports provide information identified in the Behavior Support Plan which includes a description of the incident, a description of the events leading up to the restrictive intervention, the duration of the restrictive intervention and any required follow-up actions.

Additionally, provider support staff enters notes for each individual into the electronic case record system for each date of service. Case managers and DDDS clinical support staff review this information several times a week. The DDDS Regional Program Director receives electronic notification of the use of any restrictive interventions and reviews the report. Improper or unauthorized use of a restrictive intervention is considered abuse and is investigated through the critical event reporting processes.

Restrictive intervention information for each individual is reviewed by the member's support team at least bi-monthly or more frequently, as indicated in the Behavior Support Plan. Restrictive intervention information is reviewed by the PROBIS committee.

The Office of Quality Improvement conducts Individual and Focused case reviews that include record reviews. For waiver participants for whom a restrictive intervention was applied, OQU conducts an interview with the participant to determine if the intervention was performed appropriately. Undocumented use of a restrictive procedure is reported to the Regional Program Director who is responsible for follow up to ensure the individual's health and safety and to determine how to prevent further use of undocumented restrictive interventions.

The DDDS Office of Quality Improvement is also responsible for monitoring provider compliance with training requirements, including the requirement for training for provider staff in DDDS-approved crisis intervention techniques.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

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

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

The DDDS Policy on "Use of Restraints or Restrictive Interventions for Behavior Support" prohibits the use of seclusion for any reason. It is defined in the policy as one of the "prohibited practices".

The Quality Service Review (QSR) process conducted by the DDDS Office of Quality Improvement includes on-site inspection, record review, and individual survey, to ensure a standardized approach to measure compliance with DDDS quality standards. This includes monitoring the absence of prohibited restrictive interventions, including seclusion. Program evaluators from the Office of Quality Improvement (OQI) complete the QSR to measure compliance with the DDDS provider standards which are consistent with the goals of the CMS HCBS Settings Rule, DDDS policies and procedures, and individual outcomes.

The case manager also asks the waiver participant if they have been isolated for any period as part of their face to face monitoring visits with the waiver participant. The case manager must use language that can be understood by the waiver participant.

Both the OQI Program Evaluators and the case managers will conduct an environmental scan of waiver settings to determine if there appear to be places where seclusion could be imposed.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

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

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

Appendix G: Participant Safeguards

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

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

a. **Applicability.** Select one:

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

◉ **Yes. This Appendix applies** *(complete the remaining items)*

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

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

Residential Habilitation Agency Providers:

DDDS requires waiver residential habilitation agency providers to have a policy that provides for a medication management system that addresses the elements below for anyone for whom medications have been prescribed. The policy must include protocols to ensure that medication administration protocols for participants living in provider managed settings are followed in day programs, as applicable.

• An individual's ability to participate in the medication administration process
• Medication errors

Residential providers ensure that day program providers maintain a separate Medication Administration Record (MAR) for all medications administered. MARs are to be forwarded to the residential agency no later than the 5th day of the following month.

All waiver providers subject to Limited Lay Administration of Medication (LLAM) regulations are required to maintain a LLAM Monthly Medication Error Report, retained on site and readily available for inspection at all times. All waiver providers

subject to LLAM must provide an annual LLAM report to DDDS for review. This annual reporting period is July 1st to June 30th, and must be received by the DDDS LLAM program coordinator no later than July 14th.

The residential provider agency is responsible for delivering medications to the day service site in a pharmacy container labeled by the pharmacy, prescribing practitioner, or RN and must ensure that the day service provider has the most current medication order on file.

The residential provider agency is responsible for notifying the day service provider of any medication changes.

• Staff certification in LLAM

• Timely submission of required reports to DDDS of information as required by the Delaware State Board of Nursing

• Effectiveness of corrective action plans

Shared Living Providers:

DDDS requires Shared Living Providers to coordinate with the DDDS Office of Resource Development and Management (ORDM) and the support team of the waiver participant to which they are providing services to:

• Maintain an annual Shared Living Medication Administration (SLAM) program certification issued by DDDS.

• Submit monthly medication reports to the Nurse Consultant, if the waiver participant has elected to receive that service or to a designated DDDS nurse if the participant has not elected to receive Nurse Consultation.

• Assess an individual's level of ability to participate in the medication process.

• Report any medication errors to the Physician, Nurse Consultant, designated DDDS nurse or Office of Investigative Services when warranted. This must occur within 24 business hours.

Health and Medication Management Monitoring:

The initial monitoring is completed in all residential habilitation agencies by agency staff that has been assigned this role by the provider. In sharing living settings, the Nurse Consultant or designated DDDS nurse and the shared living provider work in tandem to monitor participant medication regimens. Day services follow the same protocols as the residential providers in the management of medications for waiver participants in their settings. Additional monitoring of the day service provider administration of medication is conducted by the waiver residential provider agency, the Nurse Consultant or designated DDDS nurse, and the DDDS Office of Quality Improvement through its Quality Service Reviews.

Provider Agency Role: The scope of monitoring documentation by the residential waiver provider agency includes: daily medication administration record review and weekly review of the individual's health regimen (medications, orders, proper storage, appointments, etc.).

Nurse Consultant Role: For participants receiving Nurse Consultation, the Nurse Consultant reviews the provider monitoring tool and completes a medication and health audit at least monthly and communicates the findings to the provider for timely and appropriate follow up. The Nurse Consultant refers to the previous reviews to assure the designated staff has addressed any previously identified unresolved issues. Documentation in the electronic case record, including incident reports as needed, is completed on a frequency that is specified in the DDDS Community Occurrence Reporting Policy. This monitoring system is designed to detect opportunities to mitigate risk and improve processes through a system of accountability. The system evaluates all components of the health and medication management process. The Nurse Consultant also completes a Pre-Assessment to determine if the individual can be considered for self-administration of medication. Approval for the continuance of self-administration of medications is reviewed by the team at the annual meeting or as indicated by errors, etc.

DDDS Office of Quality Improvement (OQI) Role: OQI, as part of their Quality Service Review (QSRs) requires residential habilitation agency provider staff to complete a comprehensive health and medication review for all waiver participants for whom medications have been prescribed. The agency must also observe its staff performing medication administration. Second-line monitoring is conducted on the use of behavior modifying medications as part of the monitoring of a Behavior Support Plan as described in Appendix G-2.

Per DDDS policy, a Behavior Support Plan must be developed for any individual for whom psychotropic medications are prescribed. The DDDS Peer Review of Behavioral Strategies Committee (PROBIS) must review, approve and monitor all Behavioral Support Plans that include the use of medication for the treatment of a mental illness or for the purpose of behavior control in the absence of a psychiatric diagnosis.

DDDS Policy indicates that Behavior Modifying medications be used if these steps are followed:

1. A Functional Behavioral Assessment is completed by a Behavior Analyst. If the Functional Behavioral Assessment recommends the use of a behavior modifying medication as in intervention, a referral will be made to a medical professional for further evaluation. All recommended behavior interventions must include Positive Supports.

2. If a behavior modifying medication is recommended, the prescriber shall provide a written order for the medication and note the indication for the medication use. Risks and benefits of the medication, including any side effects, will be documented as part of a risk benefit analysis. A designated support team participant shall obtain written or witnessed verbal Informed Consent for the use of the medication from the individual, Health Care Surrogate, or Guardian.

3. The medication shall be used in conjunction with the Behavior Support Plan.

4. The behavior modifying medication is only prescribed for a condition that is diagnosed according to the most current edition of the American Psychiatric Association's Diagnostic and Statistical Manual (DSM). Exceptions exist when a prescriber feels that there may be a beneficial treatment in which case it is monitored through the PROBIS committee for effectiveness.

Behavior Support Plans (BSP) that indicate the use of a psychotropic medication for the treatment of a mental illness must be reviewed by the support team prior to beginning the medication. Additionally, the BSP must be submitted to PROBIS within 90 days of beginning the medication and shall include the support team's recommendation for the frequency of future monitoring of the plan and who will monitor the continued use of the medication and its impact on the waiver participant.

A Program Manager that works for the waiver provider agency is also responsible for reviewing the participant's treatment plan for the behavior modifying medication on a monthly basis.

Monitoring includes recording the waiver participant's response to treatment in comparison to established treatment goals for which the medication was prescribed. The participant's support team is notified whenever the participant's response to treatment is not meeting established goals or if undesired side effects are identified. The support team, under the leadership a Behavior Consultant arranges for the participant to meet with the prescribing physician for further evaluation should the treatment not result in the desired outcome(s).

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

DDDS is the state agency responsible for the oversight of the policies and procedures regarding medication administration for waiver participants who receive a waiver-funded residential or day service. These are the only providers that are authorized to assist waiver participants with medication administration. Waiver participants who receive prescribed medications are encouraged to receive the Nurse Consultant waiver service as a health and safety measure. Participants who elect to receive this service are assisted by the case manager to select a provider from a set of qualified providers. For participants who choose not to receive consultative nursing, a designated DDDS nurse monitors the management of their medications. The Nurse Consultant conducts a thorough monthly Health and medication monitoring review and issues a report of findings. The report of findings is stored in the participant's electronic case record to enable the designated staff to provide necessary follow up actions. The Nurse Consultant refers to the previous reviews to assure the designated staff has addressed previously identified unresolved issues. If the individual receiving medications has elected not to receive a Nurse Consultant service, a DDDS nurse will be assigned to do the monthly review only. A third monitoring piece is performed by the DDDS Office of Quality Improvement (OQI), as part of their annual sampling process for Neighborhood Homes and Community Living Arrangements. OQI completes a comprehensive medical record review and medication assistance observation as part of this process. This review includes all settings in which a waiver participant who is living in an agency provider managed setting receives a waiver service, including day programs. A DDDS nurse provides additional Health and Medication oversight which follows the OQI annual schedule for site reviews.

The Nurse Consultant's monitoring role is designed to focus on all medication types and medication usage patterns ordered for each participant. The Nurse Consultant's methods for conducting monitoring in Neighborhood Homes and CLAs include the review of all medical issues related to the individual and the completion of a Monthly Medication and Health Audit.

The audit requires the Nurse Consultant to check the waiver participant's current Medication Administration Records (MAR) against Physicians' Orders and against medication labels to assure agreement. An accountability of medication is completed. The Nurse Consultant also performs the following tasks:

- Ensures that medications are adequately stocked, properly stored, and not expired

- Compares count sheets and the amount of medication remaining against the amount noted on the count sheet
- Assures Standing Medical Orders (SMOs) are updated annually by the physician.

Additionally, on an annual basis, OQI conducts a similar review of documentation of medications, review of medications present in the home, and direct observations of participants receiving assistance with their medication. If the individual attends a day program, they also visit and review these items there.

In Shared Living homes, the provider completes a Monthly Medication Record, which is forwarded to the participant's Nurse Consultant. This form lists all medications the participant is taking and whether the medication was "held" or changed during the reporting month. For newly ordered medications, the nurse provides consultation to the provider about any potential side effects that need to be observed and reported if they occur. The discussion includes the nurse making sure side effect information is received from the pharmacy. The frequency of monitoring by the nurse in Neighborhood Homes and Community Living Arrangements occurs at least monthly with visits to each of these residential sites. Additionally, the OQI completes thorough and comprehensive medication reviews in each site on an annual basis as a part of the licensing / certification process.

In Shared Living homes, monitoring by the nurse includes reviewing the Monthly Medication Record, monthly telephone or email contacts with the provider, and an annual home visit to meet with the participant and the provider and to verify that medications are stored as required by DDDS policy. Contacts or visits that are more frequent than the minimum requirements may be specified in the person centered plan based on the participant's health needs. The Nurse Consultant completes a quarterly health review in the electronic health record which is then forwarded to the Shared living provider to address any action steps. This review ensures all follow up physician orders are adhered to. The Nurse Consultant also participates in the individual's annual planning process, which includes discussion and documentation of the individual's medications, health status, and needs for support.

The state monitoring program gathers information concerning potentially harmful practices and employs information to improve quality by the following means: In Neighborhood Homes and CLAs, the nurse completes the medication review in the electronic record and forwards the report to the designated provider staff via electronic mail. The designated provider staff corrects any errors or makes comments and returns the form to the nurse upon completion. The nurse notifies the designated provider staff of any issues needing immediate attention. Should the medication review identify any medication errors, a Medication Incident Report (General Event Report [GER] in the electronic case record system- related to any event causing or has the ability to potentially cause injury, which has serious impact on the individual or others) is filed by the provider and reported to the OIS. The annual review by the DDDS OQI serves as an indicator as to the effectiveness of the provider and nurse consultant's monitoring of the medications.

From these reports, incident specific corrections are required of provider agencies. From the GERs, the DDDS is able to create Data Analysis Reports for the review of medication error types and risks in the assistance with medication system, as well as identify corrective actions. The reports are generated for either a provider or System Level of Inquiry. Each provider agency is required to complete a monthly LLAM medication error report and maintain it on site. This report must also be forwarded to the DDDS on a monthly basis.

Appendix G: Participant Safeguards

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

c. Medication Administration by Waiver Providers

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

○ **Not applicable.** *(do not complete the remaining items)*

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

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

Provider Administration of Medications:

The Limited Lay Administration of Medications (LLAM) curriculum provides agencies with a curriculum that is approved by the Delaware Board of Nursing for medication administration of unlicensed assistive personnel (UAP). The staff who has

successfully completed the LLAM curriculum and/or annual recertification may administer medication. The LLAM curriculum applies to all residential agency waiver providers and includes any other day settings where waiver participants may spend their day. Shared living providers must complete and adhere to the DDDS's Sharing Living Medication Administration (SLMA).

LLAM Guidelines:

State LLAM regulations require that "Unlicensed Assistive Personnel" (UAP) must successfully complete all sections of the DDDS Limited Lay Administration of Medication (LLAM) Course.

Completion of the initial LLAM course required of all newly hired staff consists of:

Attend 2 (two) consecutive classroom days for 13 (thirteen) hours.

- Successful demonstration of skills
- Written exam with passing score of 85% or better
- Successful Demonstration of 10 (ten) Supervised Field Medication Passes
- Will be completed within 60 days of 1st day of class date

A "Letter of Completion" will be issued to each participant once the classroom portion of the course is completed, but is only valid after 10 (ten) medication passes have been successfully completed and signed by the provider supervisor/designee. The "Letter of Completion" and the corresponding completed " 10 Supervised Field Medication Pass Observations" will be maintained in the employee file at the employing provider. Staff is not authorized to pass medications to DDDS individuals until these documents are signed and dated as indicated.

Failure to successfully complete all of the requirements of the program within the specified time frame of 60 days will require the participant UAP to re-take the two (2) day program before administering medications to individuals of DDDS.

If participant fails either the skill session(s) or exam, he/she may retake the session or exam one (1) time. If the participant fails a second time, he/she will be required to repeat the full two (2) day course after 6 months with recommendations from his/her supervisor that he/she is prepared to retake the course.

If a LLAM trained UAP commits two medication errors within a six (6) month time frame, he/she must repeat the entire LLAM training program including five (5) Supervised Field Medication Pass Observations before resuming LLAM duties.

Thereafter, the LLAM trained UAP must renew their training annually:

LLAM trained UAP's are required to maintain current CPR status.

The provider must monitor LLAM expiration dates for their staff. Any UAP whose LLAM training has expired will not be authorized to administer medications to DDDS individuals.

It is the provider's responsibility to monitor the number of medication errors and to take appropriate steps as outlined by this curriculum.

LLAM Instructor Qualifications

New Instructor Requirements:

- Active Delaware or compact state RN license in good standing.
- One year of clinical nursing experience, including experience in medication administration.
- At a minimum, observation of the presentation and successful completion of the core curriculum and any eligible program specific module to be taught.
- Presentation of at least one component of the core curriculum and any eligible program specific module to be taught with observation by a qualified instructor. Documentation of observation must be completed on the Limited Lay Administration of Medications (LLAM) Instructor Monitor Form and provided to the eligible program.

Once the above requirements have been completed, the nurse must submit the following documentation to the DDDS LLAM Program Coordinator:
- A copy of his/her RN license
- Resume'
- A copy of the class voucher to verify class attendance

- Limited Lay Administration of Medications Instructor Monitor Form
- Letter of Recommendation from his/her supervisor

- When the DDDS LLAM Program Coordinator determines all requirements have been met, a letter will be issued to the RN recognizing him/her as an approved instructor to teach Limited Lay Administration of Medication (LLAM) course that has been approved for the Division of Developmental Disabilities Services programs. The nurse must meet all requirements as outlined by the Board of Nursing to continue with his/her Instructor status.

Current Instructor Requirements:

- Qualified instructors must present a minimum of one core curricula and eligible program specific module per year. If an instructor fails to present in a single year, that instructor must again complete the core curriculum and any eligible program specific module before s/he will be deemed a qualified instructor.

- All instructors of courses related to "Assistance with Self-Administration of Medications" approved by the Board as of July 1, 2015 will qualify as LLAM instructors pursuant to regulation 5.3 without being required to satisfy regulations 5.3.1.3-5.3.1.4. Existing AWSAM instructors, grandfathered into the LLAM program need to present a minimum of one (1) course per year.

A list of all LLAM instructors will be maintained by the DDDS LLAM Program Coordinator and submitted annually to the Board of Nursing as part of the Limited Lay Administration of Medication (LLAM Annual Report)

Field Medication Passes

The observed field medication passes are designed to give the UAP trainee the opportunity to practice the application of the information that they have learned in the classroom. The field pass is an exercise for the UAP trainee and serves as an opportunity for the authorized observer to share his/her knowledge and expertise with the trainee.

A medication pass is defined as administering or assisting with the administration of medication(s) during one (1) medication pass time regardless of how many individuals at this time were provided medication. A trainee can only receive credit for the completion of one medication pass at a time with no exceptions. Ten (10) supervised medication passes are required because the purpose of supervised passes is to help the trainee become familiar with the entire medication process from start to finish, with no errors.

The Provider is responsible for ensuring that there is a system in place to monitor the ongoing performance and supervision of the field medication passes occurring in all of its programs.

If the LLAM trained UAP trainee fails to correctly carry out any one (1) step of the medication pass, the medication pass is considered unsuccessful and must be repeated correctly at another time after reviewing the steps of the medication process.

In the event that a LLAM trained UAP transfers from one provider to another, five (5) medication passes are required to demonstrate competency. Staff is not authorized to pass medications to DDDS individuals until the five (5) medication passes are completed and documented on the Supervised Medication Pass Observation form. LLAM renewal will continue as required, on a yearly basis, from the date of the last renewal.

The authorized observer is:

- An employee with the division of Developmental Disabilities Services (DDDS) or a DDDS contractor with a minimum of two (2) years of experience. These individuals shall have no history of medication errors over the past one (1) year and shall be current in all criteria for LLAM trained UAP's from the Limited Lay Administration of Medication (LLAM) course; or

- A supervisor with DDDS or a DDDS contractor, at least at a Program Manager or Program Coordinator level with a minimum of six (6) months of experience. These individuals shall also be current in all criteria for LLAM trained UAP's from the Limited Lay Administration of Medication (LLAM) course; or

- The Observer currently holds a valid state of Delaware nursing license, has attended the two day Limited Lay Administration of Medication (LLAM) course through DDDS and has worked with the DDDS system for a minimum of three (3) months.

There is mutual responsibility between the authorized observer and the trainee. Extreme caution and care will be made to ensure the individual's safety during the process of medication administration. A medication error could be considered neglect, resulting in criminal investigation, charges, and or fines.

The LLAM trained UAP may:

Participate solely within the confines of the core curriculum and any applicable program eligible module

Administer medication without assessing the appropriateness or effectiveness of the prescribing practitioner's medication order.

Administer injectable emergency medications pursuant to the core curriculum.

The LLAM trained UAP may not:

Administer medications through a feeding tube, including nasogastric, gastrostomy, or jejunostomy tubes.
Be a 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 Investigative Services (OIS). They are also required to make a report in the electronic case record system.

All providers and settings subject to the LLAM curriculum must provide an Annual Report to DDDS for review. This annual reporting period is July 1st to June 30th, and must be received by the DDDS LLAM program coordinator no later than July 14th. Please refer to attached "Limited Lay Administration of Medications (LLAM) Annual Report Form". The DDDS LLAM Coordinator provides this Annual Report to the Delaware Board of Nursing.

The DDDS Performance Analysis Committee (PAC) reviews reports on the rates of medication errors by type, at least annually. Data is analyzed not only by error type, but also by provider. In this way, the DDDS can analyze system-wide challenges, as well as pinpoint individual provider performance issues.

DDDS's monitoring methods are designed to identify problems in provider performance and to support follow-up remediation actions and quality improvement activities.

Data is acquired to identify trends and patterns and to support improvement strategies primarily through the electronic case record system. Additional sources of data for drawing correlations are the OQI Certification Database and the Nurse Consultant Monthly Health Audits.

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

The types of medication errors providers record and/or report to the Division of Developmental Disabilities Services include any deviation from a physician's plan of care, including Standing Medical Orders, that involve errors relative to assisting with the incorrect dose or at the incorrect time, assisting with the incorrect medication/treatment, assisting the incorrect individual with a medication/treatment, assisting with the medication/treatment via the incorrect correct route

and assisting with the medication/treatment at the correct time (or not at all).

The types of medication or treatment errors providers must record are:
A. Medication is administered to the incorrect individual
B. An individual receives the incorrect medication
C. Medication is given via an incorrect route of administration
D. Medication is administered at an incorrect time
E. Medication is administered at an incorrect dose
F. Medication is not administered at all (i.e., medication omission)
G. Medication is administered without a prescription
H. Medication is administered after the medication expiration date
I. Medication is stored incorrectly (i.e., not stored according to label instructions)
J. Medication documentation is transcribed incorrectly (e.g., failure to correctly document medication information in MAR)

It is the provider's responsibility to keep a monthly LLAM Medication error report. This report is retained on site and must be readily available for inspection at all times. A copy of the medication error report is sent to DDDS LLAM coordinator monthly. Per LLAM, providers are required to report med errors to the Nurse Consultant (if applicable), the physician, and DDDS Office of Investigative Services (OIS). They are also required to make a report in the electronic case record system.

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

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

The types of medication or treatment errors providers must record are:
A. Medication is administered to the incorrect individual
B. An individual receives the incorrect medication
C. Medication is given via an incorrect route of administration
D. Medication is administered at an incorrect time
E. Medication is administered at an incorrect dose
F. Medication is not administered at all (i.e., medication omission)
G. Medication is administered without a prescription
H. Medication is administered after the medication expiration date
I. Medication is stored incorrectly (i.e., not stored according to label instructions)
J. Medication documentation is transcribed incorrectly (e.g., failure to correctly document medication information in MAR)

It is the provider's responsibility to keep a monthly LLAM Medication error report. This report is retained on site and must be readily available for inspection at all times. A copy of the medication error report is sent to DDDS LLAM coordinator monthly. Per LLAM, providers are required to report med errors to the Nurse Consultant (if applicable), the physician, and DDDS Office of Investigative Services (OIS). They are also required to make a report in the electronic case record system.

All providers and settings subject to the LLAM curriculum must provide an Annual Report to DDDS for review. This annual reporting period is July 1st to June 30th, and must be received by the DDDS LLAM program coordinator no later than July 14th. Please refer to attached "Limited Lay Administration of Medications (LLAM) Annual Report Form". The DDDS LLAM Coordinator provides this Annual Report to the Delaware Board of Nursing.

The DDDS office of Quality Improvement will confirm that all required documentation as described in the above mentioned LLAM trained UAP criteria are present during audits, as evidence of the authorization to assist without direct supervision during the administration of medications.

A copy of the monthly error report is sent by provider to DDDS Office of Quality Improvement by the 5th of the month.

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

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

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

DDDS' is the state agency responsible for the on-going monitoring of waiver provider performance in medication management. Monitoring occurs through routine review of all medication error reports. Additionally, the DDDS Performance Analysis Committee (PAC) reviews reports on the rates of medication errors by type, at least annually. Data is analyzed not only by error type, but also by provider. In this way, the DDDS can analyze system-wide challenges, as well as pinpoint individual provider performance issues.

DDDS's monitoring methods are designed to identify problems in provider performance and to support follow-up remediation actions and quality improvement activities.

Data is acquired to identify trends and patterns and to support improvement strategies primarily through the electronic case record system. Additional sources of data for drawing correlations are the OQI Certification Database and the Nurse Consultant Monthly Health Audits.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. **Methods for Discovery: Health and Welfare**
The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. **Sub-Assurances:**

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
G-a-1: The number and percent of substantiated incidents of abuse, neglect, mistreatment, medication diversion or financial exploitation. Numerator: The number of substantiated incidents of abuse neglect, mistreatment, medication diversion or financial exploitation. Denominator: The total number of reported incidents.

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

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

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
G-a-2: The percent of participants receiving residential or day services that report that they feel safe in their waiver setting. Numerator: The number of participants receiving residential or day services that report they feel safe in their waiver setting. Denominator: The total number of participant files reviewed for the period.

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

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

		Confidence Interval = 95% Confidence interval
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
G-a-3: The percent of residential and day service providers with all-hazard emergency plans in place that met the standards of the DDDS policy. Numerator: The number of residential and day service providers that had all-hazard emergency plans in place that met the standards of the DDDS policy. Denominator: Total number of providers reviewed during the reporting period.

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

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

		Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The state 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 percent of participants receiving residential or day services that report that they feel safe in their waiver setting. Numerator: The number of participants receiving residential or day services that report they feel safe in their waiver setting. Denominator: The total number of participant files reviewed for the period.

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

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

Data Aggregation and Analysis:

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

Performance Measure:
G-b-2: The annual mortality rate for waiver participants by age, gender, and cause of death compared to DDDS baseline data established during 2001-2007. (Numerator: The number of waiver participants deaths by age, gender and cause of death: natural or medico logical. Denominator: DDDS established baseline mortality rate.)

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

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

Data Aggregation and Analysis:

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

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 =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

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

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

Performance Measure:
G-d-1: The percentage of waiver participants receiving demographically appropriate health care screenings. Numerator: The number of waiver participants who received demographically appropriate health care screenings. Denominator: The number of participants reviewed during the reporting period who should have received health screens based on their demographics

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
The Office of Quality Improvement Individual Focused Review

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

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

Individual problems are referred to the DDDS Regional Program Director as they are received or substantiated by staff. All reported incidents, deaths, or complaints are tracked and reported to the DDDS regional office immediately. A response to the report is included in the tracking system. More serious reports are investigated by staff from the DDDS Office of Investigative Services, augmented by other Division of Developmental Disabilities Services staff, as applicable. Remediation is a coordinated effort by the DDDS Administration staff, Regional Office Staff, and other concerned parties that could include law enforcement. Less serious reports are resolved by the Regional office with the assistance of the case manager and other staff. The state routinely monitors and evaluates tracking systems to ensure all reported incidents/complaints are remediated.

All complaints are reviewed at the state level to ensure issues in the complaint have been addressed and the health and safety of the consumer is ensured.

Quarterly data for all incidents entered into the statewide tracking system are reviewed to identify outliers for follow up and response by the Regional Office and the Office of Quality Improvement.

Responses are monitored at the state level to ensure action is taken.

ii. **Remediation Data Aggregation**

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

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

Responsible Party *(check each that applies)*:	**Frequency of data aggregation and analysis** *(check each that applies)*:
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 2)

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

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

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

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

Quality Improvement Strategy: Minimum Components

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

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

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

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

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

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

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

The goal of the Division of Developmental Disabilities Services' Quality Improvement Strategy (QIS) for all waiver services is to ensure that the program operates in accordance with approved program design, meets statutory and regulatory assurances and requirements, achieves desired outcomes for participants, and identifies improvement opportunities. DDDS is committed to a QIS recognizing that quality is not under the purview of just one entity. Every part of DDDS has some role or responsibility regarding quality. Consequently, DDDS collects and analyzes trend data from a variety of sources relative to outcomes and indicators identified by individuals, families, providers, stakeholders and administrative authorities, with the objective of ongoing improvement in service delivery. The current QIS includes a number of processes to monitor the quality of residential, day, and clinical consultative waiver services. The DDDS QIS is designed to:

• Monitor assurances contained in the approved waiver.
• Support collaboration with participants, their families, stakeholders, and other state agencies.
• Result in service improvement for individuals and providers of services
• Support choice and control by individuals and families
• Make information about quality of services readily available and understandable.

The DDDS Performance Analysis Committee (PAC) has the most significant role in the DDDS Quality Improvement System. The PAC includes representatives from the DDDS Office of Quality Improvement, Office of Investigative Services, DDDS Data Unit, DDDS Community Services and Administrator of the public ICF-IID operated by DDDS. Other parts of the organization are included as needed. This Committee is responsible for:

• Aggregation of discovery process data.
• Developing periodic reports on priority outcomes and performance measures for systems analysis and trending.
• Ensuring ongoing data integrity and reliability.
• Tracking system improvement strategies developed by various stakeholder groups.
• Trending discovery and remediation based data to ensure continuity of oversight by the DDDS.

In addition, other entities that also play a role in DDDS's Quality Improvement Strategy include:

• DDDS Authorized Provider Committee – This committee reviews applications from service providers who wish to become qualified to provide one or more waiver services against established qualification standards for each service. This committee then issues an approval or denial letter to the provider based on the circumstances. DDDS maintains the list of Authorized Waiver Providers on its website. This committee process supports the open and continuous enrollment of waiver service providers throughout the year. The committee also periodically reviews and may make changes to the forms and procedures used in the provider qualification process to assure ease of access for providers considering becoming a waiver provider.
• Division of Medicaid and Medical Assistance (DMMA) – DMMA is the State Medicaid Agency with administrative authority over HCBS Waiver services in Delaware. DMMA reviews performance reports issued by DDDS and provides feedback regarding both the measures, the performance data and any existing Quality Improvement Plans. At a minimum, DMMA and DDDS meet each quarter to go over the waiver performance data.
• The DMMA Quality Improvement Committee (QIC): This internal committee provides DMMA with: waiver oversight, priority setting, operating agency performance and report monitoring, review of discovery processes, development of remediation and quality improvement strategies. QIC reports to the QII Task Force through the Waiver Coordinator.
• The Quality Initiative Improvement (QII) Task Force is responsible to: integrate waiver quality strategies, oversee and provide technical support for operating agencies, provide a forum for best practice sharing among agencies, provide

support/feedback to waiver programs, review findings from discovery processes, to provide feedback on quality measurement and improvement strategies to participating agencies/program staff, and to report to the Medicaid Managed Care Quality Assurance Leadership Team.

These entities review data and reports in order to recommend system wide improvement strategies and to identify and promote promising practices. Minutes from each meeting are maintained in order to identify recommendations or follow up actions that are required and who is responsible for each action. The minutes are shared with the Division Director/Designee who reviews the quality improvement strategies and assigned responsibilities and prioritizes the recommendations when necessary.

The Division of Medicaid & Medical Assistance (DMMA) is the agency that has oversight responsibility for Medicaid including all HCBS programs. DMMA developed and implemented its Quality Management Strategy (QMS) to promote an integrated, collaborative quality management approach among DMMA, managed care, waiver, and other medical assistance programs. Delaware's State-wide QMS mission is to:

•Assure Medicaid enrollees receive quality care and services identified in waivers and Medicaid funded programs by providing oversight for monitoring and tracking activities of quality plans, assurances and improvement activities and;

•Provide ongoing oversight responsibilities assuring Medicaid funded program quality plans meet CMS requirements of "achieving ongoing compliance with the waiver assurances" and other federal requirements.

DDDS is integrated into the DMMA QMS as a participant in Medicaid's Quality Initiative Improvement (QII) Task Force. Using the HCBS quality framework as its foundation (e.g., design, discovery, remediation, and improvement), Delaware's QMS plan promotes compliance with CMS waiver assurances, and component elements. The QMS defines the roles and responsibilities of both individuals and committees, task forces, and work groups that are ultimately responsible for the development, implementation, monitoring, and evaluation of the DDDS 1915c HCBS waiver program and its quality initiatives.

The DMMA Chief of Policy, Planning and Quality is responsible for oversight of the DDDS 1915(c) waiver. The Chief and members of his staff:

• Participates in and oversees the function of all DMMA Quality Improvement Committee (QIC) monitoring and reporting activities.
• Summarizes waiver monitoring results, and presents data based reports to the QIC, documenting such in QIC meeting minutes.
• Serves as a liaison between the HCBS Waiver Operating Agencies, such as DDDS, and the DMMA task forces and work groups in order to promote the flow of information related to waiver operation and to coordinate the receipt of Operating Agency responses to DMMA inquiries.
• Participates as a member of the DMMA QII Task Force and supports presentation of QIC reports to the following DMMA multi-disciplinary committees, task forces, and work groups responsible for the development, implementation, monitoring, and evaluation of the DDDS HCBS waiver program and its quality initiatives:

Other entities with roles related to the DDDS Quality Improvement system include:

• The Medical Care Advisory Committee (MCAC): The responsibilities of the MCAC include: a Review of QMS efforts, a Forum for input from key stakeholders in to quality efforts and key clinical management concerns, a forum for input on State policy for health care delivery to Medicaid enrollees. DDDS also presents any amendments and renewals to MCAC for review as part of the public feedback process.
• The Medicaid Managed Care and Quality Assurance Leadership Team (MMCQALT): The roles & responsibilities of the MMCQALT include: oversight of QMS, reporting to Medical Care Advisory Committee, communication and support of stakeholder advisory groups, oversight and direction to the Quality Improvement Initiative Task Force.

The Delaware QMS encompasses a continuous quality improvement (CQI) process and problem-solving approach that is applied to specific and measurable performance and operational activities. The CQI process is used to: (1) monitor quality of care, service indicator, and operational performance, (2) identify opportunities for improvement that exist throughout the program, (3) implement remediation strategies to improve outcomes and performance, (4) evaluate interventions to ensure remediation strategy was successful, (5) provide stakeholders with meaningful information as to the operation of waiver services.

ii. **System Improvement Activities**

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**

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

b. System Design Changes

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

DDDS collects, analyzes & uses data to provide internal and external stakeholders with accurate, timely and important information that can be used to evaluate & make recommendations for improvements to the quality of HCB services/supports.

The Performance Analysis Committee (PAC) has primary responsibility for determining if the various discovery processes and data sources accurately measure the outcomes and performance indicators. Problems with data collection activities are corrected as needed.

Areas for each measure reviewed by the PAC include:

• Was the information timely?
• Was the information helpful in identifying statewide trends?
• Were the reports easy to understand and follow?
• Are the outcomes and indicators meaningful or should they be changed?

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

Sometimes improvement strategies for trended data result in changes to waiver service specifications, provider qualification processes, case manager monitoring protocols or DDDS training policies. These changes are sometimes discussed at meetings of the Governor's Advisory Council to DDDS to solicit stakeholder input.

Recommendations for corrective action and system improvement are shared with the DDDS operational units that will need to develop and implement improvement strategies. The operational units are required to respond to the Division Director or designee with their suggested improvement strategies. Once the improvement strategy is finalized, it is implemented and the data monitoring is used to determine if the strategy achieved the desired result.

The Performance Analysis Committee monitors the impact of system changes using a reporting tool called "Divstat". The Office of Quality Improvement (OQI) is largely responsible for the discovery part of the process. A representative of OQI sits on the PAC work together to develop monitoring tools, sampling strategies, and reporting requirements. Most discovery processes are in the domain of OQI activities. The OQI implements the revised discovery processes, measuring the effectiveness of the slated system improvement.

Results of OQI discovery data are collected and disseminated as follows:

• Reporting individual findings on an ongoing and continuous basis to waiver participants and their circle of support, waiver providers, and DDDS Administrators, requiring specific individual plans of improvement as applicable.
• Saving individual discovery process data in an OQI data base to create a sample.
• Providing quarterly, semi-annual or annual data summaries to the PAC for analysis. (PAC in turn completes the data analysis and dissemination of system and/or provider level report process.)
• Reporting discovery data and remediation efforts on a quarterly basis to the Delaware Medicaid Agency (DMMA)

As part of the DDDS continuous quality improvement process, the OQI Director:

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

The steps of this cyclical process for continuous quality improvement can be described as:

• Discovery/Assessment (based upon identified performance measures).
• Communicate findings in light of performance expectations.
• Formal review and analysis of findings.
• Plan Development / Plan Modification based upon data analysis.
• Documentation of and dissemination of Plan of Improvement to key stakeholders, including some form of training on or orientation to changes.
• Implementation of the Plan.
• Repeat processes focusing on performance-based data analysis.

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

DDDS collects, analyzes & uses data to provide internal and external stakeholders with accurate, timely and important information that can be used to evaluate & make recommendations for improvements to the quality of HCB services/supports. The Performance Analysis Committee (PAC) has primary responsibility for determining if the various discovery processes and data sources accurately measure the outcomes and indicators. Problems with data collection activities are corrected as needed. The PAC also solicits ongoing feedback from DDDS organizational units and other external stakeholders.

The PAC looks at the following aspects of data reporting:

• Was the information timely?
• Was the information helpful in identifying statewide trends?
• Were the reports easy to understand and follow?
• Are the outcomes and indicators meaningful or should they be changed?

In conjunction with the DDDS Division Director, the Office of Quality Improvement (OQI), and the PAC, proposed revisions to the DDDS Quality Management System may be submitted to the Division's Leadership Team for review. Such revisions would occur as the formal data analysis processes reveal unresolved needs within the system. Review tools, data sources, performance measures, sampling strategies, remediation activities and needed systems change are all subject to review and modification if they do not result in a structure that informs the Division about the health of the "system".

Recommendations for corrective action and system improvement are shared with the DDDS operational units that will need to develop and implement improvement strategies. The operational units are required to respond to the Division Director or designee with their suggested improvement strategies. Once the improvement strategy is finalized, it is implemented and the data monitoring is used to determine if the strategy achieved the desired result.

The Performance Analysis Committee monitors the impact of system changes using a reporting tool called "Divstat". The Office of Quality Improvement (OQI) is largely responsible for the discovery part of the process. A representative of OQI sits on the PAC work together to develop monitoring tools, sampling strategies, and reporting requirements. Most discovery processes are in the domain of OQI activities. The OQI implements the revised discovery processes, measuring the effectiveness of the slated system improvement.

Performance data produced by the PAC in the form of the "Divstat" reporting tool, is provided to the DDDS Director, the Director's Leadership Team and DMMA, which share the responsibility for analyzing the effectiveness of the Quality Improvement System to support specified goals and outcomes. Such responsibility is carried out in structured, routine meetings in which performance data is reviewed.

Each entity is empowered to raise issues such as the validity or reliability of data, effectiveness of performance measures to assess the intent of the system, training needs of providers or discovery process reviewers, and plans to provide systems improvements. It is not enough to collect and report data. The DDDS QMS is designed to drive outcome-based results, with clear accountability for who reports the data and who initiates system improvements.

The OQI and PAC shall work in tandem to adjust discovery processes (as indicated) in order to accurately design and implement performance assessment. The two QMS entities develop monitoring tools, sampling strategies, and reporting

requirements with PAC functioning as the "brain" of the division and OQI as the "eyes and ears".

If done well, continuous quality improvement is a cyclical, iterative process.

The DDDS Quality Management System has been established to support the attainment of positive outcomes for waiver participants. System-wide performance data is aggregated and shared broadly, both within and external to DDDS. Performance data is provided to DMMA on a quarterly basis at the quarterly oversight meetings with DDDS. Performance data is also provided to CMS as part of the annual 372 report.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

DDDS requires each agency provider of HCBS Waiver services to submit an annual independent audit. DDDS also requires the Agency with Choice Vendor to submit an annual independent audit. The results of this independent audit must be submitted to the Division within 3 months of the end of the provider's fiscal year. This is tracked as a waiver performance measure. Additionally, the State of Delaware Auditor's office is the entity responsible for conducting annual audits in accordance with the provisions of the Single Audit required under the OMB Uniform Guidance for state agencies within the state government of Delaware.

Per the MOU between DMMA and DDDS, DMMA is responsible for conducting utilization review of services provided under the waiver. DMMA and DDDS meet on a quarterly basis to review DDDS's performance under the waiver including all aspects of waiver administration.

All waiver claims are processed through Delaware's MMIS. Delaware employs multiple levels of processes designed to ensure proper payment of claims both pre-and post-adjudication. DMMA contracts with a fiscal agent to operate the MMIS. The current MMIS was certified by CMS as meeting the standards for automated claims processing systems per Part 11, Chapter 3 of the State Medicaid Manual.

DMMA uses a process for its post-payment review called Recipient Explanation of Medicaid Benefits (REOMB). Each month, a sample of 250 clients for whom a fee for service claim was adjudicated are selected randomly for the purpose of quality control review via the REOMB process. DXC selects all claims received for the individual within the target month. The SUR team and DMMA's Fiscal Agent (DXC) are responsible for the entire Recipient Explanation of Medicaid Benefits (REOMB) process.

All DDDS HCBS waiver members are subject to being included in the REOMB monthly sample. The monthly sample is reviewed to provide an overall assessment of the claims processing operation including: verification of claims payment accuracy, measurement of cost from errors, and establishment of a corrective action plan, if needed. The REOMB Coordinator reviews claims against the participant eligibility data, provider enrollment and contract data and rate structure. As part of the validation process, the system generates a letter on state letterhead to be mailed to each of the selected Medicaid recipients. The letter provides the recipient with dates, provider name and specific procedures which Medicaid has paid on behalf of that recipient. The letter asks the recipient to indicate whether or not the services were provided and whether he/she was asked to make any payment for these services. It also provides a space for any comments the recipient wishes to make. The recipient is directed to mail the letter back in a postage paid envelope. If the recipient does not respond to the letter, no additional follow up is conducted. If it is determined that an overpayment was made, a findings letter is mailed to the provider via certified mail. If no overpayment is received within fourteen days, arrangements are made with DMMA's fiscal agent to recoup funds from provider. This can include setting up an accounts receivable for the overpayment to be applied against future claims.

The MMIS contains a Surveillance and Utilization Review (SUR) sub-system which organizes data and creates reports used by staff of the Surveillance and Utilization Review (SUR) Unit within DMMA. The reports us algorithms to detect patterns in paid provider claims which may indicate fraud and/or abuse. The SUR team uses these reports and other tools to identify specific providers on which to perform audits and investigations, referring providers as appropriate to the Medicaid Fraud Control Unit (MFCU) within the Delaware Attorney General's Office as required in the Delaware Administrative Code, Section 13940. DMMA works closely with its Attorney General's Office to prosecute instances of provider fraud. A Memorandum of Understanding is in place between the Delaware DHSS and the Delaware Attorney General's Office which formalizes the responsibilities of each party regarding the investigation and prosecution of Medicaid fraud.

The standard Medicaid Provider Contract for Services requires all providers of services to maintain or make available such records as are necessary to fully substantiate the nature and extent of services rendered to DMAP eligibles, including the provider's schedule of fees charged to the general public to verify comparability of charges provided to non-DMAP individuals and to make all records available to federal or state auditors for the purpose of conducting audits to substantiate claims, costs, etc.

Negative findings from post-payment validation activities are reported to the provider in writing by the entity that discovered the finding. For DMMA, this will be the REOMB Coordinator, the SUR unit or MFCU. For DDDS this will be the DDDS Office of Quality Improvement. The DDDS Offices of Community Services and Budget, Contracts and Business Services play a role in detecting in appropriate billing through their routine monitoring efforts. All findings are reported to OQI for follow up with the provider. Depending on the finding, a corrective action plan may be required. The provider will be notified in writing by OQI if a corrective action plan will be required. DDDS must approve the CAP before it can be implemented. While the correspondence will come from OQI, OQI may enlist the help of other parts of DDDS to monitor the implementation of the corrective action plan and report back to OQI so that can determine when the corrective action plan may be closed.

The case managers in the Community Services and administrative staff of the DDDS Day and Transition Unit, which is also part of Community Services, monitor provider case notes and the receipt of services against the person centered plan in the electronic case record on a monthly basis. Discrepancies are reported to the Office of Budgets, Contracts and Business Services (OBCBS) for initial investigation.

Staff from OBCBS work in tandem with staff from the DDDS Office of Quality Improvement, under the Office of Residents Protection, and Community Services to provide financial expertise when investigating deficiencies that involve provider or participant finances that are discovered through quality monitoring, abuse/neglect investigations, case manager monitoring or guardian or participant complaints. While Office of Resident Protection coordinates investigations and any provider probation process due to service deficiencies, ORP is able to call on the resources of OBCBS for assistance as needed.

If staff from OBCBS or Community Services identify or suspect an provider as submitting inappropriate claims, after three months without correction OQI may place the provider on probation which triggers enhanced monitoring of the provider in accord with the mandated Quality improvement Plan to correct the problem.

Delaware believes this process is advantageous, as it connects both a programmatic and fiscal viewpoint to the provider oversight strategies.

A case of deficiency in implementation of proper and frequent financial oversight may result in OQI placing a provider on probation status for 3-6 months depending on the severity of the deficiency and the amount of time necessary for corrective action. OQI conducts monthly follow-up to verify implementation of approved corrective actions, with enhanced oversight of spending records, billing, or other specific monitoring as each case warrants. If improvement is not apparent after the first probation period, it can be extended another 3-6 months with ongoing increased monitoring and technical assistance. If the provider has not corrected the deficiency at the end of the second probation period, DDDS may end the business relationship with the agency.

Agency With Choice Broker:
Because the Agency With Choice vendor will be serving as the employer of record, it will submit and be paid for claims for self-directed services in the same manner as other fee for service Medicaid claims. The DDDS AWC liaisons will be responsible for monitoring claims paid to the AWC broker as the provider. The DDDS AWC liaisons will be responsible for ensuring that the AWC provider claims match what was paid to the employee. More detail regarding this process is provided in Appendix E, as required in that section.

In addition to monitoring claims submitted by the AWC broker, DDDS will also monitor performance against contractual requirements. Such requirements will include maintenance of documentation to comply with IRS and US DOL requirements such as: provider screening and training, copy of IRS Forms W-4 and I-9, accuracy of wage payments and withholding, payment of overtime and travel, as required.

Quarterly, the DDDS AWC Liaisons will verify AWC vendor payment/filing of the State Income Tax, Unemployment Tax, Workers Compensation and IRS Forms 940 and 941 and Forms W-2/W-3.

Annually, DDDS will also review the AWC broker's standard operating procedures and required reporting on performance metrics such as timeliness of payroll and payment of other invoices by the AWC vendor, participant satisfaction, and timeliness of response to customer calls where a message is left after hours, complaints resolution, etc. as specified in the contract. These processes are described in more detail in Appendix E.

Additional detail on financial integrity processes is provided in section I-2-d Billing Validation Process.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. **Methods for Discovery: Financial Accountability Assurance:**
The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. **Sub-Assurances:**

a. ***Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.*** *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
I-a-1: The percentage of claims paid only for those services specified in the person centered plan. (Numerator: number of claims paid only for those services specified in the person centered plan; Denominator: number of paid claims for the period)

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDDS Data Sources - Prior authorizations entered into the MMIS pursuant to the person centered plan; paid claim detail in the MMIS against the authorization.

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

Data Aggregation and Analysis:

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

Performance Measure:
I-a-2: The percentage of provider attendance reports reviewed for day and residential services that match what was claimed.(Numerator: Number of provider attendance reports reviewed for day and residential services that match what was claimed; Denominator: Number of provider attendance reports reviewed for the period)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Attendance records submitted by the providers and claims, as processed in the MMIS

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

Data Aggregation and Analysis:

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

Performance Measure:
I-a-3: The percentage of DDDS waiver provider agencies that submit completed annual audited financial statements. (Numerator: the number of DDDS waiver provider agencies that submit completed annual audited financial statements; Denominator: Number of DDDS waiver provider agencies.)

Data Source (Select one):
Financial audits
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Performance Measure:
I-a-4: Percentage of waiver claims which are prior-authorized.(Numerator: Number of paid claims that are prior authorized; Denominator: Number of paid claims for the period.)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Data Sources - MMIS data on paid DDDS waiver claims

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

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.***

Performance Measures

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

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

Performance Measure:
I-a-5: The percent of rates for waiver services adhering to reimbursement methodology in the approved waiver. (Numerator: Number of rates for waiver services adhering to reimbursement methodology in the approved waiver; Denominator: Number of waiver rates.)

Data Source (Select one):
Other
If 'Other' is selected, specify:
The DMMA Reimbursement Unit reviews all waiver rates computed by DDDS to determine if they were computed pursuant to the approved methodology.

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

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Each time new rates are computed	

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

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

In addition to the manual claim verification described herein, the MMIS contains a Surveillance & Utilization Review (SUR) sub-system which organizes and analyzes claims data based on pre-set algorithms to create reports used by SUR unit staff. Reports are designed to detect patterns in paid provider claims which may indicate fraud and/or abuse.

The SUR team uses these reports and other tools to identify specific providers on which to perform audits/investigations, referring providers as appropriate to the Medicaid Fraud Control Unit (MFCU). DMMA works closely with the Attorney General's Office to prosecute instances of provider fraud.

The MFCU itself may also initiate investigations based on information received independent of DMMA (anonymous information, information from other law enforcement agencies, etc.) In these cases the MFCU works with the SUR staff to identify what error or fraud occurred.

In cases where it is decided that funds have been paid to providers for services that determined to not comply with DMMA's published standards, DMMA will authorize its fiscal agent, to perform an adjustment on those targeted claims in order to set up an accounts receivable against future claims to recoup any overpayments. If the accounts receivable does not result in a collection within a reasonable period of time, DMMA begins collection efforts to require the provider to send a check for the outstanding accounts receivable. This recoupment action is independent of any criminal prosecution or civil action the MFCU/Attorney General's Office may initiate.

When documentation is received, it is reviewed by the SUR nurses or other DMMA subject matter experts. The subject matter experts (physicians, nurses, pharmacy, laboratory or optometrist, etc.) examine the documentation for accuracy of coding, quality of care and appropriateness of services billed. The determinations are returned to the auditor. The auditor reviews the determinations and recommendations of the medical consultant and compiles the final report.

The case dispositions include, but are not limited to:

1. No further action/ no evidence of fraud. For these cases, there is no overpayment identified and the case is closed and the provider is notified of the results by letter.

2. Problems identified requiring provider education /no evidence of fraud. The provider is referred for appropriate training and, if applicable, a request for repayment is sent to the provider by certified mail.

3. Overpayment identified no evidence of fraud - a request for reimbursement is sent to the provider by certified mail. When the majority of the services in question are not justifiable, the reviewer may recommend a full-scale audit of the provider. A full-scale audit is defined as an expanded scope review. This is generally performed in the field and includes a greater number of claims for review in the problematic area or in general areas.

The request for repayment letter explains the findings of the review and gives the provider 30 days to dispute any findings of the review. If, after the 30 day limit the provider has not notified Medicaid they wish to dispute the findings or they have not repaid the overpayment, the recoupment account is established in order to recover the overpayment. The provider may request an administrative hearing per the procedure described in the DMAP General Policy Manual on the DMAP website.

If warranted, follow up reviews are scheduled at 6 to 12 month time periods from results notification. Providers who do not comply with required corrective action or where the dollar amount identified as overpaid is in excess of $500.00 may be candidates for follow-up reviews.

4. Referral to MFCU - If any of the findings in the reviews meet the criteria established with the Delaware Medicaid Fraud Control Unit in the Department of Justice, the case will be referred to that Unit.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix I: Financial Accountability

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

a. **Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

DDDS is responsible for the development of statewide rates for waiver services through an MOU with DMMA, Delaware's Medicaid agency. DMMA is responsible for the final review & approval of all rates and for ensuring that rates are computed consistent with the approved methodology.

Rates for most Lifespan waiver services are based on a "market basket" methodology established in 2004. This includes residential habilitation, day habilitation, pre-vocational service, supported employment individual & group (added in October 2013), supported living, clinical consultation: behavioral & nurse (added to the methodology in 2012) and community participation, newly added under this amendment.

The last rebasing study for Direct Support Professional (DSP) rates was conducted in CY2013 at the direction of the Delaware General Assembly; results were published in January 2014. All DDDS HCBS providers completed a wage and cost survey in CY2013 and interviews were conducted interviews with a representative cross section of 13 of the providers to validate the survey data, revisit assumptions and make sure nothing was missed in the survey.

The revisions to the composition of the market basket, the assumptions & the resulting rates were shared in draft with the provider agencies, advocates and other key stakeholders. Feedback was incorporated into the design and final rates. The Delaware provider association representing most of the DDDS waiver providers endorsed this approach.
The report produced a set of recommended "Benchmark rates" for each service.

The methodology begins with the selection of a wage for each type of DSP. Wage data was obtained from the U.S. DOL BLS and job postings from national internet employment sites for job classifications with similar requirements & duties.

In addition to the wage, the market basket methodology adds the following components, as appropriate to each service:

• employment related expenses (%)
• program indirect expenses (%)
• administrative expenses (%)

Employment Related Expenses include benefits paid to or for workers above salary and wages. They include expenses such as health insurance, workers comp, unemployment compensation, state/federal payroll taxes, criminal background checks and training.

Program Related Expenses support the delivery of the service but are either non-salary expenses or are a step removed from the direct delivery of the service. These include program management, rent, utilities, program supplies, technology expenses (phones, laptops, network, software licenses), vehicle costs for staff, quality assurance, staff recruitment costs, DSP staff time spent in allowable but not billable activities.

General and Administrative Expenses include functions that are necessary for the operation of the organization but cannot be directly related to a good or service produced by the organization. This includes: payroll and accounting, legal counsel, outside audit fees, general liability insurance, managerial salaries, corporate overhead, rent, utilities, office equipment and subscriptions.

These costs are either converted to percentages that are multiplied by the direct support hourly wage rate as a set of recursive percentages in order to develop an hourly provider DSP benchmark rate for each service or were added as individual cost factors, or a combination of both, depending on the service.

The formula to compute the hourly rate for each service using the rate components (expressed as a percentage) is as follows:

(DSP wage+(DSP*(1+ERE))/(1-PI)/(1-GA))

Transportation to and from the service setting is a component part of the service for residential habilitation, day habilitation and prevocational service and is paid as an add-on to the direct support unit cost rate. Rates for residential services do not include any costs associated with room and board.

The estimated cost of implementing the Benchmark rates was $37 million, of which the state share was $18 million. As of the date

when the 2014 benchmark rates were adopted. This is not likely to change in the near future.

The legislature determines the level of funding that may be available for services and rate increases each year. The legislature adopted the Benchmark rates from the 2014 study as the standard and all subsequent rate increases have been applied using the rebasing study within available funds. Some service rates are currently paid at a lower percentage of the benchmark than others. As funding for a rate increase has been made available, the goal is to use it to "level up" the rates to the same % of the benchmark over time. Over time, this approach would result in all services being at the same percent of the benchmark, but lack of available funding has limited Delaware's ability to implement rate increases.

The DSP rates are periodically re-based using cost data from the most current period available. Each year, the Epilogue of the Budget Act enacted by the Delaware General Assembly indicates that DDDS "may rebase, once every one to three years" its Direct Support Professional rates. A date has not been set for the next rate rebase study. DDDS waiver rates are published on the DDDS website each year.

DDDS uses the Inventory for Client and Agency Planning (ICAP) assessment tool to determine the number of direct support hours needed for each waiver member for residential, day and employment services. The division also uses a separate structured assessment protocol, for waiver members that have behavioral or medical challenges that require additional support hours beyond what is indicated from the ICAP. For Nurse and Behavioral Consultation, DDDS uses custom-developed behavioral and nursing assessment instruments and protocols to determine the appropriate number of support hours based on the needs of each member.

While all rates are initially computed as hourly rate, they may be billed as 15 minute, hourly or per diem rates. Per diem rates are computed by multiplying the hourly rate for the service by the number of hours of support needed per day. 15 minute unit rates are computed by dividing the computed hourly rate by four.

The rate for the DDDS State-operated day habilitation program is computed on an annual basis using prior year actual annual costs, including personnel, benefits, program related expenses such as rent, utilities and supplies, and administration (using the indirect cost rate approved by the Division of Cost Allocation (DCA), U.S. DHHS). The total actual costs are divided by actual units of service to calculate a daily rate for this service.

Supported Employment - Small Group: DDDS must perform additional computations to the rate for this service to account for the number of waiver members in the group. Before the base rate is divided by the number of members in the group, a gross up factor is applied to the base rate for this service. This is to ensure that overhead costs are properly captured, based on the assumption that simply dividing the base rate by 2 - 8 group members would not adequately capture an agency's incremental costs in delivering the service. The unit cost rate is then divided by the number of waiver members in the group from 2 – 8.

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

Community Transition: The approved provider of will submit an invoice with applicable receipts to DDDS for reimbursement. Invoices must be approved by DDDS before payment is made.

Specialized Medical Equipment, not otherwise covered under the State Plan, Assistive Technology equipment and Home or Vehicle Modifications: Bids or estimates of cost for a job, equipment, or supplies are obtained from at least two vendors the individual chooses or is assisted to choose. The lowest and best price will be authorized by DDDS if the price is reasonable based on the purchase experience of the DDDS or DMMA for similar jobs, equipment or supplies and up to the maximum allowed for the service, as described in Appendix C. Bids or estimates must be obtained from at least two vendors so that DDDS can select the most reasonable bid based on the work to be performed which may take into account such elements as the time necessary to perform the work. In the event that the time necessary to obtain two bids will result in a delay in receiving the service that could pose a health or safety risk to the participant, DDDS may waive this requirement but will use internet resources, within the time available, to identify a reasonable cost for the same or similar products and services.

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

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

• Provider Overhead Expenses

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

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

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

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

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

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Providers submit claims for DDDS HCBS waiver services to the MMIS which is operated by a fiscal agent under contract to DMMA. Claims are adjudicated in the MMIS and payment is made by the fiscal agent. All claims for waiver services are prior authorized by DDDS staff. Providers must bill against the approved authorization which indicates the maximum number of units for a specified period, the service which has been authorized and the unit rate. The provider can bill a lower number of units or a lower rate than what is authorized in order to reflect actual utilization, but they cannot bill more than what is authorized. An MMIS edit causes the claim to be paid at the lesser of the billed amount or the "rate on file", which is the rate on the Prior Authorization for most DDDS waiver claims.

Providers submit electronic claims for DDDS waiver services in the HIPAA-standard 837 professional claim transaction first to a clearinghouse, Business Exchange Services (BES) which screens them against both HIPAA and Delaware proprietary minimum claim criteria. Claims are accepted, in which case they pass to the MMIS for adjudication if they meet the minimum criteria, or are rejected back to the provider along with the rejection reason. Providers can submit paper claims on the HCFA 1500 or the UB04 directly to HP, but this capability is being phased out by DMMA as part of its "go green" initiative. Paper claims are scanned into the MMIS. Providers can use any claims software that results in a HIPAA-standard clean claim. HIPAA compliant claims software is made available to DMAP providers free of charge via download from the DMAP website. Provider billing procedures are described in detail in a series of Provider Manuals on the DMAP website.

Provider claims are accepted 24/7 and are processed for payment once a week after the close of business each Friday. Funds for paid claims are available for payment the Monday following the Friday financial cycle.

DDDS staff submit Medicaid claims for the state-operated services: day habilitation and clinical consultation: nursing and behavioral.

DDDS also submits claims on behalf of shared living providers who have voluntarily re-assigned their payment to a government agency per CMS Bulletin 94-4. These providers are individuals who meet the provider qualifications for shared living and who have waiver participants living in what is essentially a family home. As a group, these providers do not generally have the infrastructure necessary to submit and reconcile HIPAA compliant claims. This process is more fully described under Item I-3-g-i.

It is DDDS's intention to explore value-based purchasing models for waiver services to reinforce expectations with providers for the delivery of high quality waiver services.

Appendix I: Financial Accountability

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

c. Certifying Public Expenditures *(select one)*:

◉ **No. State or local government agencies do not certify expenditures for waiver services.**

○ **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

***Select at least one*:**

☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

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

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

In addition to the financial integrity methods described in I-1, DDDS performs the following billing validation activities.
a) Recipient Eligibility for Waiver Services: Applicants who are enrolled in the DDDS waiver are assigned one of four categories of aid in DCIS (Delaware Client Information System), the eligibility/enrollment client database of Delaware DHSS. The aid categories then pass to the MMIS in a nightly automated data feed. The aid categories indicate whether the waiver participant is receiving SSI or is in the waiver Special Income Group. Edits have been established in the MMIS to require prior authorization for waiver claims based on their assignment to one of the four DDDS waiver aid categories. MMIS claim edits for participants enrolled with a waiver aid category require the dates of service for a waiver claim to be within the eligibility start and stop dates for the waiver aid category in order for the claim to process as paid as a waiver service. DMMA has also assigned specified procedure codes to be used for waiver services. These codes are set up so that they cannot be used for non-HCBS clients.
(b)Service is included in PCP: The waiver participant's PCP includes a list of the waiver services the client has chosen to receive. Among the DDDS program units that assist in the oversight of waiver services are the Office of Community Services which employs the case managers that oversee residential, day, employment and clinical services. The case manager and other designated employees communicate the amount, duration and frequency of each waiver service included in the PCP to the DDDS Office of Budget, Contracts and Business Services where a Prior Authorization is entered into the MMIS for each authorized waiver service. When a claim for a waiver service is submitted, the MMIS checks the claim against the Prior Authorization data in the MMIS. The PA number on the claim must match the PA number in the MMIS before the claim will be processed. Once a matching PA is found, the MMIS then performs additional edits to compare the Medicaid ID number, the provider NPI, the procedure code, the units of service and the rate billed against those elements recorded on the PA. As long as the unique client identifier, provider ID and procedure code match and the waiver eligibility, the dates of service and the rate are all within specified limits, the claim will process.

c) Services were provided: DDDS requires its providers to use an electronic case record system to document service provision. The agencies providing residential, day, prevocational, and supported employment services are also required to submit attendance/utilization reports to DDDS each month. These attendance reports are signed by an authoritative representative of the provider. Providers must also maintain case notes describing how the service they provided facilitates the ability of the client to meet their goals as described in the PCP. There must be one note per client per service per day at a minimum. DDDS has the ability to view the provider case notes in the electronic record and does so periodically to make sure that services identified as "provided" are also documented.

The DDDS Day and Transition Unit assists the case manager to monitor the utilization of day services for waiver participants based on specified triggers. They compare provider attendance records and claims data against service authorizations based on the PCP to look for: units higher or lower than what is expected, changes in Group Supported Employment ratios, waiver participants whose authorized hours are exceptions to the ICAP. Providers who are determined to be at higher risk of claim errors based on prior reviews are reviewed more closely than other providers. When a review is triggered, the Unit looks at the PCP, progress/billable notes for each day service and incident reports to ensure that services are being delivered and billed in accordance with the PCP.

Because the Agency With Choice vendor will be serving as the employer of record, it will submit and be paid for claims for self-directed services in the same manner as other fee for service Medicaid claims. The DDDS AWC liaisons described in Appendix E will be responsible for monitoring claims paid to the AWC broker as the provider. The AWC liaisons will be responsible for ensuring that the AWC provider claims match what was paid to the employee. More detail regarding this process is provided in Appendix E, as required in that section.

In addition to the DDDS post payment claim validation activities, DMMA is also responsible for retrospective auditing of paid claims and utilization review of services provided. These processes are described in section I-1 of this Appendix.

If it is determined that an erroneous or fraudulent payment has been made, DMMA has the ability to recoup payments as follows. If valid claims are expected to be submitted by the provider for a future period, DMMA instructs its fiscal agent to set up an accounts receivable to recoup the full amount of the erroneous payment. The accounts receivable is satisfied when the full amount is reached. If no future claims are expected to be submitted or if the nature of the overpayment is related to substantiated fraud or criminal activity, the DMMA Program Integrity Unit may send a letter to the provider directing it to repay the amount with a check. If the provider does not provide the payment within the timeframe specified in the letter, DMMA refers the case to the Medicaid Fraud Control Unit of the Delaware Attorney General's Office. Legal action can be pursued in court if necessary.

e. **Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. **Method of payments -- MMIS** (*select one*):

○ **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**

◉ **Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payment for all waiver services, except for Residential Habilitation delivered by a Shared Living provider, are made through an approved MMIS.

As described in section g.i. of this Appendix, DDDS has a payment arrangement with its shared living providers that allows DDDS to pay them up front each month with 100% state funds via the State accounting system. The state allows providers of shared living service under the waiver to reassign their payment to the division if they so choose. Shared living providers are individuals who have agreed to share their home with a waiver participant to provide residential habilitation.

The providers submit an invoice for each month for the client(s) to which they provide shared living support. By reassigning their payment to a governmental agency, the provider does not have to obtain HIPAA compliant electronic claims software in order to be paid. The providers are paid at the Medicaid rate for the hours of support they provide up to a maximum of the support hours indicated by the participant's ICAP score. The DDDS fiscal section creates a prior authorization in the MMIS and then creates and submits a HIPAA-compliant claim to the MMIS based on the provider invoice. DDDS deposits the revenue to the state's General Fund, since it has already paid the provider up front. The result is that the net payment for the service is the state share plus federal share at the applicable FMAP. The state share for these claims is paid from the budget of the Division of Medicaid and Medical Assistance.

The DDDS Shared Living Coordinators receive an invoice after the end of each month from each Shared Living provider that enumerates the dates of service during the month when residential habilitation was provided, consistent with the waiver standards. The invoice contains the documentation necessary to support a Medicaid claim as required under section 2500.2 of the State Medicaid Manual.. The Shared Living Coordinators are in routine contact with the Shared Living Providers. The

Coordinators check the invoice against the attendance, case notes in the electronic case record and the "Change of Status" record as in the DDDS Registry to look for gaps in service, such as hospitalizations, that were not reported by the Shared Living provider. Any discrepancies are investigated. By contract, the Shared Living providers are required to report all absences to DDDS. The Shared Living Coordinators enter the monthly data into a spreadsheet that is sent to the DDDS Office of Budget, Contracts and Business Services (OBCBS) along with a scanned PDF of the provider invoice. A Senior Accountant in OBCBS checks the invoice against the contracted rate for each participant receiving Shared Living (ICAP hours x standard hourly payment rate for Shared Living expressed as per diem). The Senior Accountant enters the participant utilization data into a separate Excel spreadsheet that is uploaded into MS Access where it is merged with data about the provider, such as the provider's SSN and bank account information. The monthly Access data file is uploaded to the state's accounting system from which the provider payments are generated. After the payment transactions have cleared the state accounting system, the Senior Accountant uses the provider invoice, which has already been verified against other data, to create a Medicaid claim to reimburse the state for the payment it made to the provider from the state accounting system. The Senior Accountant reconciles the remittance advices for the claims for each service month to the state accounts receivable and any discrepancies are followed up on and corrected.

Claims for Respite and Personal Care under the self-directed option will also be paid outside of the MMIS because the Agency With Choice vendor will be serving as the employer of record. After the AWC Broker has paid the self-directed caregiver as employee via its own accounting system, the AWC Broker will submit and be paid for Medicaid claims for self-directed services as a Medicaid provider in the same manner as other fee for service Medicaid claims. The broker will be responsible for performing all necessary tax withholding and will submit claims for the entire payment amount, inclusive of tax withholding, that it has It will be paid outside of the MMIS. More detail regarding this process is provided in Appendix E.

The DDDS AWC liaisons are responsible for monitoring payments made by the AWC broker to its employees and also for monitoring Medicaid claims submitted to reimburse for outlays to the self-directed caregivers against utilization data and case notes in the electronic case record. The Community Navigators will, by monthly contact with the participant, monitor the provision of service against the person centered plan.

○ **Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

☐ **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**

☑ **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**

☐ **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

☐ **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. **Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- (●) **No. The State does not make supplemental or enhanced payments for waiver services.**
- ( ) **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. **Payments to State or Local Government Providers.** *Specify whether State or local government providers receive payment for the provision of waiver services.*

- ( ) **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- (●) **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

The Division of Developmental Disabilities Services operates a state-run habilitation program, one neighborhood group home and provides Behavioral and Nurse Consultation Services, in addition to the network of non-government waiver providers. These are the last remaining state-operated services back from a time prior to the creation of the DDDS HCBS waiver when the state provided all of the services to support persons with intellectual disabilities. DDDS is phasing out these state-operated services through natural attrition.

Enrollment in all DDDS-operated services have been closed since July 1, 2014. Since that time, DDDS has been working to transition individuals from all state-operated services to other providers.

As of May 2017, the last 2 remaining residents in a state-operated neighborhood group (which is on the grounds of a public institution) will be transitioned to a new fully accessible home that will be managed by a private waiver provider that they chose.

DDDS has transitioned all but 75 individuals receiving Behavioral Consultation to private providers, 15 in the largest of the 3 counties and 50 in Sussex County, the southernmost county. The lack of qualified providers in Sussex County has stalled this transition. All but 27 individuals have been transitioned from the Nurse Consultation service. We expect all individuals to be transitioned to other providers by June 30, 2017.

Enrollment in DDDS state-operated Day Habilitation programs has been closed since 2011. Today there are only 90 people being served in state-operated day programs. The gradual reduction enables the state to achieve its desired outcome of ending state-operated day services with minimal negative impact on the participants.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

- ○ **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- ◉ **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- ○ **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- ◉ **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- ○ **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- ○ **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- ◉ **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

The state allows providers of shared living service under the waiver to reassign their payment to the division if they so choose. Each shared living provider has a provider agreement with the Medicaid agency. By reassigning their payment to a governmental agency, the provider allows DDDS to pay them each month with 100% state funds via the State accounting system. This means that the provider does not have to obtain HIPAA compliant electronic claims software from DMMA's fiscal agent in order to be paid. Shared living providers are individuals who have agreed to share their

home with a waiver participant to provide residential habilitation. The purpose of this arrangement is to process the payment for these providers sooner and with less administrative burden than if they submitted the claims to the MMIS themselves. The providers are paid at the Medicaid rate for the hours of support they provide up to a maximum of the support hours indicated by the participant's ICAP score. DDDS then submits the HIPAA compliant electronic claim to the MMIS on behalf of the provider and deposits the revenue to the state's General Fund. The result is that the net payment for the service is the state share plus federal share at the applicable FMAP. Because this service is the most "home-like" of the residential service options and typically results in the greatest community integration, DDDS feels that it is important to make this service the least burdensome as possible for the provider in order to encourage provider participation.

ii. Organized Health Care Delivery System. *Select one:*

- (●) **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- ( ) **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

- (●) **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- ( ) **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

  Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ( ) **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**
- ( ) **This waiver is a part of a concurrent □1115/□1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The □1115 waiver specifies the types of health plans that are used and how payments to these plans are made.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one*:

- [x] **Appropriation of State Tax Revenues to the State Medicaid agency**
- [ ] **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such

as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

☐ **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

◉ **Not Applicable.** There are no local government level sources of funds utilized as the non-federal share.

○ **Applicable**

Check each that applies:

☐ **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

◉ **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**

○ **The following source(s) are used**

Check each that applies:

☐ **Health care-related taxes or fees**

☐ **Provider-related donations**

☐ **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. **Services Furnished in Residential Settings.** *Select one:*

○ **No services under this waiver are furnished in residential settings other than the private residence of the individual.**

◉ **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. **Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

The methodology described in I-2-a. uses costs for direct support professionals and costs that are directly related to supporting those employees (such as supervision and staff training) to compute a payment rate. No costs related to the operation of the residential facilities are included in that process. DDDS determines the room and board costs for each facility which is paid either by the individual or the division with 100% state funds or a combination of both, if the individual's income is not sufficient to cover the room and board costs.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

◉ **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**

○ **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. **Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

◉ **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**

○ **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. **Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

☐ **Nominal deductible**

☐ **Coinsurance**

- [ ] **Co-Payment**
- [ ] **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. **Co-Payment Requirements.**

ii. **Participants Subject to Co-pay Charges for Waiver Services.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. **Co-Payment Requirements.**

iii. **Amount of Co-Pay Charges for Waiver Services.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. **Co-Payment Requirements.**

iv. **Cumulative Maximum Charges.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. **Other State Requirement for Cost Sharing.** Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

- (◉) **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ( ) **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: ICF/IID

Col. 1 Year	Col. 2 Factor D	Col. 3 Factor D'	Col. 4 Total: D+D'	Col. 5 Factor G	Col. 6 Factor G'	Col. 7 Total: G+G'	Col. 8 Difference (Col 7 less Column4)
1	94952.52	5045.00	99997.52	394063.00	7558.00	401621.00	301623.48
2	97647.00	5396.00	103043.00	421451.00	8229.00	429680.00	326637.00
3	98467.17	9019.00	107486.17	408352.00	6146.00	414498.00	307011.83
4	65471.20	9019.00	74490.20	424441.00	6146.00	430587.00	356096.80
5	66770.85	9019.00	75789.85	464084.00	6146.00	470230.00	394440.15

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. **Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable) Level of Care: ICF/IID
Year 1	1100	1100
Year 2	1150	1150
Year 3	1200	1200
Year 4	2372	2372
Year 5	2506	2506

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. **Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The average annual length of stay of participants receiving residential habilitation through the Lifespan Waiver is derived from actual data for days of enrollment for SFYs 10-15 based on historical paid claims data for waiver participants as reported on the annual CMS 372 report.

An alternate basis was used to determine the average length of stay data for the new population of graduates from K-12 school being added to the waiver because this is a new waiver population for which there is limited longitudinal data. The derivation of the ALOS is based on the monthly head count data for a five year period for individuals graduating from school and electing to receive DDDS non-waiver day programs. This data is maintained by the DDDS Day and Transition Unit. The Day and Transition Unit has observed seasonal patterns of enrollment as individuals graduate from school. This experience was applied to estimates for new cohorts of graduates each year. Based on this experience, we have observed that most graduates enroll in a day program the middle of August each year. To account for this, 46 days were subtracted from a 365 day year. A separate factor of 15 days was subtracted from the year to account for natural attrition due to individuals who die, move out of state or decide they no longer wish to receive a day service.

A weighted average length of stay was computed from the estimates of unique counts of participants and participant days per year across the two populations

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. **Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

The estimated number of users, units/user, and the cost/unit for individuals receiving residential habilitation and for other waiver services they receive is based on historical Medicaid expenditures as reported on the annual 372 report.

For the new waiver participants to be enrolled in demonstration years 4 and 5 under this amendment, DDDS used internally maintained available utilization and payment data for SFY15 and 16. This group is comprised of individuals who are living in the family home that will be newly enrolled in demonstration years 4 and 5. Many of these individuals are known to and receiving non-waiver services from DDDS.

Current waiver Day services - Delaware used ad hoc queries against the MMIS database to derive the average units per person and the average cost per unit for day services for SFYs 15 and 15 (WYEs 1 and 2) for existing waiver members. FY15 data from the CMS 372 report for expenditures and participant counts by service category was also used. The data was arrayed by service. The data from WYEs 1 and 2 were compared to look for consistency.

Payment and utilization data from the non-waiver participants receiving day services were obtained and arrayed for SFY16. Delaware used client counts for the two populations (waiver and currently non-waiver) to compute a weighted average number of units per person and cost per unit across the two populations to be applied to WYEs 4 and 5. Delaware made assumptions about growth in the number of newly eligible waiver members for WYEs 4 and 5 based on past participant growth in the two populations (which is largely constrained by the amount of newly appropriated funds for waiver members, and the number of individuals graduating from school for the non-waiver enrolled individuals). Estimated utilization of services across the day service array was assumed to be consistent with the distribution from the SFY16 data, the most current data set that was available at the time the estimates were computed.

Day Habilitation: Community Participation – DDDS conducted a state-funded pilot between September 2014 and Jan 2015 to explore the feasibility of this service. The estimates for both the number of individuals DDDS expects to request this service and the utilization per participant came from the pilot. The average cost per unit was computed using the DSP rate methodology for the other day services with wage and other rate components coming from the pilot.

Respite – estimates for respite were based on FY16 DDDS payment and utilization data maintained by DDDS in an excel spreadsheet to track expenditures by person by type of respite provider. Most of the expenditures are paid for self-directed caregivers and respite camps. Individuals also use Home Health Aides to a lesser extent. The cost per hour for the self-directed care was not recorded, so the Manager of the DDDS respite program provided estimates of the number of individuals for whom a specified hourly rate was believed to be paid based on the acuity of the individuals.

Personal Care – estimates were based on expenditures maintained by the DDDS Office of Budgets, Contracts and Business Services for payments made for personal care under a program DDDS calls "Individual and Family Assistance Payments" (IFAP). The data was recorded as a lump sum per family so the hourly rate of payment could not be computed. Assumptions had to be made regarding the hourly rates of payment and number of units (hours) based on information that was known about each family.

Home/vehicle modifications – estimates for the number of families who would seek this service were based on families for whom DDDS had paid for modifications in the past under the IFAP program. This data was not always recorded in a way that allowed an amount per family or per modification to be identified. Based on the amounts of past requests (some of which were not able to be funded), DDDS made the assumption that 70% of the requests would require the maximum funding of $6,000 per person and that the other 30% would be for more minor modifications to the home that would be considerably less than the maximum.

Specialized medical equipment and supplies – estimates of numbers of individuals requesting this service is based on past requests received by DDDS (some of which were not able to be funded). Most of the requests received have been for specialized wheelchairs and other devices to assist with ambulation. Estimates for the average cost of pieces of equipment were obtained from the Harmon Healthcare website. Estimates for a customized wheelchair and ranged from $2,000 to $15,000.

Assistive Technology – Data from the 2010 US Census Report (Americans with Disabilities) published in 2012 was used to estimate the number of participants who are likely to need Assistive Technology. Cost data for assistive technology items was obtained from the American PrintHouse for the Blind website.

ii. Factor D' Derivation. The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

In order to develop a revised projection of Factor D' values for amendment #1, the non-waiver cost per person from SFY11 – 16 was arrayed longitudinally. Data sources are as follows: for SFYs 11 and 12 queries run against the MMIS claims data. This data was used in lieu of the data for Factor D' that was reported on the 372 report prior to SFY13, as Delaware had accidentally

been reporting the estimates from the approved application as if they were the Factor D' actuals. This has previously been shared with CMS. SFY13-15 data came from the 372 report. Data for FY16 came from a preliminary query of the actual data for the period (it is possible more claims may process with the 365 day timely filing window). The data for the period ranged from a low of $3,922 to a high of $8,756 per person and was highly variable with no clear trend. This made it difficult to use the data to project future cost per person.

We believe that the relatively small number of waiver members (less than 1,000 members for most years) is subject to variability due to the impact of outliers. A straight average for the period would indicate a cost of $5,281, but we do not feel this would be representative of future costs. We have been enrolling more waiver members with complex medical needs who require Private Duty Nursing which is not covered under the waiver and must be accessed via the State Plan. We believe that the cost per person for SFY16 is the beginning of a trend that reflects the use of PDN, so we have used this value as the basis for estimating WYEs 3, 4 and 5. Because there is not enough data to yet establish a true trend, we have assumed a modest growth in the cost per person of 3% for WYE 3 to allow for a ramp up and then have assumed no growth for WYEs 4-5.

The cost data above is only reflective of current waiver members. This amendment will essentially double the waiver enrollment for Delaware. We do not yet have a cost profile for the members to be added as a result of the amendment. Therefore, for new waiver participants living in their family home, DDDS assumes that their utilization of State Plan services will be the same as that of the current waiver participants.

The estimate for Factor D' does not include the cost of claims for prescription drugs for that can be covered by Part D. An edit exists in the MMIS that prevent Medicaid payment for Part D covered drugs for dual eligibles who are enrolled in Part D and for whom Medicaid is paying the Part D premium. The list of Part D covered drugs is updated by DMMA's fiscal agent any time CMS makes a change to the Part D formulary. The entire list is also reviewed annually by the fiscal agent, regardless of whether any changes are made to the Part D formulary during the year. Therefore, only costs for medically necessary, non-Part D covered drugs would be included in Factor D'.

iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Delaware used data for Factor G, as reported on the CMS 372 report for SFYs 13-15, as well as preliminary cost per person data from a query of the MMIS for SFY16, as the basis the estimates for Factor G for WYEs 3-5. Both sets of cost data come from MMIS claims for residents in the state's public ICF/IID institution. An average percentage growth of 3.94% was observed over the 4 year period of the data set. This increase was applied to the SFY16 preliminary cost per person to revise the projections for WYEs 3-5.

iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

In order to develop a revised projection of Factor G' values for amendment #1, the non-waiver cost per person for institutionalized individuals from SFY11 – 16 was arrayed longitudinally. Data sources are as follows: for SFYs 11 and 12 queries run against the MMIS claims data. This data was used in lieu of the data for Factor G' that was reported on the 372 report prior to SFY13, as Delaware had accidentally been reporting the estimates from the approved application as if they were the Factor G' actuals. SFY13-15 data came from the 372 report. Data for FY16 came from a preliminary query of the actual data for the period (it is possible more claims may process with the 365 day timely filing window).
The actual Factor G' values have been relatively consistent over this 6 year period at around $6,000 per person, with the exception of SFY15, which was $11,050 per person.

The relatively small number of residents of the public ICF-IID (currently were 47 residents as of April 2017) make the Factor G' costs susceptible to variability due to the impact of outlier claims. Several extended hospitalizations occurred during SFY15 that accounted for the higher average cost that year. In SFY15 (WYE 1) hospital claims accounted for around 60% of the total Factor G' costs as compared to preliminary data for SFY16, where hospital costs accounted for only 40% of the non-ICF-IID costs. For this reason, the value for SFY15 was removed before an average cost per person was computed. Because the cost per person values used to compute the average did not show a clear trend of increased costs from year to year (some years the costs decreased), the computed average was used to project costs for WYEs 3-5 with no assumed growth in the cost per person for those future years.

The estimate for Factor G' does not include the cost of claims for prescription drugs for that can be covered by Part D. An edit exists in the MMIS that prevent Medicaid payment for Part D covered drugs for dual eligibles who are enrolled in Part D and for whom Medicaid is paying the Part D premium. The list of Part D covered drugs is updated by DMMA's fiscal agent any time CMS makes a change to the Part D formulary. The entire list is also reviewed annually by the fiscal agent, regardless of whether any changes are made to the Part D formulary during the year. Therefore, only costs for medically necessary, non-Part D covered drugs would be included in Factor G'.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services	
Day Habilitation	
Personal Care	
Prevocational Services	
Residential Habilitation	
Respite	
Supported Employment - Individual	
Supported Employment - Small Group	
Assistive Technology for Individuals not otherwise covered by Medicaid	
Clinical Consultation: Behavioral	
Clinical Consultation: Nursing	
Community Transition	
Home or Vehible Accessibility Adaptations	
Specialized Medical Equipment and Supplies not otherwise covered by Medicaid	
Supported Living	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						10561651.60
Day Habilitation - 15 minutes	15 minutes	30	3264.00	7.23	707961.60	
Day Habilitation - per diem	Day	350	220.00	127.97	9853690.00	
Community Participation - 15 minutes	15 minutes	0	0.00	0.01	0.00	
Personal Care Total:						0.00
Personal Care	hour	0	0.00	0.01	0.00	
Prevocational Services Total:						7706340.00
Prevocational Services - 15 minutes	15 minutes	30	1600.00	7.23	347040.00	
Prevocational Services - per diem	Day	400	225.00	81.77	7359300.00	
GRAND TOTAL:						104447777.30
Total Estimated Unduplicated Participants:						1100
Factor D (Divide total by number of participants):						94952.52
Average Length of Stay on the Waiver:						350

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Residential Habilitation Total:						76424372.50
Neighborhood Group Home/Comm Lvg Arrangement	Day	825	350.00	257.91	74471512.50	
Shared Living Arrangement	Day	145	350.00	38.48	1952860.00	
Respite Total:						0.00
Respite	hour	0	0.00	0.01	0.00	
Respite Camp	visit	0	0.00	0.01	0.00	
Respite ICF-IID	per diem	0	0.00	0.01	0.00	
Supported Employment - Individual Total:						4000500.00
Supported Employment - Individual -15 minutes	15 minutes	150	2100.00	12.70	4000500.00	
Supported Employment - Small Group Total:						1314900.00
Supported Employment- Small Group - 15 minutes	15 minutes	90	3000.00	4.87	1314900.00	
Assistive Technology for Individuals not otherwise covered by Medicaid Total:						0.00
AT Assessment /Training	15 minutes	0	0.00	0.01	0.00	
AT equipment or repair	item	0	0.00	0.01	0.00	
Clinical Consultation: Behavioral Total:						1547040.00
Clinical Consultation: Behavioral	15 minutes	550	192.00	14.65	1547040.00	
Clinical Consultation: Nursing Total:						2135874.00
Clinical Consultation: Nursing	15 minutes	985	156.00	13.90	2135874.00	
Community Transition Total:						0.00
Community Transition	per transition	0	0.00	0.01	0.00	
Home or Vehible Accessibility Adaptations Total:						0.00
Home/ Vehicle Modifications	item	0	0.00	0.01	0.00	
Specialized Medical Equipment and Supplies not otherwise covered by Medicaid Total:						0.00
Specialized Medical Equipment and Supplies	item	0	0.00	0.01	0.00	
Supported Living Total:						757099.20
Supported Living	Hour	30	1144.00	22.06	757099.20	
			GRAND TOTAL:			104447777.30
			Total Estimated Unduplicated Participants:			1100
			Factor D (Divide total by number of participants):			94952.52
			Average Length of Stay on the Waiver:			350

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						11122042.00
Day Habilitation - 15 minutes	15 minutes	40	3264.00	7.45	972672.00	
Day Habilitation - per diem	Day	350	220.00	131.81	10149370.00	
Community Participation - 15 minutes	15 minutes	0	0.00	0.01	0.00	
Personal Care Total:						0.00
Personal Care	hour	0	0.00	0.01	0.00	
Prevocational Services Total:						8246095.00
Prevocational Services - 15 minutes	15 minutes	40	1600.00	7.45	476800.00	
Prevocational Services - per diem	Day	410	225.00	84.22	7769295.00	
Residential Habilitation Total:						82111120.00
Neighborhood Group Home/Comm Lvg Arrangement	Day	860	350.00	265.65	79960650.00	
Shared Living Arrangement	Day	155	350.00	39.64	2150470.00	
Respite Total:						0.00
Respite	hour	0	0.00	0.01	0.00	
Respite Camp	visit	0	0.00	0.01	0.00	
Respite ICF-IID	per diem	0	0.00	0.01	0.00	
Supported Employment - Individual Total:						4394880.00
Supported Employment - Individual -15 minutes	15 minutes	160	2100.00	13.08	4394880.00	
Supported Employment - Small Group Total:						1503000.00
Supported Employment- Small Group - 15 minutes	15 minutes	100	3000.00	5.01	1503000.00	
GRAND TOTAL:						112294374.00
Total Estimated Unduplicated Participants:						1150
Factor D (Divide total by number of participants):						97647.00
Average Length of Stay on the Waiver:						350

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assistive Technology for Individuals not otherwise covered by Medicaid Total:						0.00
AT Assessment /Training	15 minutes	0	0.00	0.01	0.00	
AT equipment or repair	item	0	0.00	0.01	0.00	
Clinical Consultation: Behavioral Total:						1621401.60
Clinical Consultation: Behavioral	15 minutes	560	192.00	15.08	1621401.60	
Clinical Consultation: Nursing Total:						2221198.20
Clinical Consultation: Nursing	15 minutes	995	156.00	14.31	2221198.20	
Community Transition Total:						0.00
Community Transition	per transition	0	0.00	0.01	0.00	
Home or Vehible Accessibility Adaptations Total:						0.00
Home/ Vehicle Modifications	item	0	0.00	0.01	0.00	
Specialized Medical Equipment and Supplies not otherwise covered by Medicaid Total:						0.00
Specialized Medical Equipment and Supplies	item	0	0.00	0.01	0.00	
Supported Living Total:						1074637.20
Supported Living	hour	35	1352.00	22.71	1074637.20	
GRAND TOTAL:						112294374.00
Total Estimated Unduplicated Participants:						1150
Factor D (Divide total by number of participants):						97647.00
Average Length of Stay on the Waiver:						350

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						11477504.00
Day Habilitation - 15 minutes	15 minutes	50	3264.00	7.52	1227264.00	
Day Habilitation - per diem					10250240.00	
GRAND TOTAL:						118160604.40
Total Estimated Unduplicated Participants:						1200
Factor D (Divide total by number of participants):						98467.17
Average Length of Stay on the Waiver:						350

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	Day	350	220.00	133.12		
Community Participation - 15 minutes	15 minutes	0	0.00	0.01	0.00	
Personal Care Total:						0.00
Personal Care	hour	0	0.00	0.01	0.00	
Prevocational Services Total:						8639770.00
Prevocational Services - 15 minutes	15 minutes	50	1600.00	7.52	601600.00	
Prevocational Services - per diem	Day	420	225.00	85.06	8038170.00	
Residential Habilitation Total:						86359840.00
Neighborhood Group Home/Comm Lvg Arrangement	Day	895	350.00	268.31	84048107.50	
Shared Living Arrangement	Day	165	350.00	40.03	2311732.50	
Respite Total:						0.00
Respite	hour	0	0.00	0.01	0.00	
Respite Camp	visit	0	0.00	0.01	0.00	
Respite ICF-IID	per diem	0	0.00	0.01	0.00	
Supported Employment - Individual Total:						4715970.00
Supported Employment - Individual -15 minutes	15 minutes	170	2100.00	13.21	4715970.00	
Supported Employment - Small Group Total:						1669800.00
Supported Employment- Small Group - 15 minutes	15 minutes	110	3000.00	5.06	1669800.00	
Assistive Technology for Individuals not otherwise covered by Medicaid Total:						0.00
AT Assessment /Training	15 minutes	0	0.00	0.01	0.00	
AT equipment or repair	item	0	0.00	0.01	0.00	
Clinical Consultation: Behavioral Total:						1667865.60
Clinical Consultation: Behavioral	15 minutes	570	192.00	15.24	1667865.60	
Clinical Consultation: Nursing Total:						2267038.80
Clinical Consultation: Nursing	15 minutes	1005	156.00	14.46	2267038.80	
Community Transition Total:						0.00
Community Transition					0.00	
GRAND TOTAL:						118160604.40
Total Estimated Unduplicated Participants:						1200
Factor D (Divide total by number of participants):						98467.17
Average Length of Stay on the Waiver:						350

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	per transition	0	0.00	0.01		
Home or Vehible Accessibility Adaptations Total:						0.00
Home/ Vehicle Modifications	item	0	0.00	0.01	0.00	
Specialized Medical Equipment and Supplies not otherwise covered by Medicaid Total:						0.00
Specialized Medical Equipment and Supplies	item	0	0.00	0.01	0.00	
Supported Living Total:						1362816.00
Supported Living	Hour	40	1456.00	23.40	1362816.00	
GRAND TOTAL:						118160604.40
Total Estimated Unduplicated Participants:						1200
Factor D (Divide total by number of participants):						98467.17
Average Length of Stay on the Waiver:						350

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						27476132.94
Day Habilitation - 15 minutes	15 minutes	486	1098.00	8.11	4327723.08	
Day Habilitation - per diem	Day	1048	190.00	113.76	22651891.20	
Community Participation - 15 minutes	15 minutes	51	1341.00	7.26	496518.66	
Personal Care Total:						460200.00
Personal Care	hour	60	767.00	10.00	460200.00	
Prevocational Services Total:						10204209.20
Prevocational Services - 15 minutes	15 minutes	152	629.00	7.75	740962.00	
Prevocational Services - per diem	Day	610	187.00	82.96	9463247.20	
Residential Habilitation Total:						107263977.90
					105251737.50	
GRAND TOTAL:						155297687.78
Total Estimated Unduplicated Participants:						2372
Factor D (Divide total by number of participants):						65471.20
Average Length of Stay on the Waiver:						329

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Neighborhood Group Home/Comm Lvg Arrangement	Day	1050	325.00	308.43		
Shared Living Arrangement	Day	145	318.00	43.64	2012240.40	
Respite Total:						2036859.84
Respite	hour	536	168.00	19.58	1763139.84	
Respite Camp	visit	153	1.00	1040.00	159120.00	
Respite ICF-IID	per diem	8	12.00	1193.75	114600.00	
Supported Employment - Individual Total:						3312312.50
Supported Employment - Individual -15 minutes	15 minutes	469	565.00	12.50	3312312.50	
Supported Employment - Small Group Total:						1095517.02
Supported Employment- Small Group - 15 minutes	15 minutes	178	1677.00	3.67	1095517.02	
Assistive Technology for Individuals not otherwise covered by Medicaid Total:						24618.00
AT Assessment /Training	15 minutes	15	15.00	96.08	21618.00	
AT equipment or repair	item	15	1.00	200.00	3000.00	
Clinical Consultation: Behavioral Total:						944973.12
Clinical Consultation: Behavioral	15 minutes	746	84.00	15.08	944973.12	
Clinical Consultation: Nursing Total:						1587637.26
Clinical Consultation: Nursing	15 minutes	902	123.00	14.31	1587637.26	
Community Transition Total:						200000.00
Community Transition	per transition	50	1.00	4000.00	200000.00	
Home or Vehible Accessibility Adaptations Total:						124488.00
Home/ Vehicle Modifications	item	26	1.00	4788.00	124488.00	
Specialized Medical Equipment and Supplies not otherwise covered by Medicaid Total:						68012.00
Specialized Medical Equipment and Supplies	item	28	1.00	2429.00	68012.00	
Supported Living Total:						498750.00
Supported Living	Hour	35	600.00	23.75	498750.00	
GRAND TOTAL:						155297687.78
Total Estimated Unduplicated Participants:						2372
Factor D (Divide total by number of participants):						65471.20
Average Length of Stay on the Waiver:						329

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						30861377.64
Day Habilitation - 15 minutes	15 minutes	529	1098.00	8.19	4757095.98	
Day Habilitation - per diem	Day	1173	190.00	114.90	25607763.00	
Community Participation - 15 minutes	15 minutes	51	1341.00	7.26	496518.66	
Personal Care Total:						575250.00
Personal Care	hour	75	767.00	10.00	575250.00	
Prevocational Services Total:						11235178.79
Prevocational Services - 15 minutes	15 minutes	166	629.00	7.81	815473.34	
Prevocational Services - per diem	Day	665	187.00	83.79	10419705.45	
Residential Habilitation Total:						113558722.90
Neighborhood Group Home/Comm Lvg Arrangement	Day	1100	325.00	311.51	111364825.00	
Shared Living Arrangement	Day	155	318.00	44.51	2193897.90	
Respite Total:						2356671.68
Respite	hour	592	181.00	18.94	2029458.88	
Respite Camp	episode	170	1.00	1040.00	176800.00	
Respite ICF-IID	per diem	10	12.00	1253.44	150412.80	
Supported Employment - Individual Total:						3689286.15
Supported Employment - Individual -15 minutes	15 minutes	517	565.00	12.63	3689286.15	
Supported Employment - Small Group Total:						1213225.65
Supported Employment- Small Group - 15 minutes	15 minutes	195	1677.00	3.71	1213225.65	
Assistive Technology for Individuals not otherwise covered by Medicaid Total:						42432.00
GRAND TOTAL:						167327756.27
Total Estimated Unduplicated Participants:						2506
Factor D (Divide total by number of participants):						66770.85
Average Length of Stay on the Waiver:						328

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
AT Assessment /Training	15 minutes	20	20.00	96.08	38432.00	
AT equipment or repair	item	20	1.00	200.00	4000.00	
Clinical Consultation: Behavioral Total:						1006205.76
Clinical Consultation: Behavioral	15 minutes	786	84.00	15.24	1006205.76	
Clinical Consultation: Nursing Total:						1829117.70
Clinical Consultation: Nursing	15 minutes	937	135.00	14.46	1829117.70	
Community Transition Total:						200000.00
Community Transition	per transition	50	1.00	4000.00	200000.00	
Home or Vehible Accessibility Adaptations Total:						155488.00
Home/ Vehicle Modifications	episode	32	1.00	4859.00	155488.00	
Specialized Medical Equipment and Supplies not otherwise covered by Medicaid Total:						101010.00
Specialized Medical Equipment and Supplies	item	37	1.00	2730.00	101010.00	
Supported Living Total:						503790.00
Supported Living	Hour	35	600.00	23.99	503790.00	
GRAND TOTAL:						167327756.27
Total Estimated Unduplicated Participants:						2506
Factor D (Divide total by number of participants):						66770.85
Average Length of Stay on the Waiver:						328