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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:
There are no significant changes to the approved waiver being made in this renewal application.

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*):
Delaware Elderly and Disabled Waiver

C. **Type of Request: renewal**

☐ **Migration Waiver** - this is an existing approved waiver

☑ **Renewal of Waiver:**

Provide the information about the original waiver being renewed

Base Waiver Number: 0136

Amendment Number (if applicable):

Effective Date: *(mm/dd/yy)* 07/01/09

Waiver Number: DE.0136.R04.00
Draft ID: DE.07.04.00

Renewal Number: 04

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

Regular Waiver

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

07/01/09

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:

NA

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

☐ **Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150)**

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

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.
Purpose: The Elderly & Disabled (E&D) Waiver provides for home and community-based services for individuals aged 18 and above who are elderly or who have physical disabilities and limited ability to perform activities of daily living and would otherwise require care in a nursing facility.

Goals and objectives: The goal of the waiver is to provide services to persons in a manner which responds to each participant's abilities, assessed needs, and preferences, and ensures maximum self-sufficiency, independent functioning, and safety. This goal is accomplished through the delivery of a range of home and community-based long-term care services which target the special needs of the population.

Organizational structure: The Department of Health and Social Services (DHSS) is the designated State Medicaid agency for Delaware and, as such, has ultimate authority over the E&D Waiver. DHSS is an umbrella agency which houses twelve separate Divisions, including the Division of Medicaid and Medical Assistance (DMMA) and the Division of Services for Aging and Adults with Physical Disabilities (DSAAPD). DSAAPD is responsible for the administration and operation of the E&D Waiver. DMMA operates Delaware's Medical Assistance Unit (under the direction of the State Medicaid Director), and in this role, provides oversight over DSAAPD's administration and operation of the waiver.

Operationally, DSAAPD and DMMA share responsibilities for determining eligibility for waiver program applicants. Initial medical eligibility determinations are conducted by DSAAPD. However, DSAAPD accepts long term care medical eligibility determinations performed by DMMA for E&D Waiver medical eligibility. DMMA has responsibility for financial eligibility determination. DSAAPD, with a team of nurses and case managers, provides ongoing case management and follow-up for all individuals enrolled in the waiver program. DSAAPD and DMMA also work closely together on many aspects of the quality assurance and quality improvement systems of the waiver. Ultimately, DMMA retains authority for oversight of all waiver program operations.

As part of the quality oversight for this program, waiver staff work in coordination with the Adult Protective Services Program (APS), which responds to cases of abuse, neglect, and/or exploitation of persons living outside of licensed long term care facilities. APS is operated by DSAAPD staff. Because the waiver program includes a respite service which can be provided in long-term care facilities, DSAAPD coordinates with the Division of Long Term Care Resident's Protection (DLTCRP), which is the state agency responsible for the inspection and licensure of long term care facilities as well as the investigation of allegations of abuse within those facilities. DLTCRP, like DMMA and DSAAPD, is part of Delaware's Department of Health and Social Services. In addition, waiver staff coordinates with DSAAPD's Long Term Care Ombudsman Program (LTCOP), which investigates non-abuse-related complaints in long term care facilities. The active participation of APS, DLTCRP, and LTCOP form an important component of the quality assurance and quality improvement systems of the E&D Waiver.

Service delivery methods: The E&D Waiver includes home and community-based services made available on a statewide basis by providers under an agreement with DMMA and at the direction and request of DSAAPD. DSAAPD nurses and case managers work with participants to develop care plans in which independence and individual decision-making are maximized. Services are provided according to each individual's preferences and capabilities. Service providers and state agencies work together on an ongoing basis, through the quality assurance and quality improvement system, to protect the health and welfare of participants enrolled in the waiver program.

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/MR.

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:
The State communicates with advocacy groups, such as the State Council for Persons with Disabilities, on an ongoing basis with regard to the operation of Waivers and other programs. In addition, an announcement about the State's plans to renew the E&D Waiver is placed in the Delaware Register of Regulations and the public is invited to submit written comments. The comment period is 30 days. Following this comment period, the State reviews, considers, and responds to all comments received.

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:	Kling
First Name:	Nancy
Title:	Administrator
Agency:	Division of Medicaid and Medical Assistance
Address:	1901 N. DuPont Highway
Address 2:	Lewis Building
City:	New Castle
State:	**Delaware**
Zip:	19720

Phone:	(302) 255-9625	**Ext:**		**TTY**
Fax:	(302) 255-4425			
E-mail:	nancy.kling@state.de.us			

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

Last Name:	Bond			
First Name:	Lisa			
Title:	Planning Supervisor			
Agency:	Division of Services for Aging and Adults with Physical Disabilities			
Address:	1901 N. DuPont Highway			
Address 2:	Administration Building Annex			
City:	New Castle			
State:	**Delaware**			
Zip:	19720			
Phone:	(302) 255-9390	**Ext:**		**TTY**
Fax:	(302) 255-4445			
E-mail:	lisa.bond@state.de.us			

8. Authorizing Signature

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

Signature:	Nancy Kling
	State Medicaid Director or Designee
Submission Date:	Mar 31, 2009

Last Name:	Hill
First Name:	Harry
Title:	Director
Agency:	Division of Medicaid and Medical Assistance
Address:	1901 N. DuPont Highway
Address 2:	Lewis Building
City:	New Castle
State:	**Delaware**

Zip:	19720
Phone:	(302) 255-9627
Fax:	(302) 255-4413
E-mail:	Harry.hill@state.de.us

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

NA

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

NA

Appendix A: Waiver Administration and Operation

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

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

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

   ○ **The Medical Assistance Unit.**

   Specify the unit name:

   (Do not complete item A-2)

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

   Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.
   Division of Services for Aging and Adults with Physical Disabilities (DSAAPD)
   (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 Department of Health and Social Services (DHSS) is the designated State Medicaid agency for Delaware and, as such, has ultimate authority over the E&D Waiver. DHSS is an umbrella agency which houses twelve separate Divisions, including the Division of Medicaid and Medical Assistance (DMMA) and the Division of Services for Aging and Adults with Physical Disabilities (DSAAPD). DSAAPD is responsible for the administration and operation of the E&D Waiver. DMMA operates Delaware's Medical Assistance Unit (under the direction of the State Medicaid Director), and in this role, provides oversight over DSAAPD's administration and operation of the waiver.

In administering and operating the waiver, DSAAPD performs the following functions:

- develops internal procedures for waiver program operations
- serves as the key point of contact for program inquiries
- provides information to the public regarding the waiver
- provides initial intake for applicants
- provides Level of Care (LOC) determinations
- performs PASARR screenings
- develops, reviews, and updates care plans
- prior-authorizes services for waiver participants
- recruits service providers
- negotiates and establishes provider rates
- compiles data on current and unduplicated waiver participants
- maintains budget neutrality
- collects and compiles data for quality monitoring
- reports the results of quality monitoring to DMMA

A memorandum of understanding (MOU) between the two agencies spells out the methods used by DMMA to ensure the operating agency (DSAAPD) performs its assigned operational and administrative functions in accordance with waiver requirements.

DMMA conducts monitoring of the operation of the E&D Waiver program on an ongoing basis. Monitoring includes, but is not limited to the review of DSAAPD's provider audits/oversight reviews; quality assurance program data; policies and procedures; provider recruitment efforts; and maintenance of waiver enrollment against approved limits. Specifically, monitoring occurs through three different avenues: 1) Delaware Health and Social Services (DHSS) Quality Initiative Improvement (QII) Task Force; 2) DMMA Surveillance and Utilization Review (SUR); 3) DMMA's Delegated Services and Medical Management Unit.

QII: DSAAPD has an internal Quality Assurance system which provides information on an ongoing basis to DMMA via the Department-wide QII Task Force. The QA Unit within DSAAPD consists of oversight staff members who work with DSAAPD's Waiver Coordinator to compile and analyze program data. The QA Unit oversees the DSAAPD Quality Improvement Committee (QIC) which is made up of the Waiver Coordinator, the Chief Operations Administrator, the Adult Protective Services Administrator, the Case Manager Administrator and the Nurse Consultants. The QIC meets monthly to discuss quality performance measures, devise quality improvement initiatives, and resolve concerns and complaints. Program issues and concerns related to meeting waiver assurances are reported by DSAAPD to DMMA through the QII. DMMA, as the oversight agency, plays the central role in the operation of the QII.

SUR: DMMA maintains and operates the Medicaid Management Information System (MMIS) in accordance with Federal regulations and is responsible for associated financial and utilization reporting. MMIS includes a SUR system.

On a quarterly basis, the SUR subsystem, produces reports that compare “peer” ranking of all providers (e.g., comparing providers of a similar type in a similar geographic area) on a variety of dimensions such as service utilization, prior authorizations, invoice payments etc. Providers who deviate from the norm are examined further by the SUR team of auditors. A case under consideration may be resolved at the completion of the desk review and upon receipt of additional documentation from the provider. If it is determined that a provider has been overpaid, a letter will be 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 subsystem 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 Delegated Services and Medical Management Unit: DSAAPD submits quarterly reports to DMMA documenting results of case file review, participant questionnaires, and provider questionnaires. Other documentation, such as corrective action plans and Fair Hearing reports are also submitted to DMMA for review.

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

Appendix A: Waiver Administration and Operation

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

- (●) **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
  Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*
  Delaware contracts with a provider relations agent to perform specific administrative functions under the waiver, as indicated in Question # 7 of this section. Specific functions performed by this contractor include the ongoing recruitment and enrollment of service providers, executing the Medicaid provider agreement, and the verification of provider licensure on an annual basis.

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

Appendix A: Waiver Administration and Operation

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

- (●) **Not applicable**
- ( ) **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:
  - [ ] **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the

State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

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

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

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

Appendix A: Waiver Administration and Operation

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

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:
DMMA MMIS Status Group composed of the Chief Administrators, fiscal staff, and contract monitors review provider relations agent performance requirements. This team meets with the provider relations agent account management team twice per month to review performance measures. Performance measures include but are not limited to: timely enrollment of new providers, maintenance of provider enrollment criteria, timely response to provider inquires, billing activities, and all applicable federal and state policies and procedures. Operational policies and procedures are in place to ensure all provider activities are reviewed and approved by DMMA.

Appendix A: Waiver Administration and Operation

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

Function	Medicaid Agency	Contracted Entity

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

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

i. Performance Measures

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

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

Performance Measure:
Number and percent of performance reports reviewed by Medicaid agency. (Numerator: performance reports reviewed Denominator: all performance reports)

Data Source (Select one):
Provider performance monitoring
If 'Other' is selected, specify:
Provider Questionnaire Report

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

☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Sample is taken annually, but data collection and reporting occur quarterly	

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = Interval = +/- 5 at 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☑ **Other** Specify: Sample is taken annually, but data collection and reporting occur quarterly	

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 = Interval = +/- 5 at 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Critical events and incident reports
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:
Number and percent of months that the E&D Waiver is reviewed/evaluated during Medicaid oversight (Quality Initiative Improvement Task Force) meetings.

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

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:
Number and percent of Fair Hearing Reports reviewed by Medicaid agency.
(Numerator: Fair Hearing Reports reviewed Denominator: all Fair Hearing reports)

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:
Fair Hearing Reports

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

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

Data Aggregation and Analysis:

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

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

DMMA provides oversight of DSAAPD, in part, through the review of reports generated by DSAAPD. Reports detail findings of participant questionnaires, provider questionnaires, record reviews, and Fair Hearings. These reports enable DMMA to gauge the degree to which all waiver assurances and sub-assurances are met, including those related to level of care, qualified providers, service planning, health and welfare, and

financial accountability. DMMA oversees the Quality Initiative Improvement (QII) Task Force, which provides a forum to discuss issues and trends related to quality improvement across all Medicaid programs in the State.

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.
Problems with the functions carried out by the contracted provider relations agent are addressed during twice-monthly MMIS Status Group meetings between staff of the provider relations agency and DMMA staff, including DMMA Chief Administrators, fiscal staff, and contract monitors. Documentation of these discussions are maintained in Status Group meeting minutes. In addition, DMMA staff work directly with staff from the provider relations agency to remediate problems on an case-by-case basis, as needed.

Individual problems in waiver program operations generally are addressed by DSAAPD, through intervention by case managers, case manager supervisors, nurses, nurse supervisors, and as needed, by the DSAAPD Waiver Coordinator. Issues and problems are documented in case notes using the Tracking, Assessment, and Planning (TAP) System. Methods of remediation vary depending on the issue. Typically, issues discovered as part of the ongoing case review are discussed and resolved between front line staff and supervisors and/or provider agencies. As needed, outside entities, such as the Adult Protective Services Program (APS) are engaged for assistance and/or intervention. In addition, DSAAPD operates a Quality Improvement Committee (QIC) to discuss and resolve problems encountered during discovery. This QIC meets on a monthly basis. Members of the QIC include the Waiver Coordinator, DSAAPD Waiver operations staff, the DSAAPD Operations Manager, and a representative from APS. Remediation activities of the QIC are documented in meeting minutes. Remeditation of problems brought to the level of the DMMA's QII for discussion are documented in QII meeting minutes.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
◉ Aged or Disabled, or Both - General					
	☑	Aged	65		☑
	☑	Disabled (Physical)	18	64	
	☐	Disabled (Other)			
○ Aged or Disabled, or Both - Specific Recognized Subgroups					
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
○ Mental Retardation or Developmental Disability, or Both					
	☐	Autism			☐
	☐	Developmental Disability			☐
	☐	Mental Retardation			☐
○ Mental Illness					
	☐	Mental Illness			
	☐	Serious Emotional Disturbance			

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

This waiver provides for services for individuals aged 18 and above who are elderly or physically disabled and have limited ability to perform activities of daily living.

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:

The waiver serves both older persons(those aged 65 and over) as well as younger adults (aged 18 to 64) with physical disabilities. Despite the fact that there is a maximum age limit for adults with physical disabilities, those participants continue to be eligible for the waiver under the category of "older persons" upon their 65th birthday. Overall, there is no maximum age limit for this waiver.

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	1616
Year 2	1616
Year 3	1616
Year 4 (renewal only)	1616
Year 5 (renewal only)	1616

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 (renewal only)	
Year 5 (renewal only)	

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	
Nursing Home Transition	
Young Adult Transition	

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):*

Nursing Home Transition

Purpose *(describe):*

The state reserves capacity in each year of the waiver for persons who are transitioned out of nursing homes, including those transitioned through the Money Follows the Person initiative.

Describe how the amount of reserved capacity was determined:

Reserved capacity is based on the projected number of waiver-eligible persons transitioned out of nursing homes (25) during each year of the renewal period.

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

Waiver Year	Capacity Reserved
Year 1	25
Year 2	25
Year 3	25
Year 4 (renewal only)	25
Year 5 (renewal only)	25

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):*

Young Adult Transition

Purpose *(describe):*

The state reserves capacity in each year of the waiver for young adults who, because of their age, are no longer qualified for Children's Community Alternative Disability Program. This program provides support for severely disabled children in Delaware. The reservation of slots for this purpose will ensure a smooth transition to adult services for those who "age out" of the children's program and who are eligible to receive services under the E&D waiver.

Describe how the amount of reserved capacity was determined:

Reserved capacity is based on the projected number of waiver-eligible persons to be transitioned out of the Children's Community Alternative Disability Program (5) each year of the renewal period.

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

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

Year 4 (renewal only)	5
Year 5 (renewal only)	5

Appendix B: Participant Access and Eligibility

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

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

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

e. Allocation of Waiver Capacity.

Select one:

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

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

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

The waiver provides for the entrance of all eligible persons. Should a waiting list be needed in the future, applicants would be admitted on a first-come-first-served basis.

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:

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 4)

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

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

◉ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals**

with a community spouse for the special home and community-based waiver group.

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

- (●) **Use spousal post-eligibility rules under §1924 of the Act.**
  (Complete Item B-5-b (SSI State) and Item B-5-d)
- ( ) **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
  (Complete Item B-5-b (SSI State) . Do not complete Item B-5-d)
- ( ) **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.**
  (Complete Item B-5-b (SSI State) . Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

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

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

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

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

- (●) **The following standard included under the State plan**

  Select one:

  - ( ) **SSI standard**
  - ( ) **Optional State supplement standard**
  - ( ) **Medically needy income standard**
  - (●) **The special income level for institutionalized persons**

    (*select one*):

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

      Specify the percentage: 250
    - ( ) **A dollar amount which is less than 300%.**

      Specify dollar amount:
  - ( ) **A percentage of the Federal poverty level**

    Specify percentage:
  - ( ) **Other standard included under the State Plan**

    Specify:

- **The following dollar amount**

  Specify dollar amount: If this amount changes, this item will be revised.
- **The following formula is used to determine the needs allowance:**

  Specify:
- **Other**

  Specify:

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

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

  Specify:

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

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

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

    Specify:

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

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

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

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

Specify:

- **Other**

Specify:

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

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

Select one:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

i. Allowance for the personal needs of the waiver participant

(*select one*):

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

  Specify percentage:
- **The following dollar amount:**

  Specify dollar amount: If this amount changes, this item will be revised
- **The following formula is used to determine the needs allowance:**

  Specify formula:
- **Other**

  Specify:

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

Select one:

- **Allowance is the same**
- **Allowance is different.**

  Explanation of difference:

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

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

expenses.

Select one:

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

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

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

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

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

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

Specify the entity:

- ◉ **Other**

Specify:

Initial medical evaluations are conducted by the Division of Services for Aging and Adults with Physical Disabilities (DSAAPD), the operating agency. However, DSAAPD accepts long term care medical eligibility determinations performed by the Division of Medicaid and Medical Assistance (DMMA) for initial requests for nursing facility services. DSAAPD and DMMA employ the same methodologies for making eligibility determinations. All medical eligibility re-evaluations are conducted by DSAAPD.

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:

Registered Nurse licensed in the State of Delaware and employed by the Division of Services for Aging and Adults with Physical Disabilities or the Division of Medicaid and Medical Assistance.

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.

The State uses the Long Term Care Assessment Tool developed and used by the State's Medicaid agency to determine the level of care for the E&D Waiver program. This assessment instrument identifies an individual's physical health, mental health and social strengths and concerns. Medical verification is obtained from the participant's physician, to further support the assessment findings.

The basis for establishing a nursing facility level of care criteria is that the individual has at least one activity of daily living deficit and indicates a need, on a regular basis, for health services that should be supervised by (but not necessarily directly given by) a licensed nurse. This individual does not require hospital or skilled nursing facility care, but their cognitive or physical condition requires services that:
A) Are above the level of room and board, and
B) Can be made available only through institutional services (note: HCBS Waiver clients may be served in the community and receive these nursing home types of services at home).

CFR 42, Chapter IV, Section 440. 155

The evaluation and reevaluation of level of care is identical.

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:

Level of care evaluations are conducted on all participants who are referred or express interest in receiving the E&D Waiver services in Delaware. DSAAPD Community Services Program (CSP) staff contact a participant within 5 days and visit them within 10 days of their referral to perform an initial screening to determine interest and potential eligibility for the waiver.

If the participant is already receiving Medicaid, CSP staff refers the case to a DSAAPD Nurse to conduct a medical eligibility determination (within 90 days) to establish whether the person's condition requires a nursing facility level of care (Level of Care determination).

If Medicaid (financial) eligibility determination is required, the Division of Medicaid and Medical Assistance conducts the financial review simultaneously with DSAAPD's level of care determination. Written denial notices, including fair hearing rights, are provided whenever medical or financial eligibility is denied.

The DSAAPD Nurse performs an evaluation of the participant during a face-to-face visit, and then approves the Level of Care using the instrument described in B-6 (e).

The processes for the evaluation and reevaluation of a level of care are identical.

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):*

All participants enrolled in the E&D Waiver program are reevaluated at least annually to re-determine they continue to meet a nursing home level of care (LOC).

A DSAAPD nurse visits a waiver participant during the 10th month following admission and every year thereafter. During this re-determination visit, the nurse performs an assessment to evaluate the participant's current medical status. This assessment, along with an updated medical evaluation from the participant's physician, forms the basis for the re-determination of the participant's LOC.

The Tracking Assessment and Planning (TAP) system, DSAAPD's Long-Term Care monitoring computer application, includes tracking capabilities for Level of Care evaluations and reevaluations.
Nurses enter assessment (including re-assessment) information along with "LOC approval" indications into the TAP system.

Nurse supervisors access information in the TAP system to verify completion of reevaluations and to track the timely completion of these events. They maintain tracking sheets with due dates for all scheduled participant visits, including re-determination visits. Additionally, nurses perform peer review of case files, which include notes on evaluations and reevaluations. Any issues related to these evaluations and reevaluations are discussed with staff nurses during monthly case review meetings.

TAP is in the process of being upgraded to provide staff with "review due" schedules. It will also furnish monitoring reports to DSAAPD's Quality Assurance Unit including the status of Level of Care re-determinations and the timely completion of all required LOC re-determination tasks. Data will be available both on an individual and statewide basis to support these monitoring strategies.

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:

DSAAPD maintains the records of all evaluation and reevaluations of all participants who have applied for and those who have been active with the Waiver programs. These records are maintained electronically and a printed copy is also kept. The records are kept in DSAAPD offices for the duration of the participant's active status and at least 3 years after the case closure.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
Number and percent of all new enrollees who have a LOC indicating need for nursing home level of care. (Numerator: participants with a LOC consistent with nursing home LOC Denominator: all new enrollees)

Data Source (Select one):
Program logs
If 'Other' is selected, specify:
Case Review Log

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 Source (Select one):
Other
If 'Other' is selected, specify:
Tracking Assessment and Planning (TAP) System

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

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

Performance Measure:
Number and percent of waiver participants who received an annual re-determination of eligibility within 12 months of their initial LOC evaluation or within 12 months of their last annual LOC evaluation. (Numerator: participants receiving timely LOC re-determinations Denominator: all participants enrolled 12 months or more)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Tracking, Assessment and Planning (TAP) System

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 Source (Select one):
Program logs
If 'Other' is selected, specify:
Case Review Log

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

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

(check each that applies):		
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = =/-5 at 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
Number and percent of initial and annual LOC determinations made using state's approved tool. (Numerator: LOC determinations using specified tool Denominator: all LOC determinations)

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 = +/- 5 at 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of initial and annual LOC determinations made in which the LOC criteria were accurately applied. (Numerator: LOC determinations with correct application of criteria Denominator: all LOC determinations)

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 = +/- 5 at 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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.
Verification that an initial LOC evaluation has been completed occurs at several stages. Much of the tracking and verification for LOC determination takes place through the TAP system.

Nurses performing LOC evaluations enter assessment information into TAP and use a specific TAP action event to communicate that a LOC has been approved (i.e., to indicate the applicant met the nursing home level of care criteria). DSAAPD nurses verify that a LOC evaluation has been reviewed by entering a "disposition to financial" event into the TAP system before referring a case to the DMMA financial unit for further eligibility determination. Once financial eligibility is established, the DMMA financial unit enters a financial determination notation in TAP. The DMMA financial unit verifies medical eligibility has been established by DSAAPD. The verification of completed medical and financial eligibility determinations is communicated by the DMMA financial unit in an e-mail to a DSAAPD case management supervisor indicating the case can be opened. The TAP system itself provides a final internal check and is "hardwired" to not allow a case to be opened in the E&D Waiver unless both the financial and medical (LOC) eligibility determinations have been completed.

The TAP system also maintains data on LOC re-determinations and allows for verification at various stages. LOC instruments are built into TAP, and thus are applied uniformly.

In addition to the verification of the LOC process contained within the TAP system, nurse supervisors maintain logs to track LOC assignments, LOC evaluations, and LOC reviews. These logs are kept on file by DSAAPD nurse supervisors. Nurse supervisors also use a case review tool to denote an approval of a LOC evaluation.

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.
Nurse supervisors utilize a review tool for LOC evaluations to provide feedback to nurses assigned to each case. If an assessment has not been performed adequately, the nurse supervisor provides the assigned nurse with information on the review tool about corrections needed. These LOC's are not completed until the nurse supervisor has re-reviewed and approved the evaluation. Required corrections are documented using the case review tool.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Administrative Authority, 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).

CSP staff members performing the initial waiver screenings are responsible for informing potential waiver participants or representatives about freedom of choice by discussing in the initial interview the Medicaid Waiver Home and community-based programs and the alternative option of institutional care.

The CSP staff members performing the screening process utilize the Awareness Form I-Title XIX. This form explains long term care options. Individuals sign these forms indicating they and/or their legal guardians or representatives understand the choices and request home and community-based services or institutional care.

If a participant chooses the E&D Waiver Program, an additional Awareness Form is signed. This form describes the overall program, service choices within the program, and individual participant responsibilities. Additionally, the form presents information about the participant's freedom of choice. The form is reviewed and signed by the

participant and/or his/her legal guardian or representative and a CSP staff member. A copy of the form is given to the participant and/or his/her legal guardian or representative. A copy is also maintained in the DSAAPD case file. In addition, participants are provided with a list of current waiver providers to choose from.

Awareness forms are signed by E&D Waiver participants annually when their service choices are reaffirmed during DSAAPD nursing re-determination visits.

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.

These Freedom of Choice forms are maintained in each participant's case file folder. Files are located in the DSAAPD offices.

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):
Delaware Health and Social Services, Division of Medicaid and Medical Assistance (DMMA) and Division of Services for Aging and Adults with Physical Disabilities (DSAAPD) provide foreign language, Braille, and American Sign Language translation services for Medicaid Waiver applicants and participants as needed for education, outreach, case management and other functions of the E&D Waiver. AT & T Language Line and independently-contracted language interpreters are used for this purpose. In addition, DSAAPD maintains TTY phones for communication with persons with hearing impairment and has bi-lingual staff on board to assist Spanish-speaking participants.

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	Adult Day Services
Statutory Service	Personal Care
Statutory Service	Respite
Other Service	Personal Emergency Response Systems
Other Service	Specialized Medical Equipment and Supplies

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:
Adult Day Health

Alternate Service Title (if any):
Adult Day Services

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

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

Service Definition *(Scope):*
Services furnished in a non-institutional, community-based setting, encompassing both health and social services needed to ensure the optimal functioning of the participant. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day). Physical, occupational and speech therapies indicated in the individual's plan of care will be furnished as component parts of this service. This service does not duplicate a service provided under the state plan as an expanded EPSDT service.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
NA

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	Adult Day Care Facility

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Day Services

Provider Category:
Agency
Provider Type:
Adult Day Care Facility
Provider Qualifications
License *(specify):*
State business license or 501 (c)(3) status and Delaware Adult Day Care License as noted in Delaware Code Title 16-4402 Regulations for Adult Day Care
Certificate *(specify):*
NA
Other Standard *(specify):*
NA
Verification of Provider Qualifications
Entity Responsible for Verification:
Division of Medicaid and Medical Assistance (through EDS – provider relations agent contractor)
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:

Personal Care

Alternate Service Title (if any):

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

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

Service Definition *(Scope):*

Personal care includes assistance with activities of daily living (ADL's) (bathing, dressing, personal hygiene, transferring, toileting, skin care, eating and assisting with mobility). When specified in the plan of care, this service includes assistance with instrumental activities of daily living (IADL's) (e.g. light housekeeping chores, shopping, meal preparation). Assistance with IADL's must be secondary and essential to the health and welfare of the participant. Escort to a physician or clinic may be permitted according to the policy of the Home Health Agency. This service does not duplicate a service provided under the state plan as an expanded EPSDT service.

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

NA

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	Home Health Agency

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 Business License or 501 (c)(3) status; and State Home Health Agency License from Office of Health Facilities Licensing and Certification per Delaware Code Title 16-4406 Home Health Agencies(Licensure).
Certificate *(specify):*
NA
Other Standard *(specify):*
Please note: state regulations (Delaware Administrative Code 4406 and 4469) require that personal care services be delivered through agencies.

Verification of Provider Qualifications

Entity Responsible for Verification:
Division of Medicaid and Medical Assistance (through EDS – provider relations agent contractor)
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):

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

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

Service Definition *(Scope):*
Respite is a service provided to participants of designated home and community based waivers administered by the Division of Services for Aging and Adults with Physical Disabilities (DSAAPD). The service provides support to partcipants in their homes, assisted living facilities or nursing facilities on a short-term basis because of the absence or need for relief of those persons normally providing the care. This service does not duplicate a service provided under the state plan as an expanded EPSDT service.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
NA

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	Assisted Living Facility
Agency	Nursing Home
Agency	Home Health 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:
Assisted Living Facility
Provider Qualifications
License *(specify):*
State Business license or 501 (c)(3) status; and Delaware Assisted Living License as noted in Delaware Regulations for Assisted Living Agencies, Title 16, Part II, Chapter 11, Delaware Code
Certificate *(specify):*
NA
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Division of Medicaid and Medical Assistance (through EDS – provider relations agent contractor)
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:
Nursing Home
Provider Qualifications
License *(specify):*
State Business license or 501 (c)(3) status; and Delaware Skilled & Intermediate Care Nursing Facilities License as noted in Delaware Regulations Title 16, 3201
Certificate *(specify):*
NA
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Division of Medicaid and Medical Assistance (through EDS – provider relations agent contractor)
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 Business License or 501 (c)(3) status; and State Home Health Agency License from Office of Health Facilities Licensing and Certification per Delaware Code Title 16-4406 Home Health Agencies(Licensure)
Certificate *(specify):*
NA
Other Standard *(specify):*
Please note: Respite services in Delaware are provided by agencies in accordance with state regulations (Delaware Administrative Code 4406 and 4469)
Verification of Provider Qualifications
Entity Responsible for Verification:
Division of Medicaid and Medical Assistance (through EDS – provider relations agent contractor)
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:
Personal Emergency Response Systems

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

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

Service Definition *(Scope):*
Personal Emergency Response Systems (PERS) is an electronic device that enables waiver participants who live in the community to secure help in an emergency. The participant may also wear a portable “help” button to allow for mobility. The system is connected to the participant’s phone and programmed to signal a response center once the “help” button is activated. The response center is staffed by trained professionals. This service does not duplicate a service provided under the state plan as an expanded EPSDT service.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
NA

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Business Owner
Agency	PERS Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response Systems

Provider Category:
Individual
Provider Type:
Business Owner
Provider Qualifications
License *(specify):*
State Business license or 501 (c)(3) status
Certificate *(specify):*
NA
Other Standard *(specify):*
NA
Verification of Provider Qualifications
Entity Responsible for Verification:
Division of Medicaid and Medical Assistance (through EDS – a provider relations agent contractor)
Frequency of Verification:
Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response Systems

Provider Category:
Agency
Provider Type:
PERS Agency
Provider Qualifications
License *(specify):*
State Business license or 501 (c)(3) status
Certificate *(specify):*
NA
Other Standard *(specify):*
NA

Verification of Provider Qualifications

Entity Responsible for Verification:
Division of Medicaid and Medical Assistance (through EDS – a provider relations agent contractor)

Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:
Specialized Medical Equipment and Supplies

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

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

Service Definition *(Scope):*
Specialized medical equipment and supplies include: (a) devices, controls, or appliances, specified in the plan of care, 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. This service does not duplicate a service provided under the state plan as an expanded EPSDT service.

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

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	Business Owner

Agency	Medical Equipment/Supply Company

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Equipment and Supplies

Provider Category:
Individual
Provider Type:
Business Owner
Provider Qualifications
License *(specify):*
State Business license or 501 (c)(3) status
Certificate *(specify):*
NA
Other Standard *(specify):*
NA
Verification of Provider Qualifications
Entity Responsible for Verification:
Division of Medicaid and Medical Assistance (through EDS – a provider relations agent contractor)
Frequency of Verification:
Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Equipment and Supplies

Provider Category:
Agency
Provider Type:
Medical Equipment/Supply Company
Provider Qualifications
License *(specify):*
State Business license or 501 (c)(3) status
Certificate *(specify):*
NA
Other Standard *(specify):*
NA
Verification of Provider Qualifications
Entity Responsible for Verification:
Division of Medicaid and Medical Assistance (through EDS – a provider relations agent contractor)
Frequency of Verification:
Annually

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:

Staff of the Division of Services for Aging and Adults with Physical Disabilities (DSAAPD), including nurses and case managers, provides case management services to waiver participants.

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):

Applicants for employment in Home Health Agencies (Personal Care Services and Respite Services) are required by State Statute (DE Code16, Chapter 11, Subchapter V., §1145 and §1146) to submit to state and federal criminal background checks. The Delaware Division of Public Health ensures compliance under Title 16, Code 4406 (Home Health Agencies Licensure). Applicant refers to any person seeking employment, a current employee seeking a promotion, a person referred by a temporary agency, or a current employee of this facility when there is reasonable suspicion of conviction of a disqualifying crime since their employment. Civil penalties, denial of facility payment and/or facility closure may be invoked for infractions of this law.

Applicants for employment in Adult Day Services are required by State Statute (DE Code16, Chapter 11, Subchapter V., §1145 and §1146) to submit to state and federal criminal background checks. The Delaware Department of Health And Social Services assures compliance under Title 16, Code 4402 (Regulations for Adult Day Care Facilities). Applicant refers to any person seeking employment, a current employee seeking a promotion, a person referred by a temporary agency, or a current employee of this facility when there is reasonable suspicion of conviction of a disqualifying crime since their employment. Civil penalties, denial of facility payment and/or facility closure may be invoked for infractions of this law.

Applicants for employment in licensed facilities including Assisted Living and licensed Nursing Homes are required to submit to state and federal criminal history and/or background investigations. Applicant refers to any person seeking employment in a long term care facility, a current employee seeking a promotion, a person referred by a temporary agency, or a current employee of this facility when there is reasonable suspicion of conviction of a disqualifying crime since their employment. No long term care employer may hire or employ any applicant without obtaining a report of the person’s entire criminal history record from the State Bureau of Identification and a report from the Department of Health and Social Services pursuant to the Federal Bureau of Investigation appropriation Title II of Public Law 92-544. These checks are conducted on an annual basis by the

State of Delaware and monitored by the Division of Long Term Care Resident's Protection (DLTCRP) that is the licensing and governing agency in Delaware for assisted living and nursing facilities. Civil penalties, denial of facility payment and/or facility closure may be invoked for infractions of this law. These regulations can be found in Delaware Regulations for Assisted Living Agencies, Title 16, Part II, Chapter 11, Subchapter IV Code of Delaware and Delaware Regulations for Nursing Homes.
Each long term care facility refers applicants to the fingerprint and criminal background checks process with the state police and the FBI. DLTCRP receives the results of the background checks from state and federal authorities. DLTCRP then sends the facility a letter with the results of the investigation. The facility is able to proceed with hiring the applicant, if s/he was not disqualified through the background check process. DLTCRP licensing staff visits each facility once a year and does random samples from employees' files to make sure the hiring was legitimate.

Licensure entities, as described above, verify that mandatory background checks for designated service personnel have been conducted. This verification in conducted on a scheduled basis according to state law. Issuance and/or renewal of licensure is contingent upon meeting all requirements, including compliance with background checks. Electronic Data Systems (EDS), the provider relations agent, verifies licensure status at the time of provider application and annually thereafter.

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):

The Division of Long Term Care Residents Protection (DLTCRP) maintains a listing of all persons in the State of Delaware who have a substantiated case of abuse, neglect, mistreatment, and/or financial exploitation in their backgrounds. State of Delaware law requires all long term care facilities check this Registry before hiring any new employee. No health care service provider, nursing facility or similar facility or child care facility shall hire any person seeking employment without requesting and receiving an Adult Abuse Registry check for such person from the Division of Long Term Care Residents Protection. This requirement applies to all employees of Personal Care, Respite, Adult Day, Assisted Living and Nursing Home service providers. Assurance to the Abuse Registry Screening is accomplished during the licensure certification and annual re-certification process of their respective Delaware licensing body. During the annual re-certification process DLTCRP reviews the background checks of all employees that have been hired since the initial licensure certification or the last re-certification process. Any employer who is required to request and receive an Adult Abuse Registry check and fails to do so shall be subject to a civil penalty of not less than $1,000 nor more than $5,000 for each violation. The Justice of the Peace Courts shall have jurisdiction over this offense. (71 Del. Laws, c. 201, § 1; 70 Del. Laws, c. 186, § 1; 72 Del. Laws, c. 476, § 1; 75 Del. Laws, c. 147, § 1.)

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	
Nursing Home	
Assisted Living	

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.

As pertaining to Respite care services within Assisted Living facilities, the goal is to provide a 24 hour Respite service within the licensed facility for the waiver participant. Delaware licensed assisted living facilities provide a homelike environment and provides participants with an opportunity for self-expression and encourages interaction with community, family and friends. The Assisted Living service program includes the provisions of housing and meals within a "homelike" environment, services provided to meet an individual participant's wishes and needs, as identified by a standardized assessment instrument; and a philosophy of care that emphasizes consumer independence, choice, privacy and dignity. Delaware assisted living facilities provide supportive and health services based on a social model of care rather than on an institutional medical care model.

For Respite care services to be performed within a licensed Nursing home the goal of the facility is to provide care in a manner and in an environment that promotes maintenance or enhancement toward the participant's quality of life as determined in the participant care plan.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Nursing Home

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Specialized Medical Equipment and Supplies	☐
Personal Emergency Response Systems	☐
Personal Care	☐
Respite	☑
Adult Day Services	☐

Facility Capacity Limit:

Limit set by state licensing entity, Division of Long Term Care Residents Protection

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:

NA

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Assisted Living

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Specialized Medical Equipment and Supplies	☐
Personal Emergency Response Systems	☐
Personal Care	☐
Respite	☑
Adult Day Services	☐

Facility Capacity Limit:

Limit set by state licensing entity, Division of Long Term Care Residents Protection

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:

NA

Appendix C: Participant Services

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

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

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

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

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

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

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom

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

○ **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:

Medicaid's provider relations agent provides prospective Elderly & Disabled (E&D) providers access to a comprehensive Delaware Medical Assistance Program (DMAP) web site. This web site provides detailed information about the Medicaid E&D waiver program and complete enrollment instructions. In addition to the DMAP web site, the provider relations agent has a toll-free phone line available for general information. Elderly & Disabled providers are instructed to first make contact with the Division of Services for Aging and Adults with Physical Disabilities (DSAAPD) when inquiring about the opportunity to enroll as an E&D Medicaid waiver provider. DSAAPD has it own web site and toll-free phone line available for general information.

The Waiver Coordinator carries out a pre-qualification process for prospective waiver providers. DSAAPD's Waiver Coordinator informs prospective providers about the following needed documentation:

Qualifications – Providers will describe the individual's or the organization's expertise in area of the proposed project, and experience in operating any similar projects. A summary of similar current and completed projects should be included. All individual and agency wavier provider applicants must provide the following specific documentation according to their category of enrollment to demonstrate compliance with state licensure requirements.

- Adult Day Services Provider: Business License or 501 (c)(3) status; Delaware Adult Day Care Facility License
- Personal Care Provider: Business License or 501 (c)(3) status; Delaware Home Health Agency License
- Respite Care Provider: Business License or 501 (c)(3) status; Delaware Home Health Agency License or Delaware Assisted Living License or Delaware Skilled & Intermediate Care Nursing Facilities License
- Personal Emergency Response Systems Provider: Business License or 501 (c)(3) status
- Specialized Medical Equipment and Supplies Provider: Business License or 501 (c)(3) status

Work Plan - This section must explain the provider's approach for operating a program, which meets the Service Specification requirements. The Work Plan description must provide information, which describes how the provider will meet the criteria listed in the Service Specifications for each of the following areas:

1. Service Area (geographical)
2. Service Location (address and hours/days of operation)
3. Plans to meet the service standards of the program
4. Internal program evaluation and monitoring

Project Staffing - This section must document staffing to provide waiver services. Agencies are required to provide an organizational chart and individuals are required to provide a resume.

Budget – Providers will need to submit a budget proposal for evaluation and comparison. Budget format will be

provided by DSAAPD, and will reflect the cost reimbursement units for service in question.

Audit – Providers are required to submit an annual independent audited financial statement, a tax return, or their A-133 audit (required for providers who receive more than $500,000 in federal funds) for review.

Once the pre-qualification material has been reviewed, DSAAPD will conduct an introductory meeting with the provider for pre-approval. This meeting will confirm the provider's ability to provide service under the E&D Waiver. Once the pre-approval meeting is completed, DSAAPD will authorize Electronic Data Systems (EDS) to send out a waiver enrollment application to the potential provider. When the EDS provider relations agent receives the completed application, EDS will contact DSAAPD and DMMA to determine a reimbursement rate and a provider billing number will be established. The effective date is generally the first date of service as listed on the provider application unless otherwise noted by DSAAPD. Providers are encouraged to complete the waiver enrollment application in a timely fashion as timely filing guidelines apply for billing purposes. Once the provider agency returns an approved application, EDS will notify both the DSAAPD and DMMA Waiver Coordinator to effectively start the provider agency's ability to provide E&D Waiver services.

The qualification and enrollment of providers occurs on a continuous basis.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

i. Sub-Assurances:

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

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

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

Performance Measure:
Number and percent of new waiver provider applicants, by provider type, who obtained appropriate licensure/certification in accordance with state law and waiver provider qualifications prior to service provision. (Numerator: provider applicants with appropriate licensure/certification prior to service provision Denominator: all new providers requiring licensure/certification)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider enrollment application

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 Source (Select one):
Other
If 'Other' is selected, specify:
Provider enrollment tracking tool (MMIS)

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

Performance Measure:
Number and percent of providers, by provider type, continuing to meet applicable licensure/certification following initial enrollment. (Numerator: providers who meet licensure/certification requirements Denominator: all providers requiring licensure/certification)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider enrollment tracking tool (MMIS)

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

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

Data Source (Select one):
Provider performance monitoring
If 'Other' is selected, specify:
Provider Questionnaire

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: Sample is drawn annually, but data collection and reporting occur quarterly	

Data Aggregation and Analysis:

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

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

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

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

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

Performance Measure:
Number of non-licensed/non-certified provider applicants, by provider type, who met waiver provider qualifications prior to service provision. (Numerator: non-licensed/non-certified provider applicants who meet qualifications prior to service provision Denominator: all new non-licensed/non-certified providers)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider enrollment application

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 Source (Select one):
Other
If 'Other' is selected, specify:
Provider enrollment tracking tool (MMIS)

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

Performance Measure:
Number of non-licensed/non-certified provider, by provider type, who continue to meet waiver provider qualifications. (Numerator: non-licensed/non-certified providers who meet qualifications Denominator: all non-licensed/non-certified providers)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider enrollment tracking tool (MMIS)

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

	☐ **Other** Specify:	

Data Source (Select one):
Provider performance monitoring
If 'Other' is selected, specify:
Provider Questionnaire

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: Sample is drawn annually, but data collection and reporting occur quarterly	

Data Aggregation and Analysis:

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

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

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

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

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

Performance Measure:
Number and percent of calendar quarters in which training is conducted by provider relations agent. (Numerator: calendar quarters in which training is conducted Denominator: all calendar quarters)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider Relations Agent Newsletter

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: Provider relations agent	☐ **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.
Ongoing adherence to the state licensing standards is achieved through the state licensing renewal process carried out by the Division of Public Health (DPH). EDS, the provider relations agent, uses MMIS software to track license renewal requirements dates. Through MMIS, license expiration dates are tracked, and a provider is automatically decertified when renewal paperwork has not been received. (See section b. below.)

DSAAPD nurses and case managers perform ongoing monitoring of the quality of provider service delivery through regularly-scheduled participant visits. In addition, the quality of work performed by service providers is monitored through participant questionnaires, which are administered on a quarterly basis by DSAAPD.

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.
Providers who do not meet all credentialing requirements, including training requirements associated with credentialing, are deactivated within the MMIS system. As a result of this deactivation, claims payment and

enrollment of participants with the provider are terminated. When this occurs, the DSAAPD Waiver Coordinator contacts the provider and/or the provider relations agent to make sure updated credentials are available and loaded into the MMIS system. In the rare instance in which the deactivation of a service provider resulted in the loss of service to a participant, the assigned DSAAPD case manager would work with the participant to select an alternate service provider.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

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

○ **Applicable** - The State imposes additional limits on the amount of waiver services.

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

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

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:
Care Plan

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

- ☑ **Registered nurse, licensed to practice in the State**
- ☐ **Licensed practical or vocational nurse, acting within the scope of practice under State law**
- ☐ **Licensed physician (M.D. or D.O)**
- ☐ **Case Manager** (qualifications specified in Appendix C-1/C-3)
- ☑ **Case Manager** (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

A DSAAPD case manager must meet the minimum qualifications for the State of Delaware Senior Social Worker/Case Management position. Following are the minimum qualifications for employment is this position:
- Experience in interviewing and assessing clients
- Experience in caseload management and casework practices
- Experience in human service work determining eligibility for benefits and/or services
- Knowledge of federal and state rules and regulations as they apply to human services programs

- Ability to communicate effectively

Social Worker.

Specify qualifications:

Other

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

(a) Supports and Information
The Division of Services for Aging and Adults with Physical Disabilities (DSAAPD) furnishes each participant and/or his/her legal guardian or representative with an Awareness Form upon enrollment in the waiver program. This form provides information about services available under the waiver; rights and responsibilities under the waiver; and who to contact for questions and concerns regarding waiver services. Prior to the establishment of the care plan, the case manager reviews the Awareness Form with the waiver participant and/or his/her legal guardian or representative. The participant is encouraged to actively engage in the care planning process and, as noted below, is also encouraged to involve others who can provide him/her with support in directing the process.

(b) Participant’s Authority
The participant or the participant’s legal representative has complete authority to include in the care planning process whomever he/she would like. In fact, the participant or the participant’s legal representative is actively encouraged to include others, e.g., family members and/or other interested persons.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

(a) Participation in E&D care plan development
The individual participant is the central figure in the development of his/her care plan under this waiver. As noted above, participants are encouraged to bring family members and/or other interested persons to participate in the development of their care plans. If, for whatever reason, a participant can not be present for the development of his/her care plan, then his/her representative must be present. DSAAPD nurses and case managers participate in the care plan development process. Service providers may also participate. Care plans must be developed and approved prior to or on the date of a participant’s receipt of services.

The participant continues to be the central figure in the process of updating care plans. A care plan is updated at least annually by a DSAAPD nurse and case manager in conjunction with the participant. The care plan is reviewed at least annually during the level of care determination process initiated by the DSAAPD nurse and more often, as required, when a participant's needs change. The re-determination process takes place through an in-person visit, as described in Appendix D-2 below. Care plan revisions are triggered by changes in a participant’s service needs observed and documented by nurses and case managers during scheduled monitoring visits or at any other other time when changes in functional conditions indicate the need for re-evaluation. (For more details about monitoring visits, see section D-2.)

Because the individual participant is the central figure in the care planning process, planning meetings are scheduled at times and locations convenient to the participant. DSAAPD staff customize the visits in this regard to meet the needs of the participants.

(b) Assessments
Initial screening for the E&D waiver is conducted by DSAAPD Community Services Program (CSP) staff and the level of care assessments are performed by DSAAPD nurses as part of the waiver eligibility determination process. (In some cases, this level of care determination may be provided by staff from the Division of Medicaid and Medical Assistance [DMMA], the State Medicaid agency. DMMA staff members perform this level of care determination only in cases in which participant’s initial request is for nursing home services.)

Follow-up assessments are conducted prior to the care plan process by DSAAPD nurses. Such assessments are carried out by reviewing physical evaluations as well as through in-person interviews with participants. These assessments are designed to secure information about participant strengths, capacities, needs, preferences, desired outcomes, health status, and risk factors.

(c) Informing participants
The DSAAPD case manager has principle responsibility for informing participants of services available under the waiver. As part of the service planning process, the case manager reviews program information with the participant, including a list of available providers, as well as information related to:

- Hospitalizations
- Patient pay amounts
- 12-month re-determination process
- Freedom of choice of providers
- Participant responsibilities
- E&D care plan negotiation
- Managed Risk Agreement (See the risk assessment and mitigation description in section D-1-e below.)
- Agency discharge criteria
- Hospice options
- Fair Hearing options
- Medicare Part D prescriptions

Written information related to the program is presented to participants through the Awareness Form discussed in D-1-

c.

(d) Addressing individual needs and preferences
As noted above, the individual participant or the participant's legal representative is the principal participant in the care plan development process. He or she is encouraged to involve family members or other interested persons to make sure individual needs, preferences, and goals are communicated and understood. The care plan form itself is designed to include information on special needs for each activity and service listed in the agreement.

Health care needs (including physical health and mental health) are addressed specifically in the care planning process. The care plan addresses needs such as health maintenance (medication management, monitoring of health status) and special medical needs.

(e) Coordination of services
Services for a participant enrolled in the E&D Waiver are coordinated by the case manager. Each participant has a written care plan that specifies the type of assistance or special needs for that particular participant. In addition to the ADL and IADL assistance needed, the care plan addresses additional participant goals, needs (including health care needs), and preferences. The nurse and case manager is responsible for following up to see the participant's needs are met. The review/monitoring of the care plan, which includes non-waiver as well as waiver services, takes place as described in section D-2 below.

(f) Assignment of responsibilities
The DSAAPD nurse and case manager are responsible for overseeing and monitoring the implementation of the care plan. Specifically, nurses and case managers who are involved in the development and approval of a care plan monitor and document its implementation. These nurses and case managers are involved in the revision of care plans, as needed.

(g) Plan updates
The State does not make use of interim care plans. However, follow-up calls and visits by DSAAPD nurses and case managers are made on a scheduled basis and if, on the basis of these contacts it is evident that service needs have changed, individual care plans are revised. Plans are revised at other times when changes in a participant's condition warrent re-evaluation. Each waiver participant receives, at the minimum, two visits annually from a case manager and two from a nurse, including interim visits and annual re-determination visits.

Changes in condition are reported through the following processes:
-Providers report to DSAAPD case managers and/or nursing staff all significant changes in functional level
-DSAAPD case managers and/or nurses report significant changes in functional level
-Participants, family members, physicians and/or other interested persons report significant changes in functional level

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Introduction/Background

A key objective of the risk assessment process is to promote individual choice while minimizing the risk to waiver participants. As described below, the care plan development process includes risk assessment and, on an as-needed basis, the development of a risk agreement. This process ensures waiver participants make independent choices with an understanding of related risks.

Process

Risks are assessed during the initial participant assessment process and during the development of the care plan. As part of these processes, participant health status and support needs are determined, along with individual participant preferences. These factors are ascertained through physical evaluations as well as participant interviews. When it is

determined that participant preferences present identifiable risks, a risk agreement is incorporated into the care plan.

The following are criteria for a risk agreement:
-The risks are tolerable to all parties participating in the development of the risk agreement;
-Mutually agreeable action is identified which provides the greatest amount of participant autonomy with the least amount of risk; and
-The participant is capable of making choices and decisions and understanding consequences.

If a risk agreement is made a part of the care plan, it will:
-Clearly describe the problem, issue or service that is the subject of the risk agreement;
-Describe the choices available to the participant as well as the risks and benefits associated with each choice, the service provider's recommendations or desired outcome, and the participant's desired preference;
-Indicate the agreed-upon option;
-Describe the agreed-upon responsibilities of the service provider, the participant or the participant's legal representative, and any third parties;
-Become a part of the care plan, be signed separately by the participant or the participant's legal representative and any other third party with obligations under the risk agreement; and
Include a time frame for review.

Back-Up Plans

Back up plans become part of each participant's record. Individual back-up plans are in place for services included in the care plan. Case managers maintain lists of alternate service providers (along with contact information) to carry out needed support activities to safeguard the health and welfare of the participant should the regular provider become unavailable. The case managers contact the back-up providers and schedule services as needed.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

Prior to the development of a care plan, participants and/or their legal guardians or representatives are provided with an Awareness Form which includes information about the freedom to choose among providers. Participants and/or their legal guardians or representatives are also given a list of providers and can choose among these service providers. The information is provided to participants at least annually during re-determination visits. In addition, provider lists can be made available to a participants and/or their legal guardians or representatives at any time during their enrollment in the waiver program. DSAAPD staff ensure that participants undertand that they may chose freely among providers and are available to provide support in participants' decision-making process by providing additional information and/or answering questions upon request.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

The Division of Services for Aging and Adults with Physical Disabilities (DSAAPD), the operating agency, and the Division of Medicaid and Medical Assistance (DMMA), the oversight agency, have a memorandum of understanding detailing roles and responsibilities under this waiver. As part of this memorandum, the care plan oversight responsibility of DMMA is delineated. Specifically, DMMA is responsible for overseeing DSAAPD's review of the care plans.

DMMA's oversight of DSAAPD's review of care plans takes place in the following manner:

1) DSAAPD nurses develop all initial and updated care plans. These care plans are reviewed and approved by

DSAAPD nurse supervisors. The content of care plans are documented in case review sheets completed by nurse supervisors. Case review sheet data are compiled by the DSAAPD Waiver Coordinator and communicated to DMMA quarterly in a Case Review Report. Case review reports document the review of various items in a participant's case file, including the care plan. With regard to the care plan, the presense of certain elements is documented, including: involvement of stakeholders; update(s) triggered by status change(s); identification of providers; authorization of services; individual health care needs; participant approval; and emergency back-up plan(s). DSAAPD nurse supervisors remediate problems discovered during care plan review on an individual basis with staff nurses. DMMA review of quarterly care plan reports provides additional routine and periodic oversight of the care plan development process.
2) Additionally, participant questionnaires administered by DSAAPD staff verify participant involvement in the care planning process and in the selection of service providers. Results of participant questionnaires are reported to DMMA on a quarterly basis.
3) Finally, any issues related to the care planning process discovered during case reviews and/or participant questionnaires can be addressed by DSAAPD and DMMA through DMMA's Quality Initiative Improvement (QII) Task Force. The QII provides a forum for developing improved approaches to meeting waiver assurances, including those related to the care planning process.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

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

- ☑ **Medicaid agency**
- ☐ **Operating agency**
- ☐ **Case manager**
- ☐ **Other**

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

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

a) DSAAPD nurses and case managers assigned to individual cases are responsible for monitoring the implementation of care plans and for participants' health and welfare. DSAAPD nurses have developed and implemented indicators that have been integrated into their monitoring tools. The process ensures immediate identification of quality concerns and implementation of remediation strategies.

b) Monitoring and follow-up activities include phone contact as well as in-person visits by nurses and case managers assigned to each case. (See section c below for monitoring schedule information.)

During monitoring contacts, nurses and case managers assess:
- services are furnished in accordance with the care plan
- participants have access to service identified in the care plan
- participants exercise free choice of provider
- services meet participant' needs
- back-up plans are effective
- participants' health and welfare are being protected
- participants have access to non-waiver services in the care plan
- patient pay amounts are delineated

Specific methods for carrying out monitoring visits are described below.

Nurses assess participants during their monitoring visits and fill out a monitoring form to record information about the current health status of each client. These assessments may include, for example, information about cardio-pulmonary status, respiration, mobility, transfer capacity and other measures of health and well-being. Record is made of the receipt of non-waiver services, such as skilled nursing and other State Plan services. Nurses also indicate, based on examination of and discussion with a participant, whether the care plan meets his/her needs or whether it requires amending. Finally, nurses also indicate whether or not the visit has raised a quality assurance (QA) concern. In such cases, the findings trigger a quality assurance/quality improvement response on the part of DSAAPD. (See Quality Improvement section below.)

Likewise, case managers meet with participants during their in-person visits, and record their observations/findings on a monitoring form. This form allows the case manager to record a range of information about a participant's receipt of services indicated in the care plan. In addition, case managers use this form to describe any problems experienced by the participant. During the course of the visit, a participant is asked if he/she or his/her caregiver knows how to contact DSAAPD staff; this information is recorded on the monitoring form. Importantly, the form prompts the case manager to indicate whether or not the care plan is meeting the participant's needs or whether an amendment is recommended. Finally, case managers, like the nurses, use the form to indicate, based on the findings during the monitoring visit, whether quality assurance (QA) concerns have been raised. In such cases, the findings trigger a quality assurance/quality improvement response on the part of DSAAPD. (See Quality Improvement section below.)

Back-up plans and free-choice of provider issues are addressed at point of entry, and during monitoring contacts, as needed. (Back-up plan contents are described in section D-1-d above.) Case managers work with participants on an individual basis if, during the course of follow-up monitoring contacts, or at any time between contacts, the participant expresses the wish to choose a different provider.

Nurses and case manager supervisors meet with staff on a monthly basis for case review, during which time issues are discussed and problems resolved.

If services are not being delivered in accordance with a participant's care plan, the assigned case manager generally contacts the service agency involved in order to resolve the problem. Ongoing problems can be brought to the attention of case management supervisors, and subsequently to DSAAPD's Quality Improvement Committee (QIC) and DMMA's Quality Initiative Improvement (QII) Task Force for resolution and remediation. DSAAPD Waiver Coordinator can work with DMMA, as needed, to terminate the service agreement of a provider whose service provision is inadequate.

c) Each waiver participant receives at least four contacts per year, two from a case manager and two from a nurse. At a minimum, two of these contacts (one each from the case manager and the nurse) are made through face-to-face visits.

Contacts are made according to the following timetable:

- Within the first 30 days of case opening, a DSAAPD case manager contacts the participant;
- Between the tenth and twelfth month each year, the DSAAPD case manager and DSAAPD nurse make a re-

determination visit;
- By the end of the twelfth month each year, a new care plan is finalized.

b. Monitoring Safeguards. *Select one:*

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

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

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
Number and percent of waiver participants who have Service Plans that are adequate and appropriate to their needs, capabilities and desired outcomes, as indicated in the assessment. (Numerator: participants with adequate and appropriate Service Plans Denominator: all participants)

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 = +/- 5 at 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
Number and percent of Service Plans and related Service Plan activities that comport with DSAAPD Service Plan development procedures. (Numerator: Service Plans developed in accordance with procedures Denominator: all Service Plans)

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 = +/- 5 at 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of participants who report being involved in the development of their Service Plans. (Numerator: participants who indicate involvement in Service Plan development Denominator: a representative sample of participants)

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

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 = +/- 5 at 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Sample is drawn annually, but data collection and reporting occur quarterly	

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:
Number and percent of participants who report having been offered the opportunity to choose providers. (Numerator: participants who indicate having choice of providers Denominator: a representative sample of participants)

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

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 = +/- 5 at 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Sample is drawn annually but data are collected and reported on	

	quarterly	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
Number and percent of Service Plans reviewed and revised before the waiver participant's annual review date. (Numerator: Service Plans reviewed and revised on time Denominator: all service plans for participants enrolled for 12 months or more)

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 = +/- 5 at 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of waiver participants whose Service Plan was revised, as needed, to address changing needs. (Numerator: participants whose Service Plans were revised as needed Denominator: all participants whose changing needs warranted Service Plan updates)

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 = +/- 5 at 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
Number and percent of waiver participants who received services in the type, amount, frequency and duration specified in the Service Plan. (Numerator: participants who received services as specified in their Service Plans Denominator: all participants)

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 = +/- 5 at 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

Performance Measures

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

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

Performance Measure:
Number and percent of waiver participants whose records contain an appropriately completed and signed Awareness Form (freedom of choice form) that specifies choice was offered between institutional care and waiver services. (Numerator: participants who completed/signed an Awareness Form specifying choice of care location Denominator: all participants)

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 = +/- 5 at 95%

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of waiver participants whose records contain an appropriately completed and signed Awareness Form (freedom of choice form) that specifies choice was offered among waiver services and providers. (Numerator: participants who completed/signed an Awareness Form indicating choice of providers Denominator: all participants)

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 = +/- 5 at 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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.
Supervisory reviews ensure care plans are completed fully and accurately and they are consistent with assessed needs. Review sheets are completed for each case.

The MMIS system is hardwired to disallow claims for which there is no prior authorization. The prior authorization of services occurs at least annually following re-determination and update of the care plan. This

internal check ensures the revisions of the care plan are completed in a timely manner.

Additionally, prior authorization reports generated by MMIS provide indications of actual service utilization.

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.
A care plan that has not been adequately completed is returned to the assigned case manager along with the review sheet which indicates corrections needed on the plan. Case manager supervisors are available to provide support in the development of such a care plan to ensure that it appropriately addresses the care needs of the participant. The process is repeated until the care plan is approved by the case manager supervisor.

Nurses and case manager supervisors meet with staff on a monthly basis for case review, during which time issues are discussed and problems resolved.

If services are not being delivered in accordance with a participant's care plan, the assigned case manager generally contacts the service agency involved in order to resolve the problem. Ongoing problems can be brought to the attention of case management supervisors, and subsequently to DSAAPD's Quality Improvement Committee (QIC) and DMMA's Quality Initiative Improvement (QII) Task Force for resolution and remediation. DSAAPD Waiver Coordinator can work with DMMA, as needed, to terminate the service agreement of a provider whose service provision is inadequate.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix E: Participant Direction of Services

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

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

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

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

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

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

When an individual applies for services under this waiver, he or she is assessed to determine medical and financial eligibility. Following this eligibility determination process, written correspondence is mailed to this individual related to his or her eligibility to receive services under the Elderly &Disabled (E&D) Waiver by the assigned DSAAPD nurse or case manager. Included in this information is a Fair Hearing notice.

A Fair Hearing notice indicates:

- Denial of service, reduction of service, suspension of service, or termination of service can generate a Fair Hearing.
- The individual has the right to appeal and to be heard in a Fair Hearing if he/she is dissatisfied with the action.
-The individual must make a request if he/she wishes to obtain a Fair Hearing.
- The individual may be represented by legal counsel (referrals are made as needed) or other persons of his/her choice at the Fair Hearing.

- The individual may discuss this action with a member of the agency's staff.
- Filing a grievance/complaint will not interfere with the individual's Fair Hearing rights.
- The individual's benefit may continue if the issue in question is not one of state or federal law.
- If the individual's benefit continues, individual may be responsible for repayment should the outcome of the Fair Hearing not be in favor of the individual.
-In order for the individual to continue to receive Medicaid benefits, a request for the continuation of benefits must be made prior to the effective date of the action.
- The individual may contact DSAAPD or DMMA to request a Fair Hearing.

Fair Hearing notices accompany notification of all other adverse actions. In such cases, notices are sent by mail to individual participants by a DSAAPD nurse or case manager. Any adverse action, including action related to choice of home and community-based services (HCBS) vs. institutional service; choice of provider of service; and the denial, reduction, suspension or termination of service is accompanied by the Fair Hearing notice described above. A DSAAPD nurse or case manager assists individuals in pursuing Fair Hearings by providing them with information about Community Legal Aid services, as needed.

Documentation concerning Fair Hearing notification is kept on file by DSAAPD and DMMA.
In addition, DSAAPD informs DMMA about fair hearing requests and decisions by completing and submitting a Fair Hearing Report for each case in which a fair hearing is requested.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

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

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The State operates an additional dispute resolution process**

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

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

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

- ( ) **No. This Appendix does not apply**
- (●) **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

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

Division of Services for Aging and Adults with Physical Disabilities (DSAAPD)
Division of Long Term Care Residents Protection (DLTCRP)
Division of Public Health (DPH)
Division of Medicaid and Medical Assistance (DMMA)

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

(a) Types of grievances/complaints

Participants in the waiver program, their families, and/or legal representatives are given the opportunity to register grievances/complaints on any aspect of care, including but not limited to: abuse, neglect, exploitation, quality of care, facility management, or other matters of concern.

(b) Process and timelines for addressing grievances/complaints; and (c) Mechanisms for resolving grievances/complaints

Processes and timelines for addressing and resolving grievances/complaints depend on two factors: 1) the nature of the grievance/complaint; and 2) whether the waiver participant is receiving services in a licensed long-term care (LTC) facility or outside of a licensed LTC facility. (Note: Under the E&D Waiver, respite services may be provided in licensed LTC facilities.)

The list below summarizes the agencies responsible for responding to and resolving grievances/complaints by types of grievances/complaints and location of service provided.

1. Abuse, neglect or exploitation in licensed LTC facilities:
Division of Long-Term Care Residents Protection (DLTCRP)
2. Abuse, neglect or exploitation outside of licensed LTC facilities:
DSAAPD, Adult Protective Services (APS)
3. Non-Abuse, neglect or exploitation in licensed LTC facilities:
DSAAPD, Office of State Ombudsman (OSO)
4. Non-Abuse, neglect or exploitation outside of licensed LTC facilities:
DSAAPD, Community Services Program (CSP); Division of Public Health (DPH)

Processes and timelines for addressing and resolving grievances/complaints by the responsible agencies are detailed below.

Regardless of the nature of the grievance/complaint or the location of the service, the presence of a grievance/complaint system does not interfere with a participant's right to a Fair Hearing. Agencies responsible for addressing and resolving grievances/complaints ensure that such fair hearing rights are clearly communicated and reinforced with participants during the grievance/complaint intake process. These rights are described in F-1 above.

Allegations of abuse, neglect or exploitation in licensed LTC facilities:

The Division of Long-Term Care Residents Protection (DLTCRP) is the state licensing agency and the agency charged with investigating allegations of abuse, neglect, and exploitation within licensed long-term care facilities (Title 29 DE Code § 7971).

Upon admission to a long-term care facility, a participant and/or family member or legal representative is given a copy of residents' rights under the Delaware Code, including the phone number for DLTCRP.

Follow-up investigations take place according to the following timelines: In most instances, DLTCRP contacts the person who made the report within 48 hours of the receipt of the report to obtain additional information. (Certain investigations identified under the state law are investigated within 24 hours.)

Investigations and resolution of grievances/complaints can take various forms depending on the nature of the grievance/complaint. Investigators typically make facility visits (either announced or unannounced), interview witnesses and other involved parties, review documents, and report on findings.

Allegations of abuse, neglect or exploitation outside of licensed LTC facilities:

The Adult Protective Services (APS) program, which is operated by the Division of Services for Aging and Adults with Physical Disabilities, investigates complaints of abuse, neglect or exploitation for persons who live outside of

licensed facilities (Title 31 DE Code Chapter 39).

Participants in the waiver program, their families, and/or legal representatives are notified of the availability of APS services during the initial home visit by the CSP staff. They also brief and remind participants, their families, and/or legal representatives about APS services during contacts and re-determination visits. These briefings include information about APS' after hour client services and contact information.

As needed, referrals are made to APS from providers, participants, family members, legal representatives and/or other interested parties.

Follow-up investigations take place according to the following timelines: Severe physical abuse or neglect or inadequate self-care is investigated within 24 hours. Other instances are investigated within 5 days.

Investigations and resolution of grievances/complaints can take various forms depending on the nature of the grievance/complaint. Investigators typically make home visits (either announced or unannounced), interview witnesses and other involved parties, review documents, and report on findings.

Allegations of other than abuse, neglect or exploitation in licensed LTC facilities:

The Long-Term Care Ombudsman Program, otherwise known as the Office of State Ombudsman (OSO), which is operated by The Division of Services for Aging and Adults with Physical Disabilities, responds to non-abuse related complaints and works with residents and facilities to resolve those complaints (Title 16 DE Code § 1150).

Upon admission to a long-term care facility, a participant and/or family member or legal representative is given a copy of residents' rights under the Delaware Code, including the phone number for OSO.

Follow-up investigations take place according to the following timelines: OSO responds to grievances/complaints by returning phone calls the next business day. Actual investigations begin between the next business day to within 10 days depending on the nature of the grievance/complaint.

Investigations and resolution of grievances/complaints can take various forms depending on the nature of the grievance/complaint. Investigators typically make facility visits (either announced or unannounced), interview witnesses and other involved parties, review documents, and report on findings.

Allegations of other than abuse, neglect or exploitation outside of licensed LTC facilities:

Grievances/complaints about a provider may include grievances/complaints about any aspect of participant care, or other matters of concern to participants, families and/or legal representatives. They can be made in person, by telephone or in writing by waiver participants, their representatives, providers, and/or interested persons.

Grievances/complaints can be made to the provider and/or DSAAPD. When the grievance/complaint is to the provider, the provider shall document and investigate as appropriate utilizing the provider's documented grievance/complaint procedure.

For home health agencies and adult day care facilities, DPH state regulations (4402 and 4406) outline requirements for ensuring participant rights, including procedures that must be in place for communication between agencies and participants.

Per home health agency regulations 4406 (Sections 4.9 and 4.10), a home health agency must establish written policies regarding rights and responsibilities of patients. Policies must be consistent with Title 16 and Title 31 of the Delaware Code and the Division of Public Health Regulations regarding patient rights. Policies and procedures are made available to participants, families, and/or legal representatives upon acceptance into the waiver program. Policies must be reviewed annually, revised as necessary, and presented to the professional advisory group and to the governing body.

For adult day care facilities, Delaware State regulation 4402 (Section 14.0) which deals with quality improvement, requires that the day care provider develop and implement a documented on-going quality improvement program. Programs will include at a minimum:
• an internal process that tracks performance measures;
• a review of the program's goals and objectives at least annually;
• a review of the grievance/complaint process;
• a review of actions taken to address identified issues; and

• a process to monitor the satisfaction of the participants and/or their representatives with the program.

Registering a grievance/complaint does not adversely impact the benefits of a participant. The participant is informed in writing at the time of application and at the time of any action affecting their benefits of: 1) their right to a fair hearing; and 2) the method by which they may request a hearing.

Any grievance/complaint received at DSAAPD is referred to the contracted entity for resolution per the agency's established problem resolution procedures and according to approved timelines. When there is no resolution, the agency refers the grievance/complaint to DSAAPD's CSP staff for resolution. If the grievance/complaint is unable to be resolved at this level, the CSP supervisors notify the DSAAPD Medicaid Waiver Coordinator for resolution/remediation.

The Waiver Coordinator works with DMMA on either resolution or remediation of the grievance/complaint as applicable. The Coordinator will resolve grievances/complaints in accordance with Delaware's Medical Assistance Program policy (DMAP's General Policy, Section 9.0 Appendix D.)

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

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

- (●) **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*

If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

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

The E&D Waiver provides for services in a variety of settings, including private homes, adult day care centers, and, in the case of respite services, licensed long-term care facilities. In Delaware, responses to critical events depend in large part on the location in which the event takes place.

For events which take place in licensed long-term care facilities, Delaware has split the responsibility between two agencies: the Division of Long Term Care Residents Protection (DLTCRP) and the Division of Services for Aging and Adults with Physical Disabilities' (DSAAPD) Office of the State Ombudsman (OSO). Delaware law gives authority to the DLTCRP to respond to and investigate critical events in licensed long term care facilities. The OSO works closely with DLCTRP by responding to other complaints made by or on behalf of residents in licensed long-term care facilities.

Authority is given to DSAAPD's Adult Protective Services Program (APS) to respond to and investigate critical events made by or on behalf of impaired adults who live outside of licensed facilities.

DLTCRP has statutory authority under Title 29 DE Code; OSO has authority under Title 16 DE Code, and APS has authority under Title 31 DE Code.

a) Types of critical incidents

In Delaware, a critical event or incident is referred to as an "incident" under DLTCRP's Investigative Protocol. Under

Delaware law, an incident can be defined as anything that has a negative outcome on the resident. Specific instances cited include circumstances under which:

• A resident's or patient's health or safety is in imminent danger;
• A resident or patient has died due to alleged abuse, neglect or mistreatment;
• A resident or patient has been hospitalized or received medical treatment due to alleged abuse, neglect or mistreatment;
• The complaint or report alleges the existence of circumstances that could result in abuse, neglect, mistreatment and could place a resident's or patient's health or safety in imminent danger;
• A resident or patient has been the victim of financial exploitation or risk thereof and exigent circumstances warrant an immediate response.

For APS, critical events or incidents (as defined in Title 31, Chapter 39 §3910) include abuse, mistreatment, exploitation, and neglect. Also, APS investigates cases of inadequate self-care (self-neglect) and disruptive behavior.

Within the E&D Waiver, critical events or incidents include abuse, neglect, mistreatment, or exploitation; unnatural or suspicious death; medication errors with health and welfare implications; theft allegations; any incident involving a participant who alleges abuse or neglect and is hospitalized, or is removed from their residence, or visits an emergency room; hospitalization as a result of injury or any incident resulting in harm to participants

b) Individuals/entities required to report critical events or incidents

The incident reporting system in Delaware requires that all critical events or incidents be reported to the appropriate agency. Any employee of a facility or anyone who provides services on a regular or intermittent basis to a facility resident or participant in the waiver, and who has reasonable cause to believe that a waiver participant or facility resident has been abused, mistreated, neglected or financially exploited, or who has knowledge of the occurrence of other critical events or incidents must report such events or incidents.

c) Timelines for reporting

A written report must be filed by the employee or service provider within 8 hours after the employee or service provider first gains knowledge of the abuse, mistreatment, neglect, financial exploitation or other critical event or incident. A telephone report may be filed immediately, but it must be followed by a written incident report within 8 hours. APS operates an after-hours service and provides a contact number to police and first responders.

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

Information concerning protections from abuse, neglect, and exploitation is provided to all participants in this waiver program. Because of the different agency responsibilities related to critical incidents in the state (see G-1-b above), the process for providing this information varies somewhat depending on whether or not a waiver participant receives services in a licensed long-term care facility. Processes for providing information concerning protections from abuse, neglect, and exploitation for persons receiving services in long-term care facilities and for persons receiving services outside of long-term care facilities are described below.

Information concerning protections from abuse, neglect, and exploitation for waiver participants receiving services in long-term care facilities:

At the time of service in a long-term care facility, the facility admissions director and the DSAAPD case manager provide participants, families, and/or legal representatives with information (verbally and in writing) about how to report an incident in which a participant perceives that his/her rights have been violated. Participants, families and/or legal representatives are informed about the types of incidents as well as the methods for reporting incidents of abuse, neglect, mistreatment and exploitation. The DSAAPD case manager is available to assist participants, families, and/or legal representatives with filing a report, if necessary.

In addition, upon admission, waiver participants, family members, and/or legal representatives are given a copy of the Residents' Rights and a list of telephone numbers to call for assistance. The list includes telephone numbers for the State Long Term Care Ombudsman (OSO), Delaware Long Term Care Residents Protection (DLTCRP), the Attorney General's office, the Delaware Helpline, Medicaid Hotline, local law enforcement, and the contracted case manager.

Additionally, the telephone numbers for OSO and DLTCRP are displayed in public places at each long-term care

facility.

Information concerning protections from abuse, neglect, and exploitation for waiver participants receiving services outside of long-term care facilities:

During the initial screening by DSAAPD Community Services Program (CSP) staff, the LOC assessment by the DSAAPD nurse, and the case management assessment process, participants, family members, and/or legal representatives are informed about how to report an incident in which a participant perceives that his/her rights have been violated. Specifically, participants, families, and/or legal representatives are informed about the types of incidents and the methods for reporting incidents of abuse, neglect, mistreatment and exploitation. They are provided with emergency contact numbers and toll free phone numbers for each county for reporting abuse, neglect or exploitation, including the number for Adult Protective Services (APS). Information about how to report incidents is reinforced during face-to-face visits by APS social workers, during complaint investigations, and during re-determination visits. Case managers are trained about APS policies and procedures, and remind participants about APS' contact information.

Participants are instructed to contact 911 during any emergency or the Mental Health Crisis Unit if a person presents a danger to him/herself or others.

APS also conducts community presentations upon request and works closely with various community groups to educate them on the identification and prevention of abuse. APS distributes flyers and other material at senior centers, hospitals, doctor's offices, or any other places where vulnerable adults may have contact. Participants, family members, and/or legal representatives are encouraged to avail themselves of the various activities, conferences, and training events offered by the Consumer Fraud office within the Attorney General's office.

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

Responsibility for review of and response to critical events or incidents for waiver participants receiving services in long-term care facilities:

As stated in G-1-b, incidents for which DLTCRP has oversight responsibility must be reported by the long-term care facility to DLTCRP within 8 hours of the knowledge, or the notification of, an event or incident. DLTCRP operates an incident reporting database that allows them to track information to ensure the appropriate planning and follow-up. DLTCRP and/or OSO investigate incidents with participants. Once a complaint or report is received, OSO and/or DLTCRP review the incident for completeness of information, investigate the incident, determine if there are any problems, and if so, determine a plan of corrective action. Each agency determines if additional collaboration is needed to arrive at a resolution.

Investigations, follow-up, and resolution of complaints can take various forms depending on the nature of the complaint. Investigators typically make facility visits either announced or unannounced, interview witnesses, interview other involved parties, review relevant documents, and report their findings. Findings are communicated in writing to participants and involved parties. The memorandum of understanding between OSO and DLTCRP facilitates information sharing and cooperation.

For incident investigation, OSO's designated ombudsman or DLTCRP's designated investigator is responsible for evaluating each incident by reviewing the data elements in the report and making a determination about what should be done.

OSO initiates an investigation within the established timeline based on the type of incident. OSO refers any complaint involving abuse, neglect, mistreatment, or exploitation to DLTCRP within 8 hours (next business day). For all other types of complaints, OSO initiates an investigation within 10 business days. Generally, reports received by OSO are entered it into the Ombudsman's Production System, are investigated, plan of action determined, and closed in the Ombudsman's Production System no longer than 90 days after receipt or referral. A case may remain open over 90 days if exigent circumstances mandate that an investigation is prudent, necessary, and within the best interest of the resident.

In DLTCRP, an incident involving immediate jeopardy to the participant is investigated within 48 hours; an incident of actual harm is investigated within 3 working days and completed within 10 days; an incident with a potential for more than minimal harm, is investigated within 10 working days and completed within 30 days; an incident with a potential for minimal harm is investigated within 10 working days, and completed within 45 days; all investigations

not addressed above are completed within 30 days unless extenuating circumstances exist.

Both agencies communicate investigation outcomes to all parties in writing.

Responsibility for review of and response to critical events or incidents for waiver participants receiving services outside of long-term care facilities:

APS is the designated agency to receive, investigate, and respond to critical incidents of abuse or neglect of clients living receiving services outside of long-term care facilities.

Incidents of sexual abuse, physical abuse or severe neglect or severe inadequate self-care must be investigated immediately or within 24 hours of the report. All other incidents or reports that are not of an emergency nature are investigated within 5 working days.

All reports are made to the Intake Unit of DSAAPD and then referred to APS for investigation. As part of the initial complaint investigation, a social worker makes an unannounced visit to assess the participant and his/her situation. The social worker gathers information from the report and from available collateral contacts. The purpose of the interview is to begin the assessment process, determine the level of risk, determine the participant's mental capacity, and determine if services are needed. It is also the time to investigate the allegation of abuse or neglect and if the case needs to be reported to law enforcement for prosecution. Other assessment issues are determined such as the participant's ability to care for him/herself, whether there is a need for protective services, completing a comprehensive social history and evaluation, identifying what areas of a participant's needs must be meet, and therefore formulating an appropriate service plan to meet these needs.

When the APS social worker substantiates the complaint and determines that the adult is in need of protective services, the APS worker establishes a care plan within 5 days of the home visit. The care plan is developed in conjunction with the participants, their families, and/or legal representatives. This information is shared with DSAAPD E&D Waiver staff. The goals and objectives of the APS care plan are then integrated with the current E&D Waiver care plan. When there is a danger of imminent harm, the appropriate victim assistance services are implemented immediately.

Upon completion of the assessment and investigation process, the outcome is communicated verbally and/or in writing to participants, their families, and/or legal representatives and to the person who originated the complaint. The timeline for communicating the results differ based on the type of event. For physical abuse, results are communicated within 1 to 2 days; for other events other than financial exploitation, results are communicated within 10 days. The results for a financial exploitation event may take more than 10 days depending on the investigations completed by the Department of Justice. However, the source of referral is periodically informed about these on-going investigations.

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

Responsibility for oversight of critical incidents and events in long-term care facilities:

DLTCRP has responsibility for oversight and follow-up of incidents involving E&D waiver participants receiving services in long-term care facilities. Facilities are required to report incidents within 8 hours of notification of, or knowledge of, an incident as listed in G-1-b. DLTCRP researches all critical incidents listed in G-1-b through participant interviews, provider interviews, review of pertinent records and case conferences with all necessary parties. DLTCRP may request that further follow-up be provided by provider and/or in some cases, by other appropriate investigatory agencies (ex; Professional Regulations, DPH, DSAAPD, OSO, and the Attorney General's office).

DLTCRP has a process for facility investigation that includes review of incidents. DLTCRP conducts an on-site survey of each facility at least once every year. This frequency could increase if number and type of complaints associated with a facility warrants more immediate review, and/or the identification of harmful practices cited by DLTCRP requires the development and approval of a plan of correction. Long-term care facilities and the OSO notify DLTCRP and advise them about concerns, or adverse experiences related to critical events and/or incidents.

DLTCRP will provide a report to OSO regarding the outcome of any investigations of cases referred by OSO, and will provide the outcomes of survey activity and any plans of corrections. Reports will be generated on an ongoing basis as investigations occur. DLTCRP and OSO will meet on an as needed basis to review information that has been previously provided and discuss any findings related to incident reporting or other related issues or concerns.

OSO will analyze all incident occurrence data for identification of trends and patterns. The OSO will provide DSAAPD's Waiver Coordinator with data related to incidents involving E&D Waiver participants receiving services in long-term care facilities. Both the OSO and DLTCRP will be available on an as needed basis to discuss related issues with DSAAPD's Quality Improvement Committee (QIC).

Responsibility for oversight of critical incidents and events for waiver participants receiving services outside of long-term care facilities:

APS has responsibility for oversight and follow-up of incidents involving E&D waiver participants for waiver participants receiving services outside of long-term care facilities.

Referrals and investigations regarding cases are documented and communicated to DSAAPD E&D Waiver staff on an ongoing basis. APS also reports waiver participant critical incident data to the APS advisory board, the DSAAPD Waiver Coordinator, and DSAAPD's Quality Improvement Committee (QIC) for review and, as needed, remediation. Ongoing concerns may also be brought to the attention of DMMA's Quality Initiative Improvement (QII) Task Force for discussion and development of strategies for systems improvement.

Appendix G: Participant Safeguards

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

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

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

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

In Delaware, the responsibility for detecting the unauthorized use of restraints or seclusion is divided among several state agencies. Following is a summary of the responsibilities of each agency:

Division of Long Term Care Residents Protection (DLTCRP)
Provider type: Licensed long term care facilities
Strategy: Licensure survey, complaint survey
Frequency: Annually, or more often as needed

DSAAPD, Office of State Ombudsman (OSO)
Provider type: Licensed long term care facilities
Strategy: Complaint remediation/resolution
Frequency: As needed

DSAAPD, Community Services Program (CSP)
Provider type: All providers
Strategy: Care plan monitoring
Frequency: Ongoing

Division of Public Health (DPH)
Provider type: Home health agencies; adult day care facilities
Strategy: Licensure survey, complaint remediation and resolution
Frequency: Initial application, renewals as needed

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

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

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

Appendix G: Participant Safeguards

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

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

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

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

In Delaware, the responsibility for detecting the unauthorized use of restrictive interventions is divided among several state agencies. Following is a summary of the responsibilities of each agency:

Division of Long Term Care Residents Protection (DLTCRP)
Provider type: Licensed long term care facilities
Strategy: Licensure survey, complaint survey
Frequency: Annually, or more often as needed

DSAAPD, Office of State Ombudsman (OSO)
Provider type: Licensed long term care facilities
Strategy: Complaint remediation/resolution
Frequency: As needed

DSAAPD, Community Services Program (CSP)
Provider type: All providers
Strategy: Care plan monitoring
Frequency: Ongoing

Division of Public Health (DPH)
Provider type: Home health agencies; adult day care facilities
Strategy: Licensure survey, complaint remediation and resolution
Frequency: Initial application, renewals as needed

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

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

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

Appendix G: Participant Safeguards

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

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

a. Applicability. Select one:

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

b. Medication Management and Follow-Up

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

The participant's physician and long-term care facility's nursing staff have "first line" responsibility for assuring E&D Waiver participant's medication regimens are prescribed appropriately and managed effectively. This responsibility includes:
• ensuring medication regimens (including self-administration, medication supervision, and medication administration) are delivered as ordered by the prescribing medical professionals;
• documenting oversight and implementation of the medication regimen outlined in the service agreement;
• reporting to the prescribing medical professionals any issues related to the medication regimen, including but not limited to participant compliance and reported and/or observed changes in the participant's response to the medications;
• reviewing the medication regimen at admission, when modifications to the regimen are made, and concurrently with all Uniform Assessment Instrument (UAI)-based assessments; and
• providing or arranging for the review of the medication regimen, as needed, by a pharmacist for all participants who have multiple prescribing medical professionals and/or have medications ordered for the purpose of modifying or controlling behavior.

The nurse at the assisted living facility is responsible for conducting an UAI-based assessment at admission.

The long-term care facility nurse is responsible for:
• confirming that the level of medication assistance ordered is being delivered;
• identifying risk factors to management of the medication regimen (e.g., cognitive limitations, multiple medications and/or prescribing medical professionals);
• ensuring that medications are properly labeled, stored and maintained;
• ensuring that the desired effect of each medication is achieved, and if not, that the appropriate authorized prescriber is informed; and
• ensuring that any unresolved discrepancy of controlled substances shall be reported to the Delaware Office of Narcotics and Dangerous Drugs.

DLTCRP is responsible for conducting annual surveys of the long-term care facility providers. During a survey, medication regimens will be reviewed for any potentially harmful medications (i.e., behavior modifiers such as antidepressants).

DLTCRP is also responsible for:

• on-site survey of medication management practices during the annual facility survey; and
• investigation of complaints related to medication management issues.

DMMA utilizes an automated Drug Utilization and Review (DUR) process. The automation of the DUR

process allows for real time monitoring of participant's medication regimens. When a pharmacy claim is submitted to DMMA for payment, it is immediately evaluated for dose optimization, quality limitations, duplicate therapies and compliance with the preferred drug list. This automated process is backed-up by a pharmacy team, which follows up when medication issues are indicated.
Changes in functional levels are communicated to DSAAPD case managers and nurses through the processes described in Section D-1 (d).

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

DLTCRP is responsible for conducting annual surveys of long-term care facilities to review medication regimens for any potentially harmful medications (e.g., behavior modifiers such as antidepressants.) As stated previously in Appendix G-1-b, OSO and DLTCRP are informed of any significant medication errors and follow-up.

DLTCRP monitors medication management practices through regular survey activities and complaint investigations. Survey activities include the review of medication logs and a random sample of participant records. DLTCRP survey activities are conducted at least once per year per facility. This frequency could increase if number and type of complaints warrant more immediate review, or the identification of harmful practices cited by DLTCRP requires the development and approval of a plan of correction. The long-term care facility advises DLTCRP about any concerns or adverse experiences regarding medication errors.

During a provider survey, the records of participants are randomly selected for review by DLTCRP. Where there is evidence of harmful practices, the long-term care facility will be required to submit a plan of corrective action. The plan will be forwarded to the OSO by DLTCRP.

DLTCRP will provide a report to OSO regarding the outcome of any investigations of cases referred by OSO, and will provide the outcomes of survey activity and any plans of corrections. DLTCRP and OSO will meet on an as needed basis to review information that has been previously provided and discuss any findings related to incident reporting or other related issues or concerns.

OSO will analyze all incident occurrence data for identification of trends and patterns. The OSO will provide DSAAPD's Waiver Coordinator with data related to incidents involving E&D Waiver participants receiving services in long-term care facilities. Both the OSO and DLTCRP will be available on an as needed basis to discuss related issues with DSAAPD's Quality Improvement Committee (QIC). The collection and reporting of these data are components of the overall quality improvement strategy reviewed by the State Medicaid agency.

Appendix G: Participant Safeguards

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

c. Medication Administration by Waiver Providers

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

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

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

The administration of medication is limited to medical personnel who are professionally licensed to do so in accordance with the DE Code e.g., physicians licensed to practice in the State of Delaware, and nurses licensed to practice in Delaware.

Medication administration is a routine nursing service expected to be provided. Medication administration includes oral medications, injections and blood sugar monitoring. Under an amendment to the Delaware Nursing Practice Act, assistance with self-administration of medications, other than by injection, may be provided by caregivers who have successfully completed a State Board of Nursing approved medication training program [24 Delaware Code. Chapter 19. Subsection 1921 (a) (16)] Delaware regulations (3225.8.9 – 3225.8.10) require assisted living facilities maintain records of those persons who have fulfilled the above-referenced requirements for assisting residents with the self-administration of medications.

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

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

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

  DLTCRP

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

  All medication errors.

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

  Significant error or omission(19.7.7.5 of the Regulations).
- **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

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

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

DLTCRP monitors medication management in long-term care facilities through standard survey activities conducted at least annually and through complaint surveys which may occur on a more frequent basis than the standard survey, or when harmful practices cited by DLTCRP require the development and approval of a plan of correction. DLTCRP staff provide on-site visits and facility inspections according to standard protocols and, as needed, oversee the development and implementation of corrective action plans.

Standardized communications regarding medication errors and/or omissions and other deficiencies that adversely impact waiver participants have been established through a formal operating agreement between OSO and DLTCRP. DLTCRP will provide a report regarding the outcome of survey activity and corrective action plans to OSO.

OSO will analyze all incident occurrence data for identification of trends and patterns. The OSO will provide DSAAPD's Waiver Coordinator with data related to incidents involving E&D Waiver participants receiving services in long-term care facilities. Both the OSO and DLTCRP will be available on an as needed basis to discuss and remediate problems related to medication management with DSAAPD's Quality Improvement Committee (QIC).

These data are part of the overall quality improvement strategy for the waiver and are made available to DMMA by DSAAPD's Waiver Coordinator.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

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

i. Performance Measures

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

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

Performance Measure:
Number and percent of critical incidents investigated within required timeframes. (Numerator: number of critical incidents investigated in a timely manner Denominator: all critical incidents)

Data Source (Select one):
Critical events and incident reports
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:
Number and percent of experience/satisfaction survey respondents who indicated knowledge of how to report instances of abuse, neglect or exploitation. (Numerator: participants reporting a knowledge of how to report incidents Denominator: a representative sample of participants)

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

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 = =/- 5 at 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☑ **Other** Specify: Sample is drawn annually, but data collection and reporting occur quarterly	

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:
Number and percent of experience/satisfaction survey respondents who reported they are always treated with respect. (Numerator: participants reporting always being treated with respect Denominator: a representative sample of participants)

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

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 = +/- 5 at 95%

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Sample is drawn annually, but data collection and reporting occur quarterly	

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:
Number and percent of experience/satisfaction survey respondents who reported that waiver providers do not make them feel threatened or in danger. (Numerator: participants who do not feel threatened or endangered by providers Denominator: a representative sample of participants)

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

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 = +/- 5 at 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Sample is drawn annually, but data collection and reporting occur quarterly	

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:
Number and percent of service providers who have grievance procedures on file with DSAAPD. (Numerator: providers with grievance procedures on file Denominator: all providers)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider enrollment application

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:
Number and percent of service providers who have emergency preparedness plans on file with DSAAPD. (Numerator: providers with emergency preparedness plans on file

Denominator: all providers)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider enrollment application

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.
Each waiver participant has a DSAAPD case manager and nurse assigned to his/her case. The ongoing relationship between the waiver participant and the assigned DSAAPD case manager and nurse is the first line of defense against possible occurrences of abuse, neglect or exploitation. All contacts are documented in TAP case notes. Ongoing case review by DSAAPD staff supervisors ensures these contacts are maintained by the assigned nurses and case managers.

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.
When difficulties occur in the delivery of services by waiver providers, participants are made aware of providers' procedures to follow for problem resolution. DSAAPD case managers and nurses are available to intervene and assist participants in resolving these concerns.

DSAAPD case managers and nurses have ongoing relationships with providers and can work directly with them to address participants' concerns with service delivery, satisfaction, and other matters. Delaware's size is especially helpful in this regard. Because of the relatively small population and the small geographic size of the State, close working relationships between case managers, nurses, and providers are typically established. These relationships result in facilitated communications for problem solving and other benefits, such as shared in-service training.

Issues that cannot be resolved at the case manager or nurse level are brought to the attention of the case manager or nurse supervisor for further intervention. Such issues or difficulties in service delivery or participant satisfaction are also brought to the attention of the Waiver Coordinator for resolution. Problems with service delivery can be brought to the attention of DSAAPD's Quality Improvement Committee (QIC) and DMMA's Quality Initiative Improvement (QII) Task Force for resolution and remediation. As needed, the DSAAPD Waiver Coordinator can work with DMMA to terminate the service agreement of a provider whose service provision is inadequate.

An important aspect of the health and welfare maintenance for this waiver is access to supports through the Adult Protective Services (APS) Program and, in the case of persons receiving respite services in long-term care facilities, the Division of Residents Protection (DLTCRP) and the Office of State Ombudsman (OSO). DSAAPD case managers and nurses have the ability to consult with APS, DLTCRP and OSO staff in cases in which abuse, neglect, or exploitation is suspected. In some cases, consultation may lead to a formal referral for intervention by APS or DLTCRP. Documentation of this type of referral is kept in TAP case notes. As noted in previous sections of this appendix, remediation actions vary depending on the nature and location of critical incidents. For example, DLTCRP develops corrective action plans for long-term care facilities which are out of compliance with requirements under the state's licensure laws.

APS staff members participate in the overall quality management strategy to provide feedback through representation on the QIC. Staff representatives from DLTCRP and OSO are available to meet with the QIC on an as-needed basis.

Lastly, the DSAAPD case managers and nurses can refer waiver participant concerns about provider agencies to the Division of Public Health (for licensing issues), or to the SUR Unit (for fraud and billing irregularities). Such referrals are documented in case notes within the TAP system.

ii. Remediation Data Aggregation

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

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

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

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

◉ **No**

○ **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 2)

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

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

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

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

Quality Improvement Strategy: Minimum Components

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

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

state spells out:

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

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

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

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

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

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

Trending, prioritizing, and implementing system improvements are carried out as a result of the analysis of aggregated discovery and remediation information. DMMA has delegated many of these processes to DSAAPD, but takes an active role in several components and retains oversight over the E&D Waiver Quality Improvement Strategy as a whole.

The quality improvement mechanisms employed by DSAAPD for the E&D Waiver are also used as part of the quality improvement strategies for the other waivers operated by DSAAPD: the Assisted Living Waiver (#0332.91) and the Acquired Brain Injury Waiver (#0481). DMMA also makes use of its quality improvement systems for multiple Medicaid programs, including the three waivers operated by DSAAPD as well as for the AIDS Waiver (#4159390.R2) operated by DMMA and the MR/DD Waiver (#0009.90.R4) operated by the Division of Developmental Disability Services.

The processes of trending, prioritizing and improvement are conducted by various entities involved in the overall E&D Waiver Quality Improvement Strategy. These processes include: reviewing and analyzing reports to document changes in program outcomes; conducting ongoing dialog with front-line staff; holding regularly-scheduled meetings to identify improvement opportunities; and as needed, developing and implementing corrective action plans.

Specific reports generated include:

- Particpant Questionnaire Report
- Provider Questionnaire Report
- Complaint/Incent Log
- Fair Hearing Report
- Case Review Report

These reports are compiled by DSAAPD staff and submitted to DMMA on a quarterly basis, with the

exception of Fair Hearing Reports, which are completed on an ongoing basis as needed. Systems improvements that result from the review and analysis of these reports are communicated to providers, participants, and other interested persons on an ongoing basis as described in H-1-b-i below.

Following is a description of the specific trending, prioritizing, and/or system improvement processes carried out by the various entities involved in the E&D Waiver Quality Improvement Strategy.

DSAAPD Waiver Coordinator: The DSAAPD Waiver Coordinator plays a central role in all phases of the E&D Waiver Quality Improvement Strategy. The Waiver Coordinator is directly involved in compiling and analyzing data collected through provider surveys, participant surveys, Fair Hearing Reports, Complaint/Incident Logs, Record Reviews, and other tools used in the discovery process, as described in various appendices of this application. The Waiver Coordinator presents the findings directly to the DSAAPD Quality Assurance (QA) Unit and to the DMMA Delegated Services and Medical Management Unit for further review. The Coordinator works with both of these entities to identify trends in the findings and to prioritize system improvement responses. Additionally, the Waiver Coordinator serves as an active member of the Quality Improvement Committee (QIC) and the Quality Initiative Improvement (QII) Task Force to develop avenues for systems improvement. The Waiver Coordinator also works directly with E&D Waiver staff to implement system changes that result from any corrective action plans requested by the DSAAPD QA Unit and/or the DMMA Delegated Services and Medical Management Unit.

Community Services Program (Waiver) Staff: E&D Waiver staff members in the Community Services Program play an active role in the process of implementing systems improvements. Waiver staff members are involved in all phases of the E&D Waiver Quality Improvement Strategy leading up to these improvement activities. They are responsible, for example, for collecting information through the Participant Questionnaire, Record Review Tool, Complaint/Incident Log, Fair Hearing Report, Case Review Log, and Tracking, Assessment and Planning (TAP) System. Nurse supervisors, case management supervisors, and program administrators are in contact with the Waiver Coordinator on an ongoing basis to remediate individual problems. These same staff members participate in the system improvement process through monthly meetings of the QIC for more formalized remediation sessions as well as for the development of plans for program improvements. As needed, Waiver staff work with the Waiver Coordinator to implement changes in response to corrective action plans requested by DSAAPD's Quality Assurance Unit or DMMA's Delegated Services and Medical Management Unit and/or changes recommended by the QIC.

DSAAPD Quality Assurance (QA) Unit: The DSAAPD QA Unit provides support to the Waiver program through the ongoing analysis of outcome data and by actively participating in planning system improvements. Specifically, the QA Unit receives all reports generated by the Waiver coordinator and tracks trends in meeting performance measures. As needed, the QA Unit works with the Waiver Coordinator to develop corrective action plans to address the need for improvements. The QA Unit also staffs DSAAPD's Quality Improvement Committee (QIC) which facilitates monthly discussions leading to remediation and systems improvement.

DMMA Delegated Services and Medical Management Unit: The DMMA Delegated Services and Medical Management Unit reviews outcome reports submitted by the DSAAPD Waiver Coordinator, identifies trends, prioritizes needed improvements, and as needed, requests the development of corrective action plans. The Delegated Service Unit also oversees the Quality Initiative Improvement (QII) Task Force, which provides a venue across various State Medicaid programs, including the E&D Waiver, for discussion of issues and plans for systems improvements.

Quality Improvement Committee (QIC): The QIC meets on a monthly basis to discuss problems and plan for remediation and system improvements. The QIC is organized and staffed by DSAAPD's QA Unit. Membership includes the DSAAPD Waiver Coordinator, E&D Waiver staff (nurse and case manager supervisors and program administrators), staff from Adult Protective Services Program, and others as needed. DSAAPD's Waiver Coordinator oversees the implementation of plans developed by the QIC.

Quality Initiative Improvement (QII) Task Force: The QII Task Force is staffed by the DMMA Delegated Services and Medical Management Unit and meets on a monthly basis. This task force is responsible for providing oversight of waiver program quality activities that validate compliance with assurances, quality improvement plans, and State and Federal requirements. The QII Task Force is responsible for providing a process and a structure for quality reporting, and for monitoring development toward review and approval of quality plans. The task force is also responsible for assuring that waivers and other Medicaid funded programs operate on a path toward continuous quality improvement, seeking opportunities to enhance quality activities and outcomes resulting in improved care to Medicaid Enrollees. The QII Task Force meetings serve as an integrated forum for internal and external partners that support quality reporting, monitoring, and identification

of best practices. DSAAPD's Waiver Coordinator oversees the implementation of any improvement opportunities for the E&D Waiver identified by the QII.

Adult Protective Services (APS): The APS Program supports the quality improvement processes of the E&D Waiver at all phases. APS Staff have principle responsibility for discovery and remediation in cases of abuse, neglect or exploitation of participants. As described in Appendix G, APS works closely with E&D Waiver staff during these phases. APS staff participate on the QIC and, through that venue, engage in more formalized remediation discussions as well as provide input in planning for system improvements.

Division of Long Term Care Residents Protection (DLTCRP): DLTCRP is the agency designated by the State of Delaware to inspect and license long-term care facilities and to investigate allegations of abuse, neglect and exploitation in those facilities. In this role, DLTCRP has responsibility for discovery and remediation of critical incidents which are reported by or on behalf of E&D Waiver participants who receive respite care in long-term care facilities, as described in Appendix G.. DLTCRP staff members are available on an as needed basis to the QIC to participate in discussions and planning for quality improvement as they relate to the provision of services in long-term care facilities.

Office of State Ombudsman (OSO): As described in Appendix G, OSO is the agency designated by the State of Delaware to investigate non-abuse, neglect or exploitation complaints made by or on behalf of residents of long-term care facilities. OSO, like the E&D Waiver, is operated by DSAAPD. OSO has a role in the discovery and remediation phases of the E&D Waiver Quality Improvement System for the waiver, but also works with the Waiver Coordinator to identify trends in outcomes related to services provided in long-term care facilities. The OSO is available to meet with the Waiver Coordinator and E&D Waiver staff on an ongoing basis to assist in remediation activities. In addition, the OSO is available on an as-needed basis to attend meetings of the QIC for more formalized remediation discussions and to participate in identifying and planning for systems improvement opportunities.

Service Providers: Service Providers play an active role in all phases of the quality improvement process for the E&D Waiver, including discovery, remediation, and systems improvement. Providers communicate with the E&D Waiver staff on an ongoing basis to identify and remediate problems. Problem identification is formalized through a provider questionnaire, administered annually, as well through provider meetings, held quarterly by EDS, the Provider Relations Agent and semi-annually by the DSAAPD Waiver Coordinator. As needed, providers work directly with the Waiver Coordinator and/or the QIC to assist in planning for system improvements.

All of these entities play an important role in the quality improvement strategy for this waiver. Clearly, many of the roles and functions of these entities are interrelated. Ultimately, DSAAPD and DMMA share responsibility for implementing waiver program design changes that result from the various processes described above.

ii. System Improvement Activities

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

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system

design changes. If applicable, include the State's targeted standards for systems improvement.

DMMA and DSAAPD share responsibility for monitoring and assessing system improvements. DMMA, as the Medicaid agency, retains authority over this process, but delegates to DSAAPD responsibility for carrying out many of these activities on an ongoing basis.

Following is a description of the specific entities within DSAAPD and DMMA who have responsibility for monitoring and assessing systems improvements, and the processes that they employ to carry out these functions.

DSAAPD QA Unit: DSAAPD's QA Unit plays a principle role in monitoring and evaluating the effectiveness of system improvement activities described in H.1.a.i above. The QA Unit works closely with Waiver Coordinator in developing corrective action plans and in tracking progress made as a result of those plans. In addition, the effectiveness of system improvement activities is assessed during monthly QIC meetings. The QA Unit also assesses the impact of system improvements through the quarterly analysis of changes in program measurement data.

DMMA Delegated Services and Medical Management Unit: The Delegated Services and Medical Management Unit monitors and tracks progress in meeting goals set forth in corrective action plans developed in response to problems evidenced in quarterly reports submitted by DSAAPD. The Delegated Services and Medical Management Unit works with the DSAAPD Waiver Coordinator and the DSAAPD QA Unit to track progress on a quarterly basis.

DSAAPD and DMMA make findings related to these assessments available to stakeholders through a number of avenues. Providers are given program updates through quarterly meetings held by EDS, the provider relations agent, as well as through semi-annual provider meetings convened by DSAAPD's Waiver Coordinator. As needed, changes are made to the E&D Waiver provider manual, which is published on the Delaware Medical Assistance Program (DMAP) website. Participants, families, and other interested parties are informed of program developments through a variety of means, including in-person visits, notification by mail, and/or through postings on DSAAPD's website, as needed.

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

The DSAAPD QA Unit coordinates with the DMMA Delegated Services and Medical Management Unit on an as-needed basis to plan for changes in the E&D Waiver Quality Improvement Strategy, such as making adjustments to the various data collection tools used in the discovery process and to the reports used to aggregate findings.

Monthly meetings of the QII also afford an opportunity for DSAAPD and DMMA to evaluate the effectiveness of the Quality Improvement Strategy for the E&D Waiver.

The E&D Waiver Quality Improvement Strategy is also evaluated during quarterly meetings between DMMA and DSAAPD. These quarterly meetings include the Director of DMMA, the Director of DSAAPD, the head of DSAAPD's Quality Assurance Unit, and the head of DMMA's Delegated Services and Medical Management Unit, as well as other staff involved in the operation and oversight of the waiver. These high level meetings afford both divisions the opportunity to present issues and concerns related to the waiver program, including the effectiveness of the E&D Waiver Quality Improvement Strategy. Discussions generated during these meetings can lead to adjustments in the Quality Improvement Strategy to improve its functionality. Areas of improvement, for example, might include more streamlined communications or more efficient data sharing across system components.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

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

The Delaware State Plan for Medical Assistance identifies the Delaware Department of Health and Social Services (DHSS) as the single state agency responsible for the administration of Delaware's Medicaid program. Within DHSS, there are a number of divisions involved in the administration of the Medicaid program. While the Division of Medicaid and Medical Assistance (DMMA) has primary responsibility for Medicaid in Delaware, other divisions within DHSS assist DMMA with the operation of its Home and Community-Based waivers. The Division of Aging and Adults with Physical Disabilities (DSAAPD) is the operating agency of the E&D waiver. DMMA has responsibility for oversight of E&D waiver.

Delaware employs multiple levels of processes designed to ensure proper payment of claims both pre-and post-adjudication. DMMA contracts with Electronic Data Systems (EDS) to act as its fiscal agent for Medicaid claims payment functions using Delaware's Medicaid Management Information System (MMIS) certified by CMS as meeting the standards for automated systems of this type. All provider service claims are processed through Delaware's MMIS.

Services under the E&D waiver must be prior authorized by the assigned DSAAPD case manager. Prior authorization numbers are entered into the MMIS and claims that do not have the prior authorization number or that are billed for more than the allowable units of service under the authorization are rejected. Additionally, case managers are responsible for monitoring the receipt of services under the E&D waiver and will be able to determine if services are not being provided in accordance with the plan of care. In addition, per the MOU between DMMA and DSAAPD, DSAAPD conducts periodic reviews and audits of service delivery providers, waiver limits, access to care, corrective action plans, etc., and submit reports to DMMA on a quarterly basis.

Additionally, the DMMA Claims Processing Assessment System (CPAS) Coordinator in the Information Systems Unit of DMMA receives a monthly sample of claims generated from the MMIS for the purpose of quality control review. The monthly sample is reviewed to provide an overall assessment of the claims processing operation including: verification of claims payment accuracy, measurement of cost from errors, and establishment of a corrective action plan if needed. The CPAS Coordinator reviews claims against the client eligibility data, provider eligibility data and rate structure. E&D Waiver claims are subject to being included in the CPAS monthly sample.

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

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

For waiver services for which rates are based on provider costs, DSAAPD requires providers to submit an annual independent audited financial statement or a tax return completed by an independent third party or their OMB A-133 audit (required for entities who receive more than $500,000 annually in federal funds). DSAAPD ensures the appropriate documents are received and reviewed annually.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance

complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:
Number and percent of claims for waiver services which are prior-authorized.
(Numerator: claims which are prior-authorized Denominator: all claims)

Data Source (Select one):
Financial records (including expenditures)
If 'Other' is selected, specify:
MMIS Prior Authorization and Utilization 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: Provider Relations Agent	☐ **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:
Number and percent of claims which are processed and paid for according to the reimbursement methodology in the waiver application. (Numerator: claims which are processed and paid for in accordance with approved methodology Denominator: all claims)

Data Source (Select one):
Financial records (including expenditures)
If 'Other' is selected, specify:
MMIS Claims 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: Provider Relations Agent	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation	**Frequency of data aggregation and**

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The Medicaid Surveillance Utilization and Review Unit (SUR) performs reviews of providers to identify fraud, abuse, non-compliance and errors by billing providers. Reviews are to include (but are not limited to) in-patient services, outpatient services, home health services, physicians and pharmacies. The reviews are performed on a quarterly basis.

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.
Providers are selected by the SUR review team for review as a result of the providers ranking on the SRGR330, Provider Profile Exception Ranking Report as it relates to a comparison of the SRGR320, Provider Summary Profile Report (Exceptions) or as the result of a request for review. Sources of requests for review include, (but are not limited to), EDS, Division of Social Services Customer Relations Unit, other providers and recipients.

MSA or designee reviews the SRGR330, Provider Profile Exception Ranking Report to identify the providers with the highest ranking for exceptions and the greatest number of exceptions. After review the 330 reports, the MSA determines the minimum number of exception for review or any other criteria as appropriate.

The SUR review team compares the findings on the SRGR330 report with the SRGR320, Provider Summary Profile Report (Exceptions) to review specific areas in which the provider excepted. The MSA analyzes profiles in order to select providers for review.

The SRGR330, SRGR320 and any other pertinent reports are available in Computer Output to Laser Disc (COLD), for the auditors review.

The SUR team performs an in-depth examination of the providers overall practice patterns. The auditor initiates the investigation by reviewing the exceptions that are listed on the SRGR 320 report and by requesting an SRGR130 report and any other applicable report. The SRGR130, Selected Provider Detail Report (Claims Detail) provides the detailed information regarding Medicaid utilization. This report contains 1 to 15 months of claim details for selected providers based on either date of payment or date of services. The report includes a summary of activity by type of service, procedure, diagnosis and place of service at the end of each detail listing.

The SUR team analyzes the provider claims details, keeping in mind the exception areas & selects a sample of claims detail for documentation and review. Using the Claims Detail, the reviewer may send verification letters to various recipients on the reports selected if appropriate.

When documentation is received it is reviewed by the SUR nurses or appropriate Medicaid Medical Consultant . The Medicaid Medical consultants (physicians, nurses, pharmacy, laboratory or optometrist) will examine the documentation for accuracy of coding, quality of care and appropriateness of services billed. The determinations are returned to the auditor. The auditor reviews the determinations and recommendations of the medical consultant and compiles the final report.

The case dispositions include, but are not limited to:

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

2. Problems identified requiring provider education – no evidence of fraud. Refer for appropriate provider education and, if applicable, a request for reimbursement is sent to the provider by certified mail.

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

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

The request for reimbursement letter explains the findings of the review and gives the provider 30 days to dispute any findings of the review. If, after the 30 day limit the provider has not notified Medicaid that they wish to dispute the findings or they have not reimbursed the overpayment, the recoupment account is established in order to recover the overpayment. The provider may request an administrative hearing per the DMMA general policy provider manual.

If warranted, follow up reviews are scheduled at 6 to 12 month time periods from results notification. Providers who are reluctant to comply with corrective action or where dollar amount identified as overpaid is in excess of $500.00 may be candidates for follow-up reviews.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

Yes

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

Appendix I: Financial Accountability

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

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

Generally, the Medicaid Reimbursement Unit (MRU) of the Division of Medicaid and Medical Assistance is responsible for setting rates for Medicaid services, including some waiver services. However, as this E&D waiver is operated by the Division of Service for Aging and Adults with Physical Disabilities (DSAAPD) and the state share for claims for these services comes from DSAAPD's budget, DSAAPD sets the rates for E&D waiver services. DMMA provides oversight and technical assistance in the rate setting process. These responsibilities are outlined in an MOU between the two divisions.

The rate setting method for all waiver services is the same.

In 1985 baseline rates were established using provider cost reports and norms for the region. Public comments on the rate setting methodology were accepted through the Delaware Register of Regulations.

In subsequent years the baseline rates were inflated as a result of rising provider costs. Provider costs are documented in the Application for Rate/Rate Change for Delaware's Elderly and Disabled Medicaid Waiver Service. This application requires providers to submit their costs for personnel, consultants, contracted services, travel, supplies, equipment and furniture, space, training, profit and miscellaneous expenses. These costs and market requirements are used to determine the annual increase in provider rates. Since rates are cost specific they vary by provider.

In any given year, the enhancement of rates is matched against the availability of budgeted funds. Negotiated or calculated rate increases may not be fully funded by the Delaware state legislature in any given year. For waiver services, it is DHSS's policy that proposed increases must be fully funded. Therefore, in years in which the calculated costs exceed the state waiver budget allocation, actual reimbursement rates may not equal proposed increases. Providers are invited to comment on proposed rate increase at the public budget hearing for the DHSS and again at the Joint Finance Committee Hearing for DSAAPD.

The DSAAPD Waiver Coordinator carries out a pre-qualification process for prospective new waiver providers. New providers are required to submit the Application for Rate/Rate Change for Delaware's Elderly and Disabled Medicaid Waiver Service as part of the budget in the pre-qualification process. Once the budget and other pre-qualification materials have been reviewed, DSAAPD conducts an introductory meeting. Rates are negotiated and agreed upon at this meeting. The rate is sent to DMMA for review and is loaded into the system by EDS.

All wavier participants receive a copy of their care plans that includes a list of authorized waiver services and the cost of the services. Service costs reflect provider approved rates. The waiver participant keeps a copy of the care plan and a signed copy is maintained in the participant record.

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

As with billings for all services provided under the Delaware Medical Assistance Program (DMAP), claims for E&D waiver services are adjudicated by the State's Medicaid Fiscal Agent, EDS, in the MMIS which it manages for DMMA. Providers submit electronic claims in the HIPAA standard 837 transactions (professional or institutional) first to a clearinghouse, Business Exchange Services (BES) which screens them against both HIPAA and Delaware

proprietary minimum claim criteria. Claims are then accepted, in which case they are passed to the MMIS for adjudication if they meet the minimum criteria, or are rejected back to the provider along with the rejection reason. Providers may also submit paper claims on the HCFA 1500 or the UB04 directly to EDS. Paper claims are scanned into the MMIS. Providers may use any claims software that results in a HIPAA standard clean claim. HIPAA compliant claims software, designed by EDS (called Provider Electronic Solutions) is made available to DMAP providers free of charge via download from the DMAP website. Provider billing procedures are described in detail in a series of Provider Manuals on the DMAP website.

Provider claims are accepted 24/7 and are processed for payment once a week after close of business each Friday. Funds for paid claims are considered available for payment the Monday following the Friday financial cycle. Providers may elect to receive payments via check or EFT.

Appendix I: Financial Accountability

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

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

- (○) **No. State or local government agencies do not certify expenditures for waiver services.**
- ( ) **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

***Select at least one*:**

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

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

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

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

Appendix I: Financial Accountability

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

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

Eligibility of Recipients - Applicants for Long Term Care Medicaid are screened against both financial and medical

criteria before being enrolled in the E&D Waiver. If they are enrolled in the waiver, they are assigned an eligibility category unique to the E&D Waiver. This category is used by the MMIS during claims processing to determine which claims can be paid, consistent with waiver service limitations and requirements programmed into the MMIS. The start and stop dates for the period of time the recipient is eligible for E&D waiver services is part of the eligibility record for each waiver recipient stored in the MMIS.

Once eligible for E&D waiver services, each participant is assigned to a case manager. All E&D waiver services must be prior authorized by the case manager with time or unit limits that are entered into the MMIS. The MMIS uses those service limits, combined with the Aid Category code to determine how to adjudicate claims. The MMIS checks each claim submitted by a provider against the eligibility record to insure the person receiving that service was eligible for waiver services on the date of service and that the service was authorized and did not exceed programmed service limitations. It is the case manager's responsibility to monitor each participant's receipt of services pursuant to the care plan and the resulting prior authorizations. Per the MOU between DMMA and DSAAPD, DSAAPD periodically reviews claims data against plans of care to monitor over and under utilization of services. DMMA is responsible for retrospective auditing of paid claims and utilization review of services provided through DSAAPD. This include at the SUR unit review of service utilization.

Provider Eligibility – Only providers enrolled to provide services under the E&D waiver are paid for waiver services. For this purpose, unique waiver taxonomies are assigned to service providers for the E&D waiver. These taxonomies are associated with the provider in the MMIS at the time of enrollment. The MMIS is programmed to only accept claims for waiver services for E&D waiver recipients from providers who are authorized to submit claims under one of the E&D waiver taxonomies.

The amount paid on each claim is based on a rate table which, for the E&D waiver, is based on a combination of procedure code, taxonomy and, in some cases, provider ID, if the rate is provider-specific. Automated pricing algorithms ensure the amount paid for a service meets state policy for that service (i.e. paying the lesser of the billed amount or the rate on file in the MMIS).

During the claims adjudication process, the MMIS is programmed to select a random sample of participants for whom claims were submitted which the system then generates a letter on pre-printed state letterhead to be mailed to each of the selected clients. The letter provides the participant with dates, provider names and specific procedures which Medicaid has been asked to pay on behalf of that participant and asks the participant to indicate whether or not the services were provided and whether he/she was asked to make any payment for these services. It also provides a space for any comments the participant wishes to make. The participant is directed to mail the letter back. Returned letters warranting further investigation are referred to the Surveillance and Utilization Review (SUR) Unit (See Appendix I-1).

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

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

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

- (●) **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- ( ) **Payments for some, but not all, waiver services are made through an approved MMIS.**

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

- ( ) **Payments for waiver services are not made through an approved MMIS.**

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

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

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

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

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

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

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

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

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

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

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

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

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

No. The State does not make supplemental or enhanced payments for waiver services.

Yes. The State makes supplemental or enhanced payments for waiver services.

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

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

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

No. State or local government providers do not receive payment for waiver services. Do not complete Item I-3-e.

Yes. State or local government providers receive payment for waiver services. Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish: *Complete item I-3-e.*

Currently, there are no state or local government entities enrolled as providers in this waiver program. However, the state would enter into an agreement with any willing, qualified provider of services under this waiver, including a public provider. Any approved public provider under this waiver would receive the same reimbursement rates as non-public providers.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.

The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.

The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- (●) **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- ( ) **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- (●) **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- ( ) **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- (●) **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- ( ) **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish

services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

- (●) **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- ( ) **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

  Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ( ) **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one*:

- [x] **Appropriation of State Tax Revenues to the State Medicaid agency**
- [ ] **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

  If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

- [ ] **Other State Level Source(s) of Funds.**

  Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2- c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

- (●) **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.
- ( ) **Applicable**

Check each that applies:

- [ ] **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

- [ ] **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2- c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

- (●) **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- ( ) **The following source(s) are used**

Check each that applies:

- [ ] **Health care-related taxes or fees**
- [ ] **Provider-related donations**
- [ ] **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- ○ **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- ◉ **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

The E&D Waiver provides for respite services in long-term care facility settings as well as in the private residences of participants. Respite services are made available on a short term basis to provide relief to caregivers. Long-term care facility providers receive a per diem payment for needed non-room and board services provided to the participant. The rate includes only those provider costs related to health maintenance (basic nursing care, clinical consultants, social services, dietitian services and activity therapy, etc.).This per diem rate is the same amount made available for daily respite provided in a private home. The respite per diem rate does not cover the room and board costs in any setting.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ◉ **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- ○ **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- ◉ **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- ○ **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**
  - **i. Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- ☐ **Nominal deductible**
- ☐ **Coinsurance**
- ☐ **Co-Payment**
- ☐ **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

- (●) **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ( ) **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	15708.05	6765.00	22473.05	70247.00	2424.00	72671.00	50197.95
2	16199.66	6967.00	23166.66	72284.00	2494.00	74778.00	51611.34
3	16678.40	7176.00	23854.40	74380.00	2567.00	76947.00	53092.60
4	17175.52	7392.00	24567.52	76537.00	2641.00	79178.00	54610.48
5	17692.74	7614.00	25306.74	78757.00	2718.00	81475.00	56168.26

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Number Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		Nursing Facility
Year 1	1616	1616
Year 2	1616	1616
Year 3	1616	1616

Year 4 (renewal only)	**1616**	1616
Year 5 (renewal only)	**1616**	1616

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

Average length of stay (LOS) for waiver clients is assumed to be 296 days per year. This figure is based on the average number of eligibility days for clients who are currently being served in Delaware's Elderly and Disabled Waiver. This average was calculated by accumulating the total number of "client days" (a single day of any one client's day of eligibility is "1" client day) between 10/01/2007 and 09/30/2008 where the MMIS eligibility records showed the client as being active in the E&D waiver and dividing that number (332,931) by the number of unique Medicaid ID Numbers attached to those target eligibility records (i.e. unique clients, 1,123)

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

Utilization and cost patterns in the current E&D waiver served as a basis for the cost estimates in the E&D waiver renewal.

E&D waiver claims data for dates of service in FFY 2008 (10/01/2007 thru 09/30/2008) were used to compile this estimate of waiver costs. Claims data was extracted from the "DE Title XIX Ad Hoc Universe" database, a collection of data tables extracted from the Medicaid Management Information System database each week.

The three main claims tables (Drug, Institutional, and Professional) were queried for any E&D claim for dates of service in FFY 2008. Both regular and crossover claims were extracted.

The E&D waiver service procedure codes list were also extracted from the MMIS data. These procedure codes were used to score the claims as to whether or not the claim involved an E&D waiver service and into what specific waiver service category (e.g. "Personal Care", "Emergency Response", etc.) that procedure code fell. Total units of service were divided by the number of clients on those claims to obtain an average utilization per client and the percent of overall E&D clients availing themselves of the service. The calculated length of stay, percent of clients using services, average client usage, and unit costs were applied to the client count and length of stay numbers to obtain estimated waiver service costs for year 1.

A unit price inflation factor of 3% was used to increase the unit costs from year to year.

In addition, eligibility records for E&D clients were extracted to obtain the total number of "client days" for the waiver for FFY 2008.

The estimated average annual stay of 296 days, or 43weeks or 10 months was used in the calculation of Factor D.

ii. Factor D' Derivation. The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D Prime cost estimates were calculated by using the same claim extract used to estimate the cost for Factor D services including all paid, current, non-voided E&D claims for dates of service in FFY 2008. Those claims which are not related to any service which will be provided under the waiver were considered Factor D Prime claims.

The total costs of these services was compiled and divided two ways, 1) by the number of clients eligible any day in the E&D waiver in FFY 2008 and 2) by the total sum of eligibility days in the E&D waiver in FFY year 2008. The average cost per client was used in the waiver cost estimates for year 1.

In making these calculations, Medicare Part D “clawback” payments(prorated by the estimated percentage of Medicare eligible clients) were addedto arrive at a true per client cost for regular State Plan services.

For subsequent years, costs are inflated by the same inflation factor by which each year's waiver services unit prices are inflated.

iii. Factor G Derivation. The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The total individual days for persons in facilities in SFY 2008 were calculated and grouped by private vs. state facilities. This count of days was retrieved from the unit of service counts on long term care facilities’ “room and board” claims. It was learned that 12% of the individual days were in state facilities while the remaining 88% were in private facilities.

The average length of stay for an E&D waiver participant is estimated to be 296 days. For the purpose of this calculation it was assumed that if this individual was to be placed in a nursing home 12% of those days would be in a state facility and 88% would be in a private facility. The average per diem rates in effect on January 1, 2008 (as calculated and maintained by the Medicaid Reimbursement Unit of the States’ Division of Medicaid and Medical Assistance) for state facilities ($396.62) and private facilities ($207.65) was multiplied by these day counts to obtain an estimate Factor G costs for calendar year 2008.

The inflation factor used in Factors D and D' was applied to this calculation (applied only once) to obtain the estimated Factor G costs for waiver year 1. For subsequent years of the waiver the inflation factor of 2.9 % (Bureau of Labor Statistics Aug 07 to Aug 08 inflation – The same as used for Factor G and G Prime in AIDS Renewal) was applied to the previous year's Factor G amount.

iv. Factor G' Derivation. The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

All claims for dates of service in SFY 2008 where the individual was, at the time of service, a resident in an intermediate care facility were extracted from the State's MMIS database. Those claims for nursing home room and board services were used to obtain the total days (units of service on per diem claims) while those persons were in a nursing home.

All other claims for those persons were used to compile the total costs of other services (i.e. Factor G'). The total costs compiled were divided by the total count of per diem individual/days to obtain a cost per day for "other" services (Factor G'). That figure ($7.96 per day) was inflated by the previously described inflation factor to arrive at the waiver year 1 Factor G' figure of $8.19 per day. Multiplying that daily amount by 296 days is $2,424.24 for the waiver year 1 Factor G' estimate.

Subsequent waiver years' Factor G' amount was inflated by the same inflation factor (as used in factor G above) from the previous year's amount.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “*manage components*” to add these components.

Waiver Services

Specialized Medical Equipment and Supplies
Personal Emergency Response Systems
Personal Care
Respite
Adult Day Services

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Specialized Medical Equipment and Supplies Total:						**845587.80**
Specialized Medical Equipment and Supplies	Product	1002	290.00	2.91	**845587.80**	
Personal Emergency Response Systems Total:						**463823.10**
Personal Emergency Response Systems	Month	1131	10.00	41.01	**463823.10**	
Personal Care Total:						**19628222.04**
Personal Care	15 minutes	1374	1806.00	7.91	**19628222.04**	
Respite Total:						**835865.52**
Respite	15 minutes	259	408.00	7.91	**835865.52**	
Adult Day Services Total:						**3610712.96**
Adult Day Services	Day	307	136.00	86.48	**3610712.96**	
				GRAND TOTAL:		**25384211.42**
				Total Estimated Unduplicated Participants:		**1616**
				Factor D (Divide total by number of participants):		**15708.05**
				Average Length of Stay on the Waiver:		296

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to

automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Specialized Medical Equipment and Supplies Total:						**871740.00**
Specialized Medical Equipment and Supplies	Product	1002	290.00	3.00	**871740.00**	
Personal Emergency Response Systems Total:						**477734.40**
Personal Emergency Response Systems	Month	1131	10.00	42.24	**477734.40**	
Personal Care Total:						**20223768.60**
Personal Care	15 minutes	1374	1806.00	8.15	**20223768.60**	
Respite Total:						**886557.00**
Respite	15 minutes	259	420.00	8.15	**886557.00**	
Adult Day Services Total:						**3718850.64**
Adult Day Services	Day	307	136.00	89.07	**3718850.64**	
				GRAND TOTAL:		**26178650.64**
				Total Estimated Unduplicated Participants:		**1616**
				Factor D (Divide total by number of participants):		**16199.66**
				Average Length of Stay on the Waiver:		296

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Specialized Medical Equipment and Supplies Total:						**897892.20**
Specialized Medical Equipment and Supplies	Product	1002	290.00	3.09	**897892.20**	
Personal Emergency Response Systems Total:						**492098.10**
Personal Emergency Response Systems	Month	1131	10.00	43.51	**492098.10**	
Personal Care Total:						**20819315.16**
Personal Care					**20819315.16**	

	15 minutes	1374	1806.00	8.39		
Respite Total:						**912664.20**
Respite	15 minutes	259	420.00	8.39	**912664.20**	
Adult Day Services Total:						**3830328.48**
Adult Day Services	Day	307	136.00	91.74	**3830328.48**	
				GRAND TOTAL:		**26952298.14**
				Total Estimated Unduplicated Participants:		**1616**
				Factor D (Divide total by number of participants):		**16678.40**
				Average Length of Stay on the Waiver:		296

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4 *(renewal only)*

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Specialized Medical Equipment and Supplies Total:						**924044.40**
Specialized Medical Equipment and Supplies	Product	1002	290.00	3.18	**924044.40**	
Personal Emergency Response Systems Total:						**506914.20**
Personal Emergency Response Systems	Month	1131	10.00	44.82	**506914.20**	
Personal Care Total:						**21439676.16**
Personal Care	15 minutes	1374	1806.00	8.64	**21439676.16**	
Respite Total:						**939859.20**
Respite	15 minutes	259	420.00	8.64	**939859.20**	
Adult Day Services Total:						**3945146.48**
Adult Day Services	Day	307	136.00	94.49	**3945146.48**	
				GRAND TOTAL:		**27755640.44**
				Total Estimated Unduplicated Participants:		**1616**
				Factor D (Divide total by number of participants):		**17175.52**
				Average Length of Stay on the Waiver:		296

Appendix J: Cost Neutrality Demonstration

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5 *(renewal only)*

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Specialized Medical Equipment and Supplies Total:						**953102.40**
Specialized Medical Equipment and Supplies	Product	1002	290.00	3.28	**953102.40**	
Personal Emergency Response Systems Total:						**522069.60**
Personal Emergency Response Systems	Month	1131	10.00	46.16	**522069.60**	
Personal Care Total:						**22084851.60**
Personal Care	15 minutes	1374	1806.00	8.90	**22084851.60**	
Respite Total:						**968142.00**
Respite	15 minutes	259	420.00	8.90	**968142.00**	
Adult Day Services Total:						**4063304.64**
Adult Day Services	Day	307	136.00	97.32	**4063304.64**	

GRAND TOTAL:	**28591470.24**
Total Estimated Unduplicated Participants:	**1616**
Factor D (Divide total by number of participants):	**17692.74**
Average Length of Stay on the Waiver:	296