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

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

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

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

1. Request Information

A. The **State** of **Delaware** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.
B. **Program Title:**
DDDS Lifespan Waiver
C. **Waiver Number:DE.0009**
Original Base Waiver Number: DE.0009.
D. **Amendment Number:DE.0009.R07.01**
E. **Proposed Effective Date:** *(mm/dd/yy)*
07/01/17
Approved Effective Date: 07/01/17
Approved Effective Date of Waiver being Amended: 07/01/14

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:
Delaware proposes to amend the 1915(c) DDDS Waiver to increase the waiver enrollment limits to include people with IDD living at home with their family. Delaware will also add new family support services designed to meet the needs of individuals living with their family to the current menu of services. New services to be added to current waiver are: respite and personal care which includes a self-directed option, home and vehicle modifications, assistive technology and specialized equipment and supplies. All the services Delaware proposes adding to the current waiver are compliant with the CMS HCBS Rule. Delaware renames the "DDDS Waiver" to the "DDDS Lifespan Waiver" to reflect the continuum of waiver enrollment across the lifespan of the recipients.

3. Nature of the Amendment

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

Component of the Approved Waiver	Subsection(s)
☑ Waiver Application	2., 3., 6-I.
☑ Appendix A – Waiver Administration and Operation	3., 5., 6., 7.
☑ Appendix B – Participant Access and Eligibility	B-1-b, B-3-a, c, f, B-
☑ Appendix C – Participant Services	C-1/C-3, C-a-2, C-a-
☑ Appendix D – Participant Centered Service Planning and Delivery	D-1-a, b, c, d, e, f. g,
☑ Appendix E – Participant Direction of Services	All

Component of the Approved Waiver	Subsection(s)
☑ **Appendix F – Participant Rights**	
☑ **Appendix G – Participant Safeguards**	All
☑ **Appendix H**	H-1-a, b
☑ **Appendix I – Financial Accountability**	I-2-a, b, d
☑ **Appendix J – Cost-Neutrality Demonstration**	J-2-a, b, c-i, ii

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

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

Specify:
Delaware proposes the following changes:

Appendix B:
• B-1-b: Description of target group was changed to allow for inclusion of individuals with IDD that are not in immediate need of a waiver residential setting.
• B-3-a: was revised to increase the maximum number of participants
• B-3-c: was revised to add reserved capacity for specified purposes
• B-3-f: was revised to change the criteria to prioritize entry into the waiver using the reserved capacity groups. Delaware desires to prioritize initial entry upon approval of the amendment by CMS to individuals who have left school and receiving a DDDS day service as of the effective date (this population is already known to the state).
• B-4-b: TEFRA group – Delaware added this group; this was an oversight from previous versions
- B-4-b: Delaware has elected to cover the adult expansion population codified at 42 CFR 435.119 under the waiver.
• B-5-b-i: was revised to indicate a different maintenance allowance for individuals who do not receive residential habilitation services

Appendix C:
• C-1/C-3 New services were added:
o Statutory Service: Respite
o Statutory Service: Personal Care
o Statutory Service: Day Habilitation: Community Participation
o Extended State Plan Service: Assistive Technology
o Other Service: Home or Vehicle Modifications
o Other Service: Specialized Medical Equipment
o Other Service: Community Transition
• C-1: Language was added within day habilitation and pre-vocational service descriptions to ensure individuals have maximum opportunities for community integration
• C-1: Residential Habilitation: needs based criteria was added for this service consistent with the criteria previously used to prioritize entry into the waiver, now that individuals living in his/her family home can enroll in the waiver. Language was also added to the provider qualifications for Residential Habilitation Agency indicating that Delaware accepts facility licensure/certification from other states for out of state facilities as meeting the requirement for facility licensure if they are comparable to the Delaware standards. This has been a long-standing DDDS practice but has not previously been expressed in the application.
• Performance Measure C-a-4: was deleted because it measured the same thing as C-a-1
• C-1-b & c: were changed to indicate that case management will be furnished under a TCM State Plan Option for two specified target groups.
- C-2-e: The amendment indicates that relatives and guardians may be caregivers under the self-directed option for Respite and Personal care and outlines necessary safeguards

Appendix D:
• In general, “Plan of Care” has been replaced with “Person Centered Plan” throughout the document.

• Appendix D: DDDS no longer uses the Essential Lifestyle plan as its person centered planning tool. The new planning tools are described.
• D-1 and D-2: Language was added to describe differences between the way the person centered planning process and monitoring of the plan is conducted for waiver participants living in a waiver residential setting and those who live in his/her family home
• Quality Improvement a-i-e-ii and b-i: these sections were revised to provide a better description of DDDS's processes for discovery and remediation regarding waiver services.

Appendix E:
Delaware has added a self-direction option for the new waiver services for Respite and Personal Care for individuals who live in a non-provider managed setting. Delaware will use the Agency with Choice model to manage the self-directed option.

Appendix G:
• Appendix G was revised to reflect changes to the DHSS policy on reporting of abuse and neglect and the DDDS policy on reportable incidents.
• G-3: was revised based on changes to the Delaware curriculum regarding assistance with administration of medication and clarifying differences in training requirements and monitoring of Shared Living providers from Residential Habilitation agency providers.
• Performance Measure G-a-1: was changed from counting the number of participants with incidents of abuse, etc. to counting the number of incidents of abuse, etc. We believe that this will result in a more reliable measure of participant health and safety trends over time.

Appendix H:
This section was generally revised to highlight the role of the DDDS Performance Analysis Committee and the new reporting tool called "DivStat" that is used to monitor waiver performance measures.

Appendix I: Rate Determination Methods
• I-2-a: Rate methodologies have been added for the new waiver services from Appendix C
• I-2-d: Additional detail regarding billing validation methods was provided and the AWC broker is referenced

Appendix J:
• J-2-a, b: Unduplicated count of participants per year, average length of stay and derivations of Factors D were updated to incorporate assumptions related to the new waiver participants
• J-2-d: Counts of participants and utilization data have been added for the new waiver services added in Appendix C.
• J-2-d: Counts for participants and units have been increased for all DDDS day services offered under the current waiver, as the amended waiver will include individuals with IDD that have left school and will live at home but need one or more day or other waiver service to prevent institutionalization
- Counts of new waiver participants and units assume an annual utilization, although it is likely that enrollment will be phased in over the first few months.

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

1. Request Information (1 of 3)

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

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

C. Type of Request: amendment

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

○ **3 years** ◉ **5 years**

Original Base Waiver Number: DE.0009
Waiver Number:DE.0009.R07.01
Draft ID: DE.008.07.03

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

Regular Waiver

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

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**

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

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☐ **Nursing Facility**

Select applicable level of care

○ **Nursing Facility as defined in 42 CFR □□440.40 and 42 CFR □□440.155**

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

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

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

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

1. Request Information (3 of 3)

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

Select one:

◉ **Not applicable**

○ **Applicable**

Check the applicable authority or authorities:

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

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

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

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

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

☐ **§1915(b)(2) (central broker)**

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

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

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

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

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

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

☐ **A program authorized under §1115 of the Act.**

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.
Check if applicable:
☑ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.
The Division of Developmental Disabilities Services (DDDS) Home and Community Based Services Lifespan Waiver provides services and supports as an alternative to institutional placement for individuals with intellectual developmental disabilities (IDD) (including brain injury), autism spectrum disorder or Prader-Willi Syndrome.

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

The objectives of the DDDS Lifespan Waiver are to:

1. Promote independence for individuals enrolled in the waiver and promote the engagement of family and other natural supports whenever possible;

2. Offer an alternative to institutionalization through the provision of an array of services and supports that promote community integration and independence;

3. Protect the health and safety of the participants receiving services under the waiver.

4. Ensure the highest standards of quality and best practices, through a network of qualified providers.

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

3. Components of the Waiver Request

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

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

◉ **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
○ **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. Participant Rights. Appendix F specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Improvement Strategy. Appendix H contains the Quality Improvement Strategy for this waiver.

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

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

4. Waiver(s) Requested

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

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

○ **Not Applicable**

◉ **No**

○ **Yes**

C. Statewideness. Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

◉ **No**

○ **Yes**

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

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

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.
Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Improvement. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.

I. Public Input. Describe how the State secures public input into the development of the waiver:
Between Aug - Dec 2013, the DDDS Director held 12 information gathering forums with family groups to gather information for the design of a "family support" HCBS waiver.

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

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

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

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

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

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

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

$2,700 limit for Respite/Personal Care – the public indicated that this amount was too low. DDDS explained this limit was derived based on available state funding and that it is significantly more than DDDS is able to allow currently using only state funds.

Waiver financial limit 250% FBR- a commenter recommended raising the limit to 300% FBR. Response indicated that the state's

financial constraints do not allow for an expansion it at this time.

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

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

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

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

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

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

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

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

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

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

7. Contact Person(s)

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

Last Name: Williams

First Name: Glyne

Title: Chief of Policy, Planning and Quality

Agency: Division of Medicaid and Medical Assistance

Address: 1901 N Dupont Hwy

Address 2: Lewis Bldg

City:

New Castle

State: **Delaware**

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

Last Name: Nonnenmacher

First Name: Marie

Title: DDDS Deputy Director

Agency: Division of Developmental Disabilities Services

Address: 2540 Wrangle Hill Road, Suite 200

Address 2:

City: Bear

State: **Delaware**

Zip: 19701

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8. Authorizing Signature

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

Signature:

Kimberly Xavier

State Medicaid Director or Designee

Submission Date: May 18, 2017

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

Last Name: Williams

First Name: Glyne

Title: Chief of Policy, Planning and Quality

Agency: Division of Medicaid and Medical Assistance

Address: 1901 N. Dupont Hwy

Address 2: Lewis Building

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Attachments

Attachment #1: Transition Plan

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

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

Specify the transition plan for the waiver:

Attachment #2: Home and Community-Based Settings Waiver Transition Plan
Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.
Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.
To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.
Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.
Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

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

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

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

FEBRUARY 2016 NOTE TO REVIEWER
On November 30, 2015, CMS submitted comments (via email) on the Delaware Statewide Transition Plan (the Plan). Delaware's Department of Health and Social Services (DHSS) is updating the Plan to respond to those comments and to reflect the current status of implementation activities as of February 2016. We direct you to the following sections of the Plan that contain updated information:
1. New sections "February 2016 Update to DDDS Waiver Assessment and Remediation Plan" for new information since publication of the Plan in September 2015;
2. Attachment 5 for CMS comments on the Plan and DHSS' responses;
3. Attachment 6 for updated state systemic assessments by provider setting type;
4. Attachment 7 for DDDS provider and member surveys; and
6. Attachment 9 for comments from March 2016 public comment period DDDS/DMMA responses.
We have also updated the Plan timelines on pages 20 and 47 to note, when appropriate, revised tasks, new tasks, new dates, and completion status. All new information is highlighted in bold text.
The Plan is an evolving process. In some instances our assessment activities and approaches have deviated from our original plan. In other instances we have added more detail regarding processes. We refer you to this new and updated information for the current status of our approaches, activities, and timeframes.

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

The intent of the rule, also referred to as the "Community Rule," is to ensure that people receiving federally funded HCBS have opportunities to access community services in the most-integrated settings possible. This includes opportunities to seek employment and work in competitive settings, engage in community life, control personal resources, and participate in the community to the same extent as people who do not receive HCBS. DHSS understands how important these services are to Medicaid enrollees and will work collaboratively with individuals, their loved ones, and other stakeholders to ensure continuity of services, minimal disruption, and support during implementation.

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

PURPOSE
The purpose of the Plan is to describe the process the State of Delaware will use to:
• Assess current State and provider policies, standards and practices against the Community Rule;
• Assess waiver services and settings against the Community Rule;
• Develop strategies to remediate situations that are determined not to be in compliance; and
• Demonstrate Delaware's full compliance with the Community Rule by March 17, 2019.
The specific elements addressed in the Plan include the following:
1. A description of the process to assess current policies, standards, practices, etc. against the Community Rule requirements for both the State and providers.
2. A description of the process that will be used to assess waiver services and settings against the Community Rule requirements, including timeframes for completion of various tasks.
3. A description of the process that was used to solicit public comment in the development of the draft Plan, including a 30 day comment period.
4. A summary of public comment received.
5. A description of how the public comment was used in the development of the Plan.
6. Time frames for producing a summary of how each setting meets or does not meet the federal Home and Community-Based (HCB) settings requirements.
7. Time frames for bringing State and provider policies, standards, practices, etc. into compliance.
8. Time frames for bringing all HCB settings into compliance.
9. A plan for ensuring the health and safety of participants who reside or are served in locations that need to meet corrective action requirements for the setting to come into compliance during the State's specified transition time.
The intent of the Plan is to: 1) ensure that participants receive Medicaid HCBS in settings that are integrated in and support full access to the greater community, 2) ensure the health and welfare of participants and 3) maintain the ability to receive federal funding for critical community based supports and services.
The Plan can be viewed online at: http://dhss.delaware.gov/dhss/dmma/hcbs_trans_plan.html.

OVERVIEW OF HCBS IN DELAWARE
Delaware provides multiple HCBS for Medicaid recipients through four federally approved programs: 1) Division of Developmental Disabilities Services (DDDS) 1915(c) waiver, 2) Diamond State Health Plan (DSHP), 3) Pathways to Employment (Pathways) program and 4) Promoting Optimal Mental Health for Individuals through Supports and Empowerment (PROMISE) program. PROMISE and Pathways are administered by DMMA's sister agencies within DHSS. PROMISE is administered by Delaware's Division of Substance Abuse and Mental Health (DSAMH) under Delaware's 1115 demonstration. Pathways is administered jointly by DDDS and the Division of Services for Aging and Adults with Physical Disabilities (DSAAPD) under concurrent 1915(b)(4) and 1915(i) authorities.
The DDDS waiver, operated by DDDS under a Memorandum of Agreement with DMMA provides HCBS as an alternative to institutional placement for individuals 12 and over with intellectual developmental disabilities (IDD), including brain injury, autism spectrum disorder and Prader Willi Syndrome. As of September 2014, 980 individuals are enrolled in the DDDS waiver.
The DSHP demonstration was initially approved in 1995, and implemented on January 1, 1996. The demonstration mandatorily enrolls Medicaid recipients into managed care organizations (MCOs). In addition to acute care services such as physician and nursing services, the demonstration also provides HCBS to eligible individuals (who would otherwise receive care in a nursing facility) through a mandated managed care delivery system called DSHP-Plus. As of December 2014, 176,454 individuals are enrolled in DSHP and 11,640 are enrolled in DSHP- Plus.

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

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

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

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

Prevocational Services: Prevocational Services provide learning and work experiences, including volunteer work and/or internships, where the individual can develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated community settings. Services are expected to produce specific outcomes to be achieved, as determined by the individual and his/her services and supports planning team through an ongoing person-centered planning process evaluated annually. Prevocational Services may be furnished in fixed site locations or in community based settings.
Individuals receiving Prevocational Services must have employment-related goals in their person-centered services and supports plan; the general habilitation activities must be designed to support such employment goals. Competitive, integrated employment in the community for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities is considered to be the optimal outcome of Prevocational Services.

Residential Habilitation: Residential Habilitation Services can include assistance with acquisition, retention, or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-institutional community based setting. The scope of these services is based on the individual's need and can be around-the-clock or blocks of hours. Residential Habilitation Services may be provided in a neighborhood group home setting, a supervised or staffed apartment (community living arrangement), or a shared living arrangement (formerly titled adult foster care).
The following activities may be performed under all Residential Habilitation:
• Self-advocacy training that may include training to assist in expressing personal preferences, self-representation, and individual rights and to make increasingly responsible choices.
• Independent living training may include personal care, household services, child and infant care (for parents themselves who are developmentally disabled), and communication skills such as using the telephone.
• Cognitive services may include training involving money management and personal finances, planning and decision making.
• Implementation and follow-up counseling, behavioral or other therapeutic interventions by residential staff, under the direction of a professional, that are aimed at increasing the overall effective functioning of an individual.
• Emergency Preparedness.
• Community access services inclusions that explore community services available to all people, natural supports available to the individual, and develop methods to access additional services/supports/activities desired by the individual.
• Supervision services may include a person safeguarding an individual with developmental disabilities and/or utilizing technology for the same purpose.

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

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

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

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

Supported Living: Supported living is support that is very individualized and is provided in a residence that is owned or leased by the waiver member. The amount and type of supports provided are dependent upon what the individual needs to live successfully in the community and must be described in their Plan of Care (ELP) but cannot exceed 40 hours per week for each member. Daily hours of support may vary based on the needs of the individual. Supported living encourages maximum physical integration into the community and is designed to assist the individual in reaching his or her life goals in a community setting.
The types of supports provided in these settings are tailored supports that provide assistance with acquisition, retention, or improvement in skills related to:
• Activities of daily living, such as personal grooming and cleanliness, domestic chores, or meal preparation, including planning, shopping, cooking, and storage activities;
• Social and adaptive skills necessary for participating in community life, such as building and maintaining interpersonal relationships, including a Circle of Support;
• Locating and scheduling appropriate medical services;
• Instrumental activities of daily living such as learning how to maintain a bank account, conducting banking transactions, managing personal finances in general;
• Learning how to use mass transportation;
• Learning how to select a housemate;
• How to acquire and care for a pet; and
• Learning how to shop.
The individual may want to learn a new skill or may have some proficiency in certain parts of a skill but want to learn how to complete the entire task independently. Supported living must be provided based on the individualized needs of each waiver member and at naturally occurring times for the activity, such as banking and those related to personal care. Supported living is provided on a one-on-one basis. If services are provided with two or more individuals present, the amount of time billed must be prorated based on the number of consumers receiving the service. Payments for Supported Living do not include room and board.

APPROACH TO DEVELOPING THE STATEWIDE TRANSITION PLAN
In 2014, DMMA initiated a process to re-procure MCOs for the DSHP program. The purpose of this re-procurement was to improve program oversight and administration as well as the quality of services offered to MCO members. This process began in 2013 with the drafting of a new MCO contract. In January 2014, DMMA published the request for proposal and new contracts were implemented January 1, 2015. DMMA conducted an extensive readiness review with the MCOs, which included both desk reviews of policies and procedures and onsite reviews with key MCO staff. Thus, 2014 was a resource-intense period for DMMA and the MCOs as well as a period of significant transition. As a result, DMMA is at the early stages in its assessment activities related to the Plan.
DDDS has taken a lead role, with support by and coordination with DMMA, focusing on preliminary assessment of the DDDS waiver for compliance with the Community Rule. The results of this preliminary assessment are outlined below in the Plan.
It is important to note that the Plan identifies at a high level the activities and requirements that will be implemented for the DDDS waiver and the DSHP demonstration. For additional insight or intent regarding the Plan and the State's intent, we refer you to the responses to comments received on the Plan at the end of this document.

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

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

Additional stakeholder feedback will come from the governing structure for the Plan. For the DDDS portion of the Plan, the Advisory Council to the Division of Developmental Disabilities Services (Advisory Council to DDDS) will serve as the steering committee for feedback in implementing the Plan. Various workgroups will be established by the Advisory Council to DDDS to implement specific tasks. It is our intent that the composition of the work groups will be representative of family members who represent the varying support needs of people within the DDDS service system and other key stakeholders. Similar to DDDS, DMMA will draw upon the experience and expertise of a stakeholder group, the Governor's Commission on Community Based Alternatives for Individuals with Disabilities (Governor's Commission on CBAID), as the key stakeholder advisory entity during the assessment processes for DSHP.
Although the description below regarding assessment and remediation activities is organized according to program area (DDDS waiver and DSHP demonstration), Delaware is committed to providing a comprehensive, coordinated approach to determining compliance with the Community Rule. This means that where appropriate, processes for the programs, activities and timeframes for the programs will be comparable.

Multiple agencies are involved in administering the State's Medicaid program. As such, a cross-agency team will monitor DMMA's assessment and remediation activities. The team will consist of representatives from DMMA, DDDS, DSAAPD, DSAMH and the Division of Long Term Care Residents Protection (DLTCRP). Other agencies will be included in the process as appropriate and as warranted by specific

tasks. The team will meet at a minimum, monthly, but will meet more frequently if necessary depending on the task at hand. Regularly scheduled meetings will enable the team to touch base on key issues, to ensure that tasks remain on track and to develop and implement any necessary course modifications. Updates will be provided to key leadership, including the DHSS Secretary. DDDS will report to DMMA, on a regular frequency, regarding the status of implementing the DDDS waiver portion of the Plan.

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

STATEWIDE TRANSITION PLAN TIMELINE
Note to reviewer: Updates to the activity dates noted in the chart below can be found in the February 2016 updates to DSHP and DDDS assessment and remediation activities found later in the document.
The following is a high level timeline noting all phases of the Plan. Details regarding the activities in each phase and associated timeframes are described later in the Plan.
Activity Estimated Start Date Estimated End Date
Preparing and Submitting the Plan for CMS Approval
1st Stakeholder meeting for DDDS waiver transition plan. January 21, 2015 N/A
Incorporate stakeholder feedback into DDDS waiver transition plan. January 21, 2015 February 5, 2015
2nd Stakeholder meeting for DDDS waiver transition plan. January 28, 2015 N/A
Post the Plan for public comment. February 6, 2015 March 9, 2015
Publish the Plan in newspaper and on DMMA website. February 6, 2015 N/A
1st Public Hearing for the Plan (New Castle County). February 23, 2015 N/A
2nd Public Hearing for the Plan (Kent County). February 27, 2015 N/A
Review, incorporate and respond to public comments on the Plan. March 9, 2015 March 13, 2015
Modify the Plan and post on DMMA website (including summary of public comments and state response). On or before March 17, 2015 N/A
Submit the Plan to CMS for approval. On or before March 17, 2015 N/A
Implementing the Plan
Phase 1: Development of survey instruments and process to assess compliance with Community Rule. DDDS: February 2015 DDDS: July 2015
DSHP: April 2015 DSHP: July 2015
Phase 2: Implementation of survey instruments and processes developed in Phase 1 to assess compliance with Community Rule. DDDS: August 2015 DDDS: December 2015
DSHP: August 2015 DSHP: January 2016
Phase 3: Use assessment results and other data sources to create inventory of services and settings vis-à-vis compliance with Community Rule. DDDS: January 2016 DDDS: February 2016
DSHP: February 2016 DSHP: March 2016
Phase 4: Develop and approve remediation strategies to bring non-compliant services, settings, policies, etc. into compliance with Community Rule. DDDS: February 2016 DDDS: July 2016
DSHP: April 2016 DSHP: August 2016
Phase 5: Implement remediation strategies. DDDS: August 2016 DDDS: March 17, 2019
DSHP: September 2016 DSHP: March 17, 2019
Phase 6: Monitor ongoing compliance. DDDS: August 2016 DDDS: March 17, 2019
DSHP: September 2016 DSHP: March 17, 2019

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

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

DDDS Waiver Assessment and Remediation Plan
Phase 1: Development of survey instruments and processes to assess compliance with the Community Rule
Start Date: February 2015
End Date: July 2015

DDDS will work with the Advisory Council to DDDS and any work groups convened by the Advisory Council to DDDS to develop survey instruments and protocols to assess the extent to which the following either: comply with, are contradictory to or are silent on the requirements under the Community Rule:
• State laws, regulations, policies, etc. and provider policies; and
• HCBS and HCB settings.

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

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

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

Phase 2: Implementation of survey instruments and processes developed in Phase 1 to assess compliance with the Community Rule
Start Date: August 2015
End Date: December 2015

Assessment of State Laws, Regulations, Policies, etc.
The sub-work group of the Advisory Council to DDDS will work with staff of DDDS to administer the survey tool against State laws, regulations, policies, etc. to determine compliance with the Community Rule. A final report will be issued with the findings of the group. The report will indicate for each requirement under the Community Rule whether the State:
• Has sufficient written guidance and processes in place to ensure compliance.
• Has some written guidance and processes in place that must be augmented in order to ensure compliance.
• Has no written guidance or processes in place to ensure compliance.

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

The review process will include the following State, Department and Division documents and related practices, at a minimum:
• Delaware Code
o Title 16, Chapter 11, Subchapter II. Rights of Patients
o Title 16, Chapter 55, Subchapter I. Declaration of General and Special Rights of Persons Diagnosed with Intellectual Disabilities and Other Specific Developmental Disabilities
o Title 25, Part III Landlord/Tenant Code
• Delaware Administrative Code
o Title 16, DHSS, Section 3000 DLTCRP, 3310 Neighborhood Homes for Persons with Developmental Disabilities (interpretive guidelines)
o Title 16, Section 3320 Intensive Behavioral Support and Educational Residence (IBSER)
• Department Policies
o PM 24 – Safeguarding client funds
o PM 25 Voter Registration – Federally Funded Programs
o PM 31 Site Selection for People with Disabilities
o PM 36 Standardized Requirements During the Development Phase of Community Based Residential Homes for the DHSS/Division
o PM 40 w/ Addendum A: Criminal Background Check
o PM 46 Policy Memorandum concerning Patient Abuse/Injury/Self Harm, etc.
o PM 62 Housing/Rent Calculations
• DMAP DDDS Provider Manual (on DMAP website)
• DDDS Waiver Provider Certification Application
• DDDS Waiver Service Provider Qualifications DDDS Waiver Application July 1, 2014 renewal approved by CMS
• DDDS Provider Contracts:
o Day and Residential Appendix A
o Residential Appendix A-1
o Shared living contract Appendix A and related documents
o Other contract documents
• DDDS standards
o DDDS Waiver Certification Standards Manual (on DDDS website)
• DDDS manuals
o A Guide to the Division of Developmental Disabilities Services In Delaware by the Arc of Delaware May 2010
o Case Manager Desk Manual
o ELP Manual and Forms (under revision)

o Nurse Consultant Manual
o Behavioral Consultant Manual (under revision)
• DDDS policies
o Community Services
o "Administrative" Policies (apply across all services)
• DDDS monitoring tools
o Case Manager monthly contact (in ECR)
o Office of Quality Improvement (OQI) Survey tool (used in the CSR and also in agency reviews)
• Staff performance plans
o Senior Social Worker/Case Manager (DDDS Case Managers)
o Social Worker/Case Manager Supervisor
• Provider lease agreements
• DDDS Provider Lease Approval form
• DDDS Curriculum for Direct Support Professional from the College of Direct Support

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

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

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

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

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

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

Based on the results of the survey, an authorized representative of each provider will attest in writing whether they believe that their organization settings are either fully compliant with the Community Rule or that remediation is necessary. Providers that indicate that remediation is necessary will be required to submit a Corrective Action Plan to the State within 30 days of submission of the provider-self assessment. The Corrective Action Plan must be approved by the State before it can be implemented.
Under the oversight of the Advisory Council to DDDS, the DDDS Office of Quality Improvement (OQI) will conduct "look-behind" reviews of a sample of the provider self-assessment survey results to validate the provider self-assessments. Look-behind reviews will include onsite visits. The Advisory Council to DDDS will assist in developing the methodology for the look-behind reviews, including sample composition and the process for onsite visits. The DDDS and DMMA will ensure that all review processes are conflict free and will develop dispute resolution processes for the findings.

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

Provider settings/services that will be reviewed for compliance as part of this process include:
• Neighborhood group homes;
• Community living arrangements (staffed apartments);
• Shared living arrangements;
• Day habilitation facilities and non-facility-based programs;
• Prevocational facilities and non-facility based programs; and
• Supported Employment providers.

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

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

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

Phase 3: Use assessment results and other data sources to finalize inventory of services and settings vis-à-vis compliance with the Community Rule
Start Date: January 2016
End Date: February 2016

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

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

All Other Settings
DDDS staff will use the results of the following data sources to populate the inventory with the initial compliance status as outlined above:
• Provider self-assessments; and
• Look-behind reviews conducted by the Advisory Council to DDDS sub-work group.
An appeal process will be developed for providers to dispute the State's findings of non-compliance.

Phase 4: Develop remediation strategies to bring non-compliant services, settings policies, etc. into compliance with the Community Rule
Start Date: February 2016
End Date: July 2016

Based on the inventory of Delaware HCBS residential and non-residential settings, remediation will need to be developed for any services or settings that are determined to not meet the federal HCBS requirements. Providers for which remediation is necessary will be required to submit a Corrective Action Plan to the State within 30 days of submission of the provider self-assessment.
To the extent that remediation strategies have financial implications for the providers and for the State, budget strategies may need to be developed by the State.
Phase 5: Implement remediation strategies
Start Date: August 2016
End Date: March 17, 2019

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

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

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

Phase 6: Monitor ongoing compliance
Start Date: August 2016
End Date: Ongoing

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

July 2015 Update to DDDS Waiver Assessment and Remediation Plan

State Self-Assessment Results
The results of the DDDS review of applicable state laws, regulations and policies are included as a new Attachment 3 to the Plan. The attachment is presented as a matrix that provides an overview of the extent to which current state laws, regulations and policies are compliant with the Community Rule final requirements, using the CMS exploratory questions as guidelines for the compliance review. Specifically, the matrix notes:
• The specific state document reviewed to determine compliance;
• Identified gaps, if any; and
• Recommended steps for remediation, including development of new policy.

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

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

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

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

Other
DDDS has continued to engage stakeholders in meaningful discussions regarding implementation of the Plan, issues of concern and impact on service delivery. The following represents some of the stakeholder engagement activities that have occurred since March 2015:
• Presentation at meetings of stakeholder groups;
• Presentation at National Association of Councils on Developmental Disabilities 2015 Annual Conference; and
• Presentation to the DDDS Case Management Conference June 21, 2015.

February 2016 Update to DDDS Waiver Assessment and Remediation Plan

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

The DDDS Director issued a final report of findings to the Advisory Council to DDDS at one of its regular monthly meetings. A revised version of the report will include an updated version of the matrix, included in Attachment 6, that more clearly indicates for each requirement under the HCBS Rule whether the State written laws and rules are:
• Compliant
• Not compliant and require either removal or revision to be become compliant
• Silent

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

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

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

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

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

Assessment of Provider Settings and Policies
DDDS worked with the Advisory Council to DDDS to develop survey instruments and protocols to assess the extent to which providers either comply or do not comply with the requirements under the HCBS Rule.
Provider settings/services that are being reviewed for compliance as part of this process include:
• Neighborhood group homes
• Community living arrangements (staffed apartments)
• Shared living arrangements
• Day habilitation facilities and non-facility-based programs
• Prevocational facilities and non-facility based programs
• Supported employment providers
• Supported living providers
• Provider settings regulated by the IBSER regulations

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

Providers were informed that they must be prepared to provide documentation of how they meet the HCBS Rule requirement for any requirements they indicate they are meeting for each setting. They were informed that the following types of items would constitute acceptable forms of documentation that they are complying with each requirement: citations or excerpts from written documents they maintain, training curricula, or staff performance plans.

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

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

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

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

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

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

DDDS will issue a Report of Findings to each provider based on the desk review of the provider's survey results. This Report will include a preliminary finding that the setting is either compliant or is non-compliant but could become compliant with modification or cannot become compliant. Providers that are determined to be non-compliant must submit either a CAP or must indicate that they cannot come into compliance in which case a plan to transition waiver members to a compliant provider will be developed.
The CAP must be submitted to the State within 60 days of receiving the Report of Findings. The State must approve the provider's proposed remediation strategies. While, in general, the State does not expect providers to take remedial action until the Plan is approved by the State, providers may choose to initiate remediation strategies prior to receiving approval of their CAP. If they do this, however, they run the risk that the proposed remediation strategy may not be accepted by the State. It is anticipated, however, that there may be settings and services where only "minor" remediation may be necessary.

As part of DDDS's review of provider self-assessments, it will look for areas of non compliance that appear to be common across all providers, since this suggests that a more comprehensive remediation strategy may need to be pursued across all providers.

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

Look-behind reviews will include onsite visits to inspect the setting itself and to view written materials or other documentation that support the provider's self-assessment of their status compliance with each requirement they are responsible for meeting under the Rule. DDDS will present a draft process outline to the Advisory Council to DDDS for conducting the look-behind reviews at its meeting in February. The outline will include how the settings will be selected for inclusion in the sample, who will conduct the onsite review, how will the results of the review be recorded, and how will the results be communicated to the provider.
Any assessment results that indicate approved deviations from the requirements under the HCBS Final Rule for specific waiver members must be supported by the individual needs of the waiver member and articulated in the person-centered plan. For the purpose of this review, a Behavior Support Plan developed per DDDS policy is considered to be part of the person-centered plan. Where deviation is recommended, the following standard must be met:
• Identification of a specific condition or individualized need that is directly proportionate to the deviation being recommended;
• Documentation of positive interventions and supports tried prior to the recommended deviation from the requirements, including less intrusive methods of meeting the need that were tried and did not work;
• Ongoing periodic review to measure the effectiveness of the deviation from standard practice;
• Establishment of a timeframe within which the deviation should be discontinued if it is no longer needed or effective;
• An assurance that the interventions and supports will cause no harm to the individual; and
• Informed consent of the individual or legal representative (see 42 CFR §441.301(c)(2)(xiii)(G)).

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

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

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

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

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

DDDS intends to assign the same member of the DDDS Office of Quality Improvement to conduct the look-behind reviews for all sites operated by the same provider selected for review. Because providers would be expected to have common policies and procedures, this is likely to result in a streamlined review process across the settings with a consistent approach to the review.
The protocols for selecting the sample and for conducting the reviews were presented to the Advisory Council for DDDS at its February 2016 meeting.

Remediation
In addition to the Report of Findings that will be issued after the desk audits are completed, DDDS will issue a separate Report of Findings to each provider for which an onsite look-behind review was conducted. This Report will include a preliminary finding that the setting is either compliant, is non-compliant but could become compliant with modification or cannot become compliant. Providers with non-compliant settings must submit a CAP within 60 days of receiving the Report indicating that they are not compliant. The CAP must provide sufficient details regarding the following key elements:
• The specific non-compliant issue(s).
• Corrective actions to be taken to ameliorate the non-compliant issue.
• Dates by which the actions will be taken and the person responsible for each action.
• The strategy that will be employed to monitor progress toward coming into compliance.
• Strategy for continuous monitoring to ensure continued compliance.

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

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

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

The State will ensure that throughout the remediation phase, measures will be put in place to continuously monitor participant health and

welfare and the quality of care. State staff and stakeholders will be engaged in this activity.
A single remediation strategy may be recommended to address multiple areas of non compliance if appropriate. The CAP must be approved by the State.

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

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

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

Providers will have an opportunity to appeal any findings, observations, or other areas of noncompliance with HCBS Final Rule. Provider requests must be submitted in writing on company letter head to the assigned DDDS Quality Improvement Facilitator within 15 days of receiving the Report of Findings and note the following:
• The specific level or area of non-compliance in question
• Rationale why the provider believes the finding is inaccurate
• Evidence to justify the appeal request

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

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

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

Homes on the Grounds of a Public Institution
Several years ago, before the HCBS Final Rule was promulgated, DDDS made a policy decision to get out of the business of providing direct residential services in competition with private providers. DDDS determined that its role should be as an oversight agency. Over the past several years, DDDS has reduced the census in state-operated homes and day habilitation settings by a combination of closing new referrals, natural attrition, and planned moves. Consumers have already been assisted by the DDDS case manager in selecting other providers/locations through a thoughtful, deliberate process. No one was rushed, and in all cases the needs and preferences of the waiver members and their families were solicited and honored. Many of the new residential sites they selected were closer to their guardians, families, and friends. The families were very pleased with these moves. DDDS described this process of natural attrition in Appendix D, sections 1 and 2 of its most recent waiver renewal that was effective July 1, 2014.
As of January 2015, two women remain in a waiver group home on the grounds of the Stockley Center, the State's only public ICF-IID facility. It is DDDS' intention to close this waiver residence. For this reason, the State does not intend to request heightened scrutiny. The women have intensive medical needs that require a specialized residence. A home is in the process of being built for these participants using the Universal design architecture (i.e. wider doorways, bigger bedrooms to accommodate medical equipment, etc.). The members have agreed to this setting. The new setting is under development on new property location that is compliant with HCB settings requirements (i.e. the property is not isolating in nature and allows for community integration). We are expecting a move-in date before the end of 2016. The new setting will be licensed by DLTCRP prior to being occupied and the provider chosen by the two waiver members will be surveyed prior to relocating the members to ensure compliance with all applicable HCB settings requirements.

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

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

When transition to a new setting is required, DDDS will use the process described in Appendix D of its approved HCBS waiver application to assist waiver members in selecting waiver services and settings that will meet their needs. DDDS case managers will assist consumers in selecting other providers/locations through a thoughtful, deliberate process. Consideration will be given to elements of the home that may be important to the waiver member, such as proximity to guardians, families, friends, and community resources, availability of public transportation, and type of residence. Consideration will be given to support features that are necessary to ensure that the waiver member's needs will be met. As with any provider network, providers tend to develop specialty areas. Waiver members will be guided toward selecting providers who can best meet their needs, whatever they may be.
As noted in response to public comments in the September 17, 2015 update to the Plan, DHSS has no plans to remove any of the current services from the system. We are committed to supporting the needs and preferences of individuals within the requirements of the HCBS final regulations.

Ongoing Monitoring
Monitoring of compliance with the HCBS Final Rule will occur long before the March 17, 2019, federal implementation date. The DDDS Office of Quality Improvement will be tasked with monitoring progress on CAPs and will also begin routine monitoring of compliance with the requirements of the HCBS Final Rule, effective July 1, 2016, using the new survey tool it has created. DDDS anticipates developing several strategies to monitor DDDS waiver provider settings for compliance with the HCBS Final Rule.
One important strategy will be to incorporate some of the HCBS Final Rule requirements in current licensing processes. Neighborhood group homes for people with intellectual disabilities, intensive behavior support and educational residence, and rest care homes in which residential habilitation is provided are the only three waiver settings that are required to be licensed by the Division of Long Term Care Residents Protection (DLTCRP). DLTCRP performs annual inspections of all licensed sites and enforces environmental home standards. These standards largely involve attributes of the physical plan in which the service is delivered, as opposed to addressing the experience of the individuals who are receiving the services. In addition to licensure regulations, which only cover some of the waiver service categories, DDDS has been working on a revised set of standards for waiver providers that incorporate the requirements from the HCBS Final Rule and also incorporate measures for member satisfaction. The new standards will be implemented on July 1, 2018. The DDDS standards will be a companion to the DLTCRP licensure requirements that are codified in regulation. DDDS and DLTCRP are in the process of developing a memorandum of understanding (MOU) that will clearly define the roles of each Division in monitoring these two types of waiver residences.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Comments on Statewide Transition Plan
The Plan was made available for review during three public comment periods – the first, from February 6, 2015 through March 9, 2015, the second, from July 27, 2015 through August 29, 2015, and the third, from February 1, 2016 to March 22, 2016. The purpose of the second public comment period was to receive feedback on updates to the Plan since the initial March 2015 publication. The purpose of the third public comment period was to receive feedback on updates to the Plan since the September 2015 publication.
During the first public comment period, comments were received from organizations and individual stakeholders including providers, parents, family members and friends of HCBS participants in Delaware. Nearly one hundred and thirty (130) comments were received from individuals. The following organizations submitted comments on the Plan:
• Disability Law Program at the Delaware Community Legal Aid Society, Inc. (DECLASI)
• Delaware Association of Rehabilitation Facilities (DelARF)
• Governor's Advisory Council for Exceptional Citizens (GACEC)
• Chimes Delaware
• State Council for Persons with Disabilities (SCPD)
• Delaware Developmental Disabilities Council
• National Association of Councils on Developmental Disabilities (NACDD)
• Easter Seals
• University of Delaware

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

During the August, 2015 public comment period, DHSS again received comments from organizations and individuals. We received nineteen (19) individual comments. The following organizations submitted comments on the Plan:
• Delaware Association of Rehabilitation Facilities (DelARF)
• Chimes Delaware
• State Council for Persons with Disabilities (SCPD)
• Delaware Developmental Disabilities Council
• Families Speaking Up
• CERTS, Inc.
• Centers for Disabilities Studies

The charts in Attachments 1 and 2 provide a summary of the comments received and State responses, where applicable, to issues identified in both public comment periods. The charts also note the changes that were made to the Plan in response to feedback.
During the February, 2016 public comment period, DHSS again received comments from organizations and individuals. We received 34 individual comments. The following organizations submitted comments on the Plan:
• Chimes Delaware
• State Council for Persons with Disabilities (SCPD)
• Delaware Developmental Disabilities Council
• Families Speaking Up
• CERTS, Inc.
• Centers for Disabilities Studies
• Community Legal Aid Society, Inc. Disabilities Law Program
• Elwyn Delaware
• Kent-Sussex Industries (KSI)
• Easter Seals Delaware & Maryland's Eastern Shore
• Endless Possibilities in the Community (EPIC)
• Arc of Delaware
• Governor's Advisory Council for Exceptional Citizens (GACEC)
• National Health Law Program
• Autism Delaware

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

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

Site Specific Assessment Activities and Results

Introduction:
The Delaware Statewide Transition Plan for Compliance with Home and Community-Based Setting Rule (the Plan) was last updated and submitted to the Centers for Medicare & Medicaid (CMS) March 30, 2016. The Plan received initial CMS approval July 14, 2016. From this point forward, the Plan will be amended to provide updates and the current status of DHSS transition plan activities. This is the first amendment, which also addresses CMS comments received July 14, 2016. Amendment 1 is a supplement to and builds on the Plan and demonstrates the evolution of DHSS activities to demonstrate compliance with all applicable federal requirements. The Plan is a living document that will continue to be updated as activities are completed and issues are identified.
Provider Self-Assessments, Participant Survey and Desk Review
As described in the Plan (pages 33-37), DDDS mandated the completion of comprehensive site-specific provider self-assessments of all HCB settings where participants receive HCBS under the DDDS HCBS waiver. The initial phase of this process consisted of the provider-self assessments and desk reviews conducted by DDDS staff of various documents providing a status report and onsite reviews. The provider self-assessment tool was mandatory for all providers of HCBS under the DDDS waiver and all settings. In addition to addressing all federal HCB setting requirements, the provider self-assessment required providers to indicate if the setting was on or immediately adjacent to an institution. Additional details regarding the provider self-assessment can be found in the Plan (pages 33-35).

The following table shows the complete results of the site-specific provider self-assessment for all DDDS HCBS provider settings.
Setting Type Compliant Compliant w/
Modification Removed from Program Heightened
Scrutiny
Day Habilitation 6 28 1 0
Prevocational Service 5 3 0 0
Residential Habilitation* 0 429 1 0
Supported Employment 8 1 0 0
Total Settings (482) 19 461 2 0

*Neighborhood Group Home, Community Living Arrangement, Shared Living

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

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

The participant survey was launched on February 20, 2016 and was distributed to DDDS case managers and participant guardians to help encourage participant engagement with the survey. A separate survey instrument was created for recipients of residential and day services, so some members received both surveys. To protect the confidentially of participants, DDDS collects minimal identifying information in order to connect a member to a specific setting; participants are not publicly identified or shared with providers. DDDS conducted three regional trainings for case managers between February 2 and February 4, 2016 on how to assist the member to complete the survey, how to avoid influencing participant responses and submission procedures for completed surveys. Case managers and guardians have begun supporting participants in completing the survey on paper, and then mailing the survey to DDDS. Because the waiver members and their families had recently completed the NCI survey and to avoid "over surveying" the waiver population, DDDS decided that, for members who did not have a guardian, the survey would be completed during their next annual person-centered plan review date. This means that the surveys will not be conducted for all waiver members until February 2017.
To the extent that it was available during the time the desk audits and onsite reviews were being completed, the participant survey data was used as an additional input in the validation process. At the time of this amendment, DDDS has distributed 2,074 participant surveys and received 813 completed submissions, yielding a current response rate of 39% for the participant survey. DDDS is in the process of collecting at a minimum, at least one participant survey for each HCB setting and will keep the survey open until February 20, 2017. Assuming DDDS will receive a final participant response rate similar to DMMA (85%), DDDS hopes to receive, on average, three participant surveys for each setting.

DDDS conducted desk reviews of all provider settings, between November 2015 and January 2016, as an additional validation measure. The purpose of the desk review was threefold: to ensure that each survey question was answered, to ensure that additional comments were provided where required and to validate the responses, to the extent possible, with information DDDS already had on hand. DDDS used other available data sources such as: past provider evaluations, annual Quality Service Reviews (QSR), current/past incident reports and case manager notes to validate the results of all provider self-assessments. Following submission of the March 30, 2016 iteration of the Plan, CMS requested clarification on the difference between "setting presumed not to be compliant" and "settings likely to be compliant". The language CMS questioned appeared in the original March 2015 Delaware submission of the Plan. In subsequent revisions, new "update" sections were added to the Plan to indicate both changes to the original submission and to update progress toward meeting plan milestones, but the original language was largely unchanged. In the interim, when the data became available from the provider self-assessments, it was organized into the categories enumerated on page 4 of the CMS June 2016 feedback to Delaware, instead of the categories listed in the original submission of the Plan (page 16).

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

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

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

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

The DDDS Office of Quality Improvement (OQI) was responsible for performing validation activities under the oversight of the DDDS Advisory Council which approved the methodology for selecting the sample and the procedures for conducting the reviews at its monthly meeting of February 18, 2016. As noted in the Plan (pages 36-37), DDDS selected a 20% sample of HCBS settings to receive an onsite review. By design, the 20% sample included at least one service and setting per provider agency. Shared Living settings were not included in the onsite all agencies that were noted for non-compliance due to the residency agreement. The pool for the 20% sample included all settings that were issued a CAP during the desk review process. Within the construct indicated above, specific setting locations were selected for review if they were already scheduled for a QSR during the onsite review period. Lastly, specific providers and settings were selected for the review if the provider self-assessment responses indicated non-compliance in three or more responses across the four domains of the survey or if the participant survey indicated differences from the provider responses in multiple areas. In total, 76 settings were selected for an onsite review, which represented all 40 in-state provider agencies. No out of state provider agencies were selected for the onsite review. As indicated in the Plan (pages 40), DDDS will accept the survey results for compliance with the HCBS final rule of the state in which these agencies are physically located.
The onsite review team used a standardized tool developed for the onsite reviews primarily based on the Council on Quality and Leadership (CQL) toolkit and customized for each type of waiver service. The tool included specific evaluation questions related to participant choice of a non-disability setting, setting location relevant to other institutional settings, findings from previous QSRs, the provider self-assessment, participant surveys, incident reports and interviews with staff/participants at the setting. The standardized tool included review areas that were exclusively focused on evaluating the isolation of individuals from the broader community. DDDS also required provider settings to submit policies, procedures and staff orientation materials in advance of the review and were included as part of the onsite review process.

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

Onsite Review Findings and Remedial Actions
At the conclusion of the site-specific assessment process, DDDS was able to display the results for the provider settings in four categories:
• Category 1: Setting is compliant with federal HCB settings requirements.
• Category 2: Setting will be compliant with modifications.
• Category 3: Setting cannot meet federal HCB setting requirements and will be removed from the program.
• Category 4: Delaware will submit the setting for CMS heightened scrutiny review.

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

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

Setting Type	Compliant	Compliant w/ Modification	Removed from Program	Heightened Scrutiny
Day Habilitation	3	4	0	0
Prevocational Service	4	0	0	0
Residential Habilitation*	48	15	0	0
Supported Employment	1	1	0	0
Total Settings (76)	56	20	0	0

*Neighborhood Group Home, Community Living Arrangement, Shared Living

Following the completion of the onsite reviews, DDDS issued a "Notice of Findings" to each provider setting noting areas of non-compliance with federal HCB settings requirements. Provider settings were also given the opportunity to dispute any of the non-compliance findings and submit a request for reconsideration within 10 days from the date of the notice (see the Plan for details regarding the provider dispute resolution process page 39). No provider settings appealed the results of the onsite review.
Provider settings that were deemed "compliant" following the site-specific assessment process were notified by the DDDS of their compliance and required no remedial action. These provider settings will be subject to ongoing monitoring activities moving forward by DDDS, including annual QSRs.

Provider settings that were deemed "non-compliant with modification", were issued a "Notice of Findings" and were required to submit a CAP describing in detail the remediation activities (for each non-compliant finding) that will be implemented to ensure compliance and the associated timeframe to complete the activities. Provider settings were required to submit their CAP to DDDS within 60 days of receipt of the notice for each non-compliant finding. CAPs for all settings were submitted within the required timeframe and will be closely monitored by DDDS. To sufficiently address the CAP, providers are required to submit evidence to DDDS for each non-compliant finding noted in the "Report of Findings". The evidence required by the provider varies based on the type of non-compliant finding. For example, a provider noted for not having locks on bedroom doors are required to submit a work order and other evidence to demonstrate compliance. Providers noted for not offering participant choice pertaining to their daily schedule, are required to submit revised policies and procedures and describe steps the

provider will take to enable participants more autonomy with their daily schedules. DDDS will validate all evidence submitted for each non-compliant finding through future QSR reviews and annual site evaluations and will provide technical assistance as appropriate. DDDS has also developed a quality manual that details standards by service type to assist providers with implementing the federal HCB setting requirements in their CAP. DDDS requires that all provider settings are in compliance with federal HCB settings requirements by March 17, 2019.

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

Setting Type Compliant Compliant w/
Modification Removed from Program Heightened
Scrutiny
Day Habilitation 5 29 1 0
Prevocational Service 6 2 0 0
Residential Habilitation* 0 429 1 0
Supported Employment 9 0 0 0
Total Settings 482 20 460 2 0
*Neighborhood Group Home, Community Living Arrangement, Shared Living

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

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

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

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

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

Case managers will ensure that all services are in place in advance of the member's relocation and will monitor the transition to ensure successful placement and continuity of services. Case managers will conduct an onsite review of the member's new setting prior to the member's relocation and will touch base with members within the first 30 calendar days following transition, 90 calendar days after transition and ongoing as part of regularly scheduled visits to monitor the success of the transition.
Case managers will update the person-centered service plan as appropriate at all stages of the relocation process to note any identified issues and follow-up activities required with the member or the member's providers.

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

during the standing HCBS oversight quarterly meeting. This will be a standing agenda item.

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

Appendix A: Waiver Administration and Operation

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

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

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

○ **The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

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

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

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

Specify the division/unit name:

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

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

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

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

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

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

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

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

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

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

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

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

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

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

   ◉ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
   Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*
   The following functions are performed by contracted entities:

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

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

Fiscal Agent - DMMA contracts for claims processing and provider payment

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

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

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

Appendix A: Waiver Administration and Operation

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

◉ **Not applicable**

○ **Applicable -** Local/regional non-state agencies perform waiver operational and administrative functions.
Check each that applies:

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

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

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

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

Appendix A: Waiver Administration and Operation

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

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

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:
For the Provider Relations and Fiscal Agent Contracts, DMMA convenes an MMIS Status Group composed of the Chief Administrators, fiscal staff, IT staff and other DMMA managers to review the performance of the contracted fiscal agent, including the provider relations function. This team meets once a month to assess performance measures under the fiscal agent contract and to discuss changes that need to be made to the MMIS or to the fiscal agent procedures. Performance measures include but are not limited to: timely enrollment of new providers, maintenance of provider enrollment criteria and timely response to provider inquires. Operational policies and procedures are in place to ensure all provider activities are reviewed and approved by DMMA.

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

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

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. **Methods for Discovery: Administrative Authority**

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

i. **Performance Measures**

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

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

Where possible, include numerator/denominator.

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
Annual enrollment limits from approved waiver application as compared to the # of unique Medicaid IDs queried from the Title XIX Ad Hoc Universe database with a DDDS waiver aid category.

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

Data Aggregation and Analysis:

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

Performance Measure:
A-4: Number and Percent of Fair Hearing Reports reviewed by the Medicaid agency (Numerator: Number and Percent of Fair Hearing Reports reviewed by the Medicaid agency, Denominator: Number and Percent of Fair Hearing Reports

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

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☑ **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):*

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

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

Data Source (Select one):
Meeting minutes
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
DMMA instituted a quality improvement strategy that includes routine review of DDDS's administration of the DDDS HCBS waiver program each quarter, using the quarterly face to face meetings to identify program strengths and opportunities for improvement. Some of the DDDS processes reviewed by DMMA at the quarterly meetings include feedback from DDDS quarterly meetings that are open to all waiver providers and DDDS monthly meetings with Day Service and employment providers, DDDS complaint and incident logs and fair hearing reports. In addition, DDDS has renewed its participation in the National Core Indicators project as an additional source of data about the satisfaction of waiver participants. The NCI surveys started to be conducted in 2014. After review of the reported information DMMA requests a corrective action plan when applicable. DMMA follows up in 60 days when corrective action plans are required to assure changes for improvement took place.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
After review of the reported information, Division of Medicare and Medicaid Assistance (DMMA) may request a corrective action plan. A corrective action plan is to be sent to DMMA within 30 days of notification of problems identified. DMMA follows up with the agency within 60 days to assure corrective measures are implemented to avoid future incidents from re-occurring.

The Division of Medicare and Medicaid Assistance (DMMA) has a Memorandum of Understanding with the Division of Developmental Disabilities Services (DDDS) delegating administrative duties. DMMA receives quarterly reports from the DDDS in advance of a quarterly meeting with administrative and quality assurance staff of DDDS. Findings in the report are discussed and trends noted. DMMA may request additional information and corrective action based on a review of data reported and discussed. Meeting minutes record discussions and follow-up/remediation required of DDDS by DMMA.

Performance measure related to waiver policy review: A review of waiver policies by DMMA prior to implementation ensures appropriate application of waiver principles that are consistent with the waiver application and other established Medicaid principles.

In addition, the DMMA will, through ongoing review of plans of care, utilization review/quality review processes provided by DDDS, and data obtained through the MMIS monitor to ensure compliance with all assurances and sub-assurances. If the DMMA discovers a policy/procedure was implemented by DDDS without DMMA's approval, DMMA immediately notifies DDDS in writing such policy or policy modification is not effective pending the review and approval of DMMA. The DMMA performs an expedited review of the applicable policy or policy modification, and provides a written response regarding the disposition of the policy or policy modification. If revisions to the policy are needed, DMMA advises DDDS regarding needed revisions, with subsequent review and approval required by DMMA prior to implementation of the policy or policy modification. If approved, the effective date of such policy or policy modification is no earlier than the date of approval by DMMA.

Issues which require individual remediation may come to DMMA's attention through quarterly review of DDDS Quality

Management Reports, as well as through day-to-day activities of the DDDS, e.g., review/approval of provider agreements, utilization review and Quality Review processes, complaints from DDDS Waiver recipients related to waiver participation/operation by phone or letter, etc. Remediation activities are reported to DMMA by the DDDS as follow-up to these activities, and aggregated in the DDDS Quality Management Reports.

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ Aggregated or Disabled, or Both - General					
	☐	Aged			☐
	☐	Disabled (Physical)			
	☐	Disabled (Other)			
☐ Aged or Disabled, or Both - Specific Recognized Subgroups					
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
☑ Intellectual Disability or Developmental Disability, or Both					

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	☑	Autism	12		☑
	☐	Developmental Disability			☐
	☑	Intellectual Disability	12		☑
☐ Mental Illness					
	☐	Mental Illness			
	☐	Serious Emotional Disturbance			

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

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

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

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

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

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

◉ **Not applicable. There is no maximum age limit**

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

○ **A level higher than 100% of the institutional average.**

Specify the percentage:

○ **Other**

Specify:

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

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

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

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

○ **The following dollar amount:**

Specify dollar amount:

The dollar amount *(select one)*

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

Specify the formula:

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

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

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

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

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	1100
Year 2	1150
Year 3	1200
Year 4	2372
Year 5	2506

b. **Limitation on the Number of Participants Served at Any Point in Time.** Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

◉ **The State does not limit the number of participants that it serves at any point in time during a waiver year.**

○ **The State limits the number of participants that it serves at any point in time during a waiver year.**

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

Table: B-3-b

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

Appendix B: Participant Access and Eligibility

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

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

○ **Not applicable. The state does not reserve capacity.**

◉ **The State reserves capacity for the following purpose(s).**

Purpose(s) the State reserves capacity for:

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

Appendix B: Participant Access and Eligibility

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

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

Aged out of Pathways to Employment 1915(i)

Purpose *(describe)*:

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

Describe how the amount of reserved capacity was determined:

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

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

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

Appendix B: Participant Access and Eligibility

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

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

School graduates

Purpose *(describe)*:

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

Describe how the amount of reserved capacity was determined:

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

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

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

Appendix B: Participant Access and Eligibility

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

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

Individuals returning to the community after a period of institutionalization

Purpose *(describe):*

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

Describe how the amount of reserved capacity was determined:

The number of reserved slots was based on historical data.

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

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

Appendix B: Participant Access and Eligibility

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

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

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

Purpose *(describe):*

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

Describe how the amount of reserved capacity was determined:

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

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

Waiver Year	Capacity Reserved

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

Appendix B: Participant Access and Eligibility

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

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

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

e. Allocation of Waiver Capacity.

Select one:

- ◉ **Waiver capacity is allocated/managed on a statewide basis.**
- ○ **Waiver capacity is allocated to local/regional non-state entities.**

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a *(select one)*:
   - ◉ **§1634 State**
   - ○ **SSI Criteria State**
   - ○ **209(b) State**
2. **Miller Trust State.**

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

○ **No**
◉ **Yes**

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

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

☐ **Low income families with children as provided in §1931 of the Act**
☑ **SSI recipients**
☐ **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
☑ **Optional State supplement recipients**
☐ **Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

○ **100% of the Federal poverty level (FPL)**
○ **% of FPL, which is lower than 100% of FPL.**

Specify percentage: [ ]

☐ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
☑ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
☑ **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
☐ **Medically needy in 209(b) States (42 CFR §435.330)**
☐ **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
☑ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

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

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

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

Select one and complete Appendix B-5.

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

Check each that applies:

☑ **A special income level equal to:**

Select one:

○ **300% of the SSI Federal Benefit Rate (FBR)**

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

Specify percentage: 250

○ **A dollar amount which is lower than 300%.**

Specify dollar amount:

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

☐ **Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**

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

☐ **Aged and disabled individuals who have income at:**

Select one:

○ **100% of FPL**

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

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

☑ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State uses *spousal* post-eligibility rules under §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.

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

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

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

Select one:

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

(*select one*):

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

Specify the percentage:

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

Specify dollar amount:

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

Specify percentage:

◉ **Other standard included under the State Plan**

Specify:

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

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

○ **The following dollar amount**

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

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

Specify:

○ **Other**

Specify:

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

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

  Specify:

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

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

    Specify dollar amount: [ ] If this amount changes, this item will be revised.
  - ( ) **The amount is determined using the following formula:**

    Specify:

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

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

  Specify dollar amount: [ ] The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
- ( ) **The amount is determined using the following formula:**

  Specify:
- ( ) **Other**

  Specify:

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

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

Select one:

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

◉ **The State does not establish reasonable limits.**

○ **The State establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

i. Allowance for the personal needs of the waiver participant

(*select one*):

○ **SSI standard**

○ **Optional State supplement standard**

○ **Medically needy income standard**

○ **The special income level for institutionalized persons**

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

Specify percentage:

○ **The following dollar amount:**

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

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

Specify formula:

◉ **Other**

Specify:

For waiver enrollees that do not receive a residential habilitation service, the state will provide a maintenance needs allowance that is equal to the individual's total income as determined under the post eligibility process, which includes

income that is placed in a Miller Trust. For those waiver participants that meet the criteria to receive residential habilitation services, the state will provide a maintenance needs allowance set at the Adult Foster Care Rate, which is the SSI standard plus the Optional State Supplement amount.

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

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

Select one:

◉ **Allowance is the same**
○ **Allowance is different.**

Explanation of difference:

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

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

Select one:

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

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

- (●) **The provision of waiver services at least monthly**
- ( ) **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

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

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

- (●) **Directly by the Medicaid agency**
- ( ) **By the operating agency specified in Appendix A**
- ( ) **By an entity under contract with the Medicaid agency.**

Specify the entity:

- ( ) **Other**

Specify:

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

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

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

Level of Care Criteria ICF/IID:

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

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

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

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

(●) **The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**

( ) **A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

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

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

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

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

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

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

( ) **Every three months**

( ) **Every six months**

(●) **Every twelve months**

( ) **Other schedule**
Specify the other schedule:

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

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

○ **The qualifications are different.**
Specify the qualifications:

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

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

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

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

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

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. **Sub-Assurances:**

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

Performance Measures

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

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

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

Data Source (Select one):

Operating agency performance monitoring
If 'Other' is selected, specify:
The Division's Office of Health Information Management maintains the completed Level of Care assessments.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ 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 levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

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

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

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

Performance Measures

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

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

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

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

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

Data Aggregation and Analysis:

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

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

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

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

Data Aggregation and Analysis:

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

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

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

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

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
In addition to the internal reviews of 100% of the Level of Care assessment forms, DMMA also reviews a sample of the forms in preparation for the quarterly meetings with DDDS at which any issues with the assessments can be discussed.

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The DDDS Performance Analysis Committee (PAC) meets monthly to review DivStat data. At those meetings, measures that fall short of the standard are reviewed and corrective action is discussed. Quality Improvement Plans (QIP) are developed as necessary. Progress against QIPs is monitored at the monthly meetings. Performance data is routinely shared with parts of the organization that are responsible for the operational area captured by the measure (for instance, the case managers, fiscal staff, etc.) and assignments are made for implementing corrective actions necessary to improve performance. The PAC then tracks the performance data to see if the corrective action is having the desired effect, as indicated by improved data results.

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

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

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):
DDDS ensures all DDDS applicants with limited proficiency in English have full access to DDDS services in his primary language, if needed. DDDS uses a vendor on the DHSS contract for the purchase of interpretative (oral and written) services. The vendor provides language services on a twenty-four hour, seven day a week basis for multiple languages. They are equipped to provide language experts in all areas of DDDS service need.

For those persons who are deaf or hard of hearing or who are visually impaired, the DDDS, through existing DDDS and local agencies and

resources provide full access to DDDS services.

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

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

Appendix C: Participant Services

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

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

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Day Habilitation

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1: 04 Day Services

Sub-Category 1: 04020 day habilitation

Category 2: 04 Day Services

Sub-Category 2: 04070 community integration

Category 3:

Sub-Category 3:

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

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

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

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

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

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

Day Habilitation - Community Participation

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

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

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

The provider must actively promote and be capable of providing opportunities for full access to participate in the greater community for those waiver participants that express a desire for such access and for whom it would not be contrary to their health and safety needs as articulated in their person centered plan. The provider must demonstrate that they support individuals

to exercise their option to achieve their desired level of participation in the community. To the greatest extent possible, individuals should be exposed to a broad array of community experiences so that they can make informed choices about what they like and what they don't like.

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Day Habilitation

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Day Habilitation

Provider Category:
Agency
Provider Type:
Day Habilitation
Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Must adhere to all standards, policies, and guidelines in the State of Delaware DDDS Day Habilitation Standards, including:

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

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

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

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Developmental Disabilities Services

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Personal Care

Alternate Service Title (if any):

Personal Care

HCBS Taxonomy:

Category		Sub-Category	
Category 1:	08 Home-Based Services	**Sub-Category 1:**	08030 personal care
Category 2:	08 Home-Based Services	**Sub-Category 2:**	08020 home health aide
Category 3:	08 Home-Based Services	**Sub-Category 3:**	08010 home-based habilitation
Category 4:		**Sub-Category 4:**	

Service Definition *(Scope)*:

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

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

Personal care can include assistance, support and/or training in activities such as meal preparation; laundry; routine household care and maintenance; activities of daily living such as bathing, eating, dressing, personal hygiene; shopping and money management; reminding/observing/monitoring of medications; supervision; socialization and relationship building;

transportation; leisure choice and participation in regular community activities; attendance at medical appointments.

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

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

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

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

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

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

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

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

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

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Care

Provider Category:
Agency

Provider Type:
Home Health Agency

Provider Qualifications

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

Certificate *(specify)*:

Other Standard *(specify)*:
Must be enrolled with Delaware Medicaid as a Home Health Agency under the State Plan.

Verification of Provider Qualifications

Entity Responsible for Verification:
DMMA's contracted provider relations agency

Frequency of Verification:
Annually

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Care

Provider Category:
Agency

Provider Type:
Agency with Choice

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

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

Verification of Provider Qualifications

Entity Responsible for Verification:
Delaware Division of Developmental Disabilities Services

Frequency of Verification:
Annually

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Care

Provider Category:
Agency

Provider Type:
Personal Attendant Services Agency (PASA)

Provider Qualifications

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

Certificate *(specify)*:

Other Standard *(specify)*:

Verification of Provider Qualifications

Entity Responsible for Verification:

DMMA's contracted provider relations agent

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Prevocational Services

Alternate Service Title (if any):

HCBS Taxonomy:

Category	Sub-Category
Category 1: 04 Day Services	**Sub-Category 1:** 04010 prevocational services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Prevocational Services

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Prevocational Services

Provider Category:
Agency
Provider Type:
Prevocational Services
Provider Qualifications

License *(specify)*:

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

Other Standard *(specify)*:
Must be credentialled by the Division of Developmental Disabilities as a qualified provider of Prevocational Services.

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

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

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

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:
Division of Developmental Disabilities Services

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Statutory Service

Service:
Residential Habilitation

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02011 group living, residential habilitation
Category 2:	**Sub-Category 2:**

02 Round-the-Clock Services	02021 shared living, residential habilitation
Category 3:	**Sub-Category 3:**
16 Community Transition Services	16010 community transition services
Category 4:	**Sub-Category 4:**

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

Residential services can include assistance with acquisition, retention, or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-institutional community-based setting. These services are individually planned and coordinated through the individual's Person Centered Plan (PCP)The scope of these services are based on the individual's need and can be around-the-clock or blocks of hours.

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

Payments for shared living arrangement services are not made for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement. The methodology by which the costs of room and board are excluded from payments for Shared Living is described in Appendix I.

The following activities may be performed under all Residential Habilitation:

- Self-advocacy training that may include training to assist in expressing personal preferences, self-representation, and individual rights and to make increasingly responsible choices.

- Independent living training may include personal care, household services, child and infant care (for parents themselves who are developmentally disabled), and communication skills such as using the telephone.

- Cognitive services may include training involving money management and personal finances, planning and decision making.

- Implementation and follow-up from mental health counseling or behavioral or other therapeutic interventions by residential staff, under the direction of a professional, that are aimed at increasing the overall effective functioning of an individual.

- Emergency Preparedness

- Community access services that explore community services available to all people, natural supports available to the individual, and develop methods to access additional services/supports/activities desired by the individual.

Supervision services may include a person safeguarding an individual with developmental disabilities and/or utilizing technology for the same purpose.

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

Services provided under a shared living arrangement include personal care and supportive services (e.g., homemaker, chore, attendant care, companion, medication oversight (to the extent permitted under State law)) provided in a DDDS-certified private home by a principal care provider who lives in the home. A Shared Living arrangement is furnished to adults who receive these services in conjunction with residing in the home. The Division, although committed to one-person Shared Living homes, does allow for exceptions to the one-person rule. This exception automatically includes married couples who choose to live in a Shared Living arrangement. An individual (or their team on behalf of the individual) may request an exception to increase the maximum number up to 3. The exception request will be scrutinized to ensure it is consumer-driven and in the best interest of the individual already residing in the home. Exceptions to allow for up to 3 adult siblings who want to remain together or where 2 individuals are very close and want to live together are examples of exception requests that are very likely to be approved.

Separate payment is not made for homemaker or chore services furnished to a participant receiving shared living arrangement services, since these services are integral to and inherent in the provision of shared living arrangement services.

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

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

The need for residential services must be demonstrated in the individual's care plan and must describe the exploration of other services in more integrated settings and the determination that they would not meet the individual's needs. The amount, frequency and duration, and of these services are specified by the individual's care plan. There are no specified limits.

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:
Agency

Provider Type:
Residential Habilitation Agency

Provider Qualifications

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

Certificate *(specify)*:

Other Standard *(specify)*:
Must be credentialled by the Division of Developmental Disabilities as a qualified provider of Residential Habilitation.

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

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

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

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:

Individual

Provider Type:

Shared Living Provider

Provider Qualifications

License *(specify)*:

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

Certificate *(specify)*:

Other Standard *(specify)*:

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Developmental Disabilities Services

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

Respite

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
09 Caregiver Support	09012 respite, in-home
Category 2:	**Sub-Category 2:**
08 Home-Based Services	08020 home health aide
Category 3:	**Sub-Category 3:**
09 Caregiver Support	09011 respite, out-of-home
Category 4:	**Sub-Category 4:**
09 Caregiver Support	09011 respite, out-of-home

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

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

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

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

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

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

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

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

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The total payment for Respite and Personal Care services, combined, is limited to $2,700 per waiver participant per waiver demonstration year. Respite cannot be provided to waiver participants who receive residential habilitation in a provider-managed setting. If a waiver participant enrolled for less than an entire demonstration year, the annual limit will be prorated by the number of months remaining in the demonstration year.

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

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

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

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

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
Agency with Choice
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Must have a Medicaid administrative contract with the state to perform the function of an Agency with Choice Broker for individuals receiving respite or personal care. The broker will be responsible for ensuring that all self-directed caregivers meet applicable qualifications prior to the delivery of service. The broker must comply with all applicable state and federal requirements including the U.S. Fair Labor Standards Act.
Verification of Provider Qualifications
Entity Responsible for Verification:
Delaware Developmental Disabilities Services
Frequency of Verification:
Annually

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Shared Living Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Delaware Division of Developmental Disabilities Services

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Public ICF/IID

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

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

Other Standard *(specify):*

Must be owned or operated by a government entity

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Long Term Care Residents Protection

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Personal Attendant Services Agency (PASA)

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DMMA's contracted Provider Relations Agent

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

DMMA's contracted Provider Relations Agent

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

DDDS Residential Habilitation Agency

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Delaware Division of Developmental Disabilities Services

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

Supported Employment - Individual

HCBS Taxonomy:

Category	Sub-Category
Category 1: 03 Supported Employment	**Sub-Category 1:** 03021 ongoing supported employment, individual
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope)*:

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

Supported individual employment may also include support to establish or maintain self-employment, including home-based self-employment. Supported employment services are individualized and may include any combination of the following services: vocational/job-related discovery or assessment, person-centered employment planning, job placement, job development negotiation with prospective employers, job analysis, job carving, training and systematic instruction, job coaching, on the job employment supports, social skills training, benefits support, training and planning, transportation, asset development and career advancement services, implementation of assistive technology, and other workforce support services including

services not specifically related to job skill training that enable the waiver participant to be successful in integrating into the job setting. Personal care services may be provided as a component under this service and included in the rate paid to providers, but personal care/assistance may not compromise the entirety of the service.

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

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Supported Employment

Appendix C: Participant Services

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

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

Provider Category:
Agency

Provider Type:
Supported Employment

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Must be credentialled by the Delaware Division of Developmental Disabilities Services as a qualified provider of Supported Employment.

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

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

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

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Developmental Disabilities Services

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Habilitation

Alternate Service Title (if any):

Supported Employment - Small Group

HCBS Taxonomy:

Category		Sub-Category	
Category 1:	03 Supported Employment	**Sub-Category 1:**	03022 ongoing supported employment, group
Category 2:		**Sub-Category 2:**	
Category 3:		**Sub-Category 3:**	
Category 4:		**Sub-Category 4:**	

Service Definition *(Scope)*:

Supported Employment Small Group Employment Support are services and training activities provided in regular business, industry, and community settings for groups of two (2) to eight (8) workers with disabilities. Examples include mobile crews and other employment work groups. Small group employment support must be provided in a manner that promotes integration into the workplace and interaction between participants and people without disabilities in those workplaces. Individuals must be compensated at or above the minimum wage and the outcome of this service must be sustained paid employment and work experience leading to further career development and individual integrated community based employment for which an individual is compensated, at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Supported employment small group

employment supports may be a combination of the following services: vocation/job related discovery or assessment, person center employment planning, job placement, job development, social skills training, negotiation with prospective employers, job analysis, training and systematic instruction, job coaching, benefits supports, training and planning, transportation and career advancements services.

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

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

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

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Supported Employment

Appendix C: Participant Services

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

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

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

Certificate *(specify)*:

Other Standard *(specify)*:
Must be credentialled by the Division of Developmental Disabilities as a qualified provider of Supported Employment.

Must adhere to all standards, policies, and guidelines in the State of Delaware Day Program Contract including:

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

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

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

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:
Division of Developmental Disabilities Services

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Extended State Plan Service

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

HCBS Taxonomy:

Category	Sub-Category
Category 1: 14 Equipment, Technology, and Modifications	**Sub-Category 1:** 14031 equipment and technology
Category 2: 14 Equipment, Technology, and Modifications	**Sub-Category 2:** 14031 equipment and technology
Category 3:	**Sub-Category 3:**

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

Service Definition *(Scope)*:
Assistive technology means an item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of participants. Assistive technology service means a service that directly assists a participant in the selection, acquisition, or use of an assistive technology device. Assistive technology includes--
(A) the evaluation of the assistive technology needs of a participant, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the participant;
(B) services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for participants;
(C) services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;
(D) coordination and use of necessary therapies, interventions, or services with assistive technology devices, such as therapies, interventions, or services associated with other services in the service plan;
(E) training or technical assistance for the participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant; and
(F) training or technical assistance for professionals or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of participants.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Assistive Technology not otherwise covered by Medicaid. EPSDT for individuals under age 21 and other State Plan services, such as the Home Health benefit must be accessed before this waiver benefit can be accessed. To the extent that any listed services are covered under the state plan, the services under the waiver would be limited to additional services not otherwise covered under the state plan, but consistent with waiver objectives of avoiding institutionalization.

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

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

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

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

Provider Category:
Agency

Provider Type:
Assistive Technology Professional Agency
Provider Qualifications
License *(specify):*
Occupational Therapists, Physical Therapists or Speech Pathologists licensed by the Delaware Division of Professional Regulation under Title 24 of the Delaware Administrative Code, sections 2000, 2600 and 3700, respectively.
Certificate *(specify):*
Assistive Technology Professionals must be certified by ATP RESNA Rehabilitation Engineering and Assistive Technology Society of North America.
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
DMMA's contracted Provider Relations Agent
Frequency of Verification:
Annually

Appendix C: Participant Services

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

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

Provider Category:
Individual
Provider Type:
Assistive Technology Professional
Provider Qualifications
License *(specify):*
Occupational Therapists, Physical Therapists or Speech Pathologists licensed by the Delaware Division of Professional Regulation under Title 24 of the Delaware Administrative Code, sections 2000, 2600 and 3700, respectively.
Certificate *(specify):*
Assistive Technology Professionals must be certified by ATP RESNA Rehabilitation Engineering and Assistive Technology Society of North America.
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
DMMA's contracted Provider Relations Agent
Frequency of Verification:
Annually

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:
Assistive Technology Supplier
Provider Qualifications
License *(specify):*

State Business License

Certificate *(specify)*:

Other Standard *(specify)*:

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

Assistive Technology Suppliers

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Clinical Consultation: Behavioral

HCBS Taxonomy:

Category	Sub-Category
Category 1: 10 Other Mental Health and Behavioral Services	**Sub-Category 1:** 10040 behavior support
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope)*:

Behavioral Consultation:

Behavioral Consultation is provided under the Positive Behavior Support model. Behavioral Consultation results in individually designed behavior plans and strategies for waiver participants who have significant behavioral difficulties that jeopardize their ability to remain in the community due to their inappropriate responses to events in their environment. The behavioral consultation is designed to 1) decrease challenging behaviors while increasing positive alternative behaviors, and 2) assist participants in acquiring and maintaining the skills necessary to live independently in their communities and avoid institutional

placement.

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

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

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

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

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

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

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

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

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Behavioral Consultation under the Lifespan waiver is provided to individuals age 21 and over. For individuals under the age of 21, medically necessary Preventive Services, consistent with the service specifications and provider qualifications articulated in the State plan pursuant to the EPSDT benefit, must be exhausted prior to accessing the waiver benefit for Behavioral Consultation.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Behavior Consultation

Appendix C: Participant Services

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

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

Provider Category:
Agency

Provider Type:
Behavior Consultation

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Must be credentialled by the Delaware Division of Developmental Services as a qualified provider of Behavior Consultation.

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

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

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:
Division of Developmental Disability Services

Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Clinical Consultation: Nursing

HCBS Taxonomy:

Category	Sub-Category
Category 1: 11 Other Health and Therapeutic Services	Sub-Category 1: 11010 health monitoring
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:

Service Definition *(Scope)*:

Nursing Consultation:

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

Nursing Consultation consists of the following activities:

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

• Maintains on-going accurate, timely, and relevant documentation of all health care issues. Updates all required documents as changes in health conditions warrant.
• Communicates to individuals/families/guardians/other service providers about health care issues.
- Attends medical appointments with the individual if indicated/warranted.
• Assists in obtaining resources and acts as an advocate and coordinator of health care services ensuring appropriate treatment, follow-up and resolution to healthcare issues occur.
• Assists waiver participants to transition from one residential living arrangement to another.
• Adheres to DDDS healthcare protocols.
• Monitors medication administration activities performed by direct care staff or consumers and may provide consultation to a direct support professional regarding medication administration in specific situations where nursing expertise is required under the Nurse Practice Act.

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

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Nurse Consultation

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Clinical Consultation: Nursing

Provider Category:
Agency

Provider Type:
Nurse Consultation

Provider Qualifications

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

Certificate *(specify)*:

Other Standard *(specify)*:
Must be credentialled by the Delaware Division of Developmental Disabilities Services as a qualified provider of Nurse Consultation service.

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Developmental Disabilities Services

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Community Transition

HCBS Taxonomy:

Category	Sub-Category
Category 1: 16 Community Transition Services	**Sub-Category 1:** 16010 community transition services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Community Transition Service

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

- Essential furnishings, including: Bed frame, mattress and box spring or futon, dresser, wardrobe, chair, trash can, lamps, desk, small table/nightstand, bookcase, linens and pillows, window covering, wall decorations, mirrors
- Bath mats & shower curtain, grab bars and other free-standing implements to increase stability in the bathroom
- Small appliances including blow dryer, vacuum cleaner, coffee maker, toaster
- Toiletries
- Kitchen items, including: hand towels, dishes, drinkware, flatware & utensils, knives, cookware, bowls and food storage
- Initial stocking of refrigerator and pantry
- Initial supply of cleaning supplies and laundry

- Initial supply of bathroom supplies
- Clothing
- Moving expenses
- Security deposits
- Set-up fees and deposits for utility access (telephone, electric, utility, cable)
- Pest eradication
- Cleaning service prior to occupancy
- Trial visits to waiver residential settings
- Lock and key

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

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

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

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transition

Provider Category:

Agency

Provider Type:

Residential Habilitation Agency

Provider Qualifications

License *(specify)*:

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

Certificate *(specify)*:

Other Standard *(specify)*:

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

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

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

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

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transition

Provider Category:

Agency

Provider Type:

DDDS Approved Community Transition Provider

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:

Must be a DDDS-qualified provider of Community Transition Services

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Developmental Disabilities Services

Frequency of Verification:

Before services are initially rendered.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Home or Vehible Accessibility Adaptations

HCBS Taxonomy:

Category	Sub-Category
Category 1: 14 Equipment, Technology, and Modifications	**Sub-Category 1:** 14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

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

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

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

Bids or estimates must be obtained from at least two vendors so that DDDS can select the most reasonable bid based on the work to be performed which may take into account such elements as the time necessary to perform the work. In the event that the time necessary to obtain two bids will result in a delay in receiving the service that could pose a health or safety risk to the participant, DDDS may waive this requirement. Providers must issue a warranty for their work for one year from the date of purchase.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Limited to $6,000 per member every 5 years, inclusive of both services. The limit for home/vehicle modifications was based on experience from Delaware's Money Follows the Person program and is consistent with the limit for Delaware's LTSS home modification benefit limit under the 1115 waiver.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Licensed contractor
Agency	Vendors
Agency	Licensed contractor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home or Vehible Accessibility Adaptations

Provider Category:
Individual

Provider Type:
Licensed contractor

Provider Qualifications

License *(specify):*
Delaware Business License

Certificate *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:
Delaware Division of Developmental Disabilities Services

Frequency of Verification:
Prior to authorization of service and payment

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home or Vehible Accessibility Adaptations

Provider Category:
Agency

Provider Type:
Vendors

Provider Qualifications

License *(specify):*
Delaware Business License

Certificate *(specify):*

Other Standard *(specify):*
Providers must be bonded and insured. Providers must warranty their work for one year from the date of purchase.

Verification of Provider Qualifications

Entity Responsible for Verification:

Delaware Division of Developmental Disabilities Services
Frequency of Verification:
Prior to authorization of service and payment

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home or Vehible Accessibility Adaptations

Provider Category:
Agency
Provider Type:
Licensed contractor
Provider Qualifications
License *(specify):*
Delaware Business License
Certificate *(specify):*

Other Standard *(specify):*
Must be licensed as a contractor to do business within the State of Delaware and hold all applicable certifications and standards, if required by trade, and general liability insurance. Providers must warranty their work for one year from the date of purchase.
Verification of Provider Qualifications
Entity Responsible for Verification:
Delaware Division of Developmental Disabilities Services.
Frequency of Verification:
Prior to authorization of service and payment

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Specialized Medical Equipment and Supplies not otherwise covered by Medicaid

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
17 Other Services	17010 goods and services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

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

Service Definition *(Scope)*:
Specialized Medical Equipment and Services not otherwise covered by Medicaid

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

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Specialized Medical Equipment and Services not otherwise covered by Medicaid is only provided to individuals age 21 and over. All medically necessary Specialized Medical Equipment and Services for children under age 21 are covered in the State plan pursuant to the EPSDT benefit. To the extent that any listed services are covered under the state plan, the services under the waiver would be limited to additional services not otherwise covered under the state plan, but consistent with waiver objectives of avoiding institutionalization.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Durable Medical Equipment Supplier

Appendix C: Participant Services

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

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

Provider Category:
Agency

Provider Type:
Durable Medical Equipment Supplier

Provider Qualifications

License *(specify)*:
State Business License

Certificate *(specify)*:

Other Standard *(specify)*:
Must be enrolled to provide Durable Medical Equipment under the State Plan.

Verification of Provider Qualifications

Entity Responsible for Verification:
DMMA's contracted Provider Relations Agent

Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service

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

Service Title:
Supported Living

HCBS Taxonomy:

Category	Sub-Category
Category 1: 08 Home-Based Services	Sub-Category 1: 08010 home-based habilitation
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:

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

The types of supports provided in these settings are tailored supports that provide assistance with acquisition, retention, or improvement in skills related to:
- activities of daily living, such as personal grooming and cleanliness, domestic chores, or meal preparation , including planning, shopping, cooking, and storage activities;
- social and adaptive skills necessary for participating in community life, such as building and maintaining interpersonal relationships, including a Circle of Support;
- locating and scheduling appropriate medical services;
- instrumental activities of daily living such as learning how to maintain a bank account, conducting banking transactions, managing personal finances in general;
- learning how to use mass transportation;
- learning how to select a housemate;
- how to acquire and care for a pet
- learning how to shop.

The individual may want to learn a new skill or may have some proficiency in certain parts of a skill but want to learn how to

complete the entire task independently. Supported Living includes self-advocacy training to assist the participant in expressing personal preferences, self-representation, and individual rights and to make increasingly responsible choices.

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

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

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Residential Habilitation Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Living

Provider Category:
Agency

Provider Type:
Residential Habilitation Agency

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:
Delaware Division of Developmental Disabilities Services

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

Appendix C: Participant Services

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

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

◯ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.

◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.
Check each that applies:

☐ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*

☐ **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*

☑ **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*

☐ **As an administrative activity.** *Complete item C-1-c.*

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

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

Appendix C: Participant Services

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

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

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

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

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

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

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

HCBS waiver provider agencies that operate a home licensed by the DTCRP are required to utilize the BCC to determine if a person is suitable for employment, pursuant to the following laws:
11 DelC. §1141- Criminal Background Check (State and Federal),
11 Del.C. §1142- Drug Screening
11 Del.C. §8563- Child Protection Screening
19 Del.C. §708- Service Letters from previous employers
11 Del.C. §8564- Adult Abuse Registry Check

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

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

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

b. Abuse Registry Screening. Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

○ **No. The State does not conduct abuse registry screening.**

◉ **Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

An Adult Abuse Registry (AAR) is maintained by the Delaware Division of Long Term Care Residents Protection, as required by Delaware Code Title 11, §8564. A Child Protection Registry (CPR) is maintained by the Delaware Department of Services for Children, Youth and Their Families, as required by Delaware Code, Title 11, §8563.

Both an AAR and CPR check are required as a condition of employment for applicants of DDDS residential homes that may have the opportunity to have personal contact with persons receiving services. This requirement is pursuant to Delaware Code Title 11, §8564, Delaware Code, Title 11, §8563 and the DDDS policy entitled "Recruitment and Renewal of Shared Living/Respite Care Providers."

The aforementioned law regarding AAR checks also applies to temporary employment agencies and contractors that place employees or otherwise provide services to individuals in DDDS residential homes

Hiring employers who are required by either of the aforementioned laws to request an AAR and/or CPR check as a condition of employment are responsible for obtaining written authorization from the applicant for full disclosure from the agencies who maintain the AAR and CPR. Upon receipt of the written authorization, the applicable agency releases information to the hiring employer that indicates if the applicant has been a perpetrator in a substantiated investigation involving adult or child abuse, neglect, mistreatment or financial exploitation. The DDDS waiver standards for residential providers prohibit the employment of individuals with adverse findings in either the AAR or CPR check.

During the Provider Agency Certification Review Process, the Office of Quality Improvement (OQI) Program Evaluators (PEs) complete a staff qualifications & training review checklist. The PEs access the personnel files of each direct contact employee in order to verify the contracted provider agency has implemented the background check process and has received authorized legal documentation testifying to the results of the checks.

The PEs mark on the qualifications checklist, the dates the results of:

(1) the Delaware Adult Abuse Registry,
(2) the Delaware Child Abuse Registry,
(3) State of DE Criminal Background Checks, and
(4) Federal Criminal Background Checks were received by the contracted provider agency for each direct contact employee. The requirement for checks is once per employee.

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

Additionally, Delaware's Division of Long Term Care Residents Protection reviews all Criminal Background and Abuse Registry documentation in Neighborhood Group homes during annual licensing inspections.

The DDDS Office of Resource and Development Management (ORDM) ensure that every shared living provider is screened against both the Adult Abuse Registry and Child Protection Registry, prior to their enrollment as a Medicaid waiver provider.

A DDDS review panel is convened to review aspects of each application as well as ensure the completion of all required background checks.

Appendix C: Participant Services

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

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

○ **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**

◉ **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

i. Types of Facilities Subject to §1616(e). Complete the following table for each type of facility subject to §1616(e) of the Act:

Facility Type	
Neighborhood Group Home	

ii. Larger Facilities: In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

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

Each resident must have their own bedroom unless they express a preference to share a room. The room must be designed and decorated to their preferences. The homes have a one full size bathroom for every four residents, complete kitchen and a dining area. Family and friends can privately meet with a resident or individual in a room designated for social gatherings. When necessary, homes must meet any accessibility requirements of the residents. The outside appearances of the structures are to present in a manner similar to that of neighbors.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Neighborhood Group Home

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Clinical Consultation: Nursing	☐
Home or Vehible Accessibility Adaptations	☐
Day Habilitation	☐
Respite	☐

Waiver Service	Provided in Facility
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	☑

Facility Capacity Limit:

4

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☑
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

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

Appendix C: Participant Services

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

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

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

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

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

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

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

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

The Community Navigator will administer a standardized risk assessment tool that includes screening questions to determine the appropriateness of the family member/legal guardian as the caregiver for an individual. The screening tool includes such questions as:
• Does having a family member/legal guardian as direct support staff expand the individual's support circle or risk diminishing it?
• Is this about the participant's wishes, desires, and needs or about supplementing a family member's income?
• Does this family member create a barrier to increased community integration or friendship development, etc.?

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

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

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

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

○ **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

○ **Other policy.**

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

The Delaware Medicaid (DMMA) provider relations agent provides prospective DDDS Waiver providers access to the Delaware Medical Assistance Program (DMAP) web site. This website provides information about the DDDS Waiver program and completes enrollment instructions. In addition to the DMAP web site, the provider relations agent has a toll-free phone line available for general information (800-999-3371). All DMMA enrollment conditions must be met by the prospective provider before the provider can become enrolled. Providers who contact the DMAP Provider Relations agent about enrollment who have not yet been determined to meet the qualifications to provide HCBS services by DDDS are directed back to DDDS to be assessed against the applicable provider standards, since qualification by DDDS is specified as an HCBS provider enrollment criteria. Qualified providers may enroll at any time. The successful completion of the required information shall result in a contract with DMMA.

Prospective service providers have unrestricted 24-hour access to the DDDS waiver provider qualification standards and provider enrollment forms. These may be completed by prospective service providers who believe that they meet the qualifications to provide one or more of the DDDS Lifespan Waiver services. The DDDS Website (http://www.dhss.delaware.gov/dhss/ddds/cps.html) contains the instructions detailing the process.

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

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. *Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.*

Performance Measures

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

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each